FLIC and CHIP Misunderstood and Overlooked Webinar: Q&A Document

Below is a summary of the questions covered in the event. It should be noted that these are opinions and opinions vary between professionals working in this area. It is our hope that in the future, there is a standardised approach that we can all work to.

1) Do you have any tips to help patients tolerate compression?

Dr Jemell Geraghty: In short, it's about building trust with the patient and understanding their situation. We have to look at ourselves as a part of the picture when we look at any therapy. Compression can certainly be painful, but it's important to look at the application, the tolerance of the patient and the factors surrounding them. From my experience, many patients don't want compression because they have had previous bad experiences, so it's important to build trust before trying compression again. For example, I will start off by just washing their leg and putting on a simple bandage, then in their next visit, we can start to think about compression. Once a patient can see it's working, they will be more open to retrying compression, even high compression. We need to make sure we are led by the patient.

2) What skills and resources do you think GPs need to better address the needs of this client group?

Dr Jasmin Malik: There's two ways to answer this, broadly or specifically to wounds. Broadly speaking, one of the biggest issues (despite lots of great work being done) is around the barriers of the registration process. There is a brilliant training webinar for primary care and homeless health, from Groundswell and Healthy London Partnership. Find it here: https://www.youtube.com/watch?v=cBhotn4AMr0

Once this client group does turn up to an appointment, it's important to make sure where possible their needs and expectations are met. It can be daunting when a patient comes in for a 10-minute slot appointment with a multitude of health issues. Firstly, it's crucial as a clinician that we understand why the patient came in, it could be to get a medical sick note or support letter, not to address all their physical health issues. But as a clinician, it's important we put their needs first while making every contact count. If health issues are outstanding, time discussions on these problems to coincide with them attending prescription reviews or medical note renewals.

In terms of wound care, what we found worked well in CHIP, is coordinating their GP review with the time they have their appointment with the nurse. Having some flexibility to step out of the GP room and consult with the patient when with they are in with the nurse really helps with engagement. This simplifies the process as they don't need to go back to the waiting room or come back for a further appointment.

If the patient has a key worker, it's important to link in with them as they will be able to work with health professionals to encourage the patient to return.

3) Did you face any difficulties with clients coming off pain relief that they might have been reliant on?

Dr Jasmin Malik: This is a huge area, the reality of living with pain day in, day out. It's also, important to bear in mind that client may have a history of drug misuse and they may be taking various drugs, unprescribed meds, or scripted on methadone.

I'd advise that you firstly obtain the patient's drug history (street/prescribed), and then link in with both pain teams and substance misuse clinics to create a plan for what medications could be tried. It is incredibly helpful to all to have the pain clinic teams on board.

It's important to:

- Acknowledge the problem of pain.
- Respect that they do require assistance to manage this.
- Identify if they are scripted on methadone or Subutex or any other medication from the drug service or pain clinic.
- Note any analgesia that you may prescribe in primary care that could potentially interact or cause a compounding effect/OD.
- Request regular updates from the pain team/drugs team in terms of medication changes.

Now Pregabalin is a controlled drug, there are many challenges and lots of people are requesting it. Pregabalin can impact issues of addiction further down the line. That said, you may find it appropriate to address the pain this way and start with a clear plan and outline in terms of the reduction, and what the steps of management and review are.

Dr Jemell Geraghty: Only thing I would add, is to go back to what patients said in the clinic - 70% had pain, but when the compression was started, and instigated, 1/3 of them were pain-free.

Give people hope. People that live with these wounds for a long time do not think they are going to heal, they may have had previous negative experiences, so they often do not believe what you are telling them. You need to adopt a holistic approach and always remain positive.

4) Would it be possible to set up a pan-London service to send photographs of leg wounds in order to get immediate advice?

Dr Jasmin Malik: I think that would be fantastic. It'd be a logistical challenge, there would be many steps and stages to go through and there's differences in a local and regional level, but it should not be off the cards.

Dr Jemell Geraghty: This would work well alongside a multi-disciplinary team. We need expertise from GPs within homeless health, nurses, and the vascular teams.
If you have got a wound on your lower limb, it is not there for no reason. If a patient has a leg ulcer for more than 4-6 weeks, they need to have an underlying diagnosis.

5) We're struggling to source wound care training for our nurses and care assistants in substance misuse services, and also for assertive outreach. What would you recommend?

Dr Jemell Geraghty: There are a few things I can point you to that are helpful, there is a lower limb national campaign called Legs Matter, that is a collaboration of not-for-profit organisations who are trying to promote leg and foot care in the UK. There is lots of information in terms of what professionals need to look for. Also, the National Wound Care Strategy for England provides recommendations for lower limb care.

6) How can we encourage engagement and attendance?

Dr Jasmin Malik: Across Camden and Islington we have the peer advocate service Groundswell which has been greatly beneficial. If a peer advocate service is not available locally, it is worth checking in to see what other care navigation services you might be able use. AGE UK is another service that can help with this population. Think outside the box and look for funding opportunities to cover a year or two; e.g. funding for a care coordinator that could be employed to link in with both outreach services and tissue viability services.

As mentioned, in terms of engagement, it is crucial to make every contact count. Ensuring that when somebody comes to see you that you take tam to scan to identify outstanding health issues and consider how you can address this. If they are coming in to see a nurse, having your GP slot allocated at roughly the same time helps with engagement.

7) What can be done during periods of lockdown?

Dr Jemell Geraghty: During lockdown, there has been a real focus around self-care, and it does absolutely have its place. However, it is important to remember that if a wound has not healed after 4-6 weeks, there needs to be a diagnosis of the underlying issues. I'm supportive of self-care if the wound is healing, if the wound is not healing then there is an issue and that needs to be looked at.

For patients with symptoms that are self-isolating, it is important to provide them with wound packs so they can do wound care management, a simple dressing. This should only be a temporary measure.