

# A call for change: implementation of venous leg ulcer care pathways



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With the election now behind us, we can begin to consider the challenges facing the NHS and the way forward for our patients. We are all aware of the increasing demands on the service, the need for efficiency savings and the rising scarcity of resources. Therefore, we must ensure that the activities we undertake as healthcare professionals are of high value and follow the relevant care pathways (NHS England, 2016). This will enable us to provide evidence-based care and prevent unwarranted variation in outcomes for our patients.

Venous leg ulcers (VLUs) continue to pose a substantial burden for patients and the NHS, with the estimated number of people suffering in the UK greater than 730,000 — 1.5% of the general population — at a cost of £1.94 billion (Guest et al, 2016). This growing problem can no longer remain in the background. NHS RightCare Pathways (NHS England RightCare, 2017a) have been introduced to provide a national case for change, aiming to reduce unwarranted variation in care and facilitating the best use of available resources. One of the long-term condition scenarios is the fictional tale 'Betty's Story' (NHS England RightCare, 2017b). It presents two story lines, comparing a sub-optimal but typical scenario against an ideal pathway of VLU care. The first is a quite an alarming tale of professional mismanagement, where Betty is subjected to reactive and uncoordinated clinical care from a variety of practitioners, with no definitive diagnosis. Betty's health and quality of life is greatly improved in the optimal scenario and the costs to the health economy are significantly reduced. I would strongly advise any practitioners with an interest in this field to read Betty's story, as it clearly highlights the economic, quality of life and clinical impact of non-healing wounds.

Compression therapy remains the 'gold standard' management therapy for VLUs and despite this well-evidenced fact, due to a lack of knowledge, confidence or unavailability, many patients such 'Betty' do not receive therapeutic compression in a timely manner and are subjected to wound care delivery described by Guest et al (2017) as, 'patchy and disparate'. Guest et al (2012) highlighted the under-utilisation of compression

for VLUs that subsequently indicates the use of poor clinical management strategies to heal wounds, a reduced quality of life for patients, a lack of local care pathways to inform practice and the subsequent under-use of referral pathways for specialist review whether in primary or secondary care. We cannot allow this situation to persist. Many patients do receive positive, effective and timely care, especially within specialist services such as leg clubs; however, all patients have the equal right to access evidence-based, holistic care via care pathways, regardless of where that care is delivered.

Despite the wide availability of clear, evidence-based and specific venous leg ulcer guidelines by recognised national bodies, e.g. National Institute for Care and Health Excellence (2013), the implementation of these locally by Clinical Commissioning Groups (CCGs) has been inconsistent. In addition, the use of venous intervention is often considered to be of low value for chronic venous disease. We cannot continue to ignore the growing body of evidence for action. In the vascular field, we eagerly await the research findings to inform VLU practice and management from the Early Venous Reflux Ablation (EVRA) study (Imperial College, 2016), looking at the benefit of early intervention, and its effect on the duration of ulcer healing.

As clinicians, we must continue to challenge the general apathy and prejudice towards change regarding VLUs, and call for the consistent local implementation of pathways of care to deliver more effective outcomes for all concerned. Good, optimal practice does exist in a variety of healthcare settings by dedicated clinicians. Unwarranted variation in practice must continue to be challenged. We cannot continue to allow the management of people with chronic venous disease, including VLUs, to be purely reactive. We need to advocate and support a preventative approach to such individuals and their subsequent management. It will be interesting to see if the introduction of 'Betty's Story' will drive the agenda for change at a local level, and engage the attention of CCGs in investigating the root cause of sub-optimal care. We can only hope that it will facilitate future discussion and a case for further positive change to reduce variance for all concerned.