

Meeting the challenges of delivering leg ulcer services

KEY WORDS

- » Leg ulcer
- » Optimising care
- » Patient choice

The NHS is moving towards a more patient-centred service, with the Quality, Innovation, Productivity and Prevention and Any Qualified Provider agendas central to this transition. To ascertain whether a new cost-effective innovative compression product can improve a patient's quality of life during leg ulcer treatment. Two case studies were conducted to examine how quality of life issues identified during wound assessment can be classified and suitably overcome. Both patients began a regimen that involved the use of an instantly adjustable compression device. Both patients enjoyed an improvement in quality of life and mobility after using the device. The two case studies highlight the benefits of incorporating instantly adjustable compression devices into a treatment regimen, with pain and associated depression diminishing as a result.

The Quality, Innovation, Productivity and Prevention agenda (QIPP) is challenging, but the drive towards patient-focussed outcomes and personalised care brings opportunities for those involved in the delivery of leg ulcer and wound healing services. The White Paper, *Equity and Excellence: Liberating the NHS* (Department of Health [DOH], 2010) sets out the Government's vision of the public being at the heart of an NHS where patients, service users, carers, and families have far more influence and choice in their care, and where the NHS can be more responsive to the public's needs and wishes. Services will need to be focussed on the delivery of evidence-based outcomes.

Liberating the NHS: Greater Choice and Control (DOH, 2012) sets out a number of specific choice commitments around extending choice through the Any Qualified Provider (AQP) agenda. The goal of this process is to enable patients to choose AQP, resulting in an improved standard of care. By introducing choice in terms of provider, this is expected to drive up quality, empower patients, and enable innovation to support the delivery of QIPP.

Importantly, extending choice of AQP provides a vehicle to improve access, address gaps and inequalities, and improve the quality of services where patients have identified varying quality in the past. A number of services have been recommended for AQP,

including venous leg ulcer and wound healing. An implementation pack has been developed to support the process, and includes a recommended service specification and suggested outcomes and tariffs. These can be found at www.supply2health.nhs.uk.

This service encompasses both simple and complex care venous leg ulcer pathways, following an initial referral and common approach within the first 4 weeks of care within the remit of the qualified provider. The service will consist of a nurse-led model designed to reduce inappropriate referrals to secondary care and will include:

- Face-to-face assessment, referral triage, and signposting
- Development of a mutually agreed management and treatment plan to heal the wound and improve quality of life
- Implementation of the treatment plan
- Reassessment at 4 weeks
- Streaming of patients into the appropriate care pathway (simple or complex) to heal the venous leg ulcer
- Information on, and signposting to, any relevant support services, including the promotion of self-care where appropriate
- Follow-up appointment to assess the patient
- Communication with referring clinician and the patient's own GP after first consultation and again on discharge.

CAROLINE DOWSETT
Nurse Consultant Tissue
Viability, East London
Foundation Trust,
London, UK

DENISE ELSON
Clinical Specialist, Medi UK,
Hereford, UK

“To meet the QIPP agenda, and to address patients’ expectations and improve their wellbeing, the provider needs to have a thorough understanding of the wide choice of dressings and compression therapy options that are available.”

Care pathway one is tailored to simple venous leg ulcers without complications and care pathway two is for patients with complex leg ulcers (Table 1). There are a number of exclusions that include suspicion of malignancy, peripheral arterial disease, diabetes, rheumatoid arthritis, atypical ulcers, and suspected contact dermatitis, or dermatitis resistant to topical steroids.

Patients on care pathway one are expected to heal within 18 weeks, and within 24 weeks on care pathway two. Additionally, the service provider will be expected to provide management information consisting of reports related to key performance indicators (KPIs) and routine reporting requirements, as defined through a minimum dataset to include:

- Total number of assessments completed
- Patients assessed not found to meet referral criteria (payment for assessment only)
- Of those patients accepted by provider, how many are allocated to simple/complex pathway and the rationale underpinning this decision
- Performance against agreed metrics (KPIs) to include the percentage of wounds healed in the required time, patient-reported outcome measures (PROMs), and patient-reported experience measures (PREMs).

Delivering on AQP will be a challenge for leg ulcer services as many do not have a systematic approach to service delivery and data collection (Dowsett, 2012). Many providers are unable to report on leg ulcer healing and recurrence rates.

Audits can be a useful starting point to prepare services that are moving forward with AQP as they provide the mechanisms for reviewing the quality of everyday care and can supply evidence that highlight quality issues (NICE, 2002; Burgess, 2011).

The suggested tariff for care pathway one is £1152 and pathway two is £1920, although commissioners may well set this price lower, or work with providers to reach an agreed cost based on the first 6 months of data collection. Providers will need to identify cost-effective, efficient ways of treating venous leg ulcers to ensure they work within budget. Some will see this as a challenge, but it is worth remembering that poor quality care costs more (Maher and Fenton, 2010), particularly where healing times are extended and patients develop complications.

To meet the QIPP agenda, and to address patients’ expectations and improve their wellbeing, the provider needs to have a thorough understanding of the wide choice of dressings and compression therapy options that are available.

The provider also needs to be realistic when negotiating treatment goals with the patient. The ultimate goals are to optimise wellbeing, improve or heal the wound, alleviate and manage symptoms, and ensure all parties are fully engaged in this process (International Consensus, 2012). Cost, for both patient and provider, also needs to be addressed. Quality of life is known to be severely affected by chronic conditions, such as leg ulcers, especially with regard to pain, pruritus, exudate, malodour, and impaired mobility (Herber et al, 2007).

The International Consensus (2012) identified eight principles that encompass all elements of the patient’s experience. These principles can be applied to the delivery of positive PROMs and PREMs.

The following case studies highlight how quality of life issues identified at assessment can be addressed with a new cost-effective compression product.

CASE STUDIES

Mr P

Mr P, a 47-year-old man, summed up his own leg ulcer history in the following words: “I have

Table 1. Venous leg ulcer care pathways

Simple

- Venous leg ulcer with ABPI >8 and <1.3
- Wound area is less than 100 cm²
- Ulcer present for <1 year at first presentation to the service

Complex

- Venous leg ulcer with ABPI >8 and <1.3
- Wound area is >100 cm²
- Patient has lymphovenous disease
- Ulcer infected and/or patient has history of recurrent infection
- Patient has elevated protease activity (measured using a recognised diagnostic tool)
- Patient has a history of nonconcordance
- Wound has failed to reduce in size by 20–40% despite best practice at 4 weeks

ABPI, ankle–brachial pressure index.

“Mr P’s quality of life improved dramatically once he started using this device.”

fought many battles, but never won the war.” He presented with a 10-year history of bilateral venous leg ulceration (*Figure 1a*). A variety of compression systems had been used on his legs, but he admitted being noncompliant because of the impact on his employment and he was often required to take unpaid leave to attend clinic appointments. He suffered from wound malodour, extreme pain, and depression. His life revolved around work and when he was at home he spent the time lying on his bed elevating his legs, as instructed by his nurse.

The treating nurse felt that in order to achieve compliance, it was appropriate to trial a new, instantly adjustable compression device designed for venous leg ulcers (Juxta CURES™, medi UK) as an alternative to the compression bandaging. The device has a Built-in Pressure System™ (BPS), which delivers the desired level of compression (between 20 and 50mmHg) and can be instantly adjusted by the patient. This was checked by the nurse at appropriate intervals.

Mr P’s leg ulcer healed completely in 8 months using this compression device and he was then measured for below-knee, made-to-measure flatknit hosiery. (*Figure 1b*) His nurse advised that in the unlikely event his leg ulcer recurred, Mr P was to use the instantly adjustable compression garment while waiting for an appointment, preventing a delay in restarting treatment.

Mr P’s quality of life improved dramatically once he started using this device and, with the help of his partner, was able to take a holiday during this 8-month period. He resumed a normal work and social life; the pain disappeared, as did his depression. He now feels he has finally “won the war”.

Mrs J

Mrs J, a 63-year-old woman, had a 42-year history of bilateral venous leg ulcers, with disease severity worse in the left leg. A variety of compression systems had been used and all required daily treatment due to either bandage slippage or high exudate levels. She presented with the most complex of leg shapes for the application of compression bandages, the “inverted champagne leg” (*Figure 2*). The management of this leg type is often time-consuming and physically demanding on nursing staff.

Mrs J’s quality of life was severely affected by repeated episodes of cellulitis and extremely high levels of exudate resulted in her being housebound. Mrs J’s 30-year-old son left full-time employment to become her carer. In recent years, she had been encouraged to join a Leg Club, both to get out of the house and to give the nurses relief by allowing different nurses to redress her legs.

In May 2012, nurses decided to try the Juxta CURES to Mrs J’s right leg, as it was the least severe of the two. Mrs J was pleased as this device is designed to minimise bulk over the foot and she could wear something other than an orthotic shoe. She noticed swelling reduction to her leg, signs of improvement to the wound, and she requested a garment for the other leg. The nurses and Mrs J set a goal for her to have sufficient oedema and exudate reduction to enable her to attend a wedding in shop-bought shoes.

Short-stretch bandaging continued to be used on both upper legs, but slippage remained a problem so made-to-measure hosiery was designed to fit over the instantly adjustable compression garments.

Both legs continued to heal and Mrs J’s quality of life continued to improve (*Figure 2c*). She had her dressings changed once or twice a week as required. This compression system reduced



Figure 1. Mr P’s leg at the start of the new treatment in November 2011; (b) healed 8 months after treatment commenced.

the amount of nursing time involved in Mrs J's treatment, confirming Gallier's (2012, personal communication) statement that "the time spent with the patient has reduced from one and a half hours to twenty minutes". Mrs J's condition improved so much that her son no longer needs to be her carer and is planning to retrain and seek new employment.

CONCLUSION

This new cost-effective compression device for venous leg ulcer management – the Juxta CURES – assisted in improving wellbeing in both cases presented here, while still maintaining therapeutic levels of compression (Elson, 2012). Such devices need to be increasingly utilised to meet the demands of QIPP and deliver effective leg ulcer services.

WUK

REFERENCES

- Burgess R (ed.) (2011) *New Principles of Best Practice in Clinical Audit*. Radcliffe Publishing Ltd, Milton Keynes
- Department of Health (2010) *Equity and Excellence: Liberating The NHS*. White Paper. DOH, London. Available at: <http://bit.ly/cC0MnL> (accessed 18.02.2013)
- Department of Health (2012) *Liberating The NHS: Greater Choice And Control – A Summary of Responses*. DOH, London. Available at: <http://bit.ly/V1hhbE> (accessed 24.02.2013)
- Dowsett C (2012) Modernising leg ulcer services through preventing recurrence. *Wounds UK* 8(1):53–8
- Elson D (2012) The 21st Century Approach for Cost Effective Healing of Venous Leg Ulcers. Poster presentation at the Wounds UK Conference, Harrogate
- Herber OR, Schnepf W, Rieger MA (2007) A systematic review on the impact of leg ulceration on patients' quality of life. *Health Qual Life Outcomes* 5(44):1–12
- International Consensus (2012) Optimising wellbeing in people living with a wound. An expert working group review. Wounds International, London. Available at: <http://bit.ly/W5fO0k> (accessed 18.02.2013)
- Maher L, Fenton K (2010) Implementing the eight high impact actions to transform healthcare and boost efficiency. *Nurs Times* 106(3): 12–14
- NICE (2002) Principles for Best Practice in Clinical Audit. Available at: <http://bit.ly/ZmdSqv> (accessed 18.02.2013)



“This new cost-effective compression device for venous leg ulcer management – the Juxta CURES – assisted in improving wellbeing in both cases presented here, while still maintaining therapeutic levels of compression.”

Figure 2. Mrs J's lower leg, (a) anterior and (b) posterior aspects in April 2010, and (c) 6 months after treatment initiation (anterior aspect).