

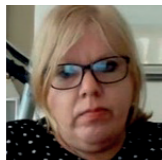
Self-care in venous leg ulcer management

A focus on implementation





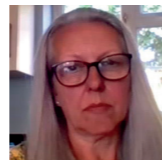
Atul Arora
GP, Sundridge Medical Practice,
Bromley



Leanne Atkin
Vascular Nurse Consultant
Mid Yorkshire NHS Trust



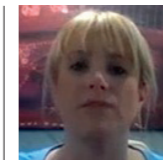
Sue Boran
Director of Nursing Programme
The Queen's Nursing Institute



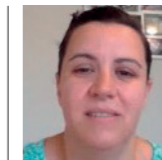
Melanie Crouch
Clinical Quality Lead
North East Essex NHS CCG



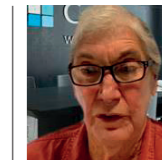
Tracy Dell
Practice Business Manager
Plane Trees Group Practice,
Halifax



Laura Hallas-Hoyes
Lead Tissue Viability Nurse
South West Yorkshire Partnership
Foundation Trust



Vanessa Townley-Hewitson
Advanced Nurse Practitioner
Plane Trees Group Practice,
Halifax



Theresa Saklatvala
Chair

The quality of care of venous leg ulcers varies greatly across the country. Specialists in the field came together in June to identify the barriers to quality care, to analyse the impact and opportunities of the COVID-19 pandemic, to compare the components of a self-care pathway and to take active steps in the direction of care equality

Self-care in venous leg ulcer management

The cost of care of venous leg ulcer (VLU) is very high when done poorly¹ – high in terms of time and resources of the healthcare system, high in terms of poor patient outcomes, and high in terms of patient and staff emotional wellbeing.

How to improve care of patients with VLU while controlling costs, with an emphasis on the promotion of supported self-care, was the overarching theme of this Roundtable discussion.

Key themes arising ranged from acknowledgement of care inequality in VLU, to barriers to best-practice delivery, and concluded with an extensive list of actions that can be taken to make a tangible change in the lives of these patients.

Key themes

There is dramatic variation in the quality of VLU care in the country

“Nobody knows how many patients are out there unless you use prevalence data” *Leanne Atkin*

There is dramatic variation in the quality of VLU care in the country, with a marked deterioration of care coinciding with the loss of a large number of District Nurses since the 1990s. While there are pockets of excellence, where you find them will be determined by whether there is strong local leadership (perhaps

the tissue viability nurse, the GP, or the commissioner) with an interest in VLU care. There is variation in who owns responsibility, who has access to specialists, who has links to a vascular team, who has evidence-based models, and who has confidence in self-care models.

The National Wound Care Strategy Programme (NWCS) has been commissioned by NHS England and NHS Improvement to reduce unnecessary variation, improve safety and optimise experience and outcomes for those individuals experiencing pressure ulcers, lower limb ulcers and surgical wounds.

VLU care does not need to be complicated

“Think about the compression, not the product” *Leanne Atkin*

“Data and evidence are what we need. We have to show that it is making a difference” *Sue Boran*

The delegates agreed that first and foremost comes the **patient**, not whether an activity is the responsibility of the GP or the commissioner.

Second in importance is the need for primary care and commissioning teams to organise themselves in delivering **clarity** in processes that



gett
shape

References

- 1 Guest JF, Ayoub N, McIlwraith T, et al. Health economic burden that different wound types impose on the UK's National Health Service. *Int Wound J* 2017;14:322-30
- 2 Atkin L, Tickle J. A new pathway for lower limb ulceration. *Wounds UK* 2016;12:32
- 3 Guest JF, Fuller GW, Vowden P. Venous leg ulcer management in clinical practice in the UK: costs of outcomes. *Int Wound J* 2018;15:29-37



work toward encouraging patients to manage themselves.

Different approaches must cater for different patient groups: the housebound, those in care homes and the mobile – it is to this group that supported self-care should first be directed.

With these three principles in mind, VLU management and treatment **do not have to be complicated**.

In Bromley, for example, the model for venous leg ulcers pivots on consistency in how primary care and commissioning teams work together in setting out and **communicating a clear strategy**. You need excellent communication between primary care and the tissue viability team, with the base in primary care, where patients are diagnosed. It is really important for primary care to have a single point of access (POA) to the multidisciplinary VLU team to ensure a quick and easy referral. The tissue viability team is then brought in to identify the extent of what can be done, and the vascular access team investigates and helps those who can

be treated, encouraging patients to self-manage, with team support around them as appropriate. This pathway has a structure similar to that for managing diabetic foot ulcers:

- Primary care clinicians identify diabetic patients with at-risk feet, and
- get them to the diabetic foot clinic straight away, where
- teams will care for them until they are healed.
- Six-month follow-ups are made by the community team.

Who takes the lead varies – it could be the tissue viability nurse, or the local vascular team, or the community lead – this is not important, as the pathway is clearly set out. No individual member should have sole lead: a MDT VLU approach should be used so all aspects of care for the VLU patient is considered and future prevention of re-occurrence of VLU.

What is important, however, is the realisation that it takes **time** and effort to communicate the pathway to fellow professionals; in the case of the Bromley

diabetic foot ulcer clinics, for example, it took between eight and nine months for clinicians in primary care to refer to the foot clinic, which again supports the case for ease of referral.

Another example of a supported self-care pathway, which is about to launch, was described by North East Essex CCG. This model champions a single point of access, with a **multidisciplinary team** doing the initial **triage**, ensuring an early and accurate **diagnosis**.

The current COVID pandemic, in encouraging patients to self-care, is seen to have created the ideal climate for roll-out of the model. COVID has created a climate for self-care as fewer patients want to go into the hospital. It has also accelerated technologies like video consultations/remote biodata monitoring, which enhances supported self-care.

Pathways help simplify and standardise care – follow, and your patients will have good outcomes.² In the case of Mid-Yorkshire NHS Trusts, local assessment appointments are made

within two weeks, and the emphasis is to keep people away from secondary care whenever possible.

However, the delegates caution wariness of the many models of care that exist in the country that are not **evidence based**.

Awareness of how to care for VLU must be raised

“The issue is clinical knowledge, and where to refer to when that patient comes in *Vanessa Townley-Hewitson*

“It might be possible to eliminate chronic ulcers forever *Leanne Atkin*

The evidence states that a small percentage of ulcers do not heal, as opposed to the approximately 50% seen in practice.¹ GPs may lack this **awareness**. As practice nurses will be the first point of contact in 90% of cases, it is essential that they be made aware of the pathway for their area, and to whom to signpost their patients. It should be the nurse who does the referral to prevent

any delay. Practice nurses should have a checklist of when to refer patients to the MDT VLU clinic – non-healing VLU can often be an underlying skin cancer, which also supports early self-supported VLU patients.

A robust care pathway with measurable KPIs represents a significant cost saving

“When you’ve got a good, robust pathway in place, that the nurses can follow, you can make massive cost savings *Laura Hallas-Hoyes*

What **KPIs** are used to measure the success of a supported self-care pathway? Wound healing is the definitive measure, but this is resource intensive. Other KPIs include the number of people who have received a holistic assessment within 14 days, how many patients are at full-strength compression with a VLU diagnosis, and how many of these have been referred for vascular assessment.

The delegates estimated that between 50 and 75% of **community nursing time** is spent delivering wound care – a robust care pathway saves in terms of staff time and products used. The cost of managing an unhealed VLU is 4.5-times more than that of managing a healed VLU (£3000 per healed VLU and £13,500 per unhealed VLU).³

The CQUIN on lower limb care raises the profile of venous leg ulcer care among PCNs, commissioners and providers

“The CQUIN raises the profile within PCNs, commissioning and providers *Leanne Atkin*

The Commissioning for Quality and Innovation (CQUIN) guidance ‘CCG11: Assessment, diagnosis and treatment of lower leg wound’ has been produced by NHS England and NHS Improvement. It raises the profile of leg ulcer management among PCNs, commissioners and providers, and provides both carrot and stick: there are fines for non-adherence, and rewards for compliance with the CQUIN. Additionally, the NWCS are currently working with PCNs to develop a Directed Enhanced Service (DES) that will impact leg ulcer care.

Will it make a difference? In addition to the financial elements, it completes the logical care process: defining a clear pathway – undertaking an assessment process – adopting clear community policies – CQUIN. The issue is that it

speaks to adult community nursing services, and not primary care, who earn points through QOF – the two reward systems are not joined up.

The prevention agenda is largely ignored

“We are currently not commissioned for proactive, preventative care *Mel Crouch*

Vascular intervention at two weeks (when the venous ulcer is curable, rather than later in the care pathway) by a vascular nurse will save the patient pain, and the health system money.

But preventative measures continue to be generally ignored, and are certainly not commissioned. In contrast, for example, delegates report that, in Canada, hosiery prescribed at an early stage halts the disease progression.

Barriers to supported self-care are to be found along the care continuum – from commissioner to patient

“The biggest barrier to getting compression is somebody to recognise that it is a venous leg ulcer *Leanne Atkin*

Variations in **clinical expertise**, limited **engagement** with self-care on the part of clinicians and patients, lack of funding (commissioning), mixed messages regarding **ownership** of the self-care programme, lack of a coordinated regard for **clinical data**, lack of **consistency** across care pathways within primary care, and limited **access** to primary care are among the key hurdles identified by the group.

Of these, a lack of **commissioning** focus on supported self-care pathways is perceived by most as the barrier of greatest impact.

There is a lack of **patient understanding** and compliance, not helped by the fact that patient education leaflets are usually not available in local languages. **Patient expectations** can be a terrible problem – it is the responsibility of the support team that self-care be sold to them, not by sales people but by healthcare professionals (HCPs). The HCP needs to inspire, motivate and instil confidence in their patients that it is safe for them to do so, and that it will be expected of them, with support as necessary.

One of the biggest barriers to supported self-care is the **early diagnosis** of a venous leg ulcer. GPs have become task-based, and may ‘see’ only the complaint with which the

Take action

Have a vision

- It is necessary to change the culture of supported self-care of VLU

Engage commissioning bodies

- Commissioning and provider cash flow have to be addressed
- There is much to do regarding the engagement of commissioning bodies. The role of the PCN is critical. There is as yet no PCN model for commissioning, as per the latest version of NHS structural reforms, but there is no reason why a simple model that requires no extra staff, reduces the burden on hospitals and builds links with the vascular team and community care should not be pushed through with all possible haste. Demonstrate savings to senior management
- Consider asserting practice-based pressure through your Practice Manager for quick, local wins
- Compression is not overtly commissioned, however, it does fit under the remit of 'immediate care', meaning that everyone can apply compression to every venous leg ulcer. It is thought that this could make a big difference immediately
- Search for a PCN directory to identify who to petition

Assume responsibility

- Supported self-care is the responsibility of everyone along the care continuum
- Clearly define what is expected of patients in terms of supported self-care

Identify a champion

- Structurally, you need a champion to lead, preferably from the community care team, to co-ordinate the PCNs and Practice Nurses, linking to secondary care

Gather data

- Data at PCN level must be gathered. There is currently considerable frustration over the fact that a lot of data is collected at practice level, but that is it not used to advance an evidence-base for establishing care pathways

Establish primary care networking assessment bases

- An assessment appointment within 14 days of notification is a first and crucial step in the care pathway
- Centralised clinics could hold all stocks, so there need be no shortages.

Empower patients

- Identify and engage patient

champions

- Make available a range of educational tools, including:
 - Case studies
 - Podcasts (we need to be more creative in primary care)
 - Social media, eg. Facebook
 - Digital patient consultation
 - Videos of how to apply compression
 - Patient leaflets in languages in addition to English
 - Booklets, such as the My Wound Care Plan booklet (published by the National Wound Care Strategy) containing key telephone numbers, to help raise awareness with patients and keep them in contact with clinicians
 - www.legsmatter.org – a resource for practical advice and information on problems with legs and feet, for patients (family and friends) and healthcare professionals
 - www.lohmann-rauscher.co.uk/blog/squeezein – the Squeeze In campaign: a self-care revolution in venous leg ulcer management

Raise awareness of clinicians

- Build awareness among HCPs through plug-in-and-play snippets of learning
- GPs have to become less task-focused and more holistic in their

appraisal of the patient

- Flexibility among HCPs will be important – no more 'not in my job description'

Engage decision makers

- Awareness and publicity are key – seek endorsement from the head of NHSE
- Become better at collecting data in such a way as to generate the reports you need

Network more

- Create opportunities for sharing experience and best-practice care outside your immediate area
- Work more collaboratively, with a framework that sets out the standards you want to meet

Focus on implementation

- Implement the National Wound Care Strategy framework locally
- Know your community - conduct more auditing and implement locally

Nationalise local excellence

- Create a DES ('you must') for venous leg ulcers that sits alongside the CQUIN ('you will benefit'): nationalise local excellence and create equality of care

Comment

Rachael Corser, Chief Nurse, East and North Hertfordshire NHS Trust

In East and North Herts, we are working across the Integrated Care Provider with Tissue Viability services, lower limb specialists (including lymphedema and leg ulcer) and diabetic foot specialists to develop and integrate clear pathways of care for individuals with lower limb ulceration. We are also developing pathways for patients with lower limb chronic oedema to prevent ulceration.

The pathways are designed to signpost the clinician and the patient to the correct course of action and referral on to specialist services, as required, to enable timely, safe and effective assessment, treatment and therefore healing of lower limb issues. These pathways are in

their development stage but will be integrated into our local care system in partnership with the CCG when they are approved.

The aim is to better manage the lower limb in the community to prevent patient and ulcer deterioration and subsequent admission to the acute is difficult for patients to deliver self-care. If they have been admitted due to a lower limb infection, they may be acutely unwell and unable to carry out self-care. Registered Nursing staff are on hand 24 hours a day, 7 days a week and will step in to take over this role for the patient.

Patients who are maintaining self-care at home prior to admission are encouraged, if able, to continue to do so whilst in the hospital: it is our goal to promote and encourage continuity of care between primary and secondary settings, always aiming for high-quality care for our community.

Sanjeev Rana, General Practitioner and Commissioner, Essex

As both a General Practitioner (GP) and a Clinical Commissioner, I believe it makes full sense for all commissioning organisations (Local, Regional and National) to focus on commissioning local venous leg ulcer (VLU) services. Annual costs of treating patients with leg ulcers (LU) in the UK have been estimated to be £1938 million.¹ The cost of managing an unhealed VLU is 4-5 times more than that of managing a healed VLU (£3000 per healed VLU and £13,500 per unhealed VLU).²

Putting the economic argument aside, patients with unhealed VLU have poor NHS journeys, with increased inappropriate clinical resource utilisation, and poor quality of life often leading to psychological issues, such as anxiety, depression and social exclusion. Clinical staff often see the VLU patient with some nervousness and trepidation, as these patients are complex, needing skilled multi-disciplinary interventions and supported self-care pathway. This leads to poor clinician morale.

Primary Care Networks (PCNs) offer an ideal opportunity to deliver a single point of access (SPA) referral into a venous leg ulcer -

multidisciplinary team (VLU-MDT) who can holistically assess, diagnose, treat and prevent future VLU in the referred patient. Having a local standardised approach to VLU management in the long run will save commissioning organisations money through optimised healthcare utilisation, clinical efficiency (one-stop shop/reduced burden to inappropriate other healthcare services) and improved staff morale.

As a GP Commissioner, I feel a PCN's developing a SPA-VLU-MDT service will not only improve patient care (and hence outcomes), but also build confidence within the PCN about tackling service redesign and improving quality of life for their staff whilst realising economic benefits. COVID-19 has both accelerated and enhanced digital technologies and their use in delivering frontline opportunity to harness these developments in developing a SPA-VLU-MDT service who can deliver high-quality, supported self-care pathway to VLU patients, improving adherence and compliance while reducing ulcer healing times.

For PCNs thinking of developing a SPA-VLU-MDT service, now is the time to assume responsibility, identify your local champions, engage with commissioning services and start to focus on design and implementation of the service.

patient presents. Neither will they be seeing a venous leg ulcer very often – leaving them with the notion that they can manage everything themselves, rather than refer to Tissue Viability or a vascular access team.

As there is very little local auditing of leg ulcer patients, it is difficult to have a view on any of the markers of wound care.

The COVID-19 pandemic presents an opportunity for the promotion and expansion of supported self-care

“There have been benefits of this pandemic (in) consolidating the work more effectively Tracey Dell

There is no doubt that the 'stay-at-home' messaging of the COVID-19 pandemic has resulted in an unmet need in terms of the backlog of patients who have not been attending clinics. Many clinics have had to be replaced with home visits but, due to the manpower involved, only approximately 60% of patients are

seen, according to one delegate. As the country unlocks, the messaging has to widen to assure patients that it is now safe to attend clinics. These patients must now be prioritised on the basis of clinical risk. However, the pandemic also provides a wonderful opportunity to further support self-care pathways, as the culture of home care has become more accepted among this community of patients during these times.

In addition, care settings will have to change the way they operate, and the consolidation of primary care network-based assessment centres and supported home-care may become the new normal.

Emphasis must be placed on implementation of pathways for supported self-care

“The multidisciplinary centralised triage system must get going Mel Crouch

As there are many models of evidence-

based supported self-care pathways in existence, and as more come into existence, it is vital that their implementation become a priority, with multidisciplinary centralised triage at their core. Models that include peer-to-peer patient support groups such as Leg Club, or that use patient passports, are key.

Making a difference

“We have been talking about this for years, and it's time we got this back on the agenda Sue Boran

“PCNs have to start to look at elements of care that can be co-ordinated at community level Atul Arora

To conclude the discussion, the delegates expressed impatience and enthusiasm for making a difference to the care of patients with venous leg ulcers. above is a list of actions and commitments from the delegates that could deliver tangible

progress in the implementation of supported self-care management.

Conclusion

Supported self-care pathways for patient with VLUs can deliver excellent patient outcomes, avoid unnecessary referral and free up capacity across the healthcare system, and the National Wound Care Strategy Programme has developed sets of recommendations for improving clinical practice.

However, there remain many hurdles to clear before self-care pathways can be widely implemented. Most pressing of them all is the matter of service commissioning: dialogue has to be opened with PCNs, to start to look at elements of care that can be co-ordinated at community level.

Those involved with caring for patients with VLUs are invited to rise to the challenge of becoming the trailblazers of a new, multidisciplinary model.

The time is right.



140 London Wall, London, EC2Y 5DN