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NHS Gloucestershire

Gloucestershire Lower Limb Wound Guidance

To support the implementation of the NWCSP Leg Ulcer Recommendations

Assessment, treatment and ongoing care

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Part of the One Gloucestershire Integrated Care System (ICS)

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Author(s)	See below
Sponsor	Jane Haros, Deputy Director of Nursing
Approved By	Marie Croft, Chief Nurse
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Authors	Role	Organisation
Helen Ballinger	Project Lead / Clinical Commissioning Manager / RN	ICB
Leah Bamford	Project Manager / Programme Officer	ICB
Sophie Belson	Professional Lead for Tissue Viability and Complex Leg Wound Service	GHC
Claire Berry	Lead Vascular Advanced Nurse Practitioner	GHFT
David Cooper	Consultant Vascular and Endovascular Surgeon	GHFT
Annalie Hamlen	Senior Quality Nurse	ICB
Louise Holliday	Medicines Optimisation Nurse Specialist	ICB
Huw James	Strategic Healthcare Partner	Essity / ICB
Joanna Manson	Consultant Vascular Surgeon	GHFT
Monique Maries	Lead Tissue Viability Nurse	GHFT
David Taylor	Senior Leg Ulcer Nurse Specialist	GHFT
Richard Wilson	Consultant Vascular Surgeon	GHFT
Sachin Kulkarni	Consultant Vascular and Endovascular Surgeon, Department Lead for Vascular Surgery, Surgical Tutor	GHFT

Glossary

ABPI: Ankle brachial pressure index (ABPI) is a non-invasive method of assessing peripheral arterial perfusion in the lower limb by measuring the ratio of systolic blood pressure at the ankle to systolic blood pressure in the arm using a manual “Doppler” ultrasound device.
Acute Limb Ischaemia: Rapid decrease in blood flow to lower limb due to acute occlusion. Symptoms are sudden-onset, acute pain, pallor, pulseless, perishingly cold paraesthesia / acute sensory change, paralysis/ acute motor dysfunction.
ANTT: Aseptic non-touch technique. This is the practice of avoiding contamination by not touching key elements of the wound or the dressing, e.g., the inside surface of a sterile dressing where it will be in contact with a wound.
Chronic Kidney Disease: is defined as a reduction in kidney function or structural damage (or both) present for more than 3 months, with associated health implications.
Chronic Limb Threatening Ischaemia (CLTI): is a clinical syndrome defined by the presence of peripheral arterial disease (PAD) in combination with rest pain, gangrene or a lower limb ulceration greater than 2 weeks in duration.
Chronic oedema: Is defined as swelling that lasts for more than 3 months.
Erythema: Inflammation of the skin, often referred to as ‘redness’ although it may present differently in a range of skin tones.
Healed: Is defined as complete epithelisation.
Hyperkeratosis: Thickening/ scaling of the outer layer of the skin, common around a leg ulcer.
Leg Ulcer: An ulcer that originates on or above the malleolus but below the knee that takes more than 2 weeks to heal.
Lymphoedema: is defined as a gradual abnormal build-up of lymph fluid in the tissues resulting from a failure of the lymphatic system. Consequences are swelling, skin and tissue changes and predisposition to infection.
Mild Graduated Compression: Compression therapy that is intended to apply 20mmHg or less at the ankle. This is about half of the therapeutic dose of strong compression therapy.
Peripheral Arterial Disease (PAD): is a common condition where a build-up of fatty deposits in the arteries restricts blood supply to the limbs.
Strong Graduated Compression: is either an elastic compression system applied to give at least 40mmHg of pressure at the ankle or an inelastic system applied in accordance with manufacturers’ recommendations. Strong compression delivers what current evidence suggests is the full therapeutic dose for treating venous leg ulcers.
Toe Pressure: Toe pressure (TP) provides a functional measure for small arteries in periphery of the lower limb. TP is used when screening for peripheral arterial disease (PAD) of the lower limb, particularly in the presence of lower limb medial arterial calcification common in those with diabetes. A toe pressure of ≥60mmHg indicates adequate perfusion to heal an ulcer if other factors are optimised.

Toe Brachial Pressure Index: The Toe Brachial Pressure Index (TBPI) is a test to assess the blood supply to the feet that is carried out by comparing the blood pressure in the arm to the pressure in the toe. The standard ABPI (Ankle Brachial Pressure Index) may yield misleading results if the arteries are calcified and stiffened. Hence, the TBPI is more reliable if the individual has diabetes or chronic kidney disease.

Venous insufficiency: Venous insufficiency is a form of venous disease where problems with the venous system affects the return of blood from the lower limb to the heart. Venous insufficiency is commonly due to failure within the valves in the veins and can affect the deep or superficial venous systems.

Venous leg ulcer: Ulcers on the leg(s) that are caused by venous insufficiency.

Introduction

The Gloucestershire Lower Limb Wound Guidance has been developed in response to a growing need for consistent, evidence-based care for patients with lower limb wounds across the county. Leg ulcers, particularly those of venous origin, represent a significant burden on both patients and the healthcare system—impacting quality of life, increasing the risk of complications, and consuming substantial clinical time and resources.
In Gloucestershire, it is estimated that over 2,000 adults are living with leg ulcers, a figure expected to rise due to demographic changes.

Purpose

The purpose of this guidance is to provide clear advice to health and care practitioners, service managers and commissioners about the fundamentals of evidence-informed care for people with leg ulcers using the National Wound Care Strategy programme findings and recommendations (Leg Ulcer Recommendations, 2024)[1]. These guidelines will support the delivery of standardised care pathways and improve holistic assessment. Implementing this guidance will achieve better patient outcomes and more effective use of healthcare resource as per the findings of the National Wound Care Strategy Programme (Leg Ulcer Recommendations, 2024)[2]. This guidance is not intended to replace the clinical judgement of healthcare professionals but act as a supporting document to enhance decision making.

Development of the Guidelines

The development of the Gloucestershire guidance has been a collaborative effort involving a wide range of stakeholders. These include representatives from:

- Primary Care
- Gloucestershire Health and Care NHS Foundation Trust (GHC)
- Gloucestershire Hospitals NHS Foundation Trust (GHFT)
- The Complex Leg Wound Service (CLWS)
- The Gloucestershire Leg Ulcer Service (GLUS)
- The ICB's commissioning, education, meds optimisation, finance, quality, and data teams

The guidance has been shaped through a series of multi-agency workshops, task and finish groups, and stakeholder engagement events. These sessions focused on aligning local practice with the NWCSP's Lower Limb Recommendations, which emphasise early assessment, timely intervention, standardised care pathways, and robust data collection

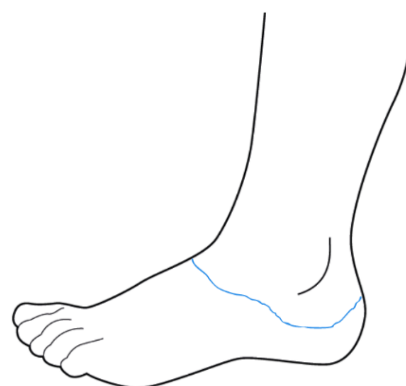
[1] https://future.nhs.uk/ImprovingWoundCare/view?objectId=225077381
[2] https://future.nhs.uk/ImprovingWoundCare/view?objectId=225077381

Key outputs from this collaborative process include:

- One Gloucestershire Lower Limb Pathway
- Pre-Doppler Lower Limb Initial Treatment Pathway (Immediate and Necessary Care), including Red Flag Assessment
- A standardised One Gloucestershire Lower Limb Compression Formulary
- A tiered Education and Training Framework for all levels of clinical staff working with lower limb wounds
- A refreshed Community Enhanced Service (CES) specification for leg ulcer care provision in primary care
- A system standard Wound Infection/Biofilm Framework
- Compression in Heart Failure Pathway for use in consultation with specialist services
- Specialist Service Referral Guidance to support appropriate referrals.

This guidance is underpinned by a strong commitment to equity, quality, and continuous improvement. It aims to ensure that every patient in Gloucestershire receives timely, appropriate, and effective care—regardless of where they live or which service they access.

Definition of a Leg Ulcer



According to the National Wound Care Strategy (NWCSP, July 2024):
Leg ulcers are ulcers on the lower leg (originating on or above the malleolus and below the knee) that have not healed within 2 weeks.

A **leg ulcer** originates above the blue line.
A **foot ulcer** originates below the blue line.

If the patient has a foot ulcer below the blue line, please see here further information: https://g-care.glos.nhs.uk/service#service-podiatry

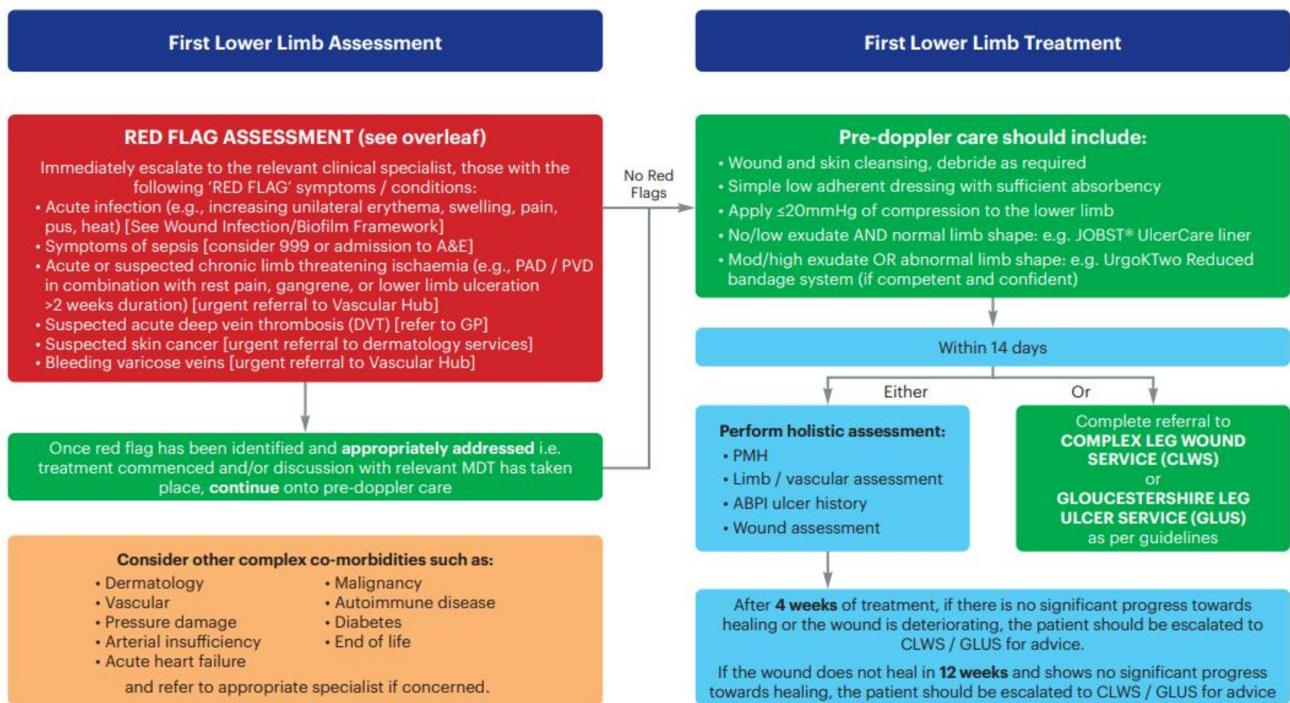
All healthcare settings should provide the pre-doppler lower limb initial wound assessment which includes the 'Red Flag Assessment' as set out by the NWCSP (2024). All healthcare professionals undertaking the pre-doppler lower limb initial treatment pathway should have completed Tier 1 wound care and lower limb training core capabilities as per the Gloucestershire Training and Education Standards for Managing a Lower Limb Wound.

Identification and Pre-Doppler Lower Limb Initial Treatment Pathway (Immediate and Necessary Care)

All settings should follow the Pre-Doppler Lower Limb Initial Treatment Pathway including the 'RED FLAG' assessment below:

Pre-Doppler Lower Limb Initial Treatment

(inc. Immediate and Necessary Care)



Immediately escalate to the relevant clinical specialist, those with the following '**RED FLAG'** symptoms / conditions:

- Acute infection (e.g., increasing unilateral erythema, swelling, pain, pus, heat) [See Wound Infection/Biofilm Framework]
- Symptoms of sepsis [consider 999 or admission to A&E]
- Acute or suspected chronic limb threatening ischaemia (CLTI) (e.g., Peripheral Artery Disease (PAD) / Peripheral Venous Disease (PVD)) in combination with rest pain, gangrene, or lower limb ulceration >2 weeks duration) [urgent referral to Vascular Hub]
- Suspected acute deep vein thrombosis (DVT) [refer to GP]
- Suspected skin cancer [urgent referral to dermatology services]
- Bleeding varicose veins [urgent referral to Vascular Hub]

RED FLAG Checklist

Acute infection of leg or foot
- Increasing unilateral redness
- Swelling
- Pain
- Pus or purulent exudate
- Heat
- Pyrexia and/or malaise

Signs of SEPSIS
- Respiration rate: more than >25 per minute
- Oxygen saturation: SpO2 < 92%
- Systolic blood pressure: < 90mmHg or drop > 40 from normal
- Pulse rate > 130 beats per minute
- Level of consciousness or new confusion
- Temperature: Pyrexic > 38°
- Non blanching rash, mottled / ashen / cyanotic
- Not passed urine in the last 18hrs
- Response only voice or pain / unresponsive

Acute or chronic limb threatening ischaemia

Acute
- Pain
- Pulseless
- Pallor
- Power loss or paralysis
- Paraesthesia or reduced sensation or numbness
- Perishing with cold

Chronic
- Intermittent Claudication
- Chronic rest pain
- Dependent rubor, pallor on elevation & reduced capillary refill
- Skin changes including ischaemic ulcers, non-healing foot wounds & gangrene
- Absent foot pulses

Suspected deep vein thrombosis
- Localised tenderness along the distribution of the deep venous system
- Entire leg swollen
- Calf swelling at least 3cm larger than the asymptomatic leg
- Pitting oedema confined to the symptomatic leg
- Collateral superficial veins (non-varicose)

Suspected skin cancer
- Does not heal within 4 weeks
- Looks unusual
- Hurts, is itchy, bleeds, crusts or scabs for more than 4 weeks
- A change in a mole or freckle

Bleeding varicose veins
- If varicose veins are bleeding, first aid should be offered and urgent referral to the Vascular Hub

Compression	Size	Use	Indication for use	Product Information
JOBST® UlcerCare Replacement Liners	Small - 4XL	Red Flag Assessment and Immediate and Necessary Care should be followed. No / Low exudate Compression liners, as well as holding a wound dressing in place, provides mild, graduated compression for ambulatory and non-ambulatory patients Can be worn for 24 hours per day	Ideal for patients that can self-care Contains silk in the liner for ease of application Only 2 measurements required Compatible with common footwear Always refer to manufactures application instructions	Available in 7 sizes Machine washable
UrgoKTwo™ Reduced Multi-layer compression bandage kit	Ankle circumference: 18cm-25cm Ankle circumference: 25cm-32cm	Red Flag Assessment and Immediate and Necessary Care should be followed. Mod / High exudate 2-layer elastic compression bandages recommended for patients with venous ulceration	Always refer to manufactures application instructions	Designed for single use only. Store away from light and heat

If no 'RED FLAG' symptoms / conditions, and at low risk of pressure damage over bony prominences, immediate and necessary care should include:

- Wound and skin cleansing, debride as required
- Simple low adherent dressing with sufficient absorbency
- **Apply ≤20mmHg of compression to the lower limb:**
    a. No / low exudate AND normal limb shape: e.g. JOBST UlcerCare liner
    b. Mod / high exudate OR abnormal limb shape: e.g. UrgoKTwo Reduced bandage system (if competent and confident)
- Closely monitor for skin integrity and signs of vascular insufficiency if there is known or suspected impaired sensation.

Those **with** 'RED FLAG' symptoms should be escalated to the relevant clinical specialist and/or service immediately and **can** be considered for first line mild graduated compression (see above) in line with clinical assessment. Compression therapy is likely to be beneficial to most **EXCEPT** those with acute or suspected chronic limb threatening ischemia. Regardless of whether the patient is appropriate for mild compression or not, following the 'RED FLAG' assessment, they should still receive a full holistic assessment as per the pathway.

Following the 'RED FLAG' assessment, for all patients:

- For people with complex comorbidities and/or receiving end of life palliative care, seek input from their other clinicians to agree an appropriate care plan. If a wound is due to thermal injury, consider referral to burns/plastics service.

- Cleanse wound and surrounding skin with full leg wash in a lined bowl or bucket and apply emollient as required. For Bi lateral leg wounds a separate liner should be used for each leg. Consider debridement if required.
- Record image(s) of wound using digital imaging and wound measurements and include in onward referral.
- Protect wound edges and surrounding skin with a barrier cream or film.
- Apply simple low adherent dressing with sufficient absorbency if wound infection is not suspected.
- Treat any leg wound infection in line the Wound Infection/Biofilm Framework.
- Signpost to relevant, high-quality information in an appropriate format, found here and identify, discuss, and incorporate opportunities for supported self-management into the treatment plan in line with each individual's capacity, capability and wishes.

Refer to one of the following for a full holistic assessment (see below) ***to be undertaken within 14 days.***

  - Continue treatment in current setting (if competent in the knowledge and skills to do so.)
  - Primary Care setting under the CES scheme
  - Complex Leg Wound Service (CLWS) if patient is **not** registered with a Gloucester City GP Practice
  - Gloucester Leg Ulcer Service (GLUS) if patient **is** registered with a Gloucester City GP Practice

Non-Healing Wound - Who should I refer to?

Not all wounds require specialist input however, if you are concerned and require specialist advice, please use the tool below to identify the most appropriate specialist service for referral.

More resources

Any wound head to knee

Tissue Viability Team

G-CARE:
Referrals & Services | G-care

GHC:
Referral for Tissue Viability Advice /Assessment - Interact

Any wound on the foot

Podiatry Team

G-CARE:
Referrals & Services | G-care

GHC:
https://www.ghc.nhs.uk/ourteams-and-services/podiatry/

Swelling to any part of the body with intact skin (no wounds)

Refer to Lymphoedema Service

A leg ulcer originates above the blue line.

A foot ulcer originates below the blue line.

Any wound from knee to ankle

Follow the Pre Doppler Pathway for all lower limb wounds before referral onto one of the following:

Complex Leg Wound Service (CLWS)
Leg ulcer without identified arterial concern.
Exception: any patient registered with Gloucester City GP (see GLUS below)
G-CARE / GHC

Gloucestershire Leg Ulcer Service (GLUS)
Leg ulcer with arterial concern **AND/OR** any patient registered with a Gloucester City GP.
G-CARE / GHFT

STOP THINK

Admit patient as an emergency if there is: clinical evidence of severe infection/sepsis with systemic signs eg tachycardia, pyrexia, hypotension or patient feeling unwell, or spreading cellulitis, crepitus or significant deterioration over a short period of time.
Refer to DVT pathway if there is suspected acute deep vein thrombosis or superficial vein thrombosis.
Consider referring for Peripheral Arterial Disease (PAD) if you suspect poor arterial blood supply

Full Holistic Assessment

As per the NWCSP, all patients should receive a full holistic assessment and treatment plan *within 14 days of initial identification*. This is to assess and identify causes and risk factors for non-healing by undertaking and documenting a comprehensive assessment that includes:

- Full history, including any previous history of leg ulceration and underlying cause.
- Review of medication.
- Pain and analgesia needs.
- Psychosocial needs.
- Possible infection.
- Nutrition.
- Record image(s) of wound using digital imaging.
- Assess the ulcer in line with the SystemOne Leg Ulcer Template (where used).
- Undertake a lower limb assessment that includes:
    - Peripheral vascular assessment (ABPI and/or TBPI using manual APBI measurement devices). Manual doppler for first assessment as per NICE guidelines NICE (2023)[3]. See Appendix B for position statement on using automated dopplers devices.
    - Skin and lymphoedematous changes.
    - Assessment for sensation.

Diagnose and identify the causes of non-healing leg ulcers and formulate a treatment plan to address those causes. Consider referral to a specialist service as per the guidance in the Gloucestershire Lower Limb Pathway and referral guidance .

This assessment should be undertaken by a registered nurse who has completed and fulfilled the tier 2 wound care and leg ulcer education, training and competencies.

[3] Diagnostics guidance [DG52] Automated ankle brachial pressure index measurement devices to detect peripheral arterial disease in people with leg ulcers. Available at: https://www.nice.org.uk/guidance/dg52. Accessed 25.05.25

Treatment

For all patients:

- Optimise management of contributing disease (e.g. diabetes, chronic kidney disease, PAD).
- Offer analgesia to alleviate pain.
- Cleanse wound and surrounding skin with full leg wash in a lined bowl or bucket and apply emollient as required. For Bi lateral leg wounds a separate liner should be used for each leg. Consider debridement if required.
- Record image(s) of wound using digital imaging and wound measurements and include in onward referral.
- Treat skin conditions (e.g., eczema) and apply emollient to surrounding skin, as needed.
- Protect wound edges and surrounding skin with a barrier cream or film.
- Apply simple low adherent dressing with sufficient absorbency if wound infection is not suspected.
- Treat any leg wound infection in line the Wound Infection/Biofilm Framework.
- Offer advice on skin care, footwear, exercise and mobility, rest, and limb elevation (to include both limbs) nutrition, and as appropriate, smoking cessation, and weight management.
- Identify, discuss, and incorporate opportunities for supported self-management within the treatment plan in line with the individual's and their carers' capacity, capability and wishes.
- Provide the individual and their relevant health care providers responsible for supporting ongoing care with verbal and written information about:
    - The diagnosis of the ulcer.
    - When to seek advice and specific information (including names and phone numbers) about who to contact from the previous clinical care provider.
    - If image(s) of the ulcer have been captured, these should be shared with the individual (if they wish) and the health care provider responsible for ongoing care using NHS compliant digital technology.
    - Signs of infection.
    - Hygiene (including hand hygiene).
    - Advice on dressing changes and taking image(s) of their own ulcer to monitor healing.
- Prior to transfer to another healthcare provider, individuals should be provided with enough dressings to care for their wound for one week and informed of the name of the clinician in that organisation, responsible for overseeing their care.

For leg ulcers due to suspected venous disease with adequate arterial supply

- If patient interested in surgical venous intervention, make onward referral to GLUS (via GP if necessary) as per the Gloucestershire Lower Limb Pathway – see patient leaflet in Appendix D to support decision making.
- Measure the leg as per One Gloucestershire Lower Limb Compression Formulary guidance, p.20.
- If the ABPI is between 0.8 and 1.4, and not contraindicated, apply strong compression therapy to give **a minimum of 40mmHg of pressure** in line with One Gloucestershire Lower Limb Compression Formulary.

Strong compression **hosiery** should be considered as **first-line** compression therapy choice where possible[1]. The need for application aids should be considered, for further information, see Gloucestershire Lower Limb Compression Formulary p. 15.

- Consideration should be given to sensation. People with impaired sensation may be unable to identify discomfort from inappropriately applied compression therapy so may require closer monitoring.
- For those with advanced, unstable cardiac failure, refer to the Compression in Heart Failure Pathway and liaise with their cardiac clinician or heart failure nurse to agree how to offer compression to optimise healing while minimising additional cardiac burden.
- Provide verbal and written information to the individual about the benefits of compression.
- If symptoms do not rapidly improve, escalate for advice in line with the Gloucestershire Lower Limb Pathway.

For leg ulcers with suspected venous disease and peripheral arterial disease ('mixed' aetiology)

For those with an **ABPI >0.5 – 0.79 OR >1.4**,

Refer to GLUS (GHFT) via GP if necessary, with the patient's consent, for diagnosis of peripheral vascular disease (venous disease and/or arterial), consideration of a duplex scan and possible vascular interventions.

With no signs of acute or chronic limb-threatening ischemia, continue with mild to medium graduated compression (RAL Class 1-2) referring to One Gloucestershire Lower Limb Compression Formulary.

For those with **an ABPI<0.5**, Severe peripheral vascular disease

This suggests chronic limb-threatening ischemia. Refer **urgently** to Vascular Hub (GHFT) via GP if necessary for possible vascular intervention as set out in the NICE Clinical Guideline for peripheral arterial disease[1] using the Peripheral Arterial Disease referral guidelines on G-care.

Do not apply compression.

For leg ulcers with peripheral arterial disease only

Refer to Vascular Hub (GHFT) for possible vascular intervention as set out in the NICE Clinical Guideline for Peripheral Arterial Disease (14) using the Peripheral Arterial Disease referral guidelines on G-care.

For leg ulcers of other or uncertain aetiology

Refer to appropriate service for an opinion depending on symptoms e.g., dermatology/rheumatology/vascular/endocrinology via the GP if necessary.

Follow-up attendances

Following the full holistic assessment, the tier 2 qualified healthcare professional will provide a treatment plan for the follow up attendances with a tier 1 or tier 2 trained healthcare professional.

At each dressing change (as per the NWCSP):

- Repeat red flag assessment.
- If appropriate, treat infection in line with Wound Infection/Biofilm Framework
- Offer analgesia to alleviate pain.
- Cleanse wound and surrounding skin with full leg wash in a lined bowl or bucket and apply emollient as required. For Bi lateral leg wounds a separate liner should be used for each leg. Consider debridement if required.
- Record image(s) of wound using digital imaging and wound measurements and include in onward referral.
- Treat skin conditions (e.g., eczema) and apply emollient to surrounding skin, as needed.
- Protect wound edges and surrounding skin with a barrier cream or film.
- Apply simple low adherent dressing with sufficient absorbency if wound infection is not suspected.
- Offer advice on skin care, footwear, exercise and mobility, rest, limb elevation (to include both limbs) nutrition and, smoking cessation and weight management.
- Review care and identify, discuss, and incorporate opportunities for supported self-management into treatment plan in line with the individual’s and their carers’ capacity, capability and wishes.
- If being treated with compression therapy, review reduction in ankle circumference and consider whether compression therapy should be adapted or changed to compression hosiery.
- Review effectiveness of treatment plan and if there is deterioration, escalate in line with Gloucestershire Lower Limb Pathway.
- A record of the review should be kept using the SystemOne Leg Ulcer Template (where used).
- Where a patient does not appear to be healing as predicted, or at any stage of treatment, the clinician can seek expert advice from the tier 2 trained healthcare professional and if further advice is needed, escalate to a tier 3 level trained healthcare professional using the relevant referral form (on G-Care) as per the Gloucestershire Lower Limb pathway and referral guidance.

Review of healing

At 4 weekly intervals (or more frequently, if concerned).

- Repeat red flag assessment.

A tier 2 trained clinician should monitor for healing by:

- Completing wound assessment in appropriate wound care/leg ulcer template.
- Taking digital wound image(s) and comparing with previous images to monitor healing.
- Measuring ankle circumference to assess for reduction in limb swelling.

Review effectiveness of treatment plan and make adjustments as necessary

- Leg ulcers that show no significant progress towards healing, or the wound is deteriorating, should be escalated to the Complex Leg Wound Service or Gloucestershire Leg Ulcer Service as per the Gloucestershire Lower Limb pathway and referral guidance.
- Review opportunities for supported self-management and discuss and incorporate into treatment plans as agreed with the individual. This may include remote monitoring techniques and consideration of donning and doffing aids.

At 12 weeks:

Monitor for healing by:

- Taking digital wound image(s) and comparing with previous images.
- Measuring ankle circumference to assess for reduction in limb swelling.

Review effectiveness of treatment plan and make adjustments as necessary.

- Leg ulcers that show no significant progress towards healing, or the wound is deteriorating, should be escalated to the Complex Leg Wound Service or Gloucestershire Leg Ulcer Service as per the Gloucestershire Lower Limb pathway. A comprehensive re-assessment should be completed.
- Review opportunities for supported self-management and discuss and incorporate into treatment plans as agreed with the individual. This may include remote monitoring techniques and consideration of donning and doffing aids.

Continue to review at 4 weekly intervals.

- **If the patient does not heal in 26 weeks, if not already referred to specialist services, patient must be escalated to the Complex Leg Wound Service or Gloucestershire Leg Ulcer Service.** For those where there is no progress to healing and other treatment is not possible, seek to agree an appropriate care plan in discussion with specialist services which may include palliation of symptoms as an acceptable outcome.

Care following healing

Once the ulcer has healed, a personalised care plan must be agreed with the patient and their carer on the self-care required to help prevent recurrence. This plan should be documented in the patient's medical record.

For **all types of healed leg ulcer**, offer care as follows:

- Advice should be given on how to reduce the risk of re-ulceration. This should be tailored to the individual but should consider skin care, footwear, healthy eating, and exercise (and if appropriate, smoking cessation).
- Verbal and written information about the diagnosis and ongoing treatment plan should be provided and discussed. Opportunities for supported self-management should be identified, discussed, and incorporated into treatment plans as agreed with the individual.
- Where compression therapy has been used effectively, the wearing of compression garments should continue following healing.
- Details should be provided for who to contact if there are any issues. Advise individuals to adhere to manufacturers' instructions regarding the replacement of compression therapy garments – see Compression Formulary.

For **all types of healed leg ulcer**, every 6 months:

- Review 6-monthly for replacement of compression garments and ongoing advice about prevention of recurrence. Advise that changes in lower limb symptoms, skin problems, or issues with compression therapy garments (e.g., hosiery) should prompt the individual to seek an earlier review which should include a comprehensive lower limb assessment that includes:
    - Reassessment of arterial and vascular status including ABPI assessment.
    - Lymphoedematous and skin changes.
    - Assessment for sensation.
    - Re-measurement of limbs.

For healed venous leg ulcers with adequate arterial supply (with or without lymphoedema)

- If, in the view of the vascular service, venous intervention (e.g., endovenous ablation) has successfully resolved venous hypertension, compression therapy may no longer be required but the patient should be advised to seek medical advice, should symptomatic varicose veins or the ulcer recur.
- If there is ongoing venous hypertension, with or without lymphoedema, encourage the use of ongoing compression therapy (usually in the form of compression hosiery) at a 'dosage' level that maintains healing and is acceptable to the individual. (This is likely to be the same or similar to the level used during healing).
- Advise individuals to adhere to manufacturers' instructions regarding the replacement of compression therapy garments.

For healed leg ulcers with venous disease and peripheral arterial disease ('mixed' aetiology) (with or without lymphoedema)

- If the level of peripheral arterial disease permits, in partnership with specialist services, encourage the use of an appropriate level of ongoing compression therapy (usually in the form of compression hosiery) and provide advice on caring for hosiery.
- Advise individuals to adhere to manufacturers' instructions regarding the replacement of compression therapy garments.
- Replace compression garments and provide ongoing advice about prevention of recurrence.
- Advise that changes in lower limb symptoms, skin problems or issues with compression therapy garments (e.g., hosiery) should prompt the individual to seek an earlier review which should include a comprehensive lower limb assessment.

For healed leg ulcers with peripheral arterial disease

- No additional care required but advise to seek immediate clinical advice if there is recurrence of PAD/Chronic limb threatening ischemia symptoms or ulceration.

For healed leg ulcers of other or uncertain aetiology

- No additional care required but advise to seek immediate clinical advice if there is recurrence of symptoms or ulceration.

Useful Contacts

Complex Leg Wound Service
complexlegwounds@ghc.nhs.uk
0300 421 8755

Gloucestershire Leg Ulcer Service
ghn-tr.legulcerserviceghnhsft@nhs.net
0300 422 3480

Tissue Viability
Tissueviability@ghc.nhs.uk
0300 421 1407

Lymphoedema
lymphoedema@ghc.nhs.uk
0300 421 7030

Podiatry
Podiatry.appointments@ghc.nhs.uk
0300 421 8800

For support with compression hosiery and bandages, please see back page of Compression Formulary

Appendices

Appendix A – QR code to access all resources referred to throughout the guidance

Appendix B – Gloucestershire Position Statement on Automated Doppler Devices

Draft Automated Doppler Position Statement V2 FINAL as at 051125.pdf