Prescribing of dressings

Guiding principles for improving the systems and processes for the supply and prescribing of wound dressings
In 2010 the NPC was asked by the Department of Health to undertake the production of guiding principles for the procurement and supply of appliances as listed in Part IX of the Drug Tariff. The NPC commissioned Morph Consultancy to support this project and to author initial drafts of the report.

The guiding principles are the product of a series of expert, focus and validation groups (see Appendix 1). The expert group initially considered all products in Part IX of the Drug Tariff. However, it was established that there was a particular need to develop guiding principles for the prescribing and supply of dressings, especially in primary care. In order to improve the quality and productivity of patient care the guiding principles consider the whole patient care pathway rather than focusing solely on the products prescribed.

The document is intended to help organisations ensure that patients have access to clinically appropriate dressings and that systems and processes are in place for:

- Assessing the type of wound and choosing a suitable dressing
- Monitoring patients’ on-going requirements for dressings
- Ensuring that quantities of dressings provided are sufficient to meet clinical needs but not excessive.

In April 2011, the NPC integrated into the National Institute for Health and Clinical Excellence (NICE). However, the guiding principles do not constitute formal guidance of the National Institute for Health and Clinical Excellence.
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Ten Guiding Principles for improving the systems and processes for the supply and prescribing of wound dressings

1. Local health economies should understand their local clinical need for tissue viability and wound management services and map this against available workforce expertise.

2. Local health economies should develop (or adopt) a prescribing policy to increase productivity and in particular reduce wastage.

3. Local health economies should understand their local procurement and prescribing arrangements for dressings across primary, secondary and social care.

4. Local health economies should develop clinical and system leadership in wound management.

5. Local health economies should work with care home commissioners and providers to ensure a high standard of wound care management in this setting; this includes screening, education, assessment, prevention and treatment.

6. Local health economies should ensure assessment for risk of developing wounds and early identification of wounds is embedded into everyday care.

7. Local health economies should develop (or adopt) standard templates for wound management care plans to be used with “at risk” patients across primary, secondary, and social care settings.

8. Local health economies should assess local training needs for wound management and implement a programme of education for all front line staff and patients. Competencies for basic skills should be developed.

9. Commissioners should consider incentives to improve wound management and prevention.

10. Local health economies should develop (or adopt) measurements for assessing the quality of the provision of wound management and prevention services.
Background

Numerous dressings are available for NHS prescribing in England. However, the evidence base to support the choice of dressing is less established and of poorer quality than in other areas of prescribing.1 Two of the factors that should be taken into account when choosing an appropriate dressing to apply to a wound are the type of wound and the stage of the healing process. The type of dressing required may change as the clinical condition of the wound or clinical condition of the patient changes.

In July 2010 the NPC published a MeReC Bulletin Evidence-based prescribing of advanced wound dressings for chronic wounds in primary care.1 The information contained in this bulletin has been used to inform the production of the guiding principles. Further advice is also available in the NICE clinical guideline CG 29: Pressure ulcers: The management of pressure ulcers in primary and secondary care.2

The emphasis throughout has been on the use of dressings in community and primary care services for patients with non-surgical wounds. However, there is some reference to secondary care services where there is likely to be an influence on dressing use in the community. Advice on the management of surgical wounds can be found in the NICE clinical guideline CG74: Surgical site infection.

Ten guiding principles have been developed to support local health economies to improve the systems and processes where dressings are used. The principles broadly follow the NHS commissioning cycle. It is recommended that a local approach is taken to determine the most appropriate service configuration to deliver patient care consistent with these guiding principles.

These guiding principles are not meant to be prescriptive but should be used to support:
- commissioners and providers in their reviews of wound management services.
- providers in improving the identification, treatment and review of patients who have wounds or are at risk of developing wounds.
- commissioners and providers to improve systems to ensure that patients can access appropriate and effective services, whilst ensuring value for money for the NHS.
Methodology

An expert group provided direction and advice on the overall approach to this work. A qualitative approach to data collection was used. The detailed operational information used to inform the development of the guiding principles was gathered and tested through two focus groups. Focus group participants were selected from a range of health care professional groups who had either a clinical or commissioning involvement in the provision of wound care services. Membership of the expert group and focus group participants are shown in Appendix 1.

The initial expert group meeting was used to determine problems with the supply of dressings in the overall context of wound management and provide a vision of an ideal wound management service. The first focus group meeting was used to expand on operational problems with the provision of dressings identified by the expert group and suggest improvements that could be made to the patient care pathway. The notes of the discussions were reviewed and categorised by the project lead using the NHS commissioning cycle as a categorisation framework. This was then used to develop the provisional content of the guiding principles. The second focus group was used to test the content of the provisional guiding principles. The final guiding principles were then amended and validated by a validation group made up of selected participants from the expert group and focus groups. Once validated, the guiding principles were circulated to stakeholders for comment. Further refinement to the content of the guiding principles was then made. Extensive notes were taken at all meetings as a record of the discussions.

The evidence base to support this document is taken from MeReC Bulletin volume 21, number 1, June 2010 Evidence-based prescribing of advanced wound dressings for chronic wounds in primary care. Further information was obtained from the NICE clinical guideline CG 29: Pressure ulcers: The management of pressure ulcers in primary and secondary care. Additional literature relating to the prevalence of wounds was identified by the expert group.
Context

Wound prevalence
At any one time around 200,000 individuals in the UK have a chronic wound (mostly leg ulcers, pressure ulcers and diabetic foot ulcers). A wound survey over one week in 2007 to establish the costs of providing wound care in Bradford and Airedale PCT found that the prevalence of wounds was 3.55 per 1000 of the population. The survey included both acute and community providers within the area. Table 1 shows the number of wounds identified across the different care settings.

Table 1 — Prevalence of wound types across different settings

<table>
<thead>
<tr>
<th>Setting</th>
<th>Pressure Ulcer</th>
<th>Leg/Foot Ulcer</th>
<th>Surgical/trauma wound</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>40</td>
<td>140</td>
<td>372</td>
<td>4</td>
<td>556 (32%)</td>
</tr>
<tr>
<td>District Nursing Service</td>
<td>178</td>
<td>310</td>
<td>414</td>
<td>40</td>
<td>942 (54%)</td>
</tr>
<tr>
<td>Independent / private sector</td>
<td>130</td>
<td>21</td>
<td>29</td>
<td>16</td>
<td>196 (11%)</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>11</td>
<td>13</td>
<td>2</td>
<td>41 (2%)</td>
</tr>
<tr>
<td>Total</td>
<td>363 (20.9%)</td>
<td>482 (27.9%)</td>
<td>828 (47.7%)</td>
<td>62 (3.6%)</td>
<td>1735</td>
</tr>
</tbody>
</table>

Sixty eight per cent of patients identified as having wounds were treated in the community, a prevalence of 2.42 per 1000 population. Most (80%) were treated by district nurses at home (55%), in community based clinics or in residential care.

In the acute sector, almost 12% of wounds were pressure ulcers of which 66% were hospital acquired and almost 32% were severe. The prevalence of pressure ulcers among the total number of hospital inpatients was 3.6% per 1000 population.

A study in Hull and East Yorkshire in 2007 found a cumulative wound prevalence of 12%. There was a prevalence of 27% in the acute hospital setting and the PCT rates ranged from 7 to 17%. The prevalence in nursing homes was 12% and prisons 1%. Many of the wounds were six weeks old or less (44.1%) but 14.8% were at least a year old. 12.8% of the wounds were considered to be infected and almost a third of patients with leg or foot ulcers were diabetic.
Prescribing of dressings

Cost of wound management

The total cost to the NHS of caring for patients with wounds was estimated to be between £2.3 and £3.1 billion per year in 2005 and 2006, which represented around 3% of the total NHS budget.

When considering the cost of wound care it is important to consider all aspects of the patient pathway and not simply the cost of dressing products. Modern dressings have been developed to manage wound exudate so that dressing changes are required less frequently reducing the risk of trauma to the wound bed. Less frequent dressing changes also reduces the associated nursing time.

The Bradford and Airedale PCT survey considered frequency of dressing change, treatment time and district nurse travelling time when estimating the costs of providing wound care. The resource costs of wound care in the PCT were estimated by combining this information with representative costs for the UK NHS and information on dressings expenditure by the PCT. The most important factors contributing to the cost of wound care were found to be the costs of wound-related hospitalisation and the opportunity cost of nursing time. A third of the patients included in the survey who were treated in hospital accounted for almost two thirds of the total costs of wound care. Implementing care pathways to avoid hospitalisation and prevent hospital-acquired pressure ulcers and other wound complications may help to reduce expenditure in this area and improve patient outcomes.

One study found that the mean annual costs per patient for healing a pressure ulcer increased with the severity of the ulcer from £1,064 for a Grade 1 ulcer to £10,551 for a Grade 4 ulcer. The cost of ulcer treatment is higher for more severe pressure ulcers because they take longer to heal and have a higher incidence of complications. Ninety per cent of the treatment costs identified in the study were attributed to nursing costs. The study concluded that treating pressure ulcers represents a very significant resource cost and this is likely to increase unless there is a concerted effort to address this issue.

Evidence-based prescribing of advanced wound dressings for chronic wounds in primary care

The summary from the June 2010 MeReC Bulletin Evidence-based prescribing of advanced wound dressings for chronic wounds in primary care stated that:

- Systematic reviews of advanced wound dressings have repeatedly highlighted the paucity of high-quality studies using clinically relevant endpoints.
- There is insufficient high-quality evidence to distinguish between any of the advanced wound dressings used in the management of chronic wounds.
- There is reasonable evidence that hydrocolloid dressings are more effective than conventional gauze dressings in healing pressure ulcers. However, there is no evidence that they are more effective than simple low-adherent dressings when used under compression for the treatment of venous leg ulcers.
- There is no robust clinical evidence that dressings containing antimicrobials (e.g. silver, iodine or honey) are more effective than unmedicated dressings for the prevention or treatment of wound infection.
- Unless the use of a specific dressing can be adequately justified on clinical grounds, it would seem appropriate for NHS health professionals to routinely choose the least costly dressing of the type that meets the required characteristics (e.g. size, adhesion, conformability, fluid handling properties etc.) and is appropriate for the type of wound and its stage of healing.
- Indiscriminate use of topical antimicrobial dressings should also be discouraged because of concerns over bacterial resistance and toxicity.
Availability of wound management products for prescribing on the NHS

The Drug Tariff determines payments to contractors for NHS services for reimbursement of the cost of the drugs and appliances supplied against an NHS prescription form and for remuneration.

Products put forward for inclusion in the Drug Tariff are assessed for whether they are:-
- Safe and of good quality
- Appropriate for GP and if relevant non-medical prescribing
- Cost effective.

Dressings, bandages and certain other appliances are included in Part IX Section A of the Drug Tariff. Manufacturers wishing to supply appliances and chemical reagents for NHS prescribing must first seek approval from the NHS Business Services Authority Prescription Services for inclusion of a product in Part IX of the Drug Tariff. The basic price for those appliances and chemical reagents ordered by a name included in Part IX is the price listed in the Drug Tariff.

NHS prescribing of dressings

Spend in England on dressings dispensed in primary care was £134 million between October 2010 and September 2011. These figures exclude dressings supplied through alternative supply routes that do not involve FP10 prescriptions which may explain some of the variance in the data.

Despite this caveat, Figure 1 shows there is a large variation between PCTs in terms of net ingredient cost (NIC) per 1000 prescribing units (PUs*). To further explore the appropriateness of prescribing wound dressings, prescribers and commissioners should use prescribing data alongside local knowledge, audit and other sources of information such as GP clinical systems.

Figure 1

Wound management and other dressings (ePACT section 20.03): NIC per 1000PUs

* The Prescribing Unit (PU) is a weighting factor that takes into account the greater need of patients aged 65 and over. Rather than compare the cost or volume of prescribing per patient, PUs are an attempt to make comparisons between general practices and organisations more valid. Patients aged 65 years and over are counted as 3 prescribing units and patients under 65 years are counted as one PU.
Prescribing of dressings

Ten Guiding Principles for improving the systems and processes for the supply and prescribing of wound dressings

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10. Local health economies should develop (or adopt) measurements for assessing the quality of the provision of wound management and prevention services.
Principle 1

Local health economies should understand their local clinical need for tissue viability and wound management services and map this against available work force expertise.

There is a lack of national data to help health economies understand their need for tissue viability services and wound management services and so local audits will be required to fully assess this.

**Local health economies may need to complete:**
A baseline audit or cross section survey to evaluate current tissue viability need compared to their current tissue viability capacity and expertise.

The audit for ‘need’ for wound management services could assess:
- Patients currently cared for by tissue viability nurses (TVNs) and district nurses (DNs) for management of existing wounds.
- An analysis of the cost and number of dressing items supplied in hospital and primary care settings.
- Patients admitted to accident and emergency departments with chronic or acute wounds.
- Hospital data detailing the types of wounds present in the hospital population related to the types and numbers of patients on different wards.

To assess current tissue viability capacity local health economies could consider:
- Current tissue viability service configuration (including the roles of DNss, community matrons and TVNs) and caseload.
- The possibility of extending existing roles to improve service delivery, for example TVNs taking on a leadership and education role or extending the roles of other healthcare staff such as community pharmacy staff or healthcare assistants to help identification of patients with or at risk of developing wounds.
- Training needs assessment to determine how existing staff could implement measures to improve service delivery.
- Referral patterns to TVNs, DNs or hospital specialists or clinics.
- TVN waiting lists.
- Clinic capacity in primary care, secondary care, treatment centres, outreach and in reach clinics.
- The role and availability of medicines management teams or data analysts in identifying prescribing trends and implementing training on prescription analysis, management, systems and products.
- The feasibility of using condition specific patient reported outcome measures (PROM) to determine the impact of services from the patient’s perspective.
Prescribing of dressings

Principle 2

Local Health Economies should develop (or adopt) a prescribing policy to increase productivity and in particular reduce wastage.

Prescriptions for wound management products may not be prescribed by a healthcare professional with expertise in this area.

In primary care prescriptions may be issued as an ‘acute’ prescription or a ‘repeat’ prescription. An acute prescription is a one-off prescription issued to treat a short-term condition or when there is a need for frequent review. Repeat prescriptions are those that may be reissued at the request of a patient, carer or GP without the patient being present.

Acute prescriptions for dressings may be issued by GPs or non-medical prescribers (NMPs), for example podiatrist or nurse prescribers. However, it is likely that repeat prescriptions will be issued by GPs as generally NMPs do not have systems in place to issue and sign repeat prescriptions. The clinician signing a prescription assumes clinical responsibility for the outcomes of the prescription. This means that some GPs will be taking clinical responsibility for wound management products which they may not have initiated and fall within a therapeutic area in which they have limited clinical expertise. Whenever possible NMPs should be encouraged to write prescriptions for dressings they are recommending rather than asking another healthcare professional to issue prescriptions on their behalf.

In most cases, in primary care dressings should be prescribed on a short term basis with periodic clinical review. It may be more appropriate to issue one or more acute prescriptions rather than repeat prescriptions. This may help to ensure that patients are clinically reviewed at appropriate intervals. Supplying small quantities on each prescription helps to minimise waste especially if it is likely that the dressing type will be changed within a short time period. There will however be some patients who need dressings on a long term basis and require less frequent review. For this group of patients a repeat prescription may be appropriate.

FP10 prescriptions may be dispensed by organisations holding a pharmacy contract. This includes community pharmacies and some home care companies. When a home care company is in receipt of a repeat prescription for a dressing, it is essential that the home care company ensures they have the endorsement of the patient, carer or healthcare professional for every single delivery. Home care companies should provide services that are integrated and supportive of local guidelines for good quality prescribing.

When dressings are prescribed they should be treated like medicines. Each product or outer package should be labelled with the patient’s name and the product should NOT be shared, for example between residents of a care home unless a ‘bulk’ prescription has been issued.

* A “bulk” prescription is an order for two or more patients, bearing the name of a school or institution in which at least 20 persons normally reside, for the treatment of at least 10 of whom a particular doctor is responsible. Such a prescription must be an order for a drug which is prescribable under the NHS and which is not designated a “Prescription Only Medicine” (POM) under Section 58(1) of the Medicines Act 1968, or for a prescribable dressing which does not contain a product which is designated POM.
Prescribing of dressings

Local formularies

It is recommended that local health economies develop and implement local formularies which should include a dressings formulary. There should be a policy for review of the formulary, including the approach for the consideration of new products and their inclusion in the formulary when appropriate.

Development of a formulary across all care interfaces (primary, secondary and social care) will help to ensure that patient care is seamless when transferred between care settings. This should include information on which dressings can be effectively used in combination. The experts involved in this work estimated from their experience that 80% of patients can be treated using dressings from a limited list or formulary.

Local health economies may wish to have in place policies and procedures governing which health care professionals may prescribe more complex, premium price dressings and for what clinical indications.

Where care homes are requesting dressings on prescriptions from GPs, the practice should be encouraged to ensure that all requests are for formulary items. One way of ensuring this is the use of prepared prescription request forms, where the care home nurses are asked to tick which products they require. Any non-formulary items would be added to the bottom of the form and so readily identified as being non-formulary.

Providers should monitor prescribing of all prescribers through the use of ePACT or other tools to demonstrate adherence to the formulary and regularly report performance.
Prescribing of dressings

Principle 3

Local health economies should understand their local procurement and prescribing arrangements for dressings across primary, secondary and social care.

Local health economies may have different models in place for procuring dressings in primary, secondary and social care. To ensure appropriate use of resources across the whole health economy it is important to understand how dressings are procured in each sector.

In the majority of cases dressings are prescribed on FP10 prescriptions in primary care. These may be dispensed by community pharmacies, dispensing doctors (for specific patients) or appliance contractors. In secondary care dressings are usually procured via a contract (with a dressings manufacturer or though NHS supplies) and supplied to patients through a hospital prescription dispensed by the hospital pharmacy or from ward stocks. Some localities have contracts with dressings manufacturers for the supply of dressings and this may include direct supply to patients.

There may be a differential between the prices paid for dressings in primary care and in secondary care although this is less likely with dressings than other appliance products.

It is important to involve all stakeholders in any consideration of procurement processes. The majority of expenditure on dressings is in primary care and so it is particularly important that primary care organisations are included in the procurement arrangements across the local health economy. It is likely that any contracts negotiated will have a high associated cost and so senior managers should be involved.

Any consideration of alternative non-prescription routes of dressing supply should take into account additional expenditure incurred through VAT (FP10 prescriptions are zero rated for VAT) and the impact on local pharmacies, GP practices and patients.
Prescribing of dressings

Principle 4

Local health economies should develop clinical and system leadership in wound management

Clinical leadership for wound management can be achieved by establishing a joint wound management steering group with explicit terms of reference. The purpose of the steering group can include:

- Formulating a general philosophy and principles for the service
- Development of care pathways across primary, secondary and social care including strategies to embed screening and assessment of patients for current and future wounds into everyday practice and training programmes
- Agreeing a local formulary and strategies to ensure appropriate prescribing
- Agreeing and putting into practice dressings procurement and delivery mechanisms
- Developing a standard data set to be included in hospital discharge letters and agreeing quantities of dressings to be provided when patients are discharged from hospital
- Developing links with patients, carers and voluntary organisations.

Membership should include representatives from primary, secondary and social care for example:

- Nurses — tissue viability nurses, community matrons, district nurses, practice nurses, secondary care nurses
- Doctors with an interest in wound care — GP, vascular surgeon
- Pharmacists
- Managers — commissioning, finance, care home
- Patient / public representative.
Principle 5

Local health economies should work with care home commissioners and providers to ensure a high standard of wound care management in this setting; this includes screening, education, assessment, prevention and treatment.

Local health economies may need to provide training for care home staff on basic wound prevention and management. This can be through care home visits or specific training events held across a local health economy. Training should include clear protocols for screening, assessment, review and monitoring of patients with simple personalised standardised documentation, guidelines for prescribing complex dressings and how to access to tissue viability expertise.

Care home managers should ensure that the quantities of dressings requested on prescription are appropriate for the clinical needs of patients and that dressings are not stock piled. Dressings should be treated in a similar way to medicines in that products should not be shared between residents (unless provided from nursing home stock or on a bulk prescription). Regular review of residents’ wound care requirements, for example every four weeks, would prevent continuation of inappropriate dressing choices or dressing combinations. If a patient has been reviewed and no longer needs a particular dressing then the prescription should be stopped by informing the patient’s GP practice.

A local TVN could be assigned to several care homes to assist with the audit and monitoring of clinical care, formulary adherence and performance reviews working with commissioners.
Prescribing of dressings

Principle 6

Local health economies should ensure assessment for risk of developing wounds and early identification of wounds is embedded into everyday care

Assessing the risk of wounds developing and the early identification of wounds is key to improving patient outcomes.

Health economies should ensure that patient assessment for risk of developing wounds and early identification of wounds is embedded into everyday practice for all health and social care workers providing direct patient care.

The RCN has developed guidance on Pressure ulcer risk assessment and prevention and their clinical practice guidelines The nursing management of patients with venous leg ulcers includes a section on the assessment of patients with leg ulcers.

Patients should be screened at regular intervals and this may include the following circumstances:

**Primary Care**
- On registration with GP practice
- When there is a clinical concern
- All over 75 year olds
- Other opportunities e.g. vaccinations
- Domiciliary settings e.g. sheltered housing

**Secondary Care**
- On admission and discharge
- Weekly as inpatients (certain wards can opt out)
- First Outpatient Appointment and when there is a clinical concern

**Social Care**
- All residents of care and nursing homes on registration
- Regular intervals depending on the type of patient and care home but at least 4 weekly or when there is a clinical concern

Healthcare workers should be trained and their competence assessed and documented to use any assessment tool developed or implemented and any associated equipment.

Assessment of patients may require the purchase of additional equipment such as hand held Doppler devices, tape measures and cameras to record the size and appearance of wounds.

Screening could be promoted proactively through public health campaigns, charities and the development of a Locally Enhanced Service (LES) for GPs and community pharmacists.
Prescribing of dressings

Principle 7

Local health economies should develop (or adopt) standard templates for wound management care plans to be used with “at risk” patients across primary, secondary, and social care settings.

Patients who are identified as being ‘at risk’ of developing wounds should enter a pathway of care delivered by a multi-disciplinary team. All providers should use the same criteria to assess and refer patients so that service delivery is consistent across providers.

The care pathway may include reference to:
- Criteria for referral to tissue viability nurses or secondary care services
- Wound / pressure prevention and injury care plans
- Compression guidelines.

**Standard template care plans**
Standard template care plans should contain treatment goals which must be recorded. Treatment goals may include social measures in addition to clinical measures. Patients should be monitored to ensure that treatment goals are met and the care plan adapted as necessary.

**Standard discharge letters**
It is well known that the continuity of patient care may reduce at the interface between care settings. Studies have shown that only half of used prescription only medicines were registered in patient discharge letters. To improve communication and continuity of patient care standard letters of discharge should be developed and should include:
- Dressing products and quantity required, indication and rationale
- Anticipated duration
- Review periods
- Responsibility for patient review.
Prescribing of dressings

Principle 8

Local health economies should assess local training needs for wound management and implement a programme of education for all front line staff and patients. Competencies for basic skills should be developed.

All health care staff from all organisations in a local health economy who are involved in patient care should receive core basic training as part of their induction process with regular updates. Staff who manage at risk patients as part of their day to day work should receive more in depth training which includes local prescribing policies, formularies and tissue viability services.

Education and training should include:
- Local frameworks for screening, assessment, treatment and prevention of wounds
- Ethical and legal concepts
- Potential risks and benefits of prevention and treatment
- How to access expert advice.

Advanced training for staff involved in more complex wound management

Any staff involved in leg ulcer management should be trained and competent in leg ulcer assessment and management including use of a handheld Doppler device for ankle brachial pressure index (ABPI) measurement and multi-layer compression bandaging. This has been addressed in some areas by delivering local bandage workshops or implementing annual checks for taking ABPI measurements.

Objective evidence to substantiate the presence or absence of significant peripheral artery disease (PAD) may be obtained reliably (except in those with highly calcified vessels) by obtaining an ankle brachial pressure index (ABPI) in both legs. Appropriate training is required due to the complexity of clinical reporting and methodological issues around interpretation and reproducibility of results.9

Multi-layer compression bandaging is the application of several bandage layers giving a graduated compression from the toes to the knee. Compression hosiery is also used for a small number of patients. Compression therapy does have potential risks. The use of compression in some patients should only be initiated under specialist advice. It should also be used with caution with patients with diabetes.10

Patient concordance is important for the continuation of compression therapy. Pain, discomfort and lack of valid lifestyle advice have been cited by patients as the main reasons for non-concordance.11
Principle 9

Commissioners should consider incentives to improve wound management and prevention

Opportunities to drive change and review wound management services include:

1. **Development of Commissioning for Quality and Innovation (CQUIN) schemes for wound management**
   The CQUIN payment framework makes a proportion of a providers’ income conditional on quality and innovation. The framework was launched in April 2009 and helps ensure quality is included in discussions between commissioners and providers. Commissioners must make 1.5% of the contract value (or equivalent non-contract activity value) available for each providers’ CQUIN scheme using the CQUIN payment framework.  

   The NHS Institute for Innovation and Improvement provide a wide range of resources for developing CQUINs e.g.  
   *Standard template for CQUIN schemes 2011/12*

2. **Development of strategies as part of “Invest to save”**
   Commissioners may consider investing in redesigning tissue viability services and increasing resources locally in the short term to realise the potential benefits from reduced patient admissions and benefits in the long term.

3. **Other local incentives to improve wound management and prescribing practice may include:**
   - Adding the prevention and management of wounds into contracts and SLAs with local providers.
   - Review of the wound management service as part of clinically led commissioning.
   - Medicines Use Review (MUR) or audit by community pharmacists as part of the community pharmacy contract to minimise waste and ensure patients prescribed dressings are regularly reviewed.
   - A Locally enhanced service (LES) for GPs
   - PCT incentive scheme for GPs for wound care formulary adherence
Prescribing of dressings

Principle 10

Local health economies should develop (or adopt) measurements for assessing the quality of the provision of wound management and prevention services. This may include:

Audit
Local audit will help to demonstrate whether formularies and care pathways are being complied with. This may include:

- Recorded clinical data
- Referral rates (including details of both the referrer and who referred to)
- When (or whether) seen by a TVN
- Formulary compliance
- Ratio of premium priced dressings prescribed against standard dressings
- Indication for complicated dressing
- Inclusion of the agreed core data set in discharge letters.

Pressure ulcers have been highlighted as one of the eight Chief Nurse's Office High Impact Actions. The incidence of pressure ulcers will be used as a basis for measuring the effectiveness of nursing care. Trusts will incur financial penalties if they are not making progress in reducing the incidence and impact of pressure ulcers.

Patient reported outcome measures
One method of measuring the impact directly on the patient is through the use of Patient Reported Outcome Measures (PROMs). These are questionnaires that seek to measure the health status or health-related quality of life (HRQoL) directly from the patient's perspective. A number of these exist for generic wounds such as the Cardiff Wound Impact Schedule, and also for specific wound types e.g. the Charing Cross Venous Leg Ulcer Questionnaire.

Expenditure on dressings in primary and secondary care

- Trends in dressing expenditure in primary care based on ePACT data.
- Local prescribing practice based on general practice audits.
- Hospital procurement data or audits.
Prescribing of dressings

NHS Evidence QIPP and shared learning examples
Examples of work to improve the management of wounds as part of the implementation of NICE guidance are available on the NICE and NHS Evidence websites through the following links:

*Improving Pressure ulceration documentation pathways*

*Supplementary prescribing in podiatry — NHS Central Lancashire*
References

1. MeReC Bulletin Evidence-based prescribing of advanced wound dressings for chronic wounds in primary care
   Volume 21 Number 01 July 2010

2. National Institute for Health and Clinical Excellence (NICE). The management of pressure ulcers in primary and


   trust in the UK. Journal of Wound Care 18: 3; 93–102

   (10): 413 – 420


7. Information provided by the Information Centre for Health and Social Care, December 2011

   between hospitals and primary care. Qual Saf Health Care 16:34-39


10. SIGN National Clinical Guidelines for the diagnosis and management of peripheral artery disease (89) October 2006

    Clin Nurs 18(3):337-49.

12. Using the Commissioning for Quality and Innovation (CQUIN) payment framework, Department of Health, 2008,
    DH_091443 last accessed 24/12/11

13. High Impact Actions for Nursing and Midwifery (NHS Institute for Innovation And Improvement) 2009

# Prescribing of dressings

## Appendix 1:

**Expert, focus, validation groups, and contributors**

### Expert group

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organization</th>
</tr>
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<tbody>
<tr>
<td>Kerry Frenz</td>
<td>Specialist Pharmacist</td>
<td>NHS Business Services Authority</td>
</tr>
<tr>
<td>Sian Fumarola</td>
<td>Tissue Viability Nurse</td>
<td>University Hospitals North Staffordshire NHS Trust</td>
</tr>
<tr>
<td>Colin Gidman</td>
<td>Head of Medicines Management</td>
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<tr>
<td>Brenda King</td>
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<td>Sheffield PCT</td>
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<tr>
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<tr>
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<td>West Essex Community Health Services</td>
</tr>
<tr>
<td>Andrea Nelson</td>
<td>Professor of Wound Healing and Director of Research</td>
<td>Leeds University</td>
</tr>
<tr>
<td>John Nicholson</td>
<td>Supply Chain Project Lead</td>
<td>London Procurement Programme</td>
</tr>
<tr>
<td>Simon Palfreyman</td>
<td>Research Nurse</td>
<td>Sheffield Vascular Institute</td>
</tr>
<tr>
<td>Peter Phillips</td>
<td>Director</td>
<td>Surgical Materials Testing Laboratory</td>
</tr>
<tr>
<td>David Oxley</td>
<td>Head of Medicines Management</td>
<td>NHS Doncaster</td>
</tr>
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### In attendance

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Jane Brown</td>
<td>Project lead – Associate Director</td>
<td>NPC</td>
</tr>
<tr>
<td>Ian Pye</td>
<td>Development and support manager</td>
<td>National Prescribing Centre</td>
</tr>
<tr>
<td>Rachel Jeynes</td>
<td>Commissioned author – Director</td>
<td>Morph Consultancy</td>
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<tr>
<td>Duncan Jenkins</td>
<td>Commissioned author – Director</td>
<td>Morph Consultancy</td>
</tr>
<tr>
<td>Colin Pearson</td>
<td>Medicines, Pharmacy and Industry Group</td>
<td>Department of Health</td>
</tr>
<tr>
<td>Natalie Cullen</td>
<td>General Prescribing Issues</td>
<td>Department of Health</td>
</tr>
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### Focus Group

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Mel Bradley</td>
<td>Pharmaceutical Advisor</td>
<td>NHS Cumbria</td>
</tr>
<tr>
<td>Wendy Field</td>
<td>Community Matron</td>
<td>Central &amp; Eastern Cheshire PCT</td>
</tr>
<tr>
<td>Paul Larkin</td>
<td>Lead Pharmacist</td>
<td>NHS Hertfordshire</td>
</tr>
<tr>
<td>Richard Lee</td>
<td>Senior Commissioning Pharmacist</td>
<td>Blackburn with Darwen Teaching Care Trust Plus</td>
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<tr>
<td>Susan Mason</td>
<td>Tissue Viability Nurse</td>
<td>NHS North Staffordshire</td>
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<tr>
<td>Michelle Proudman</td>
<td>Tissue Viability Nurse</td>
<td>NHS Manchester</td>
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<tr>
<td>Ash Soni</td>
<td>PEC Chair &amp; Community Pharmacist</td>
<td>NHS Lambeth</td>
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<tr>
<td>Dominic Wright</td>
<td>Head of Finance and Performance</td>
<td>NHS London</td>
</tr>
<tr>
<td>Lisa Silver</td>
<td>GP and PBC Chair</td>
<td>Nettlebed, Oxfordshire</td>
</tr>
<tr>
<td>Debbie Gleeson</td>
<td>Lead Nurse, Tissue Viability</td>
<td>Whiston Hospital, Liverpool</td>
</tr>
<tr>
<td>Harry Ward</td>
<td>Director of Commissioning</td>
<td>Wolverhampton City PCT</td>
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<tr>
<td>Julie Lonsdale</td>
<td>Deputy Head of Medicines Management</td>
<td>NHS North Lancashire</td>
</tr>
<tr>
<td>Neil Frankland</td>
<td>Principal Pharmacist</td>
<td>Regional Drug and Therapeutics Centre – Newcastle</td>
</tr>
<tr>
<td>Stephen King</td>
<td>Deputy Head of Podiatry</td>
<td>NHS South East Essex</td>
</tr>
<tr>
<td>Thelma Gardiner</td>
<td>Diabetes Nurse Specialist</td>
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</table>
## Prescribing of dressings

### Validation Group

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### Contributors

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<tbody>
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<td>David Green</td>
<td>Interface Development Pharmacist</td>
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<tr>
<td>Lorna McCann</td>
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</tr>
<tr>
<td>Mandeep Butt</td>
<td>Head of Medicines Management</td>
<td>NHS Westminster</td>
</tr>
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The National Prescribing Centre (NPC) is responsible for helping the NHS to optimise its use of medicines. NPC is part of the National Institute for Health and Clinical Excellence (NICE), an independent organisation providing national guidance on promoting good health and preventing and treating ill health.

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