THE AUSTRALASIAN COLLEGE OF PODIATRIC SURGEONS (ACPS) FOOT AND ANKLE SERVICES

HISPOCIAL DEPARTMENT OF HEALTH AND ACTION OF HEALTH

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INTRODUCTION

The Department of Health has welcomed a policy submission from the Australasian College of Podiatric Surgeons (ACPS) to allow podiatric surgeons' access to the MBS ^{\$47F}, 17 December 2020). This submission represents a new application which is grounded in the data previously provided to MSAC in submission 1344.2 (see Appendix I) and contains additional information and clarification as per the Department's recommendation. The submission provides new evidence to support access by podiatric surgeons to a limited number of MBS items for foot and ankle surgery.

This submission is built upon the principles of equity of access, flexibility in health care delivery and reducing cost burden to Australians who are seeking necessary and appropriate care from podiatric surgeons. This includes both privately insured and non-insured individuals.

If successful, the positive benefits to the community from a policy perspective are significant and appropriate.

Podiatric surgeons have been providing both **inpatient** and outpatient services (foot an ankle surgery) across Australia, including in regional and remote areas for over 40 years. The title '*Podiatric Surgeon*' is protected under national law, and podiatric surgeons are recognised in various State and Federal legal instruments, including:

- Health Legislation Amendment (Podiatric Surgery and Other Matters) Bill 2004;
- National Health Amendment (Prostheses) Act 2005; and
- Private Health Insurance Legislation Amendment Bill 2018.

The training accreditation and activity of Podiatric surgeons is subject to the same regulatory framework as other surgical providers within the provisions of the National Regulation and Accreditation Scheme (NRAS or the National Scheme) under the Health Practitioner Regulation National Law (the National Law).

Uniquely, public funding via Medicare is not available for the patients of podiatric surgeons. Medicare funding for surgical or procedural services, is currently restricted to medical, dental, nurse practitioners and midwives. Foot and ankle surgery is funded by the MBS if delivered by registered medical practitioners.

The purpose of this application is to seek approval from the Department of Health for a limited range of MBS item codes that will address the current inequity in access and the associated confusion and distress experienced by the public seeking the care of podiatric surgeons.

From a policy perspective, allowing podiatric surgeons to access a limited number of MBS funded codes will close the functional gap between the previous legislative reforms (listed above) to normalise podiatric surgeons within the health care sector. Such access represents positive health policy reform.

This policy initiative has precedent, a similar arrangement exists that allows benefits for surgical services performed by Approved Dental Practitioners for the specialty of Oral and Maxillofacial Surgery.

ROLE OF THE PODIATRIC SURGEON IN SERVICE PROVISION IN AUSTRALIA

As noted in the MSAC Application 1344.2, foot and ankle services are currently provided by general practitioners, orthopaedic surgeons, and general surgeons. Similarities in the type of procedures and overall care package provided by these groups and podiatric surgeons was noted in the MSAC applications. Importantly it was noted that podiatric surgeons differ from all other providers of foot and ankle surgery because they publish outcomes data where none exist for all other provider groups.

Podiatric surgeons are granted specialist registration with the Podiatry Board of Australia after completing **extensive specialised postgraduate training and education in podiatric medicine and surgery**. Podiatric surgeons are competent in the diagnosis and treatment of disease, injuries and defects of the human foot and related structures, and use surgical and non-surgical processes to care for bone, joint and soft tissue pathology (Australian & New Zealand Podiatry Accreditation Council Inc., 2012). Under S3AAA of the Health Insurance Act 1973, registered podiatric surgeons are recognised as specialist podiatrists who are approved as accredited and gazetted by the Minister for Health as qualified to provide surgical procedures of the foot and ankle. These procedures are the same as those provided by general, orthopaedic and vascular surgeons.

A key role for podiatric surgeons is contributing to safe, effective and cost-efficient clinical care within multidisciplinary health care teams involving general practitioners, specialists and other health professionals, with appropriate referrals undertaken to support improved quality, safety and health care standards and practice (Australian & New Zealand Podiatry Accreditation Council Inc., 2012).

Podiatric surgeons provide **clinically relevant** non-cosmetic foot & ankle surgical and non-surgical services in a variety of settings, including large private hospitals. They perform surgery under general anaesthesia with specialist anaesthetists and under local anaesthesia which the podiatric surgeon administers. Podiatric surgeons work in collaboration with general practitioners, medical and surgical specialists, nurses and allied health practitioners.

Australian podiatric surgeons have been operating within the Australian hospital system for more than 40 years, with multiple publications supporting the safety and effectiveness of surgery provided by podiatric surgeons (Tamir et al., 2008, van Netten et al., 2013, Thomson and Butterworth, 2020, Matthews et al., 2018) (see also Appendix II). Internationally, podiatric surgeons provide **government funded surgery**: including in the United States of America, and the United Kingdom. Satisfaction with podiatric foot and ankle surgery performed internationally is high.

While Australian podiatric surgeons have the necessary training, skills and regulatory recognition to perform foot and ankle surgery, equity of access and affordability of podiatric surgeons presents as a significant barrier to the community due to a lack of appropriate MBS funding.

The exclusion of Podiatric surgeons from accessing the MBS for procedures which they already safely and effectively conduct in the private setting is ultimately anticompetitive, and unnecessarily limits competition in the market, and certainly market contestability. Competition is important to community welfare because it provides consumers with choice and incentivises providers to reduce costs and maximise use of scarce resources (Australian Government Productivity Commission, 2014).

In acknowledgment of Australia's ageing population and forecasted increase in demand for health services, the 2015 Competition Policy Review (Harper Review) recommended that in the human services (Harper et al., 2015):

...user choice should be placed at the heart of service delivery...

There is another significant issue facing the patients of podiatric surgeons, this relates to the difficulty encountered with referral to medical specialists including anaesthetists and specialist services such as pathology and radiology.

Without access to referral to specialists through the MBS, podiatric surgeons are unable to effectively refer patients in a timely and safe manner for further evaluation when clinically necessary. This has a direct impact on patient safety and does not occur for any other registered surgical specialities in Australia.

ACCESSING FOOT AND ANKLE SURGERY IN AUSTRALIA: THE CURRENT STATE

Currently in Australia, patients may access surgical treatment for foot and ankle surgery by a podiatric surgeon via multiple pathways. The surgery, if undertaken, is performed in a range of settings as appropriate to the clinical pathology and patient requirements.

The current access model is confusing to the consumer. There is inconsistency with funding, and there may be anger and confusion with private health funds. Further, consumers have difficulties with seamless clinical care due to referral pathways not being supported appropriately by the MBS.

Currently patients are **referred by a GP or medical specialist** to either a **podiatric surgeon** or an **orthopaedic surgeon**. Those who are assessed as eligible for surgical treatment are either treated within rooms or admitted to hospital for surgery. Reimbursement via MBS items is possible only in the case of surgery performed by orthopaedic surgeons. No such access is available for podiatric surgeons. The clinical management algorithm for patients needing foot or ankle surgery included was included in MSAC 1344.2 application. In the section on clinical governance below a revised and more detailed clinical algorithm is presented.

MBS funded non-surgical podiatric activity for patients with a chronic condition rose from 395,000 funded services in 2007 to 3.1 million in 2017. MBS activity relating to foot and ankle services has also increased.

UNMET CLINICAL NEED

Demand for foot and ankle surgical services will continue to rise as the Australian population ages, and the risk factors for surgery increase. For example, almost two-thirds of the current population are classified as overweight or obese, and with an estimated prevalence of 1 in 20 Australians having diabetes, a known risk factor for amputation (Davis et al., 2018). The ageing population is at increased risk of a number of foot and ankle conditions that may require surgical correction, including bunion (*hallux abducto valgus*) (Nix et al., 2010), hammer and claw toes (Mishra et al., 2017), osteoarthritis in the big toe (*hallux rigidus*) (Gilheany et al., 2008), and heel pain conditions (Schwartz and Su, 2014).

People with diabetes are at elevated risk of foot and ankle complications including amputation (Frykberg et al., 2020). For example, those with diabetes are more likely to suffer ulceration if they have hammer and claw toes. Diabetes Australia report from 2017, highlights that almost 5 in 100 public hospital beds is the direct result of diabetic foot admissions. This has equated to an annual spend of \$1.6 billion dollars. Thus the ageing population, and the rise in obesity and the chronic conditions that accompany these (e.g., diabetes) mean the need for foot and ankle services in Australia will increase.

Despite this growing demand, the supply of podiatric surgical services is effectively capped. Orthopaedic surgeons face workforce shortages (see Workforce Issues, below), and long hospital waiting lists act as a deterrent to seeking surgical care. The waiting times for elective foot and ankle surgery reflect the overall wait time for orthopaedic surgery (see Appendix II). Patients awaiting surgery by orthopaedic surgeons have some of the longest waiting times for surgical procedures in the country.

But we can reduce these wait times

By providing MBS funded item codes to podiatric surgeons, it is expected that the waiting lists for foot and ankle surgery will decrease (see Table 2). Many of these people are awaiting relatively simple procedures, such as toenail surgery, correction of hammer toes or removal of bunions, all of which podiatric surgeons currently operate on within the private sector. Extending MBS funding to podiatric surgeons will assist the reduction of these waiting lists, encourage more retention and uptake of private insurance and increase opportunities for podiatric surgical participation within the public sector. As such, providing access to MBS funding represents good health policy.

Key points

- 1. Podiatric surgeons have the skills and expertise to perform a range of foot and ankle surgery; including for hallux abducto valgus, hammer and claw toes, hind foot/ ankle pathology, ingrown toenails, hallux rigidus, arthritis, nerve impingement and benign tumours.
- 2. There are extensive wait lists for publicly funded foot and ankle surgery in Australia
- 3. There is extensive evidence that podiatric surgeons have the skills, knowledge and professionalism to undertake specialist foot and ankle surgery
- Providing MBS items for the services of podiatric surgeons to perform foot and ankle surgery may improve surgical wait times.
- There is outcomes evidence to support the complete package of care delivered to patients by podiatric surgeons

The current lack of MBS rebates for podiatric surgical services and referral pathways presents as a barrier to delivery of world best practice.

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WORKFORCE ISSUES

Workforce issues and an ageing population mean will only increase the demands on an already strained situation.

As noted above, there remains significant demand for publicly funded foot and ankle surgery. In 2016, there were 1,286 orthopaedic surgeons employed in Australia (Australian Government - Department of Health, 2016). Not all of these surgeons provide foot and ankle surgical services. A 2016 report suggested that almost one-quarter of orthopaedic surgeons are aged 60 or over (Australian Government - Department of Health, 2016). NSW, TAS, VIC and WA have less orthopaedic surgeons per 100,000 population than the national average (Australian Government - Department of Health, 2016). The number of new fellows per year has remained reasonably static (about 50 per year) for the period 2013-2015. Thus the Department of Health have flagged the ageing workforce and the duration of the training program as significant workforce concerns for **orthopaedic surgeons**.

Indicator	Description Status
Ageing of workforce	Workforces with higher average ages are more susceptible to higher exit rates due to retirements.
Replacement rate	This measure indicates whether trainee numbers are sufficient to replace the numbers leaving the workforce.
Duration of training program	This measure indicates how long it takes to train a replacement workforce.

FIGURE 1 ORTHOPAEDIC SURGERY WORKFORCE CONCERNS (AUSTRALIAN GOVERNMENT - DEPARTMENT OF HEALTH, 2016)

The Royal Australasian College of Surgeons has also identified workforce issues, recommending that in order to maintain 2010 ratios of orthopaedic surgeons to the population aged 65 or over, more than 680 additional surgeons are needed (Royal Australasian College of Surgeons, 2011). This exposes the health system to the risk of lengthening public hospital waiting lists. Consequently, more Australians will be forced to live with chronic pain and disability.

The number of foot and ankle surgeries performed over the last four years has decreased (Australian Institute of Health and Welfare, 2020), a trend likely due to capacity and the impacts of COVID-19, rather than demand. In the same period, the median wait times for these procedures has increased or remained steady (Australian Institute of Health and Welfare, 2020). Up to 14% of patients are waiting more than 1 year for surgery (Table 2). Wait times are particularly long in NSW and Queensland for *hallux valgus* repair.

In NSW, these foot and ankle procedures are recommended to be completed within 1 year (Category 3) (see https://www.health.nsw.gov.au/policies/manuals/Documents/pmm-12.pdf), yet up to 1 in 10 are not achieving this benchmark. Further the burden of payment if a patient elects to be treated by a podiatric surgeon falls either with the patient themselves or with the private health insurer with no funding from MBS funding, resulting in significant out-of-pocket costs.

Given the ageing population, and an increase in comorbidities, we should expect that the rates of surgical repair of foot and ankle issues is increasing. However, this is not the case (see Figure 2). This is perplexing – and perhaps reflects the decreased capacity for surgical repair, or perhaps in the case of the sharp decrease in toenail surgery in 2019-2020 reflects the suspension of elective surgery during the COVID-19 pandemic. In NSW alone, primary care consultations were reduced by 20%, and planned surgical activity was reduced by almost one-third (Sutherland et al., 2020).



FIGURE 2 NUMBER OF SELECTED FOOT AND ANKLE SURGERIES PERFORMED ANNUALLY (AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE, 2020)

In a post-COVID world, patients will likely resume their usual health care seeking behaviour (Sutherland et al., 2020), with resultant increases in demand for surgical services.

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Surgery / State		Median waiting time (days)			Proportion (%) of patients who waited more than			Total number of surgeries performed					
							365 days f	or surgery					
		2016-2017	2017-2018	2018-2019	2019-2020	2016-2017	2017-2018	2018-2019	2019-2020	2016-2017	2017-2018	2018-2019	2019-2020
Hallux	ACT	NR	NR	NR	NR	NR	NR	NR	NR	27	11	10	9
valgus	NSW	281	252	267	277	13.7	3.4	9.6	13.7	256	237	240	183
(removal)	NT	NR	NR	NR	NR	NR	NR	NR .	NR/	<5	<5	<5	7
	QLD	126	118	197	155	0.8	4.8	41	6.7	124	125	147	134
	SA	NR	NR	NR	NR	NR	NR	NR		27	27	24	23
	VIC	67	69	71	94	1.8	1.8	3.8 <	3.5	222	328	316	259
	WA	132	130	120	102	5.1	4.4	0.8	0.9	158	136	118	106
	National	137	121	142	137	7.5	3.8	5.6	7.5	818	865	858	721
Hammer	ACT	NR	NR	NR	NR	NR	NR NR	NR	NR	<5	7	<5	<5
toe correction	NSW	NR	NR	NR	NR	NR 🔍	NR	NR	NR	76	44	75	63
	NT	NR	NR	NR	NR	NR	NR	NR	NR	<5	<5	<5	NR
	QLD	NR	NR	NR	NR	NR	NR	NR	NR	37	48	55	37
	SA	NR	NR	NR	NR	SNR	ŇR	NR	NR	21	20	8	15
	VIC	63	69	80	84	0.0	4.0	2.6	2.8	211	199	156	106
	WA	NR	NR	NR	NR	NR	NR	NR	NR	46	44	19	17
	National	81	88	97	106	2.0	4.4	2.5	5.0	397	363	317	240
Toenail	ACT	NR	NR	NR	NR	NR	NR	NR	NR	22	18	25	13
surgery	NSW	46	47	44	49	0.3	0.2	0.3	1.3	655	563	613	456
	NT	NR	NR	NR 🔿	NR	NR	NR	NR	NR	20	21	27	23
	QLD	42	55	480 2	60	0.3	0.9	0.6	1.0	351	318	310	309
	SA	27	25	× 22 </td <td>25</td> <td>0.0</td> <td>0.0</td> <td>0.0</td> <td>0.7</td> <td>155</td> <td>134</td> <td>133</td> <td>134</td>	25	0.0	0.0	0.0	0.7	155	134	133	134
	VIC	26	27	29	35	0.4	0.8	0.2	0.0	522	524	520	382
	WA	21	27	29 0	48	0.4	0.0	0.4	0.6	27	136	234	169
	National	33	34	36	45	0.4	0.4	0.3	0.7	1 998	1 814	1 862	1 486

TABLE 1 MEDIAN WAIT LIST TIMES (DAYS) FOR SELECTED FOOT AND ANKLE PROCEDURES (AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE, 2020)

NR: not reported.

UNMET FINANCIAL NEED

The patients of podiatric surgeons are discriminated against and denied fair and timely access to services due to the current lack of Medical Benefits Schedule rebates for the services provided by podiatric surgeons – both for surgical services and referral pathways. This lack of MBS rebates is a barrier to the delivery of world best practice and inequitable for patients who are treated by a podiatric surgeon. It also negatively impacts rebates through the private health industry framework. **\$47G**

Currently the cost of care is borne mainly by the patient, with some private health insurers (e.g. BUPA) not covering podiatric surgery for any policy holder. These patients must bear the cost of fees in full (including surgeon fees, anaesthetist fees and hospital fees).

This situation persists despite the inclusion of podiatric surgeons within the private health insurance reform of 2018.

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Current funding arrangements for provision of foot and ankle surgery are?

- MBS-rebated surgery by vascular, orthopaedic, plastic and general surgeons in addition to GPs
- Privately funded surgery by a **podiatric surgeon** in both the inpatient and outpatient settings

This funding model is inequitable, placing reliance on funding of podiatric foot and ankle surgery on either the patient themselves, or on private health insurers. This removes patient choice when accessing foot and ankle surgical services, acting as a barrier to flexibility in health care delivery and patient choice. A significant concern when the best evidence of outcomes is available for the only group of registered specialist surgeons who do not have MBS funded for such services.

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¹ MSAC Application 1344.2 'Critique Report', p. 56.

THE ACPS PROPOSES

The ACPS is now seeking access to a smaller number of MBS items than was described in previous MSAC applications (see Appendix I). Each of the currently proposed items included in this submission is linked to evidence of activity from podiatric surgeons within Australian and supported by international experience. These specified services (although not reflective of the full scope of procedural activity) cover a range of podiatric surgeons' scope of practice which the ACPS defines as

"the diagnosis, surgical and adjunctive treatment of disease, injuries and defects of the human foot and ankle and associated structures".²

These include treatment of patients with one or more foot or ankle conditions within the following eight clinical groupings:

- hallux valgus
- hammer and claw toes
- hind foot / ankle pathology
- ingrown toenails
- hallux rigidus
- arthritis
- nerve impingement
- tumour (benign)

These patients require surgical management typically in a same day setting.

We propose that podiatric surgeons be able to access funding for the proposed list of clinical services described in this submission.

PROPOSAL FOR PUBLIC FUNDING

Since the MSAC 1344.2 submission, and as recommended by the Department (S47F), 17 December 2020), we are now proposing alternatives to the previously proposed replication of orthopaedic surgery items. In 2004, the *Health Legislation Amendment (Podiatric Surgery and Other Matters) Act 2004 (Cth)* was passed, which legislated accreditation of podiatrists in Australia, allowing access to 'profession attention' by podiatrists under the *Health Insurance Act 1973 (Cth)*. Thus, we believe the proposed services listed below would **qualify as MBS** services under MBS funding rules. The updated proposed list of MBS item descriptors have been based on existing MBS descriptors. Modifications have been made to more accurately describe contemporary podiatric foot and ankle surgical practice and are reported in Table 2 and Table 3.

We request that the legislative and regulatory enablers are put in place to support this submission.

To ensure effective and safe delivery of a package of care to patients requiring foot and ankle surgery, we will require a legislative amendment that lists podiatric surgeons as providers of professional services under the MBS. These services will be limited to those patients that have a valid referral from a general practitioner or medical specialist. Such services will be provided under appropriate clinical governance, as outlined elsewhere in this submission.

² This definition has been formally adopted by the ACPS

We are seeking two professional services MBS items, and 27 therapeutic items. We have mapped these services to those currently available to orthopaedic surgeons, but which more accurately describe podiatric surgical practices. We also seek the ability for referral to specialists, pathology and advanced imaging. We seek anaesthetist rebates when an operation is performed by a registered podiatric surgeon.

FOI 4477

TABLE 2 PROPOSED MBS ITEM DESCRIPTORS FOR PROFESSIONAL ATTENDANCES

Category 1 – Professional Attendances

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 104 (Fee: \$89.55)

Description: Professional attendance at consulting rooms or hospital by a specialist podiatric surgeon in the practice of his or her specialty after referral of the patient to him or her - each attendance, other than a second or subsequent attendance, in a single course of treatment.

Category 1 – Professional Attendances

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 105 (Fee: \$45.00)

Description: Professional attendance by a specialist podiatric surgeon in the practice of his or her specialty following referral of the patient to him or her - an attendance after the first in a single course of treatment, if that attendance is at consulting rooms or hospital.

NON PREJUDICIAL DRAFT FOR DISCUSSION

TABLE 3 PROPOSED MBS ITEM DESCRIPTORS FOR THERAPEUTIC PROCEDURES

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 51300 (Fee: \$89.00)

Description: Assistance at any operation identified by the word "Assist" for which the fee does not exceed \$XXX.XX or at a series or combination of operations identified by the word "Assist" where the fee for the series or combination of operations identified by the word "Assist" does not exceed \$XXX.XX.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 51303

Description: Assistance at any operation identified by the word "Assist" for which the fee exceeds \$XXX.XX or at a series of operations identified by the word "Assist" for which the aggregate fee exceeds \$XXX.XX.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 18272 (Fee: \$64.45)

Description: SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent in the perioperative treatment of podiatric pathology.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 49833 (Fee: \$534.00)

Description: Unilateral surgery for hallux valgus or rigidus including salvage via arthroplasty or osteotomy of metatarsal (with or without fixation).

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 49845 (Fee: \$485.40)

Description: Arthrodesis of the 1st metatarsophalangeal joint.

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 47960 (Fee: \$135.95)

Description: FOOT; Subcutaneous tenotomy as an independent procedure.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to:48400 (Fee: \$339.85)

Description: FOOT; Accessory bone of phalanx or metatarsal, bone osteotomy, osteectomy or excision (without internal fixation).

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 48403 (Fee: \$534.00)

Description: FOOT; Phalanx or metatarsal osteotomy or osteectomy of, with internal fixation.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 50106 (Fee: \$485.40)

Description: JOINT OF THE FOOT OR ANKLE, stabilisation of, involving one or more of: repair of capsule, repair of ligament with /without internal fixation, not being a service to which another item in this group applies.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 50109 (Fee: \$485.40)

Description: MAJOR JOINT OF THE FOOT OR ANKLE: arthrodesis of, not being a service to which another item in this group applies, with synovectomy if performed.

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 50127 (Fee: \$724.45)

Description: JOINT OF THE FOOT OR ANKLE, arthroplasty of, by any technique not being a service to which another item applies.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 47954 (Fee: \$388.30)

Description: TENDON, repair of, which has its insertion in the foot as an independent procedure.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 49809 (Fee: \$223.25)

Description: FOOT TENDON; open tenotomy or tenoplasty.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 49709 (Fee: \$728.10)

Description: ANKLE; ligamentous stabilisation of.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 49718 (Fee: \$388.30)

Description: FOOT; repair of Achilles tendon, tibialis posterior tendon, tibialis anterior tendon, or other major tendon.

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 48406 (Fee: \$339.85)

Description: FIBULA or TARSUS osteotomy or ostectomy of, excluding services to which items 47933 or 47936 apply.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 49854 (Fee: \$388.30)

Description: FOOT; radical plantar fasciotomy or fasciectomy of.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 31350 (Fee: \$446.90)

Description: FOOT OR ANKLE; benign tumour of soft tissue, including tumours of skin, cartilage, nerve and bone, simple lipomas and lipomata, removal of by surgical excision, where specimen is sent for histological confirmation, on a person of 10 years of age or over, not being a service to which another item in this group applies.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 39330 (Fee: \$285.45)

Description: FOOT OR ANKLE; neurolysis by open operation without transposition.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 49866 (Fee: \$310.45)

Description: FOOT; neurectomy for plantar or digital neuritis.

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 47915 (Fee: \$174.80)

Description: INGROWING NAIL OF TOE; wedge resection for, with removal of segment of nail, ungual fold & portion of nail bed.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 47916 (Fee: \$87.80)

Description: INGROWING NAIL OF TOE; partial resection of nail, with destruction of nail matrix by phenolisation, electrocautery, laser, sodium hydroxide or acid but not including excision of nail bed.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 47918 (Fee: \$242.85)

Description: INGROWING NAIL OF TOE; radical excision of nail bed.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 47930 (Fee: \$271.80)

Description: BURIED WIRE, PLATE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of requiring incision and suture, not being service to which item 47927 or 47930 applies - per bone.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 44359 (Fee: \$272.15)

Description: ONE OR MORE TOES OF ONE FOOT; amputation of, including if performed, excision of one or more metatarsal bones of the foot, performed for diabetic or other microvascular disease, excluding aftercare.

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 47726 (Fee: \$145.65)

Description: BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous small quantity.

Category 3 – Therapeutic Procedures

Proposed Item Number: [to be determined by the Department]

Current MBS Code most closely related to: 30223 (Fee: \$168.05)

Description: HAEMATOMA, ABCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare)

ECONOMIC IMPACT

.ission. The economic impact is based on the costs for the most closely associated MBS item code. This analysis, and the updated impact will be added prior to the full submission.

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CLINICAL GOVERNANCE

Nationally, the outcomes of surgeries provided by ACPS members is available publicly (https://www.acps.edu.au/publications). To our knowledge, no other craft group/specialist surgical college provides this level of clinical analysis of its members' surgical outcomes.

As part of the ACPS's commitment to best practice clinical governance, including alignment with the National Safety and Quality Health Service (SNQHS) Standards (Australian Commission on Safety and Quality in Health Care, 2017), qualitative data on patient outcomes has been routinely presented to the Chief Executive Officers of selected private hospitals in WA and SA. This model is to be expanded to a national program.

Podiatric surgeons have a robust clinical governance system, that provides qualitative & quantitative data feedback on patient outcomes.

Services by podiatric services are provided under a **clinical governance framework** (see Appendix I – ACPS Clinical Governance Framework), which includes rigorous **mandatory clinical audit** and **national peer review**. The **Clinical Governance Committee** provides oversight, and effectively supports management of clinical risks, continuous improvement, and benchmarking. Such benchmarking helps to reduce unwarranted clinical variation in outcomes. All members of the ACPS are required to comply with the governance framework, including participation in quality and audit programs.

The ACPS Registry (clinical audit) records and reports in real time all procedures undertaken by podiatric surgeons, any complications experienced by patients, additional treatment and other associated information that can track clinical outcomes. This registry is used by the ACPS to ensure its members are operating in a best practice manner and allows for continuous quality improvement.

In addition to the clinical algorithm model reported in MSAC Submission 1344.2, the ACPS has now formalised a robust **clinical governance framework** and has expanded the **Clinical Governance Committee**. Together, the policies and audit program ensure **safe**, **effective**, **person-centred care**.



FIGURE 3 MBS FUNDED PODIATRIC SURGERY PROVIDING PERSONALISED, CONNECTED, SAFE CARE

This clinical governance model helps to manage unwarranted clinical variation.

In an expansion of the previous submitted clinical algorithm, Figure 3 describes the patient journey for MBS funded podiatric surgery. This is **a patient-centred model**, based on a partnership approach between patient and surgeon. It is supported by the **ACPS Clinical Governance Framework**, from the commencement of the patient referral to final discharge.

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The ACPS Clinical Governance Framework and associated clinical governance systems allow for effective and safe patient care. The ACPS governance framework is grounded by and references external regulatory guidelines such as those published by the Australian Council on Healthcare Standards (ACHS), National Prescribing Service, Australian Health Practitioner Regulatory Authority (APRHA), Podiatry Board of Australia and various State and Federal policies and guidelines.

The ACPS Clinical Governance Framework, in concert with a suite of policies and guidelines, continually evolves based on feedback and outcomes data via the ACPS Clinical Governance Committee. This supports the College's objectives of ensuring the patient is a partner in their care for the entire patient journey. This partnership approach includes shared decision-making about options, risks, and benefits of podiatric surgery.

The following provides a description of what is to occur within each of the steps in Figure 3.

THE CORE ELEMENTS

THE PATIENT

The patient is a core partner in this model. Addressing the needs and individual circumstance of the patient in a transparent, culturally sensitive manner. This strategy of engagement ensures patient education (allowing for variation in health literacy), collaboration, and choice. In addition to specific attention to consumer rights and responsibilities, the principles of consent and communication are embedded in the process.

THE SURGEON

The surgeon will be able to demonstrate ongoing capabilities as expected, supported and monitored via the ACPS Clinical Governance Framework. This is in addition to the expectations of regulation and registration coupled with the principle of lifelong learning. The surgeon partners with the patient to safely navigate an episode of care to final discharge.

GOVERNANCE

Underpinning the whole process is recognition, compliance, and integration with the ACPS Clinical Governance Framework which incorporates monitoring, national peer review and continuing professional development (CPD). This framework also references and is supported by policy, including:

- clinical capacity & capability
- clinical governance (including mandatory clinical audit against available national benchmarks)
- safety, quality & risk policies
- clinical care standards
- incidents & complaints management processes
- credentialing & scope of practice policy

THE COLLABORATIVE JOURNEY

REFERRAL

Patients will be referred by their general practitioner or medical specialist. In order to be considered a valid referral for the purpose of MBS funding, the referral should describe the reason for referral, such as seeking assistance for a clinically relevant foot or ankle condition.

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The relationship between referrer and referee will be based upon communication systems which ensure the referrer understands the scope of practice, specific skill set of the podiatric surgeon and the potential financial impact of the referral.

This communication strategy should, where possible ensure all necessary tests, investigations and medical history are available for the podiatric surgeon.

For example, the referral should contain information which enables the podiatric surgeon to appreciate:

- the reason for referral
- health risk factors (diabetes, cardiovascular, etc.)
- previous interventions that have been used to manage the condition

The podiatric surgeon will utilise the systems within the clinical governance framework, to assess the referral prior to scheduling an assessment appointment. This will ensure the referral is relevant and or appropriate.

ASSESSMENT

The podiatric surgeon will perform a clinical assessment and determine what non-surgical and surgical treatment options are available to improve the patient's quality of life (QOL), specifically in relation to foot and ankle health.

Once options in care have been identified the podiatric surgeon will consider the patients individual circumstance to identify specific risk factors which may act as barriers to effective and safe implementation of the specific options for podiatric surgical intervention.

The process is one of **shared decision-making** based on the patient being provided with all relevant information including non-operative interventions, risks, and benefits of surgical interventions.

This process has several potential outcomes: including the need for a further assessment by the referrer or another health care practitioner. If surgery is indicated communication to the patient's referring practitioner will indicate this outcome. Where referrer/alternative review is required a detailed explanation as to reasons is provided which then supports further investigation. This is communicated to the referral source and implemented.

CARE PLAN

If the podiatric surgeon has recommended surgery a patient-centred approach to the scheduling of the surgery will be discussed. This will mean a discussion will take place which clearly outlines the risk and benefits of surgery, alternative options including obtaining a second opinion. A detailed explanation of the surgical procedure, expected outcomes, post-operative course and possible complications will then occur. An assessment and discussion will also be undertaken with the patient to determine for example whether a general or local anaesthetic is appropriate, and what other measures are required given the patient's individual risk factors such as antibiotics and pain management requirements. Factors that may impact on these decisions and must be considered include:

- medication history and allergies
- infection control issues
- blood history
- falls history & risk
- skin integrity
- cognitive impairment/ delirium
- mental health
- suicide/risk of harm
- nutrition

- aggression
- social issues
- cultural needs

Surgery and post-operative appointment dates are then determined and agreed with the patient. All information for surgery is provided to the patient and relevant hospital as part of preadmission processes. In addition, a letter to the referrer is also sent which outlines the proposed surgery date, procedure, treatment plan, possible complications and post-operative protocols that need to be followed.

SURGERY

The podiatric surgeon performs surgery according to the operative plan, acknowledging that some procedural variation is inevitable depending on operative findings. In the case of hospital admission (local or general anaesthesia) the episode of care will also be subject to standard preadmission screening by the hospital prior to confirming admission.

A **Discharge Summary** of the procedure outcomes, post-operative medications and any perioperative concerns that have arisen is provided to the patient and to the patient's referring and general practitioner. The expected post-operative course (3 to 12 months) should also be communicated to both the patient and referring practitioner.

OUTCOME

Given the preoperative screening and post-operative risk analysis process it is expected that patients will be discharged to their home environment without adverse events. s47G

All podiatric surgeons are trained in advanced life support (regulatory requirement) and provide such support in both the hospital and office settings. In all situations where sedation or general anaesthesia is used an anaesthetist is present for the entire procedure and is responsible for medical management during the surgical event and for 24 / 48 hours after the procedure.

If the patient requires overnight stay and adjunctive medical management is required, the podiatric surgeon will refer to a physician who has admitting rights at the hospital to provide such management during the admission.

Identified preoperative risk factors such as the need for thromboembolic prophylaxis will be managed through a collaborative approach with the patient's general practitioner or medical specialist to ensure appropriate perioperative medical care is provided.

The podiatric surgeon is qualified and competent in managing localised complications related to the foot or ankle surgery, for example infection, wound breakdown, and failure of fixation. Referral to physicians and or other surgeons may be indicated depending on the response to primary treatment provided by the podiatric surgeon. All patients are contacted within 24-48 hours of discharge to assess progress and the need for further intervention with the post-operative appointment being confirmed.

The podiatric surgeon is qualified and competent in recognising signs and symptoms of medical complications for example deep vein thrombosis (DVT), cardiac events, drug reactions and will refer to general practitioners, physicians and or other surgeons and/or emergency departments depending upon the circumstance.

The podiatric surgeon will, as the case indicates during the post-operative period, use the support of other healthcare practitioners such as podiatrists and physiotherapists.

DISCHARGE SUMMARY

On completion of the post-operative care, a final discharge summary is sent to the referral source.

The ACPS governance framework mandates that outcomes data is finalised within the ACPS Clinical Audit. Post-surgical satisfaction surveys are also used.

ACPS Audit: The College audit program is a real-time system which enables instant upload and reporting of data. Such data is reviewed by the ACPS Clinical Governance Committee and enables easy identification of unwarranted variation relating to surgical complications and readmissions within 28 days. Where required, surgeons are contacted for an explanation of their variation. All case outcomes are reviewed via national peer review and support the College culture of a learning organisation.

Post-Surgery Satisfaction Survey: This forms part of the Evaluation of Outcomes and identification of Unwarranted Variation in Care Outcomes. Based on a trial conducted in Western Australia a random audit of 50 admissions nationally per year will be conducted. Patients are sent a satisfaction survey post-discharge which enables an assessment as to whether care and treatment was based on a partnership approach with shared decision-making. Results are independently analysed and where required a clinical review is initiated. Reports are provided to the surgeons and to the hospital CEO where the surgeon is credentialed for surgery. Results can also be benchmarked.

CONSUMER IMPACT

Failure to proceed with foot and ankle surgery results in preventable impacts on quality of life including:

- pain;
- difficulty walking;
- difficulty wearing footwear;
- difficulty exercising;
- difficulty in participating in recreational activities;
- loss of mobility;
- loss of limb;
- loss of life;
- reduction in quality of life;
- economic losses due to work absenteeism and lack of participation in the workforce due to disability

If a patient cannot afford treatment from a podiatric surgeon, but cannot avoid it either, they need to return to their general practitioner for (an avoidable) referral to a medical practitioner and may join the waiting list for public hospital care.

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Recent publications have reported that while podiatric surgery improves health-related quality of life and is associated with lower rates of complication, including non-union, infection, and venous thromboembolism (Thomson and Butterworth). Further, post-discharge surveys on patient satisfaction have reported that almost 9 in 10 patients report being highly satisfied following podiatric surgery (Thomson and Butterworth, 2020).

Indeed, in that analysis, from 596 reported surgeries performed in WA or SA, there were only 2 readmissions (0.4%). The five most common procedures included in that analysis were wedge resections of ingrown toenail, correction of hallux valgus by osteotomy, correction of claw toe, correction of claw toe with internal fixation, or excision of exostosis of small bone (Thomson and Butterworth, 2020).

There is a high level of satisfaction with foot and ankle surgical services provided in Australia by podiatric surgeons.

As noted in MSAC Application 1344.2, it is the patient that bears the burden of avoided or delayed podiatric surgery, living with foot and ankle pain, or having their health needs met by podiatric surgeons while facing high out-of-pocket costs. **These out-of-pocket costs occur even if the consumer has private health insurance.**

If a patient cannot afford treatment from a podiatric surgeon but cannot avoid it either, they need to return to their GP for (an avoidable) referral to an orthopaedic surgeon, and either join the waiting list for public hospital care, or seek private orthopaedic care (with access to MBS items). **Surgical waiting lists are only likely to extend as patients delay surgery due to the COVID-19 pandemic.**

In all cases, the differential treatment of podiatric surgeons with respect to MBS funding has a limiting impact on consumers' choice of provider.

Therefore, this application has a significant beneficial impact for consumers.

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These costs can be reduced if patients have private health insurance that pays benefits for podiatric surgery, which only materially includes HBF, limited further as HBF currently only provide rebates for clients based in Western Australia.

Provision of MBS item codes to podiatric surgeons has the potential to positively impact patients, both financially and indirectly through improvements in quality of life due to reduced waiting times for procedures.

³ This report is provided to the Department as supporting evidence for this submission.

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APPENDIX I - MSAC SUBMISSION 1344.2

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APPENDIX IV – ACPS CLINICAL GOVERNANCE FRAMEWORK

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Foot and ankle services by Podiatric Surgeons



Response to outstanding items of interest as identified by the Department of Health

Prepared by the Australasian College of Podiatric Surgeons PO Box 248, Collins Street West, Vic 800

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ACRONYMS AND ABBREVIATIONS

Acronym/abbreviation Meaning

ACPS	Australasian College of Podiatric Surgeons
ACPSR	Australasian College of Podiatric Surgeons Registry
AHPRA	Australian Health Practitioner Regulation Agency
ALERT	Acute life-threatening emergencies, recognition and treatment
AMC	Australian Medical Council
ANZPAC	Australian and New Zealand Podiatry Accreditation Council
AOA	Australian Orthopaedic Association
AOFAS	American Orthopaedic Foot and Ankle Society scale
ASA	American Society of Anaesthesiologists
ASSET	Australian and New Zealand Surgical Skills Education and Training
AWU	University of Western Australia
BSSET	Basic surgical skills education and training
CCrISP	Care of the Critically III Surgical Patient
CPD	Continuing professional development
CRS	Clinical Rating Scale
СТ	Computed tomography scan
DAP	Decision Analytic Protocol
DMAA	Distal metatarsal articular angle
DVT	Deep vein thrombosis
EMST	Early Management of Severe
FFI-R	Foot Function Index Revised Short Form Questionnaire
FHSQ	Foot health status questionnaire
GP	General practitioner
HRQoL	Health-related quality of life
HV	Hallux abducto valgus
HVA	Hallux valgus angle
IDR	In-depth referee
IMA	Intermetatarsal angle
MBA	Medical Board of Australia
MBS	Medical Benefit Schedule
MID	Minimal important difference
Ministerial Council	Australian Health Workforce Ministerial Council
MRI	Magnetic resonance imaging
MSAC	Medical Services Advisory Committee
MPJ	Metatarsophalangeal joint
NRAS	National Registration and Accreditation Scheme
OCD	Osteochondritis dessicans
PASC	Protocol Advisory Sub-committee
PASCOM	Podiatric Audit of Surgical Outcome Measures
PATSAT	Patient satisfaction questionnaire

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PBS	Pharmaceutical Benefits Scheme
PHI	Private health Insurance
QoL	Quality of Life
RACS	Royal Australasian College of Surgeons
RACS	Royal Australasian College of Surgeons
SET	Surgical Education and Training
SF-36	Short Form 36 Health Survey
UK	United Kingdom
USA	United States of America
UWA	University of Western Australia
VTE	Venous thromboembolism

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EXECUTIVE SUMMARY

Podiatric surgeons work in a variety of settings, including hospitals. They provide both surgical and nonsurgical services. When operating they perform surgery under local anaesthesia (which is administered by the podiatric surgeons) and also patients under general anaesthesia (working with specialist anaesthetists). The title 'Podiatric Surgeon' is protected under national law, and podiatric surgeons are recognised in various state and federal legal instruments.

Podiatric surgeons work in collaboration with medical, surgical and allied health practitioners. Podiatric surgeons are subject to clinical audit and peer review.

The current lack of MBS rebates for podiatric surgical services and referrals pathways presents as a barrier to delivery of world best practice.

Main issues for MSAC consideration

As a result of our previous submission the Australasian College of Podiatric Surgeons (ACPS) has been asked to report on five key issues, which are the particular focus of this Applicant Developed Assessment Report (ADAR).

 Evidence of non-inferiority to orthopaedic surgeons. Considerable Australian and international literature demonstrates podiatric surgeons have the skills, knowledge and professionalism to undertake specialist foot and ankle surgery.s47G s47G

s47G . Australian evidence is provided on the involvement of podiatric surgeons at the High-Risk Foot Clinic, Heidelberg Repatriation Hospital to assess the safety and efficacy of percutaneous tenotomy for the management of diabetic digital ulcers in the outpatient setting between December 2015 and October 2017; and international evidence demonstrates the impact of podiatric surgeons working within teams in the NHS public and private system, which support the case that podiatric surgery outcomes are at least non-inferior to orthopaedic outcomes from the same settings.

- 2. New evidence which shows the need for podiatric surgeon services in Australia. New data shows extensive wait times for public hospital elective orthopaedic surgery of the foot and ankle, a flattening in orthopaedic surgeon numbers since 2009, and long term growth in demand for MBS funded foot and ankle surgery and elective orthopaedic surgeries, GP encounters related to plantar fasciitis, MBS-funded podiatric services available to people with chronic medical conditions and the prevalence of foot pain. Growth is highest for those aged between 55 and 64 years, which is the fastest growing population segment. Newer data on ED presentations related to dislocation, sprain and strain of joints and ligaments of the ankle or foot also show growth.
- 3. **Requested set of MBS items relevant to current scope of practice and linked to evidence.** The ACPS has almost halved its number of requested surgical MBS items to ensure each item is linked to evidence of Australian and international activity with non-inferior or superior outcomes, and specified services that cover the range and complexity of podiatric surgeons' established scope of practice in Australia and internationally.
- 4. Revised cost analysis. s47G s47G

5. Evidence to support the complete package of care delivered to patients. This report demonstrates that the complete package of care delivered to patients from podiatric surgery is equivalent to the comparator. The complete package of care provided by podiatric surgeons is safe and effective based on multiple Australian and international studies. One study from the High-Risk Foot Clinic, Austin Health, Victoria with a podiatric surgeon demonstrates effective outcomes from a multi-disciplinary setting, concluding podiatric surgery is associated with high levels of patient satisfaction and quality of care outcomes, independent of external factors such as socio-economic status. While there are no public health positions held by podiatric surgeons in Australia, podiatric surgeons work closely within multi-disciplinary teams in private health landscapes on a daily basis, and details of this are provided. Evidence is also provided from abroad, where podiatric surgeons have for decades formed integral components of multi-disciplinary teams delivering surgical services in public and private settings. Letters of Reference from Consultant Orthopaedic Surgeons from the NHS is provided to this effect.

FOOT AND ANKLE SERVICES BY PODIATRIC SURGEONS

This submission provides new evidence to support a resubmission to MSAC for podiatric surgeons to access a limited number of MBS item numbers for surgery of the foot and ankle.

The service would be used in either the public or private setting based on clinical services where there is demonstrated non-inferiority to orthopaedic surgeons. Orthopaedic surgeons are already accessing these MBS item numbers for surgery of the foot and ankle.

The target population is patients with one or more foot and ankle conditions within eight clinical groupings. The ACPS contends that successful listing in the target population and setting will lead to non-inferior clinical and safety outcomes for patients, and substantially lower out-of-pocket costs to patients.

This report follows two prior applications to the Medical Services Advisory Committee (MSAC) (Application Numbers 1344 and 1344.1), and provides information on five issues that have been identified by the Department of Health as requiring new evidence, namely:

- refinement of (and justification for) a discrete set of MBS items relevant to current scope of practice that is shorter and more evidence based than the list identified in the ACPS's previous MSAC submission (see Section A);
- 2. the unmet need for podiatric surgeons' services (see Section A);
- 3. evidence of non-inferiority to orthopaedic surgeons (see Section B);
- 4. impacts on the MBS of accessing those item numbers for which there is demonstrated noninferiority to orthopaedic surgeons (see Section E), and
- 5. assurance about the complete package of care delivered to patients, including evidence on the ability of podiatric surgeons to work in multi-disciplinary teams (see Section A and B).

These five issues were identified in response to comments made at the April 2015 and March 2016 MSAC meetings, where MSAC considered and did not support providing public funding for podiatric surgeons to access selected MBS items.

Since this time, the ACPS has collected extensive comparative data on non-inferior outcomes, community need, member activity and relative performance in Australia and internationally to address previously identified shortcomings.

ALIGNMENT WITH AGREED PICO CONFIRMATION

The PICO has not been confirmed with MSAC prior to this submission and previous applications to MSAC were based on a decision analytic protocol. The Department of Health has agreed that the ACPS is entering the Applicant Developed Assessment Report (ADAR) process at a late stage, and a ratified PICO is not required. A PICO is included in this ADAR.

PROPOSED MEDICAL SERVICE

Podiatric surgeons are podiatrists (registered specialists) who have completed extensive additional peri operative medical and surgical training in addition to a four-year undergraduate podiatry degree. Podiatric Surgeons currently operate in private practice (including private hospitals, day surgery centres, and office based settings), with selected examples of public hospital activity, as unlike in the United Kingdom and the USA, there are currently no public hospital podiatric surgical positions in Australia.

The proposed medical service includes a limited set of existing MBS codes for selected foot and ankle procedures, services and consultations to improve patient access to these surgical services in both the private and public sector.

PROPOSAL FOR PUBLIC FUNDING

No new MBS items are proposed to be listed. Rather, podiatric surgeons seek access to 23 existing surgical MBS items that are relevant to its scope of practice, based on clinical evidence of non-inferiority, the provision of a complete package of care and five general items (Table 1). Implicit in this submission is the request for MBS funding for co-administered services that are routinely used in providing a complete package of patient care by podiatric surgeon in conjunction with surgical procedures. Such co-administered services include those for imaging, pathology and anaesthesia. The referral rights requested are the same s to the current MBS rights for orthopaedic surgeons when they provide foot and ankle surgery.

MSAC has previously been advised that allowing MBS access for podiatric surgeons to co-administered therapies would be appropriate.

...This is reasonable given that: podiatric surgeons are trained to provide these services within the 'whole episode of care' model; and access to these services could improve the overall patient flow by reducing the need for the patient to return to the GP to access co-administered services...¹

General	Description
104	Professional attendance at consulting rooms or hospital by a specialist in the practice of his or her specialty after referral of the patient to him or her-each attendance, other than a second or subsequent attendance, in a single course of treatment, other than a service to which item 106, 109 or 16401 applies
105	Professional attendance by a specialist in the practice of his or her specialty following referral of the patient to him or her-an attendance after the first in a single course of treatment, if that attendance is at consulting rooms or hospital, other than a service to which item 16404 applies
51300	Assistance at any operation identified by the word "Assist." for which the fee does not exceed \$558.30 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed \$558.30
51303	Assistance at any operation identified by the word "Assist." for which the fee exceeds \$558.30 or at a series of operations identified by the word "Assist." for which the aggregate fee exceeds \$558.30
18272	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent
Surgical	
31350	BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, and bone, simple lipomas covered by item 31345 and lipomata, removal of by surgical excision, where specimen is sent for histological confirmation, on a person 10 year of age or over, not being a service to which another item in this Group applies
39330	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item 39312 applies
44359	ONE OR MORE TOES OF ONE FOOT, amputation of, including if performed, excision of one or more metatarsal bones of the foot, performed for diabetic or other microvascular disease, excluding aftercare
47915	IGTN, wedge resection for, with removal of segment of nail, ungual fold & portion of nail bed
	INGROWING NAIL OF TOF partial resection of nail, with destruction of nail matrix by phenolisation

MBS item descriptor for items proposed for access by podiatric surgeons Table 1

47918	Ingrown toenail, radical excision of nailbed	
47930	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of requiring incision and suture, not being a service to which item 47927 or 47930 applies - per bone	
47954	TENDON, repair of, as an independent procedure	
47960	TENOTOMY, SUBCUTANEOUS, not being a service to which another item in this Group applies	
48400	Phalanx, Met, accessory bone osteotomy or ostectomy (unless fixated toe applies)	
48403	Phalanx or Met osteotomy or osteectomy of, with internal fixation	
48406	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply	
49709	ANKLE, ligamentous stabilisation of	
49718	ANKLE, Achilles' tendon or other major tendon, repair of	
49809	FOOT, open tenotomy of, with or without tenoplasty	
49833	Unilateral HAV by osteotomy with or without internal fixation and with or without excision of exotoses	
49836	Bilateral HAV by osteotomy with or without internal fixation and with or without excision of exotoses	
49845	Arthrodesis of, 1st MT joint, with synovectomy if performed	
49854	FOOT, radical plantar fasciotomy or fasciectomy of	
49866	FOOT, neurectomy for plantar or digital neuritis	
50106	JOINT, stabilisation of, involving one or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies	
50109	JOINT, arthrodesis of, not being a service to which another item in this Group applies, with synovectomy if performed	
50127	JOINT OR JOINTS, arthroplasty of, by any technique not being a service to which another item applies	

POPULATION

The conditions to which podiatric surgery relates correspond to eight clinical groupings:

- hallux abducto valgus (HAV);
- hammer and claw toes;
- hind foot/ankle pathology;
- ingrown toenails;
- hallux rigidus;
- arthritis;
- nerve impingement, and
- tumour (benign).

No exclusion criteria are proposed, whether on the basis of age, severity or other factors. As set out in Section A, unmet demand among the proposed population is indicated by the following.

Wait times for public hospital elective orthopaedic surgery of the foot and ankle are poor, averaging 85 days and being the third longest wait period of all specialities, with wait times of 229 days for procedures like excision of an exostosis, leaving patients living with pain, discomfort, and reduced quality of life. With a discernible flattening orthopaedic surgeon numbers since 2009, there is unlikely to be a change in the capacity of orthopaedic surgeons to exclusively provide MBS funded foot and ankle surgeries.

Multiple data indicate that future patient demand will grow, including growth in the 105 Medicare Benefits Schedule (MBS) items exclusively associated with foot and ankle surgery (of which this submission is seeking access to 23), the number of elective orthopaedic surgeries conducted in Australian public hospitals, ED presentations related to dislocation, sprain and strain of joints and ligaments of the ankle or foot, the number of GP encounters related to plantar fasciitis, the prevalence of foot pain, MBS-funded podiatric services available to people with chronic medical conditions, and complex care needs managed by a GP.

There is also additional unmet demand from patients that cannot access podiatric surgical services because of high out-of-pocket costs. The punitive out-of-pocket cost to patients to access podiatric surgeon services without recourse to the MBS limits affordability and results in patients foregoing the care they need. Hence, the level of podiatric surgical services is effectively capped as it is necessarily limited to patients that can afford high out-of-pocket costs without recourse to the MBS. s47G

COMPARATOR DETAILS

Foot and ankle MBS services are currently performed by GPs, orthopaedic, and general surgeons. However, podiatric surgical procedures most closely align with those of orthopaedic surgeons, who are the selected comparator. s47G foot and ankle services provided by orthopaedic surgeons are the appropriate main comparator, re-iterated by MSAC at the April 2015 meeting.¹

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¹ Australian Government Medical Service Advisory Committee. 2015, 'Public Summary Document: Application 1344 — Assessment of Foot and Ankle Services by Podiatric Surgeons (foot and ankle conditions – various)', Australasian College of Podiatric Surgeons, MSAC 63rd Meeting, 1-2 April 2015, Section 9, p 5.

Both professions share similar traits in terms of:

- skill sets;
- conditions treated;
- the model of care ('whole of episode');
- patient assessment with diagnostic testing, and
- procedure variety and post-operative care, notwithstanding that orthopaedic surgeons perform a wider range of surgeries, including spine, hip and shoulder surgeries in addition to foot and ankle surgeries.

CLINICAL MANAGEMENT ALGORITHM(S)

Although clarified the clinical management algorithm is essentially unchanged by this application, except in two respects:

- For podiatric surgeons operating in a private hospital setting, outpatient clinic, day surgery centre or consultation room, there is **no change** to the clinical management algorithm aside from allowing access to MBS items for procedures that are otherwise (currently) fully funded by patients (in some cases, part funded by private health insurance). Hence the change relates to the cost to patients in private/community sectors where they already receive surgical services from a podiatric surgeon. There is no change to the clinical management algorithm for these patients.
- Unlike in the United Kingdom and USA, there are currently no funded positions for podiatric surgeons operating in Australian **public hospitals**. This could change if podiatric surgeons were able to offer their services in public hospitals, as they currently offer them in other settings. This report points to Australian examples where podiatric surgeons have operated in public hospitals as part of a publicly funded study. It is noted that most of the MBS items are proposed to be for admitted (in-hospital) patients. Therefore, allowing MBS access would enable podiatric surgeons to service public hospital patients where there is evidence of non-inferiority to orthopaedic surgeons. This would constitute a change the clinical management algorithm for admitted public hospital patients.

Hence, this proposal is about (i) expanding potential coverage of podiatric surgery activity to the public sector for surgeries that are already being provided in the private setting, and (ii) for all patients of podiatric surgeons to be able to access MBS items for specific (clinically appropriate and with noninferior outcomes) surgeries, as they are able to access them for comparable procedures performed by orthopaedic surgeons.

Key Differences in the Delivery of the Proposed Medical Service and the Main Comparator

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While there are differences in the training program for podiatric and orthopaedic surgeons (set out previously in MSAC Public Summary document for Application 1344), under S3AAA of the Health Insurance Act 1973, registered podiatric surgeons are recognised as specialist podiatrists who are approved as accredited and gazetted by the Minister for Health as qualified to provide surgical procedures of the foot and ankle. These procedures are the same as those provided by general, orthopaedic and vascular surgeons.

CLINICAL CLAIM

For the eight clinical groupings specified, podiatric surgeons are at least non-inferior to orthopaedic surgeons in terms of clinical safety and efficacy in undertaking foot and ankle surgery and associated pre-operative and post-operative care.

For the 23 surgical MBS items shown in Table 1, safety and efficacy of podiatric surgical activity would be at least non-inferior to orthopaedic surgery.

This clinical claim is presented in **Section B** of this application.

APPROACH TAKEN TO THE EVIDENCE ASSESSMENT

In order to compare the outcomes following foot and ankle surgery by podiatric and orthopaedic surgeons, data from the ACPS Registry was compared to data available from South Australia Health and Tasmania Health. All p-values are two-sided superiority (i.e. *'is there a difference'*) hypothesis tests with p<0.05 considered statistically significant.

WHAT IS THE ACPS REGISTRY?

The register referred to in the application is the national peer reviewed audit of foot and ankle surgical outcomes by fellows of the ACPS.² The ACPS audit was developed under the governance of a University research project.

² Improving the outcomes of foot and ankle surgery. Professional impact of the Australasian College of Podiatric Surgeons' audit tool. Hermann R, Meuter R, Bennett P. Journal of Foot and Ankle Research 2015, 8(Suppl 2):O18.

The project used a case study design to examine the audit activity of general, orthopaedic, plastic and podiatric surgeons who practice in Australia. Enablers and barriers to audit participation identified by the case study guided a Delphi survey of experts who practice or are associated with foot and ankle surgery. Orthopaedic surgeons practicing in the USA, UK and Australia participated in the Delphi survey.

Consensus derived from the Delphi survey guided modification of the Royal Australasian College of Surgeons (RACS) recommended list of data that should be collected and reported when auditing surgical outcomes. An online audit tool capable of reporting individual and national aggregate surgical outcomes in real-time was developed, piloted and operationalised as the ACPS national audit.

Since 2012, the ACPS national audit has provided real-time outcome reporting, practice change identification and positively affected safety and quality management within a national peer review environment.³ (2,3). Mandatory participation in the ACPS audit and peer review of adverse outcomes is required for fellows to maintain annual College accreditation. Since 2012 there has been 100% audit compliance by all ACPS fellows. ACPS National Audit Reports are available from: acps.edu.au/audit-reports/

CHARACTERISTICS OF THE EVIDENCE BASE

In addition to the analyses presented from the South Australian Health, Tasmanian Health, and ACPS Registry (ACPSR), a literature search was undertaken to assess whether there are differences in safety or effectiveness in patients undertaking ankle or foot surgery conducted by a podiatric surgeon compared to an orthopaedic surgeon. Overall the quality of available evidence is grade III-2, with data coming from administrative data, surveys or retrospective cohorts.

COMPARATIVE SAFETY

The safety of surgery undertaken by a podiatric surgeon can be shown to be non-inferior to that undertaken by an orthopaedic surgeon. s47G

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³ See Butterworth P, Terrill A, Barwick A, Hermann R, 2017, 'The use of prophylactic antibiotics in podiatric foot and ankle surgery', Infection, Disease and Health, March 2017; and Mathews J H, Terrill A J, Barwick A L. 2018, 'Venous Thromboembolism in Podiatric Foot and Ankle Surgery. Foot and Ankle Specialist.

COMPARATIVE EFFECTIVENESS

The effectiveness of surgery undertaken by a podiatric surgeon can be shown to be non-inferior to that undertaken by an orthopaedic surgeon. <u>Reason for surgery</u>: In the database analysis, and several of the other analyses reported in the literature, reason for surgery was matched between surgeon type. The reason for surgery in the literature reflected the requested scope of practice for this submission. <u>Length of Stay</u>: Of significance, length of stay in patients who undergo foot and ankle surgery with orthopaedic surgeons appears to be significantly longer than the length of stay reported in patients who undergo foot and ankle surgery with podiatric surgeons. This was also reflected in analysis of both the *SA* and *Tasmanian* datasets. <u>Patient preference</u>: Patients appear to prefer surgery undertaken by a podiatric surgeon.

ECONOMIC EVALUATION

To reflect the non-inferiority findings of the clinical evaluation a cost-minimisation is presented. The analysis estimates the cost per patient associated with complication management (DVT and infection) and prosthesis use. The cost of the requested MBS item is not included in the economic model, as the relevant MBS item and its respective cost would be the same whether delivered by a podiatric or orthopaedic surgeon.

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ESTIMATED EXTENT OF USE AND FINANCIAL IMPLICATIONS

Estimates of use and costs to the MBS are provided under a 'low' and 'high' scenario to respond to an inquiry from the Department of Health that MBS listing might result in an expanded podiatric surgeon workforce.

The 'low' scenario is based on the current podiatric surgeon workforce in the first year and forecast workforce trends as reported in the ACPS 2019 survey of the podiatric surgeon workforce.

The 'high' scenario assumes that MBS access attracts additional podiatric surgeons and enables current practitioners to expand their patient case load.

Both scenarios assume there is no substitution in activity with orthopaedic surgeons, and all podiatric surgery for the 23 requested MBS items represents a new cost to the MBS.

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CONSUMER IMPACT SUMMARY

It is patients that bear the burden of avoided or delayed podiatric surgery, living with foot and ankle pain, or having their health needs met by podiatric surgeons while facing high out-of-pocket costs.

If a patient cannot afford treatment from a podiatric surgeon but cannot avoid it either, they need to return to their GP for (an avoidable) referral to an orthopaedic surgeon, and either join the waiting list for public hospital care, or seek private orthopaedic care (with access to MBS items).

In all cases, the differential treatment of podiatric surgeons with respect to MBS funding has a limiting impact on consumers' choice of provider.

Therefore, this application has a significant beneficial impact for consumers.

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⁴ This report is provided to the Department as supporting evidence for this submission.

SECTION A

CONTEXT

The three key issues of **context** which the ACPS has been asked to substantiate for this ADAR:

- refinement of (and justification for) a discrete set of MBS items relevant to current scope of practice, that is shorter, and more evidence based than the list identified in the ACPS's previous MSAC submissions (refinement of the 'Intervention' of the PICO)
- 2. the unmet need for podiatric surgeons' services (within the 'Population' of the PICO), and
- assurance about the package of care delivered to patients, including evidence on the ability of podiatric surgeons to work in multi-disciplinary teams (part of the 'Outcome' of the PICO). We note that evidence of non-inferiority with the comparator is discussed in Section B.

These issues are addressed in a way that is consistent with investigative guidelines for an MSAC application (Section A) to facilitate the MSAC resubmission process.

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About Podiatric Surgeons

In Australia, podiatric surgeons are specialist podiatrists who are qualified and registered to provide surgical procedures of the foot and ankle. However, they are subject to limited theatre access in the private sector due to lack of MBS rebates for the services they provide, and do not have admitting rights in the public sector, as opposed to colleagues overseas. Podiatric surgeons operate in a variety of locations including day surgery facilities and hospitals. The choice of facility is guided by the complexity of the procedure, the requirement for anaesthesia, and the age and health of the patient and associated comorbidities.

Podiatric surgeons complete a training program accredited by the Australian and New Zealand Podiatry Accreditation Council. The Podiatry Board of Australia (the Board) is the governing body that oversees the registration of podiatrists and Podiatric surgeons in Australia.⁵ The Board is supported by the Australian Health Practitioner Regulation Agency (AHPRA) which is guided by the Health Practitioner National Law Act 2009. AHPRA works with the Board to ensure that Podiatric surgeons are registered, suitably trained, behave ethically and are competent. The overarching objective of AHPRA and the Board is to protect the health and safety of the public.⁶

⁵ Podiatry Board of Australia. 2017, 'Registrant data, Reporting period: 1 October 2017 – 31 December 2017', available at: http://www.podiatryboard.gov.au/About/Statistics.aspx.

⁶ Australian Health Practitioner Regulation Agency. 2015, 'Regulatory principles for the National Scheme', available at: https://www.ahpra.gov.au/About-AHPRA/Regulatory-principles.aspx.

Under S3AAA of the Health Insurance Act 1973, registered podiatric surgeons are also recognised as specialist podiatrists who are approved as accredited and gazetted by the Minister for Health as qualified to provide surgical procedures of the foot and ankle. These procedures are the same as those provided by general, orthopaedic and vascular surgeons.

In order to maintain annual College accreditation Podiatric surgeons who are members of the ACPS are required to adhere to a suite of policies that govern surgical practice. These policies include - mandatory audit participation and peer review. College members are also required to follow a clinical pathways in order to ensure that patients receive a complete package of care. The clinical pathway followed by College fellows are referred to in the Clinical Management Algorithm (figure 5).

Podiatric surgeons are already servicing a sizeable proportion of market for podiatric surgery. This is particularly so for a selection of procedures, such as:

- surgery for hallux valgus correction (equivalent MBS item(s) 49833, 49836 and 49821)
- surgery for management of Achilles tendon rupture in the ankle (equivalent MBS item 47921)
- surgery for subcutaneous tenotomy in the foot (equivalent MBS item 49806), and
- surgery for the correction of claw or hammer toe (equivalent MBS item 49848).

For these surgeries, podiatric surgeons service 30-52 per cent of the total case-load, pointing to large patient numbers that are having to access surgery privately, without recourse to the MBS (Table 2).

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A.1. ITEMS IN THE AGREED PICO CONFIRMATION

The PICO has not been confirmed with MSAC prior to this submission and previous applications to MSAC were based on a decision analytic protocol. The Department of Health has agreed that the ACPS is entering the Applicant Developed Assessment Report (ADAR) process at a late stage, and a ratified PICO is not required. A PICO is included in this ADAR.

A.2. PROPOSED MEDICAL SERVICE

Podiatric Surgeons are podiatrists who have completed extensive post graduate peri operative medical and surgical training in addition to a four-year undergraduate degree in podiatry. Podiatric surgeons currently operate in private practice (including private hospitals, day surgeries and office), with selected examples of public hospital activity, as unlike in the United Kingdom and the USA, there are currently no public hospital podiatric surgical positions in Australia.

The proposed medical service includes a limited set of existing MBS codes for selected foot and ankle treatments, services and consultations to improve patient access to these surgical services in both the private and public sector.

Key issue #1: Set of MBS items relevant to current scope of practice

A.3. PROPOSAL FOR PUBLIC FUNDING

The ACPS has refined the set of MBS items to which podiatric surgeons seek access to, in response to the request from MSAC that items be aligned to evidence of need and comparable safety and effectiveness with orthopaedic surgeons. There are 23 nominated surgical codes and 5 general codes included in this ADAR.

MBS items have been selected based on:

- published clinical literature that demonstrates podiatric surgeons are already operating in all of these areas. These studies also provide evidence of quality safety and efficacy outcomes (Table 3). The full citation for each source is provided in the reference list. We note that information on the training podiatric surgeons receive in relation to each item number can also be provided if requested;
- detailed statistical analysis comparing outcomes and patient characteristics for each item code when activity is performed by podiatric vis-à-vis orthopaedic surgeons, drawing on the past four years of data from the ACPSR and MBS data respectively (Section B);
- comparisons with government-funded podiatric surgery in the UK recorded by Podiatric and Surgical Clinical Outcome Measurement (PASCOM-10) for podiatric surgeons undertaking foot and ankle surgery and podiatrists undertaking nail surgery in the UK for the NHS or private practice over the past 9 years (Table 4); and
- Australian podiatric surgery workforce survey data on the most commonly performed procedures (Table 5).

This item list is substantially reduced from the ACPS's previous list to facilitate this application and best align with available evidence.

 Table 3
 Evidence of podiatric surgeons working in each surgical area

Therapeutic procedures

49809 FOOT, open tenotomy of, with or without tenoplasty

Clinical examples: Peroneal tendon repair, tendon transfer, adductor tendon release, flexor lengthening

Literature: Gilheany, 2019; Shane, Reeves, Cameron, & Vazales, 2016; Smith, Camasta, & Cass, 2009a; Viegas, 2003; Vosoughi, Ravanbod, Gilheany, Erfani, & Mozaffarian, 2018; (D. Samaras & Kingsford, 2013)

49866 FOOT, neurectomy for plantar or digital neuritis

Clinical examples: Neuroma excision

Literature: (P. Bennett, 2007), (Addante, Peicott, Wong, & Brooks, 1986; Brosky & Burchill, 2014; Still & Fowler, 1998)

47915 IGTN, wedge resection for, with removal of segment of nail, ungual fold & portion of nail bed

Clinical examples: Chronic painful ingrown nail

Literature: (P. Bennett, 2007; Lemont & Brady, 2002; Rusmir & Salerno, 2011 (Rounding & Hulm, 2001; D. J. Samaras & Kingsford, 2017)

47918 Ingrown toenail, radical excision of nailbed

Clinical examples: Chronic painful dystrophic nail

Literature: (P. Bennett, 2007; Cook, Jones, Dobie, Geront, & Hermann, 2008; Lemont & Brady, 2002; Metcalfe & Bristow, 2015; Rusmir & Salerno, 2011)

31350 BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, and bone, simple lipomas covered by item 31345 and lipomata, removal of by surgical excision, where specimen is sent for histological confirmation, on a person 10 year of age or over, not being a service to which another item in this Group applies

Clinical examples: Multiple lesions. Note importance of access to histology and referral to other specialist surgeons and physicians.

Literature: (Baarini & Gilheany, 2016: P. Bennett, 2007: Bours & Gilheany, 2007: Connolly & Ratcliffe, 2010: III, Sangueza, & Schwartz, 2017: Lemont & Brady, 2002: Taranto & Havlat, 2018)

48400 Phalanx, Met, accessory bone osteotomy or ostectomy (unless fixated toe applies)

Clinical examples: Hammer toes, bone spur resection

Literature: (Beech, Rees, & Tagoe, 2005; P. Bennett, 2007; Mark Gilheany, Baarini, & Samaras, 2015; Mark F. Gilheany, 2002; Mark F Gilheany & Amir, 2013; O'Kane & Kilmartin, 2005; D. Samaras & Kingsford, 2013)

49845 Arthrodesis of, 1st MT joint, with synovectomy if performed

Clinical examples: Hallux rigidus and hallux valgus surgical procedures

Literature: (P. J. Bennett; Cichero, Yates, Joyce, Williamson, & Walsh, 2019; Mark F Gilheany, Landorf, & Robinson, 2008; M. F. Gilheany & Robinson, 2009; A. J. Maher, 2017)

48403 Phalanx or Met osteotomy or osteectomy of, with internal fixation

Clinical examples: Hallux valgus. Hallux rigidus (decompression). Hammertoe correction and metatarsal osteotomies

Literature: (Bryant, 2001; Bryant, Tinley, & Cole, 2004; Cicchinelli, 2013; Harmer, Wilkinson, & Maher, 2017; Timothy Edward Kilmartin, 2005; Timothy E. Kilmartin & O'Kane, 2010)

47954 TENDON, repair of, as an independent procedure

Clinical examples: Peroneal tendon repair. Tibialis posterior tendon rupture

Literature: Reza Vosoughi, Ravanbod, Gilheany, Ali Erfani, & Mozaffarian, 2018; Smith et al., 2009a(D. Samaras & Kingsford, 2013)

50127 JOINT OR JOINTS, arthroplasty of, by any technique not being a service to which another item applies

Clinical examples: Metarso cuneiform arthritis. Hallux rigidus

Literature: (Clews, Kingsford, & Samaras, 2015; Mark F Gilheany & Amir, 2013; Roukis, Landsman, Ringstrom, Kirschner, & Wuenschel, 2003)

39330 NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item 39312 applies

Clinical examples: Distal tarsal tunnel release. Neural entrapments Eg: Morton's & Joplin's

Literature: (D. Samaras, 2011)

50109 JOINT, arthrodesis of, not being a service to which another item in this Group applies, with synovectomy if performed

Clinical examples: Talar navicular fusion for flat foot. Metarso cuneiform arthrodesis. Sub talar arthrodesis. Hammertoe arthrodesis

Literature: Camasta, Menke, & Hall, 2010; Cicchinelli, 2013; Schwartz, Kihm, & Camasta, 2015; Smith, Camasta, & Cass, 2009b

47930 BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of requiring incision and suture, not being a service to which item 47927 or 47930 applies - per bone

Clinical examples: Painful internal fixation. Loose internal fixation

Literature: (A. Maher & Wilkinson, 2011; National Audit Summary Report, 2015; National Audit Summary Report 2017)

48406 FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply

Clinical examples: Dorsal midfoot spurring. Bone graft harvest

Literature: (Feeney, Rees, & Tagoe, 2007; Smith, Camasta, & Cass, 2009; Withey, Murphy, & Horner, 2014)

49854 FOOT radical plantar fasciotomy or fasciectomy

Clinical examples: Chronic heel pain. Compartment syndromes of the foot.

Literature: (Benton-Weil, Borrelli, Weil, & Weil, 1998; Fishco, Goecker, & Schwartz, 2000; Karlock & Kirk, 2006; National Audit Summary Report 2016)

47916 INGROWING NAIL OF TOE, partial resection of nail, with destruction of nail matrix by phenolisation, electrocautery, laser, sodium hydroxide or acid but not including excision of nail bed

Clinical examples: Recurrent ingrown nail adolescent

Literature: (Dovison & Keenan, 2001; National Audit Summary Report 2017; Rounding & Hulm, 2001)

49836 Bilateral HAV by osteotomy with or without internal fixation and with or without excision of exotoses

Clinical examples: Hallux valgus techniques

Literature: (P. Bennett, 2007; Bryant, 2001; Bryant et al., 2004; M. F. Gilheany & Robinson, 2009; Timothy E. Kilmartin & O'Kane, 2010)

49833 Unilateral HAV by osteotomy with or without internal fixation and with or without excision of exotoses

Clinical examples: Hallux valgus techniques

Literature: P. Bennett, 2007; M. F. Gilheany & Robinson, 2009) (Bryant, 2001; Bryant et al., 2004; Timothy E. Kilmartin & O'Kane, 2010)

44359 ONE OR MORE TOES OF ONE FOOT, amputation of, including if performed, excision of 1 or more metatarsal bones of the foot, performed for diabetic or other microvascular disease, excluding aftercare

Clinical examples: Diabetic amputations

Literature: Joyce, Yates and Cichero, 2019, McCallum and Tagoe, 2012

49709 ANKLE, ligamentous stabilisation of

Clinical examples: repair of ruptured ankle ligaments, ankle ligament stabilisation

Literature: (DeVries, Scharer, & Romdenne, 2019; Piraino, Busch, Sansosti, Pettineo, & Creech, 2015; Rigby, Cottom, & Rozin, 2015)

49718 ANKLE, Achilles' tendon or other major tendon, repair of

Clinical examples: Achilles repair or rebalancing, tibialis posterior tendon transfer

Literature: Cicchinelli, Huerta, Carmona, & Morato, 2008(DeCarbo & Bullock, 2017; Ramanujam & Zgonis, 2017; D. Samaras & Kingsford, 2013; Shane, Reeves, Cameron, & Vazales, 2016)

47960 TENOTOMY, SUBCUTANEOUS, not being a service to which another item in this Group applies

Clinical examples: Tendon lengthening for deformity associated with flexor extensor tendon imbalance. Resulting in pain and or ulceration risk.

Literature: (Caputo, Fahoury, & Johnson, 2012; M Gilheany, 2019a, 2019b, Smith & Miller, 2019)

50106 JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation

Clinical examples: Spring ligament repair, metatarso phalangeal joint ligament repair, deltoid ligament repair

Literature: Hentges, Moore, Catanzariti, & Derner, 2014: Walters & Mendicino, 2014

Professional attendances and support services

104 SPECIALIST, REFERRED CONSULTATION – SURGERY OR HOSPITAL (Professional attendance at consulting rooms or hospital by a specialist in the practice of his or her specialty where the patient is referred to him or her) – INITIAL attendance in a single course of treatment, not being a service to which ophthalmology items 106, 109 or obstetric item 16401 apply

105 Each attendance subsequent to the first in a single course or treatment

51300 Assistance at any operation identified by the word "Assist." for which the fee does not exceed \$558.30 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed \$558.30

51303 Assistance at any operation identified by the word "Assist." for which the fee exceeds \$558.30 or at a series of operations identified by the word "Assist." for which the aggregate fee exceeds \$558.30

18272 SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent

Top 10 procedures	Count	% of total	Top 10 diagnoses	Count	% of total
Scarf Akin Variants	29 055	21.8	Hallux valgus	13 798	32.1
Lesser toe arthroplasty	17 402	13.1	Hammer toe(s)	9 458	22.0
Lesser toe arthrodesis	10 358	7.7	Hallux rigidus	4 067	9.5
Cheilectomy/exostectomy	7 377	5.5	Interdigital Neuroma	2 300	5.4
Neuroma excision	7 377	5.5	Ingrowing nail	1 490	3.5
Lesser metatarsal osteotomy	5 739	4.3	Fixation related	1 042	2.4
Fixation removal	5 713	4.3	OA-Mid foot	831	1.9
Tendon (any)	5 086	3.8	Hallux valgus rigidus	815	1.9
First MTPJ arthrodesis	3 943	2.9	Tailor's bunion	806	1.9
Amputation (unspec)	3 385	2.5	Metatarsalgia	750	1.7

Table 4Top 10 UK procedures and podiatric diagnoses for podiatric surgeons

Note: Top 10 procedures relate to 01/05/2010 to 31/12/2018. Top 10 podiatric diagnosis relate to 01/05/2010 to October 2018. Source: PASCOM-10, Summary of the first 9 years, The College of Podiatry.

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A.4. **PROPOSED POPULATION**

The conditions to which podiatric surgery relates correspond to eight clinical groupings:

- hallux abducto valgus (HAV);
- hammer and claw toes;
- hind foot/ankle pathology;
- ingrown toenails;
- hallux rigidus;
- arthritis;
- nerve impingement, and
- tumour (benign).

No exclusion criteria are proposed, whether on the basis of age, severity or other factors.

Key issue #2: Evidence of unmet need in proposed population

New data which points to unmet need in the proposed population include:

- public hospital wait times for elective orthopaedic surgery of the foot and ankle;
- workforce shortages of orthopaedic surgeons;
- strong underlying demand in foot and ankle surgeries, and
- the 'capping out' of existing podiatric surgery demand as patients are deterred by very high outof-pocket (OOPC) costs without recourse to the MBS, resulting in unmet demand.

PUBLIC HOSPITAL WAIT-TIMES FOR ELECTIVE ORTHOPAEDIC SURGERY OF THE FOOT AND ANKLE

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Table 6Wait times for foot and ankle surgeries in Australian public hospitals 2016-17

Surgery type	Waiting period (days)
Excision of exostosis	229
Removal of Bunion (hallux valgus)	169
Excision of ganglion	93
Osteotomy	84
Change of muscle or tendon length	82
Correction of hammer/claw/mallet toe	63
Toenail surgery	40

Source: CIE analysis; Australian Institute of Health and Welfare, 'Waiting times for elective surgery', available at: https://www.aihw.gov.au/reports/hospitals/elective-surgery-waiting-times-ahs-2015-16/contents/table-of-contents

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LIMITED CAPACITY WITHIN THE ORTHOPAEDIC SURGEON WORKFORCE

Without a change in the surgical supply workforce, wait times are unlikely to improve. There has been a discernible flattening in the number of orthopaedic surgeons in Australia since 2009, suggesting little change to the capacity of orthopaedic surgeons to exclusively provide MBS funded foot and ankle surgeries



The Royal Australasian College of Surgeons identified that to maintain the 2010 ratios of orthopaedic surgeons to the population aged 65 years and over, 687 additional surgeons would be required.⁸ This is a large number, and will take time to accumulate. s47G



Data source: Analysis of Australian Institute of Health and Welfare (AIHW) medical labour force data and Australian Bureau of statistics population estimates for December of each respective year.

⁸ Royal Australasian College of Surgeons. 2011, 'Surgical Workforce Projection to 2025, *Vol. 1, The Australian Workforce*, p 52: https://www.surgeons.org/media/437871/rpt_racs_workforce_projection_to_2025.pdf

GROWTH IN PATIENT DEMAND FOR FOOT AND ANKLE SURGERY

Demand for managing foot and ankle pain and disease, including demand for surgical services, is on the rise. Between 2007 and 2017, of the 105 MBS items exclusively associated with foot and ankle surgery, claims have increased by 30 per cent, up from 130 000 to just over 170 000 (Figure 3), or 3 per cent annually, outstripping population growth of 20 per cent over the same period.⁹ s47G

The number of elective orthopaedic surgeries (of which foot and ankle surgery is part) conducted in Australian public hospitals increased 15 per cent between 2011-12 and 2016-17, or 2.8 per cent annually (Figure 4).

Analysis of MBS foot and ankle procedures performed on those aged between 55 and 64 years shows that over the ten years to 2006, utilisation grew by 45 per cent (the highest growth for all age cohorts).¹¹ Growth was predominantly in procedures involving the first metatarsophalangeal joint (1st MPJ) to treat bunion or arthritis).



Figure 3 MBS utilisation associated with foot and ankle surgeries

⁹ Based on Australian Bureau of Statistics, *3101.0 Australian Demographic Statistics*, which reported a September 2017 population of 24 702 900 million and September 2007 population estimate of 20 924 200

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¹¹ Menz, H.B., Gilheany, M.F. & Landorf, K.B. 2008, 'Foot and ankle surgery in Australia: a descriptive analysis of the Medicare Benefits Schedule database, 1997-2006', *Journal of foot and ankle research*, vol. 1, no. 1.



Data source: MBS utilisation data for 105 MBS item codes included. We note that MBS item and group reports as well as Medicare standard reports from November 2018 onwards are yet to be published (as at 10 May 2019), hence 2018 estimates are not available.



Data source: Analysis of Australian Institute of Health and Welfare, Waiting times for elective surgery', available at: https://www.aihw.gov.au/reports/hospitals/elective-surgery-waiting-times-ahs-2015-16/contents/table-of-contents)

Australians have also experienced an increase in ED presentations related to dislocation, sprain and strain of joints and ligaments of the ankle or foot. In the short time since evidence has been collected, ED presentations have increased by 4 per cent — from 90 707 in 2014-15 to 94 139 in 2016-17.¹²

In addition, there has been an increase in the number of GP encounters related to plantar fasciitis, which rose by 3-per-100 000 consultations between 2000 and 2014,¹³ and the prevalence of foot pain has doubled between 2004-2006 and 2008-2010, increasing from 14.9 cent to 29.9, per cent respectively.¹⁴

¹² AIHW. 2017, 'Emergency department care 2016-17: Australian Hospital statistics', Health Services Series No. 80, p37, Table 4.7; Australian Institute of Health and Welfare. 2015, 'Emergency Department care 2014-15: Australian Hospital statistics', Health Services Series No. 65, p32, Table 4.7

¹³ Australian Family Physician. 2015, 'Plantar fasciitis in Australia in General Practice', *Focus: foot problems*, Vol. 44, no. 3: https://www.racgp.org.au/afp/2015/march/plantar-fasciitis-in-australian-general-practice.

¹⁴ Gill, T.K., Menz, H.B., Landorf, K.B., Arnold, J.B., Taylor, A.W. & Hill, C.L. 2016, 'Predictors of foot pain in the community: the North West Adelaide health study', *Journal of foot and ankle research*, vol. 9, no. 1, pp. 23; Overall prevalence in Stage II was 17.4 per cent, however, prevalence in the cohort who continued from Stage II to Stage III was lower at 14.9 per cent.

MBS-funded podiatric services available to people with chronic medical conditions and complex care needs managed by a GP have also grown from 395 000 in 2007 to 3.1 million in 2017, indicating a growing and substantial need for management and treatment of foot conditions.¹⁵

THE 'CAPPING OUT' OF EXISTING PODIATRIC SURGERY ACTIVITY INDICATES UNMET PATIENT DEMAND

Despite growing demand, the level of podiatric surgical services is effectively capped as it is necessarily limited to patients that can afford high out-of-pocket costs without recourse to the MBS.

While there is an expected degree of procedural variation, by and large the ACPS National Audit reports show that there is limited, stagnant, or declining growth in podiatric surgeries, notwithstanding the underlying factors that fuel patient demand and strong evidence of high patient satisfaction.

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¹⁵ Medicare Item Reports, available at: <u>http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp</u>

A.5. COMPARATOR DETAILS

Foot and ankle MBS services are currently performed by GPs, general, vascular and orthopaedic surgeons, however the ACPS and PASC agree that foot and ankle services provided by orthopaedic surgeons are the appropriate main comparator,¹⁶ re-iterated by MSAC at the April 2015 meeting.¹⁷ Both professions share similar traits in terms of:

- skill sets;
- conditions treated;
- the model of care ('whole of episode');
- patient assessment with diagnostic testing, and

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¹⁷ Australian Government Medical Service Advisory Committee. 2015, 'Public Summary Document: Application
 1344 — Assessment of Foot and Ankle Services by Podiatric Surgeons (foot and ankle conditions – various)',
 Australasian College of Podiatric Surgeons, MSAC 63rd Meeting, 1-2 April 2015, Section 9, p 5.

• procedure variety and post-operative care, notwithstanding that orthopaedic surgeons perform a wider range of surgeries than Podiatric Surgeons, including spine, hip and shoulder surgeries.

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A.6. CLINICAL MANAGEMENT ALGORITHM(S)

The clinical management algorithm is unchanged for this application, except in two respects:

- For podiatric surgeons operating in a private hospital setting, outpatient clinic, day surgery centre or consultation room, there is **no change** to the clinical management algorithm aside from allowing access to MBS items for procedures that are otherwise (currently) fully funded by patients (in some cases, part funded by private health insurance). Hence the change relates to the cost-to-patients in private/community sectors where they already receive surgical services from a podiatric surgeon. There is no change to the clinical management algorithm for these patients.
- Unlike in the United Kingdom and USA, there are currently no funded positions for podiatric surgeons operating in Australian **public hospitals**. This could change if podiatric surgeons were able to offer their services in public hospitals, as they currently offer them in other settings. This report points to Australian examples where podiatric surgeons have operated in public hospitals as part of a publicly funded study. It is noted that most of the MBS items are proposed to be for admitted (in-hospital) patients. Allowing MBS access to admitted public hospital patients would enable podiatric surgeons to service public hospital patients where there is evidence of non-inferiority to orthopaedic surgeons. This would constitute a change the clinical management algorithm for admitted public hospital patients.

Hence, this proposal is about expanding potential coverage of podiatric surgery activity to the public sector for surgeries that are already being provided in the private setting, and for all patients of podiatric surgeons to be able to access MBS items for specific (clinically appropriate and with noninferior outcomes) surgeries, as they are able to access them for comparable procedures performed by orthopaedic surgeons. The current and proposed clinical investigative strategy is illustrated in Table 5. In line with the clinical claim and the proposed intervention, there is no change in patient outcomes. The only change relates to providing access to MBS codes for existing private setting procedures, and enabling access to public sector activity.

Not highlighted in the last submission, yet an important point of clarification in respect to patient management, is that the ACPS has a governance structure and series of policies that all members adhere to including a clinical pathway for patient care which is attached as appendix F.



Figure 5 Clinical management algorithms

A.7. KEY DIFFERENCES IN THE DELIVERY OF THE PROPOSED MEDICAL SERVICE AND THE MAIN COMPARATOR

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It is noted that public sector foot ankle surgical activity in Australia has been almost exclusively provided by orthopaedic and vascular surgeons, unlike internationally where podiatric surgeons routinely are integrated within the public sector and in multidisciplinary teams.

While there are differences in the training program for podiatric and orthopaedic surgeons (set out previously in MSAC Public Summary document for Application 1344), under S3AAA of the Health Insurance Act 1973, registered podiatric surgeons are recognised as specialist podiatrists who are approved as accredited and gazetted by the Minister for Health as qualified to provide surgical procedures of the foot and ankle. Additionally, podiatric surgeons are registered as specialist practitioners by the Podiatry Board of Australia, a process which required ministerial approval and the title Podiatric Surgeon is protected within the same regulatory framework. These regulatory frameworks are the same as those that govern services provided by general, orthopaedic and vascular surgeons. In addition, in order to maintain annual College accreditation, ACPS members are required to follow a clinical pathway to ensure a complete package of patient care is delivered

Key issue #3: Podiatric surgeons ability to provide an equivalent package of care to patients

A complete package of care can be defined as management of patients from referral to discharge or handover to another health care practitioner for additional or extended care during perioperative management. Such management has included appropriate referral to other medical specialists before or after surgery as indicated. Podiatric surgeons have a demonstrated history of such management as highlighted in the evidence presented below.

However, there is a funding barrier in respect to podiatric surgeons to the efficient and potentially effective care in Australia. Essentially this is the is the subject of this application. described above. This funding barrier is will be clearly ameliorated by providing access to the MBS items requested in this report, in turn collaborative patient care will be enhanced.

Orthopaedic surgeons (and other surgical providers) in Australia are enabled through funding to provide an integrated multidisciplinary management algorithm. The current limitations in respect to funding for podiatric surgeons presents as a relative barrier to the seamless and efficient management of the patient in a multidisciplinary manner. Delivery of an equivalent package of care will be facilitated by support of this proposal and serve the public interest in a responsible manner.

The packaging of care delivered to patients from podiatric surgeons has been proven to be safe and effective from multiple studies from Australian and international healthcare settings, albeit data from Australia is constrained by the limited access podiatric surgeons currently have within public health systems.

A study from the High-Risk Foot Clinic, Austin Health, Victoria utilising a podiatric surgeon demonstrates effective outcomes from a multi-disciplinary setting.¹⁸ s47G

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¹⁸ Smith, S. E., & Miller, J. (2019). The Safety and Effectiveness of the Percutaneous Flexor Tenotomy in Healing Neuropathic Apical Toe Ulcers in the Outpatient Setting. Foot & Ankle Specialist, 1938640019843314. doi:10.1177/1938640019843314

Although currently there are no public health positions held by podiatric surgeons in Australia, podiatric surgeons work closely within multi-disciplinary teams within the private health landscape on a daily basis. The team for a surgical episode includes the podiatric surgeon, GP, anaesthetist, hospital nursing staff and resident doctors as a minimum. Plus, a range of allied health practitioners including podiatrists, physiotherapists and occupational therapists to ensure adequate post-operative care.

Additionally, whilst podiatric surgeons have no current MBS rebated referral to specialists, surgeons liaise with other specialists such as infectious disease consultants, haematologists, pain management consultants, rheumatologist and orthopaedic surgeons in the event of a major complication. This is also enshrined in the national guidelines for endorsement of scheduled medicines where for example collaboration with and / or referral to a medical practitioner is required if an infection is not displaying signs of resolving.

International evidence of collaborative care models in public funded and private institutions is extensive, where podiatric surgeons have long been funded as part of vital multidisciplinary teams. Multiple reports describe the broad benefits to inclusion of podiatric surgeons in such teams. The importance of podiatry in the care of complex foot problems within Australian multidisciplinary care is also documented.¹⁹

Patient satisfaction of podiatric surgery has been previously evaluated in the United Kingdom (UK).²⁰ Podiatric surgery is well established in the National Health Service in the UK with over 50 podiatric integrated surgical units. Results suggest that patient satisfaction following foot surgery rose significantly following the appointment of a podiatric surgeon within an orthopaedic department. Improvements were identified in the overall outcomes of surgery and other aspects of the patients' journey.

Within the UK and USA podiatric surgeons have been utilised for decades and form integral components of multi-disciplinary teams delivering surgical services. This is particularly so within the high -risk foot and research clearly demonstrates lower amputation rates, longer life expectancy, fewer hospitalisations and cost savings.

¹⁹ See Sumpio, B. E., Armstrong, D. G., Lavery, L. A., & Andros, G. (2010); Rogers, L. C., Andros, G., Caporusso, J., Harkless, L. B., Mills Sr, J. L., & Armstrong, D. G. (2010); Armstrong, D. G., Bharara, M., White, M., Lepow, B., Bhatnagar, S., Fisher, T., ... & Mills, J. L. (2012); Driver, V. R., Madsen, J., & Goodman, R. A. (2005); Chandra, V., Glebova, N. O., Salvo, N. L., & Wu, T. (2017); Skrepnek, G. H., Mills, J. L., & Armstrong, D. G. (2014); Chung, J., Modrall, J. G., Ahn, C., Lavery, L. A., & Valentine, R. J. (2015); Quinton, T. R., Lazzarini, P. A., Boyle, F. M., Russell, A. W., & Armstrong, D. G. (2015).

²⁰ Armanasco P, Williamson D, Yates B: Integration of podiatric surgery within an orthopaedic department: an audit of patient satisfaction with labour force implications. The Foot 2012;22:200-204.

A 12 year retrospective case review of transmetatarsal amputation (TMA) outcomes by the podiatric surgery team at a UK hospital between 2005-2017 reported excellent healing and mortality rates with low need for revision surgery, finding that TMA was an effective alternative to major limb amputation (level 3 clinical evidence).²¹

Another UK study on the type of internal fixation associated with increased risk of non-union following first metatarsophalangeal joint arthrodesis, specifically included comparisons of surgeon type. This was possible because foot and ankle surgery within the Department of Trauma and Orthopaedics at the GWH NHS Foundation Trust is performed by two consultant orthopaedic foot and ankle surgeons, two consultant podiatric surgeons, and associate specialist orthopaedic surgeons. It was noted that post-operative protocols were standardised for all surgeons. Surgeon type *was not* associated with incidence of non-union. Following multivariable binary logistic regression, the single construct locking plate with interfragmentary screw was associated with increased risk of non-union following first MTPJ arthrodesis, while the separate construct locking plate and compression screw was associated with reduced risk of non-union.²² This study supports non-inferiority of safety between podiatric surgeons and orthopaedic surgeons.

There is also international evidence of podiatric surgeons being integrated within Orthopaedic Departments leading to increased patient satisfaction. Within the National Health Service of the UK multiple Trusts (Local areas) now have podiatric surgeons working alongside orthopaedic surgeons providing teaching to both podiatric and orthopaedic trainee surgeons. The Avon Orthopaedic Centre within the North Bristol Trust is a world-renowned foot and ankle training centre having both podiatric and orthopaedic sorpovides foot and ankle orthopaedic Fellowships specifically for Australian orthopaedic trainees and more recently Australian podiatric trainees.

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²¹ Joyce, A. Yates, B., and Cichero, M. (2019), Transmetatarsal Amputation: a 12 year retrospective case review of outcomes.

²² Cichero, M., Yates, B., Joyce, A., Williamson, D., Walsh, T. (2019) 'Is the type of internal fixation used associated with increased risk of non-union following first metatarsophalangeal joint arthrodesis?', Department of Trauma and Orthopaedics, Great Western Hospital Foundation Trust, England.

We also note that general podiatrists in Australia work in team environments and multi-disciplinary teams in the public setting where they participate during undergraduate training and post graduate training. ²³Post graduate training in podiatric surgery also includes rotation internationally to sites where podiatric surgeons are working in team environments.

Podiatric surgeons are also increasingly involved in multidisciplinary training activities, as example of such an event is in appendix G. This education session is multidisciplinary involving podiatric, vascular and plastic surgeons.²⁴ Several respected Australian academics attest to the value of podiatric surgeons in the collaborative management of complex patients.

A.8. CLINICAL CLAIM

For the eight clinical groupings specified, podiatric surgeons are at least non-inferior to orthopaedic surgeons in terms of clinical safety and efficacy in undertaking foot and ankle surgery and associated pre-operative and post-operative care.

For the 23 therapeutic MBS items shown in Table 1, safety and efficacy of podiatric surgeons would be at least non-inferior to orthopaedic surgeons. This clinical claim is presented in Section B of this application.

²³ See Quinton, T. R., Lazzarini, P. A., Boyle, F. M., Russell, A. W., & Armstrong, D. G. (2015); and Lazzarini, Peter A., and Robert Fitridge.

²⁴ Diabetic Conference 2019: Urgent Diabetic Foot Surgery- a Team Approach. See conference flier at appendix G.
A.9. SUMMARY OF THE PICO

Table 8 summarises the PICO elements as described throughout Section A.

Table 8 Summary of the PICO

PICO category	Description
Population	Patients with one or more foot and ankle condition that fit into the following clinical groupings:
	Hallux abducto valgus (HV)
	Hammer and claw toes
	Hind foot/ankle pathology
	Ingrown toenails
	Hallux rigidus
	arthritis
	Nerve impingement; and
	Tumour (benign).
Intervention	Surgical treatments, services and consultations by podiatric surgeons using 23 existing MBS codes (same
	codes as comparator)
Comparator	Surgical treatments, services and consultations by orthopaedic surgeons using 23 existing MBS
	codes(same codes as intervention)
Outcomes	Podiatric surgeons are non-inferior (in terms of both safety and efficacy) compared to orthopaedic
	surgeons at performing foot and ankle surgeries, including addressing complications.

Source: CIE.

A.10. CONSUMER IMPACT STATEMENT

It is patients that bear the burden of avoided or delayed podiatric surgery, living with foot and ankle pain, or having their health needs met by podiatric surgeons whilst facing high out-of-pocket costs. If a patient cannot afford treatment from a podiatric surgeon but cannot avoid it either, they need to return to their GP for (an avoidable) referral to an orthopaedic surgeon, and either join the waiting list for public hospital care, or seek private orthopaedic care (with access to MBS items).

In all cases, the differential treatment of podiatric surgeons with respect to MBS funding has a limiting impact on consumers' choice of provider. Therefore, this application has a significant beneficial impact for consumers.

SECTION B

EVIDENCE FOR NON-INFERIORITY OF

PODIATRIC SURGEONS

A two-step approach was taken to assess whether outcomes of surgery performed by podiatric surgeons is non-inferior to that undertaken by orthopaedic surgeons. Firstly, we conducted a medical literature search, s47G

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B.1. LITERATURE SOURCES AND SEARCH STRATEGIES

The medical literature was searched on 21-22 May 2019 to identify relevant studies and systematic reviews published during the period between the database commencement to May 2019. Searches were conducted in the databases and sources described in Appendix B. Search terms are described in Appendix B. The literature search elements are presented in Table 9.

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Element of clinical question	Search terms
Population	Patients with one of more foot and ankle conditions that fit into the following clinical
	groupings:
	 Scarf Akin Variants
	Lesser toe arthroplasty
o ^C	Lesser toe arthrodesis
	Cheilectomy/exostectomy
	Neuroma excision
1 the	Lesser metatarsal osteotomy
\sim	Fixation removal
	Tendon (any)
	First MTPJ arthrodesis
	Amputation (unspec)
	Hallux valgus
	Hammer toe(s)
	Hallux rigidus
	Interdigital Neuroma

Table 9Literature search elements

²⁸ The ACPSR includes 8 142 patient records over 5 years. The South Australian and Tasmanian datasets include procedures for ICD-10 codes that map to the 23 requested MBS items. The SA data set includes 9 337 patient records over 5 years. The Tasmania data set includes 2 855 patient records over 5 years.

Element of clinical question	Search terms
	Ingrowing nail
	Fixation related
	OA-Mid foot
	Hallux valgus rigidus
	Tailor's bunion
	Metatarsalgia
Intervention	Surgical treatments, services and consultations provided by podiatric surgeons
Compositor ('f oppliochto)	
Comparator (if applicable)	Surgical treatments, services and consultations provided by orthopaedic surgeons
Outcomes (if applicable)	Patient demographics, comorbidities, reason for surgery, length of stay, complications,
	readmissions, patient satisfaction
Limits	None applied

B.2. RESULTS OF LITERATURE SEARCH

A PRISMA flowchart (Figure 6) provides a graphic depiction of the results of the literature search and the application of the study selection criteria (listed in Box 1 and Box 2) (Liberati et al., 2009). Additional studies were hand searched (n=4) and added to the results of the literature searches. Studies were selected by a single reviewer.

Studies that could not be retrieved or that met the inclusion criteria but contained insufficient or inadequate data for inclusion are listed as Excluded Studies in Appendix D. All other studies that met the inclusion criteria are listed in Appendix C. In addition to the eight studies (of nine papers), we have included in this section, the outcomes of the ACPSR vs Tasmania (*Tasmania*) and ACPSR vs SA (*SA*) analyses.



Figure 6 Summary of the process used to identify and select studies for the assessment

A profile of each included study is given in Appendix B. This study profile describes the authors, study ID, publication year, study design and quality (level of evidence and risk of bias), study location, setting, length of follow-up of patients, study population characteristics, description of the intervention, description of the comparator and the relevant outcomes assessed. Study characteristics are also summarised in a shorter format in Section B.4.

APPRAISAL OF THE EVIDENCE

Appraisal of the evidence was conducted in three stages:

Stage 1: Appraisal of the risk of bias within individual studies (or systematic reviews) included in the review. Risk of bias items were assessed for the study as a whole. (Section B.3)

Stage 2: Extraction of the pre-specified outcomes for this assessment, synthesising (meta-analysing or a narrative synthesis) to determine an estimate of effect per outcome.

Stage 3: Rating the overall quality of the evidence per outcome, across studies, based on the study limitations (risk of bias), imprecision, inconsistency of results, indirectness of evidence, and the likelihood of publication bias. This was done to provide an indication of the confidence in the estimate of effect in the context of Australian clinical practice (Evidence profile tables, Appendix C).

Stage 4: Integration of this evidence for conclusions about the net clinical benefit of the intervention in the context of Australian clinical practice. (Sections B.6-8)

B.3. RISK OF BIAS ASSESSMENT

No randomised controlled trials were identified. The risk of bias of full text studies retrieved was assessed using NICE checklist for cohort studies (NICE, 2012). An overall risk of bias was assessed for each outcome, across studies using the GRADE methodology (Guyatt et al., 2011).

B.4. CHARACTERISTICS OF THE EVIDENCE BASE

See Appendix C for details on the individual studies included in the evidence base. A summary is provided in Table 10. It is important to note that no randomised controlled trials exist that compare the outcomes of patients undergoing foot and ankle surgery performed by podiatric surgeons with foot and ankle surgery performed by orthopaedic surgeons. Comparisons are based on cohort or retrospective cohort studies involving surveys, clinical audits, or assessment of administrative data. Due to the heterogeneity of included studies, meta-analysis was not possible.

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Trial/Study	Ν	Design/ duration	Risk of bias	Patient population	Key outcome(s)
Amanasco 2012 (Amanasco et al., 2012, McCaffrey, 2014)	116	SC, Coh	High	Demographics not reported. Patients receiving podiatric surgery at a single centre by a single surgeon compared to those receiving orthopaedic surgery at a single centre by different surgeons	Patient satisfaction Complications
Bennet 2007 (Bennett, 2007)	785	MC, RCoh	High	Patients undergoing podiatric surgery by 10 podiatric surgeons. No orthopaedic arm	Demographics
Chan 2018 (Chan et al., 2018)	N=11,115 (orthopaedic) N=630 (podiatric)	RCoh	High	Humana subset of the PearlDiver Patient Record database who underwent ankle fracture fixation between 2007 and 2015	Demographics Comorbidities Complications
Cichero et al 2013 (Cichero et al., 2013)	N=34 (orthopaedic) N=75 (podiatric coordinator)	RCoh	High	Audit of medical records at Great Western Hospital Primary Care Trust between November 2008 and October 22009 for eligible diabetic foot admissions	Length of stay
Gilheany and Robinson (Gilheany and Robinsons, 2007)	N=21,834 (orthopaedic) N=1260 (podiatric)	RCoh	High	Patients undergoing great toe surgery. MBS vs Victorian podiatric surgeons audit	Volume of surgery
Helm and Ravi 2003 (Helm and Ravi, 2003)	129	Coh	High	Survey of GPs in Doncaster (UK) area	GP satisfaction
Isaac et al 2008 (Isaac et al., 2008)	242	Coh	High	Survey of orthopaedic and podiatric surgeons. Surveys sent to (i) all 156 members of the British Orthopaedic Foot and Ankle Society (BOFAS); (ii) a random selected sample of 250 British Orthopaedic	Outcomes of surgery

Table 10	Key features of the included evidence comparing foot and ankle surgery performed by podiatric
	surgeons with foot and ankle surgery performed by orthopaedic surgeons

Trial/Study	Ν	Design/ duration	Risk of bias	Patient population	Key outcome(s)
				Association (BOA) members who were not BOFAS members; and (iii) all 136 surgical fellows of the College of Podiatrists, Society of Chiropodists and Podiatrists (SoCaP)	
Kilmartin 2001 (Kilmartin, 2001)	2,335	RCoh	High	Patients undergoing surgery in the Nottingham Community Trust Podiatric Surgery (UK)	Surgical outcomes Patient satisfaction
Laxton 1995 (Laxton, 1995)	219	RCoh	High	Survey of orthopaedic surgeons, general surgeons, GPs, and podiatrists who undertake forefoot surgery in Suffolk UK	Patient satisfaction Surgery type
South Australia	N=9,337 (ortho) N=8,142 (pod)	RCoh	Low	Administrative data from SA admissions compared to ACPSR	Demographics Surgery type Complications Length of stay Readmissions
Tasmania	N=2,851 (ortho) N=8,142 (pod)	RCoh	Low	Administrative data from SA admissions compared to ACPSR	Demographics Surgery type Complications Length of stay Readmissions

Coh=cohort; MC=multi-centre; RCoh=Restropective cohort; SC=single-centre

B.5. OUTCOME MEASURES AND ANALYSIS

See Appendix C for details on the outcomes measured in the included studies, along with the statistical methods used to analyse the results. Overall, the quality of studies reported in the literature have a high risk of bias. No randomised controlled studies have been reported, so the majority of evidence presented come from either prospective or retrospective cohort studies. Given the heterogeneity of the included studies, no meta-analysis has been performed.

B.6. **RESULTS OF THE SYSTEMATIC LITERATURE REVIEW**

In the UK, podiatric surgeons often work alongside orthopaedic surgeons to manage foot and ankle pathology. This shift in clinical activities has been supported by the UK Department of Health's *Meeting the Challenge: a Strategy for the Allied Health Professions* report (UK Department of Health, 2000). Australian podiatric surgeons have been performing foot and ankle surgery in the private sector for 40 years. In 2007, an Australian analysis suggested that podiatric surgeons perform approximately 18% of first metatarsal surgeries, at least in the Victorian context (Gilheany and Robinsons, 2007). The authors noted that this suggests that podiatric surgeons do indeed have the skill set to undertake surgery, and that there should be an increase in the utilisation of such skill sets to allow for further workforce flexibility in the public sector (Gilheany and Robinsons, 2007), similar to what has been implemented in the UK setting.

DEMOGRAPHICS OF PATIENTS UNDERGOING FOOT AND ANKLE SURGERY

Database sources

The ages of patients undergoing foot an ankle surgery in the *SA Analysis* were similar between the podiatric and orthopaedic surgeons (Figure 7). Podiatric surgeons operated on a greater proportion of women compared to orthopaedists (73.8% vs 56.7%, p<0.001), and a smaller proportion of smokers (2.0% vs 13.9%, p<0.001).

Literature sources

Patient demographics of Australians undergoing foot and ankle surgery by podiatric surgeons have been published by Bennet (Bennett, 2007). This audit of 785 patients from ten podiatric surgeons reported that more women than men undergo surgery by a podiatric surgeon (80.1% vs 19.9%). The mean age of patients is 47.2 ± 18.5 years, with patients being slightly younger in Western Australia compared to South Australia or Victoria. Overall the age ranged from 7 to 92 years.

In the US claims database (Chan et al., 2018), demographics of patients undergoing ankle fracture fixation were similar between those treated by podiatric surgeons compared with orthopaedic surgeons: similar proportions were over 60 years (64% vs 66%, respectively, p=0.41), were male (36% vs 33%, respectively, p=0.11).

COMORBIDITIES OF PATIENTS UNDERGOING FOOT AND ANKLE SURGERY

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In the retrospective cohort patients undergoing surgery for ankle fracture fixation in the US had similar comorbidities regardless of their surgeon type (Charlson Comorbidity Index [CCI] 2.8 ± 3.3 in the podiatric surgeon group vs 2.7 ± 3.4 in the orthopaedic group (Chan et al., 2018).

IS IT SAFE?

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COMPLICATIONS

In the Chan et al retrospective analysis of insurance data (Chan et al., 2018), malunion or non-union of ankle fractures were higher in patients treated by podiatric surgeons (RR 1.6 [95% CU 1.2 to 2.1, p=0.002]), however no differences were reported in terms of infection, deep vein thrombosis, or irrigation and debridement. Among the subgroup of patients with unimalleolar ankle fractures, a trend towards a higher rate of malunion/non-union in ankle fractures was observed in those treated by podiatric surgeons compared with those treated by orthopaedic surgeons (6.2% versus 4.0%), although this was not statistically significant. There was a significantly higher rate in those treated by podiatric surgeons compared to orthopaedic surgeons for bimalleolar or trimalleolar fractures (8.2% vs 4.9%, RR 1.7 [95% CI 1.2 to 2.4], p=0.006) (Chan et al., 2018).

Kilmartin (Isaac et al., 2008) reported complications post-surgery in a cohort of 2,335 patients undergoing foot and ankle surgery in the Nottingham Community Trust Podiatric Surgery Service. The authors reported that all adverse reactions to surgical intervention no matter how mild or short term re reported. Complications reported included post-operative pain (n=12/2,335 (0.5%) patients with severe post-operative pain; three (0.1%) have developed chronic pain following surgery). Adverse reactions to medication accounted for 21% of all complications.

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Results of the complications analysis are presented in Table 12.

Study ID	Risk of bias	Podiatric surgeons	Orthopaedic surgeons	Absolute difference	Relative difference
Malunion/Non- union					
Chan et al 2018 (Chan et al., 2018) <i>Ankle Fracture</i>	High	7.3%	4.6%	2.7%	RR 1.6 [95% CU 1.2 to 2.1, p=0.002]
Infection					
Chan et al 2018 (Chan et al., 2018) <i>Ankle Fractur</i> e	High	3.3%	4.3%	-1.0%	p=0.23
Kilmartin (Kilmartin, 2001)	High	1.4% (confirmed infection)	- 3	N/A	N/A
Laxton 1995 (Laxton, 1995)	High	1/56 (1.7%)	0/142 (0.0%)	1.7%	NR

Table 12 Results of complications across the studies

DVT		S	S. Hr		
Chan et al 2018 (Chan et al., 2018) <i>Ankle Fracture</i>	High	3.2%	3.1%	0.1%	p=0.89
Kilmartin (Kilmartin, 2001)	High	0.4% (confirmed DVT)	-	N/A	N/A
Laxton 1995 (Laxton, 1995)	High	1/56 (1.7%)	0/142 (0.0%)	1.7%	NR
Irrigation and debridement	- Think				
Chan et al 2018 (Chan et al., 2018) <i>Ankle Fractur</i> e	High	2.2%	1.7%	0.5%	P=0.35

Study ID	Risk of bias	Podiatric surgeons	Orthopaedic surgeons	Absolute difference	Relative difference	
Pain						
Kilmartin (Kilmartin, 2001)	High	Severe post-op pain 0.5% Chronic pain 0.1%	-	N/A	N/A	
Fixation problem						
Kilmartin (Kilmartin, 2001)	High	0.4%	-	N/A	N/A	

RR=relative risk

READMISSION

Readmissions were reported in Cichero et al (Cichero et al., 2013). No difference in readmission rates

were reported. s47G

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Results of the complications analysis are presented in Table 13.

Table 13	Results of	readmission	across t	the stud	ies
Table 13	Results of	readmission	across t	the stud	ļ

	bias	surgeon	surgeon	difference	difference
Cichero et al (Cichero et al., 2013)	High	15.4% (95% Cl 12.0 to 19.5%)	17.2% (95% Cl 12.2% to 23.9%)	- 1.8%	p=0.820

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IS IT EFFECTIVE?

Summary – Is ankle and foot surgery performed by a podiatric surgeon as effective as ankle and foot surgery performed by an orthopaedic surgeon?

Reason for surgery

In the database analysis, and several of the other analyses reported in the literature, reason for surgery was matched between surgeon type. The reason for surgery in the literature reflected the requested scope of practice for this submission.

Length of Stay

The length of stay in patients who undergo foot and ankle surgery with orthopaedic surgeons appears to be significantly longer than the length of stay reported in patients who undergo foot and ankle surgery with podiatric surgeons. This was also reflected in our SA Analysis and Tasmanian Analysis: AGED

Patient preference

Patients appear to prefer surgery undertaken by a podiatric surgeon.

REASON FOR SURGERY

Database sources

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Literature sources

The scope of surgery provided by podiatric surgeons in Australia has been published previously (Bennett, 2007). A clinical audit of 785 patient files operated on by podiatric surgeons revealed the majority of operations were for acquired toe deformities (74%), peripheral neuropathy (9%), or diseases of the skin and nail (9%). The most common conditions identified in this study were: lesser toe deformities (46.1%), hallux abducto valgus (20.8%), intermetatarsal neuroma (Morton's) (7.8%), hallux rigidus/limitus (6.6%) and onychocryptosis (6.7%) (Bennett, 2007).

Amanansco and colleagues (Amanasco et al., 2012) surveyed 56 patients who underwent foot and ankle surgery by a podiatric surgeon and 60 patients randomly selected matched for surgical code and ASA code who had been operated on by an orthopaedic surgeon. Surgical procedures were matched between the two surgeon types: hallux valgus, Keller arthroplasty, first metatarsophalangeal joint fusion, lesser toe fusion, soft tissue mass excision, multiple metatarsal osteotomies, or forefoot reconstruction.

An earlier publication noted significant differences in the scope of practice were reported by Laxton (Laxton, 1995), with orthopaedic surgeons performing a greater proportion of great toe procedures and podiatric surgeons performing more lesser toe procedures.

Results of the analysis of reasons for surgery are presented in Table 14.

Study ID	Risk of	Podiatric surgeons	Orthopaedic surgeons	Absolute differenc	Relative difference
	bias		JA CO CI	е	
Amanasco 2012 (Amanasco et al., 2012)	High	Hallux valgus correction (metatarsal and/or phalangeal osteotomy) Keller (excision of the base of the proximal phalanx) arthroplasty First metatarsophalangeal joint fusion Lesser toe fusion Soft tissue mass excision, e.g. Morton's neuroma, ganglion Multiple metatarsal osteotomies Forefoot reconstruction	Hallux valgus correction (metatarsal and/or phalangeal osteotomy) Keller (excision of the base of the proximal phalanx) arthroplasty First metatarsophalangeal joint fusion Lesser toe fusion Soft tissue mass excision, e.g. Morton's neuroma, ganglion Multiple metatarsal osteotomies Forefoot reconstruction	N/A	Matched data
Bennet (Bennett, 2007)	High	Acquired toe deformities Hallux valgus (acquired) and Bunion Hallux limitus/rigidus Hammer toe Claw toes Other acquired toe deformities Diseases of the musculoskeletal system and connective tissue Exostosis (does not include subungual exostosis) Enthesopathy of ankle and tarsus (include, Charcot's foot, tarsal coalition, posterior tibial dysfunction with/without flat foot Calcaneal Spur	NR	N/A	

Table 14Results of reason for surgery across the studies

Study ID	Risk of bias	Podiatric surgeons	Orthopaedic surgeons	Absolute differenc e	Relative difference
		Other (includes metatarsus adductus, medial long arch reconstruction) Mononeuritis of lower limb Neuroma (Morton's metatarsalgia) Other peripheral nerve Diseases of skin and nails Onychocryptosis/gryphosis with/without sub-ungual exostosis Verruca plantaris3 Foreign body granuloma/soft tissue mass (epidermoid cyst) Cellulitis and foot abscess Other	E.M.		
Laxton 1995 (Laxton, 1995)	High	N=56 <u>Lesser difficulty</u> Great toe 7% Lesser toe 5% Subungual exostosis 7% <u>Intermediate difficulty</u> Ganglion 2% Great toe 2% Lesser toe 66% Amputation 7% Forefoot arthroplasty 0% Neuroma 4% Other 0%	N=142 <u>Lesser difficulty</u> Great toe 6% Lesser toe 4% Subungual exostosis 1% <u>Intermediate difficulty</u> Ganglion 6% Great toe 50% Lesser toe 21% Amputation 6% Forefoot arthroplasty 1% Neuroma 1% Other 3%	NR	P<0.001

NR=not reported

LENGTH OF STAY

The effectiveness of a podiatric high-risk foot coordinator on length of stay has been assessed in one audit (Cichero et al., 2013). This coordinator was also involved in performing surgical procedures. The length of stay was significantly shorter in those admitted with a podiatric coordinator. It is not clear whether this relates to the fact that a podiatric surgeon conducted the surgery.

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Results of the length of stay analysis are presented in Table 15.

Study ID	Risk of bias	Podiatric surgeon mean ± SD	Orthopaedic surgeon mean±SD	Absolute difference	Relative difference
Cichero (Cichero et al., 2013)	High	23.3 days	33.7 days	10.4 days (95% Cl 0.0 to 20.8 days), p=0.050	NR
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Table 15Results of length of stay across the studies

SD=standard deviation

PATIENT OR GP SATISFACTION

In the Amanasco study (Amanasco et al., 2012), patient satisfaction was assessed using a Likert scale and asking patients to indicate their overall satisfaction with their surgery by placing a cross on a 10 cm line with totally dissatisfied at one end (0%) and totally satisfied at the other end (100%). Patients in the podiatric surgeon group were significantly more satisfied with the results of their foot surgery than those in the orthopaedic surgeon group.

Helm and Ravi (Helm and Ravi, 2003) surveyed 129 GPs (129/155, 83% response rate) about their satisfaction with podiatric or orthopaedic surgery services. For all measures: speed of appointment, communication after referral, waiting time for surgery, clinical results of surgery, and patient satisfaction; GPs preferred services provided by podiatric surgeons.

In Isaac and colleagues study (Isaac et al., 2008), respondents were asked to rate their impression of the surgical outcomes obtained by cross profession surgeons. If those surgeons who had no experience of work of the other profession (5% for podiatry and 29% for orthopaedics) are excluded, for podiatric surgeons the most common perception was 'satisfactory' outcomes (51.7%), though just fewer than 32% considered orthopaedic results 'poor' or 'very poor'. Conversely, 68.1% of orthopaedic surgeons, with experience of podiatric outcomes, rated the results of their local podiatric surgeon as 'poor' or 'very poor'. It should be noted however, that the response rate to this survey was very low, particularly for orthopaedic surgeons (77 (49%) of BOFAS orthopaedic consultant surgeons, 66 (26%) of non-foot and ankle orthopaedic consultant surgeons and, but 99 (73%) of podiatric surgeons); suggesting there may be a bias in the estimates.

In the Kilmartin (Kilmartin, 2001) assessment of outcomes in the Nottingham Community Trust Podiatric survey service, 93% of patients reported being happy or very happy with the outcome of their surgery.

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The proportion of patients who were completely satisfied with their procedure was higher in patients undergoing surgery by a podiatric surgeon compared to an orthopaedic surgeon in the Laxton 1995 study, when accounting for differences in surgical type (Laxton, 1995).

Results of the patient satisfaction analysis are presented in Table 16.

Study ID	Risk of bias	Podiatric surgeon	Orthopaedic surgeon	Absolute difference	Relative difference
Amanasco 2012 (Amanasco et al., 2012)*	High	Excellent 64% Moderate 24% Poor 12%	Excellent 44% Moderate 17% Poor 39%	NR	p<0.008, Mann- Whitney U test
Helm and Ravi 2003 (Helm and Ravi, 2003)	High	Speed of appointment 3.2 Communication after referral 4.1 Waiting time for surgery 3.5 Clinical results of surgery 4.1 Patient satisfaction 4.0 1=poor, 5=excellent	Speed of appointment 2.0 Communication after referral 3.5 Waiting time for surgery 2.3 Clinical results of surgery 3.8 Patient satisfaction 3.2 1=poor, 5=excellent	NRCARE SOLGED	NR
Issac et al 2008 (Isaac et al., 2008)	High	Orthopaedic surgeon opinion of podiatric surgeon outcomes No experience 28.8% Very poor 5.5% Poor 43.9% Satisfactory 15.2% Good 6.1% Very Good 1.5%	Podiatrist opinion of orthopaedic surgeon outcomes No experience 5.4% Very poor 4.3% Poor 26.1% Satisfactory 48.9% Good 10.9% Very Good 4.3%	NR	NR

Table 16Results of patient satisfaction across the studies

Study ID	Risk of bias	Podiatric surgeon	Orthopaedic surgeon	Absolute difference	Relative difference
Kilmartin 2001 (Kilmartin, 2001)	High	Happy or very happy 93%	-	N/A	N/A
Laxton 1995 (Laxton, 1995)	High	Completely satisfied 88% (95% 88 to 88%) Analysis of comparable cases (n=19)	Completely satisfied 56% (95% CI 32 to 80%) Analysis of comparable cases (n=35)	32%	-

*Exact numbers unknown, estimated from Figure 2 in the publication

CI=confidence interval, N/A=not applicable; NR=not reported

B.7. EXTENDED ASSESSMENT OF HARMS

The extended assessment of harms is included in section B.6, above

B.8. INTERPRETATION OF THE CLINICAL EVIDENCE

On the basis of the evidence profile (summarised in Table 17), it is suggested that, relative to foot and ankle surgery performed by orthopaedic surgeons, foot and ankle surgery performed by podiatric surgeons has non-inferior safety and non-inferior effectiveness.

Foot and ankle services by Podiatric Surgeons

 Table 17
 Balance of clinical benefits and harms of ankle and foot surgery performed by a podiatric surgeon, relative to foot and ankle surgery conducted by orthopaedic surgeons, and as measured by the critical patient-relevant outcomes in the key studies

Outcomes (units) Follow-up	Participants (studies)	Quality of evidence (GRADE)	Podiatric Surgeons	Orthopaedic surgeons
Malunion	1 study	$\oplus \oplus \odot \odot$	7.3%	4.6%
Infection	5 studies	$\oplus \oplus \odot \odot$	1.4% to 3.3%	0.0% to 4.3%
DVT	3 studies	$\oplus \oplus \odot \odot$	0.4% to 3.2%	0.0% to 3.1%
Irrigation and debridement	1 study	$\oplus \oplus \odot \odot$	2.2%	1.7%
Readmission	3 studies	$\oplus \oplus \odot \odot$	0.02% to 15.4%	1.8% to 17.2%
Length of stay	3 studies	$\oplus \oplus \oplus \odot$	1 -23 days	1 to 34 days

^a GRADE Working Group grades of evidence (Guyatt et al., 2013)

High quality: We are very confident that the true effect lies close to that of the estimate of effect.

• Moderate quality: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.

⊕⊕⊙⊙ Low quality: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect.

⊕⊙⊙⊙ Very low quality: We have very little confidence in the effect estimate. The true effect is likely to be substantially different from the estimate of effect.

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SECTION C

TRANSLATION ISSUES

C.1 OVERVIEW

No pre-modelling studies were required for the economic evaluation. As presented in Section B, relative to foot and ankle surgery performed by orthopaedic surgeons, foot and ankle surgery performed by podiatric surgeons has non-inferior safety and non-inferior effectiveness. The economic evaluation presented in Section D is therefore a cost-minimisation analysis. The probabilities of potential complications is based directly on the risk findings in Section B.6. To reflect the range of results presented in Section B.6 for some outcomes, a lower and upper bound scenario approach has been taken for the cost-minimisation analysis.

C.2 APPLICABILITY TRANSLATION ISSUES

No applicability issues have been identified.

C.3 EXTRAPOLATION TRANSLATION ISSUES

No extrapolation issues have been identified.

C.4 TRANSFORMATION ISSUES

No transformation issues have been identified.

C.5 ANY OTHER TRANSLATION ISSUES

No translation issues have been identified.

C.6 RELATIONSHIP OF EACH PRE-MODELLING STUDY TO THE ECONOMIC EVALUATION

No pre-modelling studies were undertaken.

SECTION D

ECONOMIC EVALUATION

D.1 OVERVIEW

The clinical evaluation finds that relative to foot and ankle surgery performed by orthopaedic surgeons, foot and ankle surgery performed by podiatric surgeons has non-inferior safety and non-inferior effectiveness. Table 18 sets out the framework that was used to classify the clinical evidence in Section B. Based on this, a cost-minimisation analysis is appropriate for the economic evaluation.

Table 18Classification of the comparative effectiveness and safety of the proposed therapeutic medical
service compared with its main comparator and guide to the suitable type of economic evaluation

Comparative safety	Comparative effectiveness				
	Inferior	Uncertain ^a	Non-inferior ^b	Superior	
Inferior	Health forgone: need other supportive factors	Health forgone possible: need other supportive factors	Health forgone: need other supportive factors	? Likely CUA	
Uncertain ^a	Health forgone possible: need other supportive factors	? HELPACAN	?	? Likely CEA/CUA	
Non-inferior ^b	Health forgone: need other supportive factors	3EEM ALEALT	СМА	CEA/CUA	
Superior	? Likely CUA	? Likely CEA/CUA	CEA/CUA	CEA/CUA	

CEA=cost-effectiveness analysis; CMA=cost-minimisation analysis; CUA=cost-utility analysis

? = reflect uncertainties and any identified health trade-offs in the economic evaluation, as a minimum in a cost-consequences analysis

^a 'Uncertainty' covers concepts such as inadequate minimisation of important sources of bias, lack of statistical significance in an underpowered trial, detecting clinically unimportant therapeutic differences, inconsistent results across trials, and trade-offs within the comparative effectiveness and/or the comparative safety considerations

^b An adequate assessment of 'non-inferiority' is the preferred basis for demonstrating equivalence

D.2 POPULATION AND SETTINGS

The conditions to which podiatric surgery relates correspond to eight clinical groupings:

- hallux abducto valgus (HAV);
- hammer and claw toes;
- hind foot/ankle pathology;
- ingrown toenails;
- hallux rigidus;
- arthritis;
- nerve impingement, and
- tumour (benign).

Podiatric surgeons operate in the private setting in a variety of locations including day surgery facilities and hospitals. The choice of facility is guided by the complexity of the procedure, the requirement for anaesthesia, and the age and health of the patient and associated comorbidities. Podiatric surgeons do not currently have admitting rights in public hospitals.

D.3 STRUCTURE AND RATIONALE OF THE ECONOMIC EVALUATION

The economic evaluation is a cost-minimisation analysis. A summary of the key characteristics of the economic evaluation is given in Table 19.

Table 19Summary of the economic	evaluation
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Perspective	Cost of treatment and cost of managing adverse events
Comparator	Comparable surgery undertaken by an orthopaedic surgeon
Type of economic evaluation	Cost-minimisation
Sources of evidence	Clinical Evaluation Systematic Review, MBS, ACPSR
Time horizon	One treatment episode
Outcomes	Cost per treatment episode
Methods used to generate results	Expected value analysis
Discount rate	NA (time horizon is less than 1 year)
Software packages used	Microsoft Excel 2016

LITERATURE REVIEW

To contextualise the economic implications of the application, a literature review has been undertaken to identify cost-effectiveness studies in the areas of podiatric surgery and foot and ankle orthopaedic surgery. The databases searched included:

- PubMed;
- Cochrane, and
- Health technology assessment agencies (NICE, SMC and CADTH).

PubMed search

The primary database used in the literature review PubMed includes citations for biomedical literature from MEDLINE and life science journals. A search was conducted using the PubMed database on the 21st of August 2019. The search terms used, and the corresponding number of results is presented in Table 20.

Search number	Search term	Number of results
1	Foot surgery	48 491
2	Ankle surgery	32 274
3	#1 or #2	61 197
4	Podiatric surgery or podiatric surgeon	2 131
5	Orthopaedic or orthopaedic surgeon	308 804
6	#4 or #5	310 511
7	#3 and #6 [hence limiting to podiatric or orthopaedic surgery of the foot or ankle]	20 107
8	pharmacoeconomic	20 437
9	Economic evaluation	103 147
10	Economic aspect	3 401
11	Health economics	347 775
12	Economics	758 072
13	cost effectiveness analysis OR cost utility analysis	98 482
14	statistical model OR markov model OR monte carlo method OR decision theory OR decision tree	554 339
15	economic model OR cost model OR decision analysis OR decision model	288 051
16	#8 or #9 or #10 or #11 or #12 or #13 or #14 or #15	1 455 418
17	#7 and #16 [hence limiting to podiatric or orthopaedic surgery of the foot or ankle with at least one economic term]	629

Table 20	PubMed search	i strategy and	results
		JJ	

The result of the PubMed search was analysed by reviewing the abstracts and published full reports of studies that were identified as potentially relevant. These studies were assessed for inclusion in the literature review against a pre-determined set of inclusion criteria designed to assess whether the study is relevant to the issue being evaluated. Table 21 illustrates the criteria developed for inclusion of studies that are to be critically appraised. The criteria is based on the format that The Cochrane Collaboration use for their systematic reviews of the literature.

Table 21Inclusion and exclusion criteria for economic evaluations

	r	
Group	Inclusion criteria	Example reasons for exclusion
Type of study	Economic evaluations such as cost effectiveness analysis	No relevant or useable data on cost or consequences
Population	People undergoing foot and ankle surgery for selected ICD- 10 indications	Populations with an unrelated indication
Intervention	Surgery by a podiatric surgeon	Procedures undertaken by a podiatrist not podiatric surgeon
Comparator	Surgery by an orthopaedic surgeon	Inappropriate comparator or no comparator
Outcome measure	Incremental cost per improvement in quality of life measure Cost saving Benefit cost ratio	Effectiveness or health outcomes that are not measured and linked back to cost e.g. burden of disease studies, model of care assessments

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Studies that did not evaluate cost-effectiveness or include any relevant economic term were excluded. The extensive literature involving podiatric surgery relates to clinical outcomes only, with the clinical literature previously assessed in Section B.

No relevant economic studies were identified. Table 22 presents a breakdown of the studies assessed. Most studies were not economic evaluations (e.g. clinical outcomes only, assessment of a model of care, burden of disease studies). Fifty studies were economic evaluations (e.g. cost utility/cost-effectiveness) but none compared podiatric surgeons with orthopaedic surgeons. Four studies were concerned with hospital funding/resourcing.

Table 22 Categorisation of the results of the PubMed literature review

Study type		Number of studies
Not an economic evaluation		575
Wrong intervention/comparator		50
Hospital funding/resourcing	A A A	4
Total	NO CLAR	629

Cochrane database search

The Cochrane database was searched on the 2nd of September using the search term 'podiatric surgery'. No relevant economic evaluations were identified.

HTA search

A search of three Health Technology Assessment (HTA) agencies was conducted on the 21st of August 2019. The HTA's considered, search terms used, and number of identified studies is presented in Table 23.

No relevant economic evaluations were identified.

Table 23 HTA search terms and results

Agency	Country	Search terms	Relevant studies		
NICE	United Kingdom	Podiatric surgery	0		
SMC	Scotland	Podiatric surgery	0		
CADTH	Canada	Podiatric surgery	0		

STRUCTURE OF THE ECONOMIC EVALUATION

The economic evaluation takes a cost per patient perspective. A schematic of the economic evaluation structure is presented in Figure 9.



Figure 9 Structure of the economic evaluation

D.4 INPUTS TO THE ECONOMIC EVALUATION

To reflect the non-inferiority findings of the clinical evaluation a cost-minimisation is presented. The analysis estimates the cost per patient associated with complication management (DVT and infection) and prosthesis use. The cost of the requested MBS item is not included in the economic model, as it would be the same whether delivered by a podiatric or orthopaedic surgeon.



Therefore, the inputs considered in the analysis are:

- probability of infection and associated management cost
- probability of DVT and associated management cost, and
- utilisation and cost of prosthesis.

Due to uncertainty around the probability of infection and DVT the cost-minimisation presents both a lower- and upper-case scenario, with the lower case reflecting the lower risk estimates for podiatric surgeons and orthopaedic surgeons and the upper case reflecting upper risk estimates for podiatric surgeons and orthopaedic surgeons. The expected resource use and unit cost associated with adverse event management are provided in Table 24.

SECTION E FINANCIAL IMPLICATIONS

E.1. JUSTIFICATION OF THE SELECTION OF SOURCES OF DATA

An epidemiological approach has been used to estimate the financial implications of allowing podiatric surgeons to access 23 surgical MBS item numbers and five general items.

The various sources of data that have been used to support this financial analysis are set out in Table 28 below, and assumptions developed through research and expert opinion are set out in Table 29. Assumptions generated from expert opinion reflect consensus amongst 4 podiatric surgeons, each with at least 15 years of surgical experience, who provided responses based on their own clinical records.

Table 28	Results of patient satisfaction across the st	udies
Data type or	variable	Source
Volumes an	d growth	
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tudies
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1	MBS activity for 23 requested therapeutic procedures	http://www.mbsonline.gov.au/
	Average podiatric surgery procedures per surgery	ACPS Audit Registry, 2017
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Costs	
MBS item costs and rebate percentages	http://www.mbsonline.gov.au/
Weighted average MBS cost for therapeutic services covered by the 23 therapeutic MBS items included in this submission	<u>http://www.mbsonline.gov.au/</u>

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E.3. CHANGES IN USE AND COST OF OTHER MEDICAL SERVICES

Given that in relation to the 23 requested MBS items, orthopaedic surgeons and podiatric surgeons treat the same pathologies and similar range of severity of disease, it is expected that their services are interchangeable. However, it is assumed that there will be no substitution between orthopaedic and podiatric activity, so all podiatric surgery would be 'new' to the MBS.

The ACPS seeks direct referral rights (a valid referral) to request MBS subsidised pathology and imaging. In addition, they request that anaesthetist fees are MBS subsidised when the surgeon is a podiatric surgeon; in line with the coverage for anaesthetists when the surgeon is an orthopaedic surgeon. As such, estimates of co-administered pathology, imaging and anaesthetist fees are included in this section. It should be noted that podiatric surgeons can already request some MBS subsidised plain x-ray and ultra-sound services (see Section A) so there will be no change to the cost to MBS of these items, irrespective of the outcome of this application.

UTILISATION AND COST OF MBS IMAGING SERVICES

Expert opinion was used to determine which MBS items best represent the items requested most frequently by podiatric surgeons. The imaging items provided are intended as a guide to the types of imaging that podiatric surgeons request. There may be some imaging item numbers that have not been presented in this application.

With the exception of duplex ultra-sound (taken from the ACPSR DVT complication rates), expert opinion was used to estimate the frequency of each type of imaging required. The imaging items are grouped as CT, diagnostic ultra-sound, duplex ultra-sound, fluoroscopy, nuclear imaging and MRI (See Section E workbook 'Background and assumptions'). s47G

E.5. IDENTIFICATION, ESTIMATION AND REDUCTION OF UNCERTAINTY

The 'low' and 'high' scenarios presented in Section E.4 reflect the range of the expected financial impacts of the proposed listing on the MBS based on potential workforce projections and associated caseload. Moreover, the unit costs considered in the change in use and cost of other medical services reflects the most expensive unit costs and therefore possibly overestimate costs to the MBS. In light of this, no further sensitivity analysis has been undertaken.

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APPENDIX A

SEARCH STRATEGIES

BIBLIOGRAPHIC DATABASES

Electronic database	Time period searched
Embase	1947 to 21 May 2019
Medline	1946 to 21 May 2019
The Cochrane Library (CDSR, Central, DARE, HTA, HEED)	To April/May 2019
Allied and Complementary Medicine	< 1985 to May 2019

AMED (Allied and Complementary Medicine) Search Strategy: HEASTD 1982 GED ARE

- 1 Scarf Akin Variants.af. (0)
- 2 Lesser toe arthroplasty.af. (0)
- 3 Lesser toe arthrodesis.af. (0)
- 4 Cheilectomy.af. (41)
- 5 exostectomy.af. (24)
- 6 (neuroma* adj3 excis*).af. (24)
- 7 (metatarsal* adj3 osteotomy).af. (359)
- 8 Fixation removal.af. (3)
- 9 bunionectomy.af. (67)
- 10 (tendon* adj5 (foot or ankle)).af. (485)
- First MTPJ arthrodesis.af. (4) 11
- (amputat* adj5 (foot or ankle)).af. (409) 12
- 13 (amputat* adj5 (toe or toes or metatarsal*)).af. (99)
- 14 Hallux valgus.af. (952)
- 15 (Hammer toe or Hammer toes).af. (48)
- 16 Hallux rigidus.af. (211)
- 17 Interdigital Neuroma*.af. (32)
- 18 (Ingrown toenail* or Ingrowing toenail*).af. (39)
- 19 (Ingrown nail* or Ingrowing nail*).af. (4)
- 20 (Fixation related adj5 (foot or feet or ankle or toe or toes)).af. (0)
- 21 (Fixation adj5 (foot or feet or ankle or toe or toes)).af. (314)
- 22 OA-Mid foot.af. (0)
- 23 Hallux valgus rigidus.af. (2)
- 24 Tailor* bunion.af. (19)
- 25 Metatarsalgia.af. (243)
- 26 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 (2766)
- 27 podiatr*.af. (1009)
- 28 exp Podiatry/ (651)
- 29 27 or 28 (1009)
- 30 26 and 29 (67)
- 31 from 30 keep 1-67 (67)
- 32 exp Orthopedics/ (9614)
- ((orthoped* or orthopaed*) adj5 (surgeon* or surgery or physician*)).af. (864) 33
- 34 26 and 33 (95)
- 35 from 34 keep 1-95 (95)

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Cochrane search strategy:

1 exp Podiatry/ (43) 2 podiat*.af. (514) 1 or 2 (514) 4 exp Foot/ (1541) 5 exp Ankle/ (472) 6 Scarf Akin Variants.af. (0) 7 Lesser toe arthroplasty.af. (0) 8 Lesser toe arthrodesis.af. (0) 9 Cheilectomy.af. (8) 10 exostectomy.af. (1) 11 (neuroma* adj3 excis*).af. (10) (metatarsal* adj3 osteotomy).af. (83) (foot adj3 osteotomy).af. (11) ((toe or toes) adj3 osteotomy).af. (2) Fixation removal.af. (8) bunionectomy.af. (176) (tendon* adj5 (foot or ankle)).af. (173) MTPJ arthrodesis.af. (3) (amputat* adj5 (foot or ankle)).af. (440) (amputat* adj5 (toe or toes or metatarsal*)).af. (71) Hallux valgus.af. (389) (Hammer toe or Hammer toes).af. (22) Hallux rigidus.af. (51) Interdigital Neuroma*.af. (9) (Ingrown toenail* or Ingrowing toenail*).af. (72) (Ingrown nail* or Ingrowing nail*).af. (42) (Fixation related adj5 (foot or feet or ankle or toe or toes)).af. (0) (Fixation adj5 (foot or feet or ankle or toe or toes)).af. (193) OA-Mid foot.af. (0) 30 Hallux valgus rigidus.af. (2) Tailor* bunion.af. (0) Metatarsalgia.af. (54) bunion*.af. (215) 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 (3021) 3 and 34 (117) exp Surgery/ (336) (surgical* or surgeon* or surgery).af. (239652) 36 or 37 (239652) 35 and 38 (69) ((orthoped* or orthopaed*) adj5 (surgeon* or surgery or physician*)).af. (9113) 34 and 40 (185) 39 and 41 (12) from 42 keep 1-12 (12) 35 not 43 (105) 37 and 44 (57) 46 from 45 keep 1-57 (57) 34 and 40 (185) 47 not (43 or 46) (173) from 48 keep 1-173 (173)

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Embase Classic & Medline search strategy:

- 1 Scarf Akin Variants.af. (0)
- 2 Lesser toe arthroplasty.af. (0)
- 3 Lesser toe arthrodesis.af. (4)
- 4 Cheilectomy.af. (316)
- 5 exostectomy.af. (146)
- 6 (neuroma* adj3 excis*).af. (599)
- 7 (metatarsal* adj3 osteotomy).af. (3402)
- 8 Fixation removal.af. (110)
- 9 bunionectomy.af. (838)
- 10 (tendon* adj5 (foot or ankle)).af. (6791)
- 11 First MTPJ arthrodesis.af. (32)
- 12 (amputat* adj5 (foot or ankle)).af. (8772)
- 13 (amputat* adj5 (toe or toes or metatarsal*)).af. (3625)
- 14 Hallux valgus.af. (9210)
- 15 (Hammer toe or Hammer toes).af. (1128)
- 16 Hallux rigidus.af. (1718)
- 17 Interdigital Neuroma*.af. (227)
- 18 (Ingrown toenail* or Ingrowing toenail*).af. (1019)
- 19 (Ingrown nail* or Ingrowing nail*).af. (1366)
- 20 (Fixation related adj5 (foot or feet or ankle or toe or toes)).af. (0
- 21 (Fixation adj5 (foot or feet or ankle or toe or toes)) af. (2269)
- 22 OA-Mid foot.af. (0)
- 23 Hallux valgus rigidus.af. (5)
- 24 Tailor* bunion.af. (148)
- 25 Metatarsalgia.af. (2467)
- 26 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 (36814)
- 27 podiatr*.af. (22045)
- 28 exp Podiatry/ (4800)
- 29 27 or 28 (22045)
- 30 26 and 29 (2743)
- 31 exp Orthopedics/ (46971)
- 32 ((orthoped* or orthopaed*) adj5 (surgeon* or surgery or physician*)).af. (459336)
- 33 31 or 32 (489822)
- 34 26 and 33 (6405)
- 35 30 and 34 (368)
- 36 exp Surgery/ (4973880)
- 37 (surgical* or surgeon* or surgery).ab,de,kw,ot,sh,ti,tw. (4761481)
- 38 36 or 37 (7495086)
- 39 35 and 38 (306)
- 40 remove duplicates from 39 (253)
- 41 from 40 keep 1-253 (253)
- 42 30 and 38 (1725)
- 43 exp Outcomes/ (72918)
- 44 exp Treatment Outcome/ (2474330)
- 45 exp Safety/ (540601)
- 46 safe*.ab,de,kw,ot,sh,ti,tw. (2060353)
- 47 risk*.ab,de,kw,ot,sh,ti,tw. (5848645)
- 48 complication*.ab,de,kw,ot,sh,ti,tw. (2224247)
- 49 efficac*.ab,de,kw,ot,sh,ti,tw. (1924325)

- 50 effective*.ab,de,kw,ot,sh,ti,tw. (4210012)
- 51 (hospital adj3 stay).ab,de,kw,ot,sh,ti,tw. (220730)
- 52 readmission*.ab,de,kw,ot,sh,ti,tw. (66164)
- 53 infect*.ab,de,kw,ot,sh,ti,tw. (4022160)
- 54 adverse*.ti,ab,kw,ot,sh,tw. (1443759)
- 55 morbidit*.ti,ab,kw,ot,sh,tw. (1012358)
- 56 43 or 44 or 45 or 46 or 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 (17242355)
- 57 (podiat* adj3 (surgeon* or surgery or surgical*)).ti,ab,kw,ot,sh,tw. (1040)
- 58 26 and 56 and 57 (103)
- 59 exp Foot Surgery/ (7085)
- 60 56 and 57 and 59 (78)
- 61 58 or 60 (148)
- 62 remove duplicates from 61 (124)
- 63 62 not 41 (101)
- 64 from 63 keep 1-101 (101)
- 65 26 and 32 and 56 (3407)
- 66 *Orthopedics/ (27245)
- 67 exp Orthopedic Surgeons/ (6503)
- 68 66 or 67 (33403)
- 69 65 and 68 (93)
- 70 69 not (41 or 64) (89)
- 71 remove duplicates from 70 (84)
- 72 exp randomized controlled trials/ or exp randomized controlled trial/ (1310590)
- 73 randomized controlled trial.pt. (482257)
- 74 exp random allocation/ or exp randomization/ (181847)
- 75 exp Double-Blind Method/ or exp Double-Blind Procedure/ (314317)
- 76 exp Single-Blind Method/ or exp Single-Blind Procedure/ (61871)
- 77 exp placebos/ or exp placebo/ (378900)
- 78 ((single or double or treble or triple) adj2 (blind* or mask* or dumm*)).ti,ab,kw,ot,sh,tw. (395596)
- 79 random*.ab,kw,ot,sh,ti,tw. (2906035)
- 80 parallel*.ti,ab,kw,ot,sh,tw (662131)
- 81 placebo*.ab,kw,ot,sh,ti,tw. (660779)
- 82 assign*.ab,kw,ot,sh,ti,tw. (662839)
- 83 72 or 73 or 74 or 75 or 76 or 77 or 78 or 79 or 80 or 81 or 82 (4162836)
- 84 26 and 32 and 83 (420)
- 85 limit 84 to human (385)
- 86 remove duplicates from 85 (276)
- 87 71 or 86 (355)
- 88 87 not (41 or 64) (345)
- 89 (case report or comment or editorial or letter or note or review).pt,sh. (11361071)
- 90 88 not 89 (288)
- 91 (conference abstract or conference paper or conference poster or meeting abstract or meeting paper or meeting poster).pt,sh. (4172492)
- 92 90 not 91 (230)
- 93 from 92 keep 1-230 (230)

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ADDITIONAL SOURCES OF LITERATURE (INCLUDING WEBSITES)

 Source
 Location

 Australian Clinical Trials Registry
 Location



APPENDIX B STUDIES INCLUDED IN THE SYSTEMATIC REVIEW

Authors Study ID Publication year	Study design/ duration	Level of evidence ^a	Location Setting Length of follow-up	Study population characteristics	Description of intervention	Description of comparator	Relevant outcomes assessed	Measurement of outcomes and methods of analysis	Selection Bias ^b	Performance Bias ^b	Attrition Bias ^b	Detection Bias ^b
Amansco 2012 (Amanasco et al., 2012, McCaffrey, 2014)	Coh 6-10 months post-surgery (podiatric group) 11-20 months post-surgery (orthopaedic group)	-2	SC	N=116 Demographics not reported. Hallux valgus, Keller arthroplasty, first metatarsophalangeal joint fusion, lesser toe fusion, soft tissue mass excision, multiple metatarsal osteotomies, forefoot reconstruction	Surgery by podiatric surgeon (n=56)	Surgery by orthopaedic surgeon (n=60)	Patient satisfaction Complications	Questionnaire	Unclear	High	High	High
Bennet 2007 (Bennett, 2007)	RCoh	III-2	10 podiatric surgeons	N=785 Male 19.9% SA 28.5% Victoria 30.9% WA 40.5% Age 47.2±18.5 (range 7 to 92)	Podiatric surgery	N/A	Demographics					

Table 24Profiles of studies on foot and ankle surgery included in the systematic literature review
Authors Study ID Publication year	Study design/ duration	Level of evidence ^a	Location Setting Length of follow-up	Study population characteristics	Description of intervention	Description of comparator	Relevant outcomes assessed	Measurement of outcomes and methods of analysis	Selection Bias ^b	Performance Bias ^b	Attrition Bias ^b	Detection Bias ^b
Chan 2018 (Chan et al., 2018)	RCoh	-2	Claims database Ankle fracture	N=11,115 (orthopaedic) N=630 (podiatric) Over 60 years, 66% (ortho); 64% (pod) Male: 33% (ortho), 35% (pod) CCI 2.7±3.4 (ortho) 2.8±3.3 (pod)	Podiatric surgeon	Orthopaedic surgeon	Demographics Comorbidities Complications	Database extraction	High	High	Unclear	High
Cichero et al 2013 (Cichero et al., 2013)	RCoh	-2	10 months (pod) 11 months (ortho)	N=34 (orthopaedic) N=75 (podiatric coordinator) Demographics not reported	Podiatric surgeon / coordinator	Orthopaedic surgeon	Length of stay Readmission	Medical record audit	High	High	Low	Low
Gilheany and Robinson (Gilheany and Robinsons, 2007)	RCoh	111-2	N/A	N=21,834 (orthopaedic) N=1260 (podiatric) Great toe surgery	Podiatric surgeon	Orthopaedic surgeon	Volume of surgery	MBS vs Podiatric surgeons	High	High	High	High
Helm and Ravi 2003 (Helm and Ravi, 2003)	Coh	-2	N/A	Survey of 129 general practitioners	Podiatric surgeon	Orthopaedic surgeon	GP satisfaction	Survey	High	Unclear	Low	High

Authors Study ID Publication year	Study design/ duration	Level of evidence ^a	Location Setting Length of follow-up	Study population characteristics	Description of intervention	Description of comparator	Relevant outcomes assessed	Measurement of outcomes and methods of analysis	Selection Bias ^b	Performance Bias ^b	Attrition Bias ^b	Detection Bias ^b
Isaac et al 2008 (Isaac et al., 2008)	Coh	-2	Survey	Orthopaedic surgeons and podiatric surgeons	Podiatric surgeons	Orthopaedic surgeons	Outcomes of surgery	Survey	High	High	High	High
Kilmartin 2001 (Kilmartin, 2001)	RCoh	-2	4 years	Patients undergoing surgery in the Nottingham Community Trust Podiatric Surgery (UK) N=2,335	Podiatric surgeons	RELEASE NATION T	Surgical outcomes Patient satisfaction	Medical record review	High	High	Low	High
Laxton 1995 (Laxton, 1995)	RCoh	-2	Nine- months post operatively	UK podiatric and orthopaedic surgeons, nail surgery n=353 cases, survey response 219/352* (62%) *1 survey not sent as patient had died	Podiatric surgeons (n=5)	Orthopaedic surgeons (n=9)	Patient satisfaction Surgery type	Audit and survey	High	High	Low	High

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APPENDIX C EVIDENCE PROFILE TABLES

Table 25	Evidence profile table for foot and ankle surge	y performed by a podia [.]	tric surgeon compared to fo	bot and ankle surgery performed by	an orthopaedic surgeon
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Outcome (units, follow-up)	No. of studies	Bias	Inconsistency	Indirectness	Imprecision	Quality of evidence (GRADE)	No. of patients in podiatric surgeon arm	No. of patients in orthopaedic surgeon arm	Podiatric Surgeons	Orthopaedic surgeons	No. of studies	Bias
Malunion	1 study (Chan et al., 2018)	High	No serious inconsistency	No serious indirectness	Serious imprecision	000	11,115	630	7.3%	4.6%	Malunion	1 study (Chan et al., 2018)

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APPENDIX D EXCLUDED STUDIES

The following studies were excluded from this analysis as we were unable to obtain full text copies, and insufficient information was available in the abstract for data extraction:

Borthwick, A.M., *Challenging medical dominance: podiatric surgery in the National Health Service.* British Journal of Podiatry, 1999. **2**(3): p. 75-83. **Full text request sent to Author via ResearchGate.**

Glenn, L.L., *Patient-reported medical outcomes according to physician type and region*. Journal - American Podiatric Medical Association, 1995. **85**(6): p. 328-37. **Full text request sent to publisher.**

Laxton, C., Clinical audit of forefoot surgery performed by registered medical practitioners and podiatrists. J Br Podiatr Med, 1996. **51**(4): p. 46-51.

APPENDIX F

ACPS CLINICAL PATHWAY FOR

PATIENT CARE



Issued by the ACPS Council.

1. PURPOSE AND SCOPE

This resource provides a guide for the development, implementation and evaluation of clinical pathway.

2. BACKGROUND

The College recognises national standards and resources exist to assist in the development of guidelines and standards for clinical practice. The College has adopted this clinical care pathway to guide reliable delivery of safe, effective, efficient, and patient-centred care.

3. BODY OF RESOURCE

The following 17 steps are recommended in order to provide appropriate management of patients who undergo podiatric surgery.

- 1. Assessment of subjective patient complaints and objective data including medical history. Identify, evaluate and mitigate risk factors that could delay surgery. Identify comorbid conditions (eg: pulmonary, cardiac, diabetes, renal, anticoagulation, uncontrolled/undiagnosed depression or infection) which may require perioperative comanagement. Assess for characteristics that may increase risk for complications or extended length of stay (eg: older age, obesity, lower pre-op function). Identify, document and communicate the patient's personal goal for surgery.
- 2. Record an initial patient centred assessment and management plan in a standardised format such as a (S.O.A.P.) note (acronym for subjective, objective, assessment, and plan).
- 3. With patient consent inter-professional written communication (including referral where indicated) will be sent to healthcare providers who will or may manage the patient during the episode of surgical care.
- 4. Inter-professional communication may alter the final surgical plan prior to admission.
- 5. The patient will be regularly reviewed until clinical assessment indicates that discharge from podiatric care is appropriate.

- 6. Inter-professional written communication will report patient progress until the patient is discharged from podiatric surgical care.
- 7. Identify, evaluate and mitigate risk factors that could delay surgery; conduct a standard multi-speciality evaluation to assess comorbid conditions (eg: pulmonary, cardiac, diabetes, renal, anticoagulation, uncontrolled/undiagnosed depression or infection).
- 8. Assess for characteristics that may increase risk for complications or extended length of stay (eg: older age, obesity, lower pre-op function). Identify, document and communicate the patient's personal goal for surgery.
- 9. Actively engage the patient and their family or caregiver in care discussions from the pre-operative surgical consult through to post discharge care appointments, including shared decision making, education, discharge planning and rehabilitation.
- 10. Identify critical/high-risk medications to monitor in the preoperative period, such as diabetes medications, anticoagulants, beta blockers, anti rheumatologic medications and pain medications.
- 11. Implement a patient expectation management process where patients are actively engaged in the care process and in the discharge planning process before admission; set expectations about pain, mobilization (day of surgery) and where they are being discharged (home as preferred option for most patients).
- 12. Encourage value added prosthesis selection based on anatomy & activity level of patient.
- 13. Complications will be assessed according to acute/chronic condition and in/outpatient management classifications.
- 14. Referral to other healthcare providers (e.g: General Practitioner, Physician, Specialist or allied healthcare) will occur based on the ability of the podiatric surgeon to provide management and point (6).
- 15. Where patient referral for management of acute complications requiring inpatient admission is indicated a *clinical handover* protocol will be followed.
- 16. Healthcare providers who will or may manage the patient during a complication will be kept informed of patient status via inter-professional written communication.
- 17. Maintain a contemporaneous record of the above process in the patient's case notes.

4. RELEVANT DOCUMENTS

Refer to attached Clinical Pathway Diagram (Next Page)

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Review date: October 2020	To be reviewed by: ACPS Council				

DIABETIC CONFERENCE 2019 FLYER



Diabetic Conference 2019: Urgent Diabetic Foot Surgery - A Team Approach

Friday 13 December 2019





A hands-on one day cadaveric workshop on podiatric surgical techniques

CTEC at The University of Western Australia is proud to host the Diabetic Conference 2019 satellite cadaveric workshop Urgent Diabetic Foot Surgery - A Team Approach. This inaugural workshop aims to start the conversation between all those interested in the diabetic foot, how to preserve tissue using anatomically based debridement, how to avoid moving the pressure from one part to the other, how to actively change the shape of the foot to prevent damage - for example, by a simple tenotomy.

This workshop aims to provide opportunity for cross disciplinary engagement, discussion of techniques and strategies and learning about basic podiatric surgical tehcniques. The dissemination of multidisciplinary approaches can avoid major amputation and deliver better care, particularly in remote regions. Please consider being part of the conversation for change!

Thank you to Diabetic Conference 2019 sponsors: diabeteswa

If you've got it, we get it.

INTEGRA

BD

Workshop Content

Didactic & cadaveric practical sessions utilising lower leg with foot specimens:

Practical cadaveric surgical sessions:

- Flexor tenotomy
- Trans metatarsal amputation
- Chopart amputation
- Peroneus Brevis tendon transfer
- Tendo Achilles lengthening

Application of plaster

- Theoretical knowledge: Decision making in managing acute
- diabetic foot sepsis Optimising minor amputations
- Contemporary options for management of osteomyelitis
- Wound coverage with local (rotational) flaps
- What's new in Charcot
- neuroarthropathy management Practical knowledge:

Appreciation and deep understanding

- of foot anatomy with specific reference to effective drainage of diabetic foot sepsis
- Understanding of tendon structure and its appropriate dissection
- Chopart amputation
- Application of suture types to secure tendon to tendon, and/or tendon to bone
- Common procedures (indications and post operative care)



Faculty

Professor David Armstrong The University of Southern California

Professor Toby Richards

Suitable for

observe in the workshop's practical

Accreditation

RACS CPD Program accreditation

Venue

The University of Western Australia Entrance No. 2, Hackett Drive,

Fees

Register Online

Further Information

T+61 8 6488 8505

Workshop content, date and faculty may

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AUSTRALASIAN COLLEGE OF PODIATRIC SURGEONS

Clinical Governance Framework

Partnering with patients and stakeholders to deliver high-quality care and treatment

Version 1.3 2021

Version	Change Summary	Effective from	Effective To
1.1	Draft		

This document should be read with the following:

- ACPS Clinical Audit Committee Terms of Reference •
- Resource Board Terms of Reference •
- CPD Board Terms of Reference •
- Appeals Committee Terms of Reference
- International Committee Terms of Reference

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Executive Summary

The Australasian College of Podiatric Surgeons (ACPS or "the College") is committed to ensuring that high-quality care is provided to all patients at all times.

Historically this has meant adherence to national audit and peer review as component of ongoing ACPS accreditation of its surgical members.

The ACPS and its Boards and Committees recognise the need for a structured approach to clinical governance and accountability throughout a practitioner's career and this document provides a framework that ensures all members understand their clinical accountabilities. This framework is dependent on the ACPS having best practice clinical governance systems which ensure effective reporting, monitoring, and taking action capabilities within each of the committees. This framework provides a reference point against which the committees must benchmark.

The organisational structure of the ACPS is provided in Figure 1 below. The Training Program is responsible for the training of podiatric surgeons and is accredited via AHPRA and has its own Boards and Committees. The clinical governance framework is aligned and integrated via the policies and terms of reference of the Boards and Committees highlighted in red.



ACPS Organisational Chart. The college also conducts an education program which has its own separate organisational chart. This function regulated and accredited via AHPRA.

This commitment to excellence in care, treatment, and services through a best practice clinical governance framework ensures that ACPS members provide evidence-based care and treatment at all times.

This framework has been developed to support podiatric surgeons who are members of the ACPS in the goals of best patient care. The frameworks informs and as stated guides all committees. Full implementation of the framework is planned.

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The ACPS fellowship training program curriculum reflect the framework so that registrars are familiar with the structure and function of the framework. This document is part of the ACPS training program resource supporting the capabilities and standards against which the ACPS training program is accredited.

For the purpose of this document the term "member" refers to a podiatric surgeon who is complying with the annual accreditation requirements of the ACPS.

I am pleased to see the ongoing refinement and development of our processes to facilitate and support best care, transparency and accountability. This framework ensures our needs are met now and into the future, supports a partnership with our patients, and allows members to understand and deliver against their accountabilities for best practice clinical care. Finally, the ACPS and its members are committed to lifelong learning.

Mr Peter Manuel President Australasian College of Podiatric Surgeons

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Clinical Safety & Quality Policy Statement

The ACPS is committed to ensuring skilled and professional podiatric surgeons deliver best practice evidence-based care in collaboration with consumers and their families. As well as building upon and maintaining the capabilities and standards required for specialist registration via a lifelong commitment with the focus on facilitating a positive experience for all of our patients.

Our aim is to also create a culture of continuous improvement and learning. This culture will be patient centered, outward looking resulting in the delivery of high-quality care to all patients.¹

Clinical Governance

Clinical governance is a shared responsibility to ensure that all consumers receive the best care.

The ACPS Clinical Governance Framework supports all members in providing leadership, responsibility, and accountability for maintaining standards of quality, continuous improvement, minimise risk and fostering an environment of excellence in partnership with our patients.

This framework outlines the requirements for an effective clinical governance system for the ACPS. The responsibility to effectively operationalise this framework to maximise patient service quality rests with all members.

Our approach is to ensure that our clinical governance systems are driven by a focus on the right care for all patients. Our goal is to achieve great outcomes and exceed compliance expectations.

"Good integrated governance should start from the top and spread to every aspect of the organisation if high quality care is to be sustained" – Healthcare Governance Review This framework sets out the systems and processes that enable organisational accountability for the delivery of services that are safe, effective, highquality and continuously improving.

The ACPS Clinical Governance Framework is composed of the following domains²

- 1. Leadership and Culture visible, accountable, and purposeful leadership is required to cultivate an inclusive and just culture.
- 2. **Consumer Partnerships** consumer participation including shared decision-making are crucial indicators of safety and quality. Effective consumer partnerships are essential for improving healthcare outcomes and driving continuous improvement.
- 3. Workforce Capability Systems are required to support and protect podiatric surgeons to enable the delivery of safe, high-quality care. This requires comprehensive strategies and plans for developing, engaging, and retaining high-performing clinical staff.
- 4. Safety & Quality Systems Minimising and safeguarding against clinical risk requires a structured approach to safety that is based on partnerships with our patients, staff, and other stakeholders. We are determined to continue to be known for delivering high-quality and safe care.
- Clinical Practice Performance & Effectiveness – Systems are required to support clinicians to deliver evidence-based practice, monitor unwarranted variation in practice and continuously improve clinical services and outcomes.
- 6. Safe Environment for the Delivery of Care We are committed to ensuring a safe environment of care is maintained at all times.

The ACPS will work with all stakeholders to achieve an integrated clinical governance system that maintains and improves the reliability, safety and quality of our services for all patients.

These domains also reflect synergistically with policies, guidelines and accreditation standards of the national health practitioner registration and accreditation scheme

² Australian Commission on Safety & Quality in HealthCare – National Model Clinical Governance Framework (2017)

- 1. The patient is focused at the centre of all safety and quality business decisions
- 2. All priorities and strategic objectives to improve safety and quality are clearly communicated to all relevant parties
- 3. Strong clinical leadership and ownership we are committed to engaging with and listening to our members
- 4. Compliance with all legislative and regulatory requirements
- 5. The safety and quality-impact of all decisions are formally considered
- 6. Failures are disclosed errors are reported without fear of inappropriate blame, with patients and their families being told what went wrong and why
- 7. An emphasis on learning our systems are orientated towards learning from mistakes and we use improvement methods to assess identified risks and opportunities
- 8. The obligation to act is understood and the obligation to take action is accepted. The responsibility of all is unambiguous and explicit
- Accountability is clearly defined the limits of individual accountability are clear and defined roles and responsibilities are understood by all. Individuals understand when they may be held accountable for their actions.
- 10. There is a just culture members are treated fairly

Our patient's needs and experience of their care and outcomes are the focus of what we do. The interaction and partnership between patients, clinicians and care teams ensure a partnership approach to care needs.

The ACPS recognises that to become a fullyfledged learning organisation which monitors and takes action to improve the standards of clinical care is an important and challenging task. The purpose of this Framework is to provide a basis to demonstrate our commitment to the provision of safe, high-quality care:

"Clinical governance and quality improvement require a focus on evidence and data, not just trust" - CRANAplus, 2013

This Framework is applicable across all ACPS services, settings and sites and provides a road-map for determining direction and accountability at all organisational levels. This Framework acknowledges the differences in care needs, whether for inpatient or ambulatory care services.

This Framework is aligned with the *National Safety* and *Quality Health Service Standards and Jurisdictional Policy requirements.* For example: The Codes of Conduct and Registration Standards

of the Podiatry Board of Australia.

A conceptual model of the ACPS Clinical Governance Framework is as follows:



Figure 1: A conceptual model of the ACPS Clinical Governance Framework.

Domains of Clinical Governance

1 Leadership and Culture

A strong organisational culture is required to enable the ACPS to create and maintain high-quality care. This culture should involve fairness, respectfulness, and transparency and based on the principles of natural justice, innovation, lifelong learning and accountability for decisions and behaviours.

The systems in place to support leadership and culture include:

- 1. A vision for improving the quality of care;
- 2. Organisational alignment in achieving strategic goals and priorities;
- 3. Supportive, transparent and responsive culture, set and led by the governing body;
- Accountability is assigned for planning, monitoring, and improving the quality of ACPS surgical activities;
- 5. The external benchmarking of clinical performance and seeking external ideas and knowledge;
- 6. Committee and reporting structures are in place to effectively monitor and improve clinical performance;
- 7. Development and support for members at all levels of the organisation; and
- 8. Evaluating systems to test the strength of organisational culture and positive leadership systems.

The ACPS Council has executive accountability for ensuring effective clinical governance and quality improvement systems are in place.

Committees have delegated accountability to support the Council to enact this responsibility.

Effective governance means that the Board does not accept what it is told without question – Healthcare Governance Review

Signs of Success

- Member survey response rates exceed 40%
- Members report that a just culture exists
- Leaders are visible and actively seek and act on member and consumer feedback
- Actions to achieve safety and quality objectives are monitored at every level of the organisation
- Consumers are active participants in evaluating care outcomes
- Members are aware of their safety and quality responsibilities

- ACPS acts to improve clinical performance results
- Risks impacting on the organisation's ability to build and maintain a positive culture, leadership and governance systems are identified, mitigated, and controlled as much as possible.

2 Consumer Partnerships

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Effective healthcare focuses on the patient and their experience.

Effective consumer partnerships are essential for improving healthcare outcomes and driving continuous improvement. Listening and responding to the consumer is at the heart of good clinical governance.

The ACPS systems supporting consumer partnerships include:

- 1. Consumers and their needs are the primary organisational priority;
- 2. Consumers are invited to provide feedback regarding their experience;
- 3. Consumers are provided with the skills and knowledge to participate in their care;
- 4. Clear, open, and respectful communication exists between consumers and members;
- 5. Members respond to the diverse needs of consumers and the community;
- 6. The ACPS learns from and acts on the feedback on clinical care and service delivery, as provided by consumers in order to make improvements;
- 7. The rights and responsibilities of consumers are respected and promoted to the community, consumers, carers, and members; and
- 8. The systems for empowering meaningful consumer participation are regularly and rigorously evaluated.

Signs of Success

- Consumer feedback results in the identification of risks and improvements arising from consumer feedback processes
- Positive consumer survey feedback in relation to healthcare rights
- Shared understanding of goals of care relating to clinical outcomes
- Consumer representatives feel that they are contributing to improving care
- Risks impacting on the organisation's ability to partner effectively with consumers are identified, mitigated, and controlled as much as is possible
- The ACPS Consumer Engagement Strategy is under implementation

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3 Workforce Capability

Members must have the right qualifications, skills, and supervision to provide safe, high-quality healthcare and must have a commitment to life-long learning and a commitment to their patients.

Members also need to be actively engaged in, and provide leadership for, the continued improvement, planning and management of patient care, clinical services and working collaboratively to support the organisation to meet its safety and quality strategic objectives.

The ACPS systems that are in place to support and protect a skilled, competent, and proactive membership include:

- 1. Planning, allocation, and management of member needs
- 2. Members have the appropriate qualifications and experience to provide high-quality care and ongoing professional development to maintain and improve skills –
- 3. Promotion and support of multi-disciplinary teamwork is the basis of providing high-quality care
- 4. Clear communication of role expectations, responsibilities and standards of performance is provided to all members and they are supported and held accountable for meeting these expectations
- 5. Mentoring and supervision is used to support, monitor, and develop members
- 6. A defined system for managing complaints or concerns about a member is in place and is regularly reviewed for its effectiveness
- 7. A safe and fair workplace based on a just culture and mutual respect is provided, with systems in place to address issues³

Signs of Success

- Member engagement and satisfaction is measured and is a priority area of focus for the ACPS
- Members are supported to understand their safety and quality responsibilities
- There are high levels of participation in professional development planning
- There is high compliance with mandatory and competency-based training programs
- Risks impacting on the organisation's ability to develop and maintain a skilled and competent workforce are identified, mitigated, and controlled

4 Patient Safety & Quality Systems

Safety and quality systems are integrated with governance processes to enable the ACPS to actively manage and improve the safety and quality of health care.

The ACPS safety and quality systems that should be and are in place to support and create a learning environment and a comprehensive program of continuous improvement:

- 1. **Policy management system** that enables the ACPS to deliver services in accordance with agreed standards, legislation and jurisdictional requirements and reduce any risks to consumers or members
- 2. Quality improvement system delivered in partnerships with consumers that drives the ACPS quality program including audit and evaluation, consumer feedback and improvement
- 3. Determination and monitoring of safety and quality systems and clinical performance that result in system and clinical improvements. Identifying and monitoring critical safety and quality measures; unwarranted variation in clinical practice and safety and quality systems is critical to a highly reliable, improvement focused organisation.
- 4. **Risk Management system** that results in the identification, assessment, and ability of the ACPS to deliver safe, effective, and appropriate care to all patients. Consistently safe practice is built on member awareness; knowledge and participation in the system including clinical and peer audit.
- 5. Learning from Events Analysis of consumer feedback and experience along with patient incidents and complaints in partnership with consumers, their families and staff provides a mechanism to learn how well the organisational systems work and provides an opportunity to continually evolve person- and family-centred approaches to care.
- 6. Healthcare Record system that is available at the point of care, supports continuity of care and identification and communication of goals; consumer/treatment re-assessment findings; risks/critical information; and evaluation of the impact of treatment and care on the goals and is integrated with other information systems.

 $^{^{\}rm 3}$ National Safety & Quality Health Service Standard 1 – Clinical Governance

Signs of Success

- Policy, procedure, and practice guidance documents are relevant, current, culturally-inclusive and accessed by members
- Improvement actions in the ACPS Improvement plan and risks are progressed
- Key performance indicators monitored at all levels of the organisation
- Consumers are engaged in the evaluation of safety and quality systems
- Strategic clinical risks are current, monitored for control effectiveness and any treatments are actioned within timeframes
- Incidents, complaints, and consumer feedback data is reviewed, and action taken
- Medical record documentation meets best practice requirements
- Risks within organisational systems are identified, mitigated, and controlled.

5 Clinical Practice

Good clinical practice requires systems that support members to provide safe and appropriate care for each consumer with the best possible outcome, working within their clinical scope of practice.

Clinical practice should strive for patient-centred, cohesive, and integrated care at all times along the care continuum. It should ensure a shared understanding of the care pathway and goals between clinicians and consumers.

Systems in place to support clinicians to deliver evidence-based practice, monitor unwarranted variation in practice and continuously improve clinical outcomes include:

- 1. Evidence-based Care Standards are available and accessible
- 2. Clinical partnerships are developed with consumers to support active involvement by consumers in decisions and planning about current and future care
- 3. Clinical communication systems support effective partnerships by ensuring consumers receive information they need in a way that is appropriate to them
- 4. Clinicians regularly review clinical care and compare data on performance with external sources and other similar health organisations and use this to reduce unwarranted variation to practice and inform improvements in safety and quality systems and practice.
- Clinicians are supported through supervision, mentoring and coaching programs to deliver safe, evidence-based care⁴

"A good clinician will make consistently good clinical decisions but having a system of effective clinical governance means there is a structure to ensure that this is not by chance, but follows from good recruitment, continuing professional education and clinical audit. Such a system will enable good performance to be sustainable and to be spread across the organisation." – Healthcare Governance Review

Signs of Success

- Review of clinical performance data results in clinical improvement
- ACPS benchmark clinical performance results are similar or better than self-selected peers
- Outcomes of benchmarked clinical performance are reported, and improvement actions are monitored
- Positive consumer feedback in relation to involvement in care and shared decision-making
- Consumers feel they can escalate their concerns, issues to clinicians
- Positive staff feedback in relation to supervision and member support systems
 - Clinical risks are identified, mitigated, and controlled as much as is possible.

6 Safe Environment for the delivery of care

The environment promotes safe and high-quality care for consumers. Members providing inpatient and ambulatory care should ensure that:

- 1. Buildings, plant and equipment utilities, devices and other infrastructure review and maintenance programs ensure risks are known and mitigated, the environment is safe and in good working order and fit for purpose
- 2. Environmental inspections support the early identification of risks and promote best practice
- 3. Risks associated with unpredictable behaviours are known, mitigated, and are supported by access to a calm environment
- 4. Signage and way-finding systems are standardised, fit for purpose, and understood by consumers and staff
- 5. The environment recognises the importance of the cultural practices and beliefs of Aboriginal people

"One often-neglected variable is the physical environment, which shapes every patient experience and all health care delivery, including those episodes of care that result in patient harm." - AHRQ, 2012.

⁴ National Safety & Quality Health Service Standard 1 – Clinical Governance

Signs of Success

- Clinical equipment is maintained in accordance with the maintenance schedule
- Positive feedback from consumers and staff in relation to signage and way-finding
- There is a standardised approach to create a welcoming environment that recognises the cultural beliefs and practices of the patient cohort with specific programs to identify the needs of indigenous peoples
- Areas where consumers have the potential to demonstrate unpredictable behaviours are known and strategies are effective at minimising the risk
- There is high compliance with staff training
- Infrastructure and equipment risks are identified, mitigated, and controlled as much as is possible.

Reducing Clinical Risks

The primary aim of the National Safety & Quality Health Service (NSQHS) Standards (2nd Edition) is to protect the public from harm and improve the quality of health care. They describe the quality and the systems needed to deliver such care. These form the foundations for ACPS governance systems. ACPS will be accountable for:

- Monitoring Care outcomes
- Ensuring members understand the risks associated with poor infection control practices
- Ensuring members have an appreciation of medication safety including Antibiotic awareness
- Ensuring members can recognise and respond to Acute Physical and Mental Health Deterioration
- Ensuring members continue to deliver high quality patient centred care

Accountability – what does this framework mean for our members?

Members are accountable for their contribution to the safety and quality of care delivered to consumers.⁵

Consumers

Consumers and their families participate as partners to the extent that they choose. These partnerships can be in their own care, and in organisational design and governance.

Members

All podiatric surgeons have a role in the safety and quality of patients, and are expected to perform their roles with diligence, and with a patient-centred approach to the best of their ability. It is their responsibility to raise concerns when they recognise that something is not right.

Members will work in teams with professionals from a variety of disciplines based on mutual respect and clear communication, with an understanding of responsibilities, capacities, constraints and each other's scopes of practice.

Members are responsible for providing care that is patient centred, evidence based, and which focuses on safety through minimising risk while achieving optimal outcomes for patients. This is helped by them participating in clinical governance, in health safety forums and supporting other members to provide high quality services which are safe.

ACPS expects members to speak up when they have concerns about patient safety, so that these can be rectified and learnt from.

Members are accountable for their professional practice, including maintaining currency of their credentialing, registration, and professional practice.

ACPS Committees

ACPS Committees support the ACPS to implement and evaluate organisational systems, support members to work together to identify and mitigate risk and continuously improve practice. Members support the organisation to work as a single entity.

Council

The Council has daily operational accountability for system governance and monitoring.

Evaluation of the Effectiveness of the Clinical Governance System

Internal organisation Analysis

- Systems in place are best practice and support members to understand their safety and quality responsibilities
- System risks are known and mitigated
- Members partner with consumers to evaluate the appropriateness of the safety and quality systems
- Improvements identified to strengthen culture; leadership, governance; workforce capability, consumer partnerships, safety and quality systems and manage specific clinical risks are monitored.

⁵ Australian Commission on Safety & Quality in HealthCare. National Model Clinical Governance Framework (2017)

External Analysis

Members utilise independent agencies to evaluate care outcomes via patient experience surveys which are aligned to the National Safety and Quality Health Care Standards. In addition, members are required to submit care outcome data to ACPS which then supports benchmarking.

Critical reflection by ACPS

- How do we know our care is safe and effective?
- How do we ensure the quality and safety of care?
- Do we know what the red flags are?
- How will we fix what we know isn't working?
- What needs to get done to improve the quality and safety of care?
- Do we have a 'just' culture to facilitate continuous improvement in quality and safety?
- What actions do we take as a group to ensure that restrictive practices by other clinical craft groups is not tolerated?
- What actions do we take to ensure patients are empowered to meaningfully partner in their care?
- Are we frequently evaluating the impact and extent of the patient voice?
- How effective are our organisational governance systems in supporting our safe, effective, and person-centred goals for every consumer?
- What must we do to increase the effectiveness of our systems?
- Do all members feel supported to create consistently safe, person-centred, and effective care?
- What must we do to increase support for members?
- Are our members adequately skilled, engaged and empowered to provide safe, high-quality, person-centred clinical care?
- Are we achieving our purpose of providing a safe, person-centred, and effective experience for every consumer? What must we do to make more progress on achieving our purpose?
- Where is the evidence that our patients are better off?
- Do we have a shared definition/understanding of success? ⁶

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THE AUSTRALASIAN COLLEGE OF PODIATRIC SURGEONS (ACPS) FOOT AND ANKLE SERVICES

FEBRUARY 2023 // PREPARED BY THE AUSTRALASIAN COLLEGE OF PODIATRIC SURGEONS PO BOX 248, COLLINS ST WEST, VICTORIA 8007

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1 Executive summary

1.1 Introduction

The Department of Health has welcomed a policy submission from the Australasian College of Podiatric Surgeons (ACPS) to allow podiatric surgeons' access to the Medical Benefits Scheme (MBS) ^{\$47F}, 17 December 2020). This submission represents an application that is grounded in the data previously provided to MSAC in submission 1344.2 and contains additional information and clarification as per the Department's recommendations. The submission provides evidence to support access by podiatric surgeons to a limited number of MBS items for foot and ankle surgery.

This submission is built upon the principles of providing a solution to the elective surgery waiting list crisis, improving Medicare, equity of access, flexibility in health care delivery, improving access to foot and ankle surgical treatment for Aboriginal and Torres Strait islanders and reducing cost burden to Australians who are seeking necessary and appropriate care from podiatric surgeons. The submission refers to privately insured and non-insured individuals with a focus on rural populations, First Nations people, women, and the elderly.

This submission is closely aligned to the MSAC process which the ACPS has previously undertaken. Over the past two decades the ACPS has involved all stakeholders in its sustained quality improvement of training, achieving and maintaining accreditation, meeting regulation and delivering cost efficient and effective services. The result is a submission which is fit for purpose and mirrors the initiatives now identified as important by the recently released Strengthening Medicare Taskforce Report.

The benefits of a positive response to this submission will, from a policy perspective provide significant and appropriate community benefits.

Podiatric surgeons have provided inpatient and outpatient foot and ankle surgery across Australia, including in regional and remote areas, for over 40 years. The title 'Podiatric Surgeon' is protected under national law.

From 2004 to 2010 podiatric surgeons became recognised for the purposes of hospital admission, funding for prostheses, private health insurance rebates, registration as specialists and national endorsement as prescribers of scheduled medicines. Independent Accreditation of training also occurred as per the requirements of the National Regulation and Accreditation Scheme (NRAS).

The patients of podiatric surgeons receive no MBS funding for surgery and associated support services. Medicare funding for surgical services is currently restricted to medical, dental, nurse practitioners and midwives. Foot and ankle surgery is funded by the MBS *only* if delivered by registered medical practitioners. In the example of podiatric surgery this results in significant barriers to efficient, collaborative, and equitable access for service delivery.

Patient need drives our view that expansion of funding through the MBS is the rational conclusion to resolve these concerns and address the elective surgery waiting list crisis. An outcome where podiatric surgery is appropriately MBS funded is in line with a need for broad change to the current MBS arrangements as identified by Strengthening Medicare Taskforce Report. Specifically, the Strengthening Medicare Taskforce Report highlights the importance of removing barriers and facilitating all professionals working at full scope of practice in addition to addressing issues which reduce effective collaborative care.

This application seeks arrangements be made by the Department of Health for a limited range of MBS item codes for podiatric surgery. Such arrangements will address the longstanding inequity in access ending associated confusion and distress experienced by the public seeking the care of podiatric surgeons.

From a policy perspective, allowing podiatric surgeons access to a limited number of MBS funded codes will close the functional gap between previous legislative reforms and provide appropriate normalisation of podiatric surgery within the health care sector. Such access represents positive health policy reform that is fit for purpose. This is particularly the case as this submission has as one of its focus points the delivery of services to rural populations, First Nations people, women and the elderly.

Such an arrangement is not without precedent. MBS funding is provided for surgery performed by approved dental practitioners in the specialty of Oral and Maxillofacial Surgery. This arrangement was initially transitional in purpose recognising the evolution of Oral and Maxillofacial Surgery. However, oral surgeons who do not have medical degrees continue to be trained and practice in the Australian health care system.

Significantly, a referral can be made by various health care practitioners to enable MBS funding for specialist services such as pathology, anaesthesia and imaging which are medically necessary to support patients undergoing care. Again, uniquely podiatric surgeons are the only registered specialist surgeons in Australia not able to generate such a valid referral. This creates disadvantage for the thousands of patients for whom podiatric surgeons provide care.

Key Issues:

- Podiatric surgeons are recognised and accredited within the NRAS
- MBS currently only funs foot and ankle surgery provided by medical practitioners
- Access to MBS funded foot and ankle surgery is limited in regional and remote Australia
- Regional and remote communities, particularly Aboriginal and Torres Strait Islander communities
 are at increased risk of needing foot and ankle services.
- The elderly and women have increasing need for foot and ankle surgery
- The current elective surgery waiting list crisis demands action, for which we can provide an immediate and cost-effective solution.

Podiatric surgeons have provided non-surgical and surgical services to the Australian public for over 40 years. These services are not cosmetic, they aim to **reduce burden of disease** and **improve quality of life**. Podiatric surgeons are **recognised and accredited** within the National Health Practitioners regulation scheme (PBA 2023). Podiatric surgeons have a long-documented history of safety, efficacy, and low complications rates when performing foot and ankle surgery (ACPS 2023).

Podiatric surgeons in other countries are fully incorporated into health care and funded for clinical services equal to medical practitioners. Graduates of the Australian training system have rotated through these systems and in some cases permanently work in these environments. The lack of integration and funding for podiatric surgery in Australia has workforce implications because it is anachronistic and inefficient.

The above described workforce implications include Australian trained podiatric surgeons effectively encouraged to leave Australia due to funding inequality which limits work options. Conversely, graduates of both the UK and US systems who currently work in Australia do so in a limited fashion compared to their home environment. There is little incentive for more such specialist practitioners to consider migration to Australia.

If foot and ankle surgery is provided by medical practitioners (irrespective of training), patients are eligible for an MBS rebate. However, if provided by **registered specialist podiatric surgeons**, no MBS rebate is available. **This is discriminatory, does not serve the public interest and acts as a barrier to the provision of care.** Lack of funding impedes the capacity of podiatric surgeons to provide services to patients that need them.

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Despite such barriers podiatric surgeons have committed to and continue to provide innovative health care to the Australian public, including those in **regional and remote** communities, where they provide high-quality foot and ankle surgical services. Regional and remote communities as well as Aboriginal communities have been identified previously as lacking adequate podiatric services (including general services), and funding remains a challenge (Francis Health, 2017. See 7.2 Appendix II - Case for region and remote access).

In particular, it is paramount that Aboriginal and Torres Strait Islander communities receive access to costeffective foot and ankle services due to their increased risk of chronic diseases, such as **diabetes**. Indeed, the health status of the Aboriginal community has been identified as a **key service driver** that warrants separate attention from the broader population (Francis Health, 2017). **Normalising funding** for podiatric surgery will facilitate the goal of improving access to necessary clinical services particularly in these priority areas.

Lack of MBS funding to podiatric surgeons **limits consumer choice, reduces accessibility and increases marginalisation, especially in regional areas and in relation to Aboriginal and Torres Strait Islander peoples.** Such lack of MBS funding also creates fragmentation, drives unnecessary service duplication and higher costs throughout episodes of care. Lack of funding for associated services including pathology and imaging also adversely effects streamlined care. This does not reflect contemporary surgical practice in Australia or overseas, creates fragmentation and increases the economic burden on the health system by increasing unnecessary return visits to primary health providers to obtain required referrals.

1.2 Key proposals

To address the above-described barriers and provide appropriate, effective and integrated care based on our long history of service provision in rural and remote areas, the ACPS is seeking implementation of the following key proposals:

- 1. Enable patients access to a defined and discrete set of MBS rebates for procedures performed by a podiatric surgeon.
- 2. Enable general and specialist medical practitioners to provide a valid referral to podiatric surgeons for foot and ankle surgical care.
- 3. Enable a valid referral category for the necessary medical and specialist care in association with podiatric surgical episodes. This referral is primarily to be used for peri operative care and requiring the general practitioner be informed of patient progress.
- 4. Provide funding to expand comprehensive and coordinated care for people who cannot access foot and ankle surgical services, including those in regional and remote settings, and Aboriginal and/or Torres Strait Islander peoples.

These key proposals will substantively and immediately address systemic inefficiencies caused by current MBS arrangements.

1.3 Impact statement

Our proposal has a primary focus on improving patient access to affordable, high-value and best-practice foot and ankle non-surgical and surgical services provided by podiatric surgeons. This will strengthen Medicare by increasing access to surgical services to all Australians, but with particular benefits to women, the elderly and First Nations peoples. It will also free GPs to provide other services.

In addition to surgical services, podiatric surgeons are diagnosticians who are well trained in medical and nonsurgical management of foot and ankle conditions. Given the burden on general medical practice management of foot and ankle pathology by podiatric surgeons simply makes sense because of their broad skill base (*Menz et al 2022*. The Australian public deserves foot and ankle surgical services that are timely, uncomplicated, culturally safe, affordable and equal to that found internationally. Such attributes of quality service provision are central to the recommendations of this submission.

Patients will benefit from improved access to high-quality clinical services, particularly those who are marginalised, and who reside in rural and remote areas.

Improved access to care by podiatric surgeons: Enabling patients to access an MBS rebate for podiatric surgical care will improve access, especially where other medical practitioners may not be available (for example, in regional and remote settings).

Removing inefficiencies and barriers to care: Patients cared for by podiatric surgeons are limited by the lack of MBS items they can access under current MBS arrangements.

Opportunities: Enabling patients to access MBS rebates for more complete episodes of care provided by podiatric surgeons which will reduce fragmentation and ensure high-value care and continuity of care across the health system.

Our proposal to enable access to MBS rebates for podiatric surgeon performed procedures will reduce duplication, delays and inefficiencies when a patient is referred for foot and ankle surgery. It will provide opportunities for patients to receive care earlier.

1.4 Regulatory issues

It is acknowledged that to enable this reform some regulatory change will be required. Given the significant changes in respect to recognition and accreditation of podiatric surgeons which have occurred over the nearly 20 years since Health Legislation Amendment (Podiatric Surgery and Other Matters) Bill & the National Health Amendment (Prostheses) Act it is reasonable that such instruments should be updated to reflect the current situation and position of podiatric surgeons in health care.

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2 Podiatric surgeons

2.1 The role

As noted in the MSAC Application 1344.2, foot and ankle services are currently provided by general practitioners, orthopaedic surgeons, and general surgeons. Similarities in the type of procedures and overall care package provided by these groups and podiatric surgeons were noted in the MSAC applications. Importantly it was noted that podiatric surgeons differ from all other providers of foot and ankle surgery because they publish outcomes data following foot and ankle surgery. This significant real-world evidence does not exist for all other provider groups currently funded by the MBS.

Podiatric surgeons are granted specialist registration with the Podiatry Board of Australia after completing extensive specialised postgraduate training and education in podiatric medicine and surgery. Podiatric surgeons are competent in diagnosing and treatment of disease, injuries and defects of the human foot and related structures, and use surgical and nonsurgical processes to care for bone, joint and soft tissue pathology (Australian & New Zealand Podiatry Accreditation Council Inc., 2012). Under S3AAA of the Health Insurance Act 1973, accredited podiatrists (podiatric surgeons) are recognised as accredited and gazetted by the Minister for Health as qualified to provide foot and ankle surgery. Such surgery is the same or similar to that provided by general, orthopaedic and vascular surgeons.

A key role for podiatric surgeons is contributing to safe, effective and cost-efficient clinical care within multidisciplinary health care teams involving general practitioners, medical specialists and other health professionals, with appropriate referrals undertaken to support improved quality, safety and health care standards and practice (Australian & New Zealand Podiatry Accreditation Council Inc., 2012).

Podiatric surgeons provide clinically relevant non-cosmetic foot & ankle surgical and nonsurgical services in a variety of settings, including large private hospitals. They perform surgery under general anaesthesia with specialist anaesthetists and under local anaesthesia which the podiatric surgeon administers. Podiatric surgeons collaborate with general practitioners, medical and surgical specialists, nurses and allied health practitioners.

Australian podiatric surgeons have been operating within the Australian hospital system for more than 40 years, with multiple publications supporting the safety and effectiveness of surgery provided by them (Tamir et al., 2008, van Netten et al., 2013, Thomson and Butterworth, 2020, Matthews et al., 2018) (see also 7.3 Appendix III - Summary for consumers). Internationally, podiatric surgeons provide government funded surgery: including in the United States of America, and the United Kingdom. Satisfaction with podiatric foot and ankle surgery performed internationally and in Australia is high.

While Australian podiatric surgeons have the necessary training, skills and regulatory recognition to perform foot and ankle surgery, equity of patient access and affordability of podiatric surgeons presents as a significant barrier to the community and collaborative patient care is compromised due to a lack of appropriate MBS funding.

The exclusion of podiatric surgeons from accessing the MBS for procedures that they already safely and effectively conduct in the private setting is ultimately anticompetitive, and unnecessarily limits competition in the market, and certainly market contestability. Competition is essential to community welfare because it gives consumers a choice and incentivises providers to reduce costs and maximise use of scarce resources (Australian Government Productivity Commission, 2014).

In acknowledgment of Australia's ageing population and forecasted increase in demand for health services, the 2015 Competition Policy Review (Harper Review) recommended that in the human services (Harper et al., 2015):

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"...user choice should be placed at the heart of service delivery..."

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2.2 The scope of practice

Podiatric surgeons practice the diagnosis and treatment of foot and ankle disorders. They are qualified to care for bone, joint, ligament, muscle and tendon pathology of the foot and ankle, including:

- structural deformities, including bunions, hammertoes, painful flat foot and high arched foot deformity
- bone spurs
- heel pain
- nerve entrapments
- tendon and soft tissue problems
- degeneration and arthrosis of the joints of the foot and ankle
- skin and nail conditions
- congenital deformities
- trauma-related injuries, including fractures and dislocations and post-traumatic arthrosis

2.3 Training of podiatrists and a podiatric surgeon

Accredited training as a podiatric surgeon is currently available in Australia through ACPS Fellowship training. The University of Western Australia also offers a program in podiatric surgery. There are also podiatric surgeons registered with AHPRA who have trained in the USA and the UK. Podiatric surgeons differ from podiatrists in training and scope practice, the following table illustrates this.

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Podiatrist	Podiatric Surgeon (ACPS training program)
4-year undergraduate degree	4-year undergraduate degree
	2 years prevocational training
S CE	6 year accredited surgical education program
Total: 4 years	Total: 12 years

Members of the ACPS have completed extensive postgraduate medical and surgical training which enables them to perform reconstructive surgery of the foot and ankle. The qualification Fellowship of the ACPS is recognised by Australian State and Federal Governments. Members of the ACPS are included within both the Health Insurance Act and the National Health Act.

Within the NRAS all podiatrists and podiatric surgeons must be registered with the Podiatry Board of Australia and meet the Board's registration standards to practise. There are published standards and capabilities that directly relate to the training of podiatric surgeons. These standards are provided in 7.4 Appendix IV - Podiatric surgeon standards.

Training programs must be accredited to these standards. A component of this requires mapping of curriculums to ensure all the relevant capabilities are taught to a minimum AQF level 9. Specifically, these standards refer to the identification and management of medical complications in the peri operative period. Importantly, MSAC previously accepted that "podiatric surgeons receive intensive training on the foot and ankle and agreed in principle that a podiatric surgeon would provide adequate care".

2.4 The role of the podiatric surgeon in Australian service provision

In Australia, members of the ACPS principally operate in private hospitals within a surgical team, which includes anaesthetists, medical practitioners, surgical assistants, nurses, and hospital staff. This means members of the ACPS adhere strictly to the same hospital protocols as other surgical specialties. Patient care and safety are paramount, and the surgical team works closely together to ensure each patient receives the highest quality of care and respect.

Foot and ankle surgery may be performed as day case surgery, or with an overnight stay if necessary. Surgery is performed under local or general anaesthesia. In the post-operative setting, each patient is followed closely and managed according to their individual needs and phases of recovery.

2.5 Accessing foot and ankle surgery in Australia: The current state

Currently in Australia, patients may access foot and ankle surgery with a podiatric surgeon via multiple pathways. Surgery is performed in a range of settings as appropriate to the clinical pathology and patient requirements.

However, the current access model is confusing to the consumer. There is no MBS funding and inconsistency with funding from the private health insurance industry often results in consumer anger. Such anger occurs because consumers believe they are paying for hospital cover including podiatric surgery which is denied based on the lack of MBS funding for the service.

Further, consumers have difficulties with seamless clinical care due to referral pathways not being supported appropriately by the MBS. This also means that podiatric surgeons wishing to provide services within the public system are met with impenetrable barriers.

Currently in the private sector, patients are referred by a GP or medical specialist to either a podiatric surgeon, or more commonly an orthopaedic surgeon. Some patients may be referred to plastic surgeons, vascular and/ or general surgeons for foot and ankle surgery. Those patients assessed as eligible for surgical treatment are either treated within the office or admitted to hospital for surgery. Funding for the service via Medicare is available to all these providers <u>except</u> podiatric surgeons. This is despite the knowledge that it is podiatric surgeons of all the groups listed that have the most targeted training for foot and ankle surgery. Furthermore, podiatric surgeons have a publicly available safety record in respect to medical and surgical compilation that cannot be matched in evidence by the other providers.

The clinical management algorithm for patients needing foot or ankle surgery was included in the MSAC 1344.2 application. In the section on clinical governance of this submission (see Section 4, below), a revised and more detailed clinical algorithm is presented.

2.5.1 Foot and ankle services provided

The ACPS has faced significant and protracted barriers to obtaining data from state-based jurisdictions on the number of foot and ankle services provided to people. This has occurred even though all requests to obtain such data have been through various universities with associated ethics approval. Such foot and ankle services are relevant to podiatric surgeons and are comprised of only a subset of the current item codes within the MBS (see also MSAC 1344.2 application). \$47G

Elective orthopaedic surgeries (of which foot and ankle surgery is part) in Australian public hospitals remain high following solid growth since 2011, with the pandemic-related dip in 2019-20 strongly rebounding in 2020-01.


Figure 1: MBS utilization associated with foot and ankle surgeries Note: Includes 88 MBS item codes relevant to podiatric surgery. Data source: Medicare Item Reports, available at: http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp

Emergency Department (ED) presentations related to dislocation, sprain and strain of joints and ligaments of the ankle and foot are up 4.4 per cent since 2017, rebounding immediately after the pandemic-related fall in 2019-20, and MBS funded podiatric episodes of care for patients with a chronic condition and complex care needs managed by a GP rose to 3.6 million in 2021, from 491,000 10 years ago, indicating a growing and substantial demand for management and treatment of foot conditions.



Figure 2: Podiatry activity for patients with chronic conditions/complex care needs

The supply of foot and ankle surgery has been capped by flat growth in the number of orthopaedic surgeons in Australia since 2009. The result is lengthy and worsening wait times for foot and ankle surgery in Australia, among the worst of all wait times.

Wait times for elective foot and ankle surgeries in Australia remain unreasonably high due to longstanding capacity issues, worsened by the backlog of demand resulting from the COVID-19 suspension of elective surgeries in 2019-20.

- Hospital wait times for elective foot and ankle surgery are among Australia's worst in 2020-21 with an average wait time of 144 days for elective foot and ankle surgery in public hospitals.
- 5 years ago, the median wait time for elective foot and ankle surgery in public hospitals was 71 days, in line with the overall wait time for all orthopaedic surgery of 69 days. However, since then, wait times for foot and ankle surgery have diverged and are now well beyond other orthopaedic surgeries.
- Some procedures have particularly long wait times, with wait times for excision of exostosis at 311 days and hallux valgus at 262 days in 2020-21.

The flat supply of orthopaedic surgeons, combined with pandemic surgery backlogs, has fed through to other types of orthopaedic surgeries, with the median wait time for all elective orthopaedic surgery at the highest level it has been in 10 years at over 90 days, compared to a longer-term trend of around 60 days.

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Long wait times mean pain and suffering for patients and could result in more costly future treatment if the patient's condition deteriorates. This makes it critical that wait times are minimised and patients have access to timely care.

2.6 Unmet clinical need

Demand for foot and ankle surgical services will continue to rise as the Australian population ages, and the risk factors for surgery increase. For example, almost two-thirds of the current population is classified as overweight or obese, with an estimated prevalence of 1 in 20 Australians having diabetes, a known risk factor for amputation (Davis et al., 2018). The ageing population is at increased risk of many foot and ankle conditions that may require surgical correction, including bunion (hallux abducto valgus) (Nix et al., 2010), hammer and claw toes (Mishra et al., 2017), osteoarthritis in the big toe (hallux rigidus) (Gilheany et al., 2008), and heel pain conditions (Schwartz and Su, 2014).

A recent study highlights that foot, ankle and leg conditions are a relatively common reason for consultation with GPs in Australia, and the costs associated with their management are substantial Such costs are estimated at \$256 million in general practitioner costs alone (*Menz et al 2010*). These foot problems contribute to decreased ability to undertake activities of daily living, problems with balance and gait, and an increased risk of falls. Several studies have shown that foot problems have a significant detrimental impact on measures of health-related quality of life.

People with diabetes are at elevated risk of foot and ankle complications including amputation (Frykberg et al., 2020). For example, those with diabetes are more likely to suffer ulceration if they have hammer and claw toes. The Diabetes Australia report from 2017 highlights that 5 in 100 public hospital beds directly results from diabetic foot admissions. This has equated to annual spending of \$1.6 billion dollars. Thus, the ageing population, and the rise in obesity and the chronic conditions that accompany these (for example, diabetes) mean the need for foot and ankle services in Australia will increase over time.

Other studies have highlighted the impact of foot and ankle problems across the community but in particular for women, foot pain ranged from 13% to 36% (higher levels once over 45 years and higher incidence for women than men (*GATES et al 2019*).

Keenan found that in addition to having a significant burden on health services in general, foot and ankle problems contributed to an additional increased risk of having difficulty standing and walking by twofold *(KEENAN 2019).* Impacting activity, those with musculoskeletal pain are less likely to undertake activity [15], particularly if pain is present in the foot *(GILL et al 2016).*

Importantly the Public Statement Document (PSD) provided by the Medical Service Advisory Committee (MSAC) to application 1344.2 noted that the ACPS had provided the best available evidence to support the case for unmet need (PSD.1344.2 page 3). Furthermore, MSAC emphasised the demand for all orthopaedic surgery, including foot and ankle surgery is increasing.

Despite this growing demand, the supply of foot and ankle surgery is effectively capped. Orthopaedic surgeons face workforce shortages (see **Workforce Issues**, below), and long hospital waiting lists act as a deterrent to those seeking surgical care. The waiting times for elective foot and ankle surgery reflect the overall wait time for orthopaedic surgery (see 7.3 Appendix III - Summary for consumers). Patients awaiting surgery by orthopaedic surgeons have some of the longest waiting times for surgical procedures in the country.

Providing MBS funded item codes to podiatric surgeons is expected to decrease waiting lists for foot and ankle surgery. Many of these people are awaiting relatively simple procedures, such as toenail surgery, correction of hammer toes or removal of bunions, all of which podiatric surgeons currently provide within the private sector. Extending MBS funding to podiatric surgeons will assist in the reduction of these waiting lists, encourage more retention and uptake of private insurance and increase opportunities for podiatric surgical participation within the public sector. As such, providing access to MBS funding represents sound and appropriate health policy.

Key points

- 1. Podiatric surgeons have the skills and expertise to perform a range of foot and ankle surgery; including for hallux abducto valgus, hammer and claw toes, hind foot/ ankle pathology, ingrown toenails, hallux rigidus, arthritis, nerve impingement and benign tumours.
- 2. There are extensive wait lists for publicly funded foot and ankle surgery in Australia.
- 3. Extensive evidence shows podiatric surgeons have the skills, knowledge and professionalism to undertake specialist foot and ankle surgery.
- 4. Providing MBS items for the services of podiatric surgeons to perform foot and ankle surgery may improve surgical wait times.
- 5. Outcomes evidence supports the complete package of care delivered to patients by podiatric surgeons.

2.6.1 Workforce issues

Workforce inefficiencies and an ageing population mean will only increase the demands on an already strained situation.

As noted above, there remains significant demand for publicly funded foot and ankle surgery. In the most recent data from 2016, there were 1,286 orthopaedic surgeons employed in Australia (Australian Government - Department of Health, 2016). Not all of these surgeons provide foot and ankle surgical services. At that time, almost one-quarter of orthopaedic surgeons were aged 60 or over (Australian Government - Department of Health, 2016). New South Wales, Tasmania, Victoria and Western Australia have fewer orthopaedic surgeons per 100,000 population than the national average (Australian Government - Department of Health, 2016). The number of new fellows per year has remained reasonably static (about 50 per year) for the period 2013-2015. Thus, the Department of Health has flagged the ageing workforce and the duration of the training program as significant workforce concerns for orthopaedic surgeons.

The Royal Australasian College of Surgeons (RACS) has also identified workforce issues (Figure 1), recommending that in order to maintain 2010 ratios of orthopaedic surgeons to the population aged 65 or over, more than 680 additional surgeons are needed (Royal Australasian College of Surgeons, 2011). This has resulted in lengthening public hospital waiting lists. Consequently, more Australians have been forced to live with chronic pain and disability.

The number of foot and ankle surgeries performed over the last four years has decreased (Australian Institute of Health and Welfare, 2020), a trend likely due to capacity and the impacts of COVID-19, rather than demand. In the same period, the median wait times for these procedures have increased or remained steady (Australian Institute of Health and Welfare, 2020). Up to 14% of patients are waiting more than 1 year for surgery. Wait times are particularly long in New South Wales and Queensland for hallux valgus repair.

Minimal concern				
Indicator	Description	Status		
Ageing of workforce	Workforces with higher average ages are more susceptible to higher exit rates due to retirements.	•		
Replacement rate	This measure indicates whether trainee numbers are sufficient to replace the numbers leaving the workforce.	•		
Duration of training program	This measure indicates how long it takes to train a replacement workforce.	•		

Figure 3: Orthopaedic surgery workforce concerns (Australian Government - Department of Health, 2016)

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In New South Wales, these foot and ankle procedures are recommended to be completed within 1 year (Category 3) (see https://www.health.nsw.gov.au/policies/manuals/Documents/pmm-12.pdf), yet up to 1 in 10 are not achieving this benchmark. Further, consider if a patient elects to be treated by a podiatric surgeon. In such a case the payment burden falls either with the patient themselves, or with the private health insurer, with no funding from MBS funding, resulting in high out-of-pocket costs.

Given the ageing population, and an increase in co-morbidities, we should expect that the rates of surgical repair of foot and ankle conditions would increase. However, this is not the case (see Figure 4). This is perplexing – and perhaps reflects the decreased capacity for surgical repair, or perhaps in the case of the sharp decrease in toenail surgery in 2019-2020 reflects the suspension of elective surgery during the COVID-19 pandemic. In New South Wales, primary care consultations were reduced by 20%, and planned surgical activity was decreased by almost one-third (Sutherland et al., 2020).



Figure 4: Number of selected foot and ankle surgeries performed annually (Australian Institute Of Health And Welfare, 2020)

In a post-COVID world, patients will likely resume their usual health care seeking behaviour (Sutherland et al., 2020), resulting in increased in demand for surgical services.

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In addition to an available underutilised workforce, there is the potential to expand training number within Australia and or encourage international graduates to come to Australia. The Podiatry Board of Australia has now a defined strategy for registration of foreign trained podiatric surgeons.

2.6.2 Unmet financial need

The patients of podiatric surgeons are discriminated against and denied fair and timely access to services due to the lack of MBS rebates. This limits the number of surgeries podiatric surgeons perform and restricts referral pathways. This lack of MBS rebates is a barrier to the delivery of best-practice and is inequitable for patients podiatric surgeons treat. It also negatively impacts rebates through the private health industry framework. As the MSAC 1344.2 Critique Report noted, granting access to MBS rebates to podiatric surgeons *would facilitate delivery of an equivalent package of care to patients and serve the public interest in a responsible manner*.

Currently the cost of care is borne mainly by the patient, with some private health insurers (for example BUPA) not covering podiatric surgery for any policy holder. These patients must bear the cost of fees in full (including surgeon fees, anaesthetist fees and hospital fees).

This situation persists despite the inclusion of podiatric surgeons within the private health insurance reform of 2018.

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Current funding arrangements for the provision of foot and ankle surgery are:

- MBS-rebated surgery by vascular, orthopaedic, plastic and general surgeons in addition to GPs
- Privately funded surgery by a podiatric surgeon in both the inpatient and outpatient settings

The current funding model is inequitable, placing reliance on funding of podiatric foot and ankle surgery on either the patient themselves, or on private health insurers. This removes patient choice when accessing foot and ankle surgical services, acting as a barrier to flexibility in health care delivery and patient choice. A significant concern is when the best evidence of outcomes is available for the only group of registered specialist surgeons without MBS funded for such services.

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The inability to claim an MBS rebate for podiatric surgery is a barrier to the delivery of innovative models for foot and ankle care to the Australian public. As described above the demand for foot and ankle surgery has increased by 10% for both orthopaedic and podiatric surgery. This finding is remarkable given patients currently receiving podiatric surgery face high out of pocket fees due to the lack of MBS rebates. The above evidence displays that industry support in the form of health fund rebates clearly exists to facilitate podiatric surgeons meeting the increased demand for foot and ankle surgery. The only barrier preventing podiatric surgeons from meeting demand is the inability to claim an MBS rebate.

2.6.4 Public opinion strongly supports unmet need for surgery

The media has been replete with opinions from the public, the AMA and other groups stating that amount of elective surgery must increase in the interests of all Australians. As a barometer of how patients are not receiving timely surgical care these references reflect the view of the average Australian.

Melissa Cunningham, "Horror elective surgery logjam threatens blow out to 500000", 2023.

AMA, "WA private health numbers surge off back of long wait lists for public hospitals and elective surgery", 2023.

AMA, "Urgent action need on elective surgery backlog, AMA says", 2023.

Victoria Bailey, "Elective surgeries shifted from inpatient to outpatient settings", 2023.

Melissa Cunningham, "As surgery waiting times explode patients raid savings and super funds", 2023.

9 News, "'You can't run the finances like a school tuck shop", 2023.

The Age's View, "Victoria's surgery understaffed and overwhelmed", 2023.

ABC, "Elective surgery wait times significantly longer than reported", 2022.

Meg Bolton, "Elective surgery waiting list grows: Queensland health pandemic", 2022.

Callum Godde, "Hopes Melbourne's second elective surgery centre will ease wait lists", 2022.

Allanah Sciberras, "Elective wait lists blow out as health crisis worsens", 2022.

Mary Ward, "Surgery backlog highest on record as hospitals trial shorter stays to address issue", 2022.

Aisha Dow, "Winter illness wave hampers bid to tackle elective surgery backlog", 2022.

Tom Symondson, "Elective surgery is back but backlog will take years to clear without a plan", 2022.

3 Proposals

3.1 Introduction

The ACPS is seeking access to a small number of MBS items. Previous requests for MBS access by the ACPS to MSAC (see 7.1 Appendix I - MSAC submission 1344.2 7.2) were based on available numbers before the MBS review published in July 2021.

The ACPS wishes to work with the DoH to develop a list of discrete MBS item numbers that can be mapped against existing MBS numbers and represent podiatric surgical numbers as a distinct group. The applications to MSAC included evidence from systematic literature review of international experience, supported by data extracted from various state hospitals in Australia, along with real-world evidence from the ACPS Registry. The latter data sets were compared, based on a set of specified services, and outcomes were found to be comparable. These specified services (although not reflective of the full scope of procedural activity) cover a range of podiatric surgeons' scope of practice which the ACPS defines as:

"the diagnosis, surgical and adjunctive treatment of disease, injuries and defects of the human foot and ankle and associated structures"

These include treatment of patients with one or more foot or ankle conditions within the following eight clinical groupings:

- hallux valgus
- hammer and claw toes
- hind foot / ankle pathology
- ingrown toenails
- hallux rigidus
- arthritis
- nerve impingement
- tumour (benign)

These patients require surgical management typically in a same day setting.

We propose that podiatric surgeons be able to access funding for the proposed list of clinical services described in this submission.

3.2 Proposal 1 - Enable patients access to a defined and discrete set of MBS rebates for procedures performed by a podiatric surgeon

We are seek to develop a list of clinical descriptors and associated MBS codes covering the range of services we provide.

Since the MSAC 1344.2 submission, and as recommended by the Department (^{\$47F} 17 December 2020), we are now proposing alternatives to the previously submitted replication of orthopaedic surgery items.

Modified from the original MSAC submission the list below details the nature of clinical services we can provide. It is acknowledged that the recent MBS review process has altered descriptors and numbers for foot and ankle surgery, any discussion in developing a relevant list for podiatric surgery would be cognitive of such reform.

We request that the legislative and regulatory enablers be implemented to support this submission.

To ensure the effective and safe delivery of a care package to patients requiring foot and ankle surgery, we will need a legislative amendment that lists podiatric surgeons as providers of professional services under the MBS.

These services will be limited to those patients that have a valid referral from a general practitioner or medical specialist. Such services will be provided under appropriate clinical governance, as described in the ACPS Clinical Governance Framework (Appendix VIII).

We seek two professional services items, and 29 therapeutic items on the MBS. We have mapped these services to those currently available to orthopaedic surgeons, which more accurately describe podiatric surgical practices. We also seek the ability for referral to specialists, pathology and advanced imaging. We seek anaesthetist rebates when a registered podiatric surgeon operates.

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We propose enabling patients to access MBS rebates for procedures performed by a podiatric surgeon, including:

(i) Item list: Professional attendances

Item 1

Current MBS Code most closely related to: 104

Description: Professional attendance at consulting rooms or hospital by a specialist podiatric surgeon in the practice of his or her speciality after referral of the patient to him or her - each attendance, other than a second or subsequent attendance, in a single course of treatment.

Proposed item number: [To be determined by the Department]

Item 2

Current MBS Code most closely related to: 105

Description: Professional attendance by a specialist podiatric surgeon in the practice of his or her specialty following referral of the patient to him or her - an attendance after the first in a single course of treatment, if that attendance is at consulting rooms or hospital.

Proposed item number: [To be determined by the Department]

(ii) Item list: Therapeutic procedures

Item 3

Current MBS Code most closely related to: 513000

Description: Assistance a any operation identified by the word "Assist" for which the fee does not exceed \$XXX.XX of at a series or combination of operations identified by the word "Assist" where the fee for the series or combination of operations identified by the word "Assist" does not exceed \$XXX.XX **Proposed item number:** [To be determined by the Department]

Item 4

Current MBS Code most closely related to: 51303

Description: Assistance at any operation identified by the word "Assist" for which the fee exceeds \$XXX.XX or at a series of operations identified by the word "Assist" for which the aggregate fee exceeds \$XXX.XX. **Proposed item number:** [To be determined by the Department]

Item 5

Current MBS Code most closely related to: 18272

Description: SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIL NERVE, MAIN TRUNK OF, 1 or more of injection of, a local anaesthetic agent in the perioperative treatment of podiatric pathology. **Proposed item number:** [To be determined by the Department]

Item 6

Current MBS Code most closely related to: 49833

Description: Unilateral surgery for hallux valgus or rigidus including salvage via arthroplasty or osteotomy of metatarsal (with or without fixation).

Proposed item number: [To be determined by the Department]

Item 7

Current MBS Code most closely related to: 49845

Description: Arthrodesis of the 1st metatarsophalangeal joint.

Proposed item number: [To be determined by the Department]

Item 8

Current MBS Code most closely related to: 47960

Description: FOOT; Subcutaneous tenotomy as an independent procedure. **Proposed item number:** [To be determined by the Department]

Item 9

Current MBS Code most closely related to: 48400

Description: FOOT; Accessory bone of phalanx or metatarsal, bone osteotomy, osteectomy or excision (without internal fixation).

Proposed item number: [To be determined by the Department]

Item 10

Current MBS Code most closely related to: 48403

Description: FOOT; Phalanx or metatarsal osteotomy or osteectomy of, with internal fixation.

Proposed item number: [To be determined by the Department]

Item 11

Current MBS Code most closely related to: 50106

Description: JOINT OF THE FOOT OR ANKLE, stabilisation of, involving one or more of: repair of capsule, repair of ligament with /without internal fixation, not being a service to which another item in this group applies.

Proposed item number: [To be determined by the Department]

Item 12

Current MBS Code most closely related to: 50109 **Description:** MAJOR JOINT OF THE FOOT OR ANKLE: arthrodesis of, not being a service to which another item in this group applies, with synovectomy if performed. **Proposed item number:** [To be determined by the Department]

Item 13

Current MBS Code most closely related to: 50127

Description: JOINT OF THE FOOT OR ANKLE, arthroplasty of, by any technique not being a service to which another item applies.

Proposed item number: [To be determined by the Department]

Item 14

Current MBS Code most closely related to: 47954 **Description:** TENDON, repair of, which has its insertion in the foot as an independent procedure. **Proposed item number:** [To be determined by the Department]

Item 15

Current MBS Code most closely related to: 49809

Description: FOOT TENDON; open tenotomy or tenoplasty.

Proposed item number: [To be determined by the Department]

Item 16

Current MBS Code most closely related to: 49709

Description: ANKLE; ligamentous stabilisation of.

Proposed item number: [To be determined by the Department]

Item 17

Current MBS Code most closely related to: 49718

Description: FOOT; repair of Achilles tendon, tibialis posterior tendon, tibialis anterior tendon, or other major tendon.

Proposed item number: [To be determined by the Department]

Item 18

Current MBS Code most closely related to: 48406

Description: FIBULA or TARSUS osteotomy or ostectomy of, excluding services to which items 47933 or 47936 apply.

Proposed item number: [To be determined by the Department]

Item 19

Current MBS Code most closely related to: 49854

Description: FOOT; radical plantar fasciotomy or fasciectomy of.

Proposed item number: [To be determined by the Department]

Item 20

Current MBS Code most closely related to: 31350

Description: FOOT OR ANKLE; benign tumour of soft tissue, including tumours of skin, cartilage, nerve and bone, simple lipomas and lipomata, removal of by surgical excision, where specimen is sent for histological confirmation, on a person of 10 years of age or over, not being a service to which another item in this group applies.

Proposed item number: [To be determined by the Department]

Item 21

Current MBS Code most closely related to: 39330

Description: FOOT OR ANKLE; neurolysis by open operation without transposition. **Proposed item number:** [To be determined by the Department]

Item 22

Current MBS Code most closely related to: 49866

Description: FOOT; neurectomy for plantar or digital neuritis. **Proposed item number:** [To be determined by the Department]

Item 23

Current MBS Code most closely related to: 47915

Description: INGROWING NAIL OF TOE; wedge resection for, with removal of segment of nail, ungual fold & portion of nail bed.

Proposed item number: [To be determined by the Department]

Item 24

Current MBS Code most closely related to: 47916

Description: INGROWING NAIL OF TOE; partial resection of nail, with destruction of nail matrix by phenolisation, electrocautery, laser, sodium hydroxide or acid but not including excision of nail bed. **Proposed item number:** [To be determined by the Department]

Item 25

Current MBS Code most closely related to: 47918 **Description:** INGROWING NAIL OF TOE; radical excision of nail bed. **Proposed item number:** [To be determined by the Department]

Item 26

Current MBS Code most closely related to: 47930

Description: BURIED WIRE, PLATE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of requiring incision and suture, not being service to which item 47927 or 47930 applies - per bone.

Proposed item number: [To be determined by the Department]

Item 27

Current MBS Code most closely related to: 44359

Description: ONE OR MORE TOES OF ONE FOOT; amputation of, including if performed, excision of one or more metatarsal bones of the foot, performed for diabetic or other microvascular disease, excluding aftercare.

Proposed item number: [To be determined by the Department]

Item 28

Current MBS Code most closely related to: 47726

Description: BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - small quantity.

Proposed item number: [To be determined by the Department]

Item 29

Current MBS Code most closely related to: 30223

Description: HAEMATOMA, ABCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) **Proposed item number:** [To be determined by the Department]

3.2 Proposal II - Enable general and specialist medical practitioners to provide a valid referral to podiatric surgeons for foot and ankle surgical care

When a GP or specialist medical practitioner refers a patient for management of foot and ankle conditions by a podiatric surgeon a MBS rebate should apply.

3.3 Proposal III - Enable a valid referral category for the necessary medical and specialist care in association with podiatric surgical episodes.

There is another significant issue facing the patients of podiatric surgeons, this relates to the difficulty encountered with referral to medical specialists including anaesthetists and specialist services such as pathology and radiology.

Without access to referral to specialists through the MBS, podiatric surgeons are unable to effectively refer patients in a timely and safe manner for further evaluation when clinically necessary. This directly impacts patient safety and does not occur for any other registered surgical specialties in Australia.

We propose the inclusion of podiatric surgeons into the groups able to directly refer to MBS funded medical and surgical specialties, in the interests of inclusion, improved patient care, teamwork, and reduced duplication. Similar arrangements have been in place for nurse practitioners, optometrists, and dentists for many years.

The ACPS envisions a protocol whereby the GP and associated specialist is kept informed of patient progress at the start and end of the episode of surgical foot and ankle care.

Allowing podiatric surgeons to refer patients will ensure there is seamless clinical care with barriers removed. Integral to this is good communication with the patient's GP to ensure the patient is treated within the context of any other health conditions.

3.4 Proposal IV - Provide funding to expand comprehensive and coordinated care for people who cannot access foot and ankle surgical services, including those in regional and remote settings, and Aboriginal and/or Torres Strait Islander peoples

We are seeking funding through the MBS or other means to support the delivery of care to remote and rural populations including indigenous peoples. Significantly we aim to provide funding for training of indigenous podiatrist who can then to train as podiatric surgeons. This is an important initiative to support the existing pro bono efforts of podiatric surgeons in remote locations.

This recommendation focuses on ensuring high-value care for patients with **long-term**, **chronic health conditions and Aboriginal and/or Torres Strait Islander peoples**. It is intended to avoid fragmentation, delays and other inequities in care for patients who require foot and ankle surgical services.

The burden of chronic illness is growing in Australia, placing increasing pressure on the health system. This pressure is particularly felt within the following populations:

- Aboriginal and/or Torres Strait Islander peoples: Chronic diseases were responsible for 64 per cent of the total disease burden among Aboriginal and/or Torres Strait Islander peoples in 2011. Chronic diseases, such as diabetes, result in foot pathology that sometimes requires surgery. There is a high burden of avoidable death from these causes among Aboriginal and/or Torres Strait Islander peoples.
- Homeless populations: People experiencing homelessness have foot pathology at presumably the same frequency as the rest of society, yet are less likely to access primary and preventive health services. This increases the risk of later-stage diagnosis of disease, poor control of manageable conditions and hospitalisation for preventable foot conditions (for example, infections, arthritis, and wounds).

All people, but particularly the marginalised groups outlined above, should be supported and enabled to access health care provided by appropriate models of care, including the services provided by podiatric surgeons. Our services can help mitigate the risk of developing chronic foot health conditions, assist with the early identification of such conditions, improve the quality of preventive care provided, and reinforce the requirement for multilevel care for this vulnerable population.

Podiatric surgeons working with Aboriginal and/or Torres Strait Islander peoples, whether in metropolitan or remote health services, are unable to provide subsidised health services because they are not considered eligible providers under MBS. They are unable to facilitate subsidised foot and ankle surgical services, and culturally safe Aboriginal and Torres Strait Islander health worker support. The lack of access to these rebates results in patients receiving no clinical care, and little or fragmented clinical care, further marginalising an already vulnerable group.

Podiatric surgeons in Australia provide high-quality case management, care planning and care facilitation services for people with long-term foot health conditions. Their ability to diagnose, request and interpret diagnostic investigations, prescribe medicines and initiate referrals to other health professionals will enable them to serve as a crucial provider of care for people with long-term health conditions, in much the same way podiatric surgeons do in the United States and the United Kingdom.

Inequity in funding mechanisms should not prevent people from receiving comprehensive, evidencebased care. Current MBS restrictions limit patient choice and result in fragmented care. They also prevent health services from optimising the use of the podiatric surgeon—an under-utilised resource in Australia's health care system. This is particularly problematic where access to a medical practitioner is limited, and for marginalised and vulnerable populations.

From a system efficiency standpoint., increasing point-of-care access to podiatric surgeons will remove the need for onward referral for additional MBS services. This will reduce the current duplication and fragmentation experienced by many patients, particularly Aboriginal and/or Torres Strait Islander peoples and those from marginalised communities, improving system efficiency.

Currently, a patient receiving a procedure performed by a podiatric surgeon is required to pay the total cost of a procedure (without an MBS rebate), in addition to the professional attendance fee. Duplication, delays and inefficiencies can be created when a patient is referred to a medical practitioner for a procedure in order to be able to access the MBS rebate to which they are entitled. This practice also blurs care accountability and limits the role of podiatric surgeons as autonomous and independent health providers.

Research in primary care has found that duplication of services (attributed to the inability of podiatric surgeons to perform or request diagnostic and therapeutic items subsidised under the MBS) interrupts workflow and delays patient care. For example, patients may be referred to other services, including emergency departments, for some procedures because there is no adequate MBS rebate to support patients accessing this care from a podiatric surgeon.

The ability to facilitate access to MBS rebates for diagnostic and therapeutic procedures performed by podiatric surgeons will support more affordable, equitable and accessible care in primary health, community, rural and remote, and residential aged care settings. Vulnerable people are particularly affected by the lack of MBS rebates for care provided by podiatric surgeons.

This proposal will also increase the financial viability of podiatric surgical services by better recognising the broad range of services that podiatric surgeons are able to provide. This will enable more equitable and accessible health services.

Access to MBS rebates for items performed by podiatric surgeons may be cost-neutral because duplication of services would be eliminated. Access to health care for the most vulnerable patients would also be improved.

Other benefits of this recommendation may include increased professional colleague and patient satisfaction with the type of care provided, a decrease in patient waiting times due to improved access, and increased productivity as podiatric surgeons are able to contribute to the overall provision of foot and ankle surgical services.

4 Clinical governance

The outcomes of surgeries provided by ACPS members nationally are publicly available (https://www.acps.edu.au/publications). To our knowledge, no other craft group/specialist surgical college provides this level of clinical analysis of its members' surgical outcomes.

As part of the ACPS's commitment to best-practice clinical governance, including alignment with the National Safety and Quality Health Service (NSQHS) Standards (Australian Commission on Safety and Quality in Health Care, 2017), qualitative data on patient outcomes has been routinely presented to the Chief Executive Officers of selected private hospitals in WA and SA. This model is now expanding to a national program.

Podiatric surgeons have a robust clinical governance system, that provides qualitative & quantitative data feedback on patient outcomes.

Services by podiatric services are provided under a clinical governance framework (7.8 Appendix VIII - ACPS clinical governance framework), which includes rigorous mandatory clinical audit and national peer review. The Clinical Governance Committee provides oversight, and effectively supports the management of clinical risks, continuous improvement, and benchmarking. Such benchmarking helps to reduce unwarranted clinical variation in outcomes. All members of the ACPS are required to comply with the governance framework, including compulsory participation in quality and audit programs.

The ACPS Registry (clinical audit) records and reports in real-time all procedures undertaken by podiatric surgeons, any complications experienced by patients, additional treatment and other associated information that can track clinical outcomes. This real-world evidence registry is used by the ACPS to ensure its members are operating in a best-practice manner and allows for continuous quality improvement.

In addition to the clinical algorithm model reported in MSAC Submission 1344.2, the ACPS has formalised a robust clinical governance framework and has expanded the Clinical Governance Committee. The policies and audit program ensure safe, effective, person-centred care.

In expanding the previously submitted clinical algorithm, Figure 6 (refer to page 27) describes the patient journey for MBS funded podiatric surgery. This is a patient-centred model is based on a partnership between the patient and surgeon. It is supported by the ACPS Clinical Governance Framework, from the commencement of the patient referral to final discharge.

The ACPS Clinical Governance Framework and associated clinical governance systems allow for effective and safe patient care. The ACPS governance framework is grounded by and references external regulatory guidelines such as those published by the Australian Council on Healthcare Standards (ACHS), National Prescribing Service, Australian Health Practitioner Regulatory Authority (APRHA), Podiatry Board of Australia and various State and Federal policies and guidelines.

The ACPS Clinical Governance Framework, in concert with a suite of policies and guidelines, continually evolves based on feedback and outcomes data via the ACPS Clinical Governance Committee. This supports the College's objectives of ensuring the patient is a partner in their care for the entire patient journey. This partnership approach includes shared decision-making about options, risks, and benefits of poliatric surgery.

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4.1 Clinical governance framework core elements

4.1.1 The patient

The patient is a core partner in this model. Addressing the needs and individual circumstance of the patient in a transparent, culturally sensitive manner. This engagement strategy ensures patient education (allowing for variation in health literacy), collaboration, and choice. In addition to specific attention to consumer rights and responsibilities, the principles of consent and communication are embedded in the process.



4.1.2 The surgeon

The surgeon will be able to demonstrate ongoing capabilities as expected, supported and monitored via the ACPS Clinical Governance Framework. This is in addition to the expectations of regulation and registration coupled with the principle of lifelong learning. The surgeon partners with the patient to safely navigate an episode of care to final discharge.

4.1.3 Governance

Underpinning the whole process is recognition, compliance, and integration with the ACPS Clinical Governance Framework which incorporates monitoring, national peer review and continuing professional development (CPD). This framework also references and is supported by policy, including:

- clinical capacity & capability •
- clinical governance (including mandatory clinical audit against available national benchmarks) •
- safety, quality & risk policies •
- clinical care standards •
- incidents & complaints management processes •
- credentialing & scope of practice policy •

4.2 The collaborative journey

4.2.1 Referral

Patients will be referred to the podiatric surgeon by their general practitioner or medical specialist. To be considered a valid referral for the purpose of MBS funding, the referral should describe the reason for referral, such as seeking assistance for a clinically relevant foot or ankle condition.

The relationship between referrer and referee will be based upon communication systems that ensure the referrer understands the scope of practice, the specific skill set of the podiatric surgeon and the potential financial impact of the referral. This communication strategy should, where possible ensure all necessary tests, investigations and medical history are available for the podiatric surgeon. For example, the referral should contain information that enables the podiatric surgeon to appreciate the following:

- the reason for referral
- any relevant health risk factors (diabetes, cardiovascular, etc.)
- previous interventions that have been used to manage the condition

The podiatric surgeon will use the systems within the clinical governance framework, to assess the referral before scheduling an assessment appointment with the patient. This will ensure the referral is relevant and or appropriate.

4.2.2 Assessment

The podiatric surgeon will perform a clinical assessment and determine what nonsurgical and surgical treatment options are available to improve the patient's quality of life, specifically in relation to foot and ankle health. The capabilities required for a podiatric surgeon ensure that each practitioner has the necessary knowledge skills and experience to ensure this is undertaken appropriately and in accordance with relevant guidelines.

Once care options have been identified, the podiatric surgeon will consider the individual patient's circumstances to identify specific risk factors which may act as barriers to effective and safe implementation of the options for podiatric surgical intervention. The process is one of shared decision-making based on the patient being provided with all relevant information including nonoperative interventions, risks, and benefits of surgical interventions.

This process has several potential outcomes: including the need for a further assessment by the referrer or another health care practitioner. Communication with the patient's referring practitioner will indicate this outcome if surgery is indicated. Where referrer/alternative review is required, a detailed explanation as to reasons is provided which then supports further investigation. This is communicated to the referral source and implemented.

4.2.3 Care Plan

If the podiatric surgeon has recommended surgery, a patient-centred approach to scheduling the surgery will be discussed. This will mean a discussion will take place, clearly outlining the risk and benefits of surgery, and alternative options, including obtaining a second opinion. A detailed explanation of the surgical procedure, expected outcomes, post-operative course and possible complications will then occur. These consultations are supported by the issuing of detailed patient information sheets.

An assessment and discussion will also be undertaken with the patient to determine whether a general or local anaesthetic is appropriate, and what other measures are required given the patient's individual risk factors: such as antibiotics and pain management requirements.

Factors that may impact these decisions and must be considered include:

- medication history and allergies
- infection control issues
- blood history
- falls history and risk
- skin integrity
- cognitive impairment / delirium
- mental health
- suicide/risk of harm
- nutrition
- aggression
- social issues
- cultural needs

Surgery and post-operative appointment dates are then determined and agreed upon with the patient. All information for the surgery is provided to the patient and relevant hospital as part of the preadmission process. In addition, a letter to the referrer is also sent which outlines the proposed surgery date, procedure, treatment plan, possible complications and post-operative protocols that need to be followed. Anticipation of potential difficulties in such areas as wound management is also a core capability of podiatic surgical care, which may result in specific discussion with the patient's family and collaboration with other health care practitioners such as pharmacists and community nurses to ensure that the patient is appropriately supported through the episode of care.

4.2.4 Surgery

The podiatric surgeon performs surgery according to the operative plan, acknowledging that some procedural variation is inevitable depending on operative findings. In the case of hospital admission (local or general anaesthesia) the episode of care will also be subject to standard preadmission screening by the hospital prior to confirming admission.

A Discharge Summary of the procedure outcomes, post-operative medications and any perioperative concerns that have arisen is provided to the patient and to the patient's referring and general practitioner. The expected post-operative course (3 to 12 months) should also be communicated to both the patient and referring practitioner.

4.2.5 Outcome

Given the preoperative screening and post-operative risk analysis process, it is expected that patients will be discharged to their home environment without adverse events. s47G s47G

All podiatric surgeons are trained in advanced life support (as a regulatory requirement) and provide such support in both the hospital and office settings. In all situations where sedation or general anaesthesia is used an anaesthetist is present for the entire procedure and is responsible for medical management during the surgical event and for 24 / 48 hours after the procedure.

If the patient requires overnight stay and adjunctive medical management is required, the podiatric surgeon will refer the patient to a physician who has admitting rights at the hospital to provide such management during the admission.

Identified preoperative risk factors such as the need for thromboembolic prophylaxis will be managed through a collaborative approach with the patient's general practitioner or medical specialist to ensure appropriate perioperative medical care is provided.

The podiatric surgeon is qualified and competent in managing localised complications related to the foot or ankle surgery, for example infection, wound breakdown, and failure of fixation. Referral to physicians and or other surgeons may be indicated depending on the response to primary treatment provided by the podiatric surgeon. All patients are contacted within 24-48 hours of discharge to assess progress and the need for further intervention with the post-operative appointment being confirmed.

The podiatric surgeon is qualified and competent in recognising signs and symptoms of medical complications for example deep vein thrombosis (DVT), cardiac events, or drug reactions and will refer to general practitioners, physicians and/or other surgeons and/or emergency departments depending upon the circumstance.

The podiatric surgeon will, as the case indicates during the post-operative period, use the support of other health care practitioners such as podiatrists and physiotherapists.

4.2.6 Discharge summary

On completion of the post-operative care, a final discharge summary is sent to the referral source.

The ACPS governance framework mandates that outcomes data is finalised within the ACPS Clinical Audit. Postsurgical patient satisfaction surveys are also used.

ACPS Audit: The College audit program is a real-time system that enables instant upload and reporting of data. Such data is reviewed by the ACPS Clinical Governance Committee and enables easy identification of unwarranted variation relating to surgical complications and readmissions within 28 days. Where required, surgeons are contacted for an explanation of their variation. All case outcomes are reviewed via national peer review and support the College culture of a learning organisation.

Postsurgery Satisfaction Survey: This forms part of the Evaluation of Outcomes and identification of Unwarranted Variation in Care Outcomes. Based on a trial conducted in Western Australia a random audit of 50 admissions nationally per year will be conducted. Patients are sent a satisfaction survey post-discharge which enables an assessment as to whether care and treatment were based on a partnership approach with shared decision-making. Results are independently analysed and clinical review is initiated where required. Reports are provided to the surgeons and to the hospital CEO where the surgeon is credentialed for surgery. Results can also be benchmarked.

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5 Impact statement

By allowing podiatric surgeons to access MBS item codes for podiatric surgery, we have the chance to improve health outcomes, quality of life and health system sustainability.

Health outcomes can be improved by decreasing waiting times, and allowing patients to undergo surgery before their condition deteriorates. This means that less complex surgery may be required, and patients will likely have better outcomes. This is especially true for conditions that deteriorate over time (like some foot and ankle conditions associated with diabetes or arthritis).

Failure to proceed with foot and ankle surgery in a timely manner also has impacts on the patient's **quality of life**. Aside from the obvious pain and functional impairments including:

- difficulty walking
- difficulty wearing footwear
- difficulty exercising
- difficulty in participating in recreational activities
- loss of mobility
- loss of limb
- loss of life

Patients may also experience a reduction in quality of life, including enjoyment of previous activities such as sport, reductions in mental health and economic losses due to work absenteeism and lack of participation in the workforce due to disability. Recent publications have reported that while podiatric surgery improves health-related quality of life and is associated with lower rates of complication, including non-union, infection, and venous thromboembolism (Thomson and Butterworth). Further, post-discharge surveys on patient satisfaction have reported that almost 9 in 10 patients report being highly satisfied following podiatric surgery (Thomson and Butterworth, 2020).

s47G

There is a high level of satisfaction with foot and ankle surgical services provided in Australia by podiatric surgeons.

As noted in MSAC Application 1344.2, it is the patient that bears the burden of avoided or delayed podiatric surgery, living with foot and ankle pain, or having their health needs met by podiatric surgeons while facing high out-of-pocket costs. These out-of-pocket costs occur even if the consumer has private health insurance.

If a patient cannot afford treatment from a podiatric surgeon but cannot avoid it either, they need to return to their GP for (an avoidable) referral to an orthopaedic surgeon, and either join the waiting list for public hospital care, or seek private orthopaedic care (with access to MBS items). Surgical waiting lists are only likely to extend as patients delay surgery due to the COVID-19 pandemic.

In all cases, the differential treatment of podiatric surgeons with respect to MBS funding has a limiting impact on consumers 'choice of provider.

Therefore, this application has a significant beneficial impact for consumers.

s47G

By adopting the proposed approach, the health system is also supported to be more sustainable, by reducing waiting lists, and providing better access to care for those living regionally or remotely.

s47G

Provision of MBS item codes to podiatric surgeons has the potential to positively impact patients, both financially and indirectly through improvements in quality of life due to reduced waiting times for procedures. Further, it will support health system sustainability.

These impacts have been further highlighted in the four case studies in Section 6.

6 Case studies



Case Study 1 – First Nations Female Case Example – 9 February 2023

Background: A podiatric surgeon regularly consults at a Aboriginal Medical Centre in regional NSW, managing first nations patients with complex foot problems. The service is pro bono and the lack of any MBS funding for the services of podiatric surgeons results in limitations to the level of care able to be provided. There are hundreds of first nation's people who have similar presentation to this case in the region.

Patient: A\$47Ffrom an Aboriginal background presented for assessment and review of herright foot pain upon referral from her podiatrist\$47Fat NSW rural town of\$47F\$47Fat NSW rural town of

Presenting complaint: Painful black toes on right foot and unable to walk without pain.

Patient health history: Chronic obstructive pulmonary disease, peripheral arterial disease, type 2 diabetes, and smoking. All contributing to lower limb ischemia.

Assessment (summary):

Patient had extreme pain (10/10), foot pulses not detectable, limbs were cold.

Diagnosis: Critical limb ischaemia, necrotic toes, and possible bone infection.

Treatment: Local anaesthetic to temporarily improve circulation, pain management and provide comfortable dressing change. Assessment of wounds probed to bone with odorous exudate indicative of ischemia and bone infection. Sterile dressings applied and placed in a walking surgical sandal.

Management

Provided emergent care withing limits of the service and initiated referral to emergency department of local public hospital. Focus of the referral was on immediate vascular assessment, surgical debridement (likely amputation) and infectious disease co consultation. Her family was contacted, and GP informed. She was seen the next day and was told the local public hospital could not admit her for treatment. Instead, she was put on antibiotics, pain medication and sent home.

Prognosis

Patient currently waiting for her appointment. She has significant risk for loss of limb and or secondary complications which could result in death without urgent care.

Issues:

- 1. The system failed to pick up her critical ischemia and failed to act once the clinical risk was identified.
- 2. With long waiting times there is risk of further limb loss and death.

Concerns:

- I. Medical care is available for such patients, but it is,
 - a. Limited with unacceptable waiting times
 - b. Fragmented
 - c. Inadequate (patients are not easy to follow due to cultural and regional issues)
- II. The patient could see the podiatric surgeon in their private hospital for immediate care. However the cost would be more than \$5000 and she would have to drive to Sydney (4 hours away). If the podiatric surgeon had public or private hospital admitting privileges in a local hospital and MBS funding care and prevention of amputation could have been provided.
- III. The patient requires complex multi professional involvement and this is not possible with the current system restrictions on the provision of podiatric surgical services.

Summary

This is <u>not</u> about local GPs, clinicians or podiatrists not providing good care. They are aware of the inadequacies and inundated with patients like this case.

This is about podiatric surgeons being available in the area but unable to provide their services due to lack of Medicare funding, referral pathways and admission rights to local hospitals.

Case Study 2 - Lack of Medicare rebate affecting treatment

s47F on New South Wales was referred for player, however, the pain in both her 1st metatarsophalangeal joints is now impacting on her ability to train and play. Pain has now progressed to occurring during her working day. ^{\$47F} has had bilateral bunion surgery carried out on the ^{\$47F} five years ago, however, the deformity has returned and the pain is now worse than pre-surgery. Her previous surgeon now offers her no solution and all conservative care has failed. She has found no one on the ^{\$47F} who will help her.

A podiatric surgeon who consults on the NSW ^{\$47F}, reviewed ^{\$47F} feet with current X-rays (attached). It was identified that the previous surgery has been unsuccessful, leading to a return of the bunions with a markedly shorted first ray. ^{\$47F} only option now is to give up any sport or consider revisional surgery. The podiatric surgeon can carry out this specialised surgery, however, ^{\$47F} financial situation is such that she is having to attempt to save for the surgery, as no MBS is available for podiatric surgery, even at with a fee reduction offered by the podiatric surgeon.



Solution for s47F

Additional MBS item numbers 48403 and 49761 would provide ^{\$47F} and more than 9000 people like her with equitable access to affordable quality care. Such care would lead to improved quality of life, enhanced mobility and enabling satisfactory employment and purposeful contributions to regional life.

Case Study 3 - Aboriginal and Torres Strait Islander Health

s47F of New South Wales, was referred for assessment for a severely painful deviated right foot that was now leading to foot and leg deformity. She has attempted orthotics and physiotherapy, and symptoms and deformity have progressed. She can no longer walk without pain and cannot play sports.

She had waited for an assessment on the public system and was seen by a local surgeon, who informed her parent that surgery was unnecessary and that insoles should help ^{\$47F} and her parents were concerned for her short and long-term health.

A podiatric surgeon who reviewed ^{547F} observed she had a rigid flat foot that was leading to a spasm of the peroneal muscles and an internal rotation and deviation of her knee and leg. MRI assessment showed she had a mid-facet subtalar joint coalition, a condition that effects about 1% of the population. It occurs when the two main bones in the rearfoot commence fusing together. This can lead to severe deformity and marked symptoms. It is a progressive deformity and will lead to increased symptoms and deformity.

s47F options are to stop exercising and live with a deforming leg or have surgery to excise the coalition allowing for mobility in the foot. This procedure should see excellent results if carried out correctly, but success is also time dependent.

As there was no Medicare cover for ^{\$47F} could not proceed. The podiatric surgeon referred ^{\$47F} and her parents back to her general practitioner with an in-depth report outlining exactly what was occurring and her options. ^{\$47F} is back on the waiting list to be seen in the local hospital.

Solution for^{\$47F} *

Additional MBS item numbers will provide ^{\$47F} and approximately 2032 of people like ^{\$47F} with equitable access to affordable quality care, leading to improved quality of life and enhanced mobility and enabling satisfying employment and purposeful contributions to regional life.

Case Study 4 - Aboriginal and Torres Strait Islander Health

s47F New South Wales, was referred for specialist assessment to address markedly painful bunions. ^{s47F} had been suffering from pain and deformity in both her 1st metatarsophalangeal joints for many years, with symptoms impacting her ability to play ^{s47F} . All conservative care had been exhausted, and she was left unable to play sport without pain. No foot surgeon was available in her region for consultation.

Desperate for specialist consultation ^{\$47F} travelled for six-hours for a consultation with a podiatric surgeon. It was confirmed that ^{\$47F} has bilateral hallux valgus (bunions), a structural and progressive condition. As all conservative care had been exhausted, the two remaining options for ^{\$47F} were to avoid sport and live with the pain or consider surgery. ^{\$47F} parents decided the best option was surgery. The surgery was expensive and required significant travel commitment which also required overnight stays in Sydney and then returned weekly for dressing changes.



Solution for s47F

Additional MBS item numbers 48403 and 49761 will provide ^{\$47F} and 12 000 people like her with equitable access to affordable quality care. Such care would lead to improved quality of life, enhanced mobility and enabling satisfactory employment and purposeful contributions to regional life.



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Case Study 5 - Point of view of a nurse practitioner

^{s47F} working in an Aboriginal Health Service (AHS) in remote Queensland. She provides comprehensive primary and secondary health promotion and disease prevention and management services for consumers, many of whom have complex health requirements that are strongly influenced by the social determinants of health. ^{s47F} primary health care services are augmented by the fact she has expertise in the assessment and management of people with kidney disease and diabetes. Many of her patients would greatly benefit from subsidised allied health services. In addition, many of her patients would benefit from enrolment in the Closing the Gap scheme, which provides subsidised prescriptions for Aboriginal and Torres Strait Islander clients.

^{s47F} has infrequent and irregular access to a GP in her remote clinic. Although ^{s47F} has independently developed comprehensive management plans for her complex patients, which include referrals to allied health professionals, she is unable to appropriately operationalise them because NP referrals to allied health professionals are not currently available for rebate under the MBS. Her patients cannot afford to see the allied health specialists privately at the AHS, and the AHS cannot continue to provide these services without income generated by subsidised allied health appointments. In addition, current Department of Health policy precludes her from enrolling patients in the Closing the Gap scheme or accessing its initiatives, which results in her patients paying higher out-of-pocket costs.

Case Studies – additional barriers

Under current arrangements regional and remote patients cannot access reimbursement for travel costs when seeking care with a podiatric surgeon. This another example of a system which is inflexible and not cognisant of the need to address systemic barriers to appropriate care by appropriately recognised health care providers.

Similarly, patients who seek to access use superannuation funds are not able to access this unless the provider is a registered medical practitioner. This further highlights the inequity that currently exists and results in increased patient emotional and financial stress.

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8 Support

The original MSAC submission contains a list of supporting individuals and organisations.

9 Appendices

- 9.1 Appendix I MSAC submission 1344.27.2
- 9.2 Appendix II Case for region and remote access
- 9.3 Appendix IIIa Summary for consumers and Appendix IIIb Value proposition for MBS access for podiatric surgeons
- 9.4 Appendix IV Podiatric surgeon standards <u>https://www.podiatryboard.gov.au/Accreditation/Accreditation-publications-and-resources.aspx</u>
- 9.5 Appendix V Response to referred questions from the Department of Health Advisory Committee
- 9.6 Appendix VI A needs case for allowing podiatric surgeons access to the MBS
- s47 G
- 9.8 Appendix VIII ACPS clinical governance framework
- 9.9 Appendix IX Response to referred questions from the Department of Health

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The Case for Regional and Remote Healthcare Access

The impact of remoteness and the role of podiatric surgery

Data from the Australian Institute of Health and Welfare (AIHW) July 2022 displays almost all key health measures worsen with an increase in degree of remoteness.

Defining rural and remote

The AIHW report uses the <u>Australian Statistical Geography Standard Remoteness</u> <u>Structure, 2016</u> (ABS 2021d) which defines remoteness areas in 5 classes of relative remoteness:

- Major cities
- Inner regional
- Outer regional
- Remote
- Very remote.

These remoteness areas are centred on the Accessibility/Remoteness Index of Australia, which is based on the road distances people must travel for services (ABS 2021d).

As a summary around 7 million people, or 28% of the Australian population live in rural and remote areas, which encompass many diverse locations and communities (ABS 2022c). These Australians face unique challenges due to their geographic location and often have poorer health outcomes than people living in metropolitan areas. Data show that people living in rural and remote areas have higher rates of hospitalisations, deaths, injury and have less access to primary health care services, than people living in *Major cities*.

Indigenous Australians

Indigenous Australians make up 3.3% of Australia's population and in 2022 numbered between 900 000 and 1million people. Of this population 38% live in major cities and over 60% live in regional and remote areas of Australia. The proportion of the total population who were Indigenous increased with remoteness, from 1.09% in *Major cities*, to 32% in *Remote and very remote* areas.

On average, Indigenous Australians living in remote areas having higher rates of disease burden and lower life expectancy compared with those in non-remote areas. Key contributors to this include differences in educational and employment opportunities, access to health service, housing circumstances, and other factors that support healthy behaviours (such as the availability and cost of fresh fruit and vegetables). Areas of relative advantage and disadvantage also exist within these regions. Local areas and communities may experience different issues and outcomes to others and have different needs and priorities.

Access to specialist services in regional and rural Australia

Access to specialist medical and allied health practitioners is a key pillar in the delivery of health services. The current lack of specialist services in rural and remote regions is a key determinant in poor health outcomes.

Podiatric surgeons currently provide restricted services in regional areas within WA, NSW, Vic, QLD and Tas and The Northern Territory (Darwin). However, these services are limited to 3 small patient groups. These groups include patients who have private health insurance with the few companies that cover podiatric surgery. (The majority of health funds will not cover podiatric surgery until it is MBS funded.) Patients covered through compensation insurance or have means to afford high out of pocket expenses comprise the other 2 groups. Studies show only 25% of the Australian population outside of major cities has private health insurance. The low insurance coverage of podiatric surgery and lack of MBS funding means the vast majority of regional or remote Australians cannot access podiatric surgery.

This has the direct effect where unless the service is economically viable podiatric surgeons will not establish and maintain practice in regional and remote areas. A barrier results where if there is no service, patients requiring services cannot access them. In turn if there are not enough patients who can afford the service, podiatric surgeons cannot establish such services. Access to a limited number of MBS item numbers for podiatric surgery will overcome this barrier.

Another barrier to providing services to rural and remote populations is access to ancillary services. Such services are required to establish appropriate surgical care in regional and rural areas. These ancillary services include pathology such as wound cultures and blood tests. Imaging services and referral to other specialists are also required for surgery to be provided seamlessly as occurs for all other surgical specialities. The current lack of MBS rebates for patients accessing podiatric surgery is a barrier to seamless provision of these crucial ancillary services.

A distinct area of need is the establishment of multi-disciplinary diabetic foot teams in regional Australia. Currently there is not one team working within regional Australia yet these teams are the gold standard for care of the diabetic foot. A team will comprise of 5 key specialists:

- Specialist foot and ankle surgeon
- Vascular surgeon
- Endocrinologist
- Podiatrist
- Wound nurse

Australian podiatric surgeons are specifically trained in this area of foot and ankle pathology. In the United Kingdom's National Health Service and the USA podiatric surgeons comprise the position of foot and ankle surgeon within these teams. Yet in Australia where there is a high incidence of poor diabetic foot outcomes particularly in indigenous populations, there is not one podiatric surgeon employed in such teams. Furthermore, there is not one team in regional or rural Australia where there is the greatest need. Diabetes Australia's 2017 report highlights 5 in every 100 public hospital beds is taken by a patient admitted directly due to diabetic foot disease. If one of these patients goes onto require a below knee amputation, they have a less than 50% chance of surviving 5 years. It is even worse if that patient is an Indigenous Australian. Importantly the annual cost of diabetic foot disease in Australia is \$1.6 billion.

Australians living in regional and rural Australia are the most disadvantaged in terms of health access and disease burden. Providing MBS rebates to patients seeking the care of podiatric surgeons unlocks virtually all the access barriers that currently exist. It enables the financial model of the MBS to be available for these Australians requiring the care of podiatric surgeons and will also assist in the establishment of further clinics in regional Australia. It also provides access to ancillary services such as pathology, imaging and referral to specialists when required. This important and long overdue reform will permit an increase in foot and ankle specialist services in regional and rural Australia, directly improving the disease burden of foot and ankle pathology.

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AUSTRALASIAN COLLEGE OF PODIATRIC SURGEONS

Clinical Governance Framework

Partnering with patients and stakeholders to deliver high-quality care and treatment

Version 1.3

DOUNNELS'C DOUEDDAR FREEDERAR

2021

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Version	Change Summary	Effective from	Effective To
1.1	Draft		
1.2	Change in context		

This document should be read with the following:

- ACPS Clinical Audit Committee Terms of Reference •
- Resource Board Terms of Reference •
- CPD Board Terms of Reference •
- Appeals Committee Terms of Reference
- International Committee Terms of Reference •

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Executive Summary

The Australasian College of Podiatric Surgeons (ACPS or "the College") is committed to ensuring that high-quality care is provided to all patients at all times.

Historically this has meant adherence to national audit and peer review as component of ongoing ACPS accreditation of its surgical members.

The ACPS and its Boards and Committees recognise the need for a structured approach to clinical governance and accountability throughout a practitioner's career and this document provides a framework that ensures all members understand their clinical accountabilities. This framework is dependent on the ACPS having best practice clinical governance systems which ensure effective reporting, monitoring, and taking action capabilities within each of the committees. This framework provides a reference point against which the committees must benchmark.

The organisational structure of the ACPS is provided in Figure 1 below. The Training Program is responsible for the training of podiatric surgeons and is accredited via AHPRA and has its own Boards and Committees. The clinical governance framework is aligned and integrated via the policies and terms of reference of the Boards and Committees highlighted in red.



Figure 1.

ACPS Organisational Chart. The college also conducts an education program which has its own separate organisational chart. This function regulated and accredited via AHPRA.

This commitment to excellence in care, treatment, and services through a best practice clinical governance framework ensures that ACPS members provide evidence-based care and treatment at all times.

This framework implemented and support podiatric surgeons who are members of the ACPS in the goals of best patient care. The frameworks informs and as stated supports all committees. The framework is recongnised as a dynamic document which will change as the ACPS organization grows respecting that clinical care standards will change in time.
The ACPS fellowship training program curriculum reflect the framework so that registrars are familiar with the structure and function of the framework. This document is part of the ACPS training program resource supporting the capabilities and standards against which the ACPS training program is accredited.

For the purpose of this document the term "member" refers to a podiatric surgeon who is complying with the annual accreditation requirements of the ACPS.

I am pleased to see that the ongoing refinement and development of our processes to facilitate and support best care, transparency and accountability. This framework ensures the ACPS needs are met now and into the future, supports a partnership with our patients, and allows members to understand and deliver against their accountabilities for best practice clinical care. Finally, the ACPS and its members are committed to lifelong learning.

Dr Rob Hermann President Australasian College of Podiatric Surgeons

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Clinical Safety & Quality Policy Statement

The ACPS is committed to ensuring skilled and professional podiatric surgeons deliver best practice evidence-based care in collaboration with consumers and their families. As well as building upon and maintaining the capabilities and standards required for specialist registration via a lifelong commitment with the focus on facilitating a positive experience for all of our patients.

Our aim is to also create a culture of continuous improvement and learning. This culture will be patient centered, outward looking resulting in the delivery of high-quality care to all patients.¹

Clinical Governance

Clinical governance is a shared responsibility to ensure that all consumers receive the best care.

The ACPS Clinical Governance Framework supports all members in providing leadership, responsibility, and accountability for maintaining standards of quality, continuous improvement, minimise risk and fostering an environment of excellence in partnership with our patients.

This framework outlines the requirements for an effective clinical governance system for the ACPS. The responsibility to effectively operationalise this framework to maximise patient service quality rests with all members.

Our approach is to ensure that our clinical governance systems are driven by a focus on the right care for all patients. Our goal is to achieve great outcomes and exceed compliance expectations.

"Good integrated governance should start from the top and spread to every aspect of the organisation if high quality care is to be sustained" – Healthcare Governance Review This framework has established systems and processes that enable organisational accountability for the delivery of services that are safe, effective, high-quality and continuously improving.

The ACPS Clinical Governance Framework is composed of the following domains²

- 1. Leadership and Culture visible, accountable, and purposeful leadership is required to cultivate an inclusive and just culture.
- 2. **Consumer Partnerships** consumer participation including shared decision-making are crucial indicators of safety and quality. Effective consumer partnerships are essential for improving healthcare outcomes and driving continuous improvement.
- 3. Workforce Capability Systems are required to support and protect podiatric surgeons to enable the delivery of safe, high-quality care. This requires comprehensive strategies and plans for developing, engaging, and retaining high-performing clinical staff.
- 4. Safety & Quality Systems Minimising and safeguarding against clinical risk requires a structured approach to safety that is based on partnerships with our patients, staff, and other stakeholders. We are determined to continue to be known for delivering high-quality and safe care.
- Clinical Practice Performance & Effectiveness – Systems are required to support clinicians to deliver evidence-based practice, monitor unwarranted variation in practice and continuously improve clinical services and outcomes.
- 6. Safe Environment for the Delivery of Care We are committed to ensuring a safe environment of care is maintained at all times.

The ACPS works with stakeholders to achieve an integrated clinical governance system maintaining and improving the reliability, safety and quality of our services for patients.

These domains also reflect synergistically with policies, guidelines and accreditation standards of the national health practitioner registration and accreditation scheme

² Australian Commission on Safety & Quality in HealthCare – National Model Clinical Governance Framework (2017)

- 1. The patient is focused at the centre of all safety and quality business decisions
- 2. All priorities and strategic objectives to improve safety and quality are clearly communicated to all relevant parties
- 3. Strong clinical leadership and ownership we are committed to engaging with and listening to our members
- 4. Compliance with all legislative and regulatory requirements
- 5. The safety and quality-impact of all decisions are formally considered
- 6. Failures are disclosed errors are reported without fear of inappropriate blame, with patients and their families being told what went wrong and why
- 7. An emphasis on learning our systems are orientated towards learning from mistakes and we use improvement methods to assess identified risks and opportunities
- 8. The obligation to act is understood and the obligation to take action is accepted. The responsibility of all is unambiguous and explicit
- Accountability is clearly defined the limits of individual accountability are clear and defined roles and responsibilities are understood by all. Individuals understand when they may be held accountable for their actions.
- 10. There is a just culture members are treated fairly

Our patient's needs and experience of their care and outcomes are the focus of what we do. The interaction and partnership between patients, clinicians and care teams ensure a partnership approach to care needs.

The ACPS recognises that to become a fullyfledged learning organisation which monitors and takes action to improve the standards of clinical care is an important and challenging task. The purpose of this Framework is to provide a basis to demonstrate our commitment to the provision of safe, high-quality care:

"Clinical governance and quality improvement require a focus on evidence and data, not just trust" - CRANAplus, 2013

This Framework is applicable across all ACPS services, settings and sites and provides a road-map for determining direction and accountability at all organisational levels. This Framework acknowledges the differences in care needs, whether for inpatient or ambulatory care services.

This Framework is aligned with the *National Safety* and *Quality Health Service Standards and Jurisdictional Policy requirements.* For example: The Codes of Conduct and Registration Standards

of the Podiatry Board of Australia.

The model of the ACPS Clinical Governance Framework is as follows:



Figure 1: A conceptual model of the ACPS Clinical Governance Framework.

Domains of Clinical Governance

1 Leadership and Culture

A strong organisational culture is required to enable the ACPS to create and maintain high-quality care. This culture should involve fairness, respectfulness, and transparency and based on the principles of natural justice, innovation, lifelong learning and accountability for decisions and behaviours.

The systems in place to support leadership and culture include:

- 1. A vision for improving the quality of care;
- 2. Organisational alignment in achieving strategic goals and priorities;
- 3. Supportive, transparent and responsive culture, set and led by the governing body;
- 4. Accountability is assigned for planning, monitoring, and improving the quality of ACPS surgical activities;
- 5. The external benchmarking of clinical performance and seeking external ideas and knowledge;
- 6. Committee and reporting structures are in place to effectively monitor and improve clinical performance;
- 7. Development and support for members at all levels of the organisation; and
- 8. Evaluating systems to test the strength of organisational culture and positive leadership systems.

The ACPS Council has executive accountability for ensuring effective clinical governance and quality improvement systems are in place.

Committees have delegated accountability to support the Council to enact this responsibility.

Effective governance means that the Board does not accept what it is told without question – Healthcare Governance Review

Signs of Success

- Member survey response rates exceed 40%
- Members report that a just culture exists
- Leaders are visible and actively seek and act on member and consumer feedback
- Actions to achieve safety and quality objectives are monitored at every level of the organisation
- Consumers are active participants in evaluating care outcomes
- Members are aware of their safety and quality responsibilities

- ACPS acts to improve clinical performance results
- Risks impacting on the organisation's ability to build and maintain a positive culture, leadership and governance systems are identified, mitigated, and controlled as much as possible.

2 Consumer Partnerships

Effective healthcare focuses on the patient and their experience.

Effective consumer partnerships are essential for improving healthcare outcomes and driving continuous improvement. Listening and responding to the consumer is at the heart of good clinical governance.

The ACPS systems supporting consumer partnerships include:

- 1. Consumers and their needs are the primary organisational priority;
- 2. Consumers are invited to provide feedback regarding their experience;
- 3. Consumers are provided with the skills and knowledge to participate in their care;
- 4. Clear, open, and respectful communication exists between consumers and members;
- 5. Members respond to the diverse needs of consumers and the community;
- 6. The ACPS learns from and acts on the feedback on clinical care and service delivery, as provided by consumers in order to make improvements;
- 7. The rights and responsibilities of consumers are respected and promoted to the community, consumers, carers, and members; and
- 8. The systems for empowering meaningful consumer participation are regularly and rigorously evaluated.

Signs of Success

- Consumer feedback results in the identification of risks and improvements arising from consumer feedback processes
- Positive consumer survey feedback in relation to healthcare rights
- Shared understanding of goals of care relating to clinical outcomes
- Consumer representatives feel that they are contributing to improving care
- Risks impacting on the organisation's ability to partner effectively with consumers are identified, mitigated, and controlled as much as is possible
- The ACPS Consumer Engagement Strategy is implementated

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3 Workforce Capability

Members must have the right qualifications, skills, and supervision to provide safe, high-quality healthcare and must have a commitment to life-long learning and a commitment to their patients.

Members also need to be actively engaged in, and provide leadership for, the continued improvement, planning and management of patient care, clinical services and working collaboratively to support the organisation to meet its safety and quality strategic objectives.

The ACPS systems that are in place to support and protect a skilled, competent, and proactive membership include:

- 1. Planning, allocation, and management of member needs
- 2. Members have the appropriate qualifications and experience to provide high-quality care and ongoing professional development to maintain and improve skills –
- 3. Promotion and support of multi-disciplinary teamwork is the basis of providing high-quality care
- 4. Clear communication of role expectations, responsibilities and standards of performance is provided to all members and they are supported and held accountable for meeting these expectations
- 5. Mentoring and supervision is used to support, monitor, and develop members
- 6. A defined system for managing complaints or concerns about a member is in place and is regularly reviewed for its effectiveness
- 7. A safe and fair workplace based on a just culture and mutual respect is provided, with systems in place to address issues³

Signs of Success

- Member engagement and satisfaction is measured and is a priority area of focus for the ACPS
- Members are supported to understand their safety and quality responsibilities
- There are high levels of participation in professional development planning
- There is high compliance with mandatory and competency-based training programs
- Risks impacting on the organisation's ability to develop and maintain a skilled and competent workforce are identified, mitigated, and controlled

4 Patient Safety & Quality Systems

Safety and quality systems are integrated with governance processes to enable the ACPS to actively manage and improve the safety and quality of health care.

The ACPS safety and quality systems that should be and are in place to support and create a learning environment and a comprehensive program of continuous improvement:

- 1. **Policy management system** that enables the ACPS to deliver services in accordance with agreed standards, legislation and jurisdictional requirements and reduce any risks to consumers or members
- 2. Quality improvement system delivered in partnerships with consumers that drives the ACPS quality program including audit and evaluation, consumer feedback and improvement
- 3. Determination and monitoring of safety and quality systems and clinical performance that result in system and clinical improvements. Identifying and monitoring critical safety and quality measures; unwarranted variation in clinical practice and safety and quality systems is critical to a highly reliable, improvement focused organisation.
- 4. **Risk Management system** that results in the identification, assessment, and ability of the ACPS to deliver safe, effective, and appropriate care to all patients. Consistently safe practice is built on member awareness; knowledge and participation in the system including clinical and peer audit.
- 5. Learning from Events Analysis of consumer feedback and experience along with patient incidents and complaints in partnership with consumers, their families and staff provides a mechanism to learn how well the organisational systems work and provides an opportunity to continually evolve person- and family-centred approaches to care.
- 6. Healthcare Record system that is available at the point of care, supports continuity of care and and communication identification of consumer/treatment goals; re-assessment findings; risks/critical information; and evaluation of the impact of treatment and care on the goals and is integrated with other information systems.

³ National Safety & Quality Health Service Standard 1 – Clinical Governance

Signs of Success

- Policy, procedure, and practice guidance documents are relevant, current, culturally-inclusive and accessed by members
- Improvement actions in the ACPS Improvement plan and risks are progressed
- Key performance indicators monitored at the required levels of the organisation
- Consumers are engaged in the evaluation of safety and quality systems
- Strategic clinical risks are current, monitored for control effectiveness and any treatments are actioned within timeframes
- Incidents, complaints, and consumer feedback data is reviewed, and action taken
- Medical record documentation meets best practice requirements
- Risks within organisational systems are identified, mitigated, and controlled.

5 Clinical Practice

Good clinical practice requires systems that support members to provide safe and appropriate care for each consumer with the best possible outcome, working within their clinical scope of practice.

Clinical practice should strive for patient-centred, cohesive, and integrated care at all times along the care continuum. It should ensure a shared understanding of the care pathway and goals between clinicians and consumers.

Systems in place to support clinicians to deliver evidence-based practice, monitor unwarranted variation in practice and continuously improve clinical outcomes include:

- 1. Evidence-based Care Standards are available and accessible
- 2. Clinical partnerships are developed with consumers to support active involvement by consumers in decisions and planning about current and future care
- 3. Clinical communication systems support effective partnerships by ensuring consumers receive information they need in a way that is appropriate to them
- 4. Clinicians regularly review clinical care and compare data on performance with external sources and other similar health organisations and use this to reduce unwarranted variation to practice and inform improvements in safety and quality systems and practice.
- Clinicians are supported through supervision and mentoring programs to deliver safe, evidence-based care⁴

"A good clinician will make consistently good clinical decisions but having a system of effective clinical governance means there is a structure to ensure that this is not by chance, but follows from good recruitment, continuing professional education and clinical audit. Such a system will enable good performance to be sustainable and to be spread across the organisation." – Healthcare Governance Review

Signs of Success

- Review of clinical performance data results in clinical improvement
- Participation in Clinical Audit meetings
- Participation in Quality of Care reporting
- ACPS benchmark clinical performance results are similar or better than self-selected peers
- Outcomes of benchmarked clinical performance are reported, and improvement actions are monitored
- Positive consumer feedback in relation to involvement in care and shared decision-making
 - Consumers feel they can escalate their concerns, issues to clinicians
 - Positive staff feedback in relation to supervision and member support systems
- Clinical risks are identified, mitigated, and controlled as much as is possible.

6 Safe Environment for the delivery of care

The environment promotes safe and high-quality care for consumers. Members providing inpatient and ambulatory care should ensure that:

- 1. Buildings, plant and equipment utilities, devices and other infrastructure review and maintenance programs ensure risks are known and mitigated, the environment is safe and in good working order and fit for purpose
- 2. Environmental inspections support the early identification of risks and promote best practice
- 3. Risks associated with unpredictable behaviours are known, mitigated, and are supported by access to a calm environment
- 4. Signage and way-finding systems are standardised, fit for purpose, and understood by consumers and staff
- 5. The environment recognises the importance of the cultural practices and beliefs of Aboriginal people

"One often-neglected variable is the physical environment, which shapes every patient experience and all health care delivery, including those episodes of care that result in patient harm." - AHRQ, 2012.

⁴ National Safety & Quality Health Service Standard 1 – Clinical Governance

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Signs of Success

- Clinical equipment is maintained in accordance with the maintenance schedule
- Positive feedback from consumers and staff in relation to signage and way-finding
- There is a standardised approach to create a welcoming environment that recognises the cultural beliefs and practices of the patient cohort with specific programs to identify the needs of indigenous peoples
- Areas where consumers have the potential to demonstrate unpredictable behaviours are known and strategies are effective at minimising the risk
- There is high compliance with staff training
- Infrastructure and equipment risks are identified, mitigated, and controlled as much as is possible.

Reducing Clinical Risks

The primary aim of the National Safety & Quality Health Service (NSQHS) Standards (2nd Edition) is to protect the public from harm and improve the quality of health care. They describe the quality and the systems needed to deliver such care. These form the foundations for ACPS governance systems. ACPS will be accountable for:

- Monitoring Care outcomes
- Ensuring members understand the risks associated with poor infection control practices
- Ensuring members have an appreciation of medication safety including Antibiotic awareness and have Endorsement of Scheduled Medicines
- Ensuring members can recognise and respond to Acute Physical and Mental Health Deterioration
- Ensuring members continue to deliver high quality patient centred care

Accountability – what does this framework mean for our members?

Members are accountable for their contribution to the safety and quality of care delivered to consumers.⁵

Consumers

Consumers and their families participate as partners to the extent that they choose. These partnerships can be in their own care, and in organisational design and governance.

Members

All podiatric surgeons have a role in the safety and quality of patients, and are expected to perform their roles with diligence, and with a patient-centred approach to the best of their ability. It is their responsibility to raise concerns when they recognise that something is not right.

Members will work in teams with professionals from a variety of disciplines based on mutual respect and clear communication, with an understanding of responsibilities, capacities, constraints and each other's scopes of practice.

Members are responsible for providing care that is patient centred, evidence based, and which focuses on safety through minimising risk while achieving optimal outcomes for patients. This is helped by them participating in clinical governance, in health safety forums and supporting other members to provide high quality services which are safe.

ACPS expects members to speak up when they have concerns about patient safety, so that these can be rectified and learnt from.

Members are accountable for their professional practice, including maintaining currency of their credentialing, registration, and professional practice. Members are required to participate in mandatory ACPS clinical audit and encouraged to undertake reporting through the Quality of Care reports.

ACPS Committees

ACPS Committees support the ACPS to implement and evaluate organisational systems, support members to work together to identify and mitigate risk and continuously improve practice. Members support the organisation to work as a single entity.

Council

The Council has daily operational accountability for system governance and monitoring.

Evaluation of the Effectiveness of the Clinical Governance System

Internal organisation Analysis

- Systems in place are best practice and support members to understand their safety and quality responsibilities
- System risks are known and mitigated
- Members partner with consumers to evaluate the appropriateness of the safety and quality systems
- Improvements identified to strengthen culture; leadership, governance; workforce capability, consumer partnerships, safety and quality systems and manage specific clinical risks are monitored.

⁵ Australian Commission on Safety & Quality in HealthCare. National Model Clinical Governance Framework (2017)

External Analysis

Members utilise independent agencies to evaluate care outcomes via patient experience surveys which are aligned to the National Safety and Quality Health Care Standards. In addition, members are required to submit care outcome data to ACPS which then supports benchmarking.

Critical reflection by ACPS

- How do we know our care is safe and effective?
- How do we ensure the quality and safety of care?
- Do we know what the red flags are?
- How will we fix what we know isn't working?
- What needs to get done to improve the quality and safety of care?
- Do we have a 'just' culture to facilitate continuous improvement in quality and safety?
- What actions do we take as a group to ensure that restrictive practices by other clinical craft groups is not tolerated?
- What actions do we take to ensure patients are empowered to meaningfully partner in their care?
- Are we frequently evaluating the impact and extent of the patient voice?
- How effective are our organisational governance systems in supporting our safe, effective, and person-centred goals for every consumer?
- What must we do to increase the effectiveness of our systems?
- Do all members feel supported to create consistently safe, person-centred, and effective care?
- What must we do to increase support for members?
- Are our members adequately skilled, engaged and empowered to provide safe, high-quality, person-centred clinical care?
- Are we achieving our purpose of providing a safe, person-centred, and effective experience for every consumer? What must we do to make more progress on achieving our purpose?
- Where is the evidence that our patients are better off?
- Do we have a shared definition/understanding of success? ⁶

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