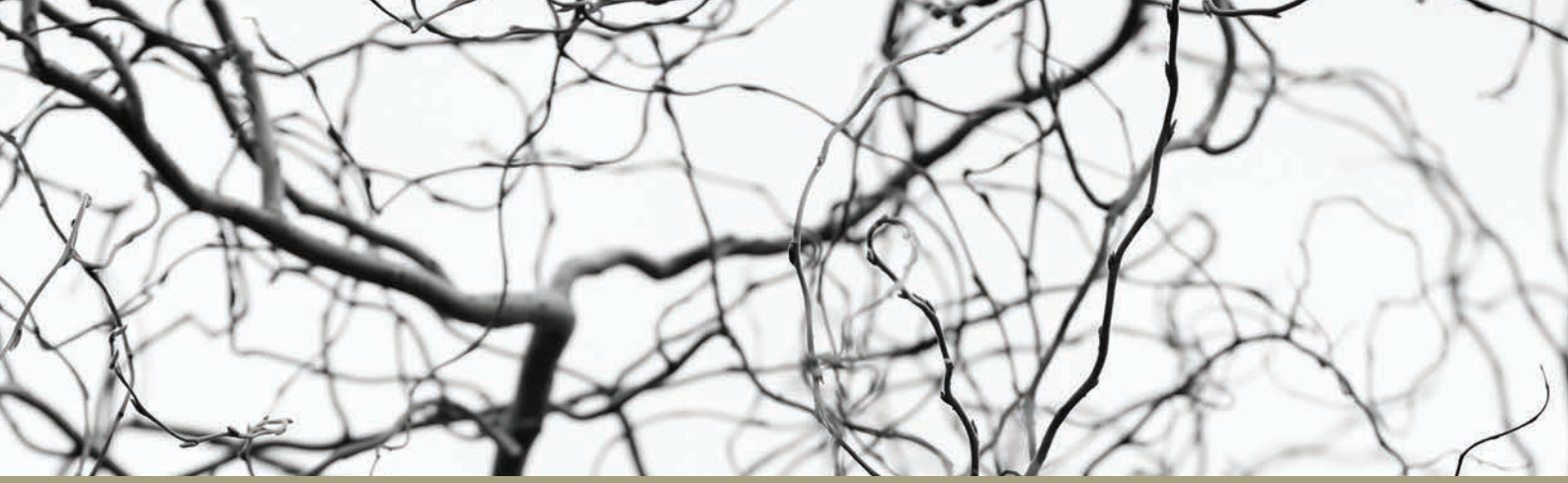

Venous Leg Ulcers: A silent crisis

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ALL-PARTY PARLIAMENTARY GROUP ON VASCULAR AND VENOUS DISEASE

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.

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FOREWORD

Derek Thomas MP, Chair of The All-Party Parliamentary Group on Vascular and Venous Disease

Pressure sores, wounds and ulcers of all types carry a heavy burden on the health and wellbeing of people across the country. They force people to learn to live with chronic pain and disrupt their lives significantly – taking a heavy toll on their mental health. They also weigh heavily on the system, as the cost of managing wounds is thought to be over £4.5 billion a year for the NHS – a figure that rivals the costs associated with other high profile conditions, such as obesity. Management of wounds requires constant attention to support healing and avoid reoccurrence. If the NHS is to reduce the burden of wounds, the system needs to focus on the cause of the wound and treat it effectively. One specific type of wound, venous leg ulcers, may benefit from a different approach.

Venous leg ulcers (VLUs) affect over 200,000 people in England, and due to an ageing population and rise in the rates of obesity, these number are expected to increase in the future. They also cost the system over £900 million per year, and have a significant impact on the quality of life of people afflicted by them. Beyond what studies may say about the impact of VLUs on quality of life, I had the privilege of listening to the experience of patients at an oral evidence session held by the All-Party Parliamentary Group on Vascular and Venous Disease. The feedback was harrowing. Stories of misdiagnosis, pain and social isolation taking a heavy toll on the physical and mental wellbeing of some of the most vulnerable people in our society made me acutely aware of the impact of venous leg ulcers have on people's lives.

More needs to be done. And fortunately, treatment is available to help those afflicted by VLUs; however, the availability of treatment varies massively across the NHS. Addressing this and ensuring all patients, no matter where you are, can access treatment will require special attention. Through this report, the All-Party Parliamentary Group for Vascular and Venous disease hopes to raise awareness to key issues affecting thousands of people with VLUs across England. The recommendations laid out in this report will set the stage for central and local bodies to take action and drive improvements in this area of unmet need.

Photographs courtesy of Parliament.uk

SUMMARY

Findings of the report

- Venous leg ulcers are painful, distressing and significantly disruptive to someone's capacity to lead a normal, independent life.

- Venous leg ulcers affect a significant number of people across the country. Estimates show that over 200,000 people seek medical help due to venous leg ulcers every year; however, these numbers are likely underestimated. Due to lack of appropriate diagnosis, the nature of around 420,000 lower limb ulcers remains unknown on a yearly basis. Many are suspected to be of venous nature. Recent studies suggest that over 75 per cent of all venous leg ulcer patients do not receive a comprehensive vascular assessment.

- Evidence suggest that the number of people with venous leg ulcers is due to increase in the future. This due to an aging and increasingly overweight population, two risk factors associated with venous leg ulceration.

- The burden that venous leg ulcers pose to the NHS is significant. Studies estimate that the UK spends between £940 million and £1.3 billion annually in managing venous leg ulcers. An overwhelming majority of these costs are attributed to primary care, where wounds are managed. Estimates show that only 2 per cent of expenditure sits in secondary care, where specialised vascular surgeons have the capacity to treat the underlying health issues causing venous leg ulcers.

- Unsurprisingly, the costs associated with the management and treatment of an active venous leg ulcer are – on average – 4.5 times greater than the ones of managing and treating a healed one over the course of a year.

- 64 per cent of clinical commissioning policies were found not compliant in providing access to venous treatment – in line with NICE guidance. This highlights a significant geographical variation in access to treatment across the country.

- High quality evidence shows that early surgical intervention has a direct relation to improved healing rates in venous leg ulcers. Follow up studies show this approach is highly likely to be cost-effective.

- Research conducted by the All-Party Parliamentary Group for Vascular and Venous Disease found that a significant number of NHS Trusts acknowledged that they do not have a pathway for venous conditions, nor multidisciplinary teams available for the treatment of venous disease.

Policy recommendations

The All-Party Parliamentary Group for Vascular and Venous Disease calls NHS England to action on the following recommendations:

Effective diagnosis and management

- NHS organisations delivering interventions for venous treatment should consider developing a multidisciplinary team along with a venous lead in place to deliver the treatment effectively.
- Ensure all NHS organisations have an appropriate treatment pathway for venous disease.
- Ensure all NHS organisations are providing appropriate training and education on venous leg ulcers.
- Assess where NHS organisations are complying with relevant NICE guidance and publish adherence rates.
- Promote awareness of venous leg ulcers to patients through a public health campaign.

Commissioning and delivery of care

- Review current commissioning policies for venous disease ensuring that NICE guidance and best practice are fully supported.
- Explore incentivisation of the appropriate identification of patients in need within the community and referral as per best practice guidelines.
- Consider a best practice tariff for providers who support high quality and expeditious care.

System capacity

- Conduct a workforce review of NHS staff to ensure the appropriate work force is in place.
- Conduct a review of centres that are delivering surgical interventions for venous leg ulcers and identify capacity challenges and potential gaps in treatment.
- Assess organisational barriers between primary and secondary care, and provide guidance on breaking down barriers.

INTRODUCTION TO LEG ULCERATION AND VENOUS DISEASE

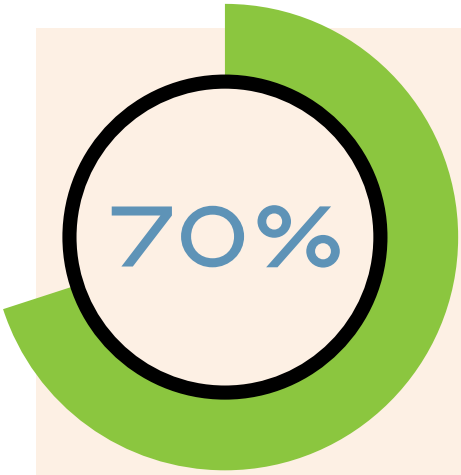
What are chronic leg ulcers?

Chronic leg ulcers are wounds that the body struggles to heal on its own, and are frequently referred to as non-healing wounds. Chronic leg ulcers are often caused by an underlying health issue with the circulatory system – of an arterial, venous or mixed nature. Venous disease is the most common cause of leg ulceration – causing around 70% of all chronic leg wounds.[1,2]

Venous disease and venous leg ulcers

Venous disease is often caused by venous incompetence, a health condition where the circulatory system has difficulty moving blood from the legs to the heart. Due to the effect of gravity, compounded by malfunctioning venous valves in the legs, blood may leak back down the veins, increasing the pressure in them – often referred as venous reflux. This increase in pressure causes swelling, pain, and varicose veins and ulcers.[2,3]

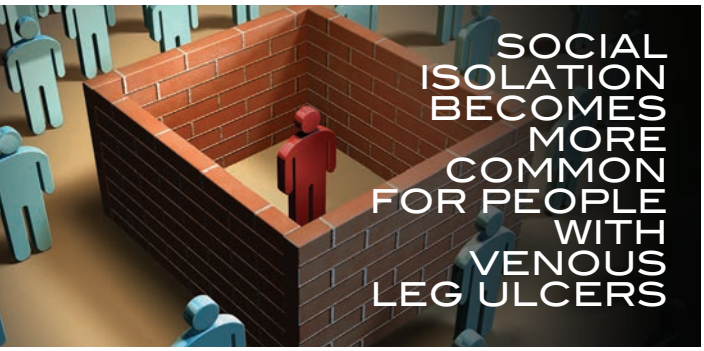
All venous leg ulcers are not all the same. The majority have incompetence of the superficial veins alone, but some have incompetence or even blockage of the deep veins as well. Generally these two categories encompass around 90 per cent of people with venous leg ulcers.[4] A final 10 per cent of people may suffer from deep venous disease alone.[4]

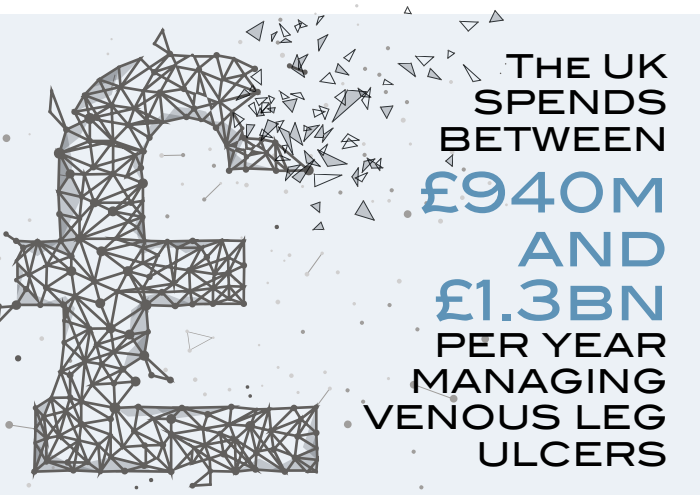


VENOUS DISEASE IS THE MOST COMMON CAUSE OF LEG ULCERATION – CAUSING AROUND 70% OF ALL CHRONIC LEG WOUNDS.

BURDEN OF VENOUS LEG ULCERS

PEOPLE PER YEAR SEEK MEDICAL HELP DUE TO VENOUS LEG ULCERS





Prevalence of venous leg ulcers

Every year over 200,000 people seek medical help due to venous leg ulcers, with studies showing that the number of new venous leg ulcers is estimated to increase. This due to an aging and increasingly overweight population, two risk factors associated with venous leg ulceration.[5]

Compounding the figures above, studies show that the current burden of venous leg ulcers to the people and system may be underestimated due to patients going undiagnosed. In addition to confirmed cases of venous leg ulceration, around 420,000 patients experienced a lower limb ulceration; however, due to not receiving an appropriate diagnosis, the nature of their health issue remains unknown. Many of these are suspected to be of venous nature.[5]

People with a venous leg ulcer

The experience for people living with venous leg ulcers is often a painful and distressing one. Normal independent life can be significantly inhibited and social isolation becomes more common.[5] Venous leg ulcers may persist for many months, and once healed are at high risk of recurrence.[1] Venous leg ulcers are a major cause of morbidity and significantly decrease health-related quality of life.[5,6]

Economic burden of venous leg ulcers

Real-world evidence highlights the significant economic burden that venous leg ulcers place on the NHS. Studies estimate that the UK spends between £940 million and £1.3 billion per year in managing venous leg ulcers.[5,7] For the NHS, the majority of that expenditure comes from community nurse visits – accounting for over 75 per cent of the costs of patient management;[5] with 14 per cent of costs accounted for dressing and compression therapy systems.[5] Shockingly, only 2 per cent of costs were incurred in secondary care, where surgical procedures take place. This is a clear sign of the existing imbalance in patient access to specialist vascular care.[5]

The costs associated with the management of venous leg ulcer are expected to rise as the number of people affected by venous disease increases.[5] Additionally, these costs do not reflect those incurred by patients themselves, and other indirect societal costs that may come as a result of patients and their carers being forced to take time off work.

YEARLY MANAGEMENT COSTS OF AN ACTIVE VENOUS LEG ULCER ARE 4.5 TIMES GREATER COMPARED TO THOSE OF A HEALED ONE.

The economic cost of poor patient outcomes

The cost associated with treating and managing an active venous leg ulcer is significantly greater than the one associated with treating and managing a healed one. On average, the costs associated with the management and treatment of an active venous leg ulcer are 4.5 times greater than the ones of managing and treating a healed one over the course of a year.[5]

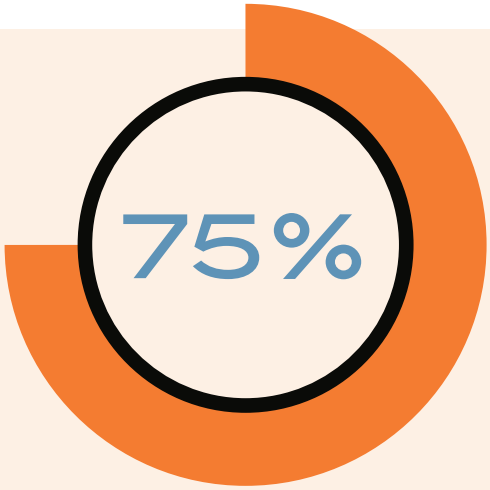
Healed venous leg ulcer[5]	Active venous leg ulcer[5]
£2,981 per year	**£13,455 per year**

THE COST BURDEN OF VENOUS LEG ULCERS TO THE NHS IS SIGNIFICANT AND EXPECTED TO RISE. ADDITIONALLY, APPROPRIATE AND TIMELY TREATMENT LEADS NOT ONLY TO IMPROVED QUALITY OF LIFE, BUT ALSO SUBSTANTIAL SYSTEM SAVINGS.

DIAGNOSIS, MANAGEMENT AND TREATMENT OF VENOUS LEG ULCERS

Diagnosis
Current NICE guidance is clear - venous leg ulcers that have not healed for two-weeks should be referred to a vascular service.[8] Upon referral, a vascular assessment should be provided using specialist equipment to confirm a diagnosis.[8] Recent studies suggest that over 75 per cent of all venous leg ulcer patients do not receive a comprehensive vascular assessment.[5]

Treatment and management
Clinical guidance suggest that diagnosis of venous disease should be followed by clinically appropriate interventional treatment to correct the underlying venous health issues.[8] Despite this, most venous leg ulcers are not seen by a specialist vascular service.[5] Whilst most management of venous leg ulcers currently takes place in primary care, specialised venous care offers the opportunity to address the underlying circulatory issues that cause venous disease.[8,9,10]



OVER 75 PER CENT OF ALL VENOUS LEG ULCER PATIENTS DO NOT RECEIVE A COMPREHENSIVE VASCULAR ASSESSMENT

Venous disease and venous leg ulcers are conditions that significantly affect the quality of life and independence of a large number of people in the UK. Current NICE guidance is supportive of specialised vascular interventional treatment; However, an alarming number of people are not referred for appropriate assessment and management.

APPG'S ORAL EVIDENCE SESSION – VENOUS LEG ULCER EXPERIENCE FROM PRACTITIONERS AND PATIENTS

In response to the need for improvements in the care of venous leg ulcers, the VVAPPG held an oral evidence session, and invited clinicians and patients to share their views and experience. Among the experiences shared, three issues were highlighted as critical for the improvement of patient outcomes: poor local-level implementation of clinical guidance and best practice, misdiagnosis and referrals to secondary care, and system capacity for diagnosis.

The clinicians in attendance shared the view that venous leg ulcers are an issue that requires stronger attention – placing emphasis on how its estimated costs to the NHS are hugely underestimated. There was consensus on the availability of clinical best practice, clearly instilled in available NICE guidance; however, poor guidance implementation at local level is driving variation in care across the country. It was suggested that clinical commissioning groups may be of the opinion that clinically appropriate treatment is too costly, and this may have implications to referrals to specialised care.

Separately to commissioning barriers, a lack of appropriate understanding of the condition at a primary care level emerged as a clear barrier. Often, such a lack of understanding has a strong impact on misdiagnosis and lack of appropriate referral to vascular surgeons. It was pointed out that current pressures on the primary care system do not facilitate the understanding of the severity of the implications for patients when venous leg ulcers are not appropriately cared for. There was clear consensus that raising awareness of venous leg ulcers, combined with educational programmes for practitioners and patients would be of benefit. Final points of feedback centred on concerns around the current capacity of healthcare organisations to be able to provide adequate diagnosis and treatment of venous leg ulcers. It was suggested that non-specialised healthcare professionals could be upskilled to aid with assessment and increase system capacity as a result.

There was consensus among the clinicians in attendance that the current standard of care is not meeting the needs of patients, to the detriment of their health outcomes, and that there is significant need for improvement.

People with venous leg ulcers were also invited to share their experience. Over the course of the session, the APPG learned about the harrowing experience of a young man that had been afflicted by venous leg ulcers for over a decade. He made note of the challenges of coming to terms with chronic pain, and the disruption the venous leg ulcers caused to his everyday living.

It was noted that despite being in a clear state of deterioration and need for specialised clinical intervention, he was unable to get an appropriate diagnosis and referral over a number of years. Persistent failure and repeated misdiagnosis led to a deterioration in the person's mental health. Bravely, he shared how he slowly abandoned hope to regain his health, and how this pushed him to develop symptoms of depression and thoughts of self-harm. Finally, the APPG learned that he was able to find respite only after he approached a private clinic. Fortunately, this person is now receiving the specialised assessment and care he needs, however outside of the NHS.

PATIENT EXPERIENCE OF CARE. THE STORY OF THELMA

The experience and examples shared in our session widely echo the concerns and worries shared in existing literature. However, we must never forget the individual human stories behind the discussions we are having. We would like to share a patient story, published by Wounds UK.[11] Please see below the story of Thelma.

Thelma was 67 years old at the time her story was documented. She was troubled by a number of health conditions, including high blood pressure and cholesterol, and spent most of her time being a full-time carer for her husband.

Thelma had two venous leg ulcers, one on each leg. The first one she had been living with for seven years, the second one only for only two. Over this period of time, she had been treated with a number of dressings and bandages, however the ulcers failed to heal. In her experience, witnessing treatments fail time and time again had taken a heavy toll on her confidence, self-image and quality of life.

It all began with pain, and pain didn't leave her. Living with chronic pain due to her ulcers started disrupting all aspects of daily life. She quickly noticed that her wounds would constantly ooze – to the point that she was forced to wash her bed linen every day. There was also the smell – caused by the exudate leaking from her ulcers. Overall, living with unhealed venous leg ulcers had negatively impacted most aspects of Thelma's life, from her ability to socialise through to her choice of clothing.

Following years of inconsistent and inappropriate treatments, which resulted in the repeated infection of her wounds, Thelma had the chance to see a vascular surgeon. After her assessment, clinically appropriate treatments were prescribed and delivered. This led to an immediate improvement to her health and quality of life. Thelma could see her health getting better week after week, and as a consequence, she did not need to visit the hospital as frequently – and required less medications. Two months into treatment, Thelma's venous leg ulcers had healed, the pain and uncomfortable smells were gone and she slowly regained confidence.

CURRENT BARRIERS FOR IMPROVED CARE IN VENOUS DISEASE – MR MANJ GOHEL

Manj Gohel is a Consultant Vascular Surgeon and Venous lead at Addenbrooke's Hospital, Cambridge and Honorary Senior Lecturer at Imperial College London. He has a strong clinical and research interest in the treatment of venous disease and leg ulcers and has been involved in venous clinical trials, based in the NHS for 20 years.

Venous disease is an area of great patient need, and the consequences of poor treatment and management place a heavy burden on patients, their families and the NHS. While great strides have been made to improve the quality of care for people with venous disease, a number of barriers remain for practitioners, patients and policy makers to overcome.

The main barrier for patients is access to appropriate tests and treatments to address the underlying venous problem. A simple, non-invasive ultrasound scan can diagnose the root cause of the ulceration and allows medical teams to plan treatment to address the venous issue. Most patients with venous leg ulcers have varicose veins and high-quality studies performed in the NHS, have showed that treatment of varicose veins accelerates healing of ulcers and reduces recurrence. By improving access to these keyhole varicose vein treatments, the impact on patient lives could be enormous. Another area of unmet need is the care of people with deep venous disease. In the past, few treatments were available, but recent years have seen enormous innovation, such as the development of deep vein stents. More work is needed to ensure access to appropriate clinical therapies are available to all people with afflicted by venous disease.

As progress is made in the development of novel approaches for the treatment of venous disease, and we cultivate a wider understanding of the positive impact they have on patients, it is worth highlighting the role that the array of vascular and wound specialists play in the successful treatment and management of this disease. Venous disease is a complex condition, with a number of associated risk factors, and multidisciplinary care should be at the centre of any service. Patient care benefits tremendously from the important role and experience offered by Community and Tissue Viability Nurses, Vascular Surgeons, Interventional and Diagnostic Radiologists, Haematologists, Dermatologists and other specialists. Wider emphasis should be placed on the availability of multidisciplinary venous teams across the NHS.

Finally, focus should be placed on the relationships between secondary and primary care practitioners. Most people with venous disease present in a primary care setting, and current pathways all too often do not allow timely diagnosis and interventions. Early diagnosis and intervention are key to improving patient outcomes, and hold the potential to make long-term savings to the system; however, it's only possible to act on this promise if all healthcare professionals taking part in the patient pathway are aligned.

The collective responsibility for overcoming these barriers rests on the shoulders of everyone involved in the planning and delivery of venous care – from the Secretary of State to frontline medical staff. Examples of best practice show that local level progress is being made; however a stronger commitment from government is required. It's time to take action and drive country-wide improvements to the care of people with venous disease.

GEOGRAPHICAL VARIATION IN PROVISION OF VENOUS TREATMENTS – MR DAN CARRADICE

Dan Carradice is an Academic Vascular and Endovascular Surgeon at Hull York Medical School and Hull University Teaching Hospitals NHS Trust. He is the Clinical Lead for Vascular Surgical services and is actively involved in leading research aiming to improve quality of life; and save life and limb. He sits on the council of the Venous Section of the Royal Society of Medicine and is an expert advisor to MHRA and NICE on Vascular issues.

Venous leg ulcers are a health issue that has a major impact on the quality of life for a significant number of people. It's important to note that venous leg ulcers are a manifestation of an underlying venous health issue. While the clinical and economic benefits from vascular interventions are clearly documented – and appropriately translated into NICE guidance – widespread restrictions in access to treatment are set in place. These practices have a strong effect on the availability of treatments at a local level, and are partially responsible for the high degree of variation in outcomes for people with venous leg ulcers.

The development of NICE guidance is a process that considers available evidence on two counts – clinical outcomes and cost-effectiveness. Current NHS framework, supported by its constitution, indicates that patients have a legal right to treatments that have been appropriately recommended by NICE for use in the NHS; however, current restrictions set by commissioning bodies cast away said principle, limiting access to treatments on criteria that fail to account for the clinical needs of the patient. Evidence suggests that there is high geographical variation in both the number of commissioners that instil these access-restricting policies, and the magnitude and nature of said restrictions.

Research conducted on the nature and detail of commissioning policies for venous care showed appalling results. At the time of research, only 36 per cent of commissioning policies were compliant with NICE guidance. The remaining 64 per cent of commissioning policies were found to be not only non-compliant, but showed a high degree of variation in the criteria used to limit access to treatment. Examples of these limitations included: waiting for the underlying issues to worsen to the point where venous leg ulcers become apparent; delaying referral or treatment, or both, for an arbitrary period of time; and rationing treatment for patients with high body mass index or those who smoke. The impact of a combination of failure to refer patients from the community and then failure to commission their treatment mean that in England research has demonstrated that as many as 90-95% of patients are denied the treatment they need under NICE guidelines.

These commissioning practices cast a shadow on the availability of treatment for some of the most vulnerable members of our society, and disregard a number of principles upon which the NHS rests. It is clear that restrictive commissioning policies have a part to play in the high variation in access to treatment, and contradict the efforts engraved in The Health and Social Care Act 2012 to reduce health inequalities.

Unfortunately there is no turnkey solution to address this issue. Clinical Commissioning Groups (CCGs) have been operating at a growing deficit, and are under pressure to engage in demand management practices. While growing efficiencies and increased investment may partially alleviate the pressures felt by CCGs, it's important for the vascular community to remain proactive. We can all help ensure misconceptions around venous disease are dispelled, help educate people on their rights and responsibilities, and engage local CCGs in dialogue.

THE CASE FOR EARLY INTERVENTION IN VENOUS LEG ULCERATION

The clinical case

A recent UK study looked at the role of superficial venous reflux, and varicose veins, in relation to the healing of venous leg ulcers. Results favoured early intervention to treat varicose veins on the basis of its clinical effectiveness. In summary, the study found that venous leg ulcers may on average heal 6.5 weeks earlier when early intervention takes place, showing a significant positive impact on the quality of life of patients.[9]

Whilst NICE guidance supports the interventional approach reflected in the study, and it enshrines a two week referral upon persistence of a leg ulcer, it does not emphasise the need for early treatment.[8] According to the results of the study, early intervention may lead to favourable patient outcomes.[9] Additionally, these findings may help dispel any perceptions that have led many practitioners to delay treatment.[4]

The cost effectiveness case

A follow up study looked into the system cost differences between early and deferred varicose vein interventions in patients with venous leg ulcers. The results of said study show that early treatment is highly likely to be cost-effective – against NICE cost-effectiveness thresholds – in patients with venous leg ulcers over one year.[4] The study shows that while early intervention does incur in higher short-term initial costs, these were quickly offset by lower community nursing costs due to quicker healing time of the ulcers.[4]

WE HAVE ESTABLISHED THAT VENOUS LEG ULCERS REPRESENT A SIGNIFICANT BURDEN TO THE WELLBEING OF A GREAT NUMBER OF PEOPLE IN THE COUNTRY, AND A SOURCE OF SIGNIFICANT PAIN AND SOCIAL ISOLATION. ADDITIONALLY, WE HAVE HIGHLIGHTED THE DAUNTING SYSTEM-WIDE COSTS ASSOCIATED WITH THE TREATMENT AND MANAGEMENT OF VENOUS LEG ULCERS, AND HOW A FOCUS ON TIMELY VENOUS INTERVENTION MAY IMPROVE VENOUS LEG ULCER HEALING RATES, QUALITY OF LIFE AND SIGNIFICANTLY REDUCE OVERALL COSTS TO THE NHS.

INSIGHTS TO THE DELIVERY OF VENOUS CARE – A LOOK AT NHS TRUSTS

Research overview

The All-Party Parliamentary Group for Vascular and Venous Disease conducted an inquiry to understand key elements of venous care among NHS Trusts in 2019. The approach consisted of submitting freedom of information (FOI) requests to trusts across England. Valid responses were received from 124 NHS Trusts. The characteristics of respondents are as follows:

- 43 acute NHS Trusts
- 27 community NHS Trusts
- 54 integrated NHS Trusts (delivering community and acute services altogether)

A number of questions were put forward; in light of rate and quality of response, data for only four of them were included in this report. The questions in reference are:

1. Do you have a formal patient pathway for the management of venous leg ulcers?

2. Do you have a multi-disciplinary team for the management of venous leg ulcers?

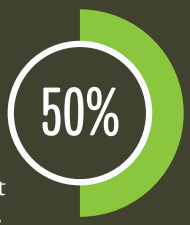
3. For patients with chronic leg ulcers, can you state who would generally be the lead clinician on their care?

4. Do you have a lead clinician for venous conditions?

Summary of results

The APPG found that the experience of care for patients will vary depending on their location. Over a third of respondent trusts declared not having a pathway for venous conditions available, with a majority of examples including acute and integrated trusts.

Over half of respondent trusts declared not having a multidisciplinary team available for the treatment of venous disease, an alarming figure when considering the complex nature of venous disease and the benefits to patient care that multidisciplinary teams provide.



While a majority of respondents did have clarity on who is to lead the treatment and management of venous leg ulcers, integrated trusts showed a high degree of inconsistency in this regard. However, is worth noting that this may be caused due to ongoing efforts in integration, which may have not been resolved at the time of our investigations.

Finally over 60 per cent of trusts were unable to clearly identify a venous lead within their organisation. And while the effects of lack of appropriate intra-trust leadership are not clear, we assume that this may have an impact on the service's capacity to improve and adapt to newfound information, guidance and best practice.

Detailed results

Question 1.

The availability of clear, consistent pathways for the diagnosis, treatment and management of venous leg ulceration is something that must be achieved across the board, at all levels of care. Patients should have the confidence that whether in a primary or secondary care setting, and regardless of where they live, they are put through a clinically appropriate venous disease pathway – from diagnosis to treatment.

Results from our investigations suggest that:

- Only 63 per cent (n=78) of respondents had a clear pathway for the management of venous leg ulcers;
- 32 per cent (n=40) did not; and 5 per cent (n=6) disclosed they were in the process of developing one.

By trust category, community trusts showed relative higher clarity in pathway availability with 96 per cent (n=26) over the 53 per cent (n=23) available from acute-specific trusts. Integrated trusts showed results similar to the ones displayed by acute trusts with 53 per cent (n=23) showing clarity and availability of a venous leg ulcer pathway.

Question 2.

The APPG inquired as to the availability of multidisciplinary teams for the treatment and management of venous leg ulcers. Results show:

- 56 per cent (n=69) of respondents did not have a multidisciplinary team available.

By trust category, community trusts had the lowest rate of multidisciplinary availability with 37 per cent (n=10), while acute trusts had 56 per cent (n=24) availability. Integrated trusts showed relatively similar results to community trusts, with 61 per cent (n=33) of respondents not having multidisciplinary team availability.

Question 3.

Question number three looked at the clinical lead responsible for the treatment and management of venous leg ulcers – results show:

- 73 per cent (n=90) of respondents had identified a clinical lead for the management and treatment of venous leg ulcers.

By trust category, relatively similar results were noted from acute and integrated trusts. Community trusts showed a higher rate of clarity, with 89 per cent (n=24) of respondents acknowledging a clear lead.

Among the answers given, the specialists identified were relatively consistent for community and acute care trusts (community and district nurses, and vascular surgeons, respectively). However, integrated trusts showed a high degree of variation in their identified clinical lead, details below:

Question three – classification of answers – responding integrated trusts (n=54)

- Vascular surgeons – 21 per cent
- Tissue viability nurse – 23 per cent
- Community or district nurse – 23 per cent
- Specialist nurse – 10 per cent
- Multiple, pathway dependent, options – 13 per cent
- Other – 10 per cent

Question 4.

The final question asked trusts on the availability of a trust-specific venous lead. Results show:

- 61 per cent (n=76) of respondents were not able to clearly identify a lead for venous conditions.

This result was consistent across acute (58 per cent – n=25), community (63 per cent – n=17) and integrated trusts (63 per cent – n=34).

Generally, the results displayed suggest high inter-trust variation across key metrics for respondent trusts. Successful outcomes rely heavily on an effective pathway being set in place. Without this, patients may struggle to access the appropriate assessment and treatment. Alongside, it is a source of concern to see that over half of respondent trusts do not have a multidisciplinary capacity for venous conditions.

While further investigations are required to understand the root cause of this variation, the All-Party Parliamentary Group for Vascular and Venous Disease would like to invite system leaders to discuss the issues these results present, and encourage the implementation of measures that would address this variation.

POLICY RECOMMENDATIONS

1

Effective diagnosis and management of patients is key to improving patient experience of care and using NHS resources effectively. It is important that patients presenting with symptoms of venous leg ulcers are able to undergo the appropriate diagnostic tests and are then placed on an appropriate pathway. This should include access to a multidisciplinary team.

NHS England should:

- NHS organisations delivering interventions for venous treatment should consider developing a multidisciplinary team along with a venous lead in place to deliver the treatment effectively.
- Ensure all NHS organisations have an appropriate treatment pathway.
- Ensure all NHS organisations are providing appropriate training and education on venous leg ulcers.
- Assess where NHS organisations are complying with relevant NICE guidance and publish adherence rates.
- Promote awareness of venous leg ulcers to patients through a public health campaign.

2

Ensuring NHS Organisations are appropriately incentivised is critical to the delivery of care. The upfront cost of providing a surgical intervention can be a limiting factor for commissioners. It is important that all those involved in care are rewarded when certain interventions are provided.

NHS England should:

- Review current commissioning policies for venous disease ensuring that NICE guidance and best practice are fully supported.
- Explore incentivisation of the appropriate identification of patients in need within the community and referral as per best practice guidelines.
- Consider a best practice tariff for providers who support high quality and expeditious care.

3

Delivering surgical interventions for venous treatment relies on there being the appropriate capacity within the system. This includes operating theatre time, appropriately trained and skilled staff and effective after care functions, such as district nurses for patients who return home.

NHS England should:

- Conduct a workforce review of NHS staff to ensure the appropriate work force is in place.
- Conduct a review of centres that are delivering surgical interventions for venous leg ulcers and identify capacity challenges and potential gaps in treatment.
- Assess organisational barriers between primary and secondary and provide guidance on breaking down barriers.

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