

Self-reported evaluation of diabetic foot care and priorities in a group of health care professionals from diabetic foot services in tuscany – a diabetic foot valley survey

Alberto Piaggese^{*1} MD, Francesco Giangreco¹ MD, Simone Barbagallo² Eng., Elisa Amato¹ DPM and Graziano Di Cianni³ MD on behalf of the Diabetic Foot Valley Tuscany Working Group⁴

¹Diabetic Foot Section, Department of Endocrinology and Metabolism, University of Pisa, Italy

²Hippocrates Research, Genova, Italy

³Diabetology Unit, Livorno, Italy

⁴Diabetic Foot Valley Tuscany Working Group (Appendix 2), Italy

*Corresponding author email alberto.piaggese@med.unipi.it

ABSTRACT

Aim To get baseline information on critical aspects on diabetic foot (DF) care in Tuscany, we surveyed the health care professionals (HCPs) working in the public regional health service (RHS), as part of the Diabetic Foot Valley Tuscany project.

Methods A 12-item questionnaire, was delivered, focusing on the amount of their time dedicated to DF care and their interest and sense of adequacy toward DF. They were then asked to indicate the critical aspects of DF care and rank them according to the level of priorities.

Results 61 out of 97 (62.9%) HCPs took part in the survey. DF care represented more than half of the workload of nearly 60% HCPs and their interest was significantly higher ($p < 0.001$) than self-reported professional adequacy/competence, and it was correlated ($p < 0.001$) with years of work for physicians. Lack of technical skills, poor knowledge of guidelines and need for professional upgrade were the most frequently selected criticalities from a clinical point of view, while lack of dedicated beds, spaces and staff were the ones from an organisational perspective. The ranking of the clinical aspects of DF care in need of upgrading assigned urgencies, infection and ischemia management the highest priority, while for the organisational aspects the priorities were revascularisation, local surgery and Charcot's foot.

Conclusions DF represents a relevant aspect of the activity of the public network of diabetology centres in Tuscany, and the interests of the HCPs is not paralleled by a sense of professional adequacy, especially for practical skills and organisational issues. This is particularly true for the aspects of DFS related to the acute manifestation of the disease, which are considered priorities when HCPs were asked to rank their needs in terms of upgrade and reorganisation.

Implication for clinical practice The information gathered with this survey will be instrumental in planning and realising the amelioration projects that the Diabetic Foot Valley Tuscany project aims to realise for improving the quality of management of DF patients in our region.

Keywords diabetic foot, health care professionals, implementation, networking, wound management

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KEY MESSAGES

- Diabetic foot (DF) management, despite representing a significant aspect of diabetology services in Tuscany, still needs to be organised and guidelines need to be implemented into clinical practice
- Aim of this study was to evaluate and rank the critical aspects of DF management in the Regional Health Service in Tuscany, and to ascertain their self-perceived level of interest and professional adequacy in managing the pathology

- The high level of interest among HCPs is not paralleled by a sense of professional adequacy, especially as far as practical skills and organisational issues are concerned.
- This is particularly true for the aspect of DFS related to the acute manifestations of the disease, a priority in terms of upgrade and reorganisation.

INTRODUCTION

Since the early 2000s the diabetologists of the public health Service of Tuscany (RHS), a 4million inhabitant Region in northwest Italy, realised the prominence of the Diabetic Foot

Syndrome (DFS) inside the clinical story of diabetes, and tried to set up an adequate clinical organisation to cope with the increasing number of patients, which were also getting more and more complex.¹

As a result of this activity, regional organisational guidelines were issued, in 2003 (DLR 1304 of 09/12/2003) and adjourned in 2016 (DLR 698 of 19/07/2016), to adapt it to a re-organisation of the RHS.^{2,3}

These initiatives, alongside the introduction of the professional figure of the podiatrist inside the staff of the diabetology services, contributed to significantly reduce the number of major amputations, and Tuscany, among the Italian Regions, constantly proved to be the more effective in preventing major amputations and deaths in DFS patients.⁴

These results were consistent and durable and were subjects of publications and comparisons with other reports from other settings, in which the figures spoke in favour of the "Tuscany model".⁵

Despite these positive notes, in more recent years major amputations and deaths increased again and a number of critical cases with negative outcomes were reported, leading the health care professional (HCPs) committed to taking care of these patients, to commit themselves to re-evaluate the entire organisation of DFS care in Tuscany, and eventually to find new solutions for a pathology that was growing in terms of prevalence and severity.

The result was the launch of the Diabetic Foot Valley Tuscany (DFVT) project, aimed to create a community of care among all the component of the teams caring for DFS in the RHS, who would focus on critical aspects still present in DFS care, elaborate amelioration projects, and evaluate the results, according to the general scheme of the project already published.⁶

The first part of the DFVT would then be obtaining from the people involved in the project their perception about the critical aspects of the pathology, both from an organisational and clinical point of view, and letting them express the need for interventions according to the relevance of the items indicated.

AIM

To evaluate and rank the critical aspects of DFS management in the Regional Health Service in Tuscany, both from a clinical and organisational point of view from the perspective of the HCPs involved in the project, and to ascertain their self-perceived level of interest and professional adequacy in managing the pathology.

METHODS

We surveyed all the 15 diabetology public services of the Tuscany Regional Health Service (TRHS) between July and September 2022, circulating an online questionnaire, asking the health care professionals (HCPs) — physicians, nurses, podiatrists — of each centre to self-evaluate both in terms of interest in caring for DFS patients and the self-perceived grade of interest in this clinical activity; we also asked them to indicate and rank in order of importance the most critical among the different components of DFS Management, both from a clinical and from an organisational point of view.

The items on which the participants were asked to express their priorities were discussed and decided by the board of the Diabetic Foot Valley Tuscany project in a meeting held in Pisa on July 22nd, 2022, aimed to promote a proactive initiative to improve the quality of DFS care in Tuscany.

In this perspective, the survey would represent the first step, by which the HCPs of the centres would express their point of view in terms of critical aspects both from a technical and organisational point of view, to then promote amelioration projects, as per the design of the project.⁶

The survey was realised by asking the participants to respond to an online questionnaire (Appendix 1), which contained a first part dedicated to characterising the responders in terms of profession, experience and setting; a second part which explored the self-reported level of interest and competence in DFS and which were the critical aspects of DF care; and a third part which asked participants to rank the criticalities in order of priority.

The third part was followed by a question that explored the will to actively participate in a project for the implementation of DF care at regional level and, in case of a positive answer, to rank in order of priority which were the topics to address in an amelioration process.

The ranking was made with two lists of twelve items each, designed to cover all the main elements related to the management of DF: the first list related to the clinical aspects of DFS care, while the second list referred to the organisational ones.

Responders were asked to assign a level of priority to each item in both lists, scoring them from 1 (= most relevant) to 12 (=least relevant); the ranking was then obtained by summing the scores of each item and ordinating them accordingly. So, in each list, the items with the lower figures are those which were considered a priority by the responders, while the ones with the highest figures are considered lower priority.

All the questionnaires were anonymised, and data were collected by a third part (Hippocrates Research), not belonging to Tuscany Health Service and not participating in the care for DFS patients.

All the responders agreed to share their answers in an aggregated form, and data were analysed in this way by using a commercial statistical software (SPSS). Figures were reported as mean and standard deviation for continuous variables, and as interquartile range for categorical variables. Kruskal-Wallis and Mann-Whitney tests were used to compare continue variables, Chi-square and Fisher's exact test for categorical ones. Uni-and multivariate logistic regressions were used to ascertain relations between variables. A p-value less than 0.05 was considered as significant.

RESULTS

From the 97 HCPs working in the diabetology centres of Tuscany Health service we collected 61 responses in total. Of these 29 (47.5%) were from physicians, 16 (26.2%) from nurses and 16 (26.2%) from podiatrists. Most of them (64%) worked inside a hospital; among the remaining 36%, 8.2% were working in nursing homes, 16.4% were visiting nurses or podiatrists and 11.5% were district nurses. Their

work experience was 15.2±10.5 years (14.5±11.5 physicians, 8.9±6.1 podiatrists and 22.7±7.3 nurses, respectively) and in 70.5% of cases they were involved in both diagnostic and therapeutic aspects of DFS care. In 27.9% of cases they were only delivering local care and in a small percentage of cases (1.6%) they had only diagnostic responsibilities.

Of the respondents, 8.2% reported they were involved for less than 20% of their working time on DFS, 16.4% between 20 and 40% of the time, 34.4% between 40 and 60%; 14.8% between 60 and 80%, while 26.2% said they were working full time on DFS care. Figure 1 shows the distribution of responders according to their relative commitment to DF Care.

Asked to score their interest in DFS care on a scale from 0=no interest at all to 10=maximum interest, the overall score was 9.48±0.99, with a significantly ($p=0.003$) higher scores from physicians, compared to nurses. As regards professional

adequacy/competence, the overall score was 7.34±1.37, with no significant differences between the groups. Self-reported interest was significantly higher ($p<0.001$) than self-reported professional adequacy/competence, both in general and for any professional category. Figure 2 shows the results of self-reporting both for interest and professional adequacy/competence.

Asked to indicate the criticalities of the management of DF from an organisational point of view via a list of items related to these aspects, the most frequent choice (39.3% of responders) indicated the lack of beds dedicated to this pathology in the public hospitals, immediately followed by lack of dedicated spaces and shortage of staff (both scored at 37.7%), poor collaboration from the other specialists being part of the team (32.8%) and poor support from the management of the hospitals (29.5%). Physicians significantly

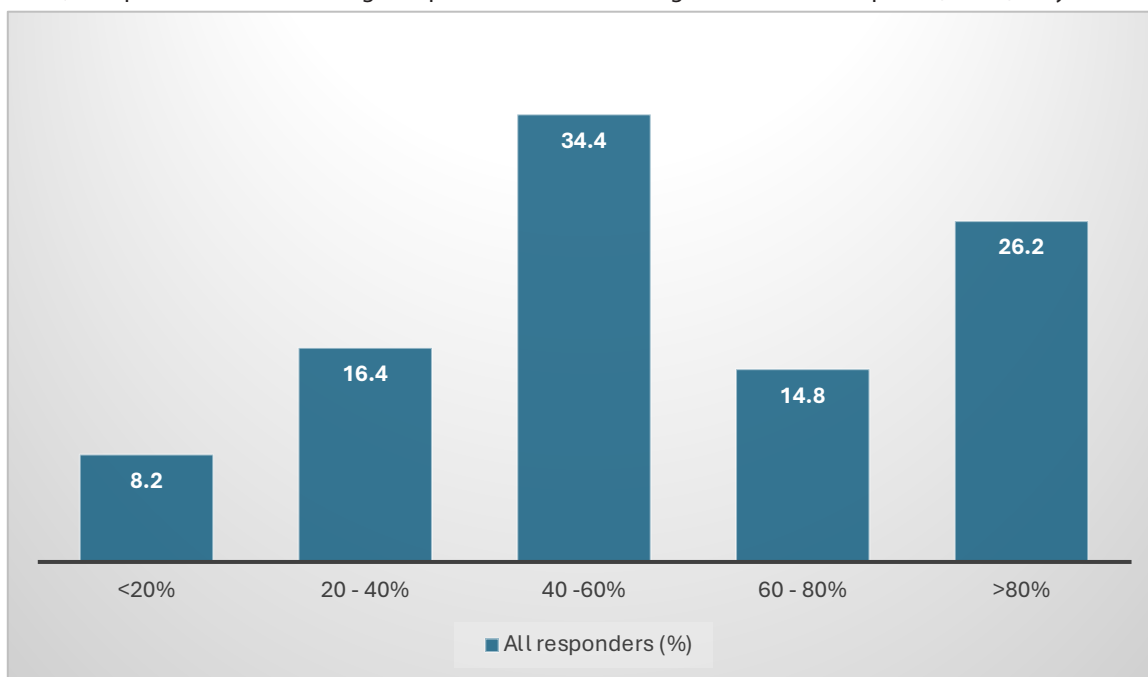


Figure 1. Average percentage of time dedicated to DFS care during the working hours



Figure 2. Self-reported scoring of interest and professional adequacy/competence towards DF care among participants. * $p<0.001$ vs self-reported interest; $p=0.003$ vs nurses

more often reported the lack of beds as an issue (62.1%, $p=0.002$) as compared to podiatrists (25.0%) and nurses (12.5%). Although no significant differences emerged for other items, the most popular critical issue for podiatrists was the lack of staff (43.8%) while for nurses it was the lack of dedicated spaces (56.3%). In Table 1 the complete results of this section of the questionnaire are reported.

In the part of the questionnaire inquiring about clinical/technical aspects, the need to improve the technical skills to adequately manage the DF was the most voted (59% of the total responders) with no differences between the professional categories, followed by the poor knowledge of international guidelines (34.4%) and the need for professional upgrade (26.2%), both shared by all three categories of professionals. In Table 2 a complete display of the answers is reported.

Of the responders 60 out of 61 (98%) said they would accept to be part of a future amelioration project on DF Care in Tuscany; the one that declined was planning retirement within a few months.

The ranking of the clinical aspects of DF care assigned to urgencies, infection and ischemia management the highest priority, while for the organisational aspects the priorities were revascularisation, local surgery and Charcot's foot. In Figure 3 and 4 the complete ranking, for clinical and organisational aspects are reported.

DISCUSSION

In a context like the one that characterises a progressive, remitting-relapsing chronic disease like DF, whose management depends on the integration of different competencies in a multidisciplinary team strategy, the level of

interest and commitment of the members of the team, as well as the feeling of adequacy and self-assurance in participating to the global *prise en charge* of the patients are extremely important to assure the best practice.

Our survey, which involved all the public diabetology centres of Tuscany, confirmed that DFS represents a significant aspect of the workload of the HCPs of the diabetology network of the RHS and revealed how their interest in and commitment to DFS was high, while the feelings of adequacy and competence were significantly lower, irrespective of the role that each HCP had inside the organisation of care.

This finding witnesses a rather common situation among those who are committed to manage DFS and reflects the gap between the real complexity of the clinical cases and the insufficient theoretical and practical formation of the staff.

Kumarasinghe et al,⁷ in a similar survey among 200 nurses in Sri Lanka found gaps in core knowledge and negative attitude toward DF care, related with an inadequate specific training in the professional curriculum and lack of update in knowledge on the job.

Bilal et al,⁸ in a similar survey among 250 nurses in India, confirmed this finding of poor knowledge and lack of evidence-based clinical practice in DF care, while Anning et al highlighted poor adherence to guidelines and low confidence with technical skills in DF care among 122 podiatrists in Australia.⁹

The need for upgrading technical skills emerged in our survey as the most critical issue independently by the professional qualification, but more intensively by physicians, who in more than two thirds of the cases, felt this was a priority for possible upgrading initiatives targeted on DF-related practical skills.

Table 1 – Frequencies of answers (more than a single item selectable) to the section of questionnaire on the critical items from an organisational point of view. In bold the higher figures for each professional category and in general, and the significant differences between the categories.

	General (%)	Physicians (%)	Podologists (%)	Nurses (%)	P
Spaces	37.7	31.3	31.3	56.3	0.204
Staff	37.7	41.4	43.8	25.0	0.469
Instrumentation	23.0	20.7	31.3	18.8	0.648
Dedicated software	8.2	10.3	6.3	6.3	0.844
Teamwork	32.8	24.1	37.5	43.8	0.365
Referral	23.0	20.7	25.0	25.0	0.923
Beds	39.3	62.1	25.0	12.5	0.002*
Organisation	18.0	10.3	12.5	37.5	0.061
Institutional support	29.5	34.5	12.5	37.5	0.216
Other	1.6	3.5	0	0	0.571

*Chi square test: physicians vs podologists and nurses

Table 2 – Frequencies of answers (more than a single item selectable) to the section of questionnaire on the critical items from clinical point of view. In bold the higher figures for each professional category and in general.

	General (%)	Physicians (%)	Podologists (%)	Nurses (%)	P*
Theoretical knowledge	14.8	13.8	25.0	6.3	0.320
Practical skills	59.0	68.9	50.0	50.0	0.323
Guidelines	34.4	24.1	37.5	50.0	0.207
Professional upgrade	26.2	34.5	25.0	12.5	0.274
Other	9.8	6.9	6.3	18.8	0.378

*Chi-square test

As other studies already underlined, the reason for this sensitivity is most likely due to the lack of specific teaching and tutoring on DFS during the professional qualification of HCPs.^{9,10}

As a matter of fact no time is dedicated to this complex matter, neither during the university curricular studies, in which only few hours are dedicated to diabetes mellitus and its complications, nor in post-doctoral specialised training, in which the organisation of the courses is delegated to

individual speciality schools. In Italy, only two schools of speciality in endocrinology and metabolism have in their programs hours specifically dedicated to DFS, while also among the schools for podiatrists the specific teaching of DF is largely jeopardised.¹¹

These gaps lead to a situation that sees, on one side, a complex pathology like DFS rising in both frequency and complexity, and, on the other side, the lack of specifically trained HCPs that can adequately take care of the patients and

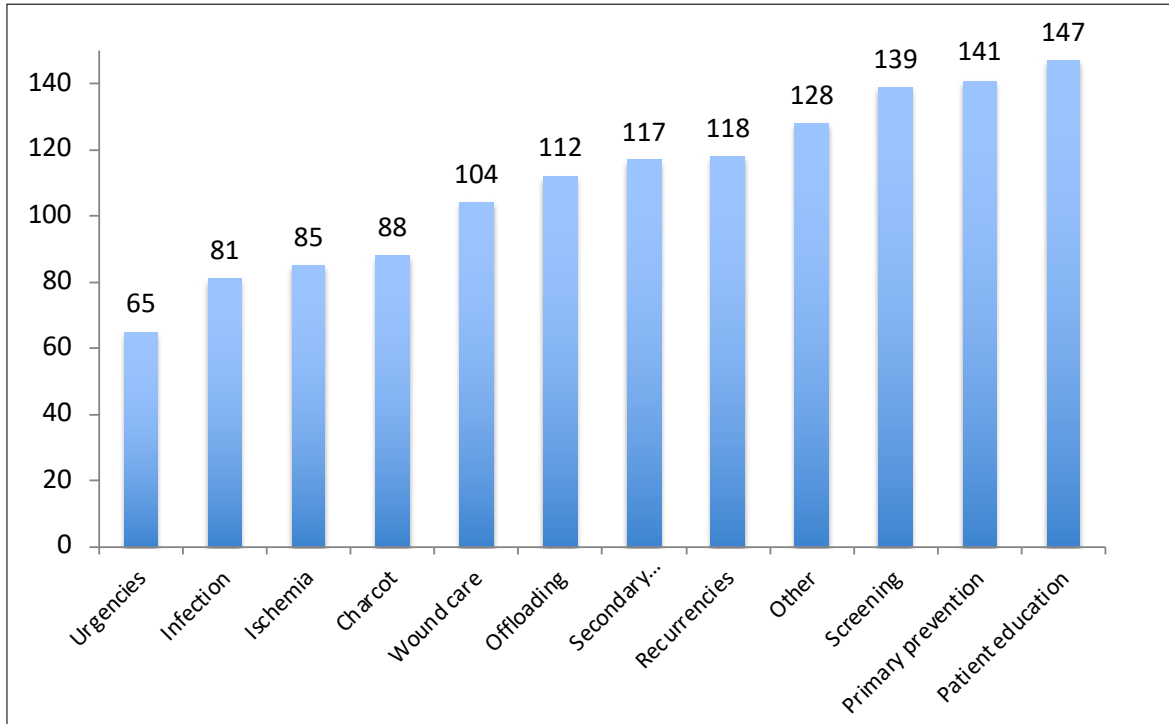


Figure 3. Technical items ranked by participants according to their level of priority. The items with the lower figures are the more relevant while the ones with higher figures are perceived as less relevant

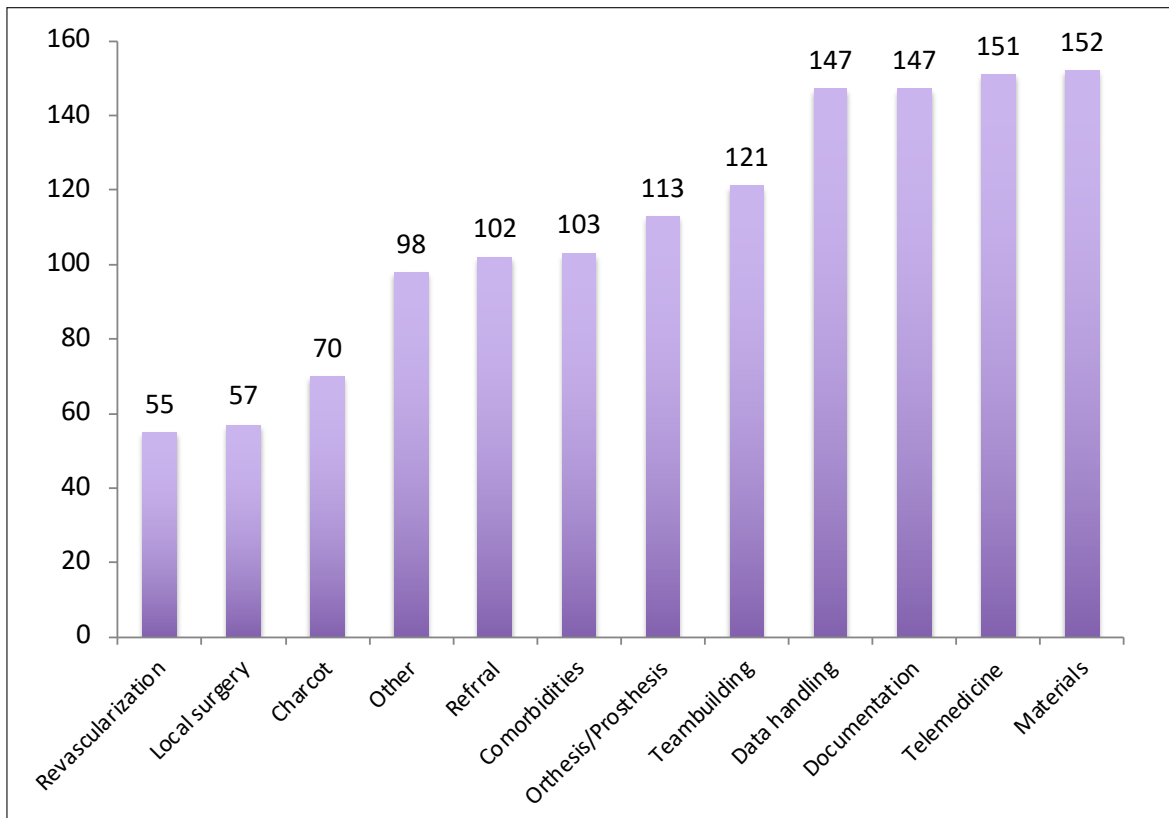


Figure 4. Organisational items ranked by participants according to their level of priority. The items with the lower figures are the more relevant while the ones with higher figures are perceived as less relevant

give timely and effective answers to their needs; the result is that most of the specialists ideally committed to take care of the patients with DFS either ignore or underestimate the problem, with harmful consequences.¹²

The indication of the lack of beds, staff and spaces dedicated to DF care emerged as a critical point from the answers of all responders, and this reflects the condition of a real difference between the need for specialist care from an increasing number of patients and the shortage of dedicated resources in the Regional Health Service organisation.

Despite two regional laws already indicated the necessity of finalising beds, spaces and staff to the care of DFS patients, their actual implementation has so far been neglected and, at present, only eight beds out of the 14,672 in the whole public health system of Tuscany are committed to DFS care, for an estimated population of 20,000 patients.¹³

This situation has been strongly perceived by the responders as one of the major constraints of adequate management of DF patients and has been associated with the frustration of not being able to deliver what is needed to address the complex needs of patients.

As Clarke et al pointed out in a study on 112 podiatrists in New Zealand, the organisational deficiencies in public healthcare systems are associated with a high risk of burnout among the HCPs involved, thus starting a vicious cycle that can only worsen the situation.¹⁴

The possibility of positive change in this situation involving HCPs has been already demonstrated by other studies, that focused on professionals involved in DF care with specific interventions.¹⁵

This evidently was our case as well, given 98% of responders were willing to be proactive in changing the situation for the better, and they indicated their priorities among the critical issues both from a clinical and organisational point of view.

As expected, the focus was set on ischemia/revascularisation, infection/local surgery, Charcot foot/urgencies, aspects that are typically related to the so called 'diabetic foot attack', an acute, or even emergent condition which deserves an organised, promptly-delivered, highly specialised team approach.¹⁶

This does not necessarily mean that other items, more related to less acute aspects of DF, like local care, off-loading or prevention, do not involve critical aspects, as evidenced by the answers given to the second part of the questionnaire, in which these items were also indicated as critical issues. It only means that the need for improving and setting up the acute phases of DF care is more stringent and perceived as a higher priority by HCPs.

We are aware of the limitations of this survey, which was carried out with a questionnaire that had not been previously validated and involved a relatively small and heterogeneous population of HCPs all working in the Tuscany Regional Health Service, without an alternative source that might cross-validate the results. For these reasons we think that our results are not generalisable.

Despite these limitations, our findings provide new and interesting information on the perception and attitudes of

HCPs toward DFS and its management and lay the basis for further initiatives to change the situation for the better.

Following this preliminary analysis, three meetings with the participation of all the members of the Diabetic Foot Valley Tuscany Project were planned, to elaborate amelioration projects which may address the criticalities that emerged from the survey.

The three meetings would focus on the acute, subacute and chronic clinical manifestation of DF, respectively, involving the participants in a discussion which would suggest solutions for the problems detected by the survey and design dedicated amelioration projects to be realised within two years from the meetings.

An indirect but substantial outcome of this activity, irrespective of the clinical results, will hopefully be the creation of a *community of practice* for DF care within the diabetology centres' network in Tuscany, which will ensure an adequate and homogeneous standard of care for these complex patients in the years to come.

CONCLUSIONS

DF syndrome represents a relevant aspect of the activity of the public network of diabetology centres in Tuscany, and HCPs are highly interested in aspects related to its management.

This high level of interest is not paralleled by a sense of professional adequacy, especially as far as practical skills and organisational issues are concerned.

This is particularly true for the aspect of DFS related to the acute manifestations of the disease, which were considered a priority when HCPs were asked to rank their needs in terms of upgrade and reorganisation.

The information gathered with this survey will be instrumental in planning and realising the amelioration projects that the Diabetic Foot Valley Tuscany project aims to realise for improving the quality of management of these patients in our Region.

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CONTRIBUTION OF THE AUTHORS

AP designed the study, analysed the data, wrote and revised the manuscript; SB collected and analysed the data and revised the manuscript; FG and EA collected and analysed the data and revised the manuscript; GDC discussed the results and revised the manuscript

DISCLOSURE

SB is partner of Hippocrates Research and receives a fee from EWMA and the Pisa International Diabetic Foot Courses for his activities in the project.

CONFLICT OF INTEREST

The authors declare no conflicts of interest in relation to their role in the writing and editing of the present article.

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APPENDICES

Appendix 1

DIABETIC FOOT VALLEY TUSCANY - ONLINE SURVEY

PROFESSION	
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YEARS OF WORK	
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PLACE OF WORK	
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HOW MUCH TIME PER WEEK DO YOU SPEND ON DIABETIC FOOT MANAGEMENT, IN YOUR JOB?					
0 %	1–20%	21–40%	41–60%	61–80%	81–100%
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

WHAT IS YOUR MAIN ROLE?	<input type="checkbox"/> DIAGNOSTIC
	<input type="checkbox"/> THERAPEUTIC
	<input type="checkbox"/> BOTH

WHAT IS YOUR LEVEL OF INTEREST IN DIABETIC FOOT MANAGEMENT?										
0 (none)	1	2	3	4	5	6	7	8	9	10 (maximum)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HOW WOULD YOU SUBJECTIVELY RATE YOUR LEVEL OF COMPETENCE IN THE MANAGEMENT OF THE DIABETIC FOOT?

0 (none)	1	2	3	4	5	6	7	8	9	10 (maximum)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

WHAT DO YOU CONSIDER TO BE THE CRITICAL ORGANISATIONAL ASPECTS OF DIABETIC FOOT MANAGEMENT?	<input type="checkbox"/> LACK OF SPACE
	<input type="checkbox"/> LACK OF STAFF
	<input type="checkbox"/> LACK OF INSTRUMENTAL EQUIPMENT
	<input type="checkbox"/> LACK OF AN ELECTRONIC MANAGEMENT TOOL
	<input type="checkbox"/> LACK OF COLLABORATION WITH OTHER SPECIALISTS
	<input type="checkbox"/> LACK OF DEFINED PATHWAYS FOR THE REFERRAL OF CASES
	<input type="checkbox"/> LACK OF DEDICATED BEDS
	<input type="checkbox"/> LACK OF KNOWLEDGE OF ORGANISATIONAL GUIDELINES
	<input type="checkbox"/> LACK OF SENSITIVITY/AVAILABILITY OF MANAGEMENT
	<input type="checkbox"/> OTHER (specify)

WHAT DO YOU CONSIDER TO BE THE CRITICAL TECHNICAL ASPECTS OF DIABETIC FOOT MANAGEMENT?	<input type="checkbox"/> LACK OF THEORETICAL KNOWLEDGE
	<input type="checkbox"/> LACK OF TECHNICAL/PRACTICAL SKILLS
	<input type="checkbox"/> LACK OF KNOWLEDGE OF GUIDELINES
	<input type="checkbox"/> LACK OF PROFESSIONAL DEVELOPMENT
	<input type="checkbox"/> OTHER (SPECIFY)

WOULD YOU AGREE TO ACTIVELY PARTICIPATE TO A PROJECT FOR IMPLEMENTING THE DIABETIC FOOT CARE IN THE REGIONAL HEALTH SERVICE?
YES* <input type="checkbox"/> NO <input type="checkbox"/>

*NB – In case the answer was “yes”, the following questions appeared

PLEASE SCORE FOR 1 (=MOST RELEVANT) TO 12 (=LEAST RELEVANT) THE FOLLOWING CLINICAL TOPICS TO BE ADDRESSED IN FUTURE AMELIORATION PROJECT ON DF CARE

TOPIC	SCORE (1 - 12)
Charcot's foot	
Infection	
Ischemia	
Offloading	
Patients education	
Primary prevention	
Recurrences	
Screening	
Secondary prevention	
Urgencies	
Wound care	
Other (please name it)	

PLEASE SCORE FOR 1 (=MOST RELEVANT) TO 12 (=LEAST RELEVANT) THE FOLLOWING ORGANISATIONAL TOPICS TO BE ADDRESSED IN FUTURE AMELIORATION PROJECT ON DF CARE

TOPIC	SCORE (1 – 12)
Charcot's foot	
Comorbidities	
Data handling	
Documentation	
Local surgery	
Materials	
Orthosis/prosthesis	
Referral	
Revascularisation	
Teambuilding	
Telemedicine	
Other (please name it)	

Appendix 2

THE DIABETIC FOOT VALLEY WORKING GROUP

Abbruzzese Lorenza DPM (Pisa), Achilli Valeria DPM (Piombino), Amato Elisa DPM (Pisa), Ambrosini Nobili Laura DPM (Pisa), Amendola Carmelina RN (Prato), Amendolia Michela DPM (Livorno), Anichini Roberto MD (Pistoia), Apicella Matteo DPM (Arezzo), Baccetti Fabio MD (Carrara), Baggiore Cristiana MD (Firenze), Banchellini Elisa DPM (Lido di Camaiore), Barbaro Valeria MD (Firenze), Barnini Genny DPM (Empoli), Baronti Walter DM (Grosseto), Bastarelli Eleonora RN (Firenze), Becherini Roberto MD (Pistoia), Bernini Arianna DPM (Empoli), Bertoli Stefania MD (Camaiore), Bini Carlotta RN (Firenze), Butini Sofia RN (Arezzo), Cacioli Elisabetta RN (Grosseto), Calabrese Maria MD (Prato), Cameron Smith Michela MD (Firenze), Casadidio Ilaria DPM (Lucca), Chelli Cristina RN (Grosseto), Colombi Claudia MD (Firenze), Costa Alessandro DPM (Lido di Camaiore), Cossu Cristina RN (Grosseto), Crisci Isabella MD (Viareggio), Cuccuru Ilaria DPM (Lucca), De Gennaro Giovanni MD (Grosseto), De Gregorio Simona DPM (Pontedera), De Luca Antonio MD Empoli, Del Bianco Elisa RN (Lucca), Della Valentina Simone DPM (Pisa), Desideri Arianna DPM (Lucca), Di Carlo Alberto MD (Lucca), Faenzi Manuela RN (Firenze), Fanelli Stefania PsyD (Arezzo), Fondelli Cecilia MD (Siena), Giangreco Francesco MD (Pisa), Golini Romina RN (Arezzo), Goretti Chiara MD (Pisa), Gori Roberta RN Firenze, Iacopi Elisabetta MD (Pisa), Ieri Matteo DPM (Firenze), Lacaria Emilia DPM (Livorno), Landini Cristina RN (Bordo San Lorenzo), Lazzeri Andrea DPM (Firenze), Lencioni Cristina MD (Lucca), Loporati Elisa MD (Pisa), Leva Teresa RN (Lucca), Lorenzetti Monica MD (Prato), Luppichini Linda DPM (Firenze), Magi Silvia DPM (Arezzo), Maionchi Dino MD (Lucca), Manetti Francesco MD (Bagno a Ripoli), Mantuano Michele MD (Arezzo), Marinelli Elisa RN (Arezzo), Marsocci Angela (MD) Prato, Martinez Carmela RN (Arezzo), Mattesimi Mary RN (Arezzo), Monami Matteo MD (Firenze), Musco Marco DPM (Firenze), Neri Barbara DPM (Prato), Nigro Rosa RN (Arezzo), Nreu Besmir DPM (Firenze), Occhipinti Margherita MD (Empoli), Orsini Paola MD (Livorno), Palladino Lavinia (Pisa), Parra Cecilia DPM (Lucca), Piacentini Marzia RN (Lucca), Piaggese Alberto MD (Pisa), Piccini Valentina MD (Empoli), Pieruzzi Letizia MD (Pisa), Polloni Catia RN (Grosseto), Postiglione Gabriella RN (Prato), Raghianti Benedetta MD (Firenze), Ranchelli Anna (Arezzo), Riitano Nicola DPM (Pisa), Rizzo Loredana MD (Grosseto), Rabuchia Anxhela DPM (Prato), Russo Chiara RN (Lucca), Sabatini Giovanna DPM (Firenze), Elisabetta Salutini MD (Pistoia), Sambuco Laura MD (Grosseto), Sandroni Sara RN (Arezzo), Sarzanini Maheva DPM (Carrara), Scatena Alessia MD (Arezzo), Serantoni Simone MD (Prato), Silverii Giovanni Antonio MD (Borgo San Lorenzo), Simi Barbara RN (Grosseto), Telleschi Massimiliano RN (Empoli), Trapani Edoardo DPM (Grosseto), Valdambri Cristiana RN (Grosseto), Vannacci Serena RN (Grosseto), Viti Secondina MD (Pescia).