Will you pick up the baton? A NICE time to deliver gold-standard PAD care

The 2012 London Olympics delivered an unprecedented number of gold medals for the UK – 63, to be exact. However, there were certain events at which we did not win gold, one being the track relay events. It seemed to boil down to poor passing of the baton between athletes. The same could be said of the timely diagnosis and management of peripheral arterial disease (PAD). Most of the NHS has no chance of winning the PAD race, until we, as clinicians, plan our strategy and learn to pass the baton correctly. We in the NHS – like our Olympic relay teams – have some work to do.

Background

PAD has been described as "underdiagnosed and undertreated" (Belch et al, 2007); approximately 20% of people in the UK over the age of 60 have some degree of PAD (Fowkes et al, 1991). PAD is a recognised contributor to lower-limb ulceration – and ultimately amputation – and a marker for increased cardiovascular morbidity (Jude et al, 2001). People with PAD have a mortality rate of approximately 30% after 5 years (Halperin, 2002). Diabetes is among the strongest risk factors for PAD, with others including smoking, advanced age, hypertension and hyperlipidaemia (American Diabetes Association, 2003).

Currently, money and time are already being used on PAD assessment, referrals and management, but often this spending has evolved within local health economies organically, without structure or strategy. For example, currently within the same NHS Trust, podiatrists and nurses may assess lower-limb arterial supply using differing clinical criteria, thresholds and referral triggers for instigating lifestyle interventions, vascular medicines, limb treatments, or surgical referrals. These differences represent a combination of poor resource utilisation, regionalisation of the type of care patients receive (described by some as a "postcode lottery"), and may impact on the vascular outcomes – both limb and life – for patients.

NICE guidance on PAD

The foundations for gold-standard care have been laid with the publication of the first NICE guidance to focus on this area (NICE, 2012). The Guideline Development Group spent 2 years researching and refining this document.

As a minimum, the publication of new NICE guidance offers the opportunity to take stock of where we are in relation to gold-standard care and where we can make local improvements – and improvements may mean changes in the design of clinical services, habits and culture, rather than simply pumping more NHS money into PAD care. For example, assessing, diagnosing and managing PAD better in community services could result in referring fewer, but more appropriate, cases to hospital vascular clinics, which could, in turn, free up surgical appointment slots to allow rapid access for people with critical limb ischaemia, thus unlocking improvement at no significant additional cost.

There are 29 recommendations in the full NICE guidance for PAD and six have been reproduced in *Box 1* for you to consider in relation to the clinical team you work in. Ask yourself: "Where is your service in relation to delivering these recommendations for all people with PAD who attend your clinic, all of the time?"

Implementation

We have the guidance on how to commission PAD services (Primary Care Commissioning, 2009) and what to deliver (Scottish Intercollegiate Guidelines Network, 2006; NICE, 2012), but have the public and all clinicians, managers and commissioners noticed? Has it been embraced and implemented uniformly across the NHS? I would suggest the simple answer so far is "no" – but some progress is being made.

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In the north-west of England, PAD assessment, diagnosis, and management services are now being commissioned and redesigned from existing clinical services in the NHS, often set up in the community, with strong links to vascular and multidisciplinary diabetic foot teams in nearby hospitals. It has been a small and quiet revolution so far, but these services now exist in Manchester, Tameside, Salford, Bury and Preston, led by experienced specialist podiatrists and nurses from a range of related clinical backgrounds (e.g. diabetic foot care, vascular, tissue viability and leg ulcer services). The clinicians involved are usually being supported and mentored by local Hospital Vascular Teams, where many of them developed their PAD competencies and experience.

PAD champion? It could be you!

Identified PAD champions are needed now in every NHS organisation to bring the guidance to life. But who should these be?

Putting Feet First: Commissioning/Planning a Care Pathway For Foot Care Services For People With Diabetes (Diabetes UK, 2012) is one of the recent collaborations published by a committee of those involved in the care of the diabetic foot. In this document it is recommended that in diabetes, even without foot ulceration: "People thought to have symptomatic peripheral arterial disease should be referred either to a vascular surgical unit for assessment, or to the MDT." However – and quite naturally – diabetic foot clinics have a foot-focused approach and I would argue are not always natural PAD champions. For example, we know that people with PAD and diabetic foot ulcers have a high cardiovascular mortality risk and yet we actively prevent them from exercising, by advising them to rest the ulcerated or vulnerable foot, often for months or years. Also, ask yourself – when was the last time you taught your foot ulcer patient the importance of their blood pressure and lipid targets, compared to teaching them about "good shoes"?

For the majority of people with PAD, aggressive cardiovascular risk management is at the heart (excuse the pun) of improving outcomes, both for life and limb. Work by Young et al (2008), and more recently Morbach et al (2012), around optimising cardiovascular medicines management in diabetic foot clinics is a promising shift, but still seems to be the exception, rather than the norm.

Diabetic foot clinic teams commonly comprise those with the skill sets required for PAD diagnosis and management, as per the new NICE guidance (2012), with physicians, specialist nurses, podiatrists and dieticians all involved. If the diabetic foot clinic "urgent care" paradigm can shift to include aggressive cardiovascular risk management as a part of foot risk management, we may start to see better outcomes with respect to both mortality and amputation.

Beyond the use of medicines, the new NICE guidance (2012) has also freed PAD from the perception of being solely a "surgical disease" with the evidence-based recommendation that structured exercise should be offered before vascular surgical interventions for the majority of people with claudication. This key recommendation does not exclude those with diabetes; nor does it exclude those with foot ulceration or prior amputation. Low impact, cardiovascular exercise offered and provided by the NHS for all people with diabetic foot ulcers and PAD? Why not?

Box 1. Six of the 29 recommendations made by NICE (2012) in *Lower Limb Peripheral Arterial Disease* (CG147). How often are these recommendations being achieved in your practice? Always? Sometimes? Never?

- 1.2.1 Offer all people with peripheral arterial disease information, advice, support and treatment regarding the secondary prevention of cardiovascular disease
- 1.3.1 Assess people for the presence of peripheral arterial disease if they are being considered for interventions to the leg or foot
- 1.3.2 Assess people with suspected peripheral arterial disease by examining the femoral, popliteal and foot pulses
- 1.5.1 Offer a supervised exercise programme to all people with intermittent claudication
- 1.6.1 Ensure that all people with critical limb ischaemia are assessed by a vascular multidisciplinary team before treatment decisions are made
- 1.6.9 Refer people with critical limb ischaemic pain to a specialist pain management service if their pain is not adequately controlled and revascularisation is inappropriate or impossible

Delivering NICE "gold"

Those 63 Olympic gold medals last summer were the culmination of years of preparation and a shared goal by our athletes, coaches, and support teams. If we in the NHS are to deliver the 29 gold-standard recommendations for PAD that NICE has established, we need local PAD champions, unity of purpose, shared responsibility and service redesign

around early detection, diagnosis and management. The PAD baton needs to be shared and passed in a timely fashion between all clinicians – community, primary care, acute – who manage people with diabetes on a day-to-day basis, hospital-based teams who treat active diabetic foot disease and vascular surgical teams.

First and foremost, like our Olympic relay runners, we need to appraise where we are now and work out how to achieve "gold" PAD care in 4 years' time. The NICE guidance (2012) informs us on what to do, but it is only by becoming –or supporting – PAD champions and initiating positive change that improvements in outcomes for people with PAD will be achieved.

So, I ask you, by the time our Olympic and Paralympic athletes go to Brazil in 2014, could you be delivering "gold" standards for your PAD patients? What's to stop you? ■

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