British Orthopaedic Foot and Ankle Society

Registry Report 2026

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BOFAS

Contents

Introduction 3
Section 1: Clinical Practice Committee 4
Section 2: Overview of PROM Scores 7
Section 3: 1st Metatarsophalangeal Joint Arthritis 10
Section 4: Hallux Valgus 15
Section 5: Ankle Arthritis 17
Section 6: Achilles Tendon Rupture 22
Section 7: Morton's Neuroma 24
Section 8: Double and Triple Arthrodesis 26
Section 9: Ankle Ligament Reconstruction 28
Section 10: Achilles Tendinopathy 30
Section 11: Contralateral Leg 33
Summary 34
References 36
Appendix A: Foot and Ankle General Pathway 38

Introduction

We are pleased to present the 2026 annual BOFAS report. The registry has been operational since 2014 and remains a valuable source of information covering foot and ankle surgery with PROMs.

The Registry currently has 10 pathways:

- Foot and Ankle Registry pathway
- 1st MTPJ Arthrodesis pathway
- 1st MTPJ Arthroplasty pathway
- Ankle Arthrodesis pathway
- Ankle Primary Arthroplasty pathway
- Ankle Revision Arthroplasty pathway
- Ankle Fracture Trauma pathway
- Distal Tibial and Foot Trauma pathway
- Achilles Rupture Trauma pathway
- Achilles Tendinopathy pathway

Now, more than at any previous time, the data within the registry have become central in demonstrating the improvements following surgery with generic and disease-specific outcome scores. In a system with limited resources, the benefit of foot and ankle procedures has been questioned by commissioners and, in some cases, funding stopped. A recent example was the restricted funding for hallux rigidus surgery by NHS Hampshire and Isle of Wight ICB. This was successfully challenged, and the status changed to criteria-based funding, following the use of robust BOFAS registry data confirming effectiveness both clinically and economically (NHS Hampshire and Isle of Wight ICB, 2026).

As of October 2026, the registry holds **28,980** pathways relating to 24,994 patients. The number of pathways has now surpassed pre-COVID levels and continues to increase year on year. The number of surgeons contributing to the registry is increasing, but we recognise that logistical challenges with data collection and submission continue to be a problem for many surgeons. The registry committee will continue to work hard to overcome these challenges and increase the data capture of all foot and ankle surgery. This year we have been able to secure the services of a statistician, who has been able to provide a more detailed and robust analysis, showing that outcomes remain consistently good across most pathways.

The national clinical directors have emphasised the importance of collecting data, such as the Outcomes and Registries Programme (ORP) datasets. These datasets are mandated by legal direction, as part of the response to the Cumberlege Review recommendations. Collecting data is central in enabling members to assure and, where necessary, improve the quality of the care they provide.

Getting it Right First Time (GIRFT), in collaboration with the BOA and its Specialist Societies, recently updated five High Volume Low Complexity (HVLC) pathways. The Hallux Valgus and Hallux Rigidus pathway strongly recommends PROM collection, with the BOFAS Registry considered the gold standard (GIRFT, 2026). In addition, NICE recommends that clinicians performing MIS hallux valgus surgery (HTG723), 1st MTPJ replacement surgery (HTG87), and extracorporeal shockwave therapy for Achilles tendinopathy (HTG426) or plantar fasciitis (HTG200), have audit and clinical governance arrangements in place: the BOFAS Registry satisfies these requirements. We encourage all foot and ankle surgeons to register and start collecting data.

The information contained within this report will be useful for BOFAS members in their appraisals and, as we continue to collect data, it will aid quality improvement and may help direct practice nationally. The Registry incorporates a downloadable personal Revalidation Report, which in conjunction with the annual report, can be used to assess your own practice against the national average.

As the dataset increases in size and the data matures, analysis is likely to reveal areas for further investigation. We will work closely with the BOFAS Scientific Committee on the direction of future research. We also wish to support independent scientific research and are developing an application process through which BOFAS members may request access to registry data for research.

Aims

The broad aims of the BOFAS Registry are in line with those of the BOA Quality Outcomes project:

- Help surgeons to track the outcomes of their patients.
- Allow Surgeons/Trusts to compare themselves to others or the average and to identify areas for improvement.
- Provide surgeons with information for revalidation.
- Provide evidence on trends in outcomes, performance of different implants/procedures/etc.
- Enable individuals and Trusts who may be potential outliers to be alerted to this in order to take action.

Section 1: Clinical Practice Committee

Background

The BOFAS Registry is the responsibility of the BOFAS Clinical Practice Committee. The role of the committee is to support the Society and Council in developing suitable processes to collect patient outcome measures.

Duties of the Outcomes Committee include:

- Working with the platform provider to enable collection of information into central BOFAS registry.
- Ensuring that the consent form remains compliant with legal requirements.
- Oversight of information governance.
- Publication of data.
- Registry funding.
- Long term strategy.

Further details regarding the BOFAS Registry can be found on the BOFAS website.

Membership of the Clinical Practice Committee

Role	Name	Role	Name
Chair	Joel Humphrey	Caldicott Guardian	Jitendra Mangwani
Secretary	Ben Hickey	Data Protection Officer	Jo Millard
Member	Tim Clough	Co-opted	Andy Goldberg
Member	Shariff Hazarika	Co-opted	Nilesh Makwana
Member	Robbie Ray	Co-opted	Lyndon Mason
Member	Peter Rosenfeld	Co-opted	Edward Wood

Uptake

Uptake of the Registry by the BOFAS membership is increasing with time, with 248 registered pathway owners; however, only a minority of members are actively entering data. A live, continuously updated list of surgeons who actively contribute to the registry can be found on the BOFAS website: https://www.bofas.org.uk/clinician/bofas-registry/contributors

Over the last few years the registry has seen a substantial increase in the total number of pathways and patients (Figure 1.1). By the end of 2025 the registry held 25,847 pathways relating to 22,431 patients, rising to 28,980 pathways and 24,994 patients by October 2026. The number of pathways is always higher than the number of patients, as some patients are entered on more than one pathway. During 2025, 2,158 dormant or inactive pathways were removed from the general Foot and Ankle pathway; the figures here are taken directly from the registry after that purge. This is still, however, only a small proportion of the overall national figures.

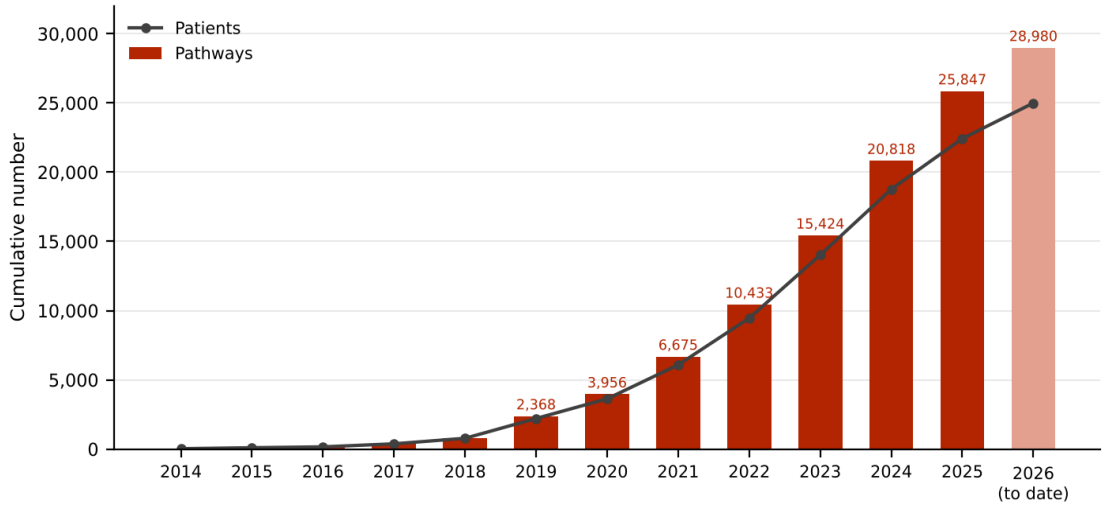


Figure 1.1 - Pathways and patients on the BOFAS registry by calendar year, 2014–2026 (2026 to date). Source: BOFAS registry (Amplitude) export, October 2026.

Compliance and Registration

Compliance for consent is high across the three pathways (≥95%). Where consent has been gained, surgeons can look back at individual outcomes. Where consent is absent, the record is anonymised. In this scenario, the PROMs enter the registry summary data, but it is not possible to identify the individual or add follow-up data.

Follow-up PROMs were originally collected using an email prompt alone. However, between 15% and 34% of cases have no email address associated with their entry. This removes the ability of the registry to automate data collection. Making use of telephone review streams can be a good solution in this scenario, if the resource is available. The introduction of an additional SMS prompt has also increased follow-up compliance (Figure 1.2).

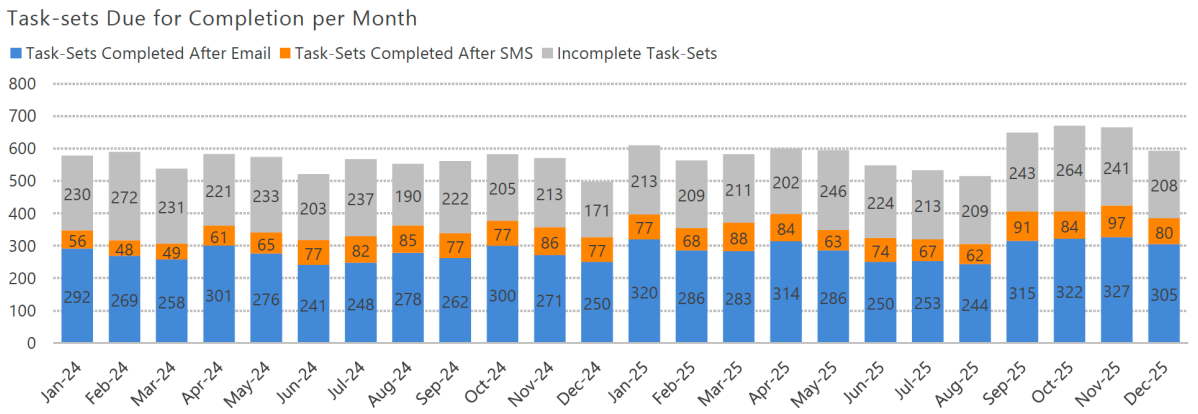


Figure 1.2 - Task-sets due for completion per month, 2024–2025, by completion route (email, SMS) and incomplete

Two methods of patient registration exist: Patient Self Registration and Clinician Registration.

Patient Self Registration

A significant development this year has been the introduction of patient self-registration. Patients can now register themselves using a QR code, entering their details directly. This has the advantage of removing the requirement for a separate consent process before data entry. All patients registering in this manner are entered on to the general Foot and Ankle Registry pathway; however, this may be changed to a specific pathway by the consultant after registration, using the 'change pathway' option, without the need for further consent.

Self-registration has had a clear effect on uptake (Figure 1.3). Before the patient portal was introduced, an average of 116 new patients a month were registered by clinicians (January to November 2025). In the 11 months since the portal opened in December 2025, an average of 172 patients a month have been registered, an increase of about 50%. Almost half of these (889 of 1,893, 47%) registered themselves through the patient portal. Clinician registrations have continued alongside self-registration, at a slightly lower rate (91 a month), so some patients who would previously have been registered by their clinician now register themselves, but the overall number entering the registry has risen substantially.

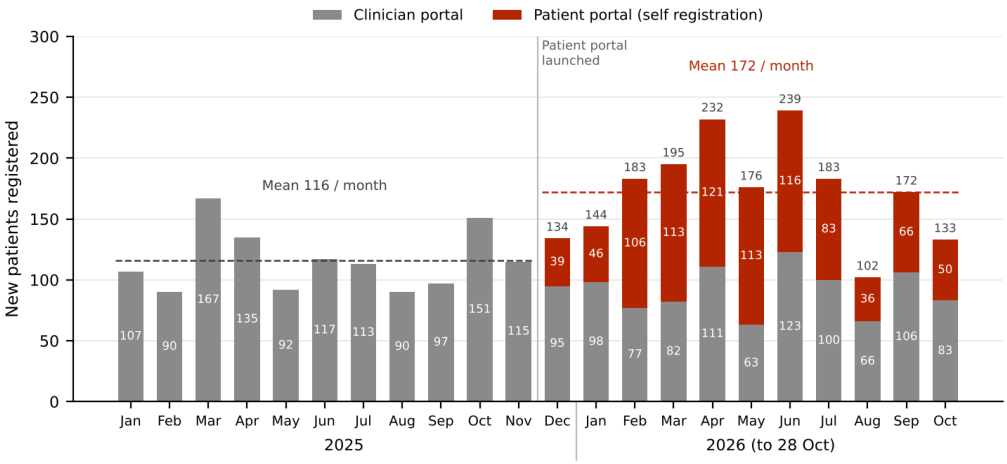


Figure 1.3 - New patients registered each month by registration method, January 2025 to October 2026 (October 2026 to 28 October). Dashed lines show the monthly mean before (January–November 2025) and after (December 2025–October 2026) the patient portal was introduced. Source: BOFAS registry (Amplitude).

Clinician Registration

With this option it is still necessary to take paper consent and file this in the notes, even though patients confirm consent online when they first log in, since their details have been entered to enable them to be contacted, and that is only legal if consent has already been taken. This method of registration allows patients to be entered directly on to the disease/procedure-specific pathways.

Details for both registration methods can be found here: https://www.bofas.org.uk/clinician/bofas-registry/documents-for-download

Contributing Sites

131 surgeons at 75 sites across England, Scotland, Wales and Northern Ireland are currently active contributors to the registry (Figure 1.4). A live, continuously updated list of contributing surgeons can be found on the BOFAS website: https://www.bofas.org.uk/clinician/bofas-registry/contributors

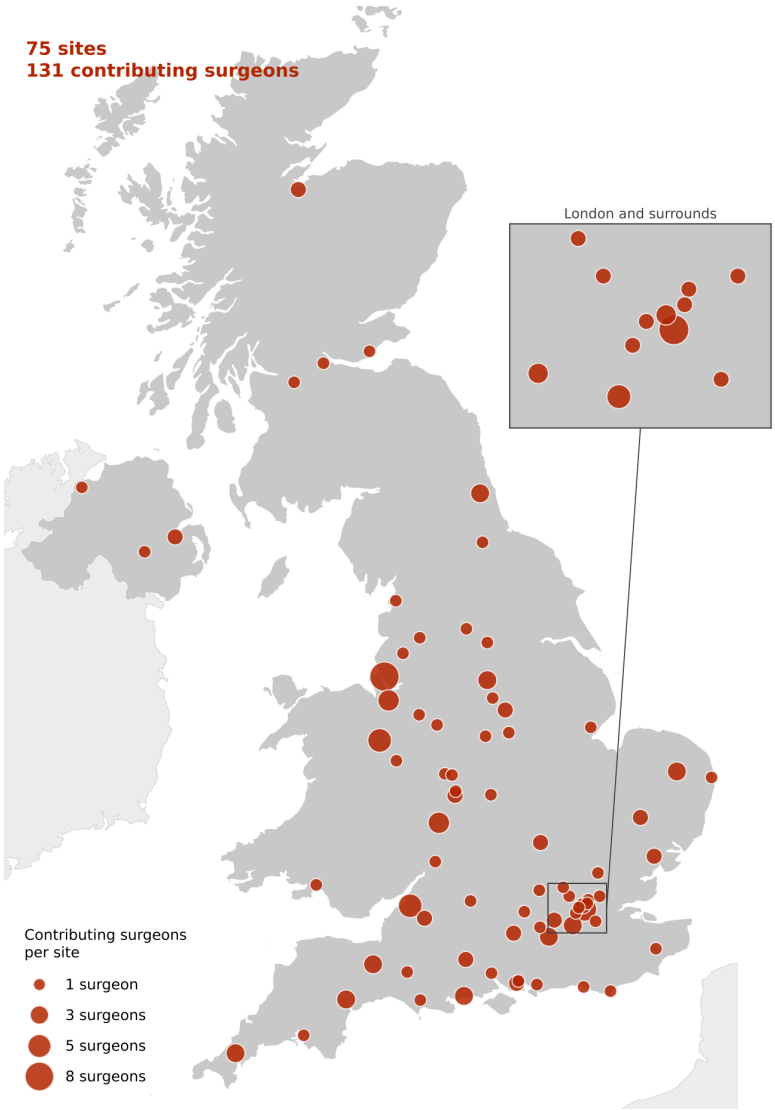


Figure 1.4 - Sites with surgeons actively contributing to the BOFAS Registry, from the BOFAS website contributors list (October 2026). Marker size shows the number of contributing surgeons at each site.

Section 2: Overview of PROM Scores

The BOFAS Registry allows foot and ankle surgeons to use the outcome scores to assess patients both pre- and post-operatively. The standard outcome scores for each pathway are detailed in Table 2.1. Other scores are available, depending on surgeon choice, and may be configured in the surgeon's registry settings. For example, one may choose to record MOxFQ & EQ-5D for all patient groups. Scores are recorded pre-operatively then routinely via email, SMS text, or in person, at regular intervals post-operatively, depending on the pathway.

EQ-5D-5L and EQ-5D Health VAS

EQ-5D is a standardised measure of health status developed by the EuroQol Group to provide a simple, generic measure of health for clinical and economic appraisal.

Manchester-Oxford Foot Questionnaire

The MOxFQ is a 16-item, self-administered PROM instrument. It assesses how foot and ankle problems impair health-related quality of life and is completed pre- and post-operatively. It was originally intended for use for hallux valgus surgery and has more recently been proven for use with a variety of foot and ankle problems.

The questionnaire consists of three domains/scales:

- Walking/standing – 7 items (MOxFQ-W)
- Pain – 5 items (MOxFQ-P)
- Social interaction – 4 items (MOxFQ-S)

The responses consist of a 5-point Likert scale (0-4), which ranges from no limitation (0) to maximum limitation (4). Scores for each domain are calculated by summating the responses in each domain. The raw scale scores are then converted to a metric from 0-100, where 100 denotes the most severe. The raw scores can also be used to generate a summary Index score (MOxFQ-Index) (Morley et al, 2013). The questionnaire has been validated.

The Achilles Tendon Total Rupture Score

The ATRS is a validated, patient reported score for measuring outcome after total Achilles tendon rupture. There are 10 parameters, each of which is scored on a scale from 0 – 10, where 0 represents major limitations/symptoms and 10 represents no limitations or symptoms.

Outcomes are recorded in the following domains:

- Are you limited because of decreased strength in the calf/Achilles tendon/foot?
- Are you limited because of fatigue in the calf/Achilles tendon/foot?
- Are you limited due to stiffness in the calf/Achilles tendon/foot?
- Are you limited because of pain in the calf/Achilles tendon/foot?
- Are you limited during activities of daily living?
- Are you limited when walking on uneven surfaces?
- Are you limited when walking quickly upstairs or uphill?
- Are you limited during activities that include running?
- Are you limited during activities that include jumping?
- Are you limited in performing hard physical labour?

The original article demonstrates good construct and convergent validity with both the FAOS and VISA-A scores. Intraclass correlation coefficient was 0.98 and the internal consistency was shown to be 0.96 (Cronbach's alpha) showing good test-retest reliability (Nilsson-Helander K et al, 2007). A modified, 'cross cultural' version of the score was validated in the English population by Carmont et al, where it was shown to have excellent reliability (Carmont M et al 2012). The minimal detectable change was 6.75 points. The BOFAS Registry uses the original Swedish/English language version. There were no significant differences in results comparing the 'cross cultural' & Swedish versions (Carmont M et al 2012). The Minimally Important Change (MIC) was determined for the Dutch version of the score (Dams OC et al 2020). Using an anchor-based approach they showed MICs of 13.5 (cf EQ-5D-5L mobility), 25.5 (cf EQ-5D-5L usual activities) and 28.5 (cf GRoC).

The Achilles Tendon Rupture Repair Score

Not to be confused with the ATRS above, the Achilles Tendon Rupture Repair Score (AS) was originally described by Leppilahti et al in 1998 for measurement of the outcome of surgically treated Achilles ruptures. The version provided by

the registry uses the modification described by Hutchison et al, who in lieu of an isokinetic dynamometer, used a single heel raise test to assess muscle strength (Hutchison AM et al 2015).

Outcomes are recorded in the following domains:

- Pain
- Stiffness
- Calf muscle weakness (subjective)
- Footwear restrictions
- Active range of motion difference between ankles
- Subjective result
- Isokinetic muscle strength (modification)

The maximum score is 100 indicating no impairment, with 0 representing a poor result. To the best of the authors' knowledge, the score and its modifications have not been validated and MIC not determined. As this outcome measure requires face to face review it is acknowledged that it is optional, should those facilities exist.

Victorian Institute of Sports Assessment

The VISA-A outcome score is specific to Achilles tendinopathy, originally described by Robinson et al, 2001. The score consists of 8 questions measuring domains of pain, function in daily living and sporting activity. The maximum score is 100, with high scores indicating a good outcome. The original article reported good reliability and stability in a sporting population; however evidence of reliability has not been established in the non-sporting population. One may therefore wish to consider additional PROMs in this group. The MIC has been estimated for patients with Insertional Achilles Tendinopathy (see below).

Olerud & Molander Ankle Score (OMAS)

The Olerud & Molander Ankle Score is a nine item, disease specific, outcome score designed to evaluate symptoms after an ankle fracture. The scale is a functional rating with a maximum score of 100, indicating an unimpaired ankle. Subjective outcomes are recorded in the following parameters: Pain, Stiffness, Swelling, Stair climbing, Running, Jumping, Squatting, Use of supports, Work/ADL.

The original article describes significant correlation with patients' reported outcomes on a linear analogue scale, range of motion, presence of osteoarthritis and presence of dislocations (Olerud & Molander, 1984). There is evidence for test-retest reliability and construct validity for the English, Swedish & Turkish versions (Garratt 2018, Nilsson 2013, Turhan 2017). The Smallest Detectable Change (SDC) is 20.6: this indicates the level of change that can be considered a real difference (Garratt 2018).

Minimally Important Change

Whilst changes in outcome scores may be statistically significant, this may or may not represent a clinically significant difference in patients' symptoms. The Minimally Important Change (MIC) represents a change in the outcome score that is clinically relevant.

The MIC for the EQ-5D index score has been shown to be 0.074 (Walters 2005).

For the MOxFQ components Walking/Standing, Pain and Social Interaction the MICs are 16, 12 and 24 respectively (Dawson 2012). The above study and the study deriving the MOxFQ Summary Index used identical data (Dawson 2012, Morley 2013). The anchor-based method used by Dawson can therefore serve to calculate an MCID for the Summary Index, yielding a value of 12.5. For the graphs in this report, an MCID of 12.5 points for the MOxFQ Summary Index and 20 points for the ATRS has been used to mark a clinically important change from baseline.

The MIC for OMAS has been estimated at 9.7 (McKeown et al, 2021).

The MICs for the ATRS range from 13.5 to 28.5 and are documented above (Dams OC et al, 2020).

For the VISA-A an MIC of 6.5 points has been suggested for Insertional Achilles Tendinopathy (McCormack et al, 2015).

In this report the MCID threshold on each graph is drawn as a single line relative to the mean baseline score.

Minimum Sample Size

Some pathways contained small numbers of participants and for all pathways only few participants had a long follow-up time. A sample size threshold was therefore imposed for the analyses, assuming the 95% confidence interval width should be smaller than the minimum clinically important difference (MCID). The MOxFQ Summary Index (the primary outcome) has an MCID of 12.5 points, and its pooled 12-month standard deviation in the two largest pathways (1st MTPJ fusion and cheilectomy) was 24.9, giving a ratio of 12.5/24.9 = 0.5. Hence, 64 participants would be needed to achieve the desired confidence interval width. The same number would be needed if MCIDs were calculated as half the standard deviation. The repeated measures nature of the data slightly improves the confidence interval width in the graphical representations, thus a minimum of 50 participants per time point was used in this report. Results at time points with fewer than 50 patients are not reported, except where marked † in the tables.

Data Analysis

As the number of cases are small, only summary data is presented in this report. As the numbers grow, we aim to provide more robust, statistical analysis. For the 1st MTPJ fusion and Ankle Fusion pathways the criteria are clearly defined, and analysis of the variables can be achieved. The general Foot and Ankle pathway is more difficult to analyse because of the sheer variety of procedures undertaken. However, in this report, we have undertaken a limited analysis based on four common diagnoses found within the pathway. We are working with Amplitude to try to achieve consistency, particularly with definition of procedures, to help us achieve this in the future.

Statistical Analysis

Where statistical tests were performed the following rules were followed: Continuous variables were tested for normality distribution and presented as means and 95% confidence intervals. Categorical and qualitative variables are expressed as numbers and percentages. The Student t-test and ANOVA was used for continuous variables if the criteria for normality and equality of variances were fulfilled. Alternatively, the Mann-Whitney U test was performed if independent variables or the Wilcoxon signed-rank test if dependent variables. Categorical variables were analysed using the Chi-square test for cell frequencies greater than 5, otherwise the Fisher's exact test was used. Missing data were included in flowcharts and descriptive analyses, allowing denominators to remain consistent in calculations.

All graphical representations of PROMs versus follow-up time were based on generalised additive mixed models (GAMMs), which allow analysing data where the same participants are measured repeatedly over time. For this report, GAMMs were used to fit penalised thin plate splines, with a participant-dependent intercept. The 95% confidence interval bands shown in the graphs correctly account for the repeated measures nature of the data. Using the actual time points at which participants provided PROMs in the data analysis avoided the data gaps resulting from the discrete time points at which PROMs were requested, thus improving the data fits. On the other hand, tabulated data was based on the discrete time points and simply contains means and 95% confidence intervals per time point, neglecting the repeated measures nature of the data.

All data was analysed using R Version 4.6.0 (R Foundation for Statistical Computing, Vienna, Austria) using the package "mgcv".

Table 2.1 - Standard PROMS for each Pathway

Pathway	MOXFQ	EQ-5D	VAS Pain	OMAS	ATRS	AS	VISA-A
1st MTP Fusion	✓	✓	✓				
Ankle Arthrodesis	✓	✓	✓				
Foot & Ankle Generic	✓	✓	✓				
TAR Primary	✓	✓					
TAR Revision	✓	✓					
Achilles Rupture					✓	✓	
Achilles Tendinopathy		✓					✓
Trauma Ankle Fracture		✓	✓	✓			
Trauma Foot & Ankle	✓	✓	✓				

Section 3: 1st Metatarsophalangeal Joint Arthritis

This year, 1st MTPJ data have been drawn from both the dedicated 1st MTPJ pathway and the 1st MTPJ subset of the Foot and Ankle General Pathway. Within the general pathway, 522 1st MTPJ procedures were recorded (mean age 56.6 years, 60.3% female), with hallux rigidus the recorded diagnosis in 59.9% and primary osteoarthritis of the 1st MTPJ in 20.7%. Cheilectomy was the commonest procedure (281, 53.8%), followed by arthrodesis (151, 28.9%), cheilectomy with Moberg osteotomy (41, 7.9%), cheilectomy with microfracture (25, 4.8%) and arthroplasty (24, 4.6%).

3.1 1st Metatarsophalangeal Joint Fusion

A total of **2,030** 1st MTPJ fusions are now held within the registry, combining the dedicated fusion pathway (1,869) and fusions recorded within the general pathway (161). This compares with 1,595 fusion pathways in the 2025 report, an increase of 435 (27%). Surgery details were available for 1,134 cases (55.9%).

The mean age was 62.3 years (SD 11.1, range 13–94) and 66.4% of patients were female. The mean BMI was 27.9, with most patients overweight or obese. Where smoking status was recorded, 7.2% were current smokers, 21.2% ex-smokers and 71.6% non-smokers. Within the dedicated pathway, additional procedures were recorded in 30.4% of cases, most commonly correction of the lesser toes (43.2% of additional procedures), with or without Weil's osteotomies. Plate fixation predominated: a plate, with or without lag or additional screws, was used in approximately four in five cases, and a small dorsal plate accounted for 91.5% of plates recorded. Screw-only constructs (including lag screws alone) were used in 16.8%.

PROM completion remains the principal limitation. Baseline MOxFQ scores were available for 44.6% of the merged cohort, falling to 27.2% at six months, 22.4% at 12 months and 5.9% at two years. VAS Pain completion was 54.6%, 32.0%, 26.1% and 5.1% at the same time points.

Both outcome measures improved substantially after fusion (Table 3.1, Figure 3.1). The MOxFQ Summary Index fell from 59.2 (95% CI 57.9–60.6) at baseline to 34.0 at six months and 30.5 (28.1–33.0) at 12 months, an improvement of 28.7 points, with no overlap of confidence intervals between baseline and any post-operative time point. VAS Pain improved from 54.1 to 29.8 at six months and 26.1 at 12 months (a 28.0-point reduction). At two years scores were slightly higher (VAS 27.9, n=103; MOxFQ 36.7, 95% CI 31.2–42.3, n=119) and the smoothed trajectories in Figure 3.1 show a small late upturn. With fewer than 6% of patients responding at two years this may reflect selective response rather than true deterioration, and it will be monitored as follow-up matures. Details of complications and revision surgery remain inconsistently documented and it is not possible to draw meaningful conclusions on these outcomes from the current dataset.

Table 3.1 - PROMS scores for 1st MTPJ Fusion (merged dataset)

	VAS Pain				MOxFQ Summary Index			
	Baseline	**6 Month**	**12 Month**	**2 Year**	**Baseline**	**6 Month**	**12 Month**	**2 Year**
Number	1,108	649	529	103	906	553	454	119
Mean	54.1	29.8	26.1	27.9	59.2	34.0	30.5	36.7
Std. Deviation	23.5	28.1	26.8	28.2	20.4	27.5	26.7	30.8
Lower 95% CL	52.7	27.7	23.8	22.5	57.9	31.7	28.1	31.2
Upper 95% CL	55.5	32.0	28.4	33.4	60.6	36.3	33.0	42.3

Table 3.2 - Characteristics of 1st MTPJ Fusion (merged dataset)

Characteristic	Level	Overall
n		2,030
Age, mean (SD) [range]		62.3 (11.1) [13–94]
BMI, mean (SD) [range]		27.89 (5.14) [11.2–60]
Sex, n (%)	Female	1,348 (66.4)
	Male	679 (33.4)
	Unknown	3 (0.1)
Smoking, n (%)	Non-smoker	426 (71.6)
	Ex-smoker	126 (21.2)
	Smoker	43 (7.2)
Surgery details available, n (%)	Yes	1,134 (55.9)

Table 3.3 - Fixation and implants, dedicated 1st MTPJ Fusion pathway (n = 1,869)

Characteristic	Level	Overall
Fixation, n (%)	Plate/s + lag screw/s	292 (30.7)
	Plate/s	278 (29.3)
	Screws + plate/s	165 (17.4)
	Screws	107 (11.3)
	Lag screw/s	52 (5.5)
	Other combinations	56 (5.9)
Plate type, n (%)	Small dorsal plate	644 (91.5)
	Other / LCDCP / reconstruction plate	60 (8.5)
Implant manufacturer, n (%)	Stryker Wright Medical	245 (42.8)
	Stryker	106 (18.5)
	Arthrex	76 (13.3)
	DePuy Synthes / Synthes	54 (9.4)
	OrthoSolutions	28 (4.9)
	Paragon28 custom implant	24 (4.2)
	Other	40 (7.0)
Additional procedure, n (%)	Additional surgery recorded	277 (30.4)

3.2 1st Metatarsophalangeal Joint Cheilectomy

Within the registry **306** 1st MTPJ cheilectomies are recorded, compared with 182 in the 2025 report. Isolated cheilectomy accounted for 281 cases (91.8%) and cheilectomy with microfracture for 25 (8.2%); a further 41 cheilectomies combined with a Moberg osteotomy are recorded in the general pathway. Techniques were open in 60.2%, percutaneous in 37.5% and arthroscopic in 2.0%. Patients were younger than those undergoing fusion (mean age 54.2 years) with a more even sex distribution (53.9% female). The recorded diagnosis was hallux rigidus in 64.6% and primary 1st MTPJ osteoarthritis in 24.2%.

PROM completion was greater than in the fusion pathway, with baseline MOxFQ available in 74.2% of cases. The MOxFQ Summary Index improved from 48.2 (45.5–50.8) at baseline to 27.4 at six months and 22.6 (18.8–26.4) at 12 months, a 25.6-point improvement. VAS Pain improved from 44.0 to 25.8 and 23.0 at six and 12 months respectively (Table 3.4, Figure 3.2). Scores at two years (VAS 23.1; MOxFQ 24.1) indicate that the improvement is sustained. Details of complications and conversion to fusion were inconsistently documented.

Table 3.4 - PROMS scores for 1st MTPJ Cheilectomy

	VAS Pain				MOxFQ Summary Index			
	Baseline	**6 Month**	**12 Month**	**2 Year**	**Baseline**	**6 Month**	**12 Month**	**2 Year**
Number	275	191	150	92	227	157	125	74
Mean	44.0	25.8	23.0	23.1	48.2	27.4	22.6	24.1
Std. Deviation	24.0	24.2	23.2	23.9	20.2	22.1	21.7	25.2
Lower 95% CL	41.2	22.4	19.3	18.2	45.5	23.9	18.8	18.3
Upper 95% CL	46.8	29.3	26.7	28.0	50.8	30.8	26.4	29.8

Table 3.5 - Characteristics of 1st MTPJ Cheilectomy

Characteristic	Level	Overall
n		306
Age, mean (SD) [range]		54.2 (10.7) [22–80]
BMI, mean (SD) [range]		27.31 (5.51) [18.4–49.9]
Sex, n (%)	Female	165 (53.9)
	Male	141 (46.1)
Smoking, n (%)	Non-smoker	204 (76.1)
	Ex-smoker	42 (15.7)
	Smoker	15 (5.6)
	Vapes	7 (2.6)
Diagnosis, n (%)	Hallux rigidus	195 (64.6)
	Primary OA of the 1st MTPJ	73 (24.2)
	Other	34 (11.2)
Procedure, n (%)	1st MTPJ cheilectomy	281 (91.8)

Characteristic	Level	Overall
	Cheilectomy and microfracture	25 (8.2)
Approach, n (%)	Open	183 (60.2)
	Percutaneous	114 (37.5)
	Arthroscopic	6 (2.0)
	Mini-open	1 (0.3)

3.3 1st Metatarsophalangeal Joint Arthroplasty

24 1st MTPJ arthroplasties were recorded within the general pathway this year (20 in the 2025 report). Patients had a mean age of 55.1 years and 79.2% were female; hallux rigidus was the indication in 87.0%. All were performed open and, where recorded, the implant was a Biovation device in 86.4% and Stryker Wright Medical in 13.6%.

With only 24 patients recorded on this pathway, below the minimum sample size of 50 (Section 2), PROM outcomes are not reported this year.

In 2025, the arthroplasty group did not show the improvement seen with fusion and cheilectomy at 6 and 12 months. Readers are directed to NICE guidance on 1st MTPJ replacement (HTG87), which recommends that audit and clinical governance arrangements are in place; the BOFAS Registry satisfies these requirements. We continue to recommend that all 1st MTPJ arthroplasty implants are entered on to the registry to allow national level reporting.

Comparison of 1st MTPJ Outcomes

Outcome trajectories for fusion and cheilectomy are shown in Figures 3.1 and 3.2. As in previous years, these outcomes were not produced as the result of a trial and the groups differ: patients undergoing cheilectomy were younger and started with less severe symptoms (baseline MOxFQ 48.2 versus 59.2). Both procedures delivered an improvement of a similar magnitude (around 26–29 MOxFQ points) by 12 months. The absolute 12-month MOxFQ score was lower after cheilectomy (22.6, 95% CI 18.8–26.4) than after fusion (30.5, 28.1–33.0), reflecting the lower starting point, whereas 12-month VAS Pain confidence intervals overlapped. Formal comparison will require case-mix adjustment.

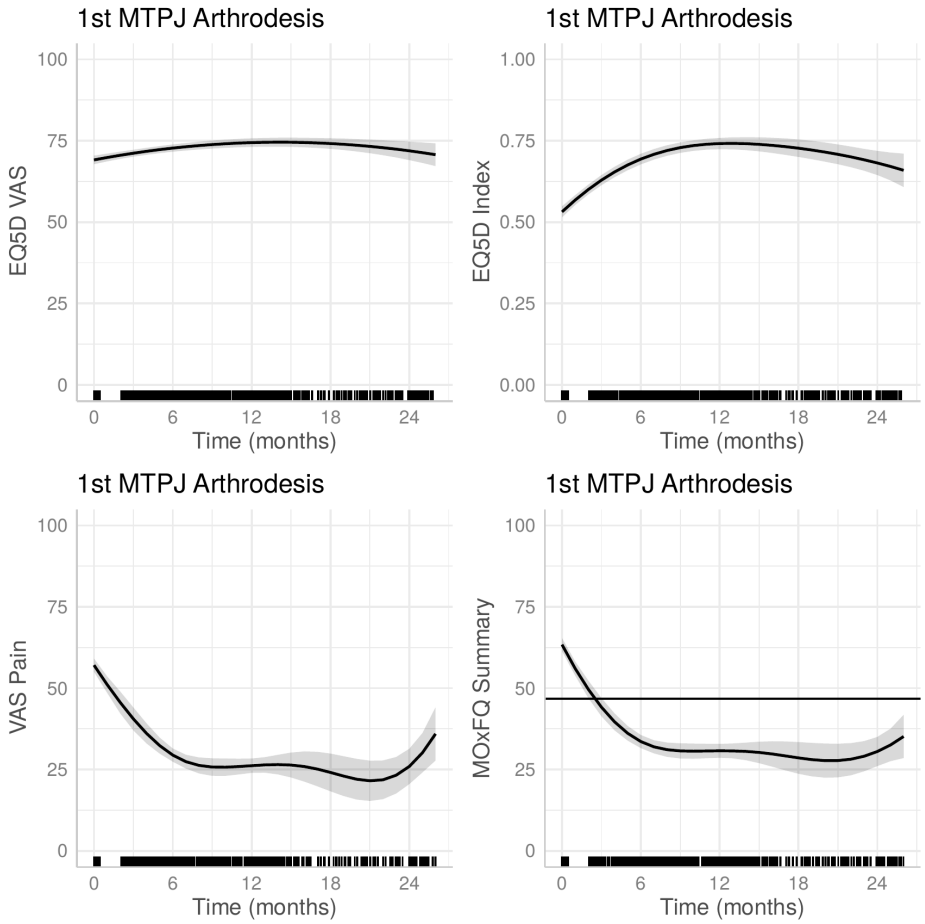


Figure 3.1a - EQ-5D VAS, EQ-5D Index, VAS Pain and MOxFQ Summary over time for 1st MTPJ Arthrodesis (smoothed mean with 95% confidence band; rug marks show individual responses). The horizontal line on the MOxFQ Summary panel marks the MCID (12.5 points) relative to baseline.

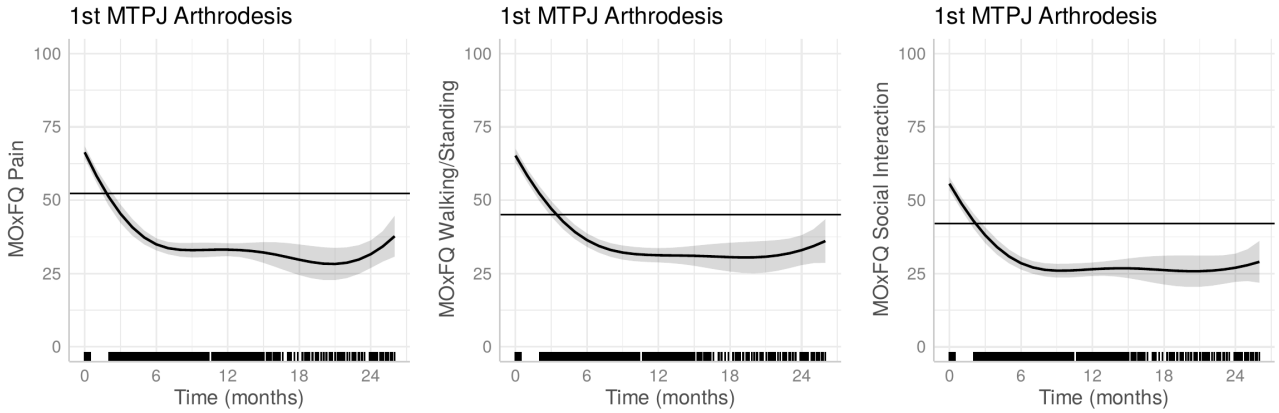


Figure 3.1b - MOxFQ Pain, Walking/Standing and Social Interaction over time for 1st MTPJ Arthrodesis (smoothed mean with 95% confidence band). The horizontal line on each panel marks the MIC relative to baseline.

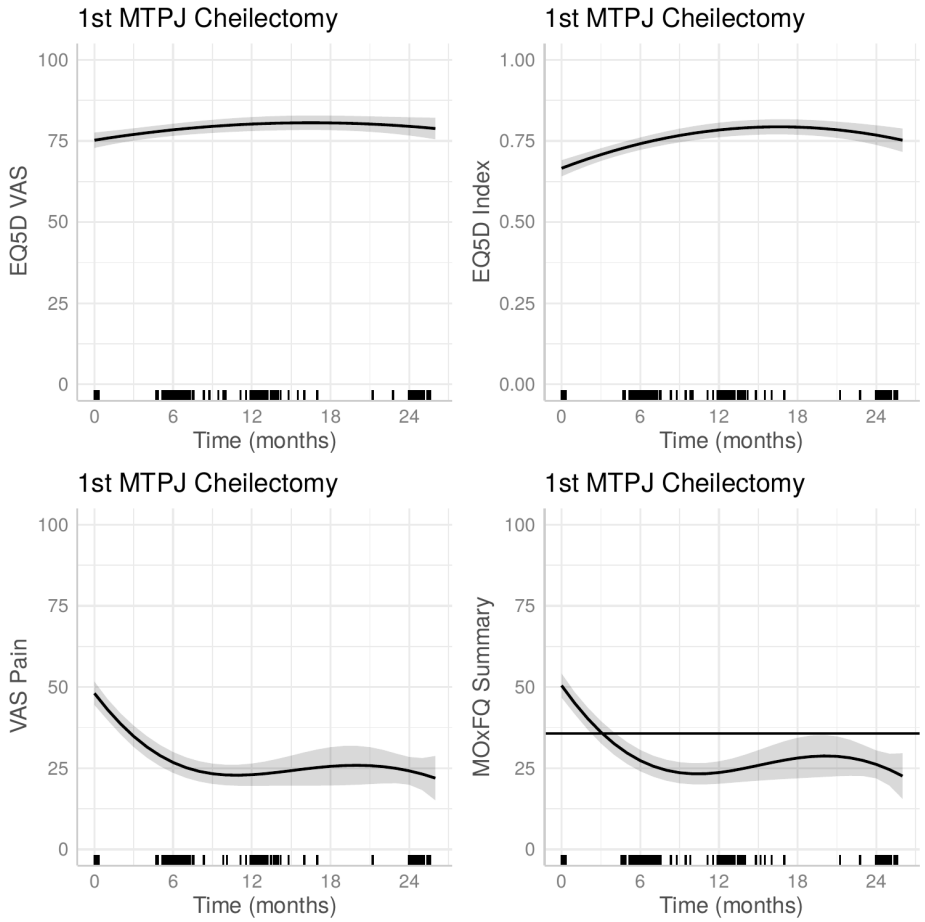


Figure 3.2a - EQ-5D VAS, EQ-5D Index, VAS Pain and MOxFQ Summary over time for 1st MTPJ Cheilectomy. The horizontal line on the MOxFQ Summary panel marks the MCID (12.5 points) relative to baseline.

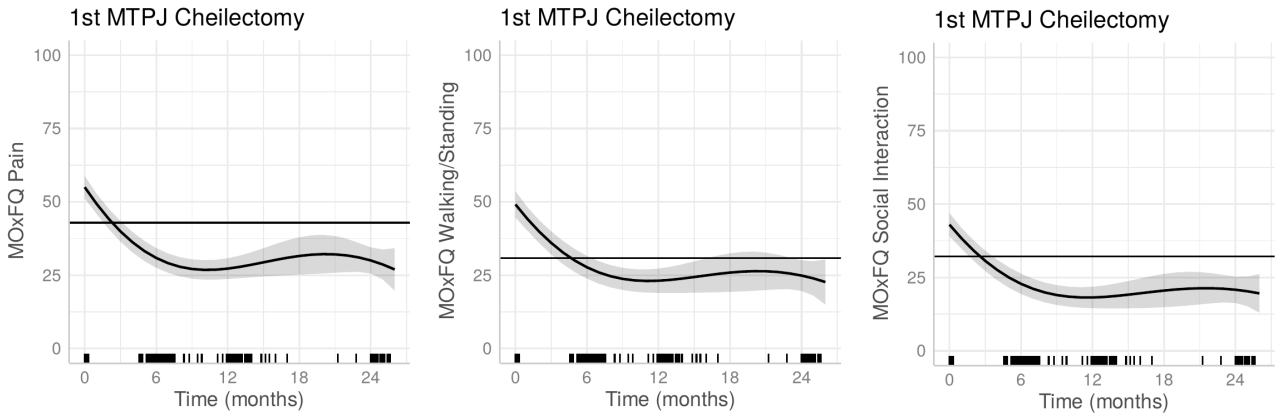


Figure 3.2b - MOxFQ Pain, Walking/Standing and Social Interaction over time for 1st MTPJ Cheilectomy (smoothed mean with 95% confidence band). The horizontal line on each panel marks the MIC relative to baseline.

Section 4: Hallux Valgus

The number of patients entered for hallux valgus correction has again increased, to **1,703** procedures within the general pathway. Baseline MOxFQ data are now available for 854 patients (639 in the 2025 report), with six-month data recorded for 591 (69% of those with a baseline score), 12-month data for 456 (53%) and two-year data for 312.

There remains a strong female preponderance (86.1%), and the mean age was 55.6 years (range 14–86); 5.9% of cases were recorded as adolescent hallux valgus. Minimally invasive chevron and Akin osteotomy was the most frequently recorded single procedure (454, 31.7%), followed by Scarf and Akin osteotomy (337, 23.5%), isolated Scarf osteotomy (118, 8.2%) and open chevron with Akin (104, 7.3%). Lapidus arthrodesis, with or without Akin osteotomy, was recorded in 64 cases (4.5%). Overall, 61.8% of procedures were open and 35.8% percutaneous.

Improvement in both outcome measures was substantial (Table 4.1, Figure 4.1). The MOxFQ Summary Index fell from 49.8 (48.3–51.3) at baseline to 27.5 at six months, 23.0 at 12 months and 21.9 (19.5–24.4) at two years. VAS Pain improved from 43.8 to 21.7, 20.3 and 18.0 at the same time points. Hallux valgus is now the pathway with the most mature two-year follow-up (VAS n=401), and outcomes continue to improve slightly between one and two years rather than deteriorating.

In 2025 there was no difference in MOxFQ improvement between open and MIS techniques, while both performed better than the small Lapidus group. This year's registry-based cost-utility analysis (Lewis et al, 2026) reached a consistent conclusion on health-related quality of life: EQ-5D-5L utility improved by 0.15 after open correction and 0.13 after MIS correction, both exceeding the MCID, with no significant difference between techniques (p=0.179). The ceiling effect of the MOxFQ in hallux valgus, noted last year, continues to limit discrimination between procedures.

Table 4.1 - PROMS scores for Hallux Valgus correction

	VAS Pain				MOxFQ Summary Index			
	Baseline	**6 Month**	**12 Month**	**2 Year**	**Baseline**	**6 Month**	**12 Month**	**2 Year**
Number	1,179	767	592	401	854	591	456	312
Mean	43.8	21.7	20.3	18.0	49.8	27.5	23.0	21.9
Std. Deviation	25.1	22.7	24.2	21.8	22.1	23.8	23.0	22.4
Lower 95% CL	42.3	20.1	18.3	15.9	48.3	25.6	20.9	19.5
Upper 95% CL	45.2	23.3	22.2	20.2	51.3	29.4	25.1	24.4

Table 4.2 - Characteristics of Hallux Valgus correction

Characteristic	Level	Overall
n		1,703
Age, mean (SD) [range]		55.6 (14.7) [14–86]
BMI, mean (SD) [range]		26.21 (5.33) [13.6–60]
Sex, n (%) (recorded n=1,434)	Female	1,234 (86.1)
	Male	200 (13.9)
Smoking, n (%)	Non-smoker	875 (76.2)
	Ex-smoker	158 (13.8)
	Smoker	86 (7.5)
	Vapes / nicotine replacement	30 (2.6)
Diagnosis, n (%)	Hallux valgus (adult)	1,350 (94.1)
	Hallux valgus (adolescent)	84 (5.9)
Procedure, n (%)	MIS chevron and Akin osteotomy	454 (31.7)
	Scarf and Akin osteotomy	337 (23.5)
	Scarf osteotomy	118 (8.2)
	Chevron and Akin osteotomy	104 (7.3)
	1st metatarsal osteotomy and Akin	82 (5.7)
	Lapidus arthrodesis ± Akin	64 (4.5)
	Chevron osteotomy	41 (2.9)
	1st MTPJ arthrodesis ± fixation	36 (2.5)
	Other	198 (13.8)
Approach, n (%)	Open	884 (61.8)
	Percutaneous	513 (35.8)
	Other / mini-open / arthroscopic	34 (2.4)

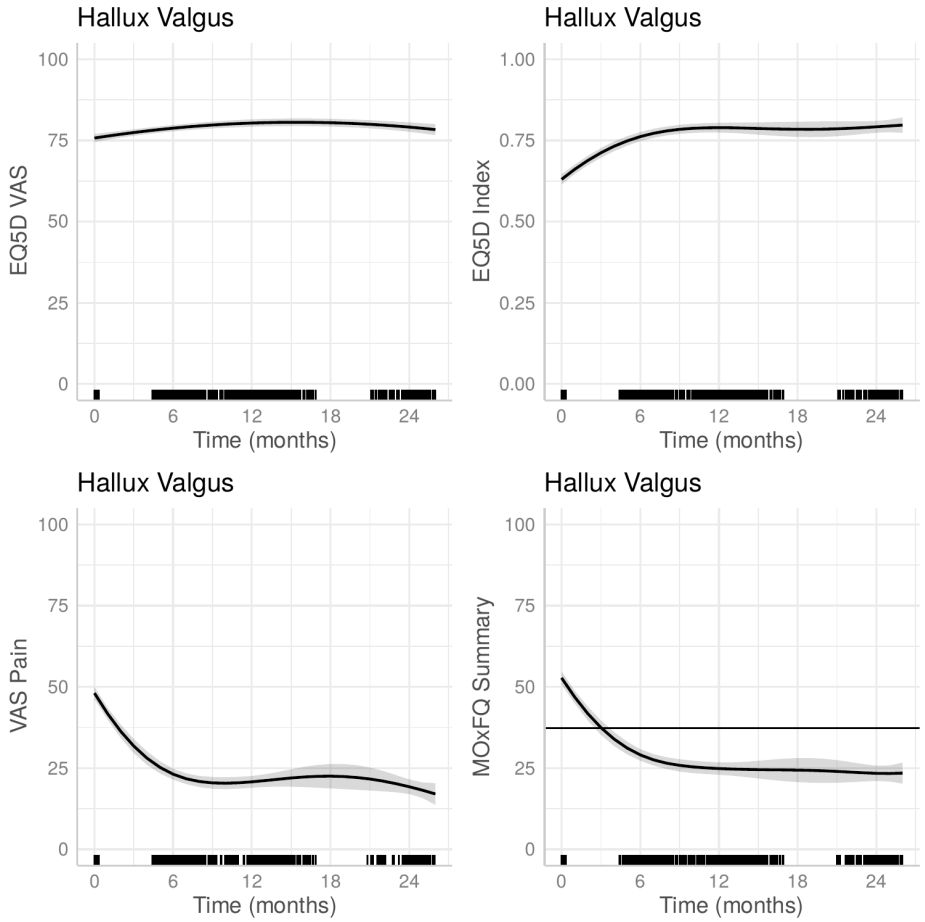


Figure 4.1a - EQ-5D VAS, EQ-5D Index, VAS Pain and MOxFQ Summary over time for Hallux Valgus correction (smoothed mean with 95% confidence band). The horizontal line on the MOxFQ Summary panel marks the MCID (12.5 points) relative to baseline.

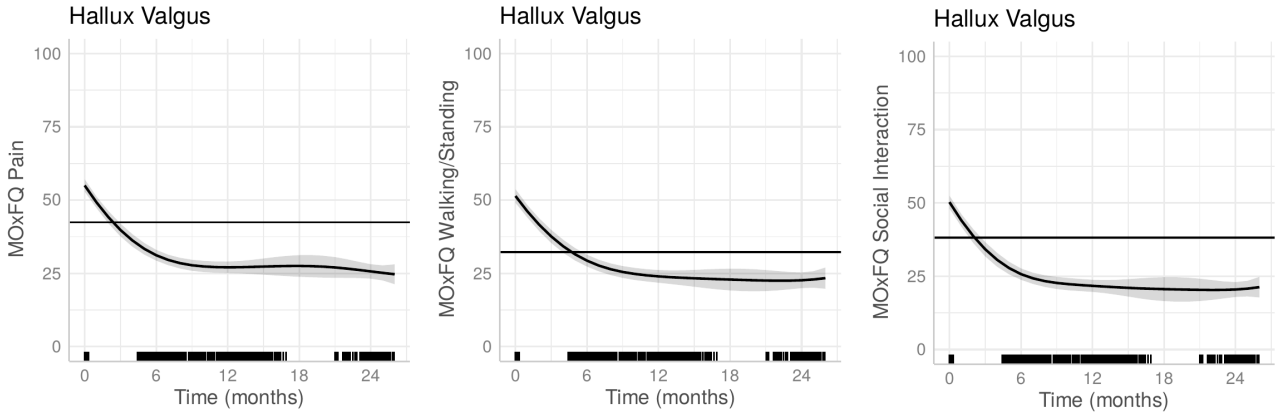


Figure 4.1b - MOxFQ Pain, Walking/Standing and Social Interaction over time for Hallux Valgus correction (smoothed mean with 95% confidence band). The horizontal line on each panel marks the MIC relative to baseline.

Section 5: Ankle Arthritis

Ankle osteoarthritis is a common condition that affects 1-4% of all adults (Murray et al, 2018). Ankle pain accounts for 10% of musculoskeletal consultations to the GP in the UK (Menz et al, 2010), and the incidence of symptomatic ankle arthritis presenting to foot and ankle surgeons has been estimated at 47.7 per 100,000 (Goldberg et al, 2012). End stage ankle arthritis can cause significant pain and disability comparable to end stage kidney disease and congestive heart failure (Saltzman CL et al, 2006). The treatment for end stage osteoarthritis is ankle arthrodesis or total ankle replacement, and both have been shown to be clinically effective. Ankle Arthritis Networks continue to develop nationally in response to the Getting It Right First Time programme, to share expertise, reduce variation and improve patient outcomes. The registry has again shown a year-on-year increase in both pathways, allowing comparative data to be assessed.

5.1 Ankle Arthrodesis

48 hospitals and 68 surgeons contributed to the pathway. The merged ankle arthrodesis dataset now contains **815** cases: 736 from the dedicated ankle arthrodesis pathway (638 in 2025, an increase of 15%) and 79 from the general pathway. Surgery details were available for 60.4%. Two thirds of patients were male (67.0%); the mean age was 62.1 years (range 18–92) and the mean BMI was 30.2. Current smoking was recorded in 7.6%, ex-smoking in 17.6% and non-smoking in 74.8%. The most common recorded indications for fusion were primary arthritis (55.3%), post-traumatic arthritis (18.4%) and ankle instability (9.2%); other indications included cavus foot correction, inflammatory arthritis and avascular necrosis of the talus. Within the general pathway, primary ankle osteoarthritis was the indication in 50.0%, with post-fracture, post-instability and malunion-related arthritis making up most of the remainder.

Primary fusion accounted for 95.9% of procedures with a recorded type and revision for 3.4%. Arthroscopic fusion (53.2%) remains more common than open fusion (42.0%), with small numbers performed mini-open or arthroscopically assisted. Cannulated screws alone were used in 73.9%, plates and screws in 13.1%, an intramedullary nail in 2.2% and other constructs in 4%, including combinations of cannulated screws and cables, staples and external fixators. Where screws were used, two screws were inserted in 81.1% and three in 10.2%; screws were most often parallel (79.7%), directed superior to inferior (89.2%) and applied medial to lateral (60.0%).

The MOxFQ Summary Index improved from 71.0 (69.2–72.7) at baseline to 41.8 at six months and 35.2 (30.9–39.5) at 12 months, a 35.8-point improvement. This was clinically relevant with the change being greater than the MIC. VAS Pain improved from 64.3 to 35.3 and 27.7, a 36.6-point reduction (Table 5.1, Figure 5.1). Two-year results are not reported, as only 12 (VAS) and 17 (MOxFQ) patients had reached two years, well below the minimum sample size of 50.

Table 5.1 - PROMS scores for Ankle Arthrodesis (merged dataset)

	VAS Pain				MOxFQ Summary Index			
	Baseline	**6 Month**	**12 Month**	**2 Year**	**Baseline**	**6 Month**	**12 Month**	**2 Year**
Number	368	206	155	12	365	200	152	17
Mean	64.3	35.3	27.7	–	71.0	41.8	35.2	–
Std. Deviation	21.9	27.1	25.3	–	17.1	26.1	27.3	–
Lower 95% CL	62.1	31.6	23.7	–	69.2	38.2	30.9	–
Upper 95% CL	66.5	39.0	31.7	–	72.7	45.4	39.5	–

– Not reported: fewer than 50 patients at this time point (minimum sample size, Section 2).

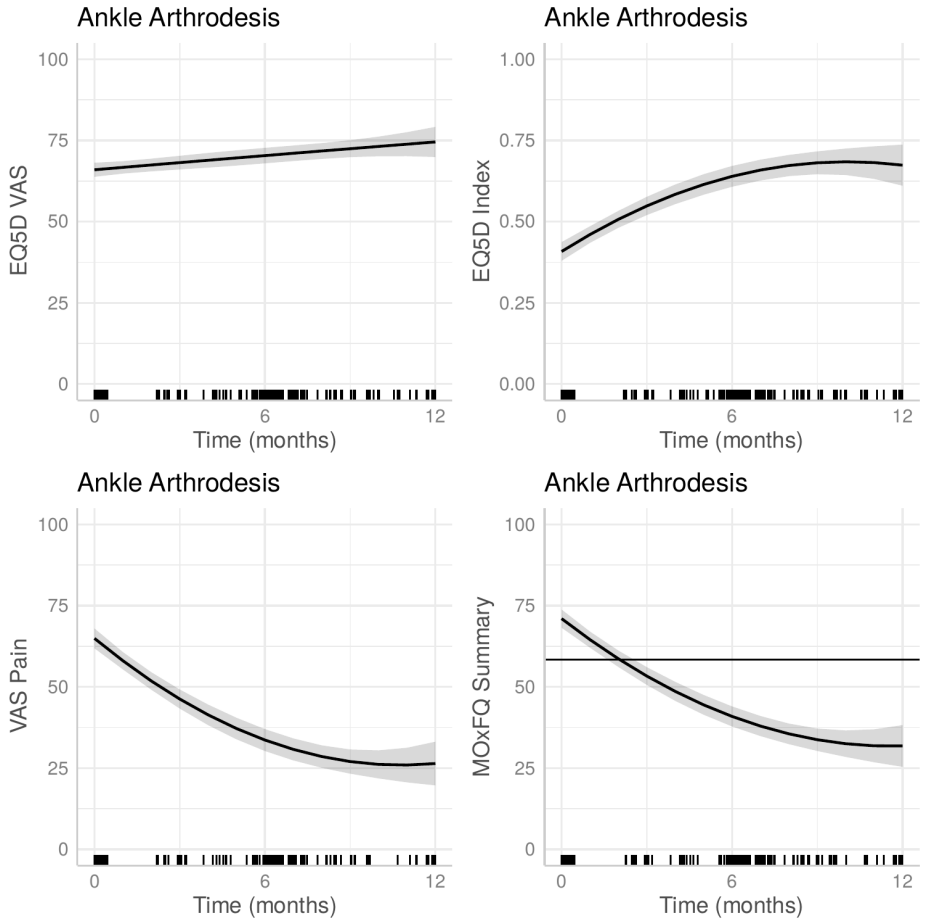


Figure 5.1a - EQ-5D VAS, EQ-5D Index, VAS Pain and MOxFQ Summary over time for Ankle Arthrodesis (smoothed mean with 95% confidence band). The horizontal line on the MOxFQ Summary panel marks the MCID (12.5 points) relative to baseline.

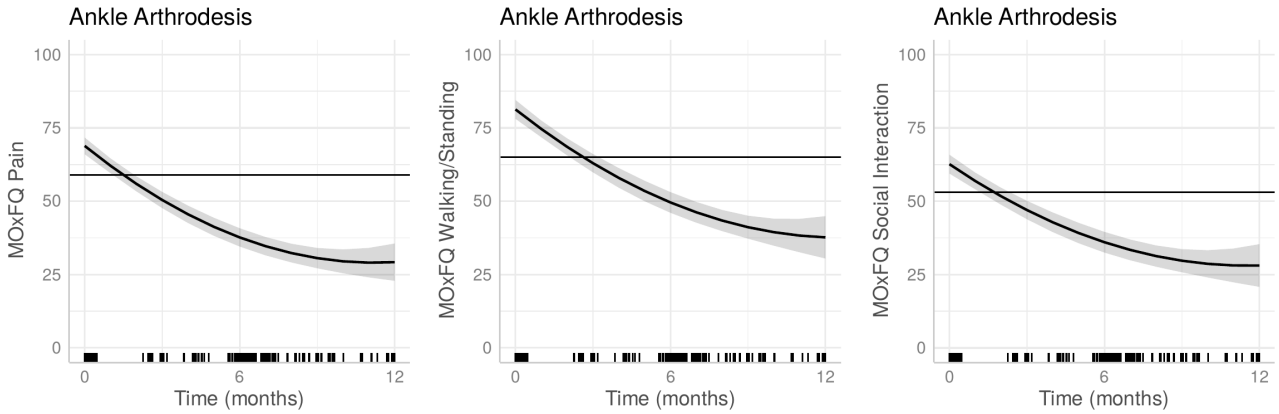


Figure 5.1b - MOxFQ Pain, Walking/Standing and Social Interaction over time for Ankle Arthrodesis (smoothed mean with 95% confidence band). The horizontal line on each panel marks the MIC relative to baseline.

Table 5.2 - Characteristics of Ankle Arthrodesis

Characteristic	Level	Overall
n (merged)	Arthrodesis pathway / general pathway	815 (736 / 79)
Age, mean (SD) [range]		62.1 (12.7) [18–92]
BMI, mean (SD)		30.15 (6.80)
Sex, n (%)	Male	546 (67.0)
	Female	269 (33.0)
Smoking, n (%)	Non-smoker	196 (74.8)
	Ex-smoker	46 (17.6)
	Smoker	20 (7.6)
Type*, n (%)	Primary	395 (95.9)
	Revision	14 (3.4)
Approach*, n (%)	Arthroscopic	214 (53.2)

Characteristic	Level	Overall
	Open	169 (42.0)
	Other (mini-open / assisted / converted)	19 (4.6)
Fixation*, n (%)	Cannulated screws	300 (73.9)
	Plates and screws	53 (13.1)
	Cannulated screws and plates	28 (6.9)
	IM ankle arthrodesis nail	9 (2.2)
	Other	16 (4.0)
Number of screws*, n (%)	Two	262 (81.1)
	Three	33 (10.2)
	One / other	28 (8.6)
Screw orientation*, n (%)	Parallel	235 (79.7)
	Crossed	34 (11.5)

**Dedicated ankle arthrodesis pathway only, where surgery details were recorded.*

5.2 Primary Ankle Arthroplasty

Within the registry, **383** primary total ankle replacement (TAR) pathways have been instituted, compared with 286 in 2025 (an increase of 34%). There were 233 males (60.8%) and 150 females; the mean age at implantation was 68.9 years (SD 9.5, range 31–90) and the mean BMI 28.2 (SD 4.8). Of those with smoking status recorded, 5.9% were active smokers, 1.0% used e-cigarettes, 20.4% were ex-smokers and 72.7% non-smokers. Primary osteoarthritis was the indication in 73.5%, post-traumatic arthritis (intra-articular fracture, trauma or malunion) in 18.0%, and inflammatory arthropathy in 6.2%.

Almost all implants were uncemented (99.1%). Where the implant was recorded, the INFINITY Total Ankle System accounted for 46.2%, with a further 11.2% recorded as PROPHECY INFINITY; the STAR prosthesis accounted for 18.8%, other Stryker implants 11.2%, other Wright Medical implants 6.2%, Corin 3.1% and INBONE/INBONE II 3.1%.

The MOxFQ Summary Index improved from 70.7 (68.4–73.0) pre-operatively to 34.2 at six months and 36.0 (31.2–40.9) at one year, an improvement of 34.7 points. This was clinically relevant with the change being greater than the MIC. VAS Pain improved from 63.9 to 26.8 at six months and 27.8 at one year (Table 5.3, Figure 5.2). Importantly, two-year data are now available for a meaningful number of patients (VAS n=89; MOxFQ n=74), and both measures remain stable between one and two years (VAS 28.6; MOxFQ 34.5).

Table 5.3 - PROMS scores for Primary Ankle Arthroplasty

	VAS Pain				MOxFQ Summary Index			
	Baseline	**6 Month**	**12 Month**	**2 Year**	**Baseline**	**6 Month**	**12 Month**	**2 Year**
Number	222	144	127	89	192	124	116	74
Mean	63.9	26.8	27.8	28.6	70.7	34.2	36.0	34.5
Std. Deviation	18.5	23.9	25.5	27.6	16.1	23.2	26.7	28.1
Lower 95% CL	61.5	22.9	23.4	22.8	68.4	30.1	31.2	28.1
Upper 95% CL	66.4	30.7	32.3	34.3	73.0	38.3	40.9	40.9

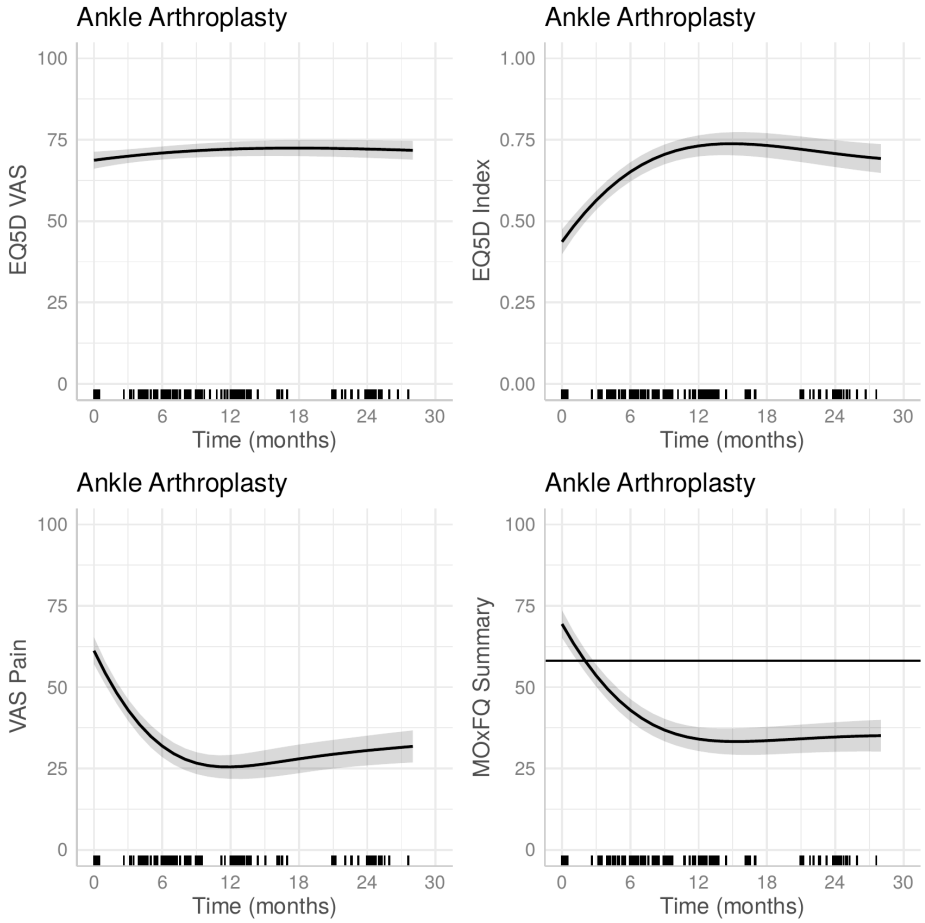


Figure 5.2a - EQ-5D VAS, EQ-5D Index, VAS Pain and MOxFQ Summary over time for Primary Ankle Arthroplasty (smoothed mean with 95% confidence band). The horizontal line on the MOxFQ Summary panel marks the MCID (12.5 points) relative to baseline.

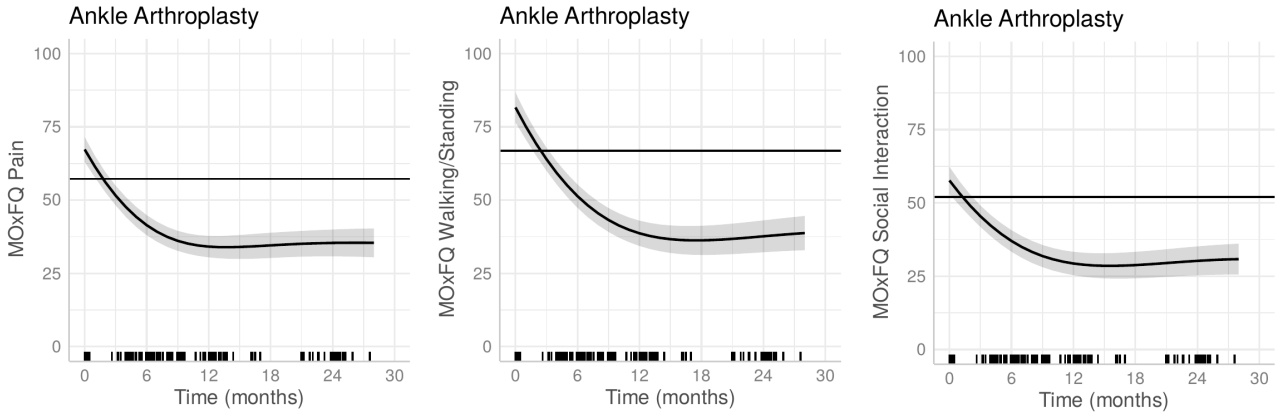


Figure 5.2b - MOxFQ Pain, Walking/Standing and Social Interaction over time for Primary Ankle Arthroplasty (smoothed mean with 95% confidence band). The horizontal line on each panel marks the MIC relative to baseline.

Table 5.4 - Characteristics of Primary Ankle Arthroplasty

Characteristic	Level	Overall
n		383
Age, mean (SD) [range]		68.9 (9.5) [31–90]
BMI, mean (SD) [range]		28.2 (4.8) [10.4–52.3]
Sex, n (%)	Male	233 (60.8)
	Female	150 (39.2)
Smoking, n (%)	Non-smoker	210 (72.7)
	Ex-smoker	59 (20.4)
	Smoker	17 (5.9)
	Vapes	3 (1.0)
Diagnosis, n (%)	Primary OA of the ankle	200 (73.5)

Characteristic	Level	Overall
	OA secondary to intra-articular fracture	26 (9.6)
	OA secondary to trauma	18 (6.6)
	Rheumatoid arthritis	15 (5.5)
	Other	13 (4.8)
Implant type, n (%)	Uncemented primary TAR	218 (99.1)
	Cemented / total talus	2 (0.9)
Manufacturer – model, n (%)	Wright – INFINITY	74 (46.2)
	Stryker – STAR	30 (18.8)
	Stryker – other	18 (11.2)
	Wright – PROPHECY INFINITY	18 (11.2)
	Wright – other	10 (6.2)
	Corin – other	5 (3.1)
	Wright – INBONE / INBONE II	5 (3.1)

Comparison of Ankle Arthritis Treatment Outcomes

As in 2025, outcomes after ankle arthrodesis and TAR are closely matched (Figures 5.1 and 5.2). Baseline scores were almost identical (MOxFQ 71.0 vs 70.7; VAS 64.3 vs 63.9), and at 12 months the confidence intervals overlapped for both MOxFQ (35.2 vs 36.0) and VAS Pain (27.7 vs 27.8). TAR scores improved slightly faster at six months. It should be noted that no information is available regarding deformity, other joint disease or radiographic success, and that patients selected for each procedure differ (TAR patients were on average 6.8 years older); the data should therefore be viewed as a generalisation of PROM outcomes for these treatments rather than a comparison of effectiveness.

Section 6: Achilles Tendon Rupture

The Achilles Tendon Rupture pathway was opened in 2020 and now contains **389** pathways (242 in 2025). A further 78 Achilles rupture cases were recorded within the general pathway, giving a merged total of 467. The pathway allows both operative and non-operative management to be recorded, along with radiological findings. The standard PROMs are the Achilles Tendon Total Rupture Score (ATRS) and Achilles Tendon Rupture Repair Score (AS).

Across the merged dataset the mean age was 50.1 years (SD 14.9) and 78.6% were male, consistent with previous years. Mean BMI was 28.4. 78.6% were non-smokers, 11.0% ex-smokers, 5.2% smokers and 4.5% used e-cigarettes. Within the dedicated pathway, acute ruptures of the tendon body were the commonest presentation (61.0%), followed by chronic ruptures (19.2%), musculotendinous junction ruptures (13.2%) and re-rupture after conservative treatment (4.4%). Fat pad herniation was recorded in 9.2% of ultrasound-assessed cases.

Surgical details were recorded for 38.6% of pathway cases. Of the operative repairs, 44.8% were open, 35.4% mini-open and 19.8% percutaneous, and most were primary acute repairs (55.0%), with delayed or chronic repairs in 22.0% and repairs of re-rupture in 7.0%. Cases recorded within the general pathway form a distinct group: they were older (mean 57.1 years), 84.6% were chronic ruptures, and reconstruction with FHL tendon transfer (with or without direct repair) accounted for 58.8% of procedures. Direct comparison between the two sources should therefore be avoided.

Outcomes are reported at six and 12 months (Table 6.1, Figure 6.1). The ATRS was 63.7 (95% CI 60.9–66.5, n=204) at six months, rising to 75.3 (72.1–78.5, n=140) at 12 months. The 12-month result is consistent with 2025, when the ATRS at 12 months was 78.9 after conservative treatment and 78.3 after minimally invasive repair. The AS was 61.0 (58.7–63.4, n=167) at six months and 62.2 (59.2–65.2, n=121) at 12 months. Details of complications and re-rupture were inconsistently documented, and it is not possible to draw meaningful conclusions from the dataset as it currently stands.

Table 6.1 - ATRS and AS for Achilles Tendon Rupture

	Achilles Tendon Rupture Repair Score (AS)		Achilles Tendon Total Rupture Score (ATRS)	
	6 Month	**12 Month**	**6 Month**	**12 Month**
Number	167	121	204	140
Mean	61.0	62.2	63.7	75.3
Std. Deviation	15.4	17.0	20.1	19.3
Lower 95% CL	58.7	59.2	60.9	72.1
Upper 95% CL	63.4	65.2	66.5	78.5

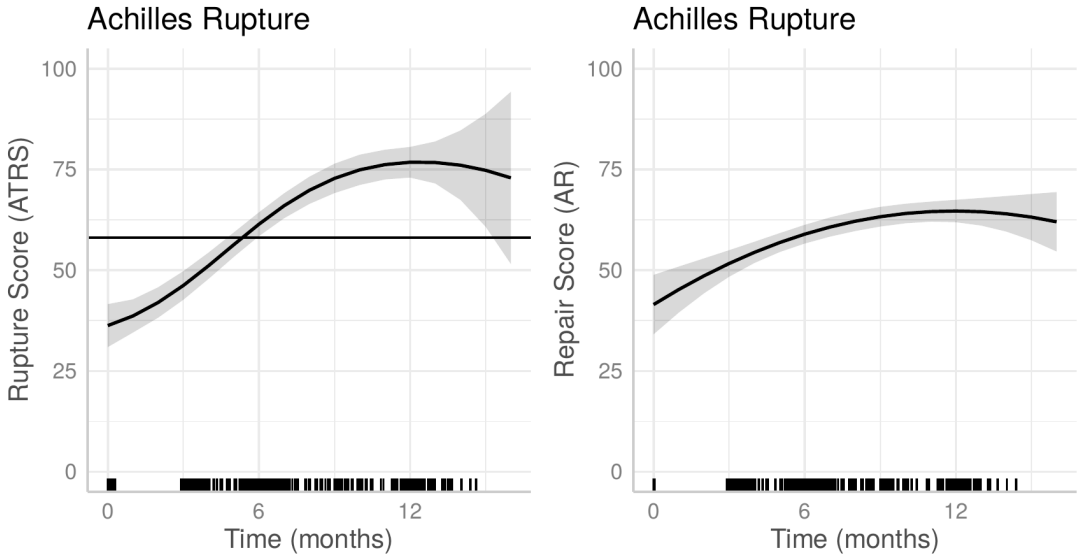


Figure 6.1 - ATRS and AS over time for Achilles Tendon Rupture (smoothed mean with 95% confidence band). The horizontal line on the ATRS panel marks the MCID (20 points) relative to baseline.

Table 6.2 - Characteristics of Achilles Tendon Rupture

Characteristic	Level	Overall
n (merged)	Rupture pathway / general pathway	467 (389 / 78)
Age, mean (SD) [range]		50.1 (14.9) [14–84]
BMI, mean (SD) [range]		28.41 (5.25) [21.9–49.8]
Sex, n (%)	Male	367 (78.6)
	Female	100 (21.4)

Characteristic	Level	Overall
Diagnosis, n (%)	Acute body rupture	111 (42.7)
	Chronic rupture	101 (38.8)
	Acute musculotendinous junction rupture	24 (9.2)
	Acute non-insertional rupture (general pathway)	12 (4.6)
	Re-rupture after conservative treatment	8 (3.1)
	Other	4 (1.5)
Repair approach*, n (%)	Open	43 (44.8)
	Mini-open	34 (35.4)
	Percutaneous	19 (19.8)
Surgery details available, n (%)	Yes	218 (46.7)

**Dedicated Achilles rupture pathway, operatively treated cases with approach recorded.*

Section 7: Morton's Neuroma

There were **213** patients registered with a diagnosis of Morton's neuroma (184 in 2025). 73.7% were female; the mean age was 53.9 years and the mean BMI 27.0. Surgical details were recorded for 177 patients. Where a procedure was recorded, resection of the neuroma accounted for 76.9% (133 cases), with 21.4% recorded as 'other' interventions; almost all operations were open (94.9%). Where recorded, half of procedures were performed under general anaesthesia alone and 29.2% with local infiltration in addition.

Baseline PROMs were available for 124 patients (VAS Pain) and 102 (MOxFQ). VAS Pain improved from 53.0 (95% CI 48.9–57.1) to 25.9 at six months and 19.6 (13.9–25.3) at 12 months, a 33.4-point reduction, and was 20.4 at two years (n=67). The MOxFQ Summary Index improved from 55.4 (51.7–59.1) to 28.6 at six months, 23.6 (16.9–30.3) at 12 months and 23.7 at two years, an improvement of 31.8 points (Table 7.1, Figure 7.1). As in 2025, most of the improvement had occurred by six months and was sustained thereafter, and the results closely mirror last year's (VAS 56.4 at baseline and 20.1 at 12 months).

Table 7.1 - PROMS scores for Morton's Neuroma

	VAS Pain				MOxFQ Summary Index			
	Baseline	**6 Month**	**12 Month**	**2 Year**	**Baseline**	**6 Month**	**12 Month**	**2 Year**
Number	124	97	56	67	102	81	52	58
Mean	53.0	25.9	19.6	20.4	55.4	28.6	23.6	23.7
Std. Deviation	23.5	24.6	21.8	22.0	19.1	27.2	24.7	26.1
Lower 95% CL	48.9	21.0	13.9	15.1	51.7	22.7	16.9	17.0
Upper 95% CL	57.1	30.8	25.3	25.6	59.1	34.6	30.3	30.4

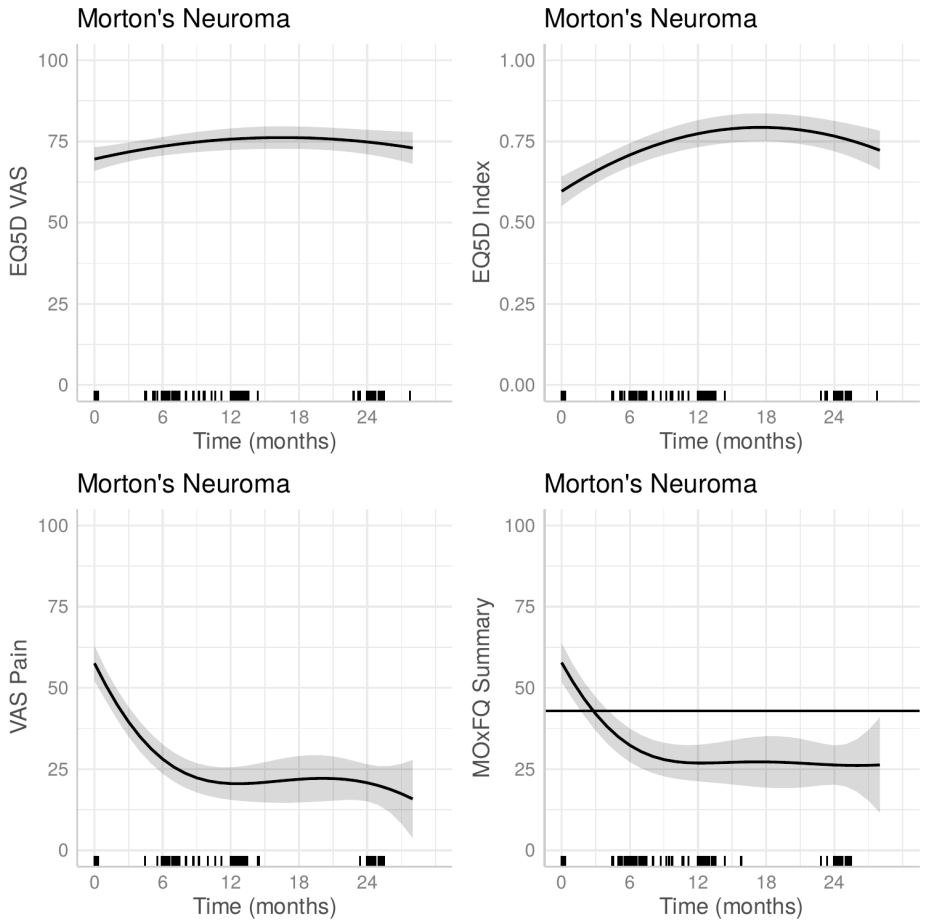


Figure 7.1a - EQ-5D VAS, EQ-5D Index, VAS Pain and MOxFQ Summary over time for Morton's Neuroma (smoothed mean with 95% confidence band). The horizontal line on the MOxFQ Summary panel marks the MCID (12.5 points) relative to baseline.

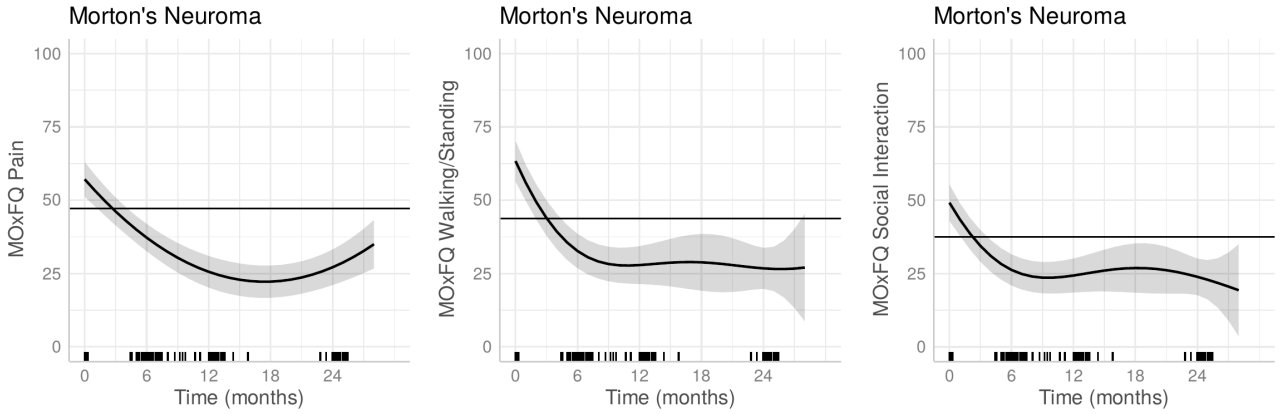


Figure 7.1b - MOxFQ Pain, Walking/Standing and Social Interaction over time for Morton's Neuroma (smoothed mean with 95% confidence band). The horizontal line on each panel marks the MIC relative to baseline.

Table 7.2 - Characteristics of Morton's Neuroma

Characteristic	Level	Overall
n		213
Age, mean (SD) [range]		53.9 (12.0) [9–87]
BMI, mean (SD) [range]		27.02 (6.47) [17.9–48.1]
Sex, n (%)	Female	157 (73.7)
	Male	56 (26.3)
Smoking, n (%)	Non-smoker	123 (76.9)
	Ex-smoker	30 (18.8)
	Smoker / vapes	7 (4.3)
Procedure, n (%)	Resection of Morton's neuroma	133 (76.9)
	Other	40 (23.1)
Approach, n (%)	Open	150 (94.9)
	Percutaneous / arthroscopic / other	8 (5.1)

The minimum recorded age of 9 years should be checked.

Section 8: Double and Triple Arthrodesis

A total of **140** double or triple arthrodeses were entered into the registry (121 in 2025): 81 triple arthrodeses (57.9%) and 59 double (talonavicular and subtalar) arthrodeses (42.1%). 62.1% of patients were female, the mean age was 61.9 years (range 13–86) and the mean BMI 29.5. Current smoking was recorded in 9.6%. The most frequent recorded indications were osteoarthritis of the hindfoot joints (26.5%) and acquired flat foot (25.0%), with tibialis posterior dysfunction or insufficiency recorded in a further 9.9%. As in previous years, the great majority of procedures were open (91.4%), with 6.5% arthroscopic and 1.4% combined.

Baseline PROMs were available for 74 patients (VAS Pain) and 62 (MOxFQ). Patients had the highest baseline MOxFQ of any cohort in this report. VAS Pain improved from 62.4 (95% CI 57.0–67.9) to 36.2 at six months and 31.0 (24.0–38.0) at 12 months, a 31.4-point reduction. The MOxFQ Summary Index improved from 72.4 (67.7–77.0) to 44.7 at six months and 37.9 (29.4–46.4) at 12 months, an improvement of 34.5 points (Table 8.1, Figure 8.1). The 12-month MOxFQ result is based on 43 patients, below the minimum of 50, and should be interpreted with caution; two-year results are not reported, as fewer than 50 patients had reached two years (VAS n=45; MOxFQ n=35). The smoothed trajectories suggest a slight upturn after 18 months. These results are consistent with 2025 (VAS 63.0 at baseline and 32.0 at 12 months), when recovery was also noted to be slower after triple than double arthrodesis.

Table 8.1 - PROMS scores for Double and Triple Arthrodesis

	VAS Pain				MOxFQ Summary Index			
	Baseline	**6 Month**	**12 Month**	**2 Year**	**Baseline**	**6 Month**	**12 Month**	**2 Year**
Number	74	60	51	45	62	54	43†	35
Mean	62.4	36.2	31.0	–	72.4	44.7	37.9	–
Std. Deviation	23.8	25.5	25.6	–	18.6	26.4	28.5	–
Lower 95% CL	57.0	29.8	24.0	–	67.7	37.7	29.4	–
Upper 95% CL	67.9	42.6	38.0	–	77.0	51.8	46.4	–

– Not reported: fewer than 50 patients at this time point (minimum sample size, Section 2).

† Fewer than 50 patients (the minimum sample size, Section 2); interpret with caution.

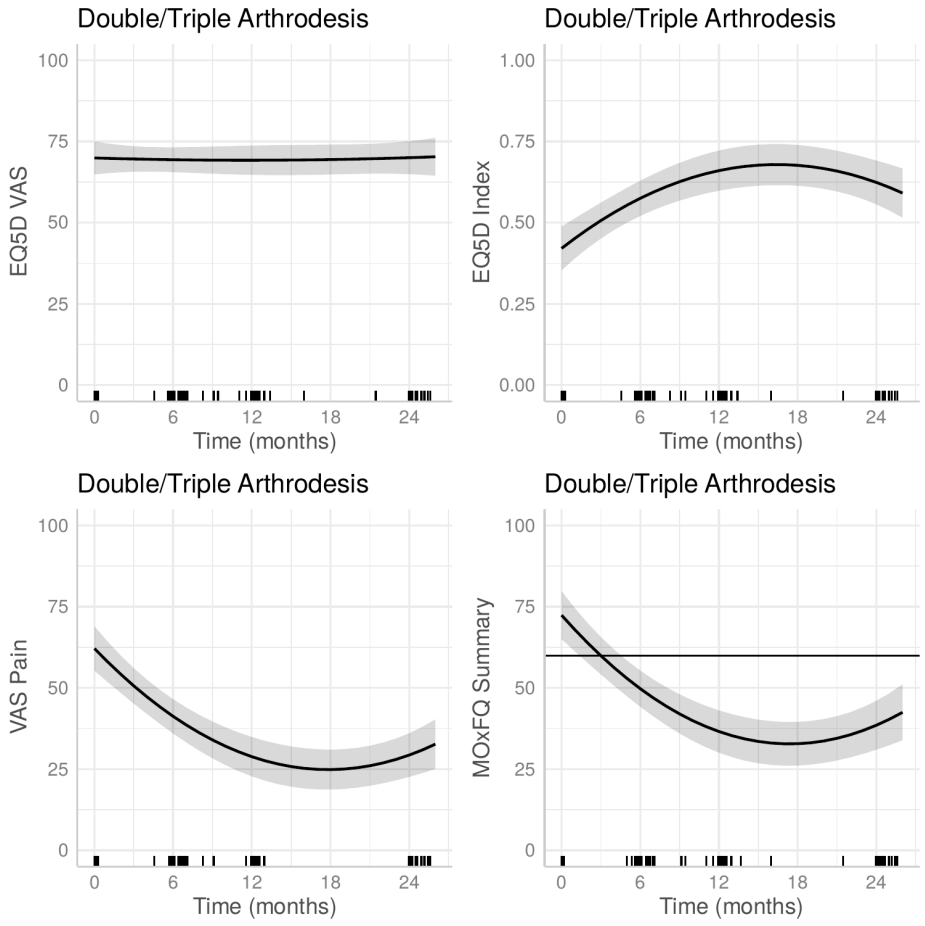


Figure 8.1a - EQ-5D VAS, EQ-5D Index, VAS Pain and MOxFQ Summary over time for Double and Triple Arthrodesis (smoothed mean with 95% confidence band). The horizontal line on the MOxFQ Summary panel marks the MCID (12.5 points) relative to baseline.

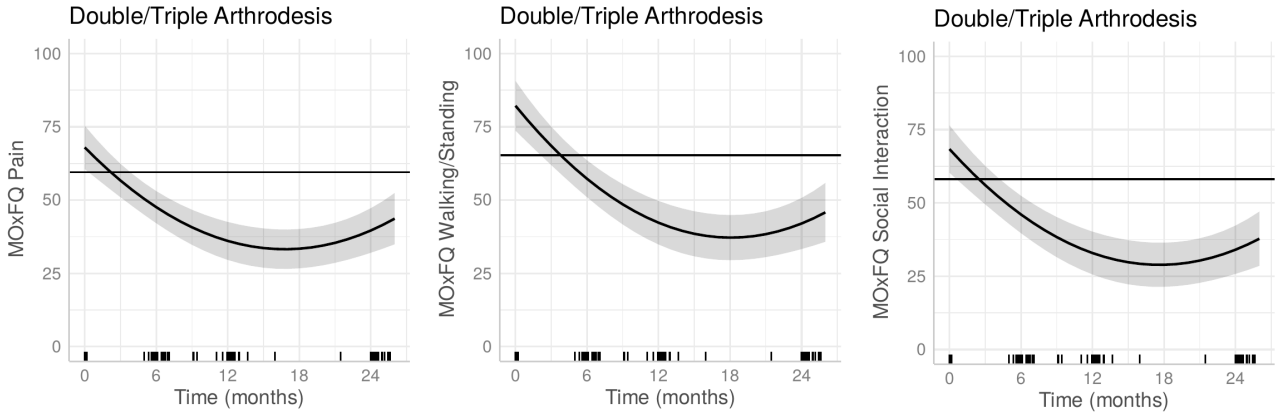


Figure 8.1b - MOxFQ Pain, Walking/Standing and Social Interaction over time for Double and Triple Arthrodesis (smoothed mean with 95% confidence band). The horizontal line on each panel marks the MIC relative to baseline.

Table 8.2 - Characteristics of Double and Triple Arthrodesis

Characteristic	Level	Overall
n		140
Age, mean (SD) [range]		61.9 (15.0) [13–86]
BMI, mean (SD) [range]		29.50 (6.13) [16.5–45.5]
Sex, n (%)	Female	87 (62.1)
	Male	53 (37.9)
Smoking, n (%)	Non-smoker	68 (72.3)
	Ex-smoker	14 (14.9)
	Smoker	9 (9.6)
	Vapes	3 (3.2)
Diagnosis, n (%)	Primary OA (joint other than ankle or 1st MTPJ)	35 (26.5)
	Acquired flat foot (pes planus)	33 (25.0)
	Tibialis posterior dysfunction / insufficiency	13 (9.9)
	Post-traumatic or secondary OA	9 (6.8)
	Other	42 (31.8)
Procedure, n (%)	Triple arthrodesis	81 (57.9)
	Double arthrodesis (TN and subtalar)	59 (42.1)
Approach, n (%)	Open	127 (91.4)
	Arthroscopic	9 (6.5)
	Combined / percutaneous	3 (2.1)

Section 9: Ankle Ligament Reconstruction

Registered ankle ligament reconstructions have more than doubled, to **320** (129 in 2025). Patients were younger than in any other pathway (mean age 39.8 years, range 11–71) and 53.4% were female, a change from 2025 when the majority were male. Chronic ankle instability was the indication in 78.7% and acute instability in 4.8%. A modified Broström repair was recorded in 57.5%, a lateral ankle ligament reconstruction in 25.3% and a standard Broström repair in 17.2%. Arthroscopic techniques were used in 53.4%, open in 40.0% and combined open and arthroscopically assisted techniques in 3.8%. Smoking (9.2%) and vaping (5.0%) were more frequent than in older cohorts.

Baseline PROM completion was high, with VAS Pain recorded for 282 patients and MOxFQ for 266 (83% of the cohort). VAS Pain improved from 42.7 (95% CI 40.0–45.4) to 21.1 at six months, 24.7 (20.8–28.5) at 12 months and 20.6 at two years. The MOxFQ Summary Index improved from 53.6 (51.2–56.0) to 23.0 at six months, 29.9 (25.8–34.0) at 12 months and 22.7 (18.1–27.2) at two years (Table 9.1, Figure 9.1). The 12-month means are slightly higher than those at six months and two years. Because fewer patients responded at six months than at 12 months (90 versus 150 for VAS), this most likely reflects differences in who responded rather than a true deterioration, and the smoothed trajectories show a steady improvement to around 18 months. The improvement is consistent with 2025, when VAS Pain improved from 41.9 to 20.2 at 12 months with no significant difference between arthroscopic and open surgery.

Table 9.1 - PROMS scores for Ankle Ligament Reconstruction

	VAS Pain				MOxFQ Summary Index			
	Baseline	**6 Month**	**12 Month**	**2 Year**	**Baseline**	**6 Month**	**12 Month**	**2 Year**
Number	282	90	150	123	266	86	135	114
Mean	42.7	21.1	24.7	20.6	53.6	23.0	29.9	22.7
Std. Deviation	23.0	23.3	24.0	24.9	20.0	22.7	24.2	24.6
Lower 95% CL	40.0	16.3	20.8	16.2	51.2	18.2	25.8	18.1
Upper 95% CL	45.4	25.9	28.5	25.0	56.0	27.9	34.0	27.2

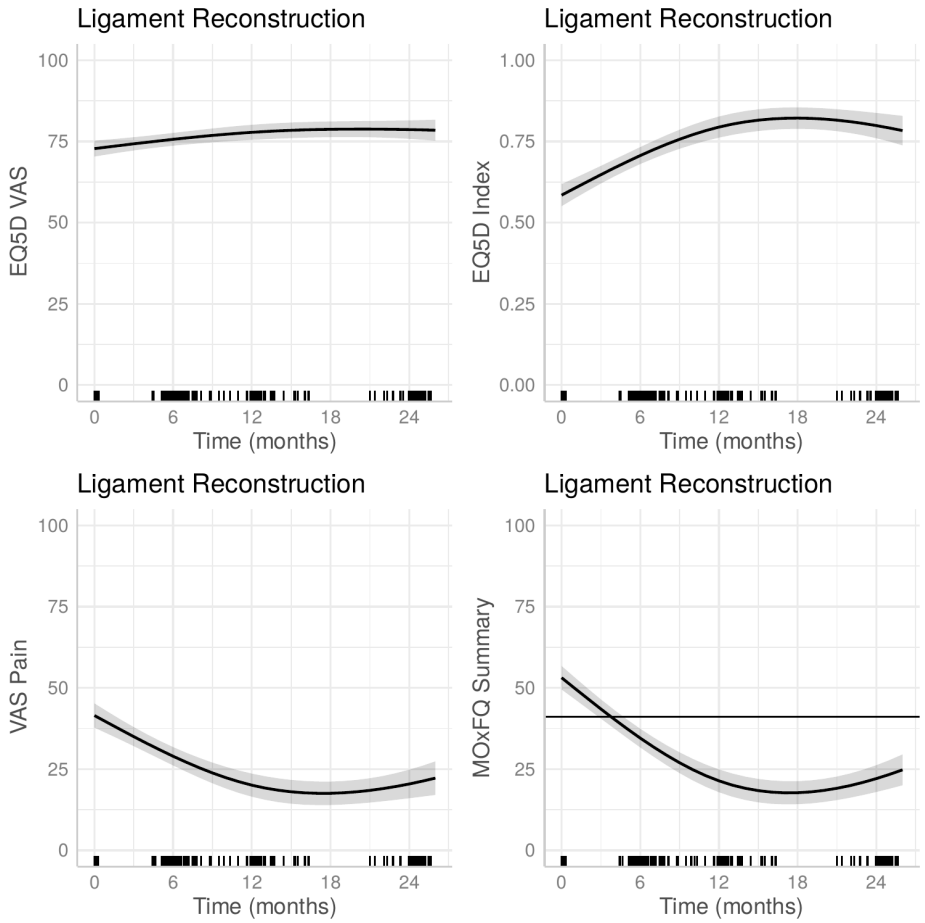


Figure 9.1a - EQ-5D VAS, EQ-5D Index, VAS Pain and MOxFQ Summary over time for Ankle Ligament Reconstruction (smoothed mean with 95% confidence band). The horizontal line on the MOxFQ Summary panel marks the MCID (12.5 points) relative to baseline.

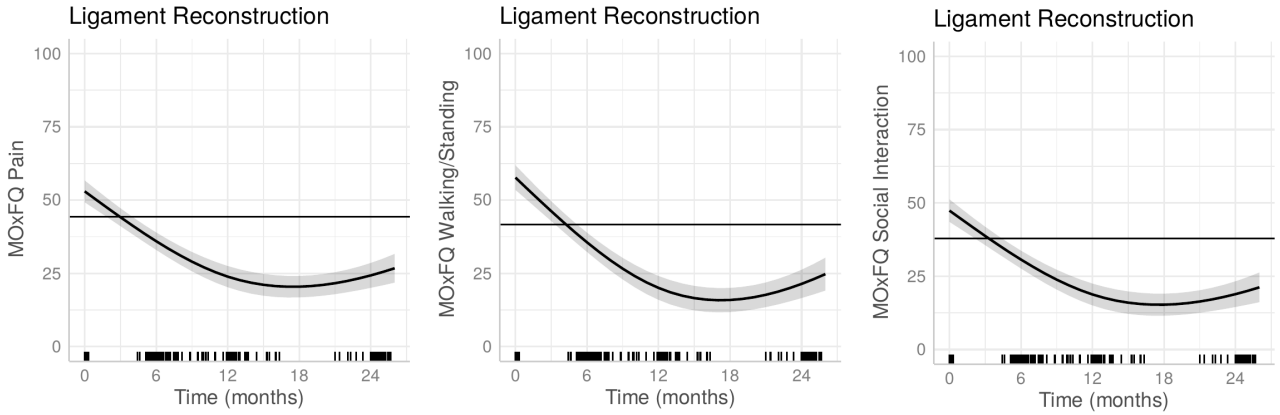


Figure 9.1b - MOxFQ Pain, Walking/Standing and Social Interaction over time for Ankle Ligament Reconstruction (smoothed mean with 95% confidence band). The horizontal line on each panel marks the MIC relative to baseline.

Table 9.2 - Characteristics of Ankle Ligament Reconstruction

Characteristic	Level	Overall
n		320
Age, mean (SD) [range]		39.8 (13.2) [11–71]
BMI, mean (SD) [range]		27.8 (6.3) [14.5–56.9]
Sex, n (%)	Female	171 (53.4)
	Male	149 (46.6)
Smoking, n (%)	Non-smoker	222 (73.3)
	Ex-smoker	35 (11.6)
	Smoker	28 (9.2)
	Vapes / nicotine replacement	18 (6.0)
Diagnosis, n (%)	Chronic ankle instability	247 (78.7)
	Acute ankle instability	15 (4.8)
	Other	52 (16.6)
Procedure, n (%)	Modified Broström reconstruction	184 (57.5)
	Lateral ankle ligament reconstruction	81 (25.3)
	Broström reconstruction	55 (17.2)
Approach, n (%)	Arthroscopic	171 (53.4)
	Open	128 (40.0)
	Combined open and arthroscopic	12 (3.8)
	Other	9 (2.7)

Section 10: Achilles Tendinopathy

The Achilles tendinopathy pathway allows PROM collection for non-operative and operative management of both insertional and non-insertional disease. The standard PROMs are EQ-5D and VISA-A, recorded at 6 months, 1 year and 2 years for operative procedures and at 6 and 12 weeks for non-operative interventions.

The merged dataset now contains **525** cases (354 in 2025): 115 from the dedicated pathway and 410 from the general pathway. 59.2% were female, the mean age was 55.0 years and the mean BMI 30.8, the highest of any cohort in the registry. Insertional disease accounted for 66.1% and non-insertional for 30.2%. Surgical details were available for 84.2%.

Insertional debridement and reattachment were the commonest operation (30.0%), followed by tendon decompression or debridement (17.6%), Zadek calcaneal osteotomy (14.1%) and resection of Haglund's deformity with bursectomy (14.1%). Gastrocnemius procedures (proximal medial gastrocnemius release, gastrocnemius slide or Baumann's procedure) accounted for 6.2%, and tendon transfer or reconstruction for 5.3%. Within the general pathway, 69.1% of procedures were open, 16.7% arthroscopic and 12.3% percutaneous.

Few VISA-A scores have been recorded, so this year outcomes are reported using VAS Pain and the MOxFQ, which were collected for a larger number of patients across the merged dataset. This is the first year that outcomes for Achilles tendinopathy have been reported. VAS Pain improved from 56.6 (95% CI 54.0–59.3, n=255) to 35.3 at six months and 24.5 (20.3–28.7, n=123) at 12 months and was 25.3 at two years (n=75). The MOxFQ Summary Index improved from 59.5 (56.3–62.7, n=139) to 35.8 at six months and 29.1 (24.3–33.9, n=89) at 12 months, an improvement of 30.4 points, and was 32.3 at two years (n=70) (Table 10.1, Figure 10.1).

Table 10.1 - PROMS scores for Achilles Tendinopathy (merged dataset)

	VAS Pain				MOxFQ Summary Index			
	Baseline	**6 Month**	**12 Month**	**2 Year**	**Baseline**	**6 Month**	**12 Month**	**2 Year**
Number	255	220	123	75	139	130	89	70
Mean	56.6	35.3	24.5	25.3	59.5	35.8	29.1	32.3
Std. Deviation	21.7	26.5	23.6	26.6	19.5	23.0	23.1	28.8
Lower 95% CL	54.0	31.8	20.3	19.2	56.3	31.8	24.3	25.6
Upper 95% CL	59.3	38.7	28.7	31.3	62.7	39.7	33.9	39.1

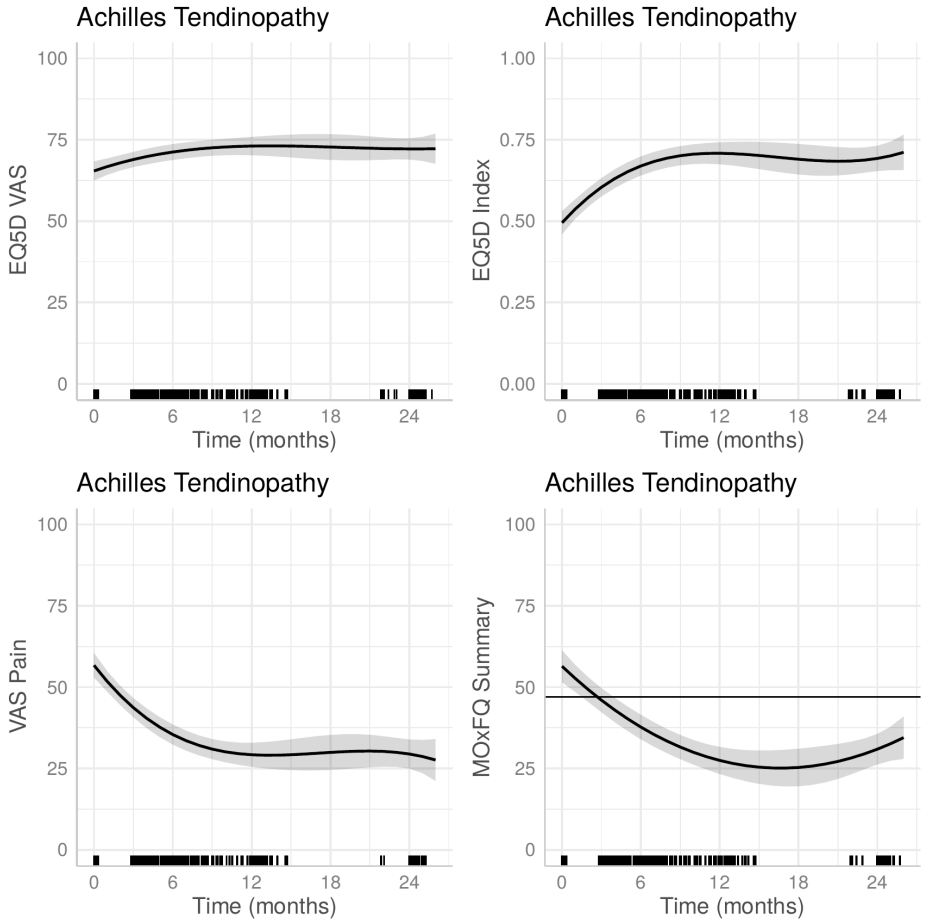


Figure 10.1a - EQ-5D VAS, EQ-5D Index, VAS Pain and MOxFQ Summary over time for Achilles Tendinopathy (smoothed mean with 95% confidence band). The horizontal line on the MOxFQ Summary panel marks the MCID (12.5 points) relative to baseline.

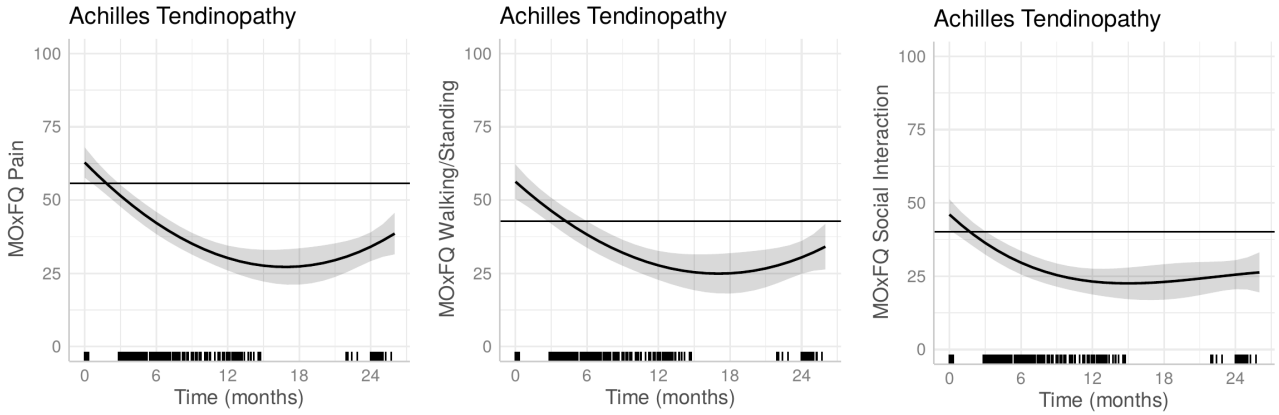


Figure 10.1b - MOxFQ Pain, Walking/Standing and Social Interaction over time for Achilles Tendinopathy (smoothed mean with 95% confidence band). The horizontal line on each panel marks the MIC relative to baseline.

Table 10.2 - Characteristics of Achilles Tendinopathy (merged dataset)

Characteristic	Level	Overall
n (merged)	Tendinopathy pathway / general pathway	525 (115 / 410)
Age, mean (SD) [range]		55.0 (10.1) [21–80]
BMI, mean (SD) [range]		30.76 (6.34) [14.7–55.3]
Sex, n (%)	Female	311 (59.2)
	Male	214 (40.8)
Smoking, n (%)	Non-smoker	310 (72.3)
	Ex-smoker	74 (17.2)
	Smoker	32 (7.5)
	Vapes / nicotine replacement	13 (3.0)
Diagnosis, n (%)	Insertional tendinopathy	341 (66.1)

Characteristic	Level	Overall
	Non-insertional tendinopathy	156 (30.2)
	Haglund's deformity / other	19 (3.7)
First procedure, n (%)	Insertional debridement and reattachment	68 (30.0)
	Tendo Achilles decompression / debridement	40 (17.6)
	Zadek calcaneal osteotomy	32 (14.1)
	Haglund's resection and bursectomy	32 (14.1)
	Haglund's resection	7 (3.1)
	Gastrocnemius release / slide / Baumann's	14 (6.2)
	Tendon transfer / reconstruction	12 (5.3)
	Other	22 (9.7)

Section 11: Contralateral Leg

On the foot and ankle general pathway, patients can input MOxFQ scores for the contralateral limb. This is referred to as "the good leg", however there is no documenting of patients who have bilateral foot and ankle pathology or other reasons for pain in the limb not undergoing surgery. Nevertheless, these data allow function in the contralateral limb to be tracked following surgery, and they now represent a very large reference group (8,623 baseline responses).

The MOxFQ Summary Index for the contralateral limb was near-normal at baseline (14.1, 95% CI 13.7–14.5) and changed little over follow-up (12.3 at six months, 11.2 at 12 months and 12.6 at two years) (Table 11.1, Figure 11.1). The Pain, Walking/Standing and Social Interaction domains follow the same flat pattern, with Social Interaction the highest of the three, as in 2025. The small post-operative improvement of around 2–3 points is far below any clinically important threshold and is consistent with the 2025 finding of no meaningful change. The contralateral score provides a useful patient-specific benchmark: operated-limb scores at 12 months (for example 23.0 after hallux valgus correction and 22.6 after cheilectomy) remain around 10 points above the contralateral limb, indicating residual, though modest, symptoms.

Table 11.1 - MOxFQ Summary Index for the contralateral leg

Variable	Baseline	6 Months	12 Months	2 Years
n	8,623	4,537	2,206	1,852
Mean	14.1	12.3	11.2	12.6
SD	19.2	18.2	17.6	18.6
Lower 95% CL	13.7	11.8	10.4	11.7
Upper 95% CL	14.5	12.8	11.9	13.4

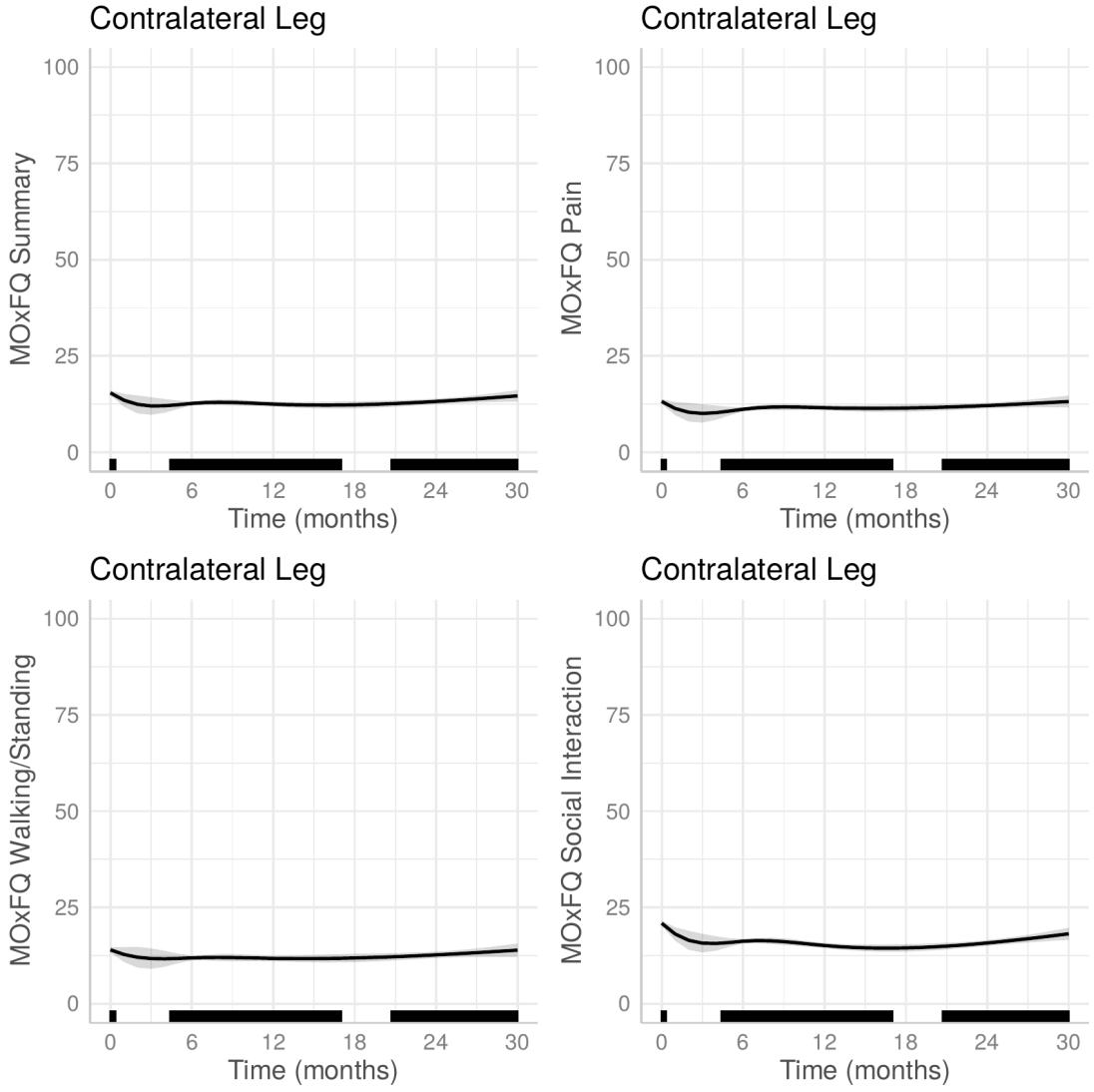


Figure 11.1 - MOxFQ Summary, Pain, Walking/Standing and Social Interaction over time for the contralateral leg

Summary

The BOFAS Registry has continued to grow. The general Foot and Ankle pathway now holds 23,364 pathways, and every condition-specific cohort reported here has increased since 2025 (Figure S.1): the merged 1st MTPJ fusion dataset has risen by 27% to 2,030 cases, 1,703 hallux valgus corrections are now recorded within the general pathway, Achilles rupture cases have almost doubled, and ankle ligament reconstructions have increased by 148%. Across every cohort with PROM data in this report, patients reported large improvements in pain and foot-specific function, which were largely maintained at two years where follow-up was available. Two-year numbers remain small, and 1st MTPJ fusion and double/triple arthrodesis (the latter based on fewer than the minimum of 50 patients at two years) show a slight rise in symptoms beyond 18 months that will be monitored as data mature. Nevertheless, participation remains voluntary, only a minority of members enter data, and PROM completion at 12 months remains below 30% in most pathways.

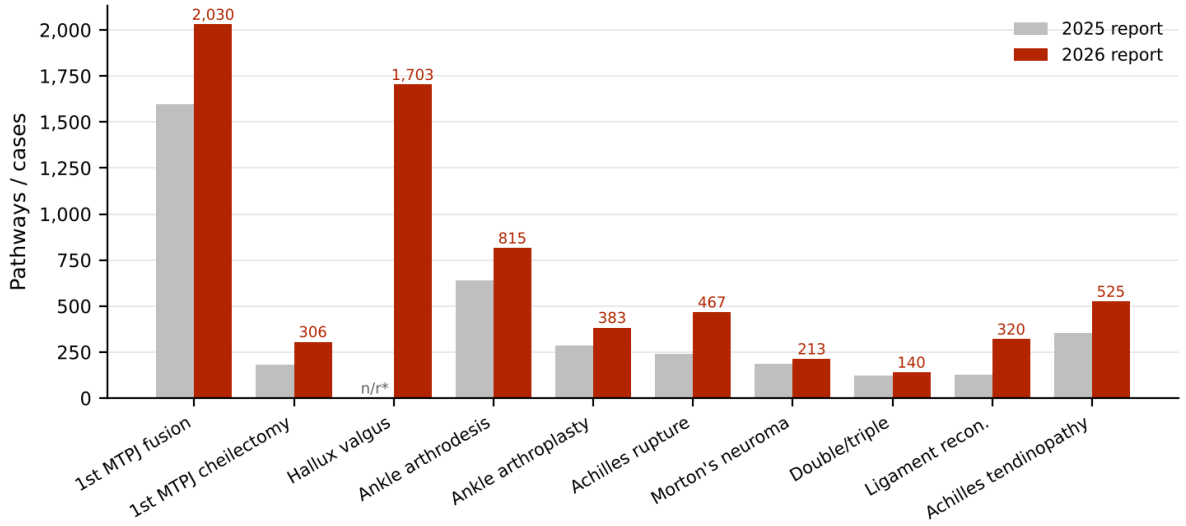


*Figure S.1 - Registry cases by cohort, 2025 and 2026 reports. *n/r: the 2025 report did not give a total number of hallux valgus procedures (639 patients had baseline MOxFQ data, compared with 854 in 2026).*

2025 figures are those quoted in the 2025 report; some 2026 totals are merged datasets and are not strictly like-for-like.

From outcomes to value

The most important development of the past year has been the use of registry data to measure value in the same terms used by NICE and NHS commissioners: the cost per quality-adjusted life year (QALY) gained. This has become urgent. Since 2021 an increasing number of Integrated Care Boards have classified foot and ankle procedures as being of limited clinical value, and in September 2025 the Hampshire and Isle of Wight ICB withdrew routine funding for surgery for hallux valgus and hallux rigidus, citing population-level value (Lewis et al, 2026). Following challenge using BOFAS registry evidence, criteria-based access to 1st MTPJ fusion has since been restored, although hallux valgus surgery remains not normally funded at the time of writing. Such decisions place a clear obligation on our specialty to show, with national data, that our operations are not only clinically beneficial, but also deliver value.

Two cost-utility analyses built on BOFAS Registry EQ-5D-5L data have now been published:

- **1st MTPJ fusion** (Wyatt et al, 2026). Among 1,199 fusion pathways, 202 patients had complete datasets. EQ-5D-5L improved from 0.53 to 0.77 at one year, exceeding the MCID by six months. A 20-year Markov model gave a discounted lifetime QALY gain of 3.33 and an ICER of £1,411 per QALY. Even in the combined worst-case scenario the ICER was only £1,754 per QALY, and in the low-cost scenario fusion became cost-saving by year 18.
- **Hallux valgus correction** (Lewis et al, 2026). Among 1,111 pathways, 306 patients had complete datasets (129 open, 177 MIS). EQ-5D-5L improved from 0.69 to 0.84 after open and 0.69 to 0.82 after MIS correction, both exceeding the MCID. The 40-year base-case ICER was £8,737 per QALY for open and £11,969 per QALY for MIS correction, and incremental sensitivity analyses ranged from cost-saving to £3,219 per QALY.

Both procedures sit far below the NICE willingness-to-pay threshold of £20,000–£30,000 per QALY and compare favourably with published estimates for hip and knee arthroplasty (Wyatt et al, 2026; Lewis et al, 2026). They build on the first national evaluation of clinical outcomes after 1st MTPJ fusion from the registry, which showed significant improvements in every MOxFQ domain and in EQ-5D at six and twelve months (Jadhakhan et al, 2025). These findings have been summarised for members and commissioners in the Society's case for protecting value in NHS foot and ankle surgery (Mason et al, 2025): restricting access to procedures

with this level of demonstrated value is not supported by the health-economic evidence.

Why the registry protects our specialty

No other dataset can make this case. Commissioning decisions are increasingly made on population-level value, and the BOFAS Registry is the only national source of prospective, procedure-specific PROMs for foot and ankle surgery in the UK. Without it, our procedures would be judged on the absence of evidence. The registry has also been written into national guidance: NICE guidance on minimally invasive hallux valgus surgery (HTG723) and 1st MTPJ replacement (HTG87) calls for audit and clinical governance arrangements that the registry satisfies, and patient-reported outcomes are central to the UK-wide Medical Device Information System established under the Medicines and Medical Devices Act 2021 following the Cumberlege review. It is likely that more foot and ankle procedures will be required to collect PROMs through the registry in the future.

The strength of this evidence depends entirely on completeness. The two economic analyses could only use the 16.9% and 27.5% of pathways with complete baseline and 12-month EQ-5D-5L data, and both identified incomplete follow-up as their main limitation. We therefore ask every member to:

- Register every patient for the procedures covered by the registry, in both NHS and independent practice;
- Record EQ-5D-5L alongside the MOxFQ (or pathway-specific score) at baseline, 12 months and two years, as EQ-5D is the measure from which QALYs are derived;
- Ensure an email address or mobile number is recorded so that automated follow-up can be sent; and
- Use the personal revalidation report at appraisal to review their own outcomes against the national average.

Further cost-utility work is now possible for ankle arthrodesis, total ankle replacement, cheilectomy and ankle ligament reconstruction as these datasets mature, together with methodological work linking the MOxFQ to EQ-5D utility. The trauma pathways, including the adult ankle fracture pathway, and revision ankle arthroplasty remain too immature to report, and we expect to include them in future reports.

BOFAS Registry Lead - Lyndon Mason

"This has been the year in which the BOFAS Registry moved from describing our outcomes to defending them. When commissioners questioned the value of bunion and big toe arthritis surgery, it was registry data, entered by our members, that allowed us to show these operations cost less than £12,000 per QALY, and in the case of 1st MTPJ fusion less than £1,500. That evidence only exists because surgeons took the time to enrol their patients. The more complete our data, the stronger our voice: I would ask every member to make registry entry part of their routine practice, so that we can continue to protect access to high-value foot and ankle surgery for our patients."



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Appendix A: Foot and Ankle General Pathway

Summary characteristics of all pathways held on the Foot and Ankle General Pathway at the time of data extraction. Diagnosis and procedure categories with fewer than 40 cases are grouped as 'Other'; percentages are of cases with the field recorded.

Characteristic	Level	Overall
n		23,364
Age, mean (SD)		53.7 (16.3)
BMI, mean (SD)		28.0 (7.1)
Sex, n (%)	Female	15,093 (64.6)
	Male	8,266 (35.4)
	Other / unknown	5 (0.0)
Diagnosis, n (%)	Hallux valgus (adult)	1,624 (21.6)
	Plantar fasciitis	462 (6.2)
	Hallux rigidus	400 (5.3)
	Primary OA (joint other than ankle or 1st MTPJ)	397 (5.3)
	Chronic ankle instability	388 (5.2)
	Acquired toe deformity	287 (3.8)
	Insertional Achilles tendinopathy	282 (3.8)
	Osteochondral defect	267 (3.6)
	Morton's neuroma	213 (2.8)
	Primary OA of the 1st MTPJ	165 (2.2)
	Non-insertional Achilles tendinopathy	128 (1.7)
	Primary OA of the ankle	123 (1.6)
	Hallux valgus (adolescent)	120 (1.6)
	Acquired flat foot	101 (1.3)
	All other diagnoses	—
Non-operative intervention, n (%)	ESWT	578 (95.5)
	Other	27 (4.5)
Procedure, n (%)	MIS chevron and Akin osteotomy	478 (8.3)
	Scarf and Akin osteotomy	369 (6.4)
	1st MTPJ cheilectomy	281 (4.9)
	Ankle debridement and cheilectomy	212 (3.7)
	Modified Broström reconstruction	184 (3.2)
	Resection of Morton's neuroma	149 (2.6)
	Scarf osteotomy	130 (2.3)
	Tarsometatarsal arthrodesis	113 (2.0)
	Chevron and Akin osteotomy	112 (1.9)
	Subtalar arthrodesis	97 (1.7)
	All other procedures	—
Approach, n (%)	Open	3,684 (64.1)
	Percutaneous	967 (16.8)
	Arthroscopic	895 (15.6)
	Other	200 (3.5)

Registry supported by
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ISSN 2632-9352