ALL-PARTY PARLIAMENTARY GROUP ON
VASCULAR AND VENOUS DISEASE

BRANCHING OUT

ASSESSING PATIENT ACCESS TO VARICOSE VEIN SERVICES IN ENGLAND

Report by the All-Party Parliamentary Group on Vascular and Venous Disease

June 2024

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Executive Summary

The All-Party Parliamentary Group on Vascular and Venous Disease (VVAPPG) has produced this report to provide an understanding of standardisation of treatment across the country in varicose vein treatment. The Group submitted Freedom Of Information (FOI) requests to all Integrated Care Boards (ICB) in the country, and followed this up with interviews with ICB leads and Vascular Leads within 6 areas, to understand in more detail if the FOI data matched practice within each ICB, and discover how each area was working to standardise policies across ICBs, improve standards of care, and provide equal access to services for patients, regardless of where they lived.

The VVAPPG acknowledges the incredible challenges within the NHS at present, and wanted to understand where those challenges were impacting on delivery of services, to highlight those to relevant national stakeholders. This report is not an attempt to hold ICBs or NHS bodies to account; but to provide a platform for NHS organisations to discuss their challenges and barriers to standardisation of care.

The VVAPPG will continue to engage with policymakers and NHS leaders to raise awareness about the need for NHS bodies to comply with NICE and EBI Guidance, to improve the outcomes for patients and save money for the NHS.

Key Findings:

- There are significant variation in patient pathways across ICBs in the country, and in some cases, within ICBs.
- Varicose vein treatment has low visibility at ICB leadership level, and at national level, meaning that challenges in access are not high on the agenda of policymakers.
- There are a range of challenges present in the system which creates inequality in access, including lack of awareness of NICE Guidance; poor communication within ICBs; lack of sharing of best practice between ICBs; and funding restrictions, which create a disincentive to treat varicose veins up stream.
- There are areas of good practice, and clinicians who see the benefit of treating patients early. However, it is not widespread, which leads to disparities in treatment and outcomes for patients.
- Arterial work is currently prioritised by vascular surgery departments due to the acute nature of the cases that present but this had led to a significant increase in chronic venous conditions such as venous ulcers.

The VVAPPG recommends that:

1. The Department of Health and Social Care and NHS England provide additional resource to ICBs to deliver additional services to support vascular clinicians, including sonographers, as well as support and guidance from Getting It Right First Time (GIRFT).
2. NICE and NHS England deliver an education campaign to all ICBs, with tailored support for clinical teams across the pathway, to support the development of knowledge on vascular and venous health and best practice in treatment.
3. ICBs shape services to meet the needs of their areas, creating effective accountability structures to empower vascular networks to deliver better outcomes for patients.
4. ICBs align policies within their own systems, and work with neighbouring ICBs to embrace and deliver best practice, reducing the postcode lottery for patients, as well as utilise capacity within the independent sector where appropriate.
5. The Department of Health and Social Care and NHS England provide funding for prevention and early interventions for varicose veins to support patients to avoid the permanent harm of venous ulceration.

Background

Currently, the cost of providing intervention to a venous patient is approximately £1100. The conservative cost of managing a venous leg ulcer patient is over £7000 per annum, without the inclusion of any nursing time. Delaying treatment for this patient group is associated with a loss in net health benefit and, as demonstrated in the NICE guidance, is proven to be less effective.

Evidence should be taken into consideration during the process of reviewing commissioning guidance within the ICS. The Early Venous Reflux Ablation (EVRA) study[1] – which was funded by the NIHR – found that access to intervention for venous ulcer patients improves healing time and reduces the chance of recurrence.

The EBI programme was introduced in the NHS with the aim of improving care quality and supporting implementation of NICE CG168. The programme also helps to reduce unwarranted variation in the care of people with varicose veins leading to better outcomes for patients.

Adoption of the NICE CG168 guidance and the EBI guidance, is a positive step towards reducing patient harm, improving the care of people with venous disease in your area and reducing the health inequality "postcode lottery" effect.

The VVAPPG engaged with ICBs across the country to discuss where variation in practice is taking place, and what support ICSs and others could use to ensure best practice is being adhered to, with current pressures in mind.

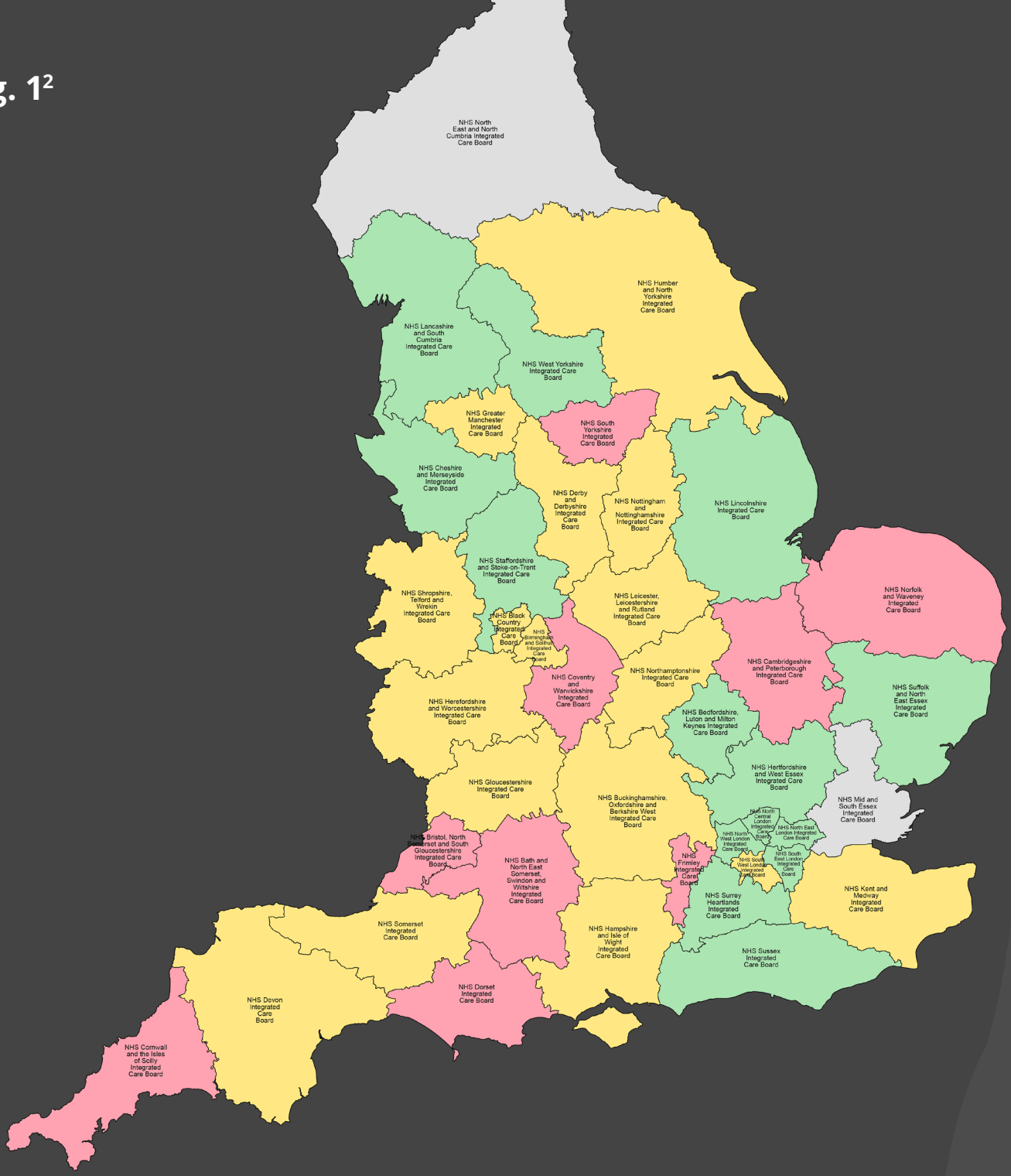
The standardisation of access to treatment for patients, and compliance with clinical guidelines, are important to reduce health inequalities and ensure the delivery of high-quality care to patients across the country.

Utilising responses to Freedom of Information (FOI) requests to ICBs across the country, the VVAPPG analysed ICB compliance of NICE CG168 Guidance (varicose veins: diagnosis and management) and the Evidence Based Intervention (EBI) guidance. We found a wide range of variation in compliance with NICE Guidance, which we explored in more detail through interviews with ICB and Vascular Unit leads from a range of ICBs. The details of these findings are found in this report.

The FOI responses painted a varied picture across the country, with areas falling under three broad categories: compliant, working towards compliance, not compliant. The below map shows this breakdown per ICB in the form of a colour coded map (Fig. 1).

1. A Randomized Trial of Early Endovenous Ablation in Venous Ulceration (2018), Manjit S Gohel et al, N Engl J Med 2018;378:2105-2114 – Accessed at https://www.nejm.org/doi/full/10.1056/NEJMoa1801214#:~:text=Early%20endovenous%20ablation%20of%20superficial%20venous%20reflux%20resulted%20in%20faster,ulcers%20than%20deferred%20endovenous%20ablation.

Fig. 1[2]



Given the range of variation in compliance with NICE and EBI Guidance on this issue, the VVAPPG undertook a number of interviews with ICB and Vascular Leads across England, to get a sense of whether the FOI response fit with experiences on the frontline, and to determine what work each area was doing to bring their practice in line with national guidance.

These discussions have been summarised in extracts below, which have been anonymised and grouped by themes of discussion, providing context to the FOI data summarised above.

2. The information gathered through FOI responses has been compiled in 2023, and may not fully represent the current compliance with NICE Guidance by ICBs at the current time. Through discussions with ICBs, it has been found that not all FOI responses are fully reflective of current practice, so this map is indicative only.

Compliance with NICE and EBI Guidance, and standardisation of practice across ICB structures

Each of our conversations explored the FOI data received on each ICB, where we questioned interviewees on their awareness of the ICB's compliance with NICE and EBI Guidance; whether it was reflective of their ICB's FOI response; and where any standardisation in policies had taken place since ICBs came into being in July 2022.

For some, there was a relatively high compliance rate with the NICE Guidance. However, these interviews highlighted a range of issues in complying with the Guidance, in particular how ICBs have standardised policies around treatment in this area across their ICB patches.

"Looking at the situation as a whole, the NICE Guidelines are liberal, and probably as good as they get. However, we want to be able to prevent ulceration. If ICBs only provide venous funding for leg ulceration, then it will not serve populations and patients in the long run.

"There are instances where I have seen vascular units circumventing ICB policies to try to have GPs apply for funding, or where vascular units list people for surgery without varicose veins to try to ensure they are seen and treated before ulceration, to prevent further damage in the long run for the patient."

Vascular Clinician

"There is some confusion on the alignment of ICB policies and provider practice. There is more than one set of criteria which is being used by clinicians at all levels of the pathway, including at General Practice level. Although this is being rationalised, there are still challenges."

Vascular Clinician

"[My ICB] has a fairly lenient criteria compared to other regions. The Vascular Network spans across three ICB areas, with a population of over 1 million. Being able to accommodate ICB polices across these three areas means that there is a clear postcode lottery for patients [given the range of compliance across the ICBs]."

Executive Director, ICB

"We have worked hard over the past few years to create the right systems and structures around this, to ensure that we are giving people an equal and equitable chance of treatment.

"We are a permissive commissioner, as long as metrics are being met. We let providers manage and police this themselves. We 'follow the noise' and let each hospital follow its own pathway. Most of these policies have been in place in each hospital for 5 years, and if they work at the minute, they won't change much, provided it is working in practice."

Executive Director, ICB

"My network – like many other networks – struggles with a reliable contact within our ICB to disseminate information on vascular services and the challenges we face in treating varicose veins to form a consensus, as well as a policy review that takes all views into account.

"In many areas vascular falls under cardiovascular – and the focus often lands on the cardiac-side of the work, leading to less focus on the vascular.

"Highlighting the impact of venous leg ulcers, varicose veins and wider venous disease – and their impact on the NHS and on patients – is vital for raising awareness and driving change."

Vascular Clinician

Awareness of Guidance

One area which featured heavily in our interviews was the variation in awareness of the NICE Guidance for this area, and the impact that had on all parts of the pathway. Although NICE had published the guidance, there was a general sense that this could be communicated more effectively to all parts of the pathway, to ensure awareness and adherence.

"When you go to conferences around the country, there is a lot of interest in this. Since 2015/16 since the trial was published, there has been a lot of discussion on this at an academic level, but this has not necessarily filtered down to clinicians, or those who are implementing the change.

"As such, there are not too many conversations on this between commissioners and clinicians, which impacts delivery. Further, because most vascular services are driven by NHS England and not commissioners, we are spending our time polishing the arterial side of things, at the expense of the venous side."

Vascular Clinician

"There is a disconnect between the NICE Guidance and the real world. People use the Guidance when it suits them. I'll often accept referrals but ignore the fact that there are funding issues which may impact on treatment, just to make sure they in the system. This means that the patient might be messed around for a number of months; but it is the only way to ensure they are in the system."

Vascular Clinician

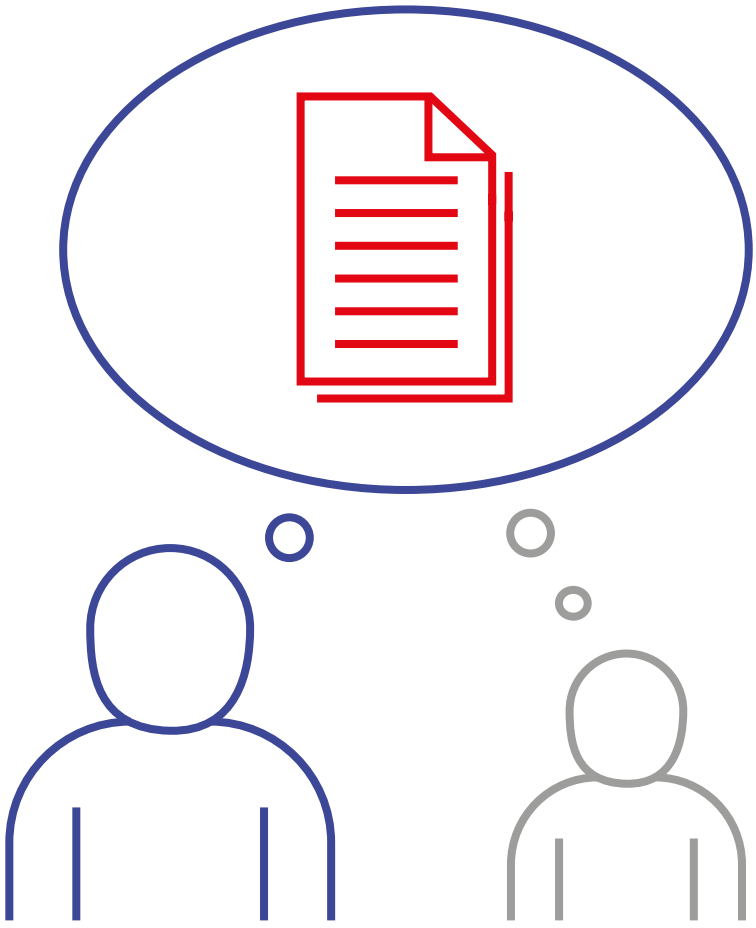
"ICBs came into being a few years ago, but there was no communication to the vascular teams about the change in policy in relation to varicose vein treatment. We went to the ICB website and saw that the criteria for treatment had changed. This is not a good way to communicate with teams who are trying to deliver change for patients.

Vascular Clinician

"There is a lack of knowledge of the NICE Guidance at General Practice level. There have been some educational events which have taken place, but it is the clinicians with an interest in the area who attend, and we often miss the people who need the education."

"It is also true that there is a changing workforce within Primary Care, not just within GPs, but including first contact practitioners, nurse practitioners, physician associates and others, and there is a need to make sure they are all aware of the Guidance, the pathway, and their responsibilities in this area."

Vascular Clinician



Common Challenges

Although many clinicians and ICB leadership teams noted the challenges with awareness of the NICE Guidelines, there were other challenges which impacted the ability of Vascular Units to deliver positive outcomes for patients, outside of their ability to meet NICE Guidelines.

These challenges spoke to wider issues within the NHS, meaning that – even if NICE Guidance is adhered to fully – challenges within the NHS will continue to impact delivery, and ultimately patient outcomes.

"Varicose veins are not a very 'sexy' area of work, and therefore it doesn't get the necessary funding required. By this, I mean that it doesn't get the national attention that it deserves – given its impact on patients across the country – so it will be easier for commissioners to ignore challenges and accept variation within their own areas.

"I have seen people in my own area go across ICB "borders" to receive treatment, as it is easier and quicker to receive treatment in neighbouring ICBs"

Vascular Clinician

"When I speak to colleagues from the Vascular space, it is clear that restrictive commissioning policies are bad for patients. However, there is no significant appetite to change commissioning policy or wider ICB work.

"We could and should be seeing patients earlier."

Vascular Clinician

"We need more sonographers. Not just because of varicose veins, but across the whole of vascular practice in the NHS. With a bit of commercial collaboration you could get veins treated; but getting patients scanned is difficult."

Vascular Clinician

"We might know what we are allowed to treat, and what we cannot; but that does not mean that it is working?"

Vascular Clinician

"Where commissioning policies and referral forms to get funding don't marry up, there are challenges for patients.

"We try to do the right thing by patients, but because of how medical training flows and constraints within the system, if colleagues across the system see restrictive policies, patients won't get referred for treatment. This causes delays for patients and leads to poorer outcomes, as they will only receive a referral once they present with significant problems. More should be done to prevent patients getting to this stage."

Vascular Clinician

"Venous leg ulcers cause real harm to patients, and in many cases it is permanent harm. Treating people at pre-ulcerative stage would have the maximum benefit to patients and the system. Treating people up-stream would save the NHS money and produce better outcomes for patients."

Vascular Clinician

"One of the biggest problems is the lack of ability to scan people. These patients are low priority within the unit in any case, so even if they are given scans and offered treatment, they are put on a waiting list, which continues to grow. Patients are not getting a great service across the country.

"There needs to be a priority for ulcer patients, with a rapid pathway to treatment."

Vascular Clinician

"Current models of delivery within arterial centres can often leave venous patients as low priority, despite venous disease representing a large number of patients who could benefit from treatment - this can create significant disease burden in the community. It is important that all avenues are explored to deliver services, including office-based outpatient settings with combined consultation and diagnosis capabilities."

Vascular Clinician

Key Findings and Recommendations

Although there has been work done to communicate NICE Guidance to ICBs, this has often not filtered down to vascular teams. Even when it is known and understood within those teams, the wider clinician group (including General Practice) does not have the requisite knowledge of the Guidance to support easy access to the pathway for patients.

There are challenges within the wider system, including a lack of supporting staff to deliver scans, which means that waiting lists for varicose vein patients continue to grow.

Furthermore, variation within and across ICB areas means that patients face a postcode lottery for care. This exacerbates poorer outcomes for patients and deepens health inequalities.

Given the low salience of vascular work in general amongst commissioners and policymakers, there is unlikely to be additional attention given to improving standards within vascular and venous treatment, which will further exacerbate poor outcomes for patients.

The VVAPPG recommends that:

1. The Department of Health and Social Care and NHS England provide additional resource to ICBs to deliver additional services to support vascular clinicians, including sonographers, as well as support and guidance from Getting It Right First Time (GIRFT).

2. NICE and NHS England deliver an education campaign to all ICBs, with tailored support for clinical teams across the pathway, to support the development of knowledge on vascular and venous health and best practice in treatment.

3. ICBs shape services to meet the needs of their areas, creating effective accountability structures to empower vascular networks to deliver better outcomes for patients.

4. ICBs align policies within their own systems, and work with neighbouring ICBs to embrace and deliver best practice, reducing the postcode lottery for patients, as well as utilise capacity within the independent sector where appropriate.

5. Department of Health and Social Care and NHS England provide funding for prevention and early interventions for varicose veins to support patients to avoid the permanent harm of venous ulceration.

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