NHS
Somerset
Clinical Commissioning Group

Service Specification No.	11X-06-2
Service	Compression Bandaging for Venous Leg Ulcers (Practice Based Service)
Commissioner Lead	Sheryl Vincent, Commissioning Manager
Provider Lead	
Period	1 April 2018 – 31 March 2019
Date of Review	TBC

1. Population Needs

National/local context and evidence base

1.1 As part of their essential General Medical Services (GMS) or Personal Medical Services (PMS) contract, Providers should continue to identify and prevent, as far as possible, the development of leg ulcers in all patients considered to be at high risk. This would include patients with previous leg ulcer history, varicose eczema, other signs of venous disease such as skin changes, lymphovenous diseases or thrombophlebitus as well as those for whom elasticated hosiery is being used. Treatment should also continue for patients with leg ulceration for whom compression therapy is not a suitable option. Staff should be appropriately trained to undertake this work.

1.2 Venous leg ulcers are a major cause of morbidity especially for older people. Leg ulcers are "areas of loss of skin below the knee on the leg or foot which take more than six weeks to heal". About 1.5-3.0 per 1000 population have active leg ulcers and prevalence increases with age up to around 20 per 1000 in people over 80 years. Leg ulceration is strongly associated with venous disease, and is typically chronic. Inappropriate treatment/inadequate management can lead to unnecessary suffering for the patient and costs to society/ the individual and the NHS.

1.3 Compression therapy has been shown to improve healing rates in patients with venous leg ulcers. Considerable damage can be caused by inappropriately applying high compression bandaging in patients with arterial and small vessel disease[1]. This enhanced service is for the treatment of those patients who have venous leg ulcers and meet the criteria set out in Appendix 1.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

Not applicable

[1] See item4.4.

3. Scope

Aims and objectives of service

3.1 The Provider will provide clinics for the treatment of patients who are unable to be managed by community services for compression dressings. Funding will be based on the management of the whole episode of care following appropriate assessment confirming the need for treatment.

Service description/care pathway

3.2 The service will fund:

- provision of staff trained in management of leg ulcers with compression bandages, including use of Doppler ultrasound to measure ankle brachial pressure index (ABPI), and additionally in some instances Pulse Oximetry
- provision of suitable clinic facilities throughout the year, including the implementation of the standards for infection control and the safe disposal of contaminated waste
- provision and arrangement of weekly clinics, including patient appointments agreed with the patient
- assessment and reassessment of the patient by trained personnel using the Somerset Leg Ulcer Assessment form:
    - continuous assessment of the ulcer, including check for infection
    - general health and social assessment
    - assessment of nutritional status
    - ascertain if referral to Social Services for benefit advice if appropriate
    - f/u Doppler, identification of ankle brachial pressure index (ABPI) measurement
    - maintenance of accurate, contemporaneous records using venous leg ulcer care pathway
- treatment with a range of compression bandages recommended under the prescribing formulary. Research indicates that recurrence rates may be lower in high compression hosiery than in medium compression hosiery and therefore patients should be offered the strongest compression with which they can comply
- provision of report on assessment and discharge information to General Practitioner (GP) provider, and provider nurse for follow up checks of healed leg ulcers as part of essential services
- staff to act as a resource to community colleagues

CONSENT

3.3 In each case the patient should be fully informed of the treatment options, risks and the treatment proposed.

3.4 National guidelines suggest that written consent should be obtained from patients. The CCG wishes the Providers to note that their interpretation of ‘written consent’ in this context is the recording of consent by Read Code. Where the Provider Read Codes

consent given, the CCG will take this to mean that the patient has been fully informed of the treatment options and risks, has been offered written information and has given consent.

3.5 The CCG would expect that there would be exceptions to this interpretation in certain circumstances (for example if a patient was not competent or appeared uncertain) and or for certain procedures where actual written consent would be required. It would be for the individual clinician to make the judgment as to what should be deemed necessary. Due consideration should be given to obtaining written consent where risks of dissatisfaction are higher, for example where visible scarring is likely.

3.6 Providers must ensure valid consent is obtained from the patient in accordance with the provider's local consent policy. For guidance on developing a consent policy providers should refer to the current Department of Health Guidance

TRAINING AND ACCREDITATION

3.7 All clinicians providing the services have completed the relevant training course and are proficient and competent in the care of people with venous leg ulceration including skills in the use of Doppler and compression bandaging, assessment and application of hosiery.

3.8 Nurses not possessing skills in the management of leg ulceration with compression bandaging are required to undertake the minimum mandatory training of two days, followed up by a half day practical assessment session. Nurses will be encouraged to practice their newly acquired skills, with a trained mentor, between training sessions until deemed competent and have all competencies signed by the trained mentor.

3.9 All practitioners providing leg ulcer services must update their knowledge and skills base every two years.

3.10 In order to maintain skill levels, individual practitioners will be expected to care for a minimum of 12 patients requiring compression bandaging per year.

INFECTION CONTROL

3.11 Providers must have infection control policies that are compliant with national guidelines, which include:

- disposal of clinical waste
- needle stick incidents
- environmental cleanliness
- standard precautions, including hand washing

SIGNIFICANT/ADVERSE EVENTS

3.12 The Department of Health emphasises the importance of collected incidents nationally to ensure that lessons are learned across the NHS. A proactive approach to the prevention of recurrence is fundamental to making improvements in patient safety.

3.13 The Provider should be aware of the various reporting systems such as:

- the National Patient Safety Agency National Reporting and Learning System

- the Medicines and Healthcare products Regulatory Agency reporting systems for adverse reactions to medication (yellow card system), and accidents involving medical devices

- the legal obligation to report certain incidents to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

3.14 In addition to any regulatory requirements the CCG wishes the Provider to use a Significant Event Audit system to facilitate the dissemination of learning, minimising risk and improving patient care and safety.

3.15 In addition to their statutory obligations, the Provider will give notification, within 72 hours of the information becoming known to him/her, of all emergency admissions or deaths of any patient treated by the Provider under this enhanced service, where such admission or death is or may be due to the Providers treatment of the relevant underlying medical condition covered by this specification. Notifications are to be sent to the Director of Quality, Safety and Governance.

3.16 Incidence of post operative Methicillin-Resistant Staphylococcus Aureus (MRSA) and/or Clostridium difficile (C.diff) infection should be regarded as an adverse incident and should be reported to the CCG Infection Control Team. Infection rates will be monitored across primary and secondary care providers to ensure infection risks are reduced.

AUDIT AND REPORTING

3.17 Evaluation and audit of primary care leg ulcer services will be undertaken regularly to ensure quality and standards, within the context of clinical governance, are being maintained.

3.18 The Provider is required to undertake audit of this service and to provide an annual report including the following information:

- the number of patients assessed for treatment; number identified as suitable, by GP practice

- the average number of attendances per patient

- the number of patients requiring longer than six week treatment

- the number of patients who do not have healed ulcers within 12 weeks

- the number of patients who have adverse outcomes due to incorrectly treated arterial disease or excessive compression

- the number of patients identified and treated for infection

- patient evaluation/satisfaction survey

- evidence of staff training and regular update

- percentage of non-attendance

3.19 Quarterly information of the number of legs currently being treated should be provided as part of the enhanced services return.

COSTS

3.20 Funding for this service will be a local price per leg for up to 13 weeks of treatment (Note: This should follow a period of four to six weeks of treatment under essential services and confirmation with the community services provider that the service is unable to accept the referral). The local price is set out in Schedule 3 Part A of the contract Particulars.

3.21 This is based on a skill mix/ team approach of:

- Band 5 Nurse – assessment, management and evaluation of ulcers, application of compression treatment either bandages or hosiery, completing care pathway and requests for patient prescriptions
- Band 2 Nurse – removal of soiled dressings, washing of legs, assisting with Doppler examinations, organising of appointments

PATIENT AND PUBLIC INVOLVEMENT

3.22 The service will conform to professional and legal requirements especially clinical guidelines and standards of good practice issued by the National Institute for Health and Clinical Excellence (NICE) and professional regulatory bodies, and legislation prohibiting discrimination. It is anticipated that for the majority of enhanced services translated information will be available via the Department of Health

3.23 If a patient wishes to communicate via a language that is not covered via these leaflets please let the CCG Equality and Diversity Lead know and use the commissioned interpretation and translation service[2] to facilitate the consultation and provision of information to the patient. Use of the interpretation/translation service should be recorded in the patient's lifelong medical record including confirmation of the first language of the patient.

3.24 Practices should encourage, consider and report any patient feedback (positive and negative) on the service that they provide and use it to improve the care provided to patients, particularly if there are plans to alter the way a service is delivered or accessed.

Population covered

3.25 The registered practice population of the provider.

3.26 As an exception and subject to prior agreement with the Commissioner, patients registered at other Somerset GP practices may be managed within this service.

Any acceptance and exclusion criteria and thresholds

3.27 **REFERRAL CRITERIA**

1. Patient has a venous leg ulcer to lower limb, excluding diabetic foot ulcers.
2. The leg ulcer has not healed in a four to six week period (evidence of non-healing to be provided by means of documentation and ulcer measurements or photographic evidence), and appropriate Doppler readings, indicating compression therapy is suitable.
3. Patient is willing to agree to compression bandaging.
4. Patients who have arterial leg ulceration and are managed without compression bandaging will be referred back to the Practice unless housebound for continued

[2] Somerset CCG Interpretation and Translation Service – the PIN for accessing this service has been given to each provider, for queries please email: translations@somerset.nhs.uk.

treatment.

5. Patients who have been in compression bandaging with venous or mixed aetiology ulcers that have healed and are in below knee compression hosiery will be referred back to the Provider nurse for healed ulcer advice and six-monthly reassessment of ankle brachial indices.

3.28 **Interdependence with other services/providers**

- Other GP Practices
- Secondary Care Vascular Services
- Tissue Viability Services
- Dietetic Services
- Dermatology Services
- Lymphoedema Specialist Services
- Social Services
- Voluntary Organisations

4. Applicable Service Standards

Applicable national standards (e.g. NICE)

4.1 *The Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infections.* The Stationary Office, 2006.

4.2 Department of Health (England) Guidance on Consent for Examination or Treatment

Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

4.3 Not applicable

Applicable local standards

4.4 1997. *Effective Health Care*. 3, Number 4.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-D)

5.2 Applicable CQUIN goals (See Schedule 4E)

6. Location of Provider Premises

6.1 The Provider's Premises are located at:

As defined in Schedule 5 Part A of the Contract Particulars

7. Individual Service User Placement

Not applicable