1) A ‘best practice’ clinical care pathway, supporting the aims of the Vascular Society’s Quality Improvement Framework for Major Amputation Surgery, and covering all aspects of the management of patients requiring amputation should be developed. This should include protocols for transfer, the development of a dedicated multidisciplinary team (MDT) for care planning of amputees and access to other medical specialists and health professionals both pre- and post operatively to reflect the standards of the Vascular Society of Great Britain and Ireland, the British Association of Chartered Physiotherapists in Amputee Rehabilitation and the British Society of Rehabilitation Medicine. It should promote greater use of dedicated vascular lists for surgery and the use of multidisciplinary records. (Vascular Society of Great Britain & Ireland (development), Medical Directors (implementation))

2) All patients with diabetes undergoing lower limb amputation should be reviewed both pre- and post operatively by the specialist diabetes team to optimise control of diabetes and management of co-morbidities. The pre-operative review should not delay the operation in patients requiring emergency surgery. (Consultant Diabetologists)

3) As recommended in the Quality Improvement Framework for Major Amputation Surgery (VSGBI), all patients undergoing major lower limb amputation should have a named individual responsible for the co-ordination of their rehabilitation and discharge (amputation/discharge co-ordinator). Their role should include the provision of detailed written information for patients and their relatives covering the whole clinical pathway. (Medical Directors, Clinical Directors)

4) The decision to undertake a major amputation should be made by a multidisciplinary team (MDT) including vascular surgery, physiotherapy, occupational therapy, diabetology, radiology, specialist nursing and an amputation/discharge co-ordinator. Where the urgency of surgery prevents this, as a minimum patients should be discussed with a consultant vascular surgeon and reviewed by a consultant anaesthetist, before amputation. (Medical Directors)

5) All Trusts should have formal access to a consultant service in rehabilitation medicine that includes the post operative care of patients after major lower limb amputation. (Medical Directors)

6) When patients are admitted to hospital as an emergency with limb-threatening ischaemia, including acute diabetic foot problems, they should be assessed by a relevant consultant within 12 hours of the decision to admit or a maximum of 14 hours from the time of arrival at the hospital, in line with current guidance. If this is not a consultant vascular surgeon then one should be asked to review the patient within 24 hours of admission. (Medical Directors)

7) A model for the medical care of amputees, should be introduced which includes regular review by a physician and a surgeon throughout the in-patient stay. The existing orthogeriatric model serves as a good example in current practice. (Medical Directors and Specialist Commissioners)

8) NICE recommends that a nutritional assessment of all patients should be made within the first 48 hours of admission (CG32). This guidance should be implemented for all patients requiring lower limb amputation. (All Health Care Professionals)
9) All patients admitted electively for lower limb amputation should be seen in a pre-assessment clinic to optimise medical co-morbidities and to plan post operative rehabilitation. *(Clinical Directors, Consultant Anaesthetists)*

10) For patients undergoing major limb amputation, planning for rehabilitation and subsequent discharge should commence as soon as the requirement for amputation is identified. All patients should have access to a suitably qualified amputation/discharge co-ordinator. *(Medical Directors)*

11) Clear guidelines on obtaining consent from patients requiring amputation should be developed to address the deficiencies identified in this study. *(Vascular Society of Great Britain & Ireland)*

12) A consultant vascular surgeon should be present in the operating theatre for all amputations performed by a non-CCT trainee. *(Medical Directors)*

13) A care bundle should be developed to ensure the structured management of amputation patients. Audit of this should form part of the National Vascular Registry *(Vascular Society of Great Britain & Ireland, Vascular Anaesthesia Society of Great Britain and Ireland)*

14) All patients undergoing lower limb amputation must be screened pre-operatively for MRSA, as recommended by the Department of Health. *(All Consultant Surgeons)*

15) As recommended in the Quality Improvement Framework for Major Amputation Surgery (VSGBI), amputations should be done on a planned operating list during normal working hours and within 48 hours of the decision to operate. Any case waiting longer than this should be the subject of local case review to identify reasons for delay and improve subsequent organisation of care. *(Medical Directors)*

16) Hospitals require a properly funded and staffed acute pain service with capacity to manage patients with critical limb ischaemia and both pre- and post-amputation pain. *(Medical Directors)*

17) Insulin should be prescribed according to National Patient Safety Agency (NPSA) recommendations. *(All Doctors)*

18) Hospitals should have clear guidelines for the management of blood glucose levels when they are outside the acceptable range. These guidelines should be implemented for all patients undergoing lower limb amputation. *(Medical Directors, All Consultants)*

19) A falls risk assessment should be undertaken in all patients undergoing lower limb amputation, and measures should be put in place to reduce the risk of a subsequent fall during the in-patient stay. *(Medical Directors, Physiotherapists)*

20) As recommended by the British Association of Chartered Physiotherapists in Amputee Rehabilitation and British Society of Rehabilitation Medicine, when it is possible to choose the level of amputation, the physiotherapist should be consulted in the decision making process regarding the most functional level of amputation for the individual. Post operative physiotherapy should commence on the first day where possible and should include exercise, oedema management and use of early walking aids as appropriate. *(Consultant Vascular Surgeons, Physiotherapists)*