

2026

Making the Case for Reform in the Vascular Sector

**NHS ENGLAND; ROYAL COLLEGE OF PODIATRY; ASSOCIATION OF
BRITISH HEALTHTECH INDUSTRIES (ABHI); VASCULAR AND VENOUS
DISEASE ALL PARTY PARLIAMENTARY GROUP (VVAPPG)**

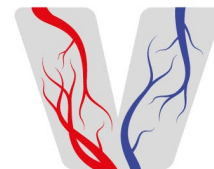


ROYAL COLLEGE
of PODIATRY

ABHI



ALL-PARTY
PARLIAMENTARY GROUP
ON VASCULAR AND
VENOUS DISEASE



Recommendations (5 Key Asks)

1. Fund and implement a National Foot Attack Pathway

1. Adopt and fund a national pathway, supported by public awareness, mandated same-day or next-day triage standards, and expanded workforce capacity (podiatry, vascular nurses, surgical and interventional radiology training).
2. Develop a national public awareness campaign (modelled on FAST for stroke) to support high-risk groups to recognise urgent foot problems and seek early assessment.

2. Establish community Foot Protection Services in every ICS

1. Commission dedicated multidisciplinary community services (“foot protection services”), linked to arterial centres, with ringfenced funding, data capture, and accountability for outcomes.
2. Mandate adoption of the National Wound Care Strategy Programme (NWCSP) best practice and “first assessment clinic” model across all ICSs.
3. Prioritise tackling health inequalities by addressing barriers faced by people in deprived areas, older adults and rural communities.

3. Set national maximum waiting times

1. Guarantee urgent vascular assessment within 5 days for inpatients and 2 weeks for outpatients, with performance transparently reported at a national level.

4. Reform commissioning to reward outcomes

1. Reform commissioning to outcomes-based models that incentivise earlier diagnosis, faster healing, reduced bed days, and fewer amputations, building on vascular CQUIN.

5. Accelerate proven innovation

1. Use the NHS Innovator Passport to fast-track adoption of cost-effective wound care technologies (e.g. compression, digital monitoring).

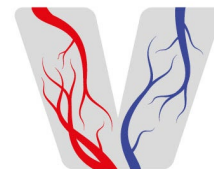
Summary of Principal Points in relation to the introduction of a Government- Led new Lower Limb Vascular Care Programme

Faster urgent care and fewer amputations. Achieving PAD-QIF time standards nationally should reduce 1 year mortality and major amputation after CLTI revascularisation; delayed revascularisation is independently associated with worse outcomes in English data.

Better venous outcomes at lower cost. Universal adoption of NWCSP lower limb recommendations and NICE LSA guided compression procurement should improve 12 and 24 week healing rates and reduce wound recurrence, shifting cost from unhealed to healed wounds. Success is measured by healing and recurrence metrics and community nurse visit volumes per healed case.

Improved diabetic foot prevention. A National Foot Attack campaign and mandated urgent pathways should reduce emergency admissions and major amputations, given that >80% of diabetes related-amputations are preceded by a foot ulcer. Success is measured via NDFA indicators: time to specialist assessment, ulcer severity at first expert review, and amputation rates¹.

¹ See [Context | Diabetic foot problems: prevention and management | Guidance | NICE](#), accessed 20th October 2025.



Foreword

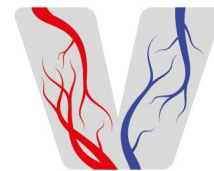
Foot and lower limb vascular disease do not affect all communities equally, with higher rates of ulceration, infection and amputation concentrated in areas of socio-economic deprivation where reliance on NHS provision is greatest and access to preventative podiatry and vascular care has often been most constrained. Intersectional factors, including low income, multimorbidity, disability, racialised disadvantage and insecure work, combine with variable community provision to create a postcode lottery in foot and lower limb outcomes, reinforcing avoidable pain, immobility and premature loss of independence. These inequalities are already visible in national datasets, where worse vascular and diabetic foot outcomes consistently map onto more deprived communities, underlining the need for proportionate universalism in lower limb vascular care, with more intensive support where risk and need are highest. A prevention led, community first model for vascular lower limb disease must therefore be explicitly designed to narrow these gaps, not simply improve average performance.

Governmental focus on vascular lower limb disease offers the Government the NHS, and system partners a visible, near-term win for the Government's 10 Year Health Plan. It represents an opportunity to cut waiting lists, relieve pressure on hospitals and reduce spend in one of the costliest and time-consuming areas of treatment, while improving outcomes and reducing inequalities in access and outcomes across England. The conditions for success are already in place. Time to treatment standards have been defined through the PAD Quality Improvement Framework, which should now be mandated and transparently reported. The National Wound Care Strategy Programme has shown how community services can transform outcomes, and the EVRA trial has provided evidence of the benefits of early venous intervention. National levers for innovation and accountability, including the Innovator Passport, are available and ready to be applied. This should be prioritised to address the highest areas of unmet need, such as lower limb vascular care. By adopting a National Foot Attack Pathway, commissioning community "foot protection services" in every Integrated Care System, aligning the workforce and mandating national standards, publishing outcomes through real-time dashboards. The Government can deliver a package that reduces amputations, speeds healing and frees hospital capacity within this Parliament.

This would show that the ambitions of the 10 Year Health Plan can be translated into measurable impact. Care would move from hospital to community through Integrated Care Systems whilst analogue processes would give way to digital documentation and remote monitoring. Sickness would be addressed earlier through prevention-first interventions such as PAD checks in NHS Health Checks, public recognition of "foot attack," and consistent compression for venous disease, delivered equitably through every ICS. This approach to lower limb vascular care also reflects the Plan's enabling pillars and the collaborative ethos shown across the vascular community during this process, from clinicians and patient advocates to industry and system leaders. This includes a new operating model with clear accountability, a re-shaped innovation strategy that brings proven technologies into use more quickly, and stronger transparency through publication of treatment times.

The opportunity is timely, achievable and politically visible. By acting now, Ministers can demonstrate progress within a single Parliament, improve patient outcomes and deliver savings to the health and care system, while taking a decisive step towards ending avoidable lower-limb amputation. Above all, this package would show that the 10 Year Health Plan is not only a set of commitments but a practical programme that can deliver real change.

Jim Shannon MP, Chair, VVAPPG and Professor Stella Vig, Deputy National Medical Director for Secondary Care and Quality and National Clinical Director for Elective Care, NHS England



Executive summary

Vascular disease remains one of the leading causes of preventable disability and premature death in the UK. Despite progress in cardiac and stroke care, outcomes for people with peripheral arterial and venous disease have not improved at the same pace. Many still experience delayed diagnosis, inconsistent referral pathways and variable access to specialist care, resulting in avoidable harm and thousands of major lower-limb amputations each year.

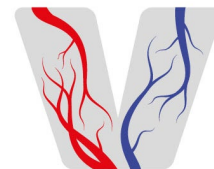
This report, commissioned by the Association of British HealthTech Industries (ABHI), produced by the Vascular and Venous All-Party Parliamentary Group (VVAPPG), and supported by NHS England and the Royal College of Podiatry, sets out a cohesive vision to transform lower-limb vascular care in England. Drawing on contributions from clinicians, patient representatives, academics and industry leaders at a parliamentary event in October 2025, it outlines practical, evidence-based steps that can be implemented within existing NHS frameworks and resources.

The central argument is that a community-first model of vascular care offers the fastest route to earlier diagnosis, better outcomes and greater efficiency. Dedicated multidisciplinary “foot protection services” within every Integrated Care System (ICS) would move care closer to home, reduce travel and access barriers, and release acute capacity by preventing deterioration and avoidable admissions. These services should be networked to arterial centres, supported by interoperable data and a strengthened community workforce.

Achieving this transformation will depend on clear national leadership, mandated standards and modernised commissioning. The report identifies five key actions to deliver measurable improvements in outcomes and equity:

1. **Fund and implement a National Foot Attack Pathway**, with mandated same-day or next-day triage and a national public awareness campaign.
2. **Establish community Foot Protection Services in every ICS**, aligned with National Wound Care Strategy Programme standards.
3. **Set national maximum waiting times** for vascular assessment and revascularisation, with transparent national reporting.
4. **Reform commissioning to reward outcomes**, incentivising prevention, faster healing and reduced amputations.
5. **Accelerate proven innovation**, using the NHS Innovator Passport to fast-track cost-effective technologies.

Together, these reforms would deliver faster urgent care, fewer amputations, improved healing rates and reduced hospital pressures. Within a year, early adopters could begin implementation; within five years, equitable, prevention-led vascular care could be embedded nationwide. With clear leadership and collaboration across Government, NHS England and the vascular community, England can take a decisive step towards the long-term goal of ending avoidable lower-limb amputations within a decade.



Background and purpose

Vascular disease remains one of the most significant causes of preventable disability and premature death in the UK. Despite advances in cardiac and stroke care, outcomes for people with peripheral arterial and venous disease have not improved at the same pace. However, too many people continue to experience delayed diagnosis, inconsistent referral pathways and uneven access to specialist care. This paper seeks to outline a cohesive vision for change, one that places prevention and early intervention at the heart of the system and ensures equitable access to high-quality, multidisciplinary care for all.

The scale of the challenge is considerable. Every year, thousands of people in the UK undergo major lower-limb amputations, many of which could have been prevented with timely detection and intervention. The personal and economic cost is profound: lives shortened, livelihoods lost, and significant pressures placed on health and social care systems. Yet evidence shows that earlier assessment, coordinated treatment and community-based support can substantially reduce the risk of amputation and mortality. This report therefore sets out a pragmatic pathway for progress which is aligned with the ambitions of the NHS 10 Year Health Plan. It aims to translate these national commitments into practical, actionable steps for improvement – within existing resources wherever possible.

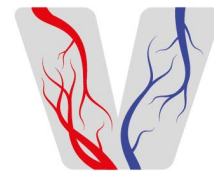
Achieving this change will require collaboration across all parts of the system. Improved outcomes will depend on strengthening the links between primary care, community services and specialist vascular teams, and on ensuring that Integrated Care Boards (ICBs) take shared responsibility for population-level vascular health. The approach advocated here combines national consistency with local flexibility, empowering systems to design models that reflect their communities while meeting common standards of care.

This is not a call for new structures or costly reorganisation, but for better alignment of what already exists. By maximising the capacity of the current workforce, improving data flows, and embedding a culture of prevention, the sector can deliver significant progress within the next five years. The recommendations that follow focus on achievable steps to modernise services, reduce unwarranted variation and prevent avoidable harm, ensuring that every limb saved and every life extended marks progress towards a more equitable, effective and prevention-focused vascular system.

This report, commissioned by the Association of British HealthTech Industries (ABHI), produced by the Vascular and Venous All-Party Parliamentary Group (VVAPPG), and supported by NHS England and the Royal College of Podiatry. Led by a Working Group², representatives from across the sector have contributed to the thinking, development and ambition of this paper and the engagement that will take place around it. The recommendations have been shaped following a parliamentary event convened by ABHI and the VVAPPG, which brought together dozens of experts and stakeholders from across the vascular community to share their experience, expertise and priorities for change.

The case for urgent action

² The Working Group includes representatives from The Association of British HealthTech Industries (ABHI), the Vascular and Venous All-Party Parliamentary Group (VVAPPG), NHS England and The Royal College of Podiatry.



Because chronic vascular conditions such as peripheral arterial disease (PAD), venous ulceration, diabetes-related foot complications, and critical limb-threatening ischaemia (CLTI) are so closely associated with age and multimorbidity, demographic pressures alone will expand the pool of patients at risk. More than 80 per cent of amputations in people with diabetes are preceded by a foot ulcer, which underlines how the combination of ageing, diabetes and vascular disease compounds the challenge and reinforces the need for prevention-led care.

The consequences of late or inconsistent care are already visible in performance data. For CLTI, the most severe form of PAD, the National Vascular Registry reports a median wait of six days from non-elective admission to revascularisation, with only half of patients treated within the recommended five-day window. Peer-reviewed studies show that longer waits are associated with worse outcomes³. These figures illustrate the avoidable deaths and harms that the NHS 10 Year Health Plan has committed to eliminating through greater standardisation and transparency.

Financial pressures mirror the human impact. Guest et al. estimated that in 2017/18 the NHS spent £8.3 billion on wound care, with £5.6 billion devoted to unhealed wounds⁴. Most of this expenditure fell on community services, confirming that earlier diagnosis and consistent adoption of compression protocols are the real levers of value. Given demographic trends and clinical pressures, these costs have almost certainly increased since the analysis was undertaken. NICE has now issued late-stage assessment guidance to help commissioners and clinicians procure effective compression at scale, removing a long-standing barrier to consistency.

The Government has also created wider policy levers that can accelerate change. The operating model set out in the 10 Year Health Plan aims to strengthen transparency and accountability, while the reshaped innovation strategy, including the new “Innovator Passport,” is designed to bring proven technologies into practice more quickly. If these tools are used in concert, vascular care can become an early, measurable demonstration of success for the Plan within this Parliament, showing how prevention, consistency and innovation can deliver measurable benefits for patients and the system alike.

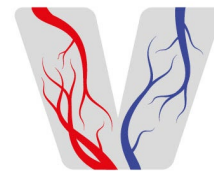
1. Why Community First is essential

A Community First approach is the fastest and most effective route to earlier detection of vascular risk and to prevention-led care delivered closer to home. By anchoring services in the community and coordinating assessment and intervention alongside GPs, nurses and podiatrists, Integrated Care Systems (ICSs) can improve outcomes for lower limb vascular disease while reducing reliance on acute settings thus directly supporting national ambitions for shifting care upstream, aligning with the neighbourhood models of care and reducing existing health inequalities within vascular care.

Community podiatrists are already a critical first point of contact for conditions such as peripheral arterial disease (PAD) and diabetic foot complications, routinely undertaking Doppler/Ankle Brachial Pressure Index

³ Li Q et al. Delays to revascularisation and clinical outcomes in chronic limb-threatening ischaemia. *Br J Surg.* 2022;109(8):717–726.

⁴ Guest JF, Fuller GW & Vowden P (2020) ‘Cohort study evaluating the burden of wounds to the UK’s National Health Service in 2017/2018: update from 2012/2013’, *BMJ Open*, 10: e045253. doi: 10.1136/bmjopen-2020-045253



(ABPI) assessment, triage, wound care and urgent referrals. National programmes—most notably the National Wound Care Strategy Programme (NWCSP) and the Health Innovation Network (HIN)—have demonstrated that when these functions are formalised into dedicated lower limb services, patient journeys and outcomes improve across diverse geographies. Standardised triage, ABPI assessment, compression initiation, wound documentation and clear escalation pathways consistently lead to earlier intervention, more efficient care, and reduced variation.

These structured services operate effectively as community lower limb hubs or “foot protection services” and should be commissioned across all ICSs to ensure equitable access and consistent standards of care. Strong links to arterial hubs provide rapid access to specialist advice, imaging and intervention, enabling community teams to manage lower-complexity wounds promptly while arterial centres focus on urgent revascularisation and complex cases. Embedding interoperable digital systems between community and acute teams will support real-time escalation, audit, digital wound monitoring, and structured outcomes tracking—key commitments of the 10 Year Health Plan.

Crucially, locating services closer to where people live reduces travel and access barriers, particularly for older patients, helps keep more people ulcer-free and ambulatory, and relieves pressure on acute vascular beds. This prevention-led, community-anchored model aligned to neighbourhood models of care, also provides the foundation for empowering patients through education and self-management support. To deliver this model at scale, investment in community workforce capability, including upskilling and protected leadership roles for podiatrists, will be essential. In combination, these elements create a sustainable, prevention-driven system that improves access, equity and outcomes across every ICS.

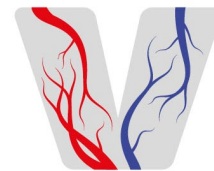
Additionally, podiatry led community foot protection services provide a practical mechanism to operationalise the health inequalities duty of ICSs by concentrating capacity, surveillance and education in high need neighbourhoods, rural communities and older populations who face the greatest barriers to accessing care. Place based podiatry models already demonstrate how targeted investment in community services, linked to arterial centres and underpinned by robust data, can reduce variation in access, drive down amputation rates and improve mobility outcomes in deprived populations. Embedding equity-focused metrics for foot and lower limb outcomes into NVR and NDFA dashboards and aligning outcomes-based commissioning with reductions in deprivation-related gaps in ulcer healing, CLTI revascularisation times and major amputation, would ensure that the proposed reforms deliver measurable progress towards fairer vascular outcomes across England.

2. Disease-specific challenges

The challenges vary across conditions but share the same pattern of delayed intervention, inconsistent standards, and poor outcomes. The evidence for peripheral arterial disease (PAD), venous disease and diabetic foot care demonstrates the scale and urgency of reform.

PAD affects around one in five people over the age of 60⁵ according to the Vascular Society’s Quality Improvement Framework. Most cases will remain stable, but a significant minority progress to chronic limb-threatening ischaemia (CLTI), which carries a high risk of amputation and death unless timely revascularisation can be undertaken. Current performance shows a critical gap: the National Vascular

⁵ Boyle J. R., Atkins E. R., Birmipili P., Pherwani A. D., Brooks M. J., Biram R. W. S., Gohil K., Williams R., Mouton R. A Best Practice Care Pathway for Peripheral Arterial Disease. *J.Vasc.Soc.G.B.Irel.* 2022;1(Supp3): S1– S13.



Registry⁶ reports that only half of patients admitted non-electively with CLTI receive revascularisation within five days, despite national standards and a Commissioning for Quality and Innovation (CQUIN) indicator introduced in 2022/23. Evidence confirms that longer waits worsen survival rates and amputation outcomes, and the disparity between those interventions with other time-critical conditions such as stroke or myocardial infarction underlines the urgency for reform⁷. Improving rapid access to vascular specialists and shared community triage capacity will be critical to closing this gap.

Venous disease poses a different, but equally significant challenge. Venous leg ulcers recur frequently and heal slowly when assessment and compression are inconsistent⁸. Delayed arterial assessments have a significant impact on intervention and adequate compression. Evidence-based care bundles, including the NWCSP Lower Limb Recommendations and the 2024 Leg Ulcer Best Practice Bundle, set out what commissioners should purchase and providers should deliver: rapid identification and assessment, compression first where appropriate, escalation to venous intervention when needed, and structured care to prevent recurrence⁹. NICE's late-stage assessment guidance now supports procurement of cost-effective compression products, removing a major barrier to consistency¹⁰. The EVRA trial in the UK further demonstrated that early endovenous ablation, in addition to compression, accelerates healing of venous ulcers and reduces recurrence, highlighting the importance of embedding best-practice venous pathways in every ICS, supported by shared data and audit systems¹¹.

Diabetes compounds the challenge further, magnifying the risks created by delayed detection and inconsistent care. It is mandated by NICE that adults with diabetes should have a foot check when diabetes is diagnosed and at least once a year after that. However, in 23/24 it was reported that only 70.6% of people with type 1 diabetes received general practice foot checks with the proportion of the people with type 2 diabetes receiving foot check examinations being 81.3%¹². Foot checks are a key opportunity to check for danger signs, to make people with diabetes understand their risk and to take preventative action if the risk is high. The amount of patients falling through the cracks is resulting in worse patient outcomes while increasing higher aggregate cost for the NHS.

Furthermore, diabetes remains the leading cause of non-traumatic lower limb amputation, with more than 80 per cent of cases preceded by a foot ulcer. Timely vascular assessment, protection, offloading, and infection control therefore represent decisive opportunities for prevention. Data from the National Diabetes Foot Audit (NDFa)¹³ and the Office for Health Improvement and Disparities (OHID) show persistent regional variation in outcomes, and where systems have acted, improvements have followed. The Manchester Amputation Reduction Strategy (MARS), for example, achieved a 40 per cent reduction in amputations over

⁶ Waton S, Johal A, Li Q, Atkins E, Cromwell DA, Williams R, Harkin DW, Pherwani AD. National Vascular Registry: 2023 Supplementary Report. London: The Royal College of Surgeons of England, November 2023.

⁷ Li Q et al. Delays to revascularisation and clinical outcomes in chronic limb-threatening ischaemia. *Br J Surg*. 2022;109(8):717–726.

⁸ Guest JF, Fuller GW, Vowden P. Cohort study evaluating the burden of wounds in the UK. *BMJ Open*. 2018;8(12): e023491.

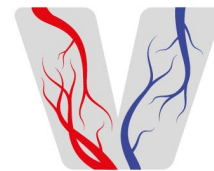
⁹ National Wound Care Strategy Programme (2024) Leg Ulcer Best Practice Bundle.

¹⁰ Guest JF et al. *BMJ Open* 2018;8(12): e023491.

¹¹ Gohel MS et al. A Randomized Trial of Early Endovenous Ablation in Venous Ulceration. *N Engl J Med*. 2018;378(22):2105–2114.

¹² UK Parliament (2025) Diabetes: Orthopaedics and Podiatry — Written Question UIN 49470 answered 6 May 2025.

¹³ National Diabetes Foot Care Audit (NDFa). *Annual Report 2023*. NHS England, 2023.



six years by levelling up multidisciplinary access¹⁴ and providing a model that could and should be replicated nationally. Ensuring that every ICS commissions a fully resourced Foot Protection Service, integrated within diabetes management pathways, will be key to sustaining these improvements. A nationally mandated “foot attack” model would embed this logic consistently, ensuring same-day or next-day triage to skilled teams and rapid vascular input. Together, these examples underline the case for consistent national pathways that reduce variation and deliver equitable vascular outcomes.

3. Enablers of change

Delivering this transformation requires targeted enablers in workforce, standards, and innovation. Workforce reform is critical, with leadership, capacity and skills all cited as limiting factors at both national and ICS level. The 10 Year Health Plan commits to a “new workforce model,” and vascular should be an early adopter that will restore podiatry numbers in community teams; create vascular community nurse roles with compression and Doppler skills; protect vascular surgical and interventional radiology training lists; and develop rotational posts linking community hubs with arterial centres to build skills and continuity. Retention incentives and clear progression routes will also be vital to sustain expertise within community services, which should be supported by a designated vascular workforce lead within the NHS.

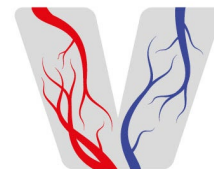
Standards and accountability are equally important. The PAD Quality Improvement Framework already defines treatment timelines, now embedded in a national CQUIN to drive consistency in practice. Government should convert and mandate these into maximum waiting time standards for urgent vascular assessment, vascular imaging and revascularisation, while mandating adoption of NWCSP recommendations and the Leg Ulcer Best Practice Bundle across all ICSs to eliminate unwarranted regional variation. Outcomes-based commissioning should follow, with payments linked to prevention, faster healing, reduced recurrence, and fewer major amputations, all supported by transparent, real-time reporting and dashboards through national datasets such as the NVR and NDFA.

Innovation is essential to accelerate adoption of best practice. The new NHS “Innovator Passport” provides a practical route to overcome barriers in HealthTech uptake. For lower limb care, priorities include digital wound documentation and monitoring, cost-effective compression products procured coherently using NICE guidance, and validated community diagnostics for PAD detection, such as automated ABPI and TBI devices. Lower limb vascular care should be positioned as an early test case for this approach, shortening procurement cycles and eliminating postcode variation, and demonstrating measurable gains in prevention and access.

4. Impact on the NHS

Accelerating urgent PAD care, standardising lower limb wound pathways, prioritising limb salvage and embedding value-based procurement will have a direct and beneficial impact on both NHS pressures and patient outcomes, supporting ICS-level delivery of prevention and early intervention. Major amputations cost the NHS tens of thousands of pounds per case, in addition to long-term social care costs, while each unhealed wound generates repeat community visits and avoidable admissions. The NHS elective backlog was around 7.4 million incomplete pathways in early 2025, with vascular surgery and interventional radiology

¹⁴ Greater Manchester & Eastern Cheshire Strategic Clinical Network. *Manchester Amputation Reduction Strategy (MARS): Final Evaluation Report*. NHS England North, 2020.



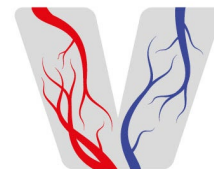
facing constraints because urgent CLTI cases compete for theatre time, endovascular suites and HDU beds, highlighting how delayed prevention increases downstream system strain¹⁵.

Guest and colleagues estimated that wound care already consumes more than £8 billion annually, with two-thirds spent on wounds that fail to heal¹⁶. By shifting care into enhanced community hubs and preventing deterioration, hospitals can release theatre capacity, high dependency beds and staff time, allowing focus on urgent and complex cases. This aligns directly with the Government's elective recovery ambitions and with the 10 Year Health Plan commitment to reduce failure demand by providing effective care closer to home and supports the wider system reforms in workforce and innovation.

The savings released by fewer admissions, shorter in-patient stays and lower wound recurrence rates will allow focussed investment in both innovation and the workforce demonstrating fiscal responsibility while improving outcomes. In doing so, the NHS can deliver sustainable, prevention-led vascular care at scale.

¹⁵ NHS England. Referral to Treatment (RTT) Waiting Times Data, January 2025. London: NHS England, 2025.

¹⁶ Guest JF, Fuller GW & Vowden P (2020) 'Cohort study evaluating the burden of wounds to the UK's National Health Service in 2017/2018: update from 2012/2013', *BMJ Open*, 10:e045253. doi: 10.1136/bmjopen-2020-045253.



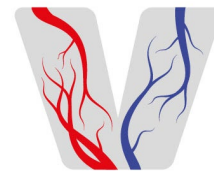
Conclusion

Vascular lower limb disease offers the Government, the NHS and system partners a visible, near-term opportunity to demonstrate the ambitions of the 10 Year Health Plan in practice. It represents an opportunity to cut waiting lists, relieve pressure on hospitals, and reduce spend in one of the most resource-intensive areas of care. The conditions for success are already in place. Time to treatment standards have been defined through the PAD Quality Improvement Framework. The National Wound Care Strategy Programme has shown how community services can transform outcomes, and the EVRA trial has provided evidence of the benefits of early venous intervention. National levers for innovation and accountability, including the Innovator Passport, are available and ready to be applied.

By adopting a National Foot Attack Pathway, commissioning community “foot protection services” in every Integrated Care System, aligning the workforce and mandating national standards, Government can deliver a package that reduces amputations, speeds healing and frees hospital capacity within this Parliament, demonstrating measurable progress within 24 months and setting a foundation for longer-term equity. This would show that the ambitions of the 10 Year Health Plan can be translated into measurable impact. Care would move from hospital to community through Integrated Care Systems while analogue processes would give way to digital documentation, remote monitoring and shared data systems. Sickness would be addressed earlier through prevention-first interventions such as PAD checks in NHS Health Checks, public recognition of “foot attack,” and consistent compression for venous disease.

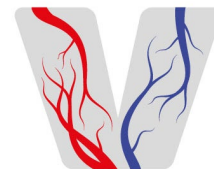
This approach also fully aligns with the Plan’s enabling pillars. A new operating model with clear accountability, a re-shaped innovation strategy that brings proven technologies into use more quickly, and stronger transparency through publication of treatment times and outcomes would all be realised in vascular care.

The opportunity is timely, achievable and politically visible. By acting now, ministers and system leaders can demonstrate tangible progress within a single Parliament, improve patient outcomes and deliver savings to the health and care system. Above all, this package would show that the 10 Year Health Plan is not only a set of commitments but a practical programme that can deliver real change.



Recommended Restructure (5 Key Asks)

- 1. Fund and implement a National Foot Attack Pathway**
 1. Adopt and fund a national pathway, supported by public awareness, mandated same-day or next-day triage standards, and expanded workforce capacity (podiatry, vascular nurses, surgical and interventional radiology training).
 2. Develop a national public awareness campaign (modelled on FAST for stroke) to support high-risk groups to recognise urgent foot problems and seek early assessment.
- 2. Establish community Foot Protection Services in every ICS**
 1. Commission dedicated multidisciplinary community services (“foot protection services”), linked to arterial centres, with ringfenced funding, data capture, and accountability for outcomes.
 2. Mandate adoption of the National Wound Care Strategy Programme (NWCSP) best practice and “first assessment clinic” model across all ICSs.
 3. Prioritise tackling health inequalities by addressing barriers faced by people in deprived areas, older adults and rural communities.
- 3. Set national maximum waiting times**
 1. Guarantee urgent vascular assessment within 5 days for inpatients and 2 weeks for outpatients, with performance transparently reported at a national level.
- 4. Reform commissioning to reward outcomes**
 1. Reform commissioning to outcomes-based models that incentivise earlier diagnosis, faster healing, reduced bed days, and fewer amputations, building on vascular CQUIN.
- 5. Accelerate proven innovation**
 1. Use the NHS Innovator Passport to fast-track adoption of cost-effective wound care technologies (e.g. compression, digital monitoring).



Indicative Timeframes for Delivery

Timeframe	Strategic Actions / Outcomes
0–12 Months	<p>System Leadership & Early Implementation</p> <ul style="list-style-type: none"> • Appoint a national vascular lead to coordinate workforce, data and pathway reform. • Mandate PAD-QIF waiting-time standards (5-day / 2-week) with national reporting via NVR/NDFA dashboards. • Publish a National Foot Attack Pathway and begin pilot rollouts in selected ICBs. • Commission early-adopter community lower-limb hubs (foot protection services) aligned to NWCSP standards. • Launch the national “Foot Attack” public awareness campaign (with Diabetes UK and OHID). • Add vascular roles (podiatry, vascular nurses, rotational posts) to the next NHS workforce planning round.
12–24 Months	<p>National Spread & Data Integration</p> <ul style="list-style-type: none"> • All ICSs operating at least one commissioned vascular or lower-limb hub linked to arterial centres. • Full implementation of NWCSP and Leg Ulcer Best Practice Bundle with performance reporting. • Routine use of interoperable community-to-acute data systems for wound documentation and triage. • Outcomes-based commissioning frameworks introduced across vascular and wound-care services. • Expanded podiatry and vascular nurse workforce with retention incentives and progression pathways.
3–5 Years	<p>Impact, Equity & System Transformation</p> <ul style="list-style-type: none"> • National reduction in major amputations by 20–25%. • Average venous leg ulcer healing times improved by 30%. • Equitable access achieved in all ICSs, evidenced through NDFA/NVR parity metrics. • Demonstrable acute-capacity release from community-first models (shorter stays, fewer emergency admissions). • Innovation fast-track process routinely used for wound-care and PAD diagnostic technologies.