The recent and ongoing changes to the NHS were instigated to absorb the increasing costs of an ageing population: the NHS needs to save £15–20 billion by the end of 2013/14 for reinvestment into frontline services (Department of Health [DH], 2010a; 2010b).

The Quality, Innovation, Productivity and Prevention (QIPP) agenda sets the challenge for clinicians to contribute to these savings by improving productivity and eliminating waste, while ensuring clinical quality and placing the patient at the centre of care (DH, 2010a; 2010b).

On an individual level, this means that we each need to look at our daily practice and identify where we can make changes that will not only lead to better care for our patients, but also improve clinical effectiveness and result in cost-savings. This is a personal, professional and moral responsibility, as it will allow us to free up resources that can be used to treat more patients, more effectively (DH, 2010a).

For those of us treating patients with wounds and oedema, compression therapy is a key area where the principles of the new NHS can be applied.

Posnett and Franks (2007) estimated that there are between 70,000 and 190,000 individuals in the UK with an open ulcer at any time, with more than 100,000 new ulcers developing annually; by 2025 this figure could reach 148,000.

Similarly, chronic oedema has been estimated to have the same incidence as leg ulceration in the UK, affecting over 100,000 people (Moffatt et al, 2003).

\[\text{Costs of leg ulcer management to the NHS in terms of dressings and other materials, medical and nursing time, and hospital resources is mostly borne in primary care and the community nursing services, and is at least £168–£198m per year (Posnett and Franks, 2007).}\]

These costs were calculated using clinical trial data in which treatment was prescribed correctly and monitored. Sadly, in reality, this is often not the case (Posnett and Franks, 2007), so these costs are likely to be much higher.

Compliance and concordance are frequently highlighted as challenges that contribute to the economic cost of leg ulcer management (Anderson, 2012), with patients who are non-concordant with compression being at risk of experiencing disease progression, delayed healing, worsening of symptoms and development of complications, all of which can send the costs of care soaring (Bianchi and Timmons, 2008).

The consequences of disease progression can also have a catastrophic impact upon the lives of patients and their families, in terms of reduced quality of life, yet these personal costs are often overlooked (Charles, 2008).

Patients that have difficulty with compression therapy are often blamed (by professionals) for interfering with or negating the effects of their treatment.‘

The benefits of using compression therapy for the management and prevention of recurrence of leg ulcers and the management of chronic oedema are well documented.

Current guidelines promote a two-step approach to compression therapy; intensive treatment using a bandaging system to promote healing and gain control of symptoms such as excess exudate and swelling, then hosiery as maintenance treatment for patients once the ulcer has healed and/or oedema reduced (International Lymphoedema Framework, 2006; Royal College of Nursing [RCN], 2006; Scottish Intercollegiate Guidelines Network [SIGN]; 2010).

The cost of leg ulcer management to the NHS in terms of dressings and other materials, medical and nursing time, and hospital resources is mostly borne in primary care and the community nursing services, and is at least £168–£198m per year (Posnett and Franks, 2007).

Patients that have difficulty with compression therapy are frequently encountered, and are often blamed (by professionals) for interfering with or negating the effects of their treatment (Moffatt, 2004). As clinicians, we need to be aware of and consider the factors that lead to non-concordance when faced with a patient who finds it difficult to tolerate compression.

We should not be hasty to attach the non-concordant label (few patients are truly non-concordant), but rather, question if we have done our utmost to find the right solution for the
individual patient, before adopting a ‘no bandage, no treatment’ attitude.

It is well documented in the literature that patients with leg ulceration and/or chronic oedema find it difficult to tolerate compression for a number of reasons, including increased pain on application, reduced mobility, sleep disturbance, previous poor experience of therapy, lack of understanding of the theory of treatment, and social pressures, such as an inability to carry out work (Hopkins and Worboys, 2005; Moffatt, 2007; Moffatt et al, 2009).

Clinician-related reasons for non-concordance with compression therapy such as inappropriate bandage selection and poor application are also commonly reported (Moffatt, 2007).

Patients labelled as non-concordant are considered difficult to manage and clinicians may use negative language, communicate poorly and blunt their emotions to patients’ suffering. This is obviously detrimental to both patient care and the therapeutic relationship (Hopkins and Worboys, 2005).

Instead, we need to work with the patient to overcome the obstacles to compression wherever possible (Brown, 2011). This can often be as simple as increasing analgesia or initially applying reduced compression while the patient becomes tolerant or it may involve us as clinicians identifying our limitations and seeking further training if needed.

In every case, to improve patient concordance, clinicians should be prepared to understand and empathise with the difficulties that the patient is experiencing on a day-to-day basis. My colleagues and I recently wore a variety of compression bandages for different 24-hour periods as part of an investigation into sub-bandage pressures.

Throughout we were all struck by the practical restrictions placed upon our normal activities of daily living while wearing the bandages. Showering, dressing and driving were all negatively affected. Fitting into our normal footwear was difficult, if not impossible.

After wearing compression for several hours, we observed a reduction in oedema in our bandage limbs, which also resulted in a high degree of bandage slippage which, in real practice, would result in time being wasted on inefficient treatment (Hopkins and Worboys, 2005).

Our sleep patterns were disturbed as a result of the discomfort arising from bandage slippage and/or the raised temperature of the bandaged limb. As we all had healthy limbs and only wore compression for a short period of time, our experience did not reflect that of patients with wounds, oedema, exudate and pain, but it did provide a small insight.

We were left with a new appreciation of the impact of compression upon patients’ lives and the need for flexibility in finding solutions that provide effective clinical outcomes but which are also compatible with the patient’s lifestyle.

Frequently, non-concordance leads to a request for specialist intervention (Moffatt, 2007), and in our experience, such referrals often involve rebuilding the patient’s trust.

Taking the time to explain to the patient the theory behind compression therapy, and that alternatives exist if a compression system is unsuccessful or unacceptable, may help the patient to think differently about their treatment. For example, explaining to the patient that compression bandaging is a relatively short-term treatment that will be followed by the use of hosiery can help them to tolerate the initial disruption and discomfort.

For compression therapy to form a successful part of management there needs to be a working relationship between clinician and patient, with the clinician aware of the patient’s needs and the patient fully understanding the aims, and importance of the compression therapy.

A male patient with leg ulceration was recently referred to our tissue viability team. For a period of four years he had been unable to tolerate compression bandaging and was considered to be non-concordant with his management plan. With the patient we discussed and explored other compression options working to resolve his concerns. We found that he was able to tolerate and use a compression leg ulcer kit that resulted in his ulcer healing fully within three months.

Another case involved a male patient with leg ulceration who had to wear safety shoes as a legal requirement at work. As multi-layer compression bandages meant that his shoes did not fit, he was faced with the decision of no treatment or no work. Again, the use of a less bulky leg ulcer kit meant that he was able to concord with his treatment while also being able to continue working.

Perhaps if from the start these patients had been offered a range of bandage and hosiery options, with the clinicians involved in their care understanding why they could not accept or tolerate the initial treatment, then maybe their concordance would have been gained from the start.

However, to do this, the clinician must not only have an awareness of current guidelines, but also be flexible enough in their clinical practice to consider alternatives.

This demands an understanding of the different compression products available, including bandaging systems and hosiery, and knowledge of the theory underpinning how the products work. It is not enough to be competent in one type of bandaging; presenting a single compression solution as the only way forward can leave a patient feeling they have no option but to decline treatment, as highlighted in the cases above.

It is also not acceptable to apply bandaging incorrectly. However, the benefit of appropriate cross-referring to other disciplines or colleagues may
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offer opportunities for new learning and may lead to a solution that was not initially obvious.

Patients should be placed at the centre of their care and given the best possible treatment, making them likely to concord and benefit from early healing and/or alleviation of symptoms and the prevention of complications.

It is obvious that practitioner knowledge and skills have an impact on patient concordance; the patient's access to effective compression should not be restricted by the experience or knowledge of their practitioner.

When a practitioner understands the key principles of compression bandaging, the types of products available and their properties, their ability to meet the patient's needs is enhanced.

This puts clinicians in a strong position to improve productivity and quality of care, use innovative practice, and prevent patients' conditions from deteriorating, and thus contribute in their own way to the required cost-savings as outlined in the QIPP agenda.

REFERENCES


DH (2010b) Equity and Excellence: Liberating the NHS. DH, London


