



# EVIDENCE SEARCH RESULTS

<b>Question/subject of request:</b>	Evidence to support the use of podiatric surgery in a community setting with a high-risk patient cohort. Is there any evidence to demonstrate cost savings of providing foot surgery in a community theatre versus acute hospital? Is there any mid-to-long term evidence to support earlier foot surgery intervention in diabetic or other high risk foot cohorts?
<b>Date requested:</b>	27/1/25
<b>Date completed:</b>	16/4/25
<b>Compiled by:</b>	Jess Pawley

## CITING THIS SEARCH

If you reference this search in any paper, publication or presentation, please let us know.

The citation format is:

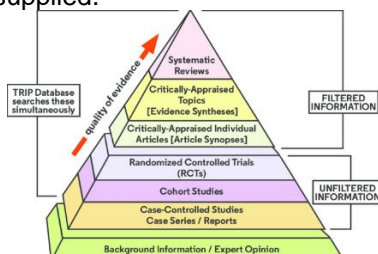
- Pawley, J., (2025). *Evidence summary: Evidence to support the use of podiatric surgery in a community setting with a high-risk patient cohort*. Taunton, UK: Somerset Foundation Trust Knowledge and Library Services.

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The results are presented according to the hierarchy of evidence which is used to rank the relative strength of results obtained from scientific research.

The design of the study and the endpoints measured affect the strength of the evidence.

Evidence hierarchies are often applied in evidence-based practices and are integral to evidence-based medicine.



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**Contents** (click to jump to each section):

**Summary of search results:**

*This summary has been generated in part by AI*

I have broken this down into two main strands:

Cost savings of foot surgery in a community theatre versus an acute hospital, and mid-to-long term evidence supporting earlier foot surgery intervention in high risk foot cohorts.

Click to jump to each section: Some key papers are described below in the summary.

- [Papers directly addressing cost savings](#)
- [Papers directly addressing patient outcomes](#)
- [Papers addressing both aspects](#)

Full list of resources can be found below. Full text has been provided where available – if you would like a paper which does not have a full text provided, please let me know.

Common themes coming through include diabetes, and conditions requiring amputation. I have also included some international examples, to provide comparison and to draw on lessons learned which may potentially be applicable here. Example from [Singapore](#) – describes the positive outcomes of a multidisciplinary approach to foot care, and [Australia](#), which describes the care of indigenous, First Nations people with foot care and recognises potential barriers to accessing services. While our demographic is different, barriers to access remain and are worth taking into account when redesigning services.

I wanted also to highlight the role and impact of primary care podiatry services, and how these can form part of the multidisciplinary approach as the first point of access for a lot of patients – [a quality improvement project from University of Exeter Medical School](#) shows how primary care referrals for diabetic foot care were improved following a change to clinical teaching.

[The study by Megerian et al. \(2022\)](#) concludes that total ankle arthroplasty (TAA) can be performed effectively and safely in both community and county hospital settings, with comparable reoperation rates and implant survival, although certain complications are more prevalent in county hospitals. Further to this, [podiatric surgery on high-risk diabetic feet can achieve good outcomes with high patient satisfaction rates, with an average cost of £1,889 per operation](#). Lastly, Corbacho et al. [evaluate the cost-effectiveness of a podiatry intervention for preventing falls in older people](#), finding that the intervention costs GBP 252 more per participant compared to usual care, with a 65% probability of being cost-effective at a threshold of GBP 30,000 per QALY gained.

[There are significant differences in postoperative outcomes between foot and ankle procedures performed by podiatrists and orthopaedic surgeons](#), with podiatrists experiencing higher rates of complications. Turcotte et al. (2022) concludes that [total ankle arthroplasty \(TAA\) can be performed safely and effectively in community hospitals, with outcomes comparable to specialised centres](#).





[An integrated surgical pathway for complex patient will help maximise pre-operative care planning and leverage existing community partnerships.](#)

Building on this, taking a multidisciplinary approach will improve surgical outcomes – this is highlighted in the evidence below, of particular interest may be the papers by [Belgaid](#) and [DiabetesontheNet](#), the latter of which demonstrates that integrating a podiatric surgery team into an established diabetic foot multidisciplinary team (MDT) improves surgical outcomes and increases the number of patients discharged from the MDT. See also Rosi et al. (2021), highlighting the importance of [early identification and multidisciplinary management of diabetic foot ulcers to reduce morbidity and mortality](#).

Similarly, the systematic review by Meza-Torres et al. (2021) highlights [that specific organisational arrangements, including multidisciplinary teams and care pathways, can prevent half of the amputations in people with diabetes and foot ulcers](#).

Maher et al. (2017) suggests that [delivering podiatric surgery in a community setting for patients with non-acute neuropathic foot ulceration can achieve considerable cost savings for the NHS](#). Hwang (2023) emphasises that early identification and treatment of high-risk wound care patients can result in faster healing and reduced health system costs. Walsh et al. (2025) found that a [podiatry-led orthopaedic triage service is cost-effective and well-received by patients](#), while Blanchette et al discuss [how integrating podiatric care into in-hospital wound care clinic settings improved healing rates and time for diabetic foot ulcers](#).

**Papers directly addressing cost benefits/savings:**

[Are Complications and Survival of Total Ankle Arthroplasty Influenced by Hospital Setting? An Analysis of 189 Cases Performed in Community and County Hospitals](#)

Megerian et al, Foot & Ankle Orthopaedics, 2022

The study concludes that total ankle arthroplasty (TAA) can be performed effectively and safely in both community and county hospital settings, with comparable reoperation rates and implant survival. However, certain complications, such as aseptic loosening and posterior tibial tendon (PTT) dysfunction, are more prevalent in county hospitals. Logistic regression analysis revealed that TAA performed in county settings is a significant predictor of these complications. While immediate outcomes are favorable, further research is needed to understand the long-term implications of these increased complication rates in county hospitals.

[A podiatric surgery high-risk community foot clinic: surgical and financial outcomes - DiabetesontheNet](#) -2020

Previously, the authors reported outcomes following conservative management of people with diabetes attending a high-risk foot podiatric surgery community clinic. This demonstrated a significant proportion of patients requiring surgical intervention where conservative measures had failed or were deemed inappropriate. The purpose of this study was to determine clinical outcomes and costs of those patients who proceeded to surgery. A retrospective cohort study was designed involving 106 consecutive podiatric surgery operations undertaken in those with or without diabetes with foot disease who are high-risk over a period of 62 months. Data analysed included demographic and surgical outcomes, including whether specific aims were met, complications, the patient-reported outcome measure, PSQ-10, qualitative data in the form of patient





expectations to gain an understanding of individual aims and cost using national tariffs assigned to Health Resource Group codes. A total of 31.6% of patients required surgery to address their foot disease. A significant proportion had concomitant comorbidities, including diabetes (88.7%), cardiovascular disease (40.2%), peripheral neuropathy (96.9%) and peripheral arterial disease (18.6%). Surgical aims were met in 93.4% of patients, with a 15.1% complication rate. The PSQ-10 score was 92.1 (SD=9.29, range 55–100), with patient expectations met in 97.8% in completed questionnaires. The mean average price of our foot surgery per operation was £1,889. Podiatric surgery on the high-risk foot can achieve good outcomes with high patient satisfaction rates.

### [Cost-Effectiveness of a Multifaceted Podiatry Intervention for the Prevention of Falls in Older People: The REducing Falls with Orthoses and a Multifaceted Podiatry Intervention Trial Findings.](#)

**Authors:** Corbacho, Belen;Cockayne, Sarah;Fairhurst, Caroline;Hewitt, Catherine E.;Hicks, Kate;Kenan, Anne-Maree;Lamb, Sarah E.;MacIntosh, Caroline;Menz, Hylton B.;Redmond, Anthony C.;Rodgers, Sara;Scantlebury, Arabella;Watson, Judith and Torgerson, David J.

**Publication Date:** 2018

**Journal:** Gerontology 64(5), pp. 503–512

**Abstract:** BACKGROUND: Falls are a major cause of morbidity among older people. Multifaceted interventions may be effective in preventing falls and related fractures. OBJECTIVE: To evaluate the cost-effectiveness alongside the REducing Falls with Orthoses and a Multifaceted podiatry intervention (REFORM) trial. METHODS: REFORM was a pragmatic multicentre cohort randomised controlled trial in England and Ireland; 1,010 participants (> 65 years) were randomised to receive either a podiatry intervention (n = 493), including foot and ankle strengthening exercises, foot orthoses, new footwear if required, and a falls prevention leaflet, or usual podiatry treatment plus a falls prevention leaflet (n = 517). PRIMARY OUTCOME: incidence of falls per participant in the 12 months following randomisation. SECONDARY OUTCOMES: proportion of fallers and quality of life (EQ-5D-3L) which was converted into quality-adjusted life years (QALYs) for each participant. Differences in mean costs and QALYs at 12 months were used to assess the cost-effectiveness of the intervention relative to usual care. Cost-effectiveness analyses were conducted in accordance with National Institute for Health and Clinical Excellence reference case standards, using a regression-based approach with costs expressed in GBP (2015 price). The base case analysis used an intention-to-treat approach on the imputed data set using multiple imputation. RESULTS: There was a small, non-statistically significant reduction in the incidence rate of falls in the intervention group (adjusted incidence rate ratio 0.88, 95% CI 0.73-1.05, p = 0.16). Participants allocated to the intervention group accumulated on average marginally higher QALYs than the usual care participants (mean difference 0.0129, 95% CI -0.0050 to 0.0314). The intervention costs were on average GBP 252 more per participant compared to the usual care participants (95% CI GBP -69 to GBP 589). Incremental cost-effectiveness ratios ranged between GBP 19,494 and GBP 20,593 per QALY gained, below the conventional National Health Service cost-effectiveness thresholds of GBP 20,000 to GBP 30,000 per additional QALY. The probability that the podiatry intervention is cost-effective at a threshold of GBP 30,000 per QALY gained was 0.65. The results were robust to sensitivity analyses. CONCLUSION: The benefits of the intervention justified the moderate cost. The intervention could be a cost-effective option for falls prevention when





compared with usual care in the UK.

### **Papers addressing patient outcomes:**

#### [Differences in Postoperative Outcomes of Common Foot and Ankle Procedures Performed by Orthopedic Surgeons and Podiatrists](#)

Chao et al, Foot & Ankle Orthopaedics, 2024

The study highlights significant differences in postoperative outcomes between foot and ankle procedures performed by podiatrists and orthopedic surgeons. Patients treated by podiatrists experienced higher rates of complications such as neuritis, nonunion, prosthetic issues, and the need for wound debridement. Orthopedic surgeons generally handled older patients with higher comorbidity indices, suggesting they managed more complex cases. Additionally, orthopedic surgeries were more frequently performed in inpatient facilities, which could impact postoperative care and monitoring. The findings raise concerns about the safety and quality of care provided by podiatrists compared to orthopedic surgeons, emphasizing the need for patients to be informed about potential risks when choosing their healthcare provider<sup>4</sup>. The authors call for further research to investigate these differences in outcomes to ensure patients can make well-informed decisions regarding their care options.

#### [Total Ankle Arthroplasty Can Be Safely and Effectively Performed in the Community Hospital Setting: A Case Series of 65 Patients](#)

Turcotte et al, The Journal of Foot & Ankle Surgery, 2022

The paper "Total Ankle Arthroplasty Can Be Safely and Effectively Performed in the Community Hospital Setting: A Case Series of 65 Patients" concludes that total ankle arthroplasty (TAA) can be performed safely and effectively in community hospitals, with outcomes comparable to specialized centers<sup>1</sup>. The study reports a low reoperation rate of 12.3% and a high implant survival rate of 96.9% over an average follow-up period of 2.42 years. It identifies specific complications, including a small percentage of implant failures (3.1%), with an average time to failure of 342 days. The findings encourage broader implementation of TAA in community hospitals, suggesting that this procedure should not be limited to academic or tertiary care facilities, thereby improving patient access to surgical options for ankle arthritis.

#### [Impact of Podiatric Surgery Consultation for Foot and Ankle Wounds on Patient Outcomes in a Community Hospital](#)

Behme et al, The Journal of Foot & Ankle Surgery, 2023





We recommend the use of this simple and cost-effective pathway to guide the interdisciplinary management of diabetic foot. A prospective study with more subjects would provide a better overview of this management pathway

[Interprofessional collaboration to support person-centered care: implementation of an integrated surgical pathway for complex foot and ankle patients](#)

**Poster Abstract**, Alvares et al, International Journal of Integrated Care, 2023

Implementation of an integrated surgical pathway for complex foot and ankle patients that maximize pre-operative care planning and leveraging existing community partnerships, both in-home and institutional; enable the delivery of person-centred care, facilitating seamless transitions from acute care to community for patients while optimizing hospital resource utilization.

[Diabetic Foot Management: How Could a Procedural Pathway Improve the Surgical Outcome?](#)

Belgaid et al, Malaysian Orthopaedic Journal, 2020

Diabetic foot ulcer is the main aetiology for non-traumatic amputation, which is a major public health care concern. A multidisciplinary approach in the management of this pathology has been shown to improve the surgical outcome. However, there are little data available on the tools we can use to pursue this multidisciplinary approach. The main goal of this cross-sectional study was to find out whether the implementation of a specific management pathway could improve the treatment outcome in the treatment of diabetic foot

We recommend the use of this simple and cost-effective pathway to guide the interdisciplinary management of diabetic foot. A prospective study with more subjects would provide a better overview of this management pathway

[Podiatric surgery and the diabetic foot: a retrospective cohort study of community-based diabetic foot surgery - DiabetesontheNet – 2024](#)

Diabetic foot multidisciplinary teams (MDT) have been shown to improve incidence and risk reduction in foot ulceration and decrease major lower-limb amputation. This Podiatric surgery team is part of a community-based foundation trust offering day-case foot surgery under a local anaesthetic. It has recently been integrated into an established diabetic foot MDT. Aims: To compare the outcomes from two cohorts who received diabetic foot surgery for the treatment or prevention of diabetic foot ulceration and/or infection before and after integration into an established diabetic foot MDT. Methods: A retrospective cohort study comparing outcomes between April 2014–November 2016, and January 2022–August 2023. A Microsoft Excel database was used to record the outcomes of interest, which included the number of referrals, demographics, surgical procedures, ulcer healing rates, complications, and whether the patient was subsequently discharged from the diabetic foot MDT clinic. Results: There was a 72% increase in referrals received in 2022/23 (179) compared to 2014/16 (104). A total of 253 procedures were performed compared to 74 in 2014/16. 92% of wounds healed in





2022/23, compared to 85.9% in 2014/16. 83% were discharged from the MDT compared to 70% in 2014/16. 73.4% of admissions resulted in healing without complication, compared to 67.5% in 2014/16 and the minor amputation rate halved over the 6-year period. Conclusion: The integration of a podiatric surgery team into an established diabetic foot MDT has improved surgical outcomes and increased the number of patients discharged from the MDT.

### **Efficiency and perceived safety of foot and ankle procedures performed on the preoperative stretcher versus operating room table.**

**Authors:** Lause, Gregory E.;Parker, Emily B.;Farid, Alexander;Smith, Jeremy T.;Chiodo, Christopher P.;Martin, Elizabeth A. and Bluman, Eric M.

**Publication Date:** Sep ,2024

**Journal:** Journal of Perioperative Practice 34(9), pp. 268–273

**Abstract:** BACKGROUND: Foot and ankle surgeons often perform minor surgeries on the preoperative stretcher instead of the operating room table. We examined whether stretcher-based and operating room table-based procedures differed with respect to operating room efficiency and staff perceptions. METHODS: We retrospectively reviewed medical records of patients undergoing minor foot and ankle surgery at an ambulatory surgery centre. We collected 'time to start', the duration between patient arrival in the operating room and incision time, and 'time to exit', the duration between procedure end time and patient exit from the operating room. Staff were surveyed regarding their perceptions of stretcher-based and operating room table-based procedures. RESULTS: 'Time to start' was significantly shorter for stretcher-based procedures, but 'time to exit' was not. Seventeen (81%) staff members thought stretcher-based procedures increased operating room efficiency. Thirteen (62%) thought stretcher-based procedures bettered staff safety. Nineteen (91%) thought stretcher-based procedures were equivalent to or better than operating room table-based procedures for patient safety. Most (67%) would recommend stretcher-based procedures. CONCLUSION: We found small but significant time savings associated with stretcher-based procedures. Without adapting surgical scheduling practices, the impact of stretcher-based procedures on overall operating room efficiency is questionable. Nevertheless, the majority of OR staff think stretcher-based procedures increase OR efficiency and are safer for staff. LEVEL OF EVIDENCE: Level IV, Retrospective case series.

### **Unplanned 30-day readmission in patients with diabetic foot wounds treated in a multidisciplinary setting.**

**Authors:** Holscher, Courtenay M.;Hicks, Caitlin W.;Canner, Joseph K.;Sherman, Ronald L.;Malas, Mahmoud B.;Black, James H. 3rd;Mathioudakis, Nestoras and Abularrage, Christopher J.

**Publication Date:** 2018

**Journal:** Journal of Vascular Surgery 67(3), pp. 876–886

**Abstract:** OBJECTIVE: Readmission rates are known to be high for vascular surgery patients in general, but there are limited data describing the risk of surgical and nonsurgical readmission among patients with diabetic foot





ulcers (DFUs). Our aim was to identify factors associated with unplanned readmission in DFU patients treated in a multidisciplinary setting. **METHODS:** We studied a single-center cohort of patients enrolled in a multidisciplinary diabetic foot service (July 2012-June 2017). Readmissions were stratified by planned vs unplanned and related vs unrelated to the wound and vascular status. Predictors of unplanned 30-day readmission were examined with univariable and multivariable logistic regression models including all covariates with P : We studied a single-center cohort of patients enrolled in a multidisciplinary diabetic foot service (July 2012-June 2017). Readmissions were stratified by planned vs unplanned and related vs unrelated to the wound and vascular status. Predictors of unplanned 30-day readmission were examined with univariable and multivariable logistic regression models including all covariates with P **RESULTS:** There were 460 admissions in 206 patients during the study period, including 99 total readmissions (21.5%). Readmissions were categorized as planned (n = 18 [18.2%]) or unplanned (n = 81 [81.8%]) and as related (n = 67 [67.7%]) or unrelated (n = 32 [32.3%]) to the wound and vascular status. The most frequent reasons for unplanned 30-day readmission were deterioration of the foot wound (41%), vascular complications (15%), gastrointestinal complications (10%), cardiac complications (8%), and acute kidney injury (8%). The average length of stay for the initial admission was 9.0 +/- 7.1 days, whereas the average unplanned readmission length of stay was 8.6 +/- 9.1 days (P = .38). On univariable analysis, hypertension (odds ratio [OR], 2.80; 95% confidence interval [CI], 1.19-6.59), peripheral arterial disease (OR, 1.80; 95% CI, 1.09-2.99), and exposure to an open vascular operation (OR, 2.64; 95% CI, 1.34-5.17) were associated with a higher risk of 30-day unplanned readmission (P = .22). After risk adjustment, only hypertension (OR, 2.80; 95% CI, 1.19-6.59) and current smoking (OR, 1.95; 95% CI, 1.02-3.73) were independently associated with 30-day unplanned readmission, but the predictive accuracy of the model was weak (C statistic = 0.69). **CONCLUSIONS:** We found a 17% unplanned 30-day readmission rate in this prospective cohort of DFU patients enrolled in a multidisciplinary diabetic foot service. Only current smoking and hypertension were independent predictors of readmission after risk adjustment. These findings suggest that implementation of a smoking cessation program may be beneficial to reduce unplanned readmissions in DFU patients. They also highlight the complexity involved in achieving comprehensive DFU care and the unpredictability of readmissions in this unique population of patients. Copyright © 2017 Society for Vascular Surgery. Published by Elsevier Inc. All rights reserved.

## Papers addressing both:

[Podiatry's role in primary care](#) – no date, prompts for open or download

[Interdisciplinary teaching in diabetic foot care - does it help primary healthcare providers identify and refer to specialist services?](#) | Fab NHS Stuff

[Health service organisation impact on lower extremity amputations in people with type 2 diabetes with foot ulcers: systematic review and meta-analysis.](#)

**Authors:** Meza-Torres, Bernardo;Carinci, Fabrizio;Heiss, Christian;Joy, Mark and de Lusignan, Simon

**Publication Date:** Jun ,2021



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**Journal:** Acta Diabetologica 58(6), pp. 735–747

**Abstract:** AIMS: Despite the evidence available on the epidemiology of diabetic foot ulcers and associated complications, it is not clear how specific organizational aspects of health care systems can positively affect their clinical trajectory. We aim to evaluate the impact of organizational aspects of care on lower extremity amputation rates among people with type 2 diabetes affected by foot ulcers. METHODS: We conducted a systematic review of the scientific literature published between 1999 and 2019, using the following key terms as search criteria: people with type 2 diabetes, diagnosed with diabetic foot ulcer, treated with specific processes and care pathways, and LEA as primary outcome. Overall results were reported as pooled odds ratios and 95% confidence intervals obtained using fixed and random effects models. RESULTS: A total of 57 studies were found eligible, highlighting the following arrangements: dedicated teams, care pathways and protocols, multidisciplinary teams, and combined interventions. Among them, seven studies qualified for a meta-analysis. According to the random effects model, interventions including any of the four arrangements were associated with a 29% reduced risk of any type of lower extremity amputation (OR = 0.71; 95% CI 0.52-0.96). The effect was larger when focusing on major LEAs alone, leading to a 48% risk reduction (OR = 0.52; 95% CI 0.30-0.91). CONCLUSIONS: Specific organizational arrangements including multidisciplinary teams and care pathways can prevent half of the amputations in people with diabetes and foot ulcers. Further studies using standardized criteria are needed to investigate the cost-effectiveness to facilitate wider implementation of improved organizational arrangements. Similarly, research should identify specific roadblocks to translating evidence into action. These may be structures and processes at the health system level, e.g. availability of professionals with the right skillset, reimbursement mechanisms, and clear organizational intervention implementation guidelines.

[Podiatry surgery and the diabetic foot: an audit of a community-based diabetic foot surgery](#)

Maher et al, The Diabetic Foot Journal, 2017

The authors undertook an initial audit to gain an understanding of the services they were delivering to people with diabetes, with reference to clinical effectiveness and safety.

This article has demonstrated that the diabetes MDT may benefit from access to a podiatric surgery service for the management of patients who have non-acute neuropathic foot ulceration that has failed to heal through the usual means. Patients can be offered surgery safely in a community setting under local anaesthesia and following treatment, most patients will heal and be discharged from the MDT. Although this audit has not looked directly at the cost of treatment, it is probable that delivering surgery in a community setting for these patients has the potential to achieve considerable cost savings for the NHS.

[Time is tissue. Want to save millions in wound care? Start early: a QI project to expedite referral of high-risk wound care patients to specialised care](#)

Hwang, BMJ Open Quality, 2023

A prospective interventional quality improvement study was performed between June 2017 and June 2018. We determined baseline referral times to the clinic and then performed three interventions. The effects on referral time, healing time and number of home care visits to achieve wound healing were collected and displayed on annotated control charts. The cost of care and potential for cost avoidance was determined by an analysis of the medical encounters of twenty chronic wound patients. Early identification and treatment of patients at high





risk for wound chronicity and complications, followed by early referral to and treatment at a specialised wound clinic, resulted in faster healing and reduced health system costs.

### **Diabetic foot in primary and tertiary (DEFINITE) care: An efficacious, synergistic and cost-effective multidisciplinary team model for diabetic foot care in Singapore.**

**Authors:** Leo, Wen Zhe;Ge, Lixia;Chandrasekar, Sadhana;Tan, Elaine;Loh, Yi Bing;Zhu, Xiaoli;Liew, Huiling;Yong, Enming;Chew, Tiffany;Hoe, Jeremy;Law, Chelsea;Lin, Jaime;Lim, Jo Anne;Lingam, Pravin;Molina, Joseph;Ang, Gary;Sun, Yan and Lo, Zhiwen Joseph

**Publication Date:** Mar ,2025

**Journal:** Seminars in Vascular Surgery 38(1), pp. 20–31

**Abstract:** Diabetic foot ulcers (DFUs) and lower extremity amputations (LEAs) threaten survival and quality of life (QoL) of patients, contributing to healthcare and economic burden. Guidelines advocate for a multidisciplinary team (MDT) approach, but limited literature exists on cost-effectiveness and collaboration with primary care. We present the outcomes of the Diabetic Foot in Primary and Tertiary (DEFINITE) Care program, an MDT initiative in Singapore across primary and tertiary care. Patients with DFU from June 2020 to 2022 were enrolled. Clinical outcomes encompassed one-year minor and major LEAs, mortality and LEA-free survival rates. Healthcare utilization outcomes included number of admissions, length of stay, and primary care and hospital visits. QoL and Patient Reported Outcome Measures (PROMs) were respectively assessed using the EuroQol Five-Dimensional Questionnaire and Diabetic Foot Ulcer Scale-Short Form. Results from DEFINITE were propensity-score matched against a retrospective cohort. Cost-effectiveness analysis was performed using Markov simulation. Subgroup analyses focused on at-risk populations, including patients without access to MDT clinics or podiatry, appointment defaulters, octogenarians, patients with end-stage renal failure and different primary care locations. Total of 2,798 patients, with a mean age of 65.7 years and majority males (61.4%), were included for analysis. DEFINITE Care patients had higher minor LEA and improved LEA-free survival rates, fewer and shorter hospital admissions, and enhanced QoL and PROMs. DEFINITE Care demonstrated greater cost-effectiveness when compared to traditional care. Outcomes varied among subgroups. DEFINITE Care is an efficacious and cost-effective MDT model which fosters collaboration between primary and tertiary care for diabetic limb salvage. Copyright © 2025 Elsevier Inc. All rights reserved.

### **Podiatric Clinical Triage in a Foot and Ankle Orthopaedic Clinic: A Randomised Trial.**



Evaluation Clinical  
Practice - 2025 - Wal

**Authors:** Walsh, Tom P.;Swalwell, Caitlin;Merlo, Greg B.;Wearing, Scott C.;Jacob, Warren;Doherty, Darren;Vandermost, Margaret and Platt, Simon



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**Publication Date:** Feb ,2025

**Journal:** Journal of Evaluation in Clinical Practice 31(1), pp. e14249

**Abstract:** RATIONALE: Hospitals are increasingly utilising allied-health professionals to provide clinical triage to patients. While these positions are routinely implemented, and several observational studies have reported positive outcomes, the effectiveness of this intervention has been rarely tested in a clinical trial. AIMS AND OBJECTIVES: The objectives of this study were to (i) evaluate a podiatry-led orthopaedic triage service using patient-reported outcome measures (PROMs), and (ii) determine if it is cost-effective in terms of incremental cost/quality-adjusted life years (QALYs). METHODS: This pragmatic, randomised, wait-list-control trial recruited participants referred to an orthopaedic foot and ankle clinic at a tertiary-level health service. Trial registration was 31 March 2020. Participants were randomised to either immediate clinical triage (intervention) or to remain on the waiting-list (control). The primary outcome measure was change in foot pain as measured by the Manchester-Oxford Foot and Ankle Questionnaire (MOxFQ) at 6-months. Core outcome measures for chronic musculoskeletal pain were also measured and cost-effectiveness calculated. RESULTS: One hundred and forty-eight participants were recruited, randomising 73 people to the intervention and 75 people to the control. No between-group differences in pain or demographics were detected at baseline. Foot pain as measured by the MOxFQ improved in both groups at 6-months follow-up, but no significant between-group differences were identified. Significant between-group differences, however, were detected in the patient global impression of change. Additionally, the intervention resulted in a 30% discharge rate, and is considered cost-effective, with each QALY gain costing £10,000. CONCLUSION: A clinical triage service has minimal impact on PROMs for foot and ankle pain or chronic musculoskeletal pain, but it is generally well-received, is cost-effective, and participants were more likely to report global improvement if they attended. Copyright © 2024 John Wiley & Sons Ltd.

**Experiences and impact of a rural Australian high-risk foot service: A multiple-methods study.**

**Authors:** Tehan, Peta Ellen;Donnelly, Hailey;Martin, Emma;Peterson, Benjamin and Hawke, Fiona

**Publication Date:** Apr ,2024

**Journal:** Australian Journal of Rural Health 32(2), pp. 286–298

**Abstract:** OBJECTIVE: Most podiatry-led high-risk foot services (HRFS) in Australia are located in metropolitan areas or large regional centres. In rural areas, where there are limited specialist services, individuals with diabetes-related foot ulceration are more likely to undergo amputation. This study aimed to explore clinicians' perceptions of a recently implemented HRFS in rural New South Wales, Australia, and compare trends of amputation and hospitalisation prior to and post-implementation of the service. SETTING: Rural HRFS in Tamworth, New South Wales, Australia. PARTICIPANTS: Health professionals working within the HRFS were recruited to participate. DESIGN: This was a multiple-methods study. For the qualitative arm, semi-structured interviews were conducted, which were analysed using a reflexive thematic approach. The quantitative arm of the study utilised a retrospective analytic design which applied an interrupted time series to compare amputation and hospitalisation trends pre- and post-implementation of the HRFS utilising diagnostic and





procedural ICD codes. RESULTS: The qualitative arm of the study derived three themes: (1) navigating the divide, (2) rural community and rural challenges and (3) professional identity. Results of the interrupted time series indicate that there was a downward trend in major amputations following implementation of the HRFS; however, this was not statistically significant. CONCLUSION: Clinicians were aware of the inequity in DFD outcomes between rural and metropolitan areas and were committed to improving outcomes, particularly with respect to First Nations peoples. Future research will explore service use and amputation rates in the longer term to further evaluate this specialised multidisciplinary care in a rural community. Copyright © 2024 The Authors. Australian Journal of Rural Health published by John Wiley & Sons Australia, Ltd on behalf of National Rural Health Alliance Ltd.

### **Demographics and outcomes of inpatients with diabetic foot ulcers treated conservatively and surgically in a metropolitan hospital network.**

**Authors:** Rosi, Luisa M.; Jones, Annabel S.; Topliss, Duncan J. and Bach, Leon A.

**Publication Date:** May ,2021

**Journal:** Diabetes Research & Clinical Practice 175, pp. 108821

**Abstract:** AIMS: To describe the demographics of patients with diabetic foot ulcers (DFU) and their impact on inpatient management. Secondary outcomes identified relationships of treatment modality with mortality, length of hospital admission, readmissions and post-admission care. METHODS: Retrospective cohort study including patients with DFU admitted to a hospital network in Melbourne, Australia from 2016 to 2018. Medical records were manually reviewed for acute admission with DFU as a major presenting diagnosis; incidental ulcers and traumatic amputations were excluded. Amputations distal and proximal to the ankle were labelled 'minor' and 'major' respectively. Patients were followed until October 31, 2019. RESULTS: Of 338 patients, 21 and 148 had major and minor amputations, and 169 were managed conservatively. 94% had  $\geq 1$  microvascular and/or macrovascular complication. Conservative management (7 days) was associated with a shorter length of stay (major 18, minor 10 days,  $p < 0.001$ ). CONCLUSIONS: Early identification and multi-disciplinary management of DFU is essential to reduce the significant morbidity and mortality associated with amputation in these complex patients. Copyright © 2021 Elsevier B.V. All rights reserved.

### **Establishing a multidisciplinary partnership integrating podiatric care into the Quebec public health-care system to improve diabetic foot outcomes: A retrospective cohort.**

**Authors:** Blanchette, Virginie; Hains, Sebastien and Cloutier, Lyne

**Publication Date:** Mar ,2019

**Journal:** Foot 38, pp. 54–60

**Abstract:** Diabetic foot ulcers (DFUs) are one of the main complications of diabetes affecting many Canadians





that need to be effectively managed. There is limited data concerning outcomes of Canadian patients with DFUs treated with a team approach in the public health system. Podiatrists are known to be key members of a multidisciplinary team approach to DFUs management, but in Quebec, Canada, they are only available in private practice. The aim of this study is to evaluate diabetic foot outcomes after integrating podiatric care into in-hospital wound care clinic settings. A 12-month retrospective cohort study was conducted into a new organization named the Pododiabetology University Center (PUC), which is described in this article. Healing rate and healing time were the outcomes measured. The analysis was performed by comparing data collected before and after the integration of the podiatrists. Preliminary results indicate that 73.2% of DFUs (n=52) healed in an average of 19.8 weeks (time to wound closure). Previous data collected on 15 individuals before the integration of podiatric care showed a 27.3% of DFUs resolved in 44.6 weeks. The findings suggest that a patient with DFUs who receives wound care from a multidisciplinary team that includes a podiatrist can improve both their healing rate and time. An integrated multidisciplinary approach including podiatrists for patients affected by acute DFU is highly suggested in the literature in order to reduce the number of hospitalizations, amputations and financial burden, which are variables that could be evaluated in further studies. Copyright © 2018 Elsevier Ltd. All rights reserved.

**[Diabetes-related major lower limb amputation incidence is strongly related to diabetic foot service provision and improves with enhancement of services: peer review of the South-West of England.](#)**

**Authors:** Paisey, R. B.; Abbott, A.; Levenson, R.; Harrington, A.; Browne, D.; Moore, J.; Bamford, M. and Roe, M.

**Publication Date:** 2018

**Journal:** Diabetic Medicine 35(1), pp. 53–62

**Abstract:** AIMS: To investigate the relationship between high diabetes-related lower limb amputation incidence and foot care services in the South-West region of England. METHODS: The introduction of 10 key elements of foot care service provision in one area of the South-West resulted in stabilization of foot ulcer incidence and sustained reduction in amputation incidence from 2007. Services introduced included administrative support, standardized general practice foot screening, improved community podiatry staffing, hospital multidisciplinary foot clinics, effective care pathways, availability of an orthotist and audit. Peer reviews of the region's diabetes foot care services were undertaken to assess delivery of these service provisions and compare this with major amputation incidence in other regions with data provided by Yorkshire and Humber Public Health Observatory Hospital Episode Statistics. Recommendations were made to improve service provision. In 2015 changes in service provision and amputation incidence were reviewed. RESULTS: Initial reviews in 2013 showed that the 3-year diabetes-related major amputation incidence correlated inversely with adequate delivery of diabetes foot care services ( $P=0.0024$ , adjusted  $R^2=0.51$ ). Repeat reviews in 2015 found that two or more foot care service improvements were reported by six diabetes foot care providers, with improvement in outcomes. The negative relationship between major amputation incidence and service provision remained strong both in the period 2012–2015 and in the year 2015 only ( $P=0.51$ ). Repeat reviews in 2015 found that two or more foot care service improvements were reported by six diabetes foot care providers, with improvement in outcomes. The negative relationship between major amputation incidence and service provision remained strong both in the period 2012–2015 and in the year 2015 only ( $P=0.56$ , and  $P=0.0005$ ,  $R^2=0.62$ , respectively). CONCLUSIONS: Major diabetes-related lower limb amputation incidence is significantly inversely correlated with foot care services provision. Introduction of more effective service provision resulted in significant reductions in major





amputation incidence within 2 years. Failure to improve unsatisfactory service provision resulted in continued high amputation incidence. Copyright © 2017 The Authors. Diabetic Medicine published by John Wiley & Sons Ltd on behalf of Diabetes UK.

**[Clinical effectiveness and cost-effectiveness of a multifaceted podiatry intervention for falls prevention in older people: a multicentre cohort randomised controlled trial \(the REDucing Falls with ORthoses and a Multifaceted podiatry intervention trial\).](#)**

**Authors:** Cockayne, Sarah;Rodgers, Sara;Green, Lorraine;Fairhurst, Caroline;Adamson, Joy;Scantlebury, Arabella;Corbacho, Belen;Hewitt, Catherine E.;Hicks, Kate;Hull, Robin;Keenan, Anne-Maree;Lamb, Sarah E.;McIntosh, Caroline;Menz, Hylton B.;Redmond, Anthony;Richardson, Zoe;Vernon, Wesley;Watson, Judith and Torgerson, David J.

**Publication Date:** 2017

**Journal:** Health Technology Assessment (Winchester, England) 21(24), pp. 1–198

**Abstract:** BACKGROUND: Falls are a serious cause of morbidity and cost to individuals and society. Evidence suggests that foot problems and inappropriate footwear may increase the risk of falling. Podiatric interventions could help reduce falls; however, there is limited evidence regarding their clinical effectiveness and cost-effectiveness. OBJECTIVES: To determine the clinical effectiveness and cost-effectiveness of a multifaceted podiatry intervention for preventing falls in community-dwelling older people at risk of falling, relative to usual care. DESIGN: A pragmatic, multicentred, cohort randomised controlled trial with an economic evaluation and qualitative study. SETTING: Nine NHS trusts in the UK and one site in Ireland. PARTICIPANTS: In total, 1010 participants aged  $\geq 65$  years were randomised (intervention,  $n = 493$ ; usual care,  $n = 517$ ) via a secure, remote service. Blinding was not possible. INTERVENTIONS: All participants received a falls prevention leaflet and routine care from their podiatrist and general practitioner. The intervention also consisted of footwear advice, footwear provision if required, foot orthoses and foot- and ankle-strengthening exercises. MAIN OUTCOME MEASURES: The primary outcome was the incidence rate of falls per participant in the 12 months following randomisation. The secondary outcomes included the proportion of fallers and multiple fallers, time to first fall, fear of falling, fracture rate, health-related quality of life (HRQoL) and cost-effectiveness. RESULTS: The primary analysis consisted of 484 (98.2%) intervention and 507 (98.1%) usual-care participants. There was a non-statistically significant reduction in the incidence rate of falls in the intervention group [adjusted incidence rate ratio 0.88, 95% confidence interval (CI) 0.73 to 1.05;  $p = 0.16$ ]. The proportion of participants experiencing a fall was lower (50% vs. 55%, adjusted odds ratio 0.78, 95% CI 0.60 to 1.00;  $p = 0.05$ ). No differences were observed in key secondary outcomes. No serious, unexpected and related adverse events were reported. The intervention costs 252.17 more per participant (95% CI -69.48 to 589.38) than usual care, was marginally more beneficial in terms of HRQoL measured via the EuroQoL-5 Dimensions [mean quality-adjusted life-year (QALY) difference 0.0129, 95% CI -0.0050 to 0.0314 QALYs] and had a 65% probability of being cost-effective at the National Institute for Health and Care Excellence threshold of 30,000 per QALY gained. The intervention was generally acceptable to podiatrists and trial participants. LIMITATIONS: Owing to the difficulty in calculating a sample size for a count outcome, the sample size was based on detecting a difference in the proportion of participants experiencing at least one fall, and not the primary outcome. We are therefore unable to confirm if the trial was sufficiently powered for the primary outcome. The findings are not generalisable to patients who are not receiving podiatry care. CONCLUSIONS: The intervention was safe and potentially effective. Although





the primary outcome measure did not reach significance, a lower fall rate was observed in the intervention group. The reduction in the proportion of older adults who experienced a fall was of borderline statistical significance. The economic evaluation suggests that the intervention could be cost-effective. **FUTURE WORK:** Further research could examine whether or not the intervention could be delivered in group sessions, by physiotherapists, or in high-risk patients. **TRIAL REGISTRATION:** Current Controlled Trials ISRCTN68240461. **FUNDING:** This project was funded by the National Institute for Health Research (NIHR) Health Technology Assessment programme and will be published in full in Health Technology Assessment; Vol. 21, No. 24. See the NIHR Journals Library website for further project information.

[Implementing an integrated diabetic foot care programme in Ireland: podiatrists' experience](#)

Pallin et al, BMC Health Services Research, 2023

International evidence suggests that an integrated multidisciplinary approach to diabetic foot management is necessary to prevent ulceration and progression to amputation. Many health systems have introduced policies or models of care supporting the introduction of this evidence into practice, but little is known about the experiences of those involved in implementation. This study addresses this gap by examining the experiences of podiatrists providing integrated diabetic foot care. Previous evidence has shown that there is often a gap between what is set out by a policy and what it looks like when delivered to service users. Results from the current study support this, highlighting that while most podiatrists work in line with national recommendations, there are specific gaps and challenges that need to be addressed to ensure successful policy implementation.

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DATABASES AND INFORMATION SOURCES USED				
x	Pubmed		HMIC	BMJ Best Practice
x	Medline		Social Policy and Practice	Cochrane Library
	Emcare		CINAHL	x TRIP
	Embase		PsycINFO	x Grey Literature
	AMED		UpToDate	x Other- KnowledgeShare Copilot AI Consensus AI NHS Fab

PURPOSE OF SEARCH		
	Patient info/health & well being	Clinical decision making (inc. patient care)
	Executive Team support	Research/Education/Professional development
x	Quality Improvement	Primary Care & Neighbourhoods Directorate support
	KM/Management decision making	Other

USER CATEGORY OF REQUESTOR		
	Medical students	Patients/public
	Nursing/midwifery students	Physician Associates
	Doctor/Psychiatrist	Public Health (Somerset CC)
	Nurses/Midwives	Other
x	Allied Health professionals	





HAS PERMISSION TO SHARE THE RESULTS BEEN OBTAINED FROM THE REQUESTOR?	
x	YES - share
	NO – do not share

KEY WORDS/SEARCH STRATEGY INCLUDING MESH HEADINGS	LIMITS USED
<p>foot surgery.mp.            podiatr* surger*.mp.            exp *Podiatry/            podiatry.mp.            (foot and surgery) mp.            (podiatry and surgery)            (podiatric and surgery)</p> <p>1 or 2 or 3 or 4 or 5 or 6 or 7</p> <p>high risk patient*            (high risk and patient*).mp            diabetic foot.mp. or Diabetic Foot/</p> <p>9 or 10 or 11</p> <p>(acute or acute hospital* or acute setting).mp            (community or community hospital* or community setting).mp.</p> <p>13 or 14</p> <p>cost saving*.mp.            cost benefit*.mp.            cost improvement*.mp.            cost improvement program* saving*.mp.            cip saving*.mp.</p> <p>16 or 17 or 18</p> <p>outcome*.mp.</p> <p>8 and 12 and 15 and 21 and 22            8 and 12 and 21            8 and 12 and 15 and 22            8 and 12 and 15 and 21            limit 26 to (yr="2015 - 2025" and "all adult (19 plus years)" and english)            limit 24 to (yr="2015 - 2025" and "all adult (19 plus years)" and english)</p>	





limit 25 to (yr="2015 - 2025" and "all adult (19 plus years)" and english)  
8 and 21  
limit 30 to (yr="2015 - 2025" and "all adult (19 plus years)" and english)

