This is not an official publication of the House of Commons or the House of Lords. It has not been approved by either House or its committees. All-Party Parliamentary Groups are informal groups of Members of both Houses with a common interest in particular issues. The views expressed in this Report are those of the group.
The APPG would like to thank the following for their input into this report:

**Strategic Clinical Networks:**
Cheshire and Merseyside Strategic Clinical Network
East of England Strategic Clinical Network
East Midlands Strategic Clinical Network
Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network
Norther England Strategic Clinical Network
London Strategic Clinical Network
South East Strategic Clinical Network
South West Strategic Clinical Network
Thames Valley Strategic Clinical Network
Wessex Strategic Clinical Network
West Midlands Strategic Clinical Network
Yorkshire and the Humber Strategic Clinical Network

**Industry:**
Boston Scientific, Cook Medical, CR Bard, Medtronic

**Others:**
Sara Petela, PB Political Consulting
Lawrence Ambrose, The College of Podiatry
Martin Fox, Pennine Acute Hospitals Trust, Manchester
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The All Party Parliamentary Group on Vascular Disease was established to raise awareness of vascular disease and to encourage actions to promote a greater priority for its prevention, early detection and best treatment. Members, patient advocates and clinicians have been working to support the group in raising the profile of this under-recognised disease area. The new Parliament provides an excellent opportunity for the group to continue promoting this issue.

The increasing prevalence of diabetes, in particular Type 2 diabetes, and the subsequent attention this condition has received has no doubt helped to shed light on the associated dangers. One of the key priorities for the group is to promote ways to reduce unnecessary lower limb amputations and associated early death, in particular amputations related to diabetes and Peripheral Arterial Disease (PAD). As part of this we undertook a scoping exercise of Strategic Clinical Networks (SCNs) to determine the levels of activity across the country in working to reduce unnecessary amputations. This report consolidates our findings and makes recommendations for how to maximise impact with admittedly limited resources.

SCNs have to work within a limited budget in an environment of austerity but with an expectation of innovation and demonstrable outcomes; no doubt a difficult task. Yet there are steps that should be taken – most of which require relatively few resources – to ensure a more standardised level of output and outcomes across the country. Amputation should be considered a failure rather than an accepted treatment option and any steps to achieve this should be promoted by SCNs. This report outlines these recommendations and I hope that these will be heeded by SCN representatives and commissioners alike.

It is heartening to read in many of the responses received from SCNs that their cardiovascular and diabetes work programmes have been shaped by the previous report published by the APPG on ‘Tackling Peripheral Arterial Disease More Effectively: Saving Lives, Saving Limbs’. I would like to thank those who have supported the work of the All Party Parliamentary Group (APPG) and those who are supporting the efforts to shed light on and reduce the number of unnecessary lower limb amputations and associated early deaths, as a result of vascular disease.

Neil Carmichael MP
Chair of the All Party Parliamentary Group on Vascular Disease
SUMMARY OF RECOMMENDATIONS

SCNs should include PAD as a wider focus of their strategies as well as diabetes

SCNs should support service redesign programmes to ensure the early detection and treatment of PAD

SCNs should identify and promote a specific pathway for dealing with PAD

SCNs should act as facilitators of coordination and cooperation with CCGs and other healthcare representatives

Every SCN should be part of a Foot Care Network for information sharing, education and benchmarking

Effective MDT working can be enhanced by regular multi professional training and education sessions which should be supported and, where possible, coordinated by SCNs

SCNs should act as the coordinator of wider stakeholders to ensure cooperation and coordination of activity

SCNs should facilitate and encourage open dialogue across central and local health structures

All CCGs/Trusts/Hospitals should have an on-call specialist vascular lead – SCNs should promote this practice

SCNs should support CCGs in developing a clear policy for referral and pathways

SCNs should factor education and awareness raising into their work programmes

The impact of training and education should be recorded and successful initiatives should be replicated nationwide

Amputation and associated modifiable early deaths should be seen as a failure of the system – this message should be promoted by SCNs

Regular/annual surveys or benchmarking should be carried out to understand progress and identify gaps in service provision

SCNs should foster a positive, regular and open communication with CCG representatives

SCNs should continue to support and encourage participation in the National Foot Care Audit
Like many bodies in the NHS, Strategic Clinical Networks (SCNs) are in relative infancy. They were established in 2013 in order to build upon the success of previous NHS networks. The overarching objective of the networks is to encourage collaboration – between healthcare professionals, patients, providers and commissioners.

SCNs focus on priority service areas to bring about improvement in the quality and equity of care and outcomes of their population, both now and in the future. SCNs are hosted and funded by NHS England, and cover conditions or patient groups where improvements can be made through an integrated, whole system approach. They have a duty to help local commissioners of NHS care reduce unwarranted variation in services and encourage innovation. SCNs are accountable to NHS England.

The conditions or patient groups chosen for the first strategic clinical networks are:

- Cancer
- Cardiovascular disease (including cardiac, stroke, diabetes and renal disease)
- Maternity and children’s services
- Mental health, dementia and neurological conditions

This report focuses on cardiovascular disease networks within the SCNs.

There are 12 SCNs which cover the different geographical areas of England.
The chancellor’s Spring Budget reiterated the Government’s commitment to reaching £22 billion in efficiency savings by 2020, yet few details have been announced about how these savings will be achieved. The rhetoric used by government and commissioners alike focuses on value rather than cost, yet undoubtedly the current climate of financial constraint will impact on the organisations and bodies operating within and around the NHS, including Strategic Clinical Networks.
SCNs are funded by NHS England. Constituent organisations are able to contribute additional funding if desired. When established in 2012, £42m was allocated to fund SCN and Clinical Senate activities. Of this, £10m was from NHS England (then the NHS Commissioning Board) running costs and the remaining £32m was from the NHS programme budget. The £10m was allocated on an ‘equal share’ basis and the £32m was allocated based on unweighted population. Allocations can also be found outlined within the Single Operating Framework for SCNs.

Budgetary constraints prevalent across the health service are undoubtedly a factor in determining the levels of investment in, and therefore output of, the SCNs.

Current details of funding amounts and allocations for each Strategic Clinical Network were requested in a written Parliamentary Question tabled by Neil Carmichael MP, the Chair of the All Party Parliamentary Group on Vascular Disease in June 2015. The question was answered by the Rt Hon Alistair Burt MP, the Minister of State for Community and Social Care at the Department of Health.

Strategic Clinical Networks’ administrative funding is allocated on an equal share basis. Programme funding is allocated on an unweighted population basis.

For both 2013/14 and 2014/15, the allocations were:

<table>
<thead>
<tr>
<th>Geographical Area (Strategic Clinical Network and Clinical Senate)</th>
<th>Admin Funding £’000</th>
<th>Programme Funding £’000</th>
<th>TOTAL £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheshire and Merseyside</td>
<td>£833</td>
<td>£1,447</td>
<td>£2,281</td>
</tr>
<tr>
<td>East of England</td>
<td>£833</td>
<td>£3,573</td>
<td>£4,406</td>
</tr>
<tr>
<td>East Midlands</td>
<td>£833</td>
<td>£2,825</td>
<td>£3,658</td>
</tr>
<tr>
<td>Greater Manchester, Lancashire and South Cumbria</td>
<td>£833</td>
<td>£2,606</td>
<td>£3,439</td>
</tr>
<tr>
<td>Northern England</td>
<td>£833</td>
<td>£1,879</td>
<td>£2,712</td>
</tr>
<tr>
<td>London</td>
<td>£833</td>
<td>£4,794</td>
<td>£5,627</td>
</tr>
<tr>
<td>South East</td>
<td>£833</td>
<td>£2,687</td>
<td>£3,520</td>
</tr>
<tr>
<td>South West</td>
<td>£833</td>
<td>£2,793</td>
<td>£3,626</td>
</tr>
<tr>
<td>Thames Valley</td>
<td>£833</td>
<td>£1,233</td>
<td>£2,066</td>
</tr>
<tr>
<td>Wessex</td>
<td>£833</td>
<td>£1,592</td>
<td>£2,426</td>
</tr>
<tr>
<td>West Midlands</td>
<td>£833</td>
<td>£3,342</td>
<td>£4,175</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>£833</td>
<td>£3,230</td>
<td>£4,063</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>£10 million</strong></td>
<td><strong>£32 million</strong></td>
<td><strong>£42 million</strong></td>
</tr>
</tbody>
</table>
In 2013/14 and 2014/15 funding allocations covered both Strategic Clinical Networks and Clinical Senates. In 2015/16, funding for Strategic Clinical Networks has been separated from that of Clinical Senates.

The 2015/16 programme budget allocations for Clinical Networks were:

<table>
<thead>
<tr>
<th>Clinical Network</th>
<th>2015/16 Programme Funding £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheshire and Merseyside</td>
<td>£1,059</td>
</tr>
<tr>
<td>East of England</td>
<td>£2,725</td>
</tr>
<tr>
<td>East Midlands</td>
<td>£2,043</td>
</tr>
<tr>
<td>Greater Manchester, Lancashire and South Cumbria</td>
<td>£1,968</td>
</tr>
<tr>
<td>Northern England</td>
<td>£1,438</td>
</tr>
<tr>
<td>London</td>
<td>£3,633</td>
</tr>
<tr>
<td>South East</td>
<td>£2,043</td>
</tr>
<tr>
<td>South West</td>
<td>£2,119</td>
</tr>
<tr>
<td>Thames Valley</td>
<td>£1,059</td>
</tr>
<tr>
<td>Wessex</td>
<td>£1,211</td>
</tr>
<tr>
<td>West Midlands</td>
<td>£2,573</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>£2,422</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>£24.3 million</strong></td>
</tr>
</tbody>
</table>

A number of SCNs referred to tight budget constraints within their responses and noted this as a reason for not undertaking more initiatives. In a climate of budgetary pressures it is unlikely SCNs will receive additional funding from central government.

It should be noted that SCN programme funding is based on an unweighted population basis, suggesting that criteria such as age of population, ethnicity of population and disease prevalence are not accounted for when allocating this funding. **The South West, for example, has been found to have higher amputation rates than other regions in the country yet this is not reflected in funding allocations.**\(^1\) Given the extent of regional variation that exists it could be expected that funding would reflect this in order to adequately meet need.

The average funding amount for Strategic Clinical Networks in 2015/16 is £2,024,000. London SCN received the highest amount of programme funding for 2015/16, receiving £3,633,000. London SCN received 243% more funding than Thames Valley, which received just £1,059,000 for the same time period. This would be expected to have an impact on the level of output of the lesser funded SCNs.

The administrative funding for SCNs is allocated on an equal share basis. This means that regardless of the variation in programme numbers or size, the budget for administrative assistance remains the same for every SCN. The administrative funding in 2015/16 is currently being determined as part of the implementation of NHS England’s Organisational Alignment and Capability Programme.

Whilst it is important to ensure a minimum allocation of administrative support, it does seem unproductive that those with significantly higher programme funding – and therefore presumably output – would receive the same allocation of funding for administrative support as those with the least programme funding. Given that the total sum of administrative support totals £10 million, it should be questioned whether or not this is the most appropriate allocation of administrative funding.

The NHS Outcomes Framework is a set of 68 indicators that measure performance in the health and care system at a national level. It has been designed to form an overarching picture of the current state of health and care services in England.

Indicators in the NHS Outcomes Framework are grouped into five domains (listed below), which set out the high-level national outcomes that the NHS should be aiming to improve.

As part of Domain 2, the 2014/15 Outcomes Framework stipulated that reducing time spent in hospital by people with long-term conditions should be a priority for Clinical Commissioning Groups.

In addition to this, within the Clinical Commissioning Group (CCG) Indicator Set, Indicator 2 lays out the need for action to reduce complications associated with diabetes, including emergency admission for diabetic ketoacidosis and lower limb amputation. Cardiovascular and diabetes networks have been created within the SCNs to achieve this.

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Preventing people from dying prematurely;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 2</td>
<td>Enhancing quality of life for people with long-term conditions;</td>
</tr>
<tr>
<td>Domain 3</td>
<td>Helping people to recover from episodes of ill health or following injury;</td>
</tr>
<tr>
<td>Domain 4</td>
<td>Ensuring that people have a positive experience of care; and</td>
</tr>
<tr>
<td>Domain 5</td>
<td>Treating and caring for people in a safe environment and protecting them from avoidable harm.</td>
</tr>
</tbody>
</table>
**Indicator 2: Enhancing quality of life for people with long-term conditions**

<table>
<thead>
<tr>
<th>Overarching indicator</th>
<th>Improvement areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Health-related quality of life for people with long term conditions (NHS OF 2)</td>
<td><strong>Ensuring people feel supported to manage their condition</strong></td>
</tr>
<tr>
<td></td>
<td>- People feeling supported to manage their condition (NHS OF 2.1)</td>
</tr>
<tr>
<td></td>
<td><strong>Improving functional ability in people with long-term conditions</strong></td>
</tr>
<tr>
<td></td>
<td>- People with COPD &amp; Medical Research Council Dyspnoea scale ≤3 referred to pulmonary rehabilitation programme</td>
</tr>
<tr>
<td></td>
<td>- People with diabetes who have received nine care processes</td>
</tr>
<tr>
<td></td>
<td>- People with diabetes diagnosed less than one year referred to structured education</td>
</tr>
<tr>
<td></td>
<td><strong>Reducing time spent in hospital by people with long-term conditions</strong></td>
</tr>
<tr>
<td></td>
<td>- Unplanned hospitalisation for chronic ambulatory care sensitive conditions</td>
</tr>
<tr>
<td></td>
<td>- Unplanned hospitalisation for asthma, diabetes and epilepsy under 19s</td>
</tr>
<tr>
<td></td>
<td>- <strong>Complications associated with diabetes including emergency admission for diabetic ketoacidosis and lower limb amputation</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Enhancing quality of life for carers</strong></td>
</tr>
<tr>
<td></td>
<td>- Health-related quality of life for carers (NHS OF 1.4)</td>
</tr>
<tr>
<td></td>
<td><strong>Enhancing quality of life for people with mental illness</strong></td>
</tr>
<tr>
<td></td>
<td>- Access to community mental health services by people from BME groups</td>
</tr>
<tr>
<td></td>
<td>- Access to psychological therapy services by people from BME groups</td>
</tr>
<tr>
<td></td>
<td>- Recovery following taking therapies (all ages and older than 65)</td>
</tr>
<tr>
<td></td>
<td>- Health-related quality of life for people with a long-term mental health condition</td>
</tr>
<tr>
<td></td>
<td><strong>Enhancing quality of life for people with dementia</strong></td>
</tr>
<tr>
<td></td>
<td>- Estimated diagnosis rate for people with dementia <em>NHS OF measure in development. No CCG measure at present</em></td>
</tr>
<tr>
<td></td>
<td>- People with dementia prescribed anti-psychotic medication</td>
</tr>
</tbody>
</table>
The All Party Parliamentary Group on Vascular Disease undertook a scoping exercise to determine the amount and focus of SCN activity throughout the country in relation to meeting Domain 2 of the NHS Outcomes Framework.

The scoping exercise was aimed at identifying the amount of activity relating to various vascular conditions including Peripheral Arterial Disease (PAD) and lower limb amputations associated with diabetes. Just as there are variations in input through programme funding allocations, there are variations in output for the different SCNs.

**KEY FINDINGS**

Findings should be viewed within the context of workforce sustainability issues, access to interventional radiology and potential changes to minimum thresholds which are widespread. Given the climate SCNs are operating in, it is possible to question their ability to make a substantial impact.

The scoping exercise identified gaps in work programme activity and areas that could – and should – be prioritised as a means of achieving the outcomes within Domain 2. Yet the picture is not wholly bleak; the exercise also found many examples of good practice and innovation, some of which are outlined below.

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**Periperal Arterial Disease (PAD)**

As of 2012, 20% of people in England over the age of 60 had PAD, which equated to 2,307,306 adults. Of this 25% had intermittent claudication (pain) and a fifth of these patients were likely to develop critical limb ischaemia, highlighting the crucial need to focus on preventing such an escalation.

PAD is strongly associated with modifiable cardiovascular events such as heart attack, stroke and early death. The five year outcome for individuals with PAD is 30% associated mortality, which rises to 50% at 10 years, worse than many cancers. There needs to be a greater focus on earlier detection of PAD in order to reduce the rate of unnecessary amputations and associated mortality.

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**Northern England SCN has identified raising awareness of PAD as a work programme priority. It is supporting a local campaign led by Fresh and supported by the British Heart Foundation which aims to raise awareness of the risks of PAD and associated amputation. No outcomes have been listed to date. The Vascular Advisory Group produced a Guideline for the Diagnosis and Management of Patients with PAD to ensure appropriate assessment and accurate diagnosis is made.**

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Peripheral Arterial Disease (PAD) Integrated Care Pathway
(for patients with North Manchester GPs)

Patient has a lower limb assessment by: GP, Nurse or Allied Health Professional

Baseline peripheral arterial assessment
Cardiovascular risks  Foot pulses  Leg symptoms  Doppler signals

- **No PAD**
  - Foot pulses palpable
  - No intermittent claudication
  - No Doppler signals non-palpable
  - No knee tap pain
  - No clinical signs of PAD

  Consider differential diagnosis

- **Suspected PAD**
  - Foot pulses non-palpable
  - Symptoms of intermittent claudication
  - Doppler signals monophasic
  - Clinical signs: eg skin / nail atrophy, cold pale feet, chronic wound, slow capillary refill time
  - Sub-optimally managed existing PAD

  Refer to the Leg Circulation Service for non-invasive lower limb vascular assessment, diagnosis / exclusion of PAD and an individually agreed management plan: education, lifestyle change, medicines, surgical options

- **Severe / critical limb ischaemia**
  - Foot pulses absent / not palpable OR
  - Doppler signals monophasic / absent

  Plus any of the following:
  - Ischaemic rest pain (toes / feet)
  - New gangrene or necrosis
  - Ankle systolic pressure < 50mmHg

  Refer urgently to Hospital Vascular Team by contacting the Vascular Team or the on-call Vascular Registrar, if it appears acutely limb threatening

- **Non-surgical management**
  - Early-moderate PAD
  - Individual management plan
  - Review in 3-12 months or if leg symptoms worsen

  Refer for surgical opinion

  - Worsening / severe / critical PAD
  - Severe lifestyle impacting symptoms
  - Ankle brachial pressure index < 0.4
  - Ankle systolic pressure < 50mmHg

  Follow up within 1 working day to ensure that Hospital Vascular Team has received and triaged the referral. Document this clearly in clinical notes.

All patients with a confirmed diagnosis of PAD should have an individually agreed management plan, which is to be reviewed periodically with their GP, the Leg Circulation Service or the Hospital Vascular Team.

The management plan will include discussing cardiovascular & limb risk and negotiating management options (lifestyle, medicines, surgery), to be reinforced by all Health Professionals involved in management of the lower limb.

**PAD / CV risk management**
- Antiplatelet therapy
- Lipid lowering therapy
- Hypertension
- Smoking
- Obesity
- Moderate cardiovascular exercise
- Glycaemic control (if has diabetes)

<table>
<thead>
<tr>
<th>Target</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiate for all with established PAD</td>
<td>NICE CG 2012, SIGN 2006</td>
</tr>
<tr>
<td>Initiate for all with established PAD</td>
<td>NICE CG 2014, SIGN 2006</td>
</tr>
<tr>
<td>BP &lt; 140/90 mmHg</td>
<td>NICE CG 2011</td>
</tr>
<tr>
<td>Aim for quit</td>
<td>NICE CG 2012, SIGN 2006</td>
</tr>
<tr>
<td>BMI &lt; 30</td>
<td>NICE CG 2014</td>
</tr>
<tr>
<td>30 minutes, 5 times per week</td>
<td>DOH 2011</td>
</tr>
<tr>
<td>Hba1c &lt; 7.0% or &lt; 53 mmol/mol</td>
<td>NICE CG 2014, IFCC 2007</td>
</tr>
</tbody>
</table>

This pathway is based on PAD consensus from NICE, SIGN, TASC II, Target PAD and local expert opinion.
Given the national focus on diabetes prevention and treatment it is hardly surprising to find that the major focus of the work carried out by the majority of SCNs was related to this condition. In contrast to this Peripheral Arterial Disease (PAD), a leading cause of lower limb amputations and premature vascular related deaths, receives a much lower profile and investment from SCNs. In fact only two SCNs, the Northern England SCN and Cheshire and Merseyside SCN, reported a dedicated project on PAD within their work programmes. A small number of others reported supporting associated projects on this condition.

Adoption of best practice pathways to tackle PAD across the country should be encouraged as a means of reducing regional variation in the treatment of PAD. Pathways such as the NHS Manchester Pennine Acute Hospitals’ Integrated Care Pathway for Peripheral Arterial Disease have been replicated in other areas, with the SCN playing an important role in encouraging uptake. Cheshire and Merseyside SCN, for example, reported that 10 out of the 12 CCGs from across the region have adopted this pathway.

Having a clear pathway for dealing with patients with PAD ensures that all patients receive the highest quality of care in a timely fashion, thus reducing the likelihood of conditions escalating and, ultimately, amputation. SCNs are well placed to identify and promote effective pathways based on local population needs. They also have, or should have, established relationships with CCGs and should use this as a lever to promote uptake of effective pathways.

Over 11,500 amputations are carried out every year, many of which are as a direct result of PAD, yet this condition receives relatively little investment of resources. Tackling PAD should feature much more highly on the work programmes of all SCNs. The APPG report on ‘Tackling Peripheral Arterial Disease more effectively’ contains further recommendations for clinicians which should be noted and promoted by SCNs.

Recommendations:

► SCNs should include PAD as a wider focus of their strategies as well as diabetes
► SCNs should support service redesign programmes to ensure the early detection and treatment of PAD
► SCNs should identify and promote a specific pathway for dealing with PAD
► SCNs should act as facilitators of coordination and cooperation with CCGs and other healthcare representatives

**Diabetes**

All SCNs reported activity relating to diabetes.

The importance of multidisciplinary working, referrals and pathways, education and awareness, and measurement of success and outcomes are explored below, with recommendations for the adoption of cost-effective steps that can be taken by SCNs in order to achieve the goal of reducing unnecessary amputations.

**Multidisciplinary Working**

The need for increased multidisciplinary working has been identified by a number of SCNs as a way of improving patient outcomes. Commissioners, podiatrists, vascular surgeons, GP leads, diabetologists, Allied Health Professionals and patient representatives all have a story to tell and ideas for how services could be improved. Ensuring all relevant practitioners are involved in the dialogue surrounding the improvement in foot care services is crucial to successfully reducing amputations. Having specifically formed groups to focus on this issue is a simple and cost effective method of ensuring cooperation, coordination and innovation. MDTs with a strong track record should be used as a model of good practice for other centres which are struggling.

Most SCNs have established networks and/or vascular clinical advisory groups in place in order to share best practice and encourage multidisciplinary working. Those networks which reported not having such networks in place recognised the need for such a forum and are in the process of re-establishing this group. The value of these networks in providing the forum for MDT communication is unparalleled and, as such, all SCNs should have these in place.

Most SCNs referenced collaboration with advisory groups, including vascular and diabetes clinical advisory groups. This joint working should be encouraged as a means of ensuring information sharing and standardisation of care. Engagement and collaboration with Academic Health Science Networks and local CCG representatives was reported by some SCNs as a

London SCN encourages multidisciplinary working through the London Foot Care Steering Group, which provides a forum for MDT clinicians to share their specialist expertise, clinical experience and strategic knowledge. This group is nominated to represent the SCN on transformation and clinical improvement programmes relating to foot care. This group works closely with the London Vascular Clinical Advisory Group and the London Diabetes SCN, highlighting the importance of collaboration and information sharing.

London SCN has created a Vascular Clinical Advisory Group with representation from eight central units working together to improve vascular services. The group has prioritised Abdominal Aortic Aneurysm and Critical Limb Ischaemia.
focus for future activity, reiterating the important role of the SCN in acting as an initiator and coordinator of this dialogue.

**Recommendations:**

► Every SCN should be part of a Foot Care Network for information sharing, education and benchmarking

► Effective MDT working can be enhanced by regular multi professional training and education sessions which should be promoted and, where possible, coordinated by SCNs

► SCNs should act as the coordinators of wider stakeholders to ensure cooperation and coordination of activity

**Referrals and pathways**

SCNs are well placed to work with NHS England to support specialised commissioning to improve pathways. As with PAD, having a clear pathway in place ensures all healthcare workers are able to make rapid, correct referrals. The risk of regional variation is reduced if successful pathways are replicated across the country. SCNs can support CCGs in developing a clear policy for referral and pathway.

Maintaining contact and cooperation with central structures ensures that local needs are heard and responded to as fully as possible. SCNs should play a crucial role in facilitating open dialogue across central and local health structures. SCNs have a role in encouraging and, where resources allow, appointing pathway coordinators within hub centres with integrated clear pathways for the diabetic foot. This would help to identify high risk patients earlier and allow referral to expert opinions and treatments sooner, which would reduce amputation rates. Few SCNs reported having such a position, in all likelihood due to funding limitations.

**Cheshire and Merseyside SCN** has developed a primary care pathway through discussion and debate at three regional stakeholder events, through ongoing correspondence with stakeholders and with reference to relevant national guidance. The pathway has been developed to align with the secondary care footcare pathway.

**Greater Manchester, Lancashire and South Cumbria SCN** has appointed a community pathways co-ordinator to work with the Network Clinical Lead on pathways to manage people presenting with claudication.

**Greater Manchester, Lancashire and South Cumbria SCN** has developed the STAMP pathway (STop unnecessary AMPutations). This integrated pathway is designed for people presenting with Critical Limb Ischaemia. The pathway supports early identification of problems in the community; quicker access to diagnostics and to secondary care clinicians.
West Midlands SCN is looking to recruit a local Clinical Director for diabetes who will be the local champion to help drive the diabetes agenda. It is envisaged that this will include work on lower limb amputation in due course.

CCGs in Manchester, Salford and Tameside have commissioned Podiatry-led PAD services to ensure early detection and best treatment, whilst saving money.6

6 Fox et al, Nursing Times 2012.
Greater Manchester SCN has supported the delivery of three workshops to raise awareness of Critical Limb Ischaemia and its diagnosis. The SCN has also produced posters to raise awareness of the condition which will be circulated to GP practices and community nursing teams.

South East Coast SCN has produced (and updates) a local foot care briefing with data on current amputation rates across the area.

Recommendations:

► SCNs should support CCGs in developing a clear policy for referral and pathways
► SCNs should facilitate and encourage open dialogue across central and local health structures
► All CCGs/Trusts/Hospitals should have an on-call specialist vascular/diabetes lead – SCNs should promote this practice

Education and awareness raising

Raising awareness extends to both patients and clinicians. SCNs are in a strong position to act as an educator and raise awareness given the breadth of individuals they connect with; including patients, commissioners and clinicians. Few SCNs referred directly to awareness raising projects, suggesting they rely on this function to be carried out by other bodies.

In particular it should be communicated to clinicians and patients that amputation is a failure of treatment, and a functioning foot with minimal surgery should be the success. SCNs are in a strong position to promote this message.

The concern with “awareness raising” projects is that they are often intangible when it comes to assessing outcomes and impact. Wherever possible the impact of training and education should be recorded and successful initiatives should be replicated.
Following the issue of the 2013/14 NHS Standard Contract for Specialised Vascular Services (Adults) the East Midlands SCN invited all local providers of vascular services to submit a self-assessment of their provision. All services responded in full and returns were shared with specialised commissioners.

South East Coast SCN undertook a project to survey those involved in the delivery of foot care services. A second survey has just been launched to establish progress. This has been widely shared amongst commissioners and has provided support on how to address any gaps. It has also been utilised within proposed vascular service changes to ensure foot care MDT is carefully considered.

Measurement of success and outcomes

Failure to measure the outcomes and impact of initiatives would seem to be the biggest downfall of the work carried out by SCNs. No doubt lack of funding plays a major part in restricting this as does the relative infancy of these bodies. Yet with transparency and benchmarking being regularly cited by commissioners and government alike, it would seem counter-intuitive to have little or no power to assess the impact and outcomes of the projects undertaken by SCNs.

Of the responses received, few reported having regular mechanisms in place to assess the impact and outcomes of their work programmes. Some SCNs reported working towards a five year timeframe to monitor the trajectory of improvement in patient outcomes as a result of SCN work; yet this would seem to go against the tide of movement towards annual reporting and regular appraisals of outcomes. Others have initiated or supported ad hoc audits or surveys aimed at assessing the impact of an initiative after its implementation. Again there are limitations to this method given the lack of regular check points.

SCNs should ensure their recommendations to CCGs continue to be implemented through the NHS England CCG Assurance process.

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A number of SCNs (London SCN and Yorkshire & the Humber SCN) have conducted audits of local foot care services to determine how a service is performing. Findings from this will allow for the groups to advise on workforce requirements and service needs.

SCNs should ensure their recommendations to CCGs continue to be implemented through the NHS England CCG Assurance process.

The South West SCN has commissioned a formal peer review programme of diabetic foot care to reduce major and minor lower extremity amputation rates. The work involved a standardised peer review of foot care services for diabetes patients across all 14 acute trusts and 11 CCGs within the South West. The review team then made recommendations for change and improvement for commissioners to take forward. Improvements reported since April 2015, when the review was completed, include improved access to podiatry and the establishment of multidisciplinary teams with job planning for specialist involvement. A six-monthly follow-up with organisations will be carried out to establish progress and identify areas where support is required.
Recommendations:

► Regular/annual surveys or benchmarking should be carried out to understand progress and identify gaps in service provision

► SCNs should foster a positive, regular and open communication with CCG representatives

► SCNs should continue to support and encourage participation in the National Foot Care Audit
### APPENDIX 1 - PRIMARY CARE FOOTCARE PATHWAY – CHESHIRE AND MERSEYSIDE SCN

**Date of diagnosis**
On same day, patient should be asked if they have any problems with their feet. If yes, full foot screening to be carried out within first 12 weeks

**Within first 12 weeks**

**Within 1 week**

**Within 1 month**

**Initial foot screening and risk satisfaction (box 1 and 2)**

**Within first 12 weeks**

**Provide standardised footcare education; network agreed footcare information and supplementary resources**

**Initiate referral to appropriate education session**

**Up to 3x contact with practice nurse to include footcare education**

**Within first 12 weeks**

**Low risk**
Annual foot screening and risk satisfaction

**Low risk**
Referral to GP for ongoing foot screening

**Pediatric FPT to carry out satisfaction and onward referral if required (box 2, 3 and 4)**

**Within first 12 weeks**

**Active foot disease**
Referral to Multi disciplinary foot team immediately. To be seen by MDFT within 24 hours.

**Clinical emergency: ensure referral for immediate surgical/medical input**

**Increased /high risk**
Referral to foot protection team. To be seen by podiatry FPT within 4 weeks

**Consider box 4 (decision triggers)**

**Pediatric FPT to carry out satisfaction and onward referral if required (box 2, 3 and 4)**

**Within 2 weeks**

**Increased risk**
Assessment by FPT and development of clinically appropriate management plan including at least 3-6 month follow up

**Within first 12 weeks**

**Discharge back to foot protection team for management based on risk status**

**High risk**
Request referral to lower limb diabetology service for medical management of diabetes if uncontrolled. Development of clinically appropriate management plan including at least 1-3 month follow up

**MDFT to follow secondary care footcare pathway**

**Low risk**
Referral to foot protection team for management based on risk status

**GP practice to record risk satisfaction at least annually. Check if still known to FPT/MDFT. Re-refer if necessary as per box 1, 2, 4**

**Within 1 week**

**Within 1 month**

**Within 2 weeks**
STAMP pathway – Stamp Out Unnecessary Amputations

Patient presents with critical limb ischaemia
Urgent review and assessment by vascular surgeon
Requires immediate attention?

YES
Urgent admission to vascular centre
Urgent imaging: duplex, CTA or MRA
Urgent intervention by vascular surgery (bypass endarterectomy, thrombectomy)/Endovascular (angioplasty and stenting or thrombolysis)
Home/Amputation

NO
Urgent investigation as outpatient locally
Urgent imaging: duplex, CTA, MRA
Semi-urgent admission to vascular centre for vascular surgery (bypass endarterectomy or thrombectomy)
Day case angioplasty and stenting (locally or at vascular centre)