

Lymphoedema and heart failure staff educational needs analysis: insights from a UK online survey. Part 2: quantitative findings

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Heart failure (HF) affects approximately 1 million people in the UK, with an estimated 200 000 new diagnoses each year (Conrad et al, 2018). It is a

complex clinical syndrome associated with reduced cardiac output, breathlessness, fatigue and peripheral oedema (McDonagh et al, 2021; National Institute for Health and Care Excellence, 2022a).

Chronic peripheral oedema (CPO), including lymphoedema, is a common but often under-recognised comorbidity in people with HF, particularly among older adults (Moffatt et al, 2017; Keeley et al, 2019). Up to 60% of patients with HF experience CPO or lymphorrhoea, and these conditions share overlapping risk factors such as ageing, multimorbidity and social deprivation (Rankin, 2016; Rossitto et al, 2019). Similarly, the average age of patients seen by lymphoedema services in Wales is 67 years, which may indicate a risk of undetected HF.

Since 2023, the Lymphoedema Wales Clinical Network (LWCN) has collaborated with HF services to investigate potential overlaps between the two conditions. As part of this work, audits have identified a substantial burden of undetected or unlinked cases. One Welsh lymphoedema service found that 50% of 100 patients with bilateral lower leg lymphoedema had a raised N-terminal pro-B-type natriuretic peptide (NT pro-BNP) and were subsequently reviewed for HF. A larger, unpublished audit conducted between September 2023 and January 2025 across three health board HF clinics identified oedema in 257 of 470 patients (53%), yet only 24 (9%) were known to their local lymphoedema service.

Abstract

Background: Managing patients with coexisting heart failure and chronic peripheral oedema or lymphoedema presents clinical challenges, particularly regarding compression therapy. **Aims:** This evaluation assessed healthcare professionals' roles, confidence, training needs and use of guidance in managing heart failure and chronic peripheral oedema or lymphoedema.

Methods: A UK-wide service evaluation survey was completed by 342 healthcare professionals. Descriptive quantitative analysis was conducted. **Results:** Compression-related care was undertaken by 97% of lymphoedema practitioners and 91% of nurses, but only 3% of heart failure professionals. Over 90% of participants requested further training, with 59% of lymphoedema staff receiving education in the last 5 years, compared to 21% of heart failure specialists. Only 16% of heart failure staff had read key compression guidelines. Top education priorities included referral pathways (64%) and compression in heart failure. Multidisciplinary webinars were the most preferred format (66%). **Conclusions:** The findings highlight the need for integrated education, shared care models and better dissemination of compression guidance to support safe and effective care for this multimorbid population.

Keywords: • heart failure • integrated education • lymphoedema • peripheral oedema • shared care models

Compression therapy is the mainstay of lymphoedema management; however, despite best practice guidance (Wounds UK, 2023; British Lymphology Society (BLS), 2024) its use in patients with coexisting HF remains contentious due to concerns about increased preload and the potential exacerbation of cardiac symptoms (Mortimer et al, 2014; Wounds UK, 2023). Compression garments and the use of bandaging in HF patients is of interest, particularly among community nurses (Cooper and Bagnall, 2016; Cooper and Brown, 2024). Even in specialist HF clinics, the presence of oedema is frequently under-recognised, leading to missed opportunities for intervention.

A national audit of HF services in England and Wales reported that 56% of hospital admissions between April 2019 and March 2020 involved patients with moderate or severe peripheral oedema (National Institute for Cardiovascular Outcomes Research, 2020). This clinical concern prompted a collaborative study, developed in Wales between lymphoedema and HF nurses and supported by the national Value in Health Care team. To ensure broad applicability and capture diverse perspectives across service settings, a UK-wide survey was promoted across all four nations with support from the National Heart Failure Forum, British Lymphology Society, and an educational grant from Essity.

Aims

This evaluation was intended to inform service development and workforce planning and aimed to:

- Identify the education and training needs of healthcare professionals (HCPs) managing patients with coexisting HF and CPO or lymphoedema
- Explore current clinical roles and practices regarding referral pathways and compression therapy
- Assess awareness and application of existing clinical guidelines
- Inform future education and collaborative practice initiatives to improve patient outcomes.

Methods

This service evaluation comprised two components: a quantitative survey analysis and a qualitative thematic analysis. The present article reports on the quantitative findings from a cross-sectional, UK-wide online survey completed by healthcare professionals. Of the 348 responses received, 342 were complete and included in the analysis. The survey was co-designed by clinicians and researchers with expertise in HF and CPO or lymphoedema. It included adapted and newly developed items to explore role-specific knowledge, confidence and educational needs.

The survey began with questions capturing demographic information such as professional role, banding and geographic location. This was followed by 17 structured questions examining clinical responsibilities, decision making, perceived competence, prior education and preferred training formats (*Table 1*). Further details on survey development, participant recruitment, ethical considerations, funding and data collection are available in the first part of this article series (Cooper et al, 2025).

Table 1. Quantitative-focused questions

Theme	Questions
Tasks, roles and clinical decisions	Q4. Which of the following education topics (listed) would enhance your role (if any)?
	Q7. If a patient without a diagnosis of heart failure presented to you with a new symptom combination of shortness of breath, bilateral leg oedema and fatigue, what, if any, would your main action(s) be?
	Q8. If chronic peripheral oedema was present, for which of the following patients would you recommend some level of lower limb compression (where there are no other red flags)?
Competence and confidence	Q6. Which tasks do you feel competent in, and which would you like extra training or education for and which are not your role or not applicable?
Previous education	Q10. Have you had any education or training on managing chronic peripheral oedema (lymphoedema) in the presence of heart failure recognition and management?
	Q11. Who provided this education or training?
	Q12. Have you read any of the documents below and (if so) did they change your practice?
Perceived education needs and resources	Q14. How well do you perceive your education needs are met regarding chronic peripheral oedema (lymphoedema) in the presence of heart failure?
	Q15. Do you feel you would benefit from education or further information on managing chronic peripheral oedema (lymphoedema) in the presence of heart failure?
	Q16. Which of the following education topics would enhance your role (if any)? (Multiple responses possible)
	Q17. What would be the best way to address these needs (if any)?
This companion article focuses on the qualitative elements of the survey. Questions 1–3 and 5, which captured demographic data, are summarised in a table in Part 1. Open-text responses to questions 9 and 13 are also explored in detail in Part 1. The full questionnaire is available from the authors on reasonable request.	

Data analysis

Anonymised quantitative data were analysed descriptively using Microsoft Excel. Frequencies and percentages were calculated for all relevant variables, including demographic characteristics, competencies and perceived education needs. The analysis investigated the demographics contained in the survey, with a focus on 11 questions outlined in *Table 1*.

Results

The survey captured responses from a broad cross-section of HCPs. The following findings are presented to illustrate patterns in current practice, competency, decision making, and the perceived value of existing guidelines and training resources.

Question 4. Which of the following is included in your role regarding patients with HF and chronic peripheral oedema?

Respondents reported a wide range of responsibilities when caring for patients with HF and CPO or lymphoedema, reflecting significant role diversity across HCPs. The most frequently selected tasks overall included advising patients on reducing the risk of cellulitis or skin infections ($n=282$; 83%). Most agreed on their role including identification of new or worsening CPO or lymphoedema (HF practitioners 66%; lymphoedema practitioners 87%; nurses 79%) providing advice on self-management ($n=256$; 75%) and referral to other services (HF practitioners 62%; lymphoedema practitioners 57%; nurses 71%).

Compression-related activities were predominantly carried out by lymphoedema practitioners and nurses. Among participants, 97% of lymphoedema practitioners and 91% of nurses were involved in measuring compression garments, and over 90% in both groups were responsible for applying bandaging or other forms of compression. By contrast, HF practitioners were more likely to manage symptoms and medication, with 97% identifying HF symptoms and 93% involved in pharmaceutical management. These role-based distinctions were further reflected in responses around diagnosis and referral.

Most participants agreed their role included identification of new or worsening CPO or lymphoedema (HF practitioners 66%; lymphoedema practitioners 87%; nurses 79%) and referral to other services (HF practitioners 62%;

lymphoedema practitioners 57%; nurses 71%). Free-text responses expanded on role descriptions, with additional tasks including health promotion, educating colleagues and managing end-of-life symptoms. This division of labour underscores the need for joined-up working and mutual understanding across specialities.

Question 6. Which tasks do you feel competent in, and which would you like extra training or education for and which are not your role or not applicable?

Overall, 63% felt confident identifying HF symptoms, while 62% knew where to find cellulitis management guidelines. However, confidence in compression therapy tasks was lower; just 48% felt confident applying compression to patients with HF, and only 46% felt they were able to assess compression suitability in this group. A substantial proportion of respondents expressed interest in further education across all task areas (range 29–45%), especially in compression assessment and referral pathways, indicating a deficit among those already performing the tasks.

Lymphoedema practitioners were the most confident in compression therapy (Table 2). However, over half still wanted more training on HF referral pathways, suggesting that multidisciplinary integration is needed. Nurses reported moderate confidence and high interest in further education, especially around assessment and referral. In contrast, HF specialists demonstrated very low confidence in compression-related tasks—only 3% felt

Table 2. Key tasks and reported competency

Tasks	Feel competent: nurse ($n=116$)		Feel competent: heart failure practitioner ($n=71$)		Feel competent: lymphoedema practitioner ($n=143$)	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
I know the referral route for patients to a heart failure service	36	31	69	97	42	29
I know which patients with chronic peripheral oedema to refer to a lymphoedema service	42	36	17	24	98	69
If a patient with chronic peripheral oedema presented with infection cellulitis, I would know where to find the latest consensus guidelines on management	63	54	11	15	135	94
I know which type of emollient would be prescribed to reduce skin problems and risk of infection	69	60	8	11	124	87
I know how to assess the suitability of a patient who has heart failure and chronic peripheral oedema (lymphoedema) for compression	49	42	8	11	97	68
I am confident in applying the appropriate strength class of compression to the lower limbs of a patient with heart failure	59	51	2	3	100	70

able to apply compression, and 66% wanted training in compression assessment.

Question 7. If a patient without a diagnosis of HF presented to you with a new symptom combination of shortness of breath, bilateral leg oedema and fatigue, what (if any) would be your main action(s)?

Most respondents indicated proactive behaviour: 68% would contact the GP for an urgent review, and 29% would refer to the emergency department. Only 5% would refer directly to an HF team, and just one respondent opted for a passive 'watch and wait' approach and this person identified in an 'other' job role (Table 3).

It is worth noting that there will be variations of referral pathways across the four nations, with most participants based in England. HF specialists had a 95% non-response rate, suggesting this scenario may fall outside their routine scope or that they only had patient contact once a diagnosis of HF was made.

Question 8. If chronic peripheral oedema was present, for which of the following patients would you recommend some level of lower limb compression (where there are no other red flags)?

Respondents were presented with clinical scenarios involving CPO across varying stages of HF. As shown in Table 4, confidence in recommending lower limb compression was highest for patients without a confirmed HF diagnosis (nurses 50%; lymphoedema practitioners 49.7%; other 41.7%) and those with compensated HF (lymphoedema practitioners 62.9%; HF practitioners 59.2%; other 41.7%).

However, this dropped sharply for decompensated HF (lymphoedema practitioners 22.4%; nurses 14.7%; HF practitioners 7%; other 16.7%) and refractory end-stage HF (lymphoedema practitioners 21.7%; nurses 12.1%; HF practitioners 9.9%; other 8.3%).

HF respondents were the least likely to recommend compression and more likely to report no access to information—for example, in cases of pulmonary oedema, 26.8% of HF staff reported lacking information, and 49.3% would not recommend compression. The 'other' group, which included healthcare assistants, GPs and service leads, showed lower overall confidence and were more likely to indicate the scenario was outside their scope of practice. These findings highlight marked variation in practice, particularly in complex HF presentations and among non-specialist roles.

Question 10. Have you had any education or training on managing chronic peripheral oedema (lymphoedema) in the presence of HF recognition and management?

Results varied substantially by role, country and band. Lymphoedema practitioners had the most recent and consistent education, with 59% receiving training in the

Table 3. Overall response to question 7

Response	n	Percentage of all respondents
If new breathlessness on slight exertion or walking, I would contact the GP for urgent review or blood tests	232	68
If breathless even at rest, I would send them to the emergency department	100	29
No response	69	20
Other	21	6
I can refer the patient straight to the heart failure team	17	5
I would take a 'watch and wait' approach and hope someone else deals with it	1	0.3

Table 4. Summary of compression recommendations and information access heart failure scenarios

Patient presentation	Highest proportion recommending compression (% and group)	Lowest proportion recommending compression (% and group)	Percentage indicating 'no access to information' (range)
No diagnosis, shortness of breath, bilateral oedema, fatigue	50% Nurse	7% HF	16.1–33.8%
Compensated HF	62.9% Lymphoedema practitioner	31.9% Nurse	12.7–25%
Decompensated HF	22.4% Lymphoedema practitioner	7% HF	26.8–43.1%
Refractory end-stage HF	21.7% Lymphoedema practitioner	8.3% Other	28.2–43.1%
Pulmonary oedema	22.4% Nurse	7% HF	26.8–38.8%

HF: heart failure; Further anonymised information on individual group responses is available from the corresponding author on reasonable request.

past 5 years. HF specialists and nurses reported lower rates of recent education—21% and 38%, respectively. Notably, 63% of HF specialists and over half of nurses had never received such training (Table 5).

Regional and banding breakdowns suggested additional disparities, with band 3–5 staff least likely to have had any relevant education, and band 7–8 staff mostly having older training (over 5 years). These disparities likely contribute to the clinical variation observed in previous questions.

Table 5. Participants' response to job role and training

Job group	No/never		Yes, over 5 years ago		Yes, within 5 years	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Heart failure	45	63	11	16	15	21
Lymphoedema practitioner	44	31	15	11	84	59
Nurse	62	53	10	9	44	38
Other	7	58	2	17	3	25

'Other' includes roles reported in small numbers, such as healthcare assistant or technician (multiple entries), foot and leg practitioner, service lead and general practitioner.

Question 11. Who provided this education or training?

Respondents reported a broad mix of training sources. The most common were self-study literature (*n*=68), online learning (*n*=64), local lymphoedema services (*n*=63), and multidisciplinary webinars (*n*=56). Other methods included national conferences, manufacturer sessions and higher education (Table 6). Qualitative comments revealed informal learning, such as colleague support, workplace exposure and experiential learning from years of practice. While this adaptability is commendable, it also risks inconsistency in care. Perceived training value was rated modestly. Higher education institutions scored highest (mean=2.6 out of 4), followed by local heart failure services (2.5) and local lymphoedema services (2.4).

Table 6. Participant response education providers

Education provider	<i>n</i>
Self-study journals or literature	68
Self-study online	64
Local lymphoedema service	63
Multidisciplinary webinar masterclass	56
National or regional conference	45
Manufacturer or supplier	40
Local heart failure service	20
Higher education institution	18
Other	12

Question 12. Have you read any of the following documents and (if so) have they changed your practice?

Guideline engagement showed clear divisions by speciality. HF practitioners had high awareness and application of the National Institute for Health and Care Excellence (NICE) (2018) (75%) and European Society of Cardiology (ESC) (2023) (79%) guidelines. In contrast, lymphoedema practitioners and nurses had low awareness of cardiology-specific documents as 60–89% had not read them. Conversely, lymphoedema and nursing staff were more likely to engage with the Wounds UK (2023) best practice statement (lymphoedema practitioners 47%; nurses 38%). Only 16% of HF specialists had read this document (Table 7). Between 4 and 25% of the respondents said they had

Table 7. Participant response: documents read or not read

Document	Nurse				Heart failure practitioners				Lymphoedema practitioners			
	Read/changed practice		Not read		Read/changed practice		Not read		Read/changed practice		Not read	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
NICE guidelines on chronic heart failure	23	20	81	70	53	75	0	0	29	20	86	60
National guidelines and or pathways	12	10	99	85	36	51	24	34	27	19	105	73
ESC guidelines: diagnosis and treatment of acute and chronic heart failure	6	5	104	90	56	79	2	3	13	9	125	87
Wounds UK best practice statement: compression therapy and peripheral oedema	44	38	55	47	11	16	60	85	67	47	48	34

National Institute for Care and Health Excellence (NICE), 2018; European Society of Cardiology (ESC), 2023; Wounds UK, 2023

read the documents but had not changed their practice with variations between healthcare professionals (HF practitioners 16–25%; lymphoedema practitioners 4–20%; nurses 4–17%).

Question 14. How well do you perceive your education needs are met regarding chronic peripheral oedema (lymphoedema) in the presence of heart failure?

Perceptions of educational adequacy were generally low across all job groups. Only 4% of lymphoedema staff and 3% of nurses said their needs were completely met. HF professionals expressed the greatest dissatisfaction: 30% said their needs were not met at all, and their average rating (1.9 out of 4) was the lowest of all groups.

Even lymphoedema professionals who rated their training most favourably reported only partial fulfilment of their learning needs (Table 8). This underscores the systemic gaps in education provision and the importance of more comprehensive, interdisciplinary training.

Question 15. Do you feel you would benefit from education or further information on managing chronic peripheral oedema (lymphoedema) in the presence of HF?

The overwhelming majority reported a benefit from further education (Table 9).

Question 16. Which of the following education topics would enhance your role, if any?

The participants selected a wide array of topics, with the top five being:

1. When to refer to the HF team (64%)
2. Exercises for patients with HF and lymphoedema (60%)
3. Differential diagnosis of swollen legs (60%)
4. Management of oedema in advanced disease (59%)
5. Knowledge of medications that increase lymphoedema (59%)

Role-based analysis revealed predictable differences: HF staff wanted lymphoedema-related training (eg compression, cellulitis treatment), while lymphoedema staff focused on HF awareness and referral knowledge. Nurses expressed broad interest across nearly all categories, suggesting their central position in delivering shared care.

Question 17. What would be the best way to address these education needs?

Respondents favoured practical and accessible learning formats. The most endorsed method was a multidisciplinary webinar or masterclass (66%), followed by local training from HF (56%) and lymphoedema teams (47%). Online learning and in-practice training were also popular (45–46%). Free-text responses highlighted preferences for:

Table 8. Participant responses to educational needs

Job group	Not at all		Partially		Mostly		Completely	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Heart failure	21	30	39	55	11	16	0	0
Lymphoedema	17	12	71	50	50	35	5	4
Nurse	29	25	65	56	19	16	3	3
Other	3	25	6	50	1	8	2	17

Table 9. Participant response to further education and training

Job group	Yes		Maybe		No	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Heart failure	68	96	3	4	0	0
Lymphoedema	125	87	14	10	4	3
Nurse	109	94	7	6	0	0
Other	11	92	1	8	0	0

- Locally tailored education
- Written guidelines and case-based materials
- Joint training between HF and lymphoedema services
- Accessible formats that reflect real-world care settings.

Discussion

This service evaluation offers a unique, two-part analysis of how HCPs engage with the complex task of managing coexisting HF and CPO or lymphoedema. The quantitative findings presented here are strengthened by insights from the accompanying qualitative analysis, revealing consistent themes of role ambiguity, variation in clinical confidence and fragmented education and service provision. The insights confirm longstanding concerns around care fragmentation, uneven training access and the cautious application of compression therapy in patients with HF. When viewed alongside recent audits, which indicate an unmet need in terms of recognising CPO lymphoedema in the presence of HF and vice versa, it is clear that there is a widespread unmet education need (Jones et al, 2024).

Competency and clinical confidence

The survey revealed striking differences in competence and confidence between job roles. While lymphoedema practitioners reported high confidence in applying compression (90%), only 3% of HF practitioners felt competent in this task. This disparity exists despite emerging guidance supporting the cautious application of compression in compensated HF when clinically appropriate (Wounds UK, 2023; Cooper and Brown, 2024).

The reluctance among HF practitioners may stem from fears of exacerbating HF symptoms or limited access to

practical training. However, when used appropriately, it may prevent complications such as cellulitis, immobility and reduced quality of life (International Lymphoedema Framework, 2012; Wounds UK, 2023). This echoes the findings of Mortimer et al (2014) and Itkin et al (2021), who describe the overlapping pathophysiology of HF and lymphatic dysfunction, reinforcing the need for interdisciplinary management.

Notably, over 60% of HF practitioners did not know where to find guidance on managing cellulitis or oedema, suggesting a gap in awareness, with many seeking colleague support and advice. A recent service evaluation revealed similar findings about lipalgia syndrome or lipoedema, particularly concerning the availability and use of guidance, and how this influences practitioners' perceptions of their competency (Cooper et al, 2025). The discrepancy between evidence and confidence underlines the importance of job-specific education and clear guidance for safe compression use in HF.

Guideline dissemination and implementation

Despite the publication of detailed guidance (Wounds UK, 2023; BLS, 2024), only 16% of HF professionals reported that these resources influenced their clinical practice, and 60% had not read them.

By contrast, 75% reported relying on the broader NICE HF guidance (NICE, 2022a; 2022b), which does not offer detailed recommendations on compression therapy. This suggests an implementation gap, where speciality guidance fails to reach or resonate with the generalist or community-based staff (Moule et al, 2016; Backhouse and Ogunlayi, 2020).

Implementation science highlights the need for tailored dissemination strategies that embed guidance into local pathways. This is particularly relevant for services that encounter patients with oedema, regardless of a formal diagnosis of HF or lymphoedema. A retrospective observational study presented at the British Heart Failure Society reported that up to 20% of patients may present with oedema in the absence of a known diagnosis of HF or lymphoedema (Jones et al, 2024). This highlights the need for guidance that is both accessible and integrated across disciplines. When guidelines are siloed or difficult to access, uptake is inevitably limited, and opportunities for timely intervention may be missed.

Multidisciplinary collaboration

A lack of integration between HF and lymphoedema services emerged as a consistent theme with siloed service delivery, fragmented pathways and confusion around roles. This finding is supported by Rankin (2016) and Keeley et al (2019), who call for integrated lymphoedema pathways that reflect the reality of multimorbidity. Professionals expressed frustration at being unable to coordinate care effectively across teams. Only 5% of respondents reported that they could make direct HF referrals; an area ripe for

service improvement. These are relevant considerations when considering the multiple services which those with CPO may present, such as HF and echocardiography clinics (Jones et al, 2024). Shared decision-making tools such as the Derby Community Health Services NHS Foundation Trust (2023) Compression Therapy Pathway are examples of good practices that could be replicated nationally.

Education and training needs

Over 90% of respondents reported that they would benefit from further education. The topics with the highest demand included recognising when to refer to HF teams, differential diagnosis of oedema, and compression therapy in HF. These findings align with the qualitative data, where staff reported learning 'on the job' and a reliance on self-study rather than formal training.

Satisfaction with existing education was modest, with HF practitioners reporting the lowest perceived fulfilment (mean score 1.9/4). Structured education from higher education institutions or local services scored highest (2.5–2.6/4), reinforcing the value of contextualised, practical training (Backhouse and Ogunlayi, 2020). Despite broad engagement with webinars and online self-study, these formats were rated lower in satisfaction. This supports adult learning theory, which emphasises the need for role-specific, case-based training embedded in everyday practice.

Implications for practice

This evaluation highlights the need for integrated, cross-speciality education and standardised care pathways to support clinicians managing coexisting HF and CPO or lymphoedema. Lymphoedema specialists felt confident with compression but required support in HF-related care.

HF practitioners were cautious about compression, and nurses—often spanning both domains—expressed uncertainty around referral processes and treatment planning. With rising HF prevalence (Conrad et al, 2018) and chronic oedema recognised as lymphatic dysfunction (Mortimer et al, 2014), multidisciplinary collaboration is essential across the patient healthcare journey. The Derby and Oxford (Oxford Health NHS Foundation Trust, 2021) HF compression pathways, and other similar tools, offer replicable models, while wider uptake of guidance from Wounds UK (2023) and BLS (2024) can help reduce practice variation.

Recommendations

- Integrated education: multidisciplinary training on compression use and co-management of HF and CPO or lymphoedema
- Guideline implementation: improve dissemination and use of relevant clinical guidance across services
- Collaborative care: strengthen links between HF and lymphoedema teams to ensure consistent decision making
- Referral pathways: standardise access to HF and lymphoedema services to avoid treatment delays

- Ongoing evaluation: monitor how education and pathway use influence patient outcomes.

Conclusions

This survey highlights significant variations in confidence, practice and education among healthcare professionals managing patients with coexisting HF and CPO or lymphoedema. While lymphoedema practitioners reported high competency in compression therapy, HF specialists and generalist nurses expressed uncertainty—particularly regarding safe compression use, referral pathways and guideline application. Despite the availability of targeted guidance, its impact on practice remains limited, underscoring a need for more accessible and integrated education. The findings support the urgent development of cross-speciality training, shared care protocols and decision-making tools to promote safe and consistent management.

Community nurses and generalists, who often act as the first point of contact for this patient group, require enhanced support to bridge gaps between cardiac and lymphatic care. Embedding multidisciplinary education and unified referral pathways into clinical practice will be essential for improving outcomes and ensuring equitable, evidence-informed care for people living with both HF and CPO or lymphoedema.

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Informed consent: Participants were presented with an information sheet as part of the online survey. By completing the survey, participants provided consent for the use of anonymised, non-identifiable data in the service evaluation and any resulting publications.

Ethics approval: Ethical approval was not required for this service evaluation, as it followed the established process within the NHS Research and Development Department. The Lymphoedema Wales Clinical Network ensured oversight through the Research and Development, Information Governance teams, and the Lymphoedema Wales Research and Evaluation Steering Group.

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Key points

- Community healthcare professionals frequently manage patients with coexisting heart failure and chronic peripheral oedema or lymphoedema, particularly in older populations.
- There is significant uncertainty regarding the safe application of compression therapy in patients with heart failure, despite existing guidelines.
- Referral pathways to heart failure and chronic peripheral oedema or lymphoedema services vary, leading to inconsistencies in practice and potential delays in care.
- Multidisciplinary collaboration and joint education initiatives are highly desired by healthcare professionals to improve patient outcomes.
- Community nurses play a pivotal role in the early identification, referral and management of these complex patient groups.

CPD reflective questions

- How confident are you in differentiating between chronic peripheral oedema and heart failure-related oedema in clinical practice?
- What steps can you take to improve your understanding and application of compression therapy in patients with coexisting heart failure and chronic peripheral oedema or lymphoedema?
- How can better collaboration between community nursing, heart failure and lymphoedema services enhance patient care outcomes?
- What additional education or training would support your role in managing patients with heart failure and chronic peripheral oedema or lymphoedema in community settings?
- How can evidence-based guidelines be better integrated into your daily practice to ensure consistent and safe care?

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