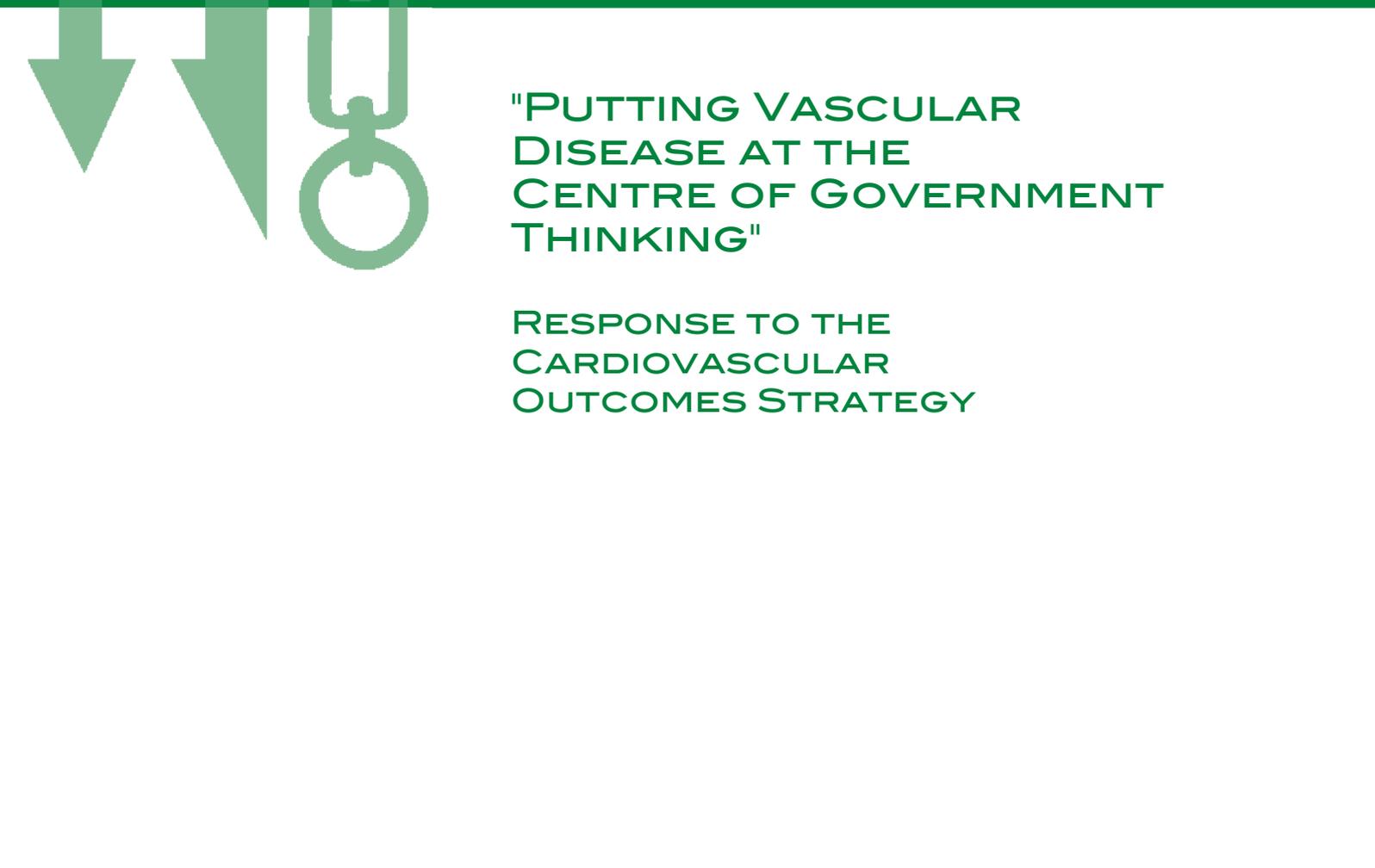




# THE ALL PARTY PARLIAMENTARY GROUP ON VASCULAR DISEASE



"PUTTING VASCULAR  
DISEASE AT THE  
CENTRE OF GOVERNMENT  
THINKING"

RESPONSE TO THE  
CARDIOVASCULAR  
OUTCOMES STRATEGY

# CONTENTS

- 3 Foreword - Neil Carmichael MP
- 4 Introduction
- 5 Prevention
- 8 Diagnosis
- 10 Treatment
- 13 Summary of Recommendations

## WITH THANKS TO:

CHRIS WINDLE  
CELINE OTTER

## WITH THANKS FOR INFORMATION AND WRITTEN EVIDENCE FROM:

HEART UK  
THE KIDNEY ALLIANCE  
THE CIRCULATION FOUNDATION  
BRITISH HEART FOUNDATION  
DIABETES UK  
THE CARDIO AND VASCULAR COALITION (CVC)  
THE BRITISH SOCIETY OF INTERVENTIONAL RADIOLOGY  
BRITISH ASSOCIATION FOR NURSING IN CARDIOVASCULAR CARE  
THE VASCULAR SOCIETY OF GREAT BRITAIN AND IRELAND  
EAST MIDLANDS CARDIOVASCULAR NETWORK  
THE NHS AAA SCREENING PROGRAMME  
CARDIAC & STROKE NETWORKS IN LANCASHIRE & CUMBRIA  
THE KINGS FUND  
MEDTRONIC LTD  
COOK MEDICAL LTD  
DR ROGER W BURY - PAST PRESIDENT OF THE BRITISH SOCIETY OF  
CARDIOVASCULAR IMAGING  
PROFESSOR MICHAEL EDMONDS, KINGS COLLEGE HOSPITAL  
MR HISHAM RASHID, KINGS COLLEGE HOSPITAL  
MR JAYARAMA MOHAN, UNITED LINCOLNSHIRE HOSPITALS NHS TRUST  
DR RAMAN UBEROI, JOHN RADCLIFFE HOSPITAL

IF YOU REQUIRE COPIES OF THE WRITTEN AND ORAL EVIDENCE SUBMITTED AS PART OF THIS  
INQUIRY, PLEASE CONTACT THE SECRETARIAT OF THE APPG ON VASCULAR DISEASE AT  
VASCULARAPPG@PBPOLITICALCONSULTING.COM



# FOREWORD

One of the major achievements of the NHS over the past decade has been improvements in patient outcomes from cardiovascular disease. However, there is a need to update and build on that work. That is why the Department of Health Cardiovascular Disease Outcomes Strategy is so very welcome.

Vascular disease should play an important part of this strategy. It is the most common precursor to coronary heart disease and heart attack, and causes stroke by affecting the arteries in your neck. This is why the All Party Parliamentary Group (APPG) on Vascular Disease wanted to inform the development of this new strategy with specific references to forms of vascular disease.

We have consulted with a range of clinicians, patient groups and other health care professionals to get expert advice from those who live with and treat vascular disease, and those that manage services. I would like to thank all of those who have contributed through submitting written evidence, or who came along to listen or give evidence at our parliamentary meeting. I have personally learned a great deal from reading through the evidence and listening to contributors at the meeting. I am now even more determined to do everything I can to push for improved vascular services and outcomes.

We hope that the Department of Health find this report useful, and incorporate our recommendations into the Cardiovascular Disease Outcomes Strategy.

*Neil Carmichael .*

**Neil Carmichael MP**  
Chair of the APPG on Vascular Disease



# 1. INTRODUCTION

- 1.1 Vascular disease represents a range of conditions that affect the body's blood vessels, accounting for 40% of deaths in the UK<sup>i</sup>. However, the general public know little about some of the main manifestations of the disease. Some examples include the form that affects the abdominal aorta, leading to abdominal aortic aneurysms (AAA), or the arteries of the lower limbs, leading to peripheral arterial disease (PAD), and in some cases amputation.
- 1.2 The disease can also affect the kidneys through renal arterial disease (RAD) and cause stroke through carotid arterial disease (CAD). More common, but not life threatening, are conditions such as varicose veins.
- 1.3 During the past decade great strides have been made in combating cardiovascular diseases (CVD) through the National Service Frameworks for Coronary Heart Disease, Diabetes and Kidney Disease and through the National Stroke Strategy. The NHS AAA Screening Programme also recognised the need to tackle this condition, which is the third biggest killer among men aged 65 or over.<sup>ii</sup>
- 1.4 However plenty more needs to be done, and there are a number of new challenges which need to be addressed:
  - It is estimated that about four in 100 men over the age of 65 will develop an AAA.<sup>iii</sup>
  - PAD affects an estimated 9% of the population, which causes painful legs when walking, ulceration and amputation.<sup>iv</sup>
  - More than half of all strokes occur because of CAD but it is a condition which is widely under-diagnosed.
  - More people are developing risk factors for vascular disease including hypertension, obesity and diabetes. Since 1996 the number of people diagnosed with diabetes has increased from 1.4 million to 2.9 million.<sup>v</sup>
  - Public awareness of many vascular diseases is worryingly low.
- 1.5 This report seeks to address some of these challenges and present solutions to improve patient outcomes. It will focus on prevention through public health initiatives and the treatment of risk factors, how to improve diagnosis and finally, models of treatment.



## 2. PREVENTION

### A silent killer

- 2.1 Vascular diseases often exhibit no symptoms but progress silently. Many patients do not realise they have the disease and do little to change their lifestyle which is likely to be a contributory factor.
- 2.2 This challenge has been identified and was the primary reason behind the very welcome development of the NHS Abdominal Aortic Aneurysm Screening Programme. Nearly 7,000 people, most of them men, die suddenly and without symptoms from AAA.<sup>vi</sup> With plans to be fully rolled out by 2013, the aim of the programme is to reduce deaths through ruptured aneurysm by 50%. The programme has been shown to save lives and in some areas has seen uptake beyond expectation. This has shown the value in screening as a form of prevention.

“Men who have an abdominal aortic aneurysm will not generally notice any symptoms which is why screening is so important. The test is simple and usually takes less than 10 minutes. Early detection through screening enables us to offer monitoring or treatment, reducing the number of deaths.”

- Jonathon Earnshaw, National Programme Director, NHS AAA Screening Programme <sup>vii</sup>

- 2.3 The success of the NHS AAA Screening Programme to date in saving lives is in stark contrast to the proportion of people eligible for the NHS Health checks that have been offered them, as well as the number that actually took up the offer. According to the Cardiovascular Coalition, in 2011-12, 14% of those eligible were offered a check.<sup>viii</sup>
- 2.4 The transfer of public health to local authorities presents both a challenge and an opportunity. Certain local authorities have shown to be innovative with the provision of local services – such as advice centres in libraries and supermarkets. When health check

responsibilities are transferred in 2013, local authorities may be as innovative when taking the service out to communities. This is particularly important when considering communities most at risk of presenting with vascular diseases.

### Making a noise

- 2.5 Most healthcare systems focus their resources towards treatment. However, there is a clear need for a greater commitment to prevention through increased public awareness of the disease and its manifestations.
- 2.6 Initiatives such as Vascular Disease Awareness Week (undertaken by the Circulation Foundation) are already doing some great work publicising the condition. During last year's event, for example, 5.6 million people were given the opportunity to read about vascular disease.<sup>ix</sup> Publicity campaigns have proven to be very effective in educating the public – shown through the successful F.A.S.T campaign on stroke.

#### Recommendation 1:

**Every effort should be made to encourage maximum uptake of the NHS AAA Screening Programme including publicising the benefits nationally and locally.**

#### Recommendation 2:

**We agree with CVC recommendations that Directors of Public Health should report on the uptake of health checks and efforts to reduce health inequalities in their annual report. Greater consideration should be given to include vascular care indicators in the Atlas of Variation. This should all be overseen by the National Commissioning Board.**

Recommendation 3:

**There should be a national (NHS) publicity campaign to highlight the prevalence of vascular disease and the factors that can increase the risk of the disease and persuade people to make lifestyle choices that will reduce incidence. Patient tools could be published in Joint British Societies guidelines.**

### Care Plan for Patients

- 2.7 The early stages of vascular disease share the principal management strategies utilised in other cardiovascular and kidney disease preventative and treatment programmes – namely lifestyle management, blood pressure control and management of other risk factors. Some contributors state that traditional education in this area has often failed because of issuing separate sets of recommendations for each therapy area. For example, eating a healthy diet protects your kidneys and can reduce your chances of contracting diabetes and can help keep your blood pressure down.<sup>x</sup>

Recommendation 4:

**Every patient presenting with early stage vascular disease should be given a Vascular Care Plan that empower patients to understand their condition, unifies preventative and basic treatment strategies across all vascular groups, simplifies self-management models such as blood pressure monitoring and provides the right information that enable patients to take part in managing their condition.**

### Treatment of risk factors

- 2.8 Certain health and lifestyle factors increase the risk of a patient developing vascular disease or exacerbating an existing condition, and should be addressed as early as possible. These include diabetes, hypertension, high cholesterol, smoking, obesity and diet. Both lifestyle change and early clinical intervention have roles in addressing these risk factors.
- 2.9 Diabetics are twice as likely to develop peripheral arterial disease (PAD) and it is one of the most common causes of amputation in England. In 2007/2008 10,763 amputations were associated with diabetes or arterial disease<sup>xi</sup> and currently 10% of patients who develop a PAD-related foot ulcer will have their foot or leg amputated. In addition if left untreated 75% of people suffering from PAD will die of a sudden heart attack or stroke.<sup>xii</sup>
- 2.10 It is crucial that diabetes is diagnosed early and treated to prevent patients developing vascular disease. As well as improving patient outcomes it will also reduce costs in the long term for the NHS to treat these conditions.<sup>xiii</sup>
- 2.11 Consideration should also be given to disseminating information among certain groups of people. For example Type 2 diabetes is six times more common in people from a South Asian background, and three times more common among those with an African or Afro-Caribbean background, than a White British background.<sup>xiv</sup>
- 2.12 Another way that we can limit the impact of diabetes is through better glycaemic control. In some patients this can be managed by changes to diet and lifestyle, or through the injection of insulin. Some patients may benefit from the use of insulin pumps. These are small computerised devices that deliver a continuous level of insulin throughout the day providing the patient with a high degree of control over blood sugar levels. This reduces the likelihood of secondary disease, such as PAD, developing. Despite the proven benefits of insulin pumps, the average rate of provision for people with type 1 diabetes is 3.7% compared to the 12% benchmark recommended by NICE.<sup>xv</sup>



**“Insulin pump therapy offers significant benefit over multiple daily injections (MDI) for some in terms of diabetes management and quality of life.”**

- Diabetes UK,  
Insulin Pump Position Statement <sup>xvi</sup>

- 2.13 High blood pressure is another risk factor for developing vascular disease. According to the British Heart Foundation as many as 5 million people in the UK are undiagnosed.<sup>xvii</sup> Those who are diagnosed, as there are often no symptoms associated with the condition it is vital that they are regularly tested.
- 2.14 Once a patient has been diagnosed with hypertension it is crucial they have their blood pressure controlled. Lifestyle change and pharmacological management are the standard treatments, and a new interventional technology called renal denervation could be considered for patients where standard treatments have failed.<sup>xviii</sup>

## Cholesterol

- 2.15 High cholesterol caused by diet and lifestyle factors, or by familial hypercholesterolemia (FH), if overlooked and untreated can also lead to vascular disease and premature death.<sup>xix</sup> The first step to reducing these deaths is raising public awareness about the dangers of high cholesterol so that problems can be quickly diagnosed and treated.

**“HEART UK’s vision is for the majority of adults in the UK to know their cholesterol levels and understand how cholesterol impacts heart disease.”**

- Jules Payne, Chief Executive, HEART UK <sup>xx</sup>

### Recommendation 5:

**As well as awareness campaigns, early intervention (lifestyle change and clinical intervention) to mitigate against risk factors should be a key part of the prevention drive as part of the new Government strategy.**

### Recommendation 6:

**Best practice on the prevention and management of vascular disease should be shared across primary care, clinical commissioning groups and local authorities.**

### Recommendation 7:

**The Strategy should consider reviewing Quality and Outcomes Framework (QOF) indicators for secondary prevention of coronary heart disease (CHD) to incorporate uptake and quality of cardiac rehabilitation and ensure that all existing targets reflect best practice guidelines.**

## 3. DIAGNOSIS

### GP awareness

- 3.1 A greater understanding of vascular disease in primary care is crucial if we are to improve patient outcomes. King's College Hospital's Professor of Diabetic Foot Medicine Mike Edmonds, terms the GP as often the first line of defence against "diabetic foot attack".<sup>xxi</sup> The GP must assess a patient's symptoms and react quickly if he or she suspects peripheral arterial disease (PAD). This is also the case with other forms of vascular and cardiovascular diseases.

**"We have to induce a mind-set of urgency... The diabetic patient has a foot attack but has it silently. They get no pain because of the neuropathy, so nobody is really too concerned."**

- Mike Edmonds, Professor of Diabetic Foot Medicine, King's College <sup>xxii</sup>

- 3.2 In some cases the condition can deteriorate rapidly and patients should be referred to specialist clinics quickly. Many secondary clinicians have reported that they are often seeing patients too late when little can be done to save legs. This requires GPs to improve their understanding of the symptoms and the services available, especially considering that less than half of those patients who require amputation in England and Wales have benefitted from any attempt to treat poor circulation to their leg.<sup>xxiii</sup>
- 3.3 For example GPs often respond to intermittent claudication - characterised by leg pain and weakness brought on by walking followed by the disappearance of symptoms after rest - by offering lifestyle advice without following up to check whether it has had a positive impact on the patient. A range of treatment options exist for those suffering intermittent claudication and patients should be referred to a vascular multidisciplinary team quickly to assess which is the most suitable, before the condition requires surgery.
- 3.4 It is crucial that education and training are provided

to GPs and other healthcare professionals to improve their knowledge of vascular disease and their risk factors. This will become increasingly important as GPs will lead the Clinical Commissioning Groups responsible for commissioning services for people living with vascular conditions.

### Recommendation 8:

**The strategy should consider how primary care professionals could be better educated or trained to support people who present with vascular conditions and associated risk factors.**

### Widening the scope of AAA screening

- 3.5 Currently the NHS Abdominal Aortic Aneurysm (AAA) Screening Programme targets men in the year they turn 65 by inviting them to attend a screening, since the majority of ruptured abdominal aortic aneurysms occur in males over this age.<sup>xxiv</sup> In the year 2010-11 the number of aneurysms detected by the Early Implementer and Phase One programmes was around half the anticipated number.<sup>xxv</sup>
- 3.6 Males aged 65 were targeted based on several decades worth of data. However, the results of the initial screenings suggest the average 65 year-old male aorta is now healthier than at the time this data was collected.
- 3.7 Some have argued that the programme should widen its remit to include invitations to men in the 65-70 age bracket who have missed out on being screened. Currently anybody who was 65 before the screening programme began must self-refer if they would like to be screened. This requires a high level of awareness among a high risk demographic.
- 3.8 The EPIC (2008) study screened 395 patients aged 60+ who were about to undergo a coronary artery bypass graft (as they suffered from acute coronary artery disease), and found a 10.1% prevalence of AAA.<sup>xxvi</sup> Some contributors suggest that the NHS AAA Screening Programme should be asked to look



at the viability of screening patients (other than 65 year olds) with risk factors such as hypertension, diabetes, hypercholesterolemia, smoking or a family history of vascular and cardiovascular disease; or who are undergoing procedures to treat related conditions.

Recommendation 9:

**The strategy should include a plan to consider the benefits of the NHS inviting patients for AAA screening at 70 and 75, and whether individuals should be targeted by risk factors such as diabetes and a history of smoking.**

### **Wider Vascular Screening – Ankle brachial pressure index**

- 3.9 It is very positive that testing for PAD now forms part of the QOF. Diabetic foot ulcer treatment and amputations account for £1 in every £150 spent by the NHS<sup>xxvii</sup>, so addressing this issue is good for the patient and the NHS budget. Moreover, patients with PAD are much more likely to have a stroke or heart attack. However, some clinicians still have concerns about capacity and availability of diagnostic tests.<sup>xxviii</sup>
- 3.10 Ankle brachial pressure index (ABPI) tests can quickly identify peripheral arterial disease (PAD) and help tackle the problem before a patient develops foot ulcers and potentially requires amputation.
- 3.11 This simple and cost effective test could be part of a national diabetes implementation plan overseen by the National Commissioning Board and clinical commissioning groups. This would monitor diabetes care as part of national framework to ensure all patients receive the same level of care.

Recommendation 10:

**The strategy should focus on the primary care diagnosis of PAD. Indicators in Quality Outcomes Framework (QOF) should also require GPs to advise patients about their foot risk level, carry out the ABPI test and refer to specialist care when appropriate.**

Recommendation 11:

**We support calls for a national diabetes implementation plan to deliver the NICE quality standard and the National Service Framework outcomes in order to save costs and improve lives.**

## 4. TREATMENT

- 4.1 Many conditions relating to vascular disease are treatable. But inaction is deadly. Timely treatment of PAD can save legs, AAA intervention can prevent rupture, and Carotid Artery Disease (CAD) intervention can prevent stroke.
- 4.2 AAA patients are usually referred for either open surgical repair, most often undertaken as an elective procedure for growing or large symptomatic or ruptured aneurysms, or less invasive endovascular repair (EVAR). EVAR is becoming the treatment of choice in large vascular units. This modern technique causes fewer peri-operative deaths and patients spend less time in intensive care while enjoying a faster return to normal activity<sup>xxxix</sup>.

**“Large aneurysms carry a high risk of rupture and ruptured aneurysms are surgical emergencies that are usually fatal. In contrast, in high quality vascular services, the post-operative mortality rate for planned surgery to repair large aneurysms is around 3-8%.”**

- The NHS AAA Screening Programme Annual Report<sup>xxxix</sup>

- 4.3 For PAD patients – following lifestyle changes and pharmacological treatment – as the condition rapidly deteriorates, early revascularisation procedures are crucial to avoid major amputation and the associated morbidity and mortality. In many ways the challenge is to induce a mindset of urgency. At Kings College labelling a patient with a diabetic foot with both infection and ischaemia (callused by PAD) as having a ‘foot attack’, as health care professionals would in the heart and stroke fields.
- 4.4 The key is referring for treatment at the earliest possible moment. But the levels of successful diagnosis vary across the country. For example one submission to the Group noted that in regions such as the Fylde Coast, patients with the disease often present late because the flat landscape doesn’t challenge patients physically.

**“Essentially, to put it bluntly, you can have a high risk foot with neuropathy ischaemia on Monday, an ulcer on Tuesday, infection on Wednesday, gangrene on Thursday and you can lose your leg on Friday. Then you have to survive the weekend in hospital.”**

- Mike Edmonds, professor of Diabetic Foot Medicine, King’s College Hospital, oral evidence to the All Party Parliamentary Group on Vascular Disease<sup>xxxix</sup>

**“The mortality rate for major amputations could be as high as 16.8%. This is significantly higher compared to the vascular procedure that would be accepted in a major vascular unit.”**

- Hisham Rashid, Consultant Vascular Surgeon, King’s College Hospital, oral evidence to the All Party Parliamentary Group on Vascular Disease<sup>xxxix</sup>

### Multi-disciplinary teams

- 4.5 The most efficient way to quickly assess, diagnose and treat vascular patients is to bring all the required skills under one roof. For example multi-disciplinary foot team clinics can call on podiatrists, nurse orthotists, microbiologists, physicians, radiologists and surgeons, so that patients can be seen by all the relevant disciplines in the same place at the same time. This reduces the number of appointments a patient requires, providing a cost effective and rapid service. More than 80 hospitals in England and Wales do not provide this service.<sup>xxxiii</sup>
- 4.6 The Group heard evidence that amputation is too often seen as a treatment for PAD. At Kings College



Hospital London, the multi-disciplinary foot team would see amputation as a failure. Whereas stroke rate from carotid procedures will be recorded and lowering these almost universally will be seen as a sense of professional pride, the same cannot be said for amputation.

- 4.7 The evidence from Kings College Hospital London, the multi-disciplinary foot team showed tremendous progress on amputation rates. If adopted across the country 80% of diabetic amputations could be reduced through following their example.<sup>xxxiv</sup>
- 4.8 Alongside the health benefits the financial case for the implementation of multi-disciplinary foot care teams is strong. For example Southampton University Hospital NHS Trust set up a team at a cost of £179,860 and reduced annual major amputations by eight with a saving of £888,979<sup>xxxv</sup>. By spending to introduce these schemes the NHS can save money and patients.

**“Patients with a diabetic foot infection or problem coming to hospital should be seen by a multi-disciplinary team. This should happen within the first 24 hours. This is where a large number of the NHS Trusts are failing; we do not have the teams and patients are not seen internally. This is why the risk of amputation is quite high.”**

- Hisham Rashid, Consultant Vascular Surgeon, King’s College Hospital, oral evidence to the All Party Parliamentary Group on Vascular Disease<sup>xxxvi</sup>

- 4.9 It is crucial that all patients are able to access an obvious pathway that ensures they receive a standardised high quality of care. It is quite unfair for a patient to be offered a major amputation when a NHS Trust next door can be performing a revascularisation procedure, improving blood flow and saving the leg. The 2011 Atlas of Variation demonstrated this ‘postcode lottery’ clearly.<sup>xxxviii</sup>

**“With 11,000 amputations per year or more, it is a substantial problem. With 60% of these complicated through or caused by diabetes and accepting the 80% reduction rate from Kings, we could be estimating at least 5,000 amputations a year could be avoided through following their example.”**

- Mr Neil Carmichael MP –  
Chair of the Vascular Disease APPG<sup>xxxvii</sup>

Recommendation 12:

**The evidence from multi-disciplinary foot care teams on the improvement of patient outcomes and saving the NHS money are clear. The strategy should mandate Vascular and Cardiac/Stroke Networks to establish these teams across the country.**

Recommendation 13:

**Nurse led foot care protection teams in the community should also be established across the country.**

Recommendation 14:

**NHS providers should be held to account for their amputation rates. Publication in the NHS Atlas of Variation is a positive development, but as more multi-disciplinary foot teams are established commissioners should stop referring to providers who do not offer this service.**

**Training of vascular specialists**

- 4.10 To succeed in combating vascular disease the best

people who have benefited from the best training, should be treating patients. This is particularly true in disciplines such as vascular radiology which are becoming increasingly specialised as technology advances. Some contributors note that vascular radiology has become a speciality in its own right yet interventional radiology training doesn't reflect this. Equally without a vascular specialism interventional radiologists are often required to perform other non-vascular procedures, causing a shortage in those able to carry out vascular surgery.

**“We have limited numbers of trainers to train new interventionists. Those trainees are then being snapped up as quickly as they are being produced.”**

- Dr Raman Uberoi, Secretary of the British Society of Interventional Radiologists<sup>xxxix</sup>

- 4.11 Some contributors claim a significant challenge is a lack of Interventional Radiologists to perform new endovascular techniques. Not enough are being trained and too many are drifting into general radiology. One survey taken by healthcare professionals in Lincolnshire looked at the number of BMJ adverts for Interventional Radiologists between February 2011 and June 2012 showing that 42% were not filled.<sup>xl</sup>
- 4.12 Some contributors have claimed the Vascular Certificate of Completion of Training provides insufficient time to train vascular specialists in the standards required by the new vascular curriculum, specifically the medical imaging and endovascular skills essential for contemporary vascular training<sup>xli</sup>. Practical experience of specialist and emergency work should also form a part of the training curriculum. In addition, a vascular surgery specialism could forge close links between interventional radiology, cardiology, diabetology, renal and stroke medicine, as well as transplant and cardiothoracic surgery.

#### Recommendation 15:

**Following Vascular Society recommendations, there should be a Vascular Speciality Training Programme of eight years, comprising two years of core surgical training and six indicative years of specialist training.**

### Specialist regional centres

- 4.13 The general consensus among professionals is that there is an urgent need to create a network of regional centres of excellence. Currently there are significant disparities in the level of care across England. For example in the south west there are 3 major amputations for every 1,000 diabetes patients, yet in the south east there is just 1.5.<sup>xlii</sup>

**“If performance across the NHS can be brought up to the level achieved by the best, then much of the pressure on local NHS budgets can be relieved without having to cut services for patients.”**

- Professor Chris Ham, CEO, King's Fund<sup>xliii</sup>

- 4.14 Regional centres can deal with emergency procedures (aneurysm rupture) on a 24/7 basis, provide greater patient access to new technology and provide more specialist and focussed training opportunities.<sup>xliv</sup>

#### Recommendation 16:

**An appropriate number of specialist regional vascular centres of excellence should be established with 24/7 high quality vascular care meeting the Vascular Society of Great Britain and Ireland's new guidelines to improve outcomes for patients.**

- 4.15 Patient access to the latest technologies is an important part about improving patient outcomes. Where investment models exist in NHS Trusts, recognised by commissioners that allow for the long-term procurement of medical technologies, it has been widely welcomed by healthcare professionals. Strategic relationships between the NHS and industry should be the norm rather than the exception.



## 5. SUMMARY OF RECOMMENDATIONS

### Recommendation 1:

Every effort should be made to encourage maximum uptake of the NHS AAA Screening Programme including publicising the benefits nationally and locally.

### Recommendation 2:

We agree with CVC recommendations that Directors of Public Health should report on the uptake of health checks and efforts to reduce health inequalities in their annual report. Greater consideration should be given to include vascular care indicators in the Atlas of Variation. This should all be overseen by the National Commissioning Board.

### Recommendation 3:

There should be a national (NHS) publicity campaign to highlight the prevalence of vascular disease and the factors that can increase the risk of the disease and persuade people to make lifestyle choices that will reduce incidence. Patient tools could be published in Joint British Societies guidelines.

### Recommendation 4:

Every patient presenting with early stage vascular disease should be given a Vascular Care Plan that empower patients to understand their condition, unifies preventative and basic treatment strategies across all vascular groups, simplifies self-management models such as blood pressure monitoring and provides the right information that enable patients to take part in managing their condition.

### Recommendation 5:

As well as awareness campaigns, early intervention (lifestyle change and clinical intervention) to mitigate against risk factors should be a key part of the prevention drive as part of the new Government strategy.

### Recommendation 6:

Best practice on the prevention and management of vascular disease should be shared across primary care, clinical commissioning groups and local authorities.

### Recommendation 7:

The Strategy should consider reviewing Quality and Outcomes Framework (QOF) indicators for secondary prevention of coronary heart disease (CHD) to incorporate uptake and quality of cardiac rehabilitation and ensure that all existing targets reflect best practice guidelines.

### Recommendation 8:

The strategy should consider how primary care professionals could be better educated or trained to support people who present with vascular conditions and associated risk factors.

### Recommendation 9:

The strategy should include a plan to consider the benefits of the NHS inviting patients for AAA screening at 70 and 75, and whether individuals should be targeted by risk factors such as diabetes and a history of smoking.

### Recommendation 10:

The strategy should focus on the primary care diagnosis of PAD. Indicators in Quality Outcomes Framework (QOF) should also require GPs to advise patients about their foot risk level, carry out the ABPI test and refer to specialist care when appropriate.

### Recommendation 11:

We support calls for a national diabetes implementation plan to deliver the NICE quality standard and the National Service Framework outcomes in order to save costs and improve lives.

### Recommendation 12:

The evidence from multi-disciplinary foot care teams on improvement patient outcomes and saving the NHS money are clear. The strategy should mandate Vascular and Cardiac/Stroke Networks to establish these teams across the country.

### Recommendation 13:

Nurse led foot care protection teams in the community should also be established across the country.

### Recommendation 14:

NHS Providers should be held to account for their amputation rates. Publication in the NHS Atlas of Variation is a positive development, but as more multi-disciplinary foot teams are established commissioners should stop referring to providers who do not offer this service.

### Recommendation 15:

Following Vascular Society recommendations, there should be a Vascular Speciality Training Programme of eight years, comprising two years of core surgical training and six indicative years of specialist training.

### Recommendation 16:

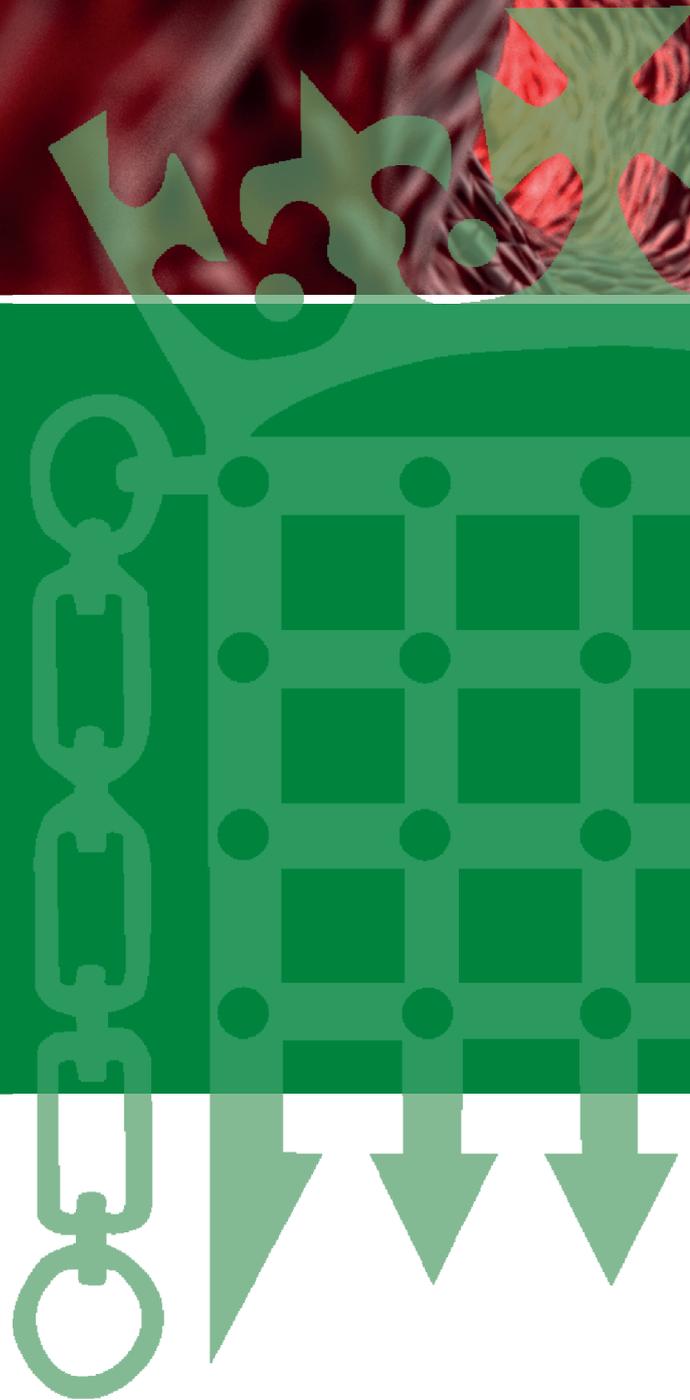
An appropriate number of specialist regional vascular centres of excellence should be established with 24/7 high quality vascular care meeting the Vascular Society of Great Britain and Ireland's new guidelines to improve outcomes for patients.

# REFERENCES

- i Circulation Foundation (2012). [online]. Available from: <http://www.circulationfoundation.org.uk/>
- ii Mr Hisham Rashid (2012). “Peripheral Vascular Disease, Revascularisation & Major amputation; the evidence.” Presented at All Party Parliamentary Group on Vascular Disease Evidence Session. House of Commons, Westminster
- iii The NHS Abdominal Aortic Aneurysm Screening Programme (2012). [online]. Available from: <http://aaa.screening.nhs.uk/aaastatistics>
- iv Circulation Foundation (2011). Campaign Toolkit. [online]. Available from: [http://www.circulationfoundation.org.uk/wp-content/uploads/2012/03/awareness\\_week\\_toolkit.pdf](http://www.circulationfoundation.org.uk/wp-content/uploads/2012/03/awareness_week_toolkit.pdf)
- v Diabetes UK, “Diabetes in the UK 2011-2012”
- vi Circulation Foundation (2011). Campaign Toolkit. [online]. Available from: [http://www.circulationfoundation.org.uk/wp-content/uploads/2012/03/awareness\\_week\\_toolkit.pdf](http://www.circulationfoundation.org.uk/wp-content/uploads/2012/03/awareness_week_toolkit.pdf)
- vii Circulation Foundation (2010). “NHS Abdominal Aortic Aneurysm Screening Programme – Parliamentary Briefing”
- viii APPG Diabetes, APPG on Heart Disease; APPG Kidney; APPG for Stroke, “Tackling Cardiovascular Diseases: Priorities for Outcomes Strategies”
- ix Circulation Foundation (2011). Campaign Toolkit. [online]. Available from: [http://www.circulationfoundation.org.uk/wp-content/uploads/2012/03/awareness\\_week\\_toolkit.pdf](http://www.circulationfoundation.org.uk/wp-content/uploads/2012/03/awareness_week_toolkit.pdf)
- x Fiona Loud, Chair Kidney Alliance (2012) “Patient and Professional Charities Together” Presented at All Party Parliamentary Group on Vascular Disease Evidence Session. House of Commons, Westminster
- xi Professor R Greenhalgh. (2009) Unacceptable major amputation rates widespread. Vasc News. [online]. Available from: <http://www.cxvascular.com/vn-features/vascular-news---feature/unacceptable-major-amputation-rates-widespread>
- xii Circulation Foundation (2011). Campaign Toolkit. [online]. Available from: [http://www.circulationfoundation.org.uk/wp-content/uploads/2012/03/awareness\\_week\\_toolkit.pdf](http://www.circulationfoundation.org.uk/wp-content/uploads/2012/03/awareness_week_toolkit.pdf)
- xiii Mr Hisham Rashid (2012). “Peripheral Vascular Disease, Revascularisation & Major amputation; the evidence.” Presented at All Party Parliamentary Group on Vascular Disease Evidence Session. House of Commons, Westminster
- xiv APPG Diabetes, APPG on Heart Disease; APPG Kidney; APPG for Stroke, “Tackling Cardiovascular Diseases: Priorities for Outcomes Strategies”
- xv The Medical Technology Group, “A Review of Insulin Pump Uptake and NICE Guidance in English Primary Care Trusts (PCTs) 27/08/2010” [online]. Available from: <http://www.mtg.org.uk/index.php/policy-initiatives/mtg-campaigns/32-pump-action>
- xvi Diabetes UK Scotland (2011), “Evidence to the Scottish Parliament’s Public Petitions Committee” [online]. Available from: [http://www.diabetes.org.uk/upload/Scotland/Insulin%20Pumps%20Supporting\\_information.pdf](http://www.diabetes.org.uk/upload/Scotland/Insulin%20Pumps%20Supporting_information.pdf)
- xviii British Heart Foundation (2012) [online]. Available from: <http://www.bhf.org.uk/heart-health/conditions/high-blood-pressure.aspx>
- xviii NICE Guidance (2012). Percutaneous transluminal radiofrequency sympathetic denervation of the renal artery for resistant hypertension [online]. Available from: <http://guidance.nice.org.uk/IPG418>
- xix Heart UK (2012). “Heart UK Manifesto” Written evidence to the APPG Vascular Disease Enquiry.
- xx *ibid*
- xxi Professor Mike Edmonds and Dr Hisham Rashid. Kings College Hospital Health Partners (2012) “The Multidisciplinary Diabetic Foot Clinic” Written evidence to the APPG Vascular Disease Enquiry.
- xxii Professor Mike Edmonds (2012). Care of the Diabetic Ischaemic patient with Peripheral Arterial Disease. Presented at All Party Parliamentary Group on Vascular Disease Evidence Session. House of Commons, Westminster.
- xxiii Medtronic Ltd (2012) “Cardiovascular Disease Outcomes Strategy – Enquiry Submission” Written evidence to the APPG Vascular Disease Enquiry.
- xxiv Circulation Foundation (2011). Campaign Toolkit. [online]. Available from: [http://www.circulationfoundation.org.uk/wp-content/uploads/2012/03/awareness\\_week\\_toolkit.pdf](http://www.circulationfoundation.org.uk/wp-content/uploads/2012/03/awareness_week_toolkit.pdf)



- xxv Dr Raman Uberoi Consultant Interventional Radiologist, John Radcliffe Hospital (2012).  
“Vascular APPG Submission” Written evidence to the APPG Vascular Disease Enquiry.
- xxvi C.A Dall’Olmo, AL Ippolita, JM McIllduff, et al EPics I Study (2010) “Evaluation of Possible Abdominal Aortic Aneurysms (in Patients who have undergone previous CABG)” [online] Available from: <http://vasculardiseasemanagement.com/article/6686>
- xxvii Professor Mike Edmonds. (2012) Care of the Diabetic Ischaemic patient with Peripheral Arterial Disease. Presented at All Party Parliamentary Group on Vascular Disease Evidence Session. House of Commons, Westminster.
- xxviii Dr Andrew Mimmagh. (2012). [online]. Available from: [http://www.pulsetoday.co.uk/newsarticle-content/-/article\\_display\\_list/13009086/peripheral-arterial-disease-added-to-qof-for-2012-13](http://www.pulsetoday.co.uk/newsarticle-content/-/article_display_list/13009086/peripheral-arterial-disease-added-to-qof-for-2012-13)
- xxix Circulation Foundation (2010). “NHS Abdominal Aortic Aneurysm Screening Programme – Parliamentary Briefing”
- xxx The NHS AAA Screening Programme (2011). “NHS AAA Screening Programme Annual Report April 2010 to March 2011” [online]. Available from: <http://aaa.screening.nhs.uk/annualreport>
- xxxi Professor Mike Edmonds (2012). “Care of the Diabetic Ischaemic patient with Peripheral Arterial Disease.” Presented at All Party Parliamentary Group on Vascular Disease Evidence Session. House of Commons, Westminster.
- xxxii Mr Hisham Rashid (2012). “Peripheral Vascular Disease, Revascularisation & Major amputation; the evidence.” Presented at All Party Parliamentary Group on Vascular Disease Evidence Session. House of Commons, Westminster.
- xxxiii Professor Mike Edmonds (2012). “Care of the Diabetic Ischaemic patient with Peripheral Arterial Disease.” Presented at All Party Parliamentary Group on Vascular Disease Evidence Session. House of Commons, Westminster.
- xxxiv Professor Mike Edmonds and Dr Hisham Rashid. Kings College Hospital Health Partners (2012)  
“The Multidisciplinary Diabetic Foot Clinic” Written evidence to the APPG Vascular Disease Enquiry.
- xxxv NHS Diabetes (2012). “Foot care for people with diabetes in the NHS in England: The economic case for change” [online] Available from: [www.diabetes.nhs.uk](http://www.diabetes.nhs.uk)
- xxxvi Mr Hisham Rashid (2012). “Peripheral Vascular Disease, Revascularisation & Major amputation; the evidence.” Presented at All Party Parliamentary Group on Vascular Disease Evidence Session. House of Commons, Westminster
- xxxvii Mr Neil Carmichael MP (2012). Comments at All Party Parliamentary Group on Vascular Disease Evidence Session. House of Commons, Westminster
- xxxviii NHS Atlas of Variation (2010). “Percentage of people in the National Diabetes Audit (NDA) having major lower limb amputations five years prior to the end of the audit period by PCT” [online] Available from: <http://www.sepho.org.uk/extras/maps/NHSAtlas2011/pdf/8.pdf>
- xxxix Dr Raman Uberoi, Consultant Interventional Radiologist, John Radcliffe Hospital (2012). “Interventional Radiology for Critical Ischaemia” Presented at All Party Parliamentary Group on Vascular Disease Evidence Session. House of Commons, Westminster
- xl Mr Jayarama Mohan, Consultant Vascular Surgeon United Lincolnshire Hospitals NHS Trust (2012). “Specialised Adult Vascular Service” Presented at All Party Parliamentary Group on Vascular Disease Evidence Session. House of Commons, Westminster
- xli Vascular Society of Great Britain and Ireland (2012). “Vascular Society, Standards of Vascular training”
- xlii Mr Hisham Rashid (2012). “Peripheral Vascular Disease, Revascularisation & Major amputation; the evidence.” Presented at All Party Parliamentary Group on Vascular Disease Evidence Session. House of Commons, Westminster
- xliii Professor Chris Ham, CEO Kings Fund (2010). [online]. Available from: <http://www.bbc.co.uk/news/health-11832233>
- xliv Hisham Rashid (2012). “Peripheral Vascular Disease, Revascularisation & Major amputation; the evidence.” Presented at All Party Parliamentary Group on Vascular Disease Evidence Session. House of Commons, Westminster



THE ALL PARTY  
PARLIAMENTARY  
GROUP ON  
VASCULAR  
DISEASE