



## All Party Parliamentary Group on Vascular Disease

**All Party Parliamentary Group on Vascular Disease aims to raise awareness of vascular disease and to encourage actions to promote a greater priority for its prevention and treatment; to encourage research into the causes of vascular disease; to advance excellence and innovation in vascular health; and to inform parliamentarians of the work of medical professionals and those who provide support services for patients and their relatives.**

**Minutes of the Group's meeting at 2pm on 6<sup>th</sup> September 2016 in Committee Room 15 in the House of Commons.**

**ATTENDEES** – The event was attended by over 50 individuals, including eight Parliamentarians. Present parliamentarians were:

- Sir Peter Bottomley MP
- Neil Carmichael MP
- Lord Colwyn
- Andrew Gwynne MP
- Liz McInnes MP
- Alan Meale MP
- Chi Onwurah MP
- Derek Thomas MP

**PRESENT MEMBERS** – Neil Carmichael MP (Chair), Chi Onwurah (Vice Chair), Sir Peter Bottomley (Vice-Chair)

**APOLOGIES** – Baroness Masham (Secretary)

**SECRETARIAT** – Paul Bristow, Sara Petela, Ella Fuller, Tom Williams – PB Consulting

### **1. INTRODUCTION FROM NEIL CARMICHAEL MP**

- Neil Carmichael welcomed attendees and introduced speakers.

### **2. ANNUAL GROUP MEETING (AGM)**

- Parliamentarians present for the AGM were: Neil Carmichael, Sir Peter Bottomley, Andrew Gwynne, Chi Onwurah, Alan Meale, Lord Colwyn, Liz McInnes, Derek Thomas
- Officers were re-elected as follows:
  - Neil Carmichael (Conservative Party) – Chair
  - Sir Peter Bottomley (Conservative Party) – Vice-Chair
  - Chi Onwurah (Labour Party) – Vice-Chair
  - Baroness Masham (Cross-bench Peer) – Secretary

- The Officers approved the Group's annual income and expenditure statement.

### **3. UPDATE FROM THE SECRETARIAT**

- The Secretariat outlined the activity that has taken place as part of the Group's latest inquiry looking at patient access to technologies for the diagnosis and treatment of Peripheral Arterial Disease (PAD).
- The inquiry launched on the 20<sup>th</sup> June 2016 and closed on the 12<sup>th</sup> August 2016.
- The inquiry invited all those with a specialist interest in the diagnosis and treatment of PAD to contribute – either through an online survey, or by submitting evidence directly to the secretariat. The group thanked those who submitted evidence and those who helped facilitate the dissemination.
- An oral evidence session was held at the Houses of Parliament on the 12<sup>th</sup> July.
- The purpose of the meeting was to discuss the report recommendations and gain wider feedback from attendees.
- As a result of this discussion the Group's report was to be updated before its final release.

### **4. GROUP DISCUSSION**

A group discussion took place, where the below comments were made.

#### **4.a. Access to diagnostic technologies**

- Clear differentiation is needed between patients with PAD or Diabetes.
- It should be made clear which organisation is responsible for implementing certain recommendations.
- There is an issue of GPs not having the knowledge or interest to diagnose. Podiatrists do have this interest and the specialist knowledge to give timely diagnosis.
- There have been specialist podiatry services set up in some areas of the country (work in the Manchester region highlighted) which has demonstrated reductions in cost; in particular podiatry led diagnostic service in primary care settings.
- The importance of exercise testing and exercise programmes should be highlighted. There is an issue of huge variation in exercise therapy across the country.
- There seems to be a lack of interest in early diagnosis by commissioners.
- NICE guidance lacks direction for diagnosing and treating PAD effectively.
- GPs cannot be incentivised anymore as they are at capacity – practice nurses screen routinely and this is the place where you might get interest and traction.
- There is an issue with some practice nurses not seeing enough patients to have the confidence to make a clinical decision. A specialist podiatrist service with support from vascular services may offer a solution.
- A national screening programme would not be possible. Screening over 50s would flag a huge number of asymptomatic cases of PAD.
- Awareness raising is important; a recommendation could be included around a national awareness raising campaign.
- One of the most effective ways of raising awareness is gathering more information and conducting research.
- Increasing screening will require the interventions/support systems available to those who are diagnosed with PAD by this screening programme. If this is not in place, screening alone will not help patients.
- With regards to screening and surveillance – non-diabetics will be symptomatic and therefore screening is not as important. However, for diabetics screening is more necessary

as often they experience no symptoms, or if they do it is at the latter stages of disease progression.

- Awareness raising must include raising awareness of exercise programmes and their importance.
- Where interventions are available, clinicians need to be available who know what they are and who can advise/refer the patient accordingly.
- For diabetes patients especially, the real focus should be on fixing the pathway that already exists and is set out by NICE guidance.
- Those with PAD should not need secondary care – need to access exercise programmes, smoking cessation clinics etc.
- It is very important that diagnostic tools are accessible for people in trouble.
- Need to think seriously about mandating ABPI as part of the vascular disease testing for over 45s as part of the NHS Health Check.
- Issue of delayed referral of CLI – need to have people in the community who feel able to confidently diagnose and refer patients.
- Priority should be the timely referral of people with CLI. Failure and delay to refer is a big issue.
- GPs are good at common diseases, however there is a wide variation of experience for conditions that are less common – it can be quite difficult to know what the condition is, what to do and who best to refer the patient to. Pathways are often not clear enough.

#### **4.b. Access to technologies to treat patients**

- Drug eluting technologies were not included in the 2012 NICE guidance on Peripheral Arterial Disease: Diagnosis and Management due to lack of evidence. The Basil 3 trial is currently being funded.
- PAD patients moving into cardiac rehab programmes could be considered.
- Smoking cessation and diet are an important element. It is important to follow up and monitor patients through the process to ensure they keep on track and to ensure this is a long term solution.
- Leisure centres could deliver exercise classes and specialists see patients every eight weeks to monitor progress. These types of partnerships should be explored.
- There is a grey area within the non-diabetic group as some non-diabetics may be pre-diabetic. Foot protection teams are seeing increasing numbers of non-diabetic as well as diabetics.
- Diabetic Multi-Disciplinary Teams (MDTs) should become Acute Lower Limb MDTs.
- A question was raised around the hub and spoke model; should the MDT be assembled from individuals across the hub or there be a MDT in every Trust?
- Electronic cigarettes have a part to play in harm reduction and are an intervention option which should be made clear to the PAD population.
- Consideration should be given to the cardiovascular outcomes strategy.

#### **4.c. System incentives**

- The German model of introducing medical technologies into the healthcare system was referenced as a model of good practice. This model embraces the use of new technologies and monitors the outcomes.
- The issue of regional variation in access to technologies means that some people do not know what to expect in terms of their treatment options.
- There is an issue of there being a two tier system of services; some centres are highly specialised and can offer the latest innovations whilst there are other services that cannot.

There is a need to organise services differently. Pressure is needed from NHS England to effectively structure how vascular services are delivered.

- Need to be clear that intermittent claudication is a benign disease which exercise will provide a solution to. Critical limb ischaemia is an aggressive disease where all interventions that are available (including drug eluting technologies) could be used.
- The cost of amputation and the follow up care from such a procedure is huge.
- A discussion occurred around how tariff should be set in order to incentivise limb salvage – tariff can perversely present a Trust with revascularisation being more expensive than amputation. Must be careful not to set limb salvage and amputation off against each other.
- Tariff is based on reference costs of how much it costs to treat patients – this is an average cost across Trusts. Granularity in the tariff system needs to be worked on.
- There is also an issue of how coding systems keep up with new technologies.
- Trusts are not seeing the savings made by CCGs as a result of good practice care as savings are seen in primary care. Commissioning entire pathways could be a way of addressing this issue.

Neil Carmichael MP thanked the attendees.

The Secretariat outlined plans to update the report before its final publication.

There being no further business the meeting then terminated.

Feedback on the minutes – please send to Sara Petela at [vappg@pbpoliticalconsulting.com](mailto:vappg@pbpoliticalconsulting.com)