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Venous leg ulcer services in the United Kingdom: A freedom of information request and national survey of clinicians

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Background: Venous leg ulceration (VLU) guidance recommends early assessment, compression, and treatment of venous hypertension. However, it is widely perceived that many patients do not receive timely clinical management, and across the country, there are variations in services commissioned to deliver care.

Methods: A survey of clinicians and Freedom of Information Request (FOIR) explored services available to treat patients with VLU. Using Burns and Kho's guidance, a questionnaire was developed and distributed via professional networks and social media. Additionally, a simplified version of the survey was submitted to 42 Integrated Care Boards (ICBs) across England as a FOIR. Descriptive statistics and subgroup analyses were used to interpret results, and common themes categorised free-text responses.

Results: Of 39 FOIR responses, 89 % report that they have a dedicated service for lower limb wounds. Services are largely nurse-led (68 %); however, 29 % are co-led by vascular surgeons and nurses. Compression therapy is routinely provided by 94 % of services, and 79 % provide care for house-bound patients. Of those specifying ulcer duration as part of the eligibility criteria to access services, 45 % required the wound to be present for four weeks or more.

95 % of respondents reported having a dedicated vascular service, and 92 % were described as a specialist service offering surgical intervention. Most (86 %) reported having a dedicated service for venous disease, of which 39 % were multi-disciplinary led as opposed to being led by vascular surgeons alone.

In contrast to the FOIR results, of 211 clinician survey responses, only 54 % reported having access to a lower limb wound service and 57 % do not routinely refer to a leg ulcer service. While the number of VLU patients treated each month varies, 54 % of primary care services report seeing over 41 patients per month. Lower limb services are predominantly nurse-led (87 %), and compression therapy is routinely provided by 95 % of services.

Considering vascular referrals, while 68 % reported having a vascular service, only 53 % routinely referred patients with VLU. The most common indication for a referral was to rule out arterial disease. Of those not routinely referring patients, 46 % reported they were unable to make direct referrals.

Conclusion: Findings indicate that services treating VLU are available throughout England, and lower limb clinics are primarily nurse-led. However, the eligibility criteria and high demand for such services mean they are not always accessible to patients in a timely manner. Further work is needed to establish strategies to improve access to VLU services.

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Introduction

Venous leg ulceration (VLU) is the most severe manifestation of lower limb venous disease and occurs due to superficial or deep vein incompetence and/or obstruction.[1] Accounting for 60 to 80 % of all lower limb wounds,[2] patients living with VLU experience,

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difficulties carrying out daily living activities and social isolation.[3] In particular, chronic pain and frequent appointments for dressing changes often inhibit patient's ability to maintain employment and participate in everyday recreational activities such as spending time with family and going on holiday.[4,5] While many patients adopt a self-care approach to help maintain independence, skills are largely developed through personal experience rather than official training, resulting in inadequate management.[6]

Western healthcare systems face a substantial burden, with recent estimates indicating that the UK National Health Service (NHS) incurs costs of £102 million annually for treating VLU.[7] In the UK, a significant portion of the costs relate to the workload of community nurses, who spend up to 50 % of their time managing care for this patient group.[8] For instance, in Hull and East Yorkshire, 151,000 nursing hours per annum were required to undertake VLU dressings, the full-time equivalent of 88.5 nurses.[9]

Considering this, it is essential that high-quality care is provided in a timely manner. According to the National Institute for Health and Care Excellence (NICE), assessment and treatment should include evaluation of arterial blood flow using the ankle brachial pressure index (ABPI) measurement, duplex ultrasound, compression therapy, and treatment of any underlying superficial venous disease.[10]

The UK healthcare system is predominantly organised into two categories; primary and secondary care services. Primary care is typically a patient's first point of contact and includes general practice, district nursing and community pharmacies. Specialised medical/surgical services, and emergency acute care are provided in secondary care hospitals. To facilitate efficient patient management, primary and secondary services are grouped into Integrated Care Boards (ICBs); statutory NHS organisations responsible for meeting the population's health needs and providing healthcare services in a set geographical area.[11] Internationally ICBs are otherwise known as a health board.

Across the UK, access to appropriate VLU treatment often requires a referral from a primary care service to a specialist team, and NICE recommend that patients with suspected VLU persisting for more than two weeks be referred to vascular surgery.[10] This is necessary as, while comprehensive assessments (including an ABPI) and treatment such as compression are predominantly delivered in primary care by nursing staff, services such as duplex ultrasound and venous intervention are primarily delivered by vascular surgical teams in hospitals.[12,13]

Unfortunately, despite this guidance being reiterated by the UK Venous Forum,[14] The National Wound Care Strategy Program (NWCSP)[15] and the European Society of Vascular Surgery (ESVS),[16] it is widely known that many patients across the UK do not receive assessment and treatment in a timely manner. This is demonstrated in the 'Burden of Wounds' study, where 78 % of patients with suspected VLU did not receive an ABPI as part of the early assessment.[17] Despite the national push to improve access to early assessment, these shortcomings persisted throughout the COVID-19 pandemic and beyond, with only 15 % receiving a ABPI as part of early assessment and 35 % fewer patients being referred to a hospital specialist.[18]

Previous survey research evaluating pathways of care for VLU also provides evidence regarding delays in care. UK-based surveys of community nurses and general practitioners (GPs) demonstrated poor adherence to NICE guidance, with only 37 % of VLU patients being referred to a vascular centre in less than six weeks.[19] The median time to vascular surgery referral was reported as approximately eight weeks, significantly longer than the two-week recommendation.[20]

Qualitative interviews with nurses explored reasons for poor assessment and referral rates. Participants expressed that many staff lack the knowledge and confidence to provide high-quality care for patients with VLU. This results in task-based care rather than a holistic approach that would include a comprehensive assessment. Additionally, organisational barriers such as staff shortages, time constraints, a lack of resources, and disjointed clinical services all impact nurses' ability to provide care in a timely manner.[21]

Given these shortcomings, it is clear that work is needed to address the barriers to care in the UK. However, improvements and adaptations to clinical services can only be planned from a clear understanding of what is currently available. This work aimed to evaluate service provisions within the UK National Health Service to treat patients with VLU. Additionally, it aimed to understand how clinicians determine what makes a patient suitable or unsuitable for referral for VLU assessment and specialist treatment.

Methods

Study design

To explore VLU services available in the UK, an online 25-question survey for clinicians was developed. While survey research provides valuable insight into participants' attitudes and experiences,[22] responses are shaped by contextual influences and their understanding of a topic.[23] Since participants' answers may be shaped by their knowledge and personal awareness of available services, a freedom of information request (FOIR) was also submitted to 42 Integrated Care Boards across England. A FOIR is a formal request made to a public authority to access routinely recorded information and is a tool used to obtain information about the activities, policies, and decisions of public bodies. This FOIR included submitting a simplified version of the full survey questionnaire to facilitate the collection of objective data. Each ICB has a dedicated business management department that coordinates the administrative aspects of service delivery. While they may not have direct knowledge and experience of what actually takes place in clinical practice, they oversee what services are commissioned within their ICB. By surveying both clinicians and ICBs any inconsistences between what services should theoretically be available and what actually occurs in clinical practice can be identified.

Survey design

When available, it is recommended that researchers use validated questionnaires to answer their research questions.[24] Given the specificity of the subject being explored, this was not an option. The survey was developed according to the Burns and Kho[25] guide for the design and conduct of self-administered surveys. This included working through the five stages of development: item generation, item reduction, questionnaire formatting, questionnaire composition, and pre-testing.[25] Both the survey and FOIR were made up of single-stage and adaptive questions. As FOIRs are primarily managed by administrative teams rather than clinicians, questions were designed to be simple and objective, so clinician input was not necessary. The survey and FOIR included questions examining the current care provisions for patients with VLU and the eligibility criteria to access such services.

Additionally, the survey included questions about service capacity, referral practices and pathways, and the location of clinical services.

After demographic data, questions were grouped into two sections: lower limb services and vascular services. A lower limb service was described as '*a healthcare service providing care for patients with chronic wounds located below the knee and above the foot*'. A vascular service was described as *'services commissioned to provide diagnostics and treatment for vascular disease. The principal clinical*

specialities involved are vascular surgery and interventional vascular radiology. Such services provide care for the needs of patients with disorders relating to the arteries, veins, and lymphatic system'. While not always the case, lower limb services are predominantly based in primary care and vascular surgery in secondary care. When considering referral practices, there was an additional question covering the speciality dermatology.

Throughout the development process, the survey was tested and reviewed by stakeholders working in the field of VLU. These included a UK National Wound Care Strategy committee member (nurse), a consultant vascular surgeon, a consultant nurse with district nursing experience, and a practice nurse working in general practice. All have an expert knowledge of VLU care in the UK and an understanding of research methodology.

For the clinician survey, the web-based Qualtrics Survey Platform (https://www.qualtrics.com) was utilised to deliver an open survey approach, allowing all responses to be anonymous. The survey starts by asking a list of screening questions to confirm eligibility. These include asking participants to identify their professional group, area of practice (primary or secondary care), and how often they see patients with VLU. Respondents were able to review and change their answers using the 'back' button, and the platform enabled a completeness check highlighting incomplete answers to the respondents; however, this could be overruled. To address the risk of duplicate responses from one participant, cookies were used to assign a unique user identifier that was set on each page.

Following the UK requirements for FOIR, questions were sent to each ICB via email in a Microsoft Word document. This included check-box questions and space for free text writing. The FOIR and survey questions are detailed in *Appendix A & B.*

Ethics

The London - Chelsea Research Ethics Committee (REC Reference: 24/LO/0275) granted ethical approval for the HCP survey. The survey was disseminated online and started with an explanation of the project that included a link to the full participant information sheet. It was then followed by the opt-in consent questions. Participants who selected *'I do not consent to participate in this survey'* were directed to the end survey page, and no data were collected.

Survey distribution

Over a period of two months (July – August 2024), the clinician survey was circulated by email to an established vascular research mailing list and via social media. These channels included clinicians from across the UK, including Scotland, Wales and Northern Ireland. In contrast ICBs operate solely within England and do not cover the wider UK. Consequently, the FOIR only represents services in England. For the clinician survey, a snowballing technique was also applied as, while not mandatory, respondents were asked to forward the survey to those they felt were appropriate.

The vascular research mailing list includes lead clinicians of 30 UK NHS Trusts that actively collaborate on VLU research and represent a wide spread of services across the UK, including primary and secondary care clinicians. Distribution across social media platforms included the following special interest groups: Royal College of Nursing forums, Practice Nurse UK forum, Leg Ulcer Forum, Tissue Viability Society, The Vascular Society, The Society of Vascular Nursing, and Lower Limb Clinicians 2gether. Additionally, the survey was distributed to HCPs in primary care by the National Institute for Health and Care Research's (NIHR) Research Delivery Network.

Survey analysis

Data from the FOIR and survey were analysed separately and summarised using descriptive statistics. Results from the FOIR were collated using an Excel spreadsheet. Similarly, using the Qualtrics survey platform, all results were exported onto an Excel spreadsheet for initial analysis. The data exported from Qualtrics did not require cleaning, as the platform allows users to group or filter responses and identifies the number of respondents to each question or missing data.

Categorical variables were summarised using frequencies and percentages. For the survey, the software Statistical Package for the Social Sciences (SPSS 29) was used to analyse how frequently options were selected in multiple-response questions. Using a thematic analysis approach, free-text responses were categorised by common themes for ease of interpretation.

In line with the EQUATOR guidelines, the CHERRIES[26] checklist was to guide reporting of these survey results.

Results

Freedom of information request

Of the forty-two ICBs, thirty-nine responded. Follow-up emails were sent to the outstanding four, all of whom initially responded to say the request for information was received, but no survey response was submitted. Despite missing three responses, the FOIR responses covered all seven regions of NHS England.

Lower limb services

Of 39 responses, 89 % reported having a dedicated service for lower limb wounds, described as a healthcare service providing care for patients with chronic wounds located below the knee and above the foot. Such services are predominantly nurse-led (68 %); however, 29 % were co-led by vascular surgeons and nurses, and 3 % were co-led by nurses and allied healthcare professionals such as podiatrists. Compression therapy was routinely provided by 94 % of services, and 79 % provide care for house-bound patients. Twenty ICBs were able to provide the eligibility requirements for accessing lower limb services. Of these responses, 45 % required the wound to be present for four weeks or more. Referrals were accepted in multiple forms (e.g. electronic or via email) by 53 % of lower limb services. Methods for referral include electronic e.g. e-referral system (34 %), email (31 %), telephone (16 %), and patient self-referral (10 %) (9 % of responding ICBs did not answer this question).

Vascular services

Vascular services were available in 95 % of the responding ICBs, and 92 % were described as specialist services with outpatient facilities, provisions for surgical intervention and 24-hour emergency services. Within vascular services, most (86 %) reported having a dedicated service for venous disease, of which 36 % are multidisciplinary led as opposed to being led by vascular surgeons alone (Fig. 1).

Clinician survey

The survey received 211 responses from a range of clinicians working in different clinical settings across the UK. Demographic data are detailed in Table 1.

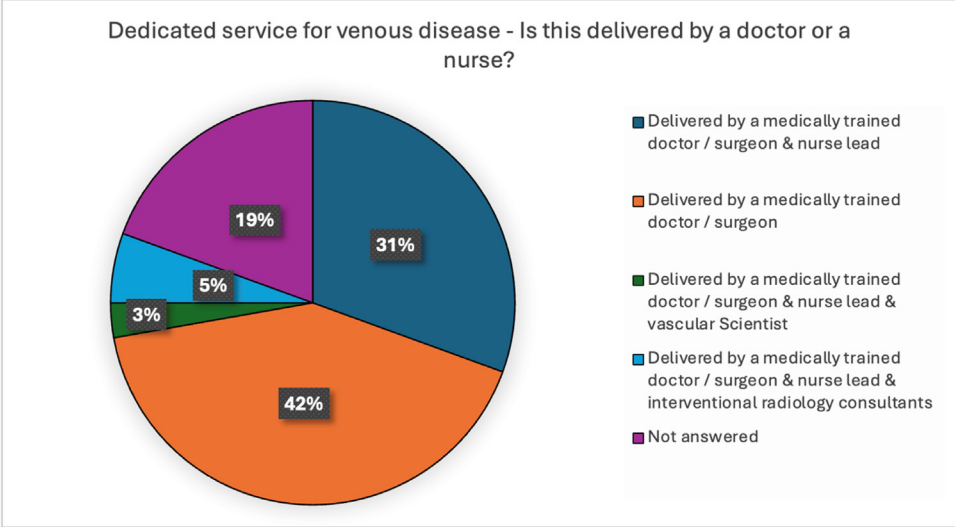


Fig. 1. Clinicians leading dedicated services for venous disease.

Table 1
One – demographic data.

Demographic Data	
What is your current professional role?	Percentage
Nurse / Healthcare Assistant	79 %
Doctor	12 %
Allied Health Professional	2 %
Other (e.g. non-clinical manager / medical deceive representative)	7 %
What type of healthcare setting do you work in?	Percentage
Primary care – GP services	10 %
Primary care – Community / District nursing services	37 %
Secondary care – Hospital inpatient	22 %
Secondary care – Outpatient services	22 %
Academic / Teaching	7 %
Other (Co-working primary & secondary care)	2 %
Georgical Region	Percentage
Northeast England	11 %
Northwest England	13 %
Yorkshire and The Humber	12 %
East Midlands	7 %
West Midlands	9 %
East of England	7 %
London	12 %
Southeast England	6 %
Southwest England	9 %
Scotland	4 %
Wales	7 %
Northern Ireland	4 %

Clinical services

Fifty four percent (89 respondents) reported having access to a dedicated lower limb service within their organisation, 41 % indicated no access, and 4 % were unsure. Referrals to such services were predominantly made electronically, either by an e-referral (75 %) system or via email. Services are commonly nurse-led (87 %); however, 10 % were co-led by nurses and doctors, and 3 % are co-led by a wider multi-disciplinary team (e.g. nurses, podiatrists & vascular scientists). Within lower limb services, 95 % are able to provide compression therapy. Among respondents, 36 % routinely provide care for house-bound patients, 8 % provide such care most of the time, 17 % offer occasional support, 33 % report not providing any care to house-bound patients, and 6 % were unsure. Although 68 % of respondents reported having access to a vascular service, 26 % said they did not.

Referral criteria

While the referral criteria for lower limb services varied (Fig. 2) common reasons were suspected venous or arterial disease. Considering wound duration, 61 % indicated that wounds must be present for six weeks or more. Conversely, 58 % reported their service accepts lower limb wounds of any duration. Diabetic foot wounds were only accepted by 27 % of services, and additional free text responses indicated that these patients would be referred to a dedicated diabetic service instead.

Referral practices

As survey respondents worked in various clinical settings (Table 1), inevitably, referral practices differed. To review this, the survey explored referral practices for lower limb services, vascular surgery and dermatology. Of those not currently working within a lower limb leg ulcer service ($n = 136$), 57 % reported that they did not routinely refer patients to one. This is unsurprising, as 46 % reported not having access to such services. For those who did, whilst there were a multitude of clinical indications prompting a referral (Fig. 3), the need to determine if compression therapy can be started was the most frequent. Common reasons for not referring to leg ulcer services included feeling able to manage wounds without additional input (34 %), being unable to initiate a referral (15 %), and being worried about the workload of specialist services (8 %).

Of those not currently working in vascular surgery (126), 53 % routinely refer patients with open VLU. When considering those who *do not* routinely refer, 110 of these respondents were nurses. Reasons for not referring included being unable to do so (46 %) and it not being part of their clinical role (12 %). Free text responses demonstrate an overall perception that only patients with *'red flags'* or signs of deteriorating arterial disease should be referred to vascular surgery. In keeping with this, the need to rule out arterial disease was the most common reason for referral to vascular surgery (Fig. 4). Additional reasons described in the free text responses included 'complex' or 'non-healing' wounds.

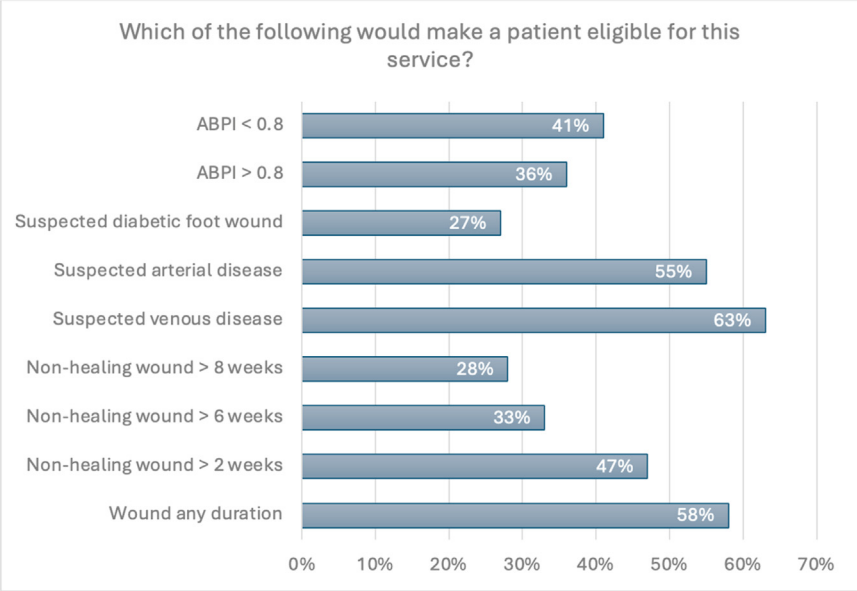


Fig. 2. Eligibility criteria for lower limb services.
NB - This was a multiple-answer question where respondents were asked to select all answers that apply.

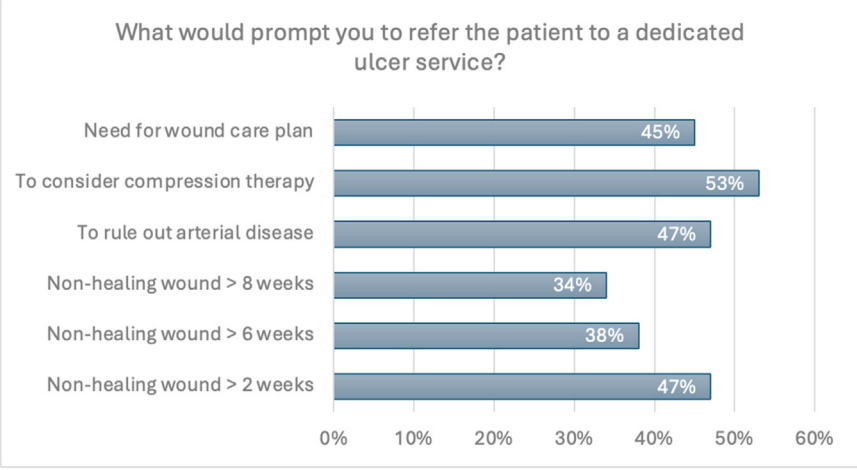


Fig. 3. Reasons for referral to a lower limb service.
NB - This was a multiple-answer question where respondents were asked to select all answers that apply.

Most respondents (64 %) did not routinely refer patients with open VLU to dermatology. However, reasons for referral include the presence of an atypical ulceration and suspicion of malignancy.

Capacity of services

While individual HCPs were most likely to see between 1 and 10 patients with VLU per week (64 %), the number of patients seen overall in a clinical service varied (Table 2). Looking specifically at the workload of primary care clinicians, 55 % of services saw over 41 patients per month (Fig. 5). This is comparable to secondary care services, where 52 % of services also reported treating over 41 patients per month (Fig. 6).

Location of services

Respondents were asked to consider where they felt was the most appropriate place for VLU-specific clinical care to occur. Unless a duplex ultrasound is required, most felt that primary care is an appropriate setting to complete wound care assessments, an ABPI and compression therapy (Fig. 7)

Table 2
Number of patients seen in a clinical service.

How many patients with open leg ulceration does your clinical service see each month?	Percentage
0	1 % (1)
1–20	22 % (39)
21–40	21 % (37)
41–60	11 % (19)
60+	37 % (64)
Unsure	9 % (15)

(n) = number of participants - 175 participants answered the question

Free text analysis

Of the 211 respondents, 72 % left a free text response. These results captured additional data from participants and were cate-

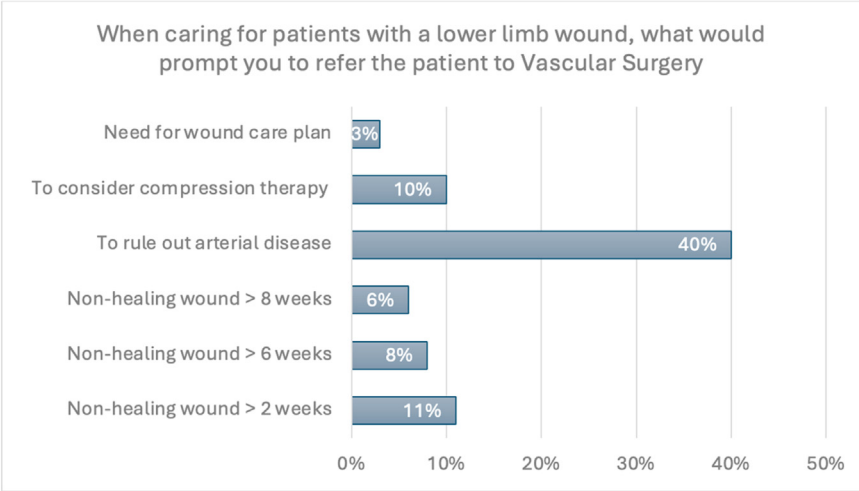


Fig. 4. Reasons for referral to a vascular service.
NB - This was a multiple-answer question where respondents were asked to select all answers that apply.

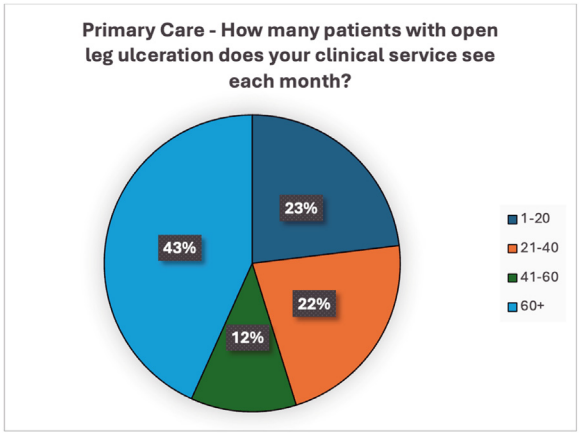


Fig. 5. Number of patients seen in primary care services.

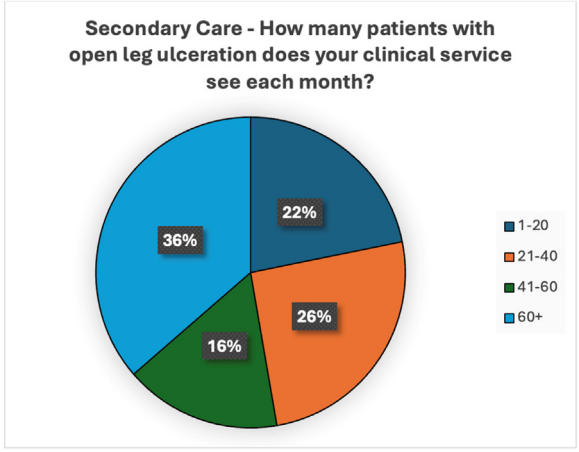


Fig. 6. Number of patients seen in secondary care services.

gorised into four key themes: *Logistical Challenges, Overwhelming Demand, Multidisciplinary Relationships, and Nurse-Led Services.*

Logistical challenges

While participants felt that dedicated 'one-stop' leg ulcer clinics should be established to ensure patients receive timely assessment and management, respondents perceived that patients currently face a 'post-code' lottery when attempting to access VLU services. Comments included:

> *'We need dedicated wound management clinics which have coverage by vascular surgery and direct involvement of community teams so seamless escalation and de-escalation can be achieved.'*

> *'Currently there is a very real "postcode lottery" in relation to leg ulcer management, the community services do not have enough competent staff to manage these patients appropriately'*

> *'I feel we don't have a venous leg ulcer service at all'*
> *Overwhelming Demand*

Where services did exist, many feel that they struggle to meet demand and this often causes delays in patient care.

> *'There are services available to refer patients for specialist advice, although they often have to wait some time to be seen.'*

> *'Our patients referred to vascular have to wait 10 months'*

> *'We need ulcer clinic slots in primary care as those in secondary and tertiary care are so full'*

Multidisciplinary relationships

An additional factor affecting the delivery of services is the strained working relationship between primary care staff and vascular surgery. Unfortunately, many primary care clinicians had the perception that staff in vascular surgery do not have an interest in patients with VLU and would prefer to focus on patients with arterial disease.

> *'Disappointing lack of communication from vascular team'*

> *'Vascular are not helpful or interested at all'*

> *'Our referrals are just rejected [by vascular surgery]'*

Nurse-Led Services

Despite the reported barriers to care, many felt that primary care services led by nurses and working in close collaboration with vascular specialists deliver high-quality VLU care.

> *'In my opinion a properly supported nurse led service is the best route'*

> *'Our excellent DN [District Nursing] team led LU [leg ulcer] clinic, and it just works'*

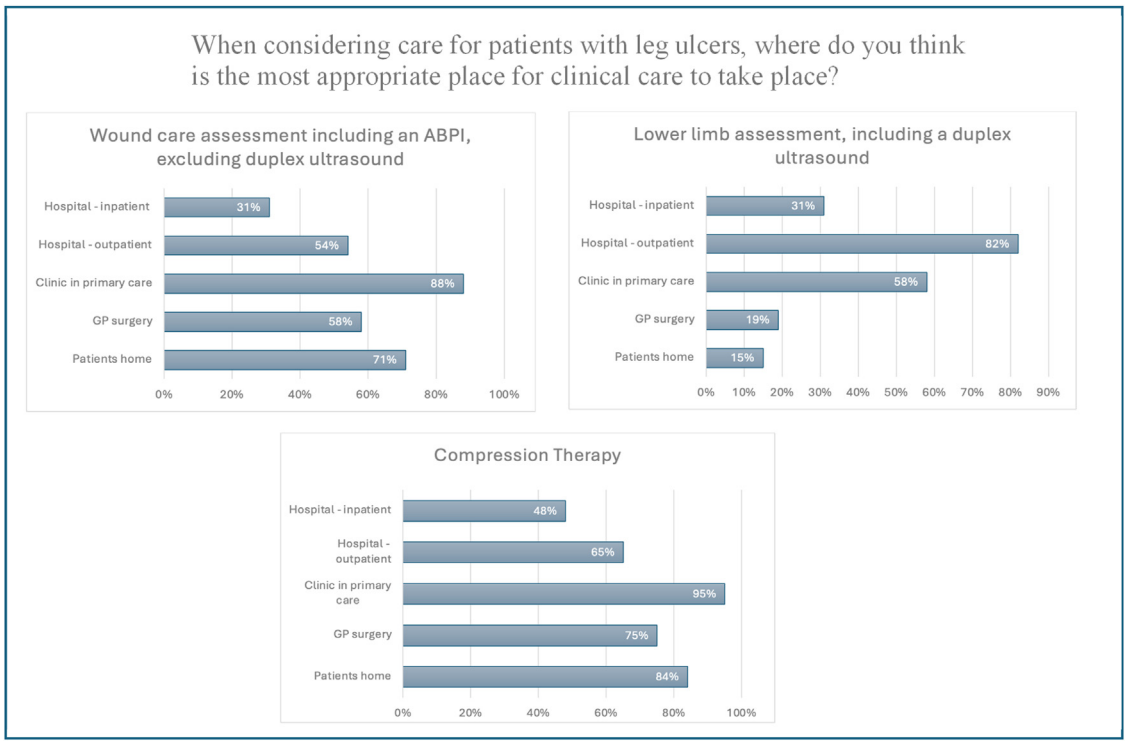


Fig. 7. Location of clinical services.
NB - This was a multiple-answer question where respondents were asked to select all answers that apply.

Discussion

Findings indicate that lower limb and vascular services treating VLU are available throughout most of England. However, there are a notable discrepancies between the FOIR and survey findings. For example, 95 % of ICBs reported having a vascular service, as opposed to only 68 % of survey respondents. Similarly, while 89 % of ICBs reported having a dedicated service for lower limb wounds, only 54 % of survey respondents said they had access to one. As ICBs often cover large geographical areas and multiple hospitals, it is likely that services may not be accessible to all clinicians and patients within that area. For example, the Greater Manchester ICB covers approximately 493 square miles and ten metropolitan boroughs[27]

In spite of sustained efforts to enhance primary care clinicians' awareness of VLU services, pathways and optimal management,[28] across the UK this remains a largely overlooked and underrecognised area of care.[29] However, it is also important to consider that findings from the clinician survey only reflect the knowledge and understanding of respondents. Although respondent may not be aware of a clinical service for VLU, this does not mean the service does not exist and may explain some of the discrepancies in results.

Despite possible access issues, it is reassuring that where dedicated lower limb services do exist, 94 % were able to provide compression therapy, and 79 % were able to care for housebound patients (according to FOIR responses). However, responses indicated that many are struggling to meet demand,[30] and this is highlighted in the survey free text responses, where a key theme was the overwhelming demand for leg ulcer care. Additionally, some respondents (8 %) reported not referring patients to help reduce the burden on nurse-led services.

Survey free-text responses also revealed that a key issue is the strained relationship between clinicians in primary and secondary care. Among respondents not working in vascular surgery, many expressed concerns that VLU care is not prioritised and communication between teams is poor. Unfortunately, qualitative research involving nurses exploring VLU care pathways confirms these concerns.[31,32] A recent study highlighted that a strong working relationship between secondary care professionals and district nurses was perceived as a facilitator of good clinical practice.[31]

Additional themes of importance derived from free-text responses include the need for dedicated one-stop clinics providing assessment and care. Implementing such services across the NHS is not a new concept, and recent figures show that the development of community diagnostic centres significantly improves NHS capacity and helps patients get a diagnosis quicker.[33] When looking specifically at vascular surgery, small-scale studies evaluating single-stop vascular assessment clinics (including duplex ultrasound) found improvements in time to diagnosis and instigation of treatment.[34] On a larger scale, similar approaches have been implemented and tested by the National Wound Care Strategy Programme with good effect, and their recommendations now suggest that ICBs should commission dedicated leg ulcer services.[35] While this is positive, to date there has been limited detailed exploration of patient experiences and preferences regarding such services. This is crucial prior to implementation to ensure effective uptake and patient engagement.

Both surveys explore access to lower limb and vascular services by evaluating referral criteria and practices. Despite NICE guidance recommending that lower limb assessment should occur within two weeks of presentation, results from the FOIR show that 45 % of services require wounds to be present for four weeks or more.

This is particularly problematic as it is well known that many GP services do not have the time or resources, such as a handheld Doppler, to carry out a comprehensive lower limb assessment, and patients are referred to lower limb services or district nursing for this to occur.[17] This suggests that even if patients were referred in a timely manner, they would not meet the eligibility criteria for many lower limb services.

It is positive that 57 % of survey respondents report routinely referring patients to vascular services, a 20 % increase from a survey conducted in 2020.[19] Unfortunately, referrals appear to be driven primarily by abnormal ABPI or signs of arterial disease rather than the need to consider venous intervention.

Exploring the logistics of referral practices, over half of lower limb services accepted multiple forms of referral, with the majority being electronic. While this is primarily done using an e-referral system, many accept referrals via email or phone call. The National Wound Care Strategy programme recently published a suggested referral proforma[36] to help improve the quality of information provided to district nurses and specialist services. Unfortunately, little is known about its implementation, and support may be needed to effectively integrate the new proforma into an e-referral system. While less common, 10 % of services allow patients to self-refer. Further information is required to understand how this works in practice and what effect it has on ulcer healing rates.

While there appears to be a trend towards developing a multidisciplinary approach, lower limb services are primarily nurse-led. Our findings indicate that clinicians view this model as an effective way to deliver timely and appropriate care. Supporting this approach to service delivery, a systematic review evaluating the impact of nurse-led clinics concluded that such services provide comparable or even superior care when compared to usual services.[37] It is perhaps unsurprising that leg ulcer clinics are predominantly nurse-led as historically wound management has often been a role designated to nurses in western healthcare systems.[38] However, when considering that 39 % of specialist venous services are now delivered by multi-disciplinary teams (surgeons and nurses), it appears nurses are taking on more advanced roles in VLU care. This can be seen in new services within the NHS, such as London's first nurse-led varicose vein intervention centre, which largely treats patients with VLU.[39]

Clinical implications

Inevitability these results suggest that many patients may not be receiving care in a timely manner. Despite the barriers faced, it is imperative that clinicians seek to assess and refer patients within the time frame specified by national and international guidelines (two weeks). To ensure this happens, fostering stronger relationships between primary and secondary care is key and the development of one-stop clinics could be an option to reduce delays.

Limitations

Unfortunately, there is no recognised number of clinicians employed to provide care for VLU patients in the UK. Additional while anecdotal differences between FOIR results and clinician survey were observed; the two samples are not directly comparable. As a result, it was not possible to calculate a sample size for clinician survey responses or conduct analysis beyond descriptive statistics.

While these findings provide useful insight into what services are available, as mentioned, one limitation of the FOIR is the geographical spread of ICBs. Many ICBs cover large geographical areas and several NHS Trusts. Additionally, ICBs do not include GP practices and do not exist outside England. The FOIR results do not show where services are in each ICB, so it is possible that some services may not be accessible to all patients due to their location. Additionally, while the survey was distributed via several different channels to ensure representation from clinicians in a variety of settings, inevitably, those who take part are more likely to have some interest in VLU care, and this presents a potential bias.

Conclusion

Findings indicate that services treating VLU are available throughout England. Lower limb clinics are primarily nurse-led and often require referral to take place four weeks after initial ulcer presentation. As a result, it is unsurprising that only a small number of eligible patients in the UK receive timely assessment and management. Additionally, the overwhelming demand for services and access issues suggests that even if a patient is eligible for VLU services, they may still face difficulties getting the care they need.

Differences between results suggest that, in reality, clinical services experience a number of challenges in delivering care to this patient group. Further work is needed to establish strategies to improve access to VLU service and this work should be informed by patient preferences and experiences.

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Ethical approval

The London - Chelsea Research Ethics Committee (REC Reference: 24/LO/0275) granted ethical approval for the HCP survey. No approval was needed to carry out the freedom of information request.

Declaration of competing interest

Nothing to note.

CRediT authorship contribution statement

Mrs Layla Bolton Saghdaoui: Writing – original draft, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Mary Wells:** Writing – review & editing, Validation, Supervision, Methodology. **Mrs Sarah Onida:** Writing – review & editing, Validation, Supervision, Methodology. **Alun Huw Davies:** Writing – review & editing, Validation, Supervision, Methodology.

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Supplementary materials

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