• Managing Cellulitis
• Any Qualified Provider
• Engaging with Parliament
• Biomechanics in the Wound Care Team
• Book Review
• Conference Reports
Contents

The Leg Ulcer Forum Journal Issue 25 – Autumn / Winter 2011

Introduction and reports

3 Editorial

4 LUF Conferences
   4 England
   7 Scotland
   8 Ireland

9 Notices

10 Picture Gallery

Clinical Articles

12 Patient View – retirement is not what I thought it would be

14 Interview with Caroline Dowsett

15 Treatment and prevention of recurrence of venous leg ulcers using RAL hosiery

19 The management of cellulitis of the lower limb

23 A new model of care – a case study

26 Clinical experiences of a protease modulating dressing in an acute setting: within a Complex Wound Clinic

30 The Podiatrist and biomechanics in the wound care team

34 Snapshot of Lichen Planus

Support Section

36 An Education Model for Link Nurses

42 Bringing Quality to Life

44 Right Nurse Right Skills – One year on

47 Engaging with Parliament

51 Pyoderma Gangrenosum – STOP GAP trial (Update)

54 Any Qualified Provider

57 Your Legs Matter

60 Word search

61 Ask LUF

63 Book Review

65 Courses

69 Our sponsors

71 Guidelines for authors

The contents of articles in this journal are the opinions of the authors, and do not necessarily reflect the opinions of the editors or the Leg Ulcer Forum
Welcome to Issue 25 of the Leg Ulcer Forum Journal

Thinking back over the last 12 months, it seems such a short time since I was sitting in the tea room writing my last editorial. This year I have spent more time than usual stuck on the M25 trying to get to or from Heathrow. While waiting for family and friends to arrive I have as usual spent time looking at peoples’ legs; I couldn’t help wondering how many had taken any precautions to reduce the risk of DVT (Deep Vein Thrombosis). This also reminded me of a conversation I overheard – a pharmacist was advising a gentleman that wearing flight socks would reduce his swollen ankles; she then proceeded to ask him his shoe size. When you consider the amount of assessment carried out in this case and probably repeated in many other pharmacies across the country, you must wonder how many near misses there are. I am sure that there are still many patients receiving compression stockings from their general practitioners for the management of lower leg oedema (and the obligatory prescription for diuretics) that do not receive an adequate assessment of their circulation.

This brings us to the complex subject of compression hosiery. The confusion over TED stockings, flight socks, British Standard and RAL; I am pleased to be able to reprint Caroline Dowsett’s article discussing the introduction of RAL compression hosiery to reduce the recurrence of venous leg ulceration. The other articles in the Journal cover some of the areas that we all face every day: Mark Collier reviews the use of Protease Modulating Dressings in the acute sector, while Kim Neill presents a project from Scotland. Alison Beasley gives her view on the management of lower leg cellulitis; I know that there are many different approaches to this thorny problem across the country, so why not put pen to paper and submit something for next year’s journal. As always the guidelines can be found on the back page.

A new aspect for us is an article from Ina Farrelly, a Podiatrist from London; she introduces biomechanics and its role within wound care. Heidi Guy and Irene Anderson introduce a different model of education that helps to fill the gap for patients between primary and secondary care. For those of you that could not attend our conference in Sheffield David Foster discusses ‘Bringing Quality to Life’. We have a couple of updates this year, one from the Queens Nursing Institute on their Right Nurse Right Skills campaign and the other from the STOP GAP trial.

Politics never seems that far away from our day to day work and Richard Shorney explains Any Qualified Provider in relation to venous leg ulceration. Many of you will already be involved with strategies to meet these challenges – let us know what is happening in your area. Alasdair Mackenzie explains the process of engaging with Parliament, something we all need to consider with all the changes that keep on taking place. We all need to get involved; I think it is wrong to assume that someone else is doing something about it.

Earlier this year Brenda King joined a valiant group and volunteered to cycle for a whole week from Liverpool to Hull, the aim was to raise awareness of leg health and treatment; her article is entertaining and I must be honest I am surprised that they all look so well in the photographs.

The remainder of the Journal contains our usual book review, word search and your questions with our answers. As I have said many times before, we need you to contribute – after all this is your Journal and your Forum. Please contact us via email legulcerforum@btinternet.com and visit the website www.legulcerforum.org. If you are reading someone else’s copy of the Journal please consider joining the Leg Ulcer Forum; despite the recent increase in membership fees we are still great value for money (see the notice on page 9).

I would like to take this opportunity to thank the authors for all their hard work and the Executive Committee members for their patience and support in the production of this journal. The Executive would like to join me in thanking our sponsors for their continuing generosity and support.

Susan Knight (Editor)
This year’s conferences were at the Aston Hotel, Sheffield in April and at Harben House, Newport Pagnell in September. The feedback was excellent with delegates commenting on the usefulness to practice and thanking us for the opportunity to discuss real clinical issues in leg ulcer management. This year we ran the conferences in two strands: one for the practitioner who wanted to develop clinical and practical skills and the other for more experienced practitioners who wanted to enhance their knowledge and share experiences of service delivery and engage in discussion and debate about services and clinical issues affecting patients.

At the Sheffield conference in April Professor David Foster, Deputy Chief Nursing Officer took the theme Bringing quality to life: policy and practice. This keynote address explained the NHS changes and the reason for ‘the pause’ that was happening at that time. Professor Foster encouraged the delegates to take any opportunity to have their say about changes and their ideas for the future. He recognised concerns that practitioners often have about speaking up but highlighted the role of organisations such as the Leg Ulcer Forum in raising issues and the opportunities that come with such a collective voice. He has followed though on this by brokering connections with other organisations since the conference to raise the profile of the needs of people with lower limb conditions. Many delegates commented how inspiring they found him and we were indeed fortunate to be able to raise the profile of leg ulcer care to a senior nurse with such commitment to patient care services.

Vascular Surgeon Daryl Baker highlighted developments in assessment and surgical management of venous disease, highlighting in particular the ESCHAR study and its finding on leg ulcer recurrence. He clearly has a very positive view on multidisciplinary working highlighting the benefits of collaborative working with tissue viability and other specialist nurses. He recommended an increase in the provision of beds for the autonomous practice of senior nurse practitioners to ensure intensive and effective intervention for some patients. He also highlighted the need to make more use of Duplex scanning. At the April conference Vascular Nurse Specialist Hazel Trender detailed her role in vascular services in Sheffield, how her role developed, the interaction she has with vascular colleagues and the impact her role has on patient care. Both speakers highlighted the importance of vascular assessment and the benefits afforded by increasing the use of Duplex scanning.

Martin Fox is a Vascular Specialist Podiatrist and spoke at both conferences. He took delegates on a journey outside the usual clinical settings and encouraged them to think about different approaches to managing peripheral arterial disease (PAD). The approach of his team is to get
out to where people are and encourage them to discuss leg symptoms and lifestyle risk factors. He reflected on approaches to helping people change habits such as smoking highlighting the need for negotiation and working on things that people are willing to try and change rather than what the professional thinks needs to be changed; he advocated that more subtle and supporting strategies are key to success. Martin also highlighted the development work at NICE on PAD guidelines and key principles in PAD services especially the need for early diagnosis and care pathways.

Tissue Viability Nurse Heidi Guy and Leg Ulcer Specialist Helen Tilbe, both from Hertfordshire presented a seminar on their approach to developing skills in the acute sector to ensure that inpatients with leg ulceration and are receiving compression therapy have a seamless continuation in their therapy while in hospital. The model works through a tripartite approach involving the community, hospital and university and is based on education, clinical skills development and robust support mechanisms underpinned by clear guidelines (see article in this journal).

The conferences were lively events and there was lots of discussion about the way in which services are delivered and the patient was always the central focus. Delegates were asked to comment on what they had learned and a key phrase stood out for me “keep striving to maintain quality care for patients, motivate others, aim high and make a change”. At Sheffield, two patients were involved in a seminar and spoke about their experiences. They described how throughout their condition in times of ulceration and in healing that a lack of understanding about their ulceration, the impact on them and a lack of knowledge about contemporary management made their lives extremely difficult and at times unbearable over many years. The turning point came when they came under the auspices of a specialist leg ulcer service. They could not praise the service highly enough and this was in terms of the clinical management but also the relationship that was built with the team and the respectful manner and collaborative approach to clinical decisions. It struck me that the delegates attending sessions such as this are already committed to patient care and the real challenge is to get healthcare professionals who are not engaged to understand the need for specialist and evidence based services at an early stage in lower limb breakdown.

National leg ulcer guidelines and the purpose and benefits of audit came into focus led by Tissue Viability Nurse Consultant Judy Harker and Leg Ulcer Specialist Nicola Whayman. Judy ran a quiz based on the guidelines and highlighted key principles; it is interesting how few people read such important documents and the delegates found it a “good prompt to what they should be doing in practice”. Participants were encouraged to use both the RCN and the SIGN guidelines as they are complementary and relevant to care anywhere in the UK; I certainly ensure my leg ulcer students use them as they underpin my teaching. Nicola presented a recent audit carried out in her clinical area and how she built on this to inform and enhance care encouraging others to engage in audit and make use of findings. She has also used the national guidelines as a foundation for the development of quality standards in leg ulcer care. These have been developed with the Leg Ulcer Forum and have now been published on the LUF website.

Other members of the Leg Ulcer Forum Team, all specialist nurses, ran workshops on a range of topics including the management of cellulitis run by Alison Beasley a nurse specialist for this condition. The clinical skills sessions ran all day and began with leg ulcer assessment and led on to bandaging and other compression techniques, the use of Doppler ultrasound and pulse oximetry and enabled discussion of clinical scenarios. There were sessions on business planning by Richard Shorney from Real Healthcare Solutions which is a skill that specialist nurses are increasingly engaged in. I ran a workshop looking at issues around competence in leg ulcer management and the issues inherent in assessing competence and how skills development is supported (or not) in practice.

The conferences were well supported by sponsors which made for a lively exhibition where delegates had the opportunity to discuss products and innovations which is how improvements are made; when industry and clinicians share ideas and the focus is directed to the patient.

We were really pleased with the conferences this year and the delegate feedback was probably the best we have had. There are lots of ideas for next year and we are already planning exciting events; we will be in Bristol on 29th March and in the North East on 20th September 2012. Please do put these dates in your diary and encourage your colleagues to join us as members and as conference delegates. We want to help you to share your enthusiasm and skills in the management of people with leg ulcers and related conditions.
This year The Leg Ulcer Forum (Scotland) had their annual conference and AGM at The Campanile Hotel in Glasgow. This proved to be a popular choice of location and venue with a good turnout of delegates. The numbers were encouraging, especially when so many nurses find it difficult to attend conferences due to time and financial constrictions. A big thank you to all who attended and hopefully we will see you or your colleagues next year.

The morning session was chaired by Irene Anderson, Chair of LUF.

We were privileged to have speakers with a long-standing and current interest in the treatments of patients with leg ulceration.

The first morning speaker was Margaret Armitage, vascular specialist nurse for NHS Greater Glasgow and Clyde. Margaret discussed the new SIGN guideline for the care of patients with leg ulceration: *Management of chronic venous leg ulcers: a national clinical guideline (SIGN 120)* which supersedes SIGN 26 1998. She highlighted the changes and additions to the guideline and strengths and weaknesses of the different recommendations.

Janice Bianchi, Medical Education Specialist then explored atypical lower leg lesions, emphasising that there are many different conditions which may cause lesions/ulceration on the lower leg. Janice identified that nurses caring for patients with leg ulcers are constantly advancing their skills of assessment and diagnosis of patients. The key point of the presentation was that identification of atypical lesions and subsequent referral where necessary was an important aspect of their role.

Keith Cutting Msc, RGN, Cert Ed (FE) Health Directions tissue viability and clinical research consultancy gave a fascinating and detailed presentation on the importance of biofilms in chronic wounds. Keith brought the delegates up to date with current thinking in both scientific and clinical communities on biofilm research.

Ally Lister presented on the Speyside Leg Club. Ally originally presented on the Leg Club 4 years ago when it was in its infancy. The advances which have been made in the last 4 years have been tremendous. It was evident from Ally’s presentation that the members really value having a Leg Club in their community. Additionally, Ally presented an extensive audit looking at many aspects of care including demographics, time to heal and the steady increase of referrals from GP colleagues.

The afternoon session was opened and chaired by LUF Chair Janice Bianchi

Kim Neill TVN NHS Ayrshire and Arran presented case studies on two patients with unusual presentations. Kim highlighted that detailed assessment often needed to ensure we reach the correct diagnosis.

Margaret Armitage gave a second presentation. This was originally presented at the Wounds UK conference in Harrogate 2010. It was identified that there was a lack of consistency in the care of patients with compression therapy leg ulcers who were admitted to hospital with other conditions. A working group was established to attempt to standardise care. Margaret described the algorithm which was produced by the group to assist nurses in decision making.

Celia Macaskill Nurse Specialist in Dermatology Liaison Nurse NHS GGC was our final speaker. Celia focussed on recognition and treatment of fungal infection. The presentation gave an in-depth and informative talk on fungal disease looking at the types of dermatophyte which affect the body particularly the lower leg and feet. The aim of the talk was to raise awareness of these conditions, be aware of differential diagnosis and update the group on treatments.
As the chairperson of the Irish Leg Ulcer Forum it was my pleasure to provide the opening address for this year’s conference entitled *From Challenge to Satisfaction*, held on 14th April 2011 in the Seagoe Hotel, Portadown, N Ireland.

At a time of financial constraints and widespread cutbacks, in particular in relation to releasing staff to attend conferences it was with excitement and anticipation that I welcomed 160 delegates from all parts of Ireland to this meeting. The organisation of the conference involved many phone calls, emails and numerous meetings of our committee which comprises tissue viability and dermatology nurses, a podiatrist and a consultant dermatologist from both North and Southern Ireland. On the day as the delegates and exhibitors arrived the time and effort involved in preparation for the conference became a distant memory, everybody seemed to interact with great anticipation and enthusiasm.

The aim of our day was to provide up-to-date evidence-based education on leg ulcer management, gain new understanding and knowledge on the appropriate use of wound dressings and to look at issues surrounding wound infection and the use of antimicrobials.

The morning was dedicated to leg ulcer management and dermatology, with the afternoon concentrating on wound infection and the appropriate use of antimicrobial dressings. Our first speaker was our president Professor Christine Moffett, CBE who gave an informative, comprehensive and thought-provoking presentation on *Differential Diagnosis and Mixed Aetiology Leg Ulcers*. We then had the pleasure of a presentation highlighting the importance of diagnosing the aetiology of leg ulcers before treatment initiated by one of our next conference will be in March 2012 venue and date to be confirmed.

Finally, as I take over as chair of Leg Ulcer Forum Scotland I would like to take the time to thank Gerry Young for all her hard work, dedication and enthusiasm as chair over the past 2 years...
our committee members Dr Nabla McLoone who provided a visual, concise, yet in-depth presentation on *Atypical Leg Ulceration*. The STEPS process on selection of the new Northern Ireland Dressing Formulary was the final presentation of the morning, presented by myself.

The afternoon kicked off with Mrs Elaine Porter a Biomedical Scientist providing a practical presentation on *Meet the Microbes* covering the various bacteria that are associated with wound infection. This was a very ‘hands-on session’ with delegates having the opportunity to view the various bacteria in petri dishes during the conference exhibition. Professor Valerie Edward-Jones continued the theme, with an interesting presentation on the appropriate use of topical antimicrobial dressings on both chronic and acute wounds. The topics selected were in response to previous comments and feedback from other education sessions held by the All Ireland Leg Ulcer Forum. The format of the day proved successful with generally positive feedback from the delegates.

Our day was chaired by our treasure Mrs Heather Ogle who coordinated events and kept everybody to time ensuring that the conference ran smoothly. Finally our past chairperson Mrs Norma Brennan gave our closing remarks and in doing so summed up the highlights of what was probably one of our most relaxed informal, yet successful conferences. We are grateful to the sponsors who helped make the day possible. The company exhibitions provided an opportunity for delegates to get to know new products. One of the sponsors summed the day up as “positive and relaxed” which was a great compliment as we begin the journey of preparation for our next conference in 2013.
Notices

Prestigious Award

In July of this year the Higher Education Academy announced 55 new National Teaching Fellows. This is a most prestigious award for excellence in higher education and support for learning. The winners were chosen from 200 nominations submitted by higher education institutions across England, Northern Ireland and Wales.

One of the people to receive this award was Irene Anderson. Although most of you will just know her as the Chair of the Leg Ulcer Forum, she is in fact a very busy person and manages to balance her (very busy) family life, with that of Lecturer and Reader in Learning and Teaching in Health Care Practice at the University of Hertfordshire.

Many of you will have read her numerous articles, regularly printed in the nursing press. But you may not know that she has also run training courses in Romania, been a reviewer for the SIGN leg ulcer guidelines (2010), as well as having managed the Change Academy for Blended Learning Enhancement (CABLE) project 2006-2010 at the University of Herts. This involved leading over 100 staff and 25 students transforming learning and teaching practice in a variety of disciplines across the University of Herts but she was also instrumental in winning the bid to disseminate these techniques in support of other institutions instigating change.

I am sure that you will want to join the members of the Executive Committee in congratulating Irene for being given this award in recognition of all the excellent and inspiring work she has done.

Membership Fee

Please note that from the 1 September 2011 the membership fee will increase to £20.

The membership fee has not been increased for many years, but members at the AGM this year voted for this inevitable increase to reflect the costs of running educational events and producing high quality educational materials. Annual membership includes this journal, access to a community of practitioners engaged in the care of people with leg ulceration and related conditions. Membership also means access to the member’s only section of the website, all the educational resources and huge discounts at our educational events.

Industry sponsors are also welcome: please contact us for details at legulcerforum@btinternet.com
Conference prize winners

Sheffield

Helen Winsom

Simon Barret with Brenda King

Newport Pagnell

Irene Anderson with Annette Downe and Lesley Lever

Lesley Whittle with Judy Harker
I am proof that retirement is not necessarily what you think it will be.
I am an 84 year old retired man. In my previous life I worked as a chartered accountant who tried to balance a sedentary job with active leisure (tennis, golf, walking, and gardening).

My mobility started to become impaired in my late 60’s and at age 72 I underwent neuro-surgery to correct an arterio-venous malfunction which had caused damage to the thoracic area (T4) of the spinal cord; thus affecting function and sensation below waist level (I could tread on one foot with the other and not realise it). Before I had leg ulceration I had regained sufficient mobility with crutches to spend sessions working in the remote areas of my 200 foot garden on a chair and to walk from the parked car into a shop or a restaurant. I self catheterise four times a day and am subject to urinary tract infections requiring antibiotic treatment (avoiding penicillin – to which I am allergic). During adult life there have been outbreaks of eczema. So I came to the leg ulcer scene with a certain amount of baggage – but with one big advantage – I feel little pain in the legs.

During the spring/summer of 2008 an ulcer manifested itself on the inside of my left foot – at a place where that foot rests on the right foot whilst sleeping. I was dressed by the practice nurses at my GP surgery until mid August (2008), when a further ulcer erupted on the lower inside of the left shin. Thereafter heavy exudation demanded daily dressings. A Doppler reading carried out by the leg ulcer service revealed a venous duplex scan (left leg) in the October and an angiogram MRI scan. Then in November ultrasound venous mapping of the right leg an echo cardiogram in December and a angioplasty procedure on the left leg in the New Year (2009). Also during July to December 2008 I required ten courses of antibiotics for repeated infection of the left leg or UTIs, and three days of IV antibiotic therapy in my local general hospital. The left leg was dressed every day during the first three months of 2009 again due to considerable levels of exudates and slough; reducing to three times a week in April and May. Then in February – at the behest of the leg ulcer service – larvae bags were applied to both ulcerated areas. Although it was a smelly experience, they did the trick and cleaned the wounds during the 14 day application. During this period I became a ‘celebrity’ with district nurses attending in pairs to gain experience! One nurse, on a study course at Hatfield University, planned to write her thesis about my leg – now there’s a claim to fame for you! At the end of June deterioration in my general health required a ten day session in my local general hospital. Then in mid August the leg ulcer clinic started four layer pressure bandaging and that has continued to date with, according to the condition of the leg ulcers, occasional mid week bandaging by a district nurse.

2010 seems to have flown by with weekly visit to the leg ulcer clinic where the specialist nurse has pursued various avenues, sought advice when appropriate, referred back to the vascular clinic when needed and generally risen to the challenge that this wretched leg of mine has thrown at them. Mid week visits by the district nurses have continued when necessary. In 2011, I contracted a fungal infection between and under the toes of the left foot, which has required additional dressings between weekly leg ulcer clinic visits. At present we appear to be winning (I hope I am not tempting fate) – and I look forward to cracking open a bottle of bubbly come the day we move onto a compression stocking!

My natural philosophy is that my cup is half full – not half empty. My experience from the spinal operation is to be positive and to concentrate on what you can do – not to dwell on what you can’t. The leg ulcer has been a serious interruption into my rehabilitation and I hope to return to progress on that front real soon. But then, I am the eternal optimist!!

Tony Thorn
Nursing Notes – Specialist Nurse

- 1994 arteriovenous malformation of spine causing paraplegia.

- Left leg ulcer developed June 2008

- Referred to local leg ulcer clinic by district nurses and assessed 18 August 2008. Circumferential left leg ulceration by this point. Doppler 0.44 left leg so we referred him to the local vascular surgeon for arterial assessment. Leg was dressed by district nurses in the interim. Seen by vascular surgeon – MR angiogram arranged and results showed left femoral artery stenosis and some stenosis to right. Venous scan clear.

- Left angioplasty only performed 9 December 2008 as the left leg was the one with the ulcer and the right was asymptomatic at that time. Vascular surgeon reviewed post angioplasty but left ABPI was still only 0.58 so compression still not commenced at that point.

- Ulcer completely covered in devitalised tissue and not responding to appropriate desloughing agents so larval therapy introduced 17 February 2009 with good results.

- Seen again by vascular surgeon April 2009 and plan was to refer to plastics for skin graft when wound bed ‘adequately granulated’ and leg still not sufficiently perfused for compression at this point.

- Another vascular review 4 August 2009 Registrar happy for us to Doppler with a view to introducing some compression to left leg (no venous problems identified on duplex scan but fixed ankle and inactive calf muscle pump due to paraplegia resulting in lower limb oedema).

- 12 August 2009 left ABPI increased to 0.65 therefore reduced compression commenced – wool, crepe and layer 4 cohesive bandage (ankle actually greater than 25cm after padding so the 3 layer bandage was giving very reduced compression at that point) to see how tolerated.

- Increased to 4 layer bandage 26 August 2009 as well tolerated but 4 layer bandage giving reduced compression to his large ankle.

- Discharged by vascular team 17 February 2010 as ulcer progressing well.

- Re-referred 17 November 2010 due to slow healing of ulcer and new ulcerated area on big toe which deteriorated to all toes and wet foot.

- Doppler reading to left leg of 0.76 and vascular surgeons still happy for us to continue with reduced compression, foot x-ray indicated no osteomyelitis.

- Podiatrist felt that there was no fungal infection therefore toes treated with antimicrobial dressings and moisturising cream.

- August 2011 nearly healed (difficult due to dependency oedema)

- 25 August 2011 ulcer healed.

- Latest Doppler results ABPI left leg 0.75 and about to go into compression hosiery to reduce risk of recurrence.

Psychological assessment

This patient always had a positive attitude and was very open to all our suggestions re treatments. He also has a very supportive family. Despite his complex medical problems and setbacks he has always remained cheerful and expressed appreciation for the leg ulcer service. I am sure his concordance and positive approach has contributed to eventual healing.

“My natural philosophy is that my cup is half full – not half empty.”
Interview
Caroline Dowsett
Susan Knight

Did you always want to be a nurse?
No. I wanted to be an air hostess but my teachers talked me out of it.

Do you have any particular memories from your nurse training?
Some great ones; being with new people and learning new skills. Some not so good ones: cleaning bed pans and hiding in the linen cupboard from a very difficult ward sister.

How did you start in the community?
Recruited by a very charming discharge liaison nurse. I had been a ward sister on a vascular ward for 4 years and was ready for a change.

Can you remember your first leg ulcer patient?
I remember the first venous leg ulcer that I put compression bandaging on. The vascular surgeon handed me 4 bandages and a set of instructions!!!

We now have a number of different bandage systems for patients and staff to choose from. Why do you think that many areas seem to choose just one system?
I am not so sure that they do anymore. In Newham we use hosiery kits, 4 layer, short stretch and 2 layer. I think many areas are starting to change. Patient choice is high on the agenda so I have no doubt we will have to move forward if we are to survive.

Why did you join the Leg Ulcer Forum?
My interest and passion has always been to improve care for leg ulcer patients. I was on the LUF committee executive for a number of years and editor of the journal. This brought a lot of ideas and good practice back into my clinical area. It was a pleasure to be part of the group.

Did being a member of the Leg Ulcer Forum give you the opportunity to do something that you otherwise might not have been able to do?
Networking locally and nationally always brings a fresh perspective and being a member gives you information and support to change and develop leg ulcer services.

Having been on the executive committee do you have any views on the direction we should be taking?
Supporting new clinical leads that are at times struggling to get services up and running. Supporting initiatives that promote patient choice.

What are you most proud of in your professional career?
Completing my PhD at City University and my Queens Nursing Institute award for outstanding service. SK
Advances in technology over the last ten years have allowed for greater choice of compression therapy. Leg ulcer services need to provide up-to-date, high quality services that ensure safety, effectiveness and improvements to the patient experience. This includes monitoring and reporting on leg ulcer healing rates and prevention of recurrence. This paper discusses a redesign in a community leg ulcer service, including the introduction of RAL compression hosiery. Healing rates improved from 36% at 12 weeks to 72%, and from 40% at 24 weeks to 100%. Recurrence rates for venous leg ulcers also reduced from 18–20% to 5.8%.

Leg ulceration affects approximately 580,000 individuals at any one time in the UK, causing increased morbidity and reduced quality of life (Callam et al, 1985; Moffatt et al, 1992). As well as associated patient costs such as pain and suffering, the cost to the NHS is between £300–600 per annum (Bosanquet, 1992; Simon and McCollum, 2004). The majority of these ulcers are of venous origin, requiring an average of 24 weeks to heal; approximately 15% never heal and recurrence is found once or multiple times in 15–71% of cases (Kurz et al, 1999).

Venous leg ulcers are the most common leg ulcer aetiology and are the result of a complex chain of events resulting from venous valvular incompetence and subsequent superficial venous hypertension (Chen and Rogers, 2007). Over half of venous ulcers are due to slowly progressive primary reflux disease that begins as varicose veins, and the remaining ulcers develop after deep vein thrombosis (DVT) and are prone to advance more rapidly to the ulcer stage in periods from six months to several years post DVT (Kistner, 2010). Venous disease is progressive and recurrent ulceration is frequently accompanied by new venous pathology, such as the development of new varicosities, new locations of reflux, or new incompetent perforating veins.

Compression therapy is the core intervention in venous leg ulcer treatment (Cullum et al, 2006). Reported healing rates of venous leg ulcers treated with compression therapy vary greatly, from 37–46% at 12 weeks and 55–68% at 24 weeks (Iglesias et al, 2004). The majority of these patients, up to 80%, are cared for in the community setting by community nurses and/or their general practitioner (Moffatt et al, 1992). Many patients are cared for in nurse-led community leg ulcer clinics, often organised by district nurses with specialist input from tissue viability or leg ulcer specialists. With recent improvements in venous ulcer services, such as the availability of tissue viability and leg ulcer specialist nurses, more patients have their ulcers healed in a timely manner and the challenge is to prevent recurrence. In some areas, prevention or well-leg clinics have been established that focus solely on health promotion and prevention of recurrence of leg ulceration (Dowsett, 2010).

**Leg ulcer services**

Many parts of the UK have followed a model of leg ulcer care based on ‘nurse-led’ community leg ulcer clinics. Rates of healing of venous leg ulcers have been shown to improve, with costs reduced when a coordinated service has been
introduced (Moffatt et al, 1992). However, these improvements are only sustainable with regular training and support from specialist services such as tissue viability and leg ulcer specialist nurses, and should be monitored and audited to ensure improved outcomes and improvements to service quality in line with current policy directives. Audit not only measures outcomes for patients, but can also identify areas where good practice or policy is not being adhered to (Vowden and Vowden, 2010).

The care of patients with venous leg ulcers has improved over the last ten years (Dowsett, 2010). Advances in technology have led to a greater choice in compression therapies. Bandages, hosiery kits and hosiery are now used in the treatment of venous leg ulcers. Early referral to leg ulcer services often means that the patient presents with a small leg ulcer and therefore compression hosiery kits or compression hosiery can be offered as a first treatment choice.

A recent meta-analysis of studies that compared a variety of bandages with specifically designed stockings for venous leg ulcer management, found that stockings were easier to use and that patients using stockings experienced less pain (Amsler et al, 2009). Additionally, a greater proportion of ulcers healed in patients treated with stockings than in those treated with bandages (62.7% versus 46.6%; P<0.01). The average time to healing (seven studies, 535 patients) was three weeks shorter with stockings (p=0.001) than with bandages (Amsler et al, 2010).

Patients are more likely to comply with compression therapy that is easy to use and reduces pain and discomfort. Developments in hosiery, such as improvements to fabric, range of available sizes and colours have lead to improvements in patient concordance, with wearing hosiery leading to a reduction in recurrence rates. In a study that followed 113 patients over 15 years, ulcer healing was 97% in patients who adhered to treatment and 55% in those who did not. Mean time to ulcer healing was 5.3 months. Ulcer recurrence was 29% in five years. In the non-adherent group, all ulcers recurred at 36 months (Maybury et al, 1991).

Redesign of leg ulcer services

In Newham, four nurse-led community leg ulcer clinics were set up in 1996, resulting in improvements to the management of patients with venous leg ulcers (Dowsett, 1997). Following the success of the leg ulcer clinics, three additional well-leg clinics aimed at preventing recurrence of venous leg ulceration were established. These clinics were organised and run by the community nursing service with specialist input from the tissue viability team. Over time, variations in practice were noted across the localities and some clinics appeared to have better patient outcomes than others.

A comparative audit of the leg ulcer clinics for 2007 and 2008 showed that care was not consistent across the localities and aspects of best practice were not being sustained. Nurses were failing to measure ankle circumferences that determined the amount of compression to be used, and many patients did not have up-to-date Doppler readings. Patients reported varying levels of satisfaction depending on which clinic they attended. Following the audit a business case for change was proposed by the tissue viability service, including the appointment of two dedicated leg ulcer coordinators from the community nursing service who would take sole

### Table 1: Compression hosiery pressures

<table>
<thead>
<tr>
<th>Title</th>
<th>Available</th>
<th>Strength</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support hosiery</td>
<td>Retail shops</td>
<td>Less than 10mmHg</td>
<td>Non-medical</td>
</tr>
<tr>
<td>Anti-embolism stockings</td>
<td>Hospitals for DVT prophylaxis</td>
<td>16-18mmHg</td>
<td>For patients, pre, peri and post surgery</td>
</tr>
<tr>
<td>Travel socks</td>
<td>Over the counter</td>
<td>20mmHg</td>
<td>For travel on planes, trains, car</td>
</tr>
<tr>
<td>British standard hosiery</td>
<td>FP 10 prescription</td>
<td>Class 1 14-17mmHg</td>
<td>Clinically effective for up to three months, four sizes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Class 2 18-24mmHg</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Class 3 25-35mmHg</td>
<td></td>
</tr>
<tr>
<td>RAL standard hosiery</td>
<td>Only available from hospital appliances in the past</td>
<td>Class 1 18-21mmHg</td>
<td>• Clinically effective for up to six months</td>
</tr>
<tr>
<td></td>
<td>Now available on FP10</td>
<td>Class 2 23-32mmHg</td>
<td>• Seven off-the-shelf sizes as well as custom-made</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Class 3 34-46mmHg</td>
<td>• Comprehensive range of styles and colours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Class 4 over 49mmHg</td>
<td>• Upper and lower limb garments</td>
</tr>
</tbody>
</table>
responsibility for the nurse-led leg ulcer clinics and the well-leg clinics. Following approval, the two coordinators worked alongside the two clinical nurse specialists in tissue viability to drive up quality and improve outcomes in the leg ulcer treatment and prevention clinics.

A number of service developments followed, including:

- Education and training of the leg ulcer coordinators
- Increased use of hosiery kits for treatment of venous leg ulcers
- A move to using RAL compression hosiery in the prevention of recurrence of venous leg ulceration.

Traditionally, British class hosiery has been used in community leg ulcer clinics, as this was available on prescription (FP10). However, the levels of compression vary significantly from RAL hosiery (Table 1) which is now available on FP10. Additionally, RAL offers more available sizes and has an extra wide calf size.

It should be noted that some centres refer to ‘European’ class hosiery, but this does not exist as a recognised classification.

**Patient outcomes and efficiency gains**

Recurrence rates in the nurse-led clinics before the changes were between 18–20%. Some of this was in part due to patients not wearing their hosiery because of poor fitting, discomfort and a general lack of concordance. Many patients failed to attend follow-up prevention appointments. The effectiveness of compression hosiery is due to correct fit, pressure generated beneath the stocking and, of course, relies on the patient wearing their stockings. The following benefits of using RAL hosiery have been seen by the leg ulcer clinics:

- Patients get a higher level of compression and are therefore more likely to remain healed
- They have more choice of size with extra wide calf and shoe size available
- They are reviewed every six months instead of three months, as the hosiery lasts for six months This has lead to increased productivity in that more patients can be seen in the clinic as less frequent visits free up time for new patients
- The cost has decreased as each patient requires less nursing time and the hosiery lasts for six months instead of the previous three months
- Patients now attend routine follow-up appointments
- ‘Regular monitoring of healing and recurrence rates through audit and patient satisfaction surveys is important for advancing practice, and also for identifying those patients who are not healing in a timely fashion.’

More importantly, the feedback from the patients has been positive. Patients report a better fit, ease of application and they are more likely to be concordant with treatment. In terms of outcomes, the recurrence rates have been reduced from 18-20% down to 5.8% for the period April-September 2010.

The leg ulcer coordinators report that they have had to request less made-to-measure hosiery, as the increased availability of sizes means that many patients who have had made-to-measure in the past now fit in sizes available on FP10. To ensure that patients receive their compression hosiery in a timely manner, the clinics carry a stock of RAL hosiery. Patients are measured, fitted and have their hosiery applied and they replace the stock on the first review visit.

As well as improving recurrence rates for venous leg ulcers, the service redesign has also impacted on the management of those patients with active leg ulcers. Care across the four localities shows an improvement in continuity and consistency in practice. A re-audit of best practice in the clinics shows an increase in the number of patients with

**Key points**

- It is important to demonstrate quality outcomes in venous leg ulcer management as part of the QIPP agenda.
- Audit can make a valuable contribution to re-design of leg ulcer services.
- RAL compression hosiery is effective in the treatment and prevention of venous leg ulcers and can improve recurrence rates of venous leg ulcers.
- As clinicians we need to be constantly looking at innovative ways to achieved clinically and cost-effective patient-centred care.
full leg ulcer assessments, measurement of ankle circumference, current ankle brachial pressure index (ABPI) readings, wound measurement taken, and up-to-date care plans. Data comparison for 2009/10 is outlined in Fig 1.

Patient treatment outcomes have also improved, with healing rates for venous leg ulcers improving from 36% at 12 weeks to 72%, and from 40% at 24 weeks to 100% for 2010. Patient reported satisfaction has also improved, with patients feeling that they are now receiving greater continuity in their care.

Conclusion
In the current healthcare climate, it is important to demonstrate how services are driving up quality, increasing productivity and increasing patient satisfaction (Dowsett and White, 2010). The three domains of quality are safety, effectiveness and patient experience and this service redesign has addressed the quality agenda and demonstrated that taking a different approach to the delivery of leg ulcer care can significantly improve patient outcomes and their experience. However, as clinicians, we need to be constantly looking at innovative ways of achieving clinically and cost-effective patient-centred care. While many patients have benefited from this service development, there are still those patients who do not heal in compression and need to be managed outside of the nurse-led community leg ulcer clinic model in more specialist areas.

Regular monitoring of healing and recurrence rates through audit and patient satisfaction surveys is important for advancing practice, and also for identifying those patients who are not healing in a timely fashion. These patients can be referred to specialist clinics where they can be considered for further investigations, surgery, advanced products such as skin substitutes, or other biological agents that are not always available in the community leg ulcer clinics.

Acknowledgements
This paper has been sponsored by an educational grant from medi UK and is based on a symposia presentation at the Wounds UK Conference in November 2010.


References

Fig 1: Leg ulcer clinic data comparisons 2009/10
Cellulitis is a spreading bacterial infection of the dermis and subcutaneous tissues. It occurs when bacteria are able to breach the skin’s defences and enter the underlying tissues. The most common bacteria are Streptococcus or Staphylococcus Aureus; however a wide range of other aerobic and anaerobic bacteria can cause cellulitis (Clinical Research Efficiency Support Team, CREST 2005). Patients with leg ulceration, dermatitis or lymphoedema of the lower limb are particularly at risk due to a loss of skin integrity (because of breaks in their skin). Nurses involved in leg ulcer care are therefore ideally placed for early recognition of the condition which should lead to more effective, timely treatment. The Lower Limb Service (LLS) in Greenwich Community Services directorate of Oxleas NHS Foundation Trust has been developed to prevent and attempt to avoid hospital admissions for people who are able to receive treatment for cellulitis of the lower limb at home or in a community hospital bed. This article aims to discuss the pathway for patients with cellulitis of the lower limb and how an unnecessary hospital admission can be avoided through collaborative working practices.

Recognition
Cellulitis of the lower limb can be identified by erythema (redness), heat, pain and swelling of (usually) one leg. The patient may have flu-like symptoms and will feel unwell and feverish with possible rigors. The area of erythema will have had a sudden onset with rapid spreading of the area involved and will be tender to touch. The area affected will be well demarcated and blistering may be present with possible leakage of serous exudate from the swollen limb, causing risk of maceration and possible ulceration. (CREST, 2005). The entry site of the infection may not be obvious, but tinea pedis, insect bites or any minor injuries may act as a portal of entry, as will leg ulcers and pre-existing skin conditions (eczema / psoriasis). The patient’s white cell count and C-reactive protein levels will be markedly raised as the numbers of white cells, especially neutrophils, increases when a clinical infection is present; C-reactive protein levels in the blood rise when an area of soft tissue is inflamed or infection is present (Beldon 2011).

Classification of cellulitis
(Eron, 2000 cited in CREST, 2005)
Cellulitis can be classified into 4 categories:

Class 1
No signs of systemic toxicity
No uncontrolled co-morbidities (see box 1)
Class 1 usually managed with oral antibiotics as an out-patient.

Class 2
Systemically ill
or
Systemically well but with co-morbidities (see box 1)
Class 2 can be managed by Intravenous (IV) antibiotics in the community.

Class 3
Significant systemic upset eg acute confusion, tachycardia, tachypnoea, hypotension
Unstable co-morbidities that may interfere with response to therapy
Limb threatening infection due to vascular compromise

Box 1: Co-morbidities
Peripheral vascular disease (PVD)
chronic venous hypertension
venous incompetence
lower limb ischaemia
cardiac disease
morbid obesity which may complicate or delay resolution of infection.
Immunosuppressed patients
Diabetes
Renal failure

Alison Beasley
Lead Clinician
Integrated Complex Wound Care Team
Oxleas NHS Foundation Trust, Greenwich Community Directorate
Class 3 requires hospital admission for IV antibiotics.

**Class 4**

Sepsis syndrome (a complex systemic inflammatory condition associated with infection)

Severe life-threatening infection eg necrotising fasciitis

Class 4 requires urgent hospital admission for intensive multiple therapy.

Utilising the classification system is the first task in the pathway as this will assist in the decision of where the patient will be treated. It is important to ensure that all those involved in care of these patients are trained in recognition of cellulitis and the same classification system.

**Avoiding hospital admissions.**

Hospital admission is very costly both financially and for the patient in terms of risk of Hospital Acquired Infection, the complications of reduced immobility and forced dependence. It is therefore

<table>
<thead>
<tr>
<th>Table 1: Intervention results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Where is the intervention?</strong></td>
</tr>
</tbody>
</table>
| Ambulance service | • Pathway to direct crew to LLS if class 1 or 2  
• Easy access to LLS available with emergency phone number  
• Intermediate care centre beds available  
• Community Nursing staff able to administer IV antibiotics | • Patient monitored at home  
• Patient admitted to intermediate care bed | Yes  
Acute admission avoided |
| GP | Information about:  
• referral criteria  
• referral process  
• patient information  
• clinic availability | • Patient monitored at home  
• Patient admitted to intermediate care bed | Yes  
Acute admission avoided |
| Urgent Care Centre (UCC) | • Practitioner based within UCC to provide immediate advice and treatment for patients for class 1 & 2 cellulitis | • Patient monitored at home  
• Patient admitted to intermediate care bed | Yes  
Acute admission avoided |
| A&E Dept | • Practitioner carrying bleep able to respond within 45mins  
• Advanced practitioner able to cannulate and provide immediate advice and treatment for patients for class 1 & 2 cellulitis | • Patient able to go home  
• Patient monitored at home  
• Patient admitted to intermediate care bed | Yes  
Yes  
Acute admission avoided |
| AMU | • Healthcare Professional (HCP) attending daily Multi-disciplinary team (MDT) ward meeting to facilitate discharge | • Patient able to return home at earlier date | Early discharge facilitated |
| Wards | • HCP to visit wards on regular basis to follow up patients with class 3 & 4 cellulitis | • Patient able to return home at earlier date | Early discharge facilitated |
The management of cellulitis of the lower limb (continued)

cost effective for community trusts and for busy acute hospitals who are trying to manage their beds effectively to adopt a system which will facilitate admission avoidance as well as early discharge.

There are various points throughout the patient pathway where it is possible to intervene and provide an alternative route from one which requires hospitalisation (see Table 1)

Management

Once the patient has been admitted into the appropriate service healthcare practitioners are advised to identify the extent of the cellulitis with an indelible marker pen and to measure the limb circumference so that any deterioration or improvement can be noted. They are advised to elevate the affected limb to reduce oedema and to take regular analgesia (CREST, 2005).

Hydration is also important and patients should be encouraged to drink more than they normally do and to check that their urine is straw-like in colour (Ellins, 2006). Pyrexia can be monitored but this may be masked in elderly patients as they do not respond to inflammatory markers as younger patients do (Roghmann et al., 2001).

Utilising the HAMMMER acronym (Beasley, 2010) provides an aide-memoire for both patients and health professionals. Any deterioration should then be detected early and if necessary enhanced therapy can be provided.

H ydrate: drink plenty of fluids – more than you usually do
A nalgesia: take pain relief on a regular basis
M onitor pyrexia: temperature still going up?
M ark off area: redness spreading?
M easure circumference of limb: is the leg increasing in size?
E levate limb: reduce swelling if possible
R ecord site: accurate documentation

Follow up

Patients are then seen after one week to ensure that the acute cellulitis has resolved. Patients are reassured that oedema and erythema may continue for some time after the infection has been treated but that regular skin care with emollients, and possibly moderate strength topical steroids twice a day, can help to improve the condition of the skin. Compression therapy with hosiery or bandages to reduce the oedema may also be commenced but only after a thorough vascular assessment including calculation of Ankle Brachial Pressure Index (ABPI) to rule out any significant arterial disease and only if the pain of the cellulitis has resolved and the patient is able to tolerate the pressure from the compression therapy (Stalbow, 2004). Calf and ankle exercises are taught to encourage venous return and so reduce the oedema.

Cellulitis of the lower limb, similar to chronic leg ulceration can prevent people from leaving their homes or from interacting with others (Brown,
In Greenwich our patients are invited to attend the Leg Excellence in Greenwich Group (an educational group which promotes self care and early recognition of cellulitis) so that they can meet others and gain some support from those with the same condition.

**Conclusion**

Cellulitis of the lower limb is a debilitating condition which can affect anyone but especially vulnerable are those with leg ulcers, dermatitis and lymphoedema (British Lymphology Society, 2010). It is important to recognise the signs and symptoms of cellulitis so that other conditions can be ruled out and appropriate antibiotic therapy commenced as soon as possible. Attempting to avoid hospital admission can prove both cost effective for the NHS but also of benefit to patients who can maintain their independence. The HAMMMER acronym can be helpful in monitoring the patient, ensuring deterioration is detected early while assisting in making the patient more comfortable, allowing a swift resolution of the infection. The involvement of specialist practitioners who are able to administer IV antibiotics as well as monitor progress/signs of deterioration and who can promote ankle exercises, skin care and management of oedema could contribute to reduction in the risk of recurrence (Nazarko, 2008). Patients can receive ongoing support and health education in the ‘drop in’ clinics.

**References**


A new model of care – a case study

Kim Neill

A new model of care was developed and piloted in Ayr, Troon and Prestwick, Ayrshire to improve healing and recurrence rates for patients with chronic leg ulcers. Key features included direct referral of leg ulcer patients by any practitioner to the leg ulcer service Specialist Nurses, who were linked to a vascular unit, providing structured, evidence-based patient focussed care plus a structured secondary prevention programme. Between May 2003 and April 2004 inclusive there were 170 patients referred to the leg ulcer service. 130 patients had predominantly venous ulcers (16 bilateral). Healing rates for the 146 ulcerated legs was 85% at 12 weeks and 95% at 26 weeks. Recurrence between 12-24 months post healing was 8%.

The following case study was part of the original pilot. It was selected to illustrate the principles of the new model of care and how the role of the leg ulcer specialist nurse within a dedicated service, working with the backup of a vascular unit, can benefit patient outcomes.

Case study
The patient, Mrs Smith was a 68 year-old retired housewife referred by the Practice Nurse to the leg ulcer service with an ulcer on the dorsum of the left foot. The ulcer was a first episode and had been present for four years. During that time she had attended the Practice Nurse interspersed with periods of self treatment and was treated with a variety of wound care products. Mrs Smith was active and independent and helped her daughter, who works, with the care of two primary school age grandchildren.

Assessment
The aim of assessment is to carry out an holistic assessment using a structured evidence-based tool in accordance with national Guidelines (SIGN 120, 2010) in order to

• provide baseline information
• aid diagnosis
• plan appropriate treatment
• enable progress to be monitored
• meet NMC record keeping guidance for nurses and midwives (2010)

SIGN120 (2010) recommends assessment is carried out systematically looking at the patient, limb and ulcer.

Assessing the patient
Past medical history
Nil of note
Smoker
Parity 2+0
BMI normal

Social factors
lives alone but helps to look after her two grandchildren who live locally

Other investigations
FBC, U/E, LFT, Glucose and Cholesterol within normal range
Nutritional screening: good appetite, BMI normal
Pulse and blood pressure normal
Venous duplex scanning was arranged

Assessing the limb
Fully mobile and active
Unrestricted ankle movement
No history of DVT, lower leg fracture, limb surgery
No night or rest pain or intermittent claudication

Kim Neill and Kathleen Turnbull currently work as Clinical Nurse Specialists in Tissue Viability, NHS Ayrshire and Arran. Prior to their current post, Kim and Kathleen ran a specialist Leg Ulcer Service for eight years in South Ayrshire.
This is one of two case studies that were presented by Kim Neill at the Leg Ulcer Forum, Scotland, Annual Education Event at the Campanile Hotel in Glasgow, March, 2011.
Ankle Brachial Pressure Index (ABPI):
Right leg 0.88 Left leg 1.00 Pulse sounds biphasic

Ankle circumference:
Measured to ensure selection of the appropriate bandage combination (Moffatt, 2007)

Leg appearance at initial assessment

Left leg appearance
mildly oedematous
moderate lipodermatosclerosis
mild ankle flare
no obvious varicose veins

Right leg appearance
nil of note

Assessing the ulcer
The ulcer was photographed and traced to provide a reliable index of progress.

A clinical description of the base and edge of the ulcer, surrounding skin, position of the ulcer, exudate levels, presence of odour, signs of infection and oedema were recorded in the wound care documentation at the initial assessment and at subsequent dressing changes. Pain levels were assessed but were not reported by the patient as problematic.

Assessment outcome
The assessment outcome indicated a venous aetiology and following agreement with the patient treatment commenced using an elastic multi-layer bandage system with initial dressing changes twice weekly reducing to once a week. The primary dressing consisted of Viscopaste™ bandage applied in strips over the ulcer with additional wound padding. According to Eagle (1999) paste bandages work particularly well under compression meeting many of the criteria of an ideal dressing for moist wound healing, with the added ability to absorb exudate and separate slough. The surrounding skin was treated with a simple emollient. Treatment was well tolerated and Mrs Smith remained under the care of the Nurse Specialists until healing was achieved at 14 weeks.

Outcome of treatment
Bilateral venous duplex scanning was carried out at the vascular unit and confirmed the venous aetiology, reporting a superficial venous incompetence. Mrs Smith was reviewed by the Vascular Consultant at the same appointment and was subsequently scheduled for varicose vein surgery. On healing at 14 weeks the patient was measured and then fitted with Class 2 compression hosiery. Daily skin care with an emollient and hosiery concordance was established supported by regular review as part of a structured secondary prevention programme and to date the ulcer has remained healed.

Discussion
It is more common to find arterial ulcers on the toes, dorsum of foot and heel (Buchan 2008). Venous ulcers usually occur between the knee and the ankle joint (SIGN 120, 2010), but as demonstrated in this case study venous ulcers can occasionally present on the foot. Despite the atypical site of the ulcer, on presentation there were obvious clinical signs of venous disease present with no clinical signs of arterial disease. This was confirmed by carrying out the ABPI and subsequent duplex scanning highlighting the importance of a holistic evidence-based assessment in order to aid diagnosis and plan the appropriate treatment.
Of concern was the fact that the ulcer had been present for 4 years and Mrs Smith had never had an appropriate leg ulcer assessment. Patients are often denied treatment due to lack of specialist knowledge, with nurses quite rightly erring on the side of caution. However, this case study clearly demonstrates the results obtained when the patient was given the appropriate assessment and treatment and highlights the need to ensure patients are referred to the appropriate specialist at an early stage of management to allow for the optimal outcome to take place.

References


One of the most common forms of tissue loss in the United Kingdom is due to leg ulcers (Briggs and Closs, 2003). It has been reported that leg ulceration affects 0.15% of the population (Burton, 1994), with 0.11% - 0.18% receiving treatment for open leg ulcers (Callam et al, 1985). The impact of leg ulcers is often underestimated with many individuals living with chronic, non-healing leg ulcers for many, many years.

Leg ulceration is a common condition usually treated in the community but occasionally some patients need referral to a specialist centre for further management. The philosophy of the Complex Wound Clinic at Pilgrim Hospital, Boston, is to treat every patient as an individual, to involve them fully in their care and also to give them time not only to develop a rapport with the staff who are looking after them, but also to allow them to express their fears and ask questions as to the planned objectives and progress to date (Collier and Radley, 2005).

The aim of this clinical evaluation was to look at the impact of a new protease modulating dressing on static, non-healing leg ulcers. This article will briefly highlight the experiences of one patient in particular who was recruited to an initial evaluation of a protease modulating dressing and who was so pleased with the results achieved within the six week evaluation period that they requested to continue with the new product after the formal evaluation period was completed.

**Protease modulating dressings**

Protease modulating dressings are intended for use on both chronic and some acute wounds. This dressing type aims to normalise the wound micro-environment of hard to heal wounds by reducing excessive inflammation, and facilitating re-epithelialisation of the wound. Matrix metalloproteinase’s (MMPs) play an important role in both tissue matrix degradation and regeneration. Wound healing requires an appropriate distribution of MMPs within the wound environment. Protease modulating dressings have specific properties intended to optimise the wound environment by regulating the increased levels of moisture and acidity during the healing process – characteristics of problematic chronic wounds in particular.

**The Complex Wound Clinic**

- Developed in collaboration with the Clinical Nurse Specialist – Dermatology within an acute (secondary) healthcare setting
- Commenced April 2003
- Accepts referrals from doctors, nurses or other qualified healthcare professionals
- Patients with a variety of aetiologies seen
- Facilitates direct referral to Vascular Consultants by Lead Nurse
- Audits demonstrate that 92% of all referred patients have ‘improved’ since attending the Complex Wound Clinic (Health Related Quality of Life - HRQoL)
- Facilitates educational visits from home and abroad

**Aims of the service**

- To facilitate early discharge of patients
- To facilitate specialist outpatient care to prevent admission / readmission
- To enable optimum use of specialist resources
- To facilitate ongoing research studies
- To facilitate collaborative care and education of both patients and practitioners within all care settings
- To promote parity of service provision across ULHT
Example of a patient's experiences during the evaluation

Patient profile (SB)

- 43yr old female – co-owner of a family retail business (on her feet all day!)
- Wound/ulceration developed in February 2002 following the removal of an external fixator
- History of Lymphoedema
- Referred to Clinic by Surgical team
- Venous Leg Ulcer with a history of recurrent local infections
- Max dimensions – 20cm x 13cm, producing exudate
- Previous management – alginates, foam, various topical antimicrobials such as honey and a variety of secondary products including carbon based products, as SB was very aware of an offensive odour that could be associated with her wound (February 2002 to September 2007 when referred to the Complex Wound Clinic).
- Initial evaluation period – 24/11/08 to 12/01/09.

Figure 1 shows SB’s ulcer at week one, week four and on completion of initial evaluation period.

Following a comprehensive assessment process (Collier, 2003), the following primary treatment objectives were identified and agreed by both the patient and the tissue viability team lead.

1. Minimise the effects of the inflammatory process
2. Re-establish a balance within the wound margins
3. Manage exudate production
4. Protect surrounding ‘healthy’ skin
5. Minimise the risk of complications e.g. infection/maceration
6. Reduce associated symptomatology e.g. odour
7. Optimise the local wound-healing environment.
8. Optimise the patients healing potential

Referral criteria to the complex wound clinic

- Any patient with a chronic ‘non-healing’ wound, with a wound history of over six months
- ‘Specialist’ follow up after discharge from the acute care setting (improved bed utilisation)
- Maintenance of patients in community settings
- Patient’s recruited to/being followed up as part of a relevant research project - ethical approval
- To facilitate a one-stop patient referral process.

Methods

Initial evaluation of the dressing was over a six week period and involved SB who has a history of leg ulceration of six and half years duration. All relevant medical history was documented; written patient consent to take part in the evaluation and for weekly photographs was also obtained. Wound condition, exudate levels and type, and peri-wound condition were documented weekly alongside pain and wound dimensions at the Complex Wound Clinic. Whilst in the community, the dressings were changed daily and a dressing record sheet completed at each change.
Patient SB was referred to the Complex Wound Clinic due to the static nature of her ulcer (had been static for a minimum period of six months) and also as they she had become frustrated with the lack of progress that she had noticed, despite the best efforts of the District Nursing teams that were currently supervising her care. In addition, SB was aware of the research reputation of the Complex Wound Clinic and wished to avail herself of “anything that might help her wounds to heal”. Over the six week evaluation period, SB’s total wound surface area reduced by 37% and the wound depth reduced from 1cm deep to shallow. Exudate levels reduced from heavy to moderate over the evaluation period. As a result she expressed the wish to continue with the protease modulating dressing when the evaluation period ended. This request was facilitated for SB through discussions that involved the first author and the cooperation of the relevant District Nursing teams and her wound has continued to make significant improvements, not only in the appearance of the wound bed, but also in significant further reductions in total surface area; associated exudate production; the reports of associated odour production and the incidence of periodic infection.

The images opposite were both taken during the patients (SB) review visit to the Complex Wound Clinic on 18th April 2011.

Figure 2 illustrates the improved condition of the ulcer (very superficial – healthy wound bed) and also shows healing achieved to date.

Figure 3 illustrates a healthy wound bed with clear evidence of new granulation tissue present and stable signs of epithelialisation.

**Comment**

Leg ulceration can affect many things in the sufferer’s life, however when improvements in exudate levels and wound bed condition can be achieved, it can positively impact on an individual’s quality of life and the utilization of available healthcare resources. The author is currently undertaking a cost comparison of the specific costs of SB’s wound management between February 2002 to November 2008 and November 2008 to the present day.

**Conclusion**

This case is typical of many patients suffering with long standing ulceration of the lower limb in the UK. In this specific case, protease modulating dressings have shown that they can not only provide the right wound environment to improve the prognosis for this (and other similar) patients, but also they have stimulated the wound healing process much more significantly than a variety of other new products that have been trialled within the Complex Wound Clinic over a similar time period previously.

Without doubt, the tissue viability team working within the Complex Wound Clinic have been more impressed by this product type than any other that they have recently evaluated, in that it has shown more significant improvements in a short time frame when compared with other groups of wound management products. It should

### Summary of weekly evaluation record sheets

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Comfort</th>
<th>Pain</th>
<th>Wound State</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 x 13 cms</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>17 x 9 cms</td>
<td>Yes</td>
<td>No</td>
<td>Improving</td>
</tr>
<tr>
<td>17.5 x 9.5cm</td>
<td>Yes</td>
<td>No</td>
<td>Deteriorated</td>
</tr>
<tr>
<td>17 x 9 cms</td>
<td>Yes</td>
<td>No</td>
<td>Improving</td>
</tr>
<tr>
<td>16 x 8 cms</td>
<td>Yes</td>
<td>No</td>
<td>Improving</td>
</tr>
<tr>
<td>15 x 8 cms</td>
<td>Yes</td>
<td>No</td>
<td>Improving</td>
</tr>
<tr>
<td>14 x 8 cms</td>
<td>Yes</td>
<td>No</td>
<td>Improving</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exudate level</th>
<th>Exudate type</th>
<th>Surrounding skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heavy</td>
<td>Serous</td>
<td>Healthy (relative)</td>
</tr>
<tr>
<td>Heavy</td>
<td>Serous</td>
<td>Healthy</td>
</tr>
<tr>
<td>Heavy</td>
<td>Discoloured</td>
<td>Healthy</td>
</tr>
<tr>
<td>Heavy</td>
<td>Serous</td>
<td>Healthy</td>
</tr>
<tr>
<td>Moderate</td>
<td>Serous</td>
<td>Healthy</td>
</tr>
<tr>
<td>Moderate</td>
<td>Serous</td>
<td>Healthy</td>
</tr>
<tr>
<td>Moderate</td>
<td>Serous</td>
<td>Healthy</td>
</tr>
</tbody>
</table>
also be noted, that these improvements do appear to have been sustained over time and the tissue viability team are confident that SB’s wound will be healed within the next few months.

**Current on-going dressing regimen**

Following cleaning of the wound bed with normal saline (if required), the protease modulating dressing is then applied and is covered by a simple secondary dressing. All dressing products are now being changed just three times a week and the current exudate levels are noted as being low.

**References**

A multidisciplinary team in theory provides the best possible care for the patient; focusing the expertise of professionals from different fields onto the issues of the patient. At its root is the recognition that most health problems are multifactorial and the knowledge to address them is not held wholly in one field. The different knowledge the podiatrist brings to the wound care team is looking at the limb beyond the wound from a biomechanical viewpoint.

It is not possible to cover the full complexities of the physiological changes the lower limb undergoes on the path to ulceration in this article nor is it its remit. However in order to focus on the area specific to biomechanics a brief overview will be given.

The cost of venous ulceration in the UK reaches into the hundreds of millions in dressings and clinical time. This does not account for the hidden costs of lost work time, pain loss of mobility and the social and psychological impact of having such a wound. It has been shown that 72% of individuals with venous ulceration go on to re-ulcerate compared with 45% with non-venous ulcers (Nelzen, 1994). It is these recurrent and hard to heal ulcers that most benefit from a multidisciplinary approach.

It is recognized that venous leg ulceration is preceded by chronic venous insufficiency (CVI). As a disease it is defined as a ‘category of venous disease in which there are chronic pathologic changes in the skin and subcutaneous tissue of the lower leg’ (Ruckley et al 2002). It can be seen as a syndrome incorporating venous and lymphatic failure, skin changes, changes in muscle structure and functioning as well as skeletal functioning.

It has long been recognised that individuals with CVI have reduced range of motion (ROM) at the ankle joint (Maton et al 2006, Barwell et al 2001, Yang 1999, Kluyse et al 1995, Back 1995, Araki et al 1994, Dickson Wright 1931). This loss of ankle ROM directly impacts on patient mobility and healing times. Healing times are affected because this loss of ROM inhibits the function of the muscle pumps of the leg and reduces the ejection volume of these pumps in particular the calf pump (Maton et al 2006, Kan YM and Delis KT 2001).

Simka (2007) in her study of 129 patients with recalcitrant leg ulcers showed that the presence of poor calf muscle pump function consistently correlated with delayed healing. Interestingly pump failure was found more often in older patients who had already undergone long unsuccessful, non-specialised care where the importance of the muscle pumps was not addressed.

There are three main vascular pumps located in the lower limb. In the thigh, calf and plantar of the foot with research indicating a smaller one initiated by the dorsiflexion of the hallux (Elsner et al 2007). All of these are activated with muscle contraction in normal gait. The plantar venous plexus is made up of one to four large veins with a diameter of 4.0+/1.2mm. They run diagonally from the lateral forefoot to the medial hind foot covering 75% of the arch area. These veins flow into the posterior Tibial veins. Compression such that occurs in walking increases the flow velocity (White et al 1996). The system of veins and lymphatics that are sandwiched between the layers of muscle is repeated in the calf and femoral pumps. As the muscles contract they push the blood and lymph upwards against gravity out of the foot and leg.

Loss of ROM and the resulting joint rigidity at the ankle and hallux prevents muscle contraction of the calf and foot leading to a reduction in the ejection volume of the calf pump and contributing to sustained ambulatory venous pressures. Literature generally proffers fear of increased pain as the trigger for loss of ROM at the ankle. However muscle biopsies of the gastrocnemious
muscle of individuals with CVI revealed a change in the composition and number of muscle fibres. These changes were indicative of denervation atrophy that results in neuropathy. Biopsies from the arms of the same individuals showed none of these changes (Taheri et al 1984). The strongest muscle of the calf pump the gastrocnemious is the major plantarflexor of the foot. It contracts across the back of both the knee and ankle. A diminishing of this vital muscle to function has huge implications for the calf and plantar foot pump. Shiman et al in their perspective article in 2009 created a flow chart (fig 1) that gives a sense of the interplay of different factors leading to venous ulceration.

Several of the factors indicated in the diagram pertain to biomechanical issues and thus fall into the podiatrists remit. At the core of this diagram is the interplay between the biomechanical and the systemic. Compression bandaging of various designs is a widely used form of treatment for venous ulceration. Lentner et al (1997) showed that compression bandaging reduces the ROM at both the ankle and the talonavicular joint. The inclusion of the talonavicular joint is significant as it is responsible for inversion and eversion motion at the ankle complex and thus shows that ROM in all planes of motion is affected. This loss of ROM at the ankle complex makes gait changes inevitable. While the author has not encountered any research detailing the physiological links between this loss of ROM and the joint mal-alignment frequently seen clinically, it is logical to assume that one change in joint function, that is loss of ROM, is linked to another, change of joint alignment. It is common to see these changes in alignment becoming fixed in rigid valgus or eversion (see fig 2) and varus or inversion (see fig 3) deformities of the foot. We have successfully used in shoe orthoses to accommodate these changes and in early stages to correct.

This patient shows marked calf muscle atrophy because his completely rigid ankle prevents normal muscle contraction in the calf.

Multiple studies have focused on the effect of exercise on increasing lost ROM at the ankle and in turn improving the ejection volume of the calf pump. In 2007 the team carried out a small pilot study on the effect of simple ankle mobilization exercises on individuals with chronic long term ulceration and loss of ankle ROM (Davies et al 2007). The aim of the study was to create a
programme that could be easily incorporated into a busy clinic setting, be safe for a patient that might have poor balance and produce measurable results.

This was successful not just in increasing existing ROM at the ankle but several of the patient group reported a reduction in pain levels from the ulcer. The team has since gone on to incorporate it into routine clinical activity not just by the podiatrist but by all the team. However the initial measurement and any follow up measurements are done by the podiatrist to ensure measurement repeatability. Given the reduced mobility of this patient group the standard manner of measuring the ankle ROM has been adapted to be done with the patient seated.

Using a tractograph (see Fig 4), the measurement is done with the knee flexed and extended. The aim is to do this before the exercise program is commenced and followed up some weeks later using the theraband. A theraband is wide elastic band available as a graduated resistance system. The gold or silver is used for these patients (see Fig 5). Any increase in ROM is a measurable reward to the patient giving them a sense of control over a situation that frequently makes them feel powerless. The exercise program has been modified from the original study to use the theraband on both dorsiflexion and plantarflexion using upper body strength to encourage dorsiflexion.

As well as the theraband exercises normal heel toe gait is encouraged. This normal pattern of gait is essential for optimal muscle pump function. This is done working with the patient in a clinical session to change their gait pattern with such simple tools as encouraging them to visualise kicking a ball while walking. Appropriate safe footwear is discussed and advised on. Slip-ons and slippers are discouraged as they all too often inhibit normal gait encouraging a shuffling gait that does not allow muscle pump function. The author is also a member of the trust’s footwear service and when appropriate may utilize adaptations to the patients shoes. These adaptations may be applied for a host of reason such as encouraging heel toe gait, redistributing pressure, increasing stability or accommodating oedema.

Wound debridement is the traditional role for a podiatrist in the wound team. However research supports and the author’s own role development within the team has shown that the profession has more to offer. Maintaining patient mobility by providing measurements, exercises, gait re-education footwear advice and if possible appropriate footwear and orthoses and help the MDT provide a one stop shop.

Editor’s Note: During the editorial process I asked Ina about the link between pain and neuropathy. Her answer is below.

“Basically the premise is that biopsy studies show that limbs affected by venous disease have muscle fibre changes. One of the hypotheses for this is the death of nerve fibres eventually leading to neuropathy but not before causing often extreme pain. This pain is frequently addressed with the use of drug dealing with nerve pain eg Gabapentin. This neuropathy causes gait changes (they don’t get normal sensory feedback) which may cause pain either in the soft tissue or joint pain. Thus you get a pain neuropathy loop, often with a biomechanical tie-in.”
References


Dickson-Wright A. (1931) The treatment of indolent ulcer of the leg The Lancet Feb 457-460


Kan YM., Delis KT. (2001) Hemodynamic effects of supervised calf muscle exercise inpatients with venous leg ulceration: prospective controlled study


Lichen planus

Lichen planus is generally a skin condition that occurs in adults over the age of 40 years. The cause is unknown; it is not familial and cannot be passed on to other people, including sexual partners. It is a non-infectious and itchy rash that can be found on many areas of the body (NHS Choices, 2010). These include:

- Arms and legs
- Mouth (oral lichen planus)
- Nails and scalp
- Vulva, vagina and penis

It is estimated that the condition affects 1-2% of the population worldwide, and is found equally in both sexes. Oral lichen planus may occur on the sides of the tongue, on the gums and inside the cheeks and lips, and is more common among females. In approximately 50% of all cases of lichen planus, the mouth is the most affected. On the arms, legs and trunk the lesions appear as small mauve, solid areas raised above the normal level of the skin surface and flat-topped. If not visually obvious then they can be palpated. The most common area to find this rash is the flexor aspect of the wrist, ankles and lower back (NHS Choices 2010, Ashton and Leppard 2005).

There is currently no single curative treatment, however it is possible to manage and control the conditions symptoms and therefore make living with this condition easier. Generally most cases clear up on their own within six to nine months. The rash rarely last more than 18 months. Potent steroid creams will help to control the intense itching; however they will not treat the rash. For those patients with extensive blistering or severe erosive mucous membrane lichen planus then systemic steroids will be required. These patients should be referred to dermatology immediately. (Ashton and Leppard, 2005)

Erosive Lichen Planus

Erosive Lichen Planus (ELP) is a rare condition that can last for a long time; it is not caused by infection or allergy. The cause of ELP is unknown, and is thought to be an autoimmune disease. This is where the T-lymphocytes attack the epidermal cells in affected areas (DermNet NZ, 2011) It causes very painful ulcers mostly affecting mucosal surfaces in the mouth and genitalia. ELP in men is much less common. It rarely affects the eyelids, external ear canal, oesophagus, larynx, bladder, anus, the palms of the hands and soles of the feet. In 1-3% of chronic cases of ELP there is a risk that they may develop into squamous cell carcinoma. This should be suspected if there is evidence of an enlarging lump or the ulcer edge is thickened (DermNet NZ, 2011).

Diagnosis is generally made by the typical history and clinical appearance. Biopsy is usually done to confirm the diagnosis and to exclude cancer. Treatment can be intermittent or continuous, general recommendations are good hygiene and the use of a non-irritating emollient. Topical steroids may be considered applied daily for a period of 4-6 weeks, maintenance treatment 1-3 times per week for the long term. The type of steroid depends on the presentation i.e. as a paste (for the mouth), ointment for any genital erosions and as a foam for the inside of the vagina or anus (DermNet NZ, 2011).

Calcineurin inhibitors for example pimecrolimus cream or tacrolimus ointment may be of help for some patients, these are applied once or twice daily for several weeks and repeated as required. Systemic steroids (prednisone) 0.5 to 1mg/kg/day can be prescribed. When the erosions have healed this must be tailed off. Calcium and vitamin D should also be considered to reduce the risk of corticosteroid-induced bone thinning (DermNet NZ, 2011).

Methotrexate is also used with some patients in a dose of 10-20 mg once a week, with folic acid to reduce the risk of potential adverse effects. If treatment is continued long term then blood tests for liver function and procollagen levels must be monitored. Acitretin a vitamin A derivative is usually used to treat severe psoriasis, but has been

Susan Knight
Queens Nurse
Tissue Viability Specialist Nurse
Milton Keynes Community Health
found in some cases to be of help in ELP. The dose is 0.25-1mg/kg/day. This should be taken after meals as it can only be absorbed through the gut wall in the presence of fat.

**Nursing assessment**

The importance of taking a good past medical history cannot be underestimated, the patient in the above picture originally presented to the district nurses with a rash and superficial ulceration. Apparently the rash settled and the ulceration improved and eventually healed with the patient being treated with compression. It is not clear if at that time the patient had erosive lichen planus on the lower leg. The patient was eventually referred to the tissue viability team when a further ulcer appeared on the plantar region of the foot and rapidly spread.

Assessment of the ulcer by the TVN (tissue viability nurse) confirmed that the ulceration was in all probability due to erosive lichen planus, although reviewing the patients past medical history did not reveal any previous lesions of this sort. But the patient had been diagnosed with lichen planus of the trunk and arms in the past. Examination of the ulceration revealed a large area of tissue loss which had developed rapidly according to the nursing records. The patient complained of extreme pain and was unable to weight bear on this limb. The large ulcer had shallow edges and the wound bed appeared unhealthy, although did not exhibit any of the classical signs of infection. The smaller areas of ulceration had slightly raised wound edges mainly due to maceration from the high levels of exudates.

This patient was referred to Dermatology for confirmation of the diagnosis made by the TVN and commenced oral therapy Acitretin. His general practitioner prescribed Tramadol for pain management and opiates for breakthrough pain, especially at dressing change. Wound management has included simple non-adhesive dressings, topical antimicrobials when the ulceration has become infected. These dressings have been secured with bandaging and changed as required depending on the level of wound exudate. There has been some improvement, but the patient is due for a review with Dermatology to consider other treatment.

**References and further reading**


http://dermnetnz.org/scaly/lichen-planus.html

http://dermnetnz.org/site-age-specific/erosive-lichen-planus.html

http://www.nhs.uk/Conditions/Lichen-planus/Pages/Treatment.aspx
It is estimated that 70-190,000 people currently suffer from an open venous leg ulcer (VLU) in the UK (Posnett and Franks, 2007). They can be cared for in clinics in hospital or the community (Campbell et al, 2005), by practice nurses in GP surgeries (Schofield et al, 2000) or at home by community nurses. It is nationally recognised that the gold standard treatment for venous leg ulcers is compression bandaging (Royal College of Nursing, 2006). In order for a nurse to apply compression competently and therefore safely, it is necessary to attend further training. There is no national standard for the level of training that is required and this may vary from being shown by a colleague to attending a module at university.

This article reports on a service development in a 480-bed hospital to improve the support and continuity of care for people receiving compression therapy when they are admitted to hospital. The context of the development, the service model and the educational approach are presented as well as reflection on developments for the future.

Locally, the population is served by a well-established leg ulcer service in the community. This service has been in place for over 17 years (Rotchell, 1999) and as such all patients in the local population who have a wound on their leg for more than six weeks can be referred to this service. Clinics are held in several locations across the north east section of the county and recently, due to merging Primary Care Trusts, have started to spread into the east. There is a team of specialist leg ulcer nurses who coordinate the service and oversee the running of the clinics which they undertake with the support of community nurses who rotate in. They see approximately 120 different patients in these clinics per week.

As a result of this well established service in the community, some patients who are admitted to hospital have compression bandaging in situ. For the year April 2010 to March 2011 there were 104 hospital episode admissions coded to lower leg ulceration, and the Tissue Viability service received and reviewed 83 patient leg ulcer referrals (see Table 1). Some patients are not referred to tissue viability, some are discharged before they are seen, some ward staff who can carry out compression will undertake this care without the involvement of the TVN.

There is little in the literature about the prevalence and care of patients with VLU in an acute care setting (Barclay et al, 1998; Dealey, 1999; Aldeen, 2007). Anecdotally, from talking to other tissue viability colleagues, these patients may be taken out of their bandaging when they are admitted to hospital. This is a discontinuation in their treatment and may result in a deterioration of their ulceration. This could also cause concern and distress for patients especially when they have been working in partnership with their community nurses; seeing their oedema reducing and ulcerated legs beginning to heal.

There are no national data on the number of patients treated in hospital with leg ulcers. Hospital Episode statistics will only list those patients coded with leg ulcer as reason for admission. This gives no indication of the type of leg ulcer or the management received and does not consider those admitted with another primary diagnosis who may also have a leg ulcer.

To enable patients with VLU to continue their compression therapy whilst in hospital a model of education, training and care delivery has been introduced. This model has evolved over the years and this article will explain how it began and how it now works in practice.
The beginnings

When the leg ulcer service began the Trust it sat within both primary and secondary care. As such when a patient was admitted to hospital the leg ulcer specialist nurses were able to maintain their bandaging by visiting them on the ward. Over time it became apparent that most patients were either being seen in the elderly care wards, vascular ward or day hospital. It was decided that these areas would benefit from having a member of staff who could apply bandages. One nurse from each of the three wards, two from the day hospital, one from out patients and one from community liaison all attended the community leg ulcer training (Box 1). These nurses rotated into the leg ulcer clinics at agreed intervals with their wards so they could maintain their skills in bandaging.

Introduction of Acute Sector Tissue Viability Nurse (TVN)

In 2002 the acute Trust’s Tissue Viability service commenced. By this time the acute and primary care Trusts were separate entities and the financial

<table>
<thead>
<tr>
<th>2010–2011</th>
<th>Newly found ulcers (not in the care of local community services)</th>
<th>3 Layer compression bandage</th>
<th>4 Layer compression bandage</th>
<th>Arterial</th>
<th>Mixed Aetiology</th>
<th>Undetermined Aetiology</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>May</td>
<td>1</td>
<td></td>
<td>2</td>
<td></td>
<td>2</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>June</td>
<td>1</td>
<td></td>
<td>2</td>
<td>1</td>
<td>3</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>July</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>August</td>
<td>2</td>
<td></td>
<td>2</td>
<td></td>
<td>4</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Sept</td>
<td>3</td>
<td></td>
<td></td>
<td>1</td>
<td>6</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Oct</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Nov</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Dec</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Jan</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>9</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>Feb</td>
<td>5</td>
<td>3</td>
<td></td>
<td></td>
<td>3</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>March</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td>8</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>15</td>
<td>16</td>
<td>5</td>
<td>6</td>
<td>42</td>
<td>101</td>
</tr>
</tbody>
</table>

Table 1: 83 patients with 101 leg ulcers seen by TVN

Community Leg Ulcer Training

Attend either:

- a two-day theory course
- Attend the leg ulcer clinics for one clinic a week for six weeks
- Competency in bandaging is assessed and signed off by senior leg ulcer nurses

Or

- The leg ulcer module at the University of Hertfordshire (UH) (which includes a competency framework)

Note: In order to undertake ABPI assessment staff must attend the University leg ulcer module.

Box 1: Community Leg Ulcer Training Policy
boundaries between them were well defined. The TVN attended the UH leg ulcer module in 2004 to enable her to carry out full leg ulcer assessments, including the use of Doppler ultrasound if required and apply compression bandaging. Practical skills were gained in the local leg ulcer clinics and relationships between the community leg ulcer service and the acute sector TVNs were forged.

Financial Boundaries Change
Due to continued changes in the financial boundaries between acute and community care, the community leg ulcer service had to cease attending the hospital to reapply compression bandaging. This led to an increase in bandaging workload for the hospital TV service. It was agreed at this time to roll out further training into the hospital. The TV service had a network of link nurses working on the wards so the wards that had had the highest rate of admissions of patients with venous leg ulcers in the last 12 months were targeted. Six nurses, one from each of 6 wards, were invited to attend training as per Box 1. At this point too, the acute Trust was no longer able to support nurses attending the community clinics on a rotational basis. This left ward nurses with large gaps of time before they would use their bandaging skills, depending upon the number of admissions they had in their departments. It was decided that the TVNs would run an annual update day for these staff and that it would be mandatory for them to attend in order for them to continue bandaging.

Expanding the In-patient Service Delivery
Each year four to six more nurses were trained in the application of bandaging. Financial boundaries widened and the PCT were no longer able to support the theoretical side of the training without funding from the acute sector. For this reason training is now delivered in-house. A ‘new recruit’ (link nurses new to compression therapy) study day was organised in conjunction with a lecturer from UH, using strategic health authority funding set aside for higher education modules.

There are now 23 nurses within the hospital who can competently and safely apply compression bandaging. All medical and surgical wards, except renal, gynaecology and ITU have a nurse with the skill.

The educational model now in place for leg ulcer compression bandage training is as follows:

New recruit to the link nurse system
Attend one-day study day introducing theory and practical skills
Attend four community nurse-led leg ulcer clinics to gain competency in application of multi-layer bandaging
Two on-the-ward assessments by TVN before competency signed off
Annual alternating half day or full day update

New recruits attend a theory-based study day, which incorporates aetiology, epidemiology, theory of bandaging and a classroom workshop to learn practical bandaging skills. The study day also encompasses key principles of patient assessment to enable the nurses to evaluate the effectiveness of compression therapy and to recognise any deterioration in the patient. This helps ensure that complications are minimised and patients receive appropriate intervention and referrals if necessary.

Following the study day the nurses attend a leg ulcer clinic once weekly for four weeks to gain practical experience of bandage application and understand the care of patients with VLU. This training is competency based and assessed by an experienced leg ulcer specialist nurse. In the hospital setting the nurses apply bandages under the supervision of the TVN at least twice before being signed off as competent.

Annual alternating half day and full day updates are a mandatory requirement.

TVNs provide ward-based supervision for those staff who have been assessed as competent but require a little more support to build their confidence.
Guidelines are in place to support the nurse bandagers. Key principles of the guidelines include:

- the link nurse can expect to be given some notice that a patient requires bandaging
- the requesting ward has to supply a nurse to cover the link nurse’s area while this person is off the ward
- the link nurse has the right to decline the invitation if the appropriate equipment is not available or there is concern about the patient
- contact must be made with the leg ulcer service to ascertain last ABPI and usual bandage regime.

The Education Strategy

Yearly updates soon come round, and delivering the same sessions year-on-year risks becoming tedious to organise and attend. Maintaining learning interest for the participants is a very important challenge. The nurses require updates/refreshment on the theory behind leg ulceration, new practices and bandage application. A blend of learning activities has been developed in recent years using a combination of background reading material, lectures/discussion, quizzes, role play and audience participation.

The education framework used to develop the compression therapy competence course is a social constructivist approach building on experiential learning (Biggs, 2003). Social constructivism is an active process where the learner develops and evolves knowledge by building on experiences and what they already know (Hunter, 2008). This is particularly pertinent to this group of link nurses who have a wealth of clinical experience that they can apply to the new knowledge they are acquiring about leg ulceration.

In this course students are encouraged to actively participate in learning activities. For instance this year, for the first time, the new recruits and the experienced bandagers attended the same study day. On the premise that the best way to learn is to teach, the more experienced nurses were asked to work in groups to prepare a resource to help the newer members understand a theoretical principle (see Box 2). The groups were carefully designed to have a fairly uniform mix of personality, experience and IT capabilities. Each group was provided with a laptop, pictures they could use to illustrate their slides and reference materials (books and journal articles). They were given time to produce a presentation which they would then present to the rest of the groups and the four new recruits. The University lecturer and the TV team were available if required.

Box 2: Group Activity

<table>
<thead>
<tr>
<th>Group A</th>
<th>Explain venous blood flow in the lower leg and explain what goes wrong in venous disease. What would be visible on the leg and why? What would it be like for the patient?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group B</td>
<td>Explain what oedema is and how it develops in the lower leg. How could oedema be assessed? What might a patient feel with this condition?</td>
</tr>
<tr>
<td>Group C</td>
<td>Explain the components of multilayer bandaging. What physiological effect does compression therapy have on the lower leg?</td>
</tr>
</tbody>
</table>

The nurses worked together to share out tasks related to the use of resources, preparation of slides and the delivery and timing of the presentation. The groups became communities of inquiry to understand theory and produce a resource but also supported each other as they dealt with the inevitable nervousness of presenting. This bond of ‘community’ is based on meaningful activity (constructive alignment), interaction, reflection, peer assessment and support (Garrison and Vaughan, 2008).

Experiential learning (Kolb, 1984) applies knowledge in a way that develops skills through experiences and activities on the premise that what people do is more important than what they know which fits logically with the development of competence (Eraut, 1994). The activity worked well. Collaborative working was excellent and the group members identified how much they knew about the topics which enhanced their self-confidence.
An activity that has proved successful is the use of questions as a means of reinforcing the benefits of working with colleagues for solving problems. An example of this is an activity with the new recruits. They were given a quiz focused on the anatomy and pathophysiology of leg ulceration, clinical features of venous disease and scientific principles of compression therapy. The questions were compiled using pre course reading that had been sent to participants but were nevertheless challenging. The new recruits were asked initially to answer the questions individually. As time progressed they were then permitted to discuss the answers with a partner and then with more members of the group. This had two key effects; pooling knowledge and facilitating discussion. In this example the group were able to reach the limit of their knowledge which helped self assessment of learning needs. In the event described here the experienced bandagers were able to answer many of the quiz questions through the presentations they had prepared. The full range of questions were finally reviewed and the lecturer consolidated the presentations picking up on any areas that required further explanation.

Throughout these exercises roles changed; the ‘teachers’ (lecturer and TVNs) became facilitators and the students took control of their learning.

Box 3: Evaluation feedback comments

“*It is a good way. It helped everybody think, update and improve our knowledge and skill, even presentation skills*”

“*Being in groups and doing the prep for the presentations was a great idea and kept everybody focused*”

“*Very interesting day. Interactive learning was very helpful*”

“*Best study day ever*”

“*New format was enjoyable*”

“*Today’s format worked very well. Much improved from the last one. Enjoyed the day very much. I now feel that I am more aware and competent with leg ulcers and compression bandaging*”

And from one of the 4 new recruits:

“*Would have preferred more structured information – that’s just me though*”

and that of their colleagues. The social aspect of working together and full engagement with learning resources focused participants on being sure of their own understanding. One new link nurse found the participation and learner focus challenging, outside previous education experience (*Box 3, see final comment*).

Differing education experiences, preferences and styles need to be taken into account when designing courses, and feedback from participants is part of reflective practice for educators. One piece of advice given by Hunter (2008) is pertinent when a new topic is introduced; that new knowledge may be initially difficult to assimilate into existing knowledge and in this initiative the ongoing support underpinning updates and skills development over a period of time recognises this aspect of continuing professional development. The nurses are healthcare professionals who bring a wealth of clinical experience to the group. Increasing knowledge and confidence become powerful tools for developing a deeper understanding of leg ulcer management and the experience of patients. The nurses are mutually supportive and are actively encouraged to engage with learning opportunities and resources to develop and deepen their knowledge; this is social constructivism applied to CPD and patient care.

Higher education needs to respond to the need for workforce development (Gulc et al, 2009). Teaching aligned to and integrated with clinical practice is much more likely to result in sustained practice changes and skills development especially when underpinned by a well thought out education strategy and workplace support. Lee (2011) suggests that large organisations make the sharing of knowledge challenging therefore leadership, facilitation and a common purpose are crucial; it is in everyone’s interest to support innovation in patient care. Key to an initiative such as this is a training needs analysis aligned with a clear vision of the expected outcome of both the initiative and the individual participant which is supported by the culture of the organisation.

**Future Developments**

There is increasing emphasis on improving quality of care (Shorney, 2010) and the development of services that meets the needs of patients (NHS Institute for Innovation and Improvement, 2009). The integrated approach...
between the TVNs, educators and practitioners has impacted positively on in-patients because where appropriate to their medical condition they can continue with compression therapy safely. The number of people benefiting from this intervention is recorded (Box 1) and in future could include recording patient satisfaction with continuity of care and prevention of lower leg related adverse events such as increased oedema, skin breakdown or leg wound infection. Feedback is collected for update events and is very positive. The number of nurses continuing in the link nurse role and their enthusiasm for learning activities and maintenance of competencies are evidence of their motivation, the value they put on this aspect of patient care and their CPD.

There is scope to develop blended learning with a range of virtual learning opportunities in the future, but this needs to be balanced with the aspects of interaction and physical skills that are beneficial to patient care and valued by the participants.

Conclusion

There is a universal need to improve leg ulcer care, especially among practitioners who are less engaged in developing skills and competencies (Anderson, 2003, Knight, 2008). The benefits of the education model in this Trust include:

- **Nurses’ confidence in their own knowledge and skills is enhanced**
- **Teamwork skills are developed; the link nurses develop mutually supportive relationships with other nurses in the hospital with the same skills**
- **New recruits feel part of a well-established group from the outset**
- **Presentation skills and confidence are developed**

The service provision for VLU patients locally has evolved over a number of years. To support this provision and ensure these patients receive continuity of a high standard of leg ulcer care, an educational plan for a small group of registered nurses has also evolved. This educational model incorporates theoretical and practical skills whilst developing personal confidence, teamwork and presentation skills.

### References

- Royal College of Nursing (2006) The nursing management of patients with venous leg ulcers London RCNi
The NHS is being reformed. The intention is to improve outcomes for patients, families and communities and to develop a culture in which two things become embedded. The first is that patients and people who use our services can be confident there is ‘no decision about me without me’ and second is that clinicians, of all disciplines, will be much more involved in leading, designing and running services. The instrument that brings this about in legislation is the Health and Social Care Bill which contains many more changes than these and its progress through Parliament is still subject to much more discussion and possible amendment. Uniquely this process has already been paused and the Government has listened to concerns about the Bill and is making improvements to it as a consequence.

Many details in the Bill are about changes to NHS organisations and the creation of new bodies. We know that there will be an NHS Commissioning Board and Clinical Commissioning Groups and we also know that Public Health England and Health Education England will be created.

What will not change is the set of values on which the NHS is built. These are stated in the NHS Constitution and are about respect and dignity, compassion, working together for patients, commitment to the quality of care, improving lives and ensuring that everyone counts. In particular, the Constitution says we need to insist on quality and strive to get the basics right every time, learn from our mistakes and build on our successes. That might seem aspirational, but we need to rise to the challenge and embed that sort of commitment into our every day practice and create a culture so that others can do likewise. So, despite the uncertainties for individuals about organisational change and their place in the reformed NHS there is a constancy, particularly important to nurses and others who give direct care, which reinforces the personal and professional values that underpin our practice.

Holding on to these values helps us make sense of what is changing around us. It is not always immediately clear what these changes will mean to patients, professionals and the public but my personal test is “what will this mean for my parents?” They happen to be quite elderly and with a range of frailties and I commonly play out in my mind what impact the new structures and policies will have on their situation and their need for integrated health and social care. Clearly you can substitute “parents” with loved ones, friends, family or anyone from your case-load or personal experience – it helps make it real. In my view this very practical test helps us really put the patient at the centre of everything we do and encourages us to listen actively to what patients and their families tell us about what they want and what can be improved.

Living your values through your practice in this way can generate creative thinking which can make the most of the opportunities in the new NHS. Services need to be transformed which takes particular skills. As nurses we are well positioned to lead service transformation and health promotion, be clinical innovators, professional partners in an ‘expert-to-expert’ relationship with patients, become entrepreneurial practitioners exploring business opportunities through social enterprises and other innovations and especially by being champions of clinical quality.

In a practical way, nurses have been effectively contributing to the NHS quality and productivity challenge facing the NHS with the need to reduce costs of £20 billion to be reinvested in services. The High Impact Actions initiative generated eight priorities, one of which is ‘your skin matters’. Although this is focused on pressure damage, it is equally applicable to the debilitating...
There has never been a better time for nurses to grasp the opportunities to reform and improve outcomes for their patients.
A year has now gone by since the launch of the ‘Right Nurse, Right Skills’ campaign. During this time the issue of nurse training, skills mix, and the role of healthcare assistants has continued to rise up the political and media agenda. This article will give an overview of the campaign’s achievements to date, and give some indication of its future direction.

The campaign was launched by the Queen’s Nursing Institute in autumn 2010 in response to growing fears about the quality of nursing care available to people, particularly vulnerable people being nursed in their own homes – whether they live in their own home, residential or care homes, or elsewhere. The QNI acknowledges, and has confirmed through information gathered from the public, that most home nursing care being delivered is of an excellent standard. Nevertheless, community nursing is under pressure to achieve more with fewer resources, which can mean that patients receive less good care. In a few high profile cases, patients have been shown to be put at risk.

In a further Times opinion piece on 22 September, Camilla Cavendish noted how many key tasks are now delegated to ‘untrained and unregulated’ healthcare assistants. As she pointed out, “Nurses and healthcare assistants dress in similar clothes: patients can’t tell the difference” – something that ought to be of concern to both patients and nurses. Working in patients’ homes is a privilege, and the patients there are some of the most vulnerable in society. The QNI is concerned that their care may suffer if the nurses or assistants who visit them are too inexperienced or unprepared. The real danger is that this decline in care will be invisible as it happens behind closed doors.

Planning and Delivery of the Campaign

The campaign was planned in three key stages. The first was to reach out to community nurses, to hear their views. The second stage was to engage with the general public, many of whom were unfamiliar with the QNI, to find out what matters most from the patient perspective. The third phase, where we will present this evidence to policy and decision makers, begins in November 2011 and will continue through 2012. The added challenge, for our timetable, has been the huge upheaval currently being experienced by the National Health Service in England.

The QNI is very concerned about the fall in district nurse numbers in recent years. QNI Director Rosemary Cook CBE, and Queen’s Nurse Candice Pellett were interviewed by The Times newspaper for an article that appeared on 30 August (Nursing come rain or shine: The district nurse, vital for the care of people in their own homes, is under threat). “Reorganisation of community services has made district nurses feel underappreciated. A lot of them opt for early retirement and may not be replaced,” commented Rosemary in the article. District nurse Candice Pellett added, “whatever label is attached to us, our specialist nursing must remain the foundation of home care. And with a dying patient you only have one chance to get it right.”

For those of you that may not be aware of the ‘Right Nurse, Right Skills’ campaign, I suggest that you look at the QNI website and enter your comments. Although the report is being written for presentation, I am sure that the QNI would be happy to hear what you feel. Especially, if your view is different from those presented here.
receive in their own homes today. The evidence it presents will form the basis of our engagement with decision makers.

Statements from patients have been illustrative; for example:

“I have recently had three months District Nursing care and valued the skills of the most experienced nurses. The limitations of the less experienced were apparent in that they can do a task to a set written plan but not adapt to changes as they arise or respond to wider needs.”

“I have seen at first hand that, due to insufficiently trained staff and inappropriate staff being sent and designated to care at home, when discharged from hospital, lead to a worsening and a readmission.”

And statements by community nurses are even more worrying:

“In essence the patients under these teams NEVER come into contact with a district nurse and have access to specialist skills and knowledge. This practice is both dangerous and unfair to patients and their families.”

“The talk of skill mix always means replacing experienced or trained nurses with untrained or inexperienced staff.”

Managers and commissioners must be aware that often it is NOT cost effective to attempt to devalue the role of the Registered nurse by skill mixing inappropriately to save a few pounds on salary costs. This often leads to tasks being performed by non-qualified personnel rather than holistic management of the patient.”

The campaign has also highlighted how difficult it can be for patients to ‘navigate the care pathways’ in community care. Traditionally this was one of the roles of the district nurse – to signpost and think creatively about what services a patient might need, and how to obtain those services. Too often, patients are unaware of services that exist or they are lost in referral pathways. This problem becomes worse as services vary so much from one area to another. The recent Palliative Care Funding Review reference came to the same conclusion.

The QNI has responded by creating a dedicated patient area on its website, where we can add information about community services that is useful to patients and carers. We also now publish a newsletter, Home Visit, specifically aimed at patients, carers and families, the first time that the QNI has tried to reach out to the general public in this way.

As the ‘Right Nurse, Right Skills’ campaign has developed, it has diversified in the range of media that we use. Initially we used posters and leaflets, which were distributed via Queen’s Nurses (both working and retired) and petition forms, which were used to gather more names and addresses of supporters, who now number over 3000. This gave us a community of readers for our newsletter, Home Visit.

We have also developed a range of online tools – an online survey to gather patient feedback and more recently an online petition. We have also come to use social media – Facebook and Twitter – in order to reach new audiences and reach them more rapidly and also more informally. This is all part of moving with the times and positioning the QNI as a credible organisation with a new generation, which includes all-important student nurses.

The QNI has recruited headline supporters, including actress and former nurse Julie Walters. Julie commented, “I do think it’s comforting to know that a trained and qualified nurse will visit us when we’re ill at home. It’s very worrying that these trained nurses are getting thin on the ground, and that they are being replaced by less experienced nurses or health care assistants. That’s why I support the QNI’s campaign: we are all potential patients, and we all deserve the best possible nursing care in our own homes, from the ‘right nurse with the right skills’.”

Key campaign objectives

The key campaign objectives have remained the same since the campaign was launched. They can be summarised as follows:

- All nurse team leaders to have specific community training so that they can ensure patients receive safe and high quality care in the home;
- All nursing teams to carry out regular audits of their skills to ensure they match patients’ needs;
- All nurses to get skills training to match patients’ needs;
- All nurses new to the community to have a programme of support during their first six months
- We also have a list of practical actions
that we hope to achieve as the campaign develops. These are:

- We will be identifying and publishing a list of educational courses that focus on preparing nurses to work in the community.
- We will be seeking out effective skills audit tools, and making these available for nurse teams to use.

We will be developing and publicising good examples of preceptorship (support) programmes for nurses new to the community, which employers can use.

**Queen’s Nurses**

The re-introduction of the Queen’s Nurse title is one way in which the QNI is helping to strengthen community nursing. While not a professional qualification, becoming a Queen’s Nurse enables community nurses to join others who are committed to the best of patient care and continued professional development. The QNI runs regular free training events that are only open to Queen’s Nurses and it also offers developmental bursaries. An annual conference for QNs is held in London, and there are also regional meetings that are becoming more important as the number of Queen’s Nurses grows. In the past year, we have seen the Queen’s Nurse network reach a ‘critical mass’ where new ideas are quickly shared, confidence is growing, and influence on employers, media and policymakers is becoming more evident.

Personally, I was also lucky enough to spend a day with Queen’s Nurse Matthew Peasey, a District Nurse employed by Surrey Community Health. I was struck by the degree of skill required to bandage a wound on the leg of an elderly female patient. Largely housebound, she typified the kind of patient who is totally reliant on a quality district nursing service in order to maintain her independence, dignity and quality of life. As people are living longer, there will be more and more people in this position, requiring skilled care in their own homes if they are to avoid repeated, traumatic spells in hospital.

**Summary**

In a period of budget austerity that some are saying may last a decade, policymakers are looking everywhere for areas to save money. Nursing is one of those areas where cuts often happen and where commissioners try to make cost savings. Unless community nurses and organisations that represent them, such as the QNI, stand up and campaign for quality nursing for patients in the home, we will only have ourselves to blame if services are continually scaled back, the skill mix of nursing teams is diluted, and we constantly have to do more with less.

The major new report, *Nursing People at Home* was published on 21 November 2011, and copies are available from the QNI. The web address is: http://www.qni.org.uk/campaigns/nursing_people_at_home_report

**References**

- The ‘Right Nurse, Right Skills’ campaign http://www.qni.org.uk/campaigns/right_nurse_right_skills
- The ‘Right Nurse, Right Skills’ campaign petition http://www.thepetitionsite.com/1/right-nurse-right-skills/
- The Queen’s Nursing Institute – Queen’s Nurses http://www.qni.org.uk/for_nurses/queens_nurses

This article © Queens Nursing Institute
The aim of Parliament’s outreach service is to give the public more information about Parliament and to make it easier for them to engage with its processes.

In this article, Alasdair Mackenzie, Parliament’s outreach officer for London and the south-east of England, gives an overview of the composition, role and work of Parliament.

Parliament and democracy

Parliament is made up of three parts: The House of Commons, the House of Lords and the Monarch. In the House of Commons, Members of Parliament (MPs) are elected as part of the democratic process. Following a general election, the political party, or parties, with the most MPs forms the Government.

Members of the House of Lords are mostly appointed by the Monarch on the recommendation of the Prime Minister. A small number of Church of England archbishops and bishops are also members.

The Monarch fulfils a formal and ceremonial role, approving Royal Assent for bills and attending the State Opening of Parliament.

Representing the people

The UK is divided into areas, called constituencies, each of which elects a single MP to represent them in Parliament. All residents of a constituency can contact the local MP about issues that affect them or that are being considered by Parliament. It does not matter whether they voted for the MP or even if they are entitled to vote at all.

If you want to find contact details of your MP, go to the Parliament website (www.parliament.uk) and enter your postcode into the ‘Find Your MP’ box at the bottom of the homepage.

Parliament and Government

Parliament and Government are separate institutions. They work closely together but have distinct roles.

The Government is responsible for running the country, implementing policy and drafting laws. Parliament is responsible for checking the Government’s work, making and amending laws and representing the people. After a general election, the leader of the party who commands a majority of support in the House of Commons, is asked to form a Government by the Sovereign, and is appointed Prime Minister.

The Prime Minister recommends ministers for formal appointment by the Monarch.
The role of the House of Commons

The House of Commons scrutinises government policies to ensure that the Government is working for the benefit of those living in the UK. This scrutiny includes:

• The questioning of ministers by MPs, either in the House or through written parliamentary questions. This process helps to inform MPs of the work of Government and to hold ministers to account

• Select committees which ‘shadow’ government departments and carry out inquiries into issues of concern. The Government must respond to the committee’s recommendations

• MPs debating issues in the House and questioning ministers when they make statements.

Taxation

As the democratically-elected part of Parliament, the House of Commons has the right to raise taxes. This provides the Government with money to deliver its policies. The Chancellor of the Exchequer presents the Budget to the House annually and the House passes a Finance Act to approve the taxes.

The role of the House of Lords

The House of Lords is the second Chamber of the United Kingdom Parliament. It plays an important part in revising legislation and keeping a check on Government by scrutinising its activities. It complements the work of the Commons, whose members are elected to represent their constituents. Members of the Lords – also known as peers - are not elected and are unpaid. They have a wide range of experience and provide a source of independent expertise.

The House spends about two thirds (60%) of its time on legislation. It examines and revises Bills from the Commons. It also initiates Bills which are usually noncontroversial. Increasingly, a bigger share of Government Bills start in the Lords, to spread the legislative loads more evenly throughout the parliamentary year between the two houses.

Scrutinising the Government

As well as revising legislation, the House questions and debates policy and other issues:

Questioning Ministers

Oral questions are asked each day (at 2.30pm from Monday to Wednesday and at 3pm on Thursdays). Four questions can be asked on Mondays and Thursdays and five on Tuesdays and Wednesdays. They allow ministers to be cross-questioned for about 30 or 40 minutes at a time when the House is at its fullest.

Debates

Most Wednesdays are for general debates. Topics are suggested by back-bench or crossbench peers and are chosen by ballot. (crossbench peers are members of the House of Lords without allegiance to a political party.) Other debates
are agreed between the business managers – ie whips of the political parties and the Convenor of the Crossbench peers – known as the ‘usual channels’.

**Statements**

Government statements on important or urgent issues are made by the Minister responsible for the subject in the House of Lords. Most statements are made in the Commons, and repeated in the Lords by a junior minister followed by a limited time for immediate questioning of the Minister.

**Parliament and Legislation**

Parliament is responsible for making laws. Most legislation comes from the Government but proposals can originate from an MP, a Lord, a member of the public or a private group. The House of Commons and House of Lords must agree the text of any proposed legislation before it can become law.

Usually, a bill passes through all its stages of consideration in one parliamentary session (generally running from November to November). Exceptions can be made to ‘carry-over’ bills to the next session. Bills can start in either the House of Commons or the House of Lords and must be approved by both Houses before becoming law.

**Where do these bills come from?**

Most bills that become Acts originate from the Government. Before a government bill is presented to Parliament it is drafted by a team of specialist lawyers. This may take place after a consultation period with the public or after a government policy statement. It is also possible for MPs and Members of the House of Lords to present bill for Parliament to consider.

**How bills are considered by Parliament**

There is a formal set of stages by which each House scrutinises, challenges and amends (changes) a bill. When both Houses agree on the text, it is sent for Royal Assent and becomes law. First and Second readings in the commons and Lords are essentially the same. There is no debate at First reading and at Second reading there is a debate on the general principles of the bill. Government bills are rarely defeated at this stage, but many Private Members’ Bills do not progress beyond this point.

When a bill has passed its Second reading, it is considered clause by clause in committee and amendments can be made to the text. In the Commons this is often delegated to a Public Bill Committee. In the Lords it usually takes place in Committee of the Whole House in the Lords Chamber.

The amended bill is then considered in Report. This stage is similar in both Houses and allows all Members to speak, vote and propose amendments. Third reading in the Commons usually takes place immediately after Report stage and is normally a short one hour debate where no further changes can be made to the bill. Third reading in the Lords can take longer and further changes can be made.

**An agreed text**

A bill that begins in the Commons is changed, agreed and reprinted before being sent to the Lords where it is further changed, agreed and reprinted.

Changes made by the Lords are sent back to the Commons for consideration. The Commons can agree, reject or amend those changes before sending these back to the Lords. This process continues until the text is agreed or until the end of the Session, in which case the process starts from the beginning in the following Session.

**Royal Assent**

Bills must receive Royal Assent before becoming Acts. When Royal Assent is given, an announcement is made in both Houses.
Legislation may come into force immediately, after a set period or after a commencement order by a government minister.

Private Members’ Bills
Private Members’ Bills are initiated by backbench MPs. These are public bills and can be on any issue. Few become law because of time constraints in Parliament. They can also be presented by Peers in the House of Lords.

The work of Select Committees
Select Committees work in both Houses. They check and report on areas ranging from the work of government departments to economic affairs. The results of these inquiries are public and may require a response from the government.

Select Committees take written and oral evidence from the public, and you can get in touch with them to ask about how to submit evidence. Contact details for each Select Committee can be found on its homepage on the Parliament website, or through the House of Commons or House of Lords Information Offices. Website addresses and phone numbers can be found at the end of this article.

Difference between the two Houses
House of Commons Select Committees are largely concerned with examining the work of government departments. Committees in the House of Lords concentrate on four main areas: Europe, science, economics, and the UK constitution.

Commons Select Committees
There is a Commons Select Committee for each government department, examining three aspects: spending, policies and administration.

These departmental committees have a minimum of 11 members, who decide upon the line of inquiry and then gather written and oral evidence. Findings are reported to the Commons, printed, and published on the Parliament website. The government then usually has 60 days to reply to the committee’s recommendations.

Some Select Committees have a role that crosses departmental boundaries such as the Public Accounts or Environmental Audit Committees. Depending on the issue under consideration they can look at any or all of the government departments.

Lords Select Committees
Lords Select Committees do not shadow the work of government departments. Their investigations look into specialist subjects, taking advantage of the Lords’ expertise and the greater amount of time (compared to MPs) available to them to examine issues.

There are currently five major Lords Select Committees: the European Union Committee, the Science and Technology Committee, the Communications Committee, the Constitution Committee and the Economic Affairs Committee.

Find out more
You can find out more about the work and history of Parliament and up-to-the-minute news of what’s going on in Parliament on the Parliament website: www.parliament.uk

It’s free to visit Parliament and watch any of the debates or committee sessions, but if you can’t come along in person, you can watch online on www.parliamentlive.tv

If you have any questions about the work of Parliament you can phone:

House of Commons Information Office
020 7219 4272

House of Lords Information Office
020 7219 3107

Parliamentary training
Parliament’s outreach service offer free parliamentary training for groups from a variety of organisations in the public, private and charitable sectors. If you would like to know more, you can e-mail us at parliamentaryoutreach@parliament.uk or phone us on 020 7219 1650.

© All photographs in this article are Parliamentary copyright
What is pyoderma gangrenosum?
The STOP GAP Trial (Study of Treatments for Pyoderma Gangrenosum patients) is currently recruiting patients around the UK who have been diagnosed with pyoderma gangrenosum (PG). PG is a rare, painful ulcerating skin condition that often affects people with an underlying systemic disease (such as inflammatory bowel disease, rheumatoid arthritis and haematological malignancies). It starts as a reddish purple papule or blister in the skin that develops into a large, deep, spreading ulcer in a matter of days.

How is the trial going?
The trial is recruiting patients from around fifty hospitals in the UK and Ireland. One hundred and forty patients are needed by April 2012. Currently (August 2011) eighty two patients have been recruited into the trial. In order to reach our recruitment target on time, it is essential that as many patients with PG as possible are referred to an investigator and considered for entry into the trial. We rely upon both secondary and community teams who see PG patients (such as tissue viability nurses), to refer to a recruiting investigator as soon as possible. It is really important that patients are not prescribed either of the trial drugs before being referred: since this would exclude them from the trial (they cannot have taken prednisolone or ciclosporin in the previous month). However, topical therapy such as Dermovate® or Protopic®, as an interim measure, is permitted.

What should I do if I see a patient that may have pyoderma gangrenosum?
If you see a patient that you suspect may have PG, please consider referring them to one of the following recruiting teams in Dermatology Departments around the UK (see next two pages). Alternatively, you can refer directly to the co-ordinating centre: Eleanor Mitchell, (contact details on the left). Further information, for patients and healthcare professionals, can be found at www.stopgaptrial.co.uk
<table>
<thead>
<tr>
<th>Region</th>
<th>Secondary care Trust</th>
<th>Principal Investigator (Dermatologist)</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East / Yorkshire</td>
<td>Bradford Teaching Hospitals NHS fTrust</td>
<td>Dr Andrew Wright</td>
<td>01274 734744</td>
</tr>
<tr>
<td></td>
<td>County Durham &amp; Darlington NHS fTrust</td>
<td>Dr Shayamal Wahie</td>
<td>0191 333 2333</td>
</tr>
<tr>
<td></td>
<td>Harrogate &amp; District NHS fTrust</td>
<td>Dr Alison Layton</td>
<td>01423 885959</td>
</tr>
<tr>
<td></td>
<td>Hull &amp; East Yorkshire Hospitals NHS Trust</td>
<td>Dr Shernaz Walton</td>
<td>01444 441881</td>
</tr>
<tr>
<td></td>
<td>The Newcastle Hospitals NHS fTrust</td>
<td>Dr Simon Meggitt</td>
<td>0191 233 6161</td>
</tr>
<tr>
<td></td>
<td>York Teaching Hospital NHS fTrust</td>
<td>Dr Calum Lyon</td>
<td>01904 631313</td>
</tr>
<tr>
<td>North West</td>
<td>Countess of Chester Hospital NHS fTrust</td>
<td>Dr Asad Salim</td>
<td>01244 365000</td>
</tr>
<tr>
<td></td>
<td>North Cumbria University Hospitals NHS Trust</td>
<td>Dr Marinela Nik</td>
<td>01228 523444</td>
</tr>
<tr>
<td></td>
<td>Royal Liverpool &amp; Broadgreen University Hospitals NHS Trust</td>
<td>Dr Hazel Bell</td>
<td>0151 282 6000</td>
</tr>
<tr>
<td>Midlands (East &amp; West)</td>
<td>University Hospitals Birmingham NHS fTrust</td>
<td>Dr Agustin Martin-Clavijo</td>
<td>0121 627 1627</td>
</tr>
<tr>
<td></td>
<td>Cambridge University Hospitals NHS fTrust</td>
<td>Dr Jane Sterling</td>
<td>01223 245151</td>
</tr>
<tr>
<td></td>
<td>Chesterfield Royal Hospital NHS fTrust</td>
<td>Dr Francisca Ezugagh</td>
<td>01246 277271</td>
</tr>
<tr>
<td></td>
<td>Derby Hospitals NHS fTrust</td>
<td>Dr Adam Ferguson</td>
<td>01332 265500</td>
</tr>
<tr>
<td></td>
<td>Nottingham University Hospitals NHS Trust</td>
<td>Dr John English</td>
<td>0115 924 9924</td>
</tr>
<tr>
<td></td>
<td>Oxford Radcliffe Hospitals NHS Trust</td>
<td>Dr Graham Ogg</td>
<td>01865 741841</td>
</tr>
<tr>
<td></td>
<td>Sandwell &amp; West Birmingham Hospitals NHS Trust</td>
<td>Dr Shireen Velangi</td>
<td>0121 554 3801</td>
</tr>
<tr>
<td></td>
<td>Sherwood Forest Hospitals NHS fTrust</td>
<td>Dr Jane Ravenscroft</td>
<td>01623 622515</td>
</tr>
<tr>
<td></td>
<td>University Hospitals of Leicester NHS Trust</td>
<td>Dr Graham Johnston</td>
<td>0116 254 1414</td>
</tr>
<tr>
<td>East Anglia</td>
<td>Basildon &amp; Thurrock University Hospitals NHS fTrust</td>
<td>Dr Gosia Skibinska</td>
<td>01268 533911</td>
</tr>
<tr>
<td></td>
<td>The Ipswich Hospital NHS Trust</td>
<td>Dr Deepak Rallan</td>
<td>01473 712233</td>
</tr>
<tr>
<td></td>
<td>James Paget University Hospitals NHS fTrust</td>
<td>Dr Robert Graham</td>
<td>01493 452452</td>
</tr>
<tr>
<td></td>
<td>Norfolk &amp; Norwich University Hospitals NHS fTrust</td>
<td>Dr Nick Levell</td>
<td>01603 286286</td>
</tr>
<tr>
<td>South West</td>
<td>Northern Devon Healthcare NHS Trust</td>
<td>Dr Karen Davies</td>
<td>01271 322577</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>-------------------------------------</td>
<td>----------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Northern Devon Healthcare NHS Trust</td>
<td>Royal Devon &amp; Exeter NHS Trust</td>
<td>Dr Chris Bower</td>
<td>01392 411611</td>
</tr>
<tr>
<td>South Devon Healthcare NHS Trust</td>
<td>Great Western Hospitals NHS Trust</td>
<td>Dr Sam Gibbs</td>
<td>01793 604020</td>
</tr>
<tr>
<td>University Hospitals Bristol NHS Trust</td>
<td>University Hospitals Bristol NHS Trust</td>
<td>Dr Giles Dunnill</td>
<td>0117 923 0000</td>
</tr>
<tr>
<td>Weston Area Health NHS Trust</td>
<td>Taunton &amp; Somerset NHS Trust</td>
<td>Dr Rachel Wachsmuth</td>
<td>01823 333444</td>
</tr>
<tr>
<td>Yeovil District Hospital NHS Trust</td>
<td></td>
<td>Dr Rachel Wachsmuth</td>
<td>01935 475122</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>South East</th>
<th>Brighton &amp; Sussex University Hospitals NHS Trust</th>
<th>Dr Paul Farrant</th>
<th>01273 696011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brighton &amp; Sussex University Hospitals NHS Trust</td>
<td>East Kent Hospitals University NHS Trust</td>
<td>Dr Susannah Baron</td>
<td>01227 766877</td>
</tr>
<tr>
<td>East Kent Hospitals University NHS Trust</td>
<td>East Sussex Hospitals NHS Trust</td>
<td>Dr Mahmud Ali</td>
<td>01323 417400</td>
</tr>
<tr>
<td>East Sussex Hospitals NHS Trust</td>
<td>Frimley Park Hospital NHS Trust</td>
<td>Dr Fiona Antony</td>
<td>01276 604604</td>
</tr>
<tr>
<td>Royal Berkshire NHS Trust</td>
<td></td>
<td>Dr Daron Seukeran</td>
<td>0118 322 5111</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>London</th>
<th>Barts &amp; The London NHS Trust</th>
<th>Dr Frances Lawlor</th>
<th>0207 377 7000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barts &amp; The London NHS Trust</td>
<td>Guys’ &amp; St Thomas’ NHS Trust</td>
<td>Dr Catherine Smith</td>
<td>0207 188 7188</td>
</tr>
<tr>
<td>Guys’ &amp; St Thomas’ NHS Trust</td>
<td>South London Healthcare NHS Trust</td>
<td>Dr Anna Chapman</td>
<td>0208 836 6000</td>
</tr>
<tr>
<td>South London Healthcare NHS Trust</td>
<td>Whipps Cross University Hospital NHS Trust</td>
<td>Dr Anthony Bewley</td>
<td>0208 539 5522</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wales</th>
<th>Betsi Cadwaladr University Health Board</th>
<th>Dr Diane Williamson</th>
<th>01745 583910</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hywel Dda Health Board</td>
<td></td>
<td>Dr Debbie Shipley</td>
<td>01267 235151</td>
</tr>
<tr>
<td>Aneurin Bevan Health Board</td>
<td></td>
<td>Dr Alex Anstey</td>
<td>01633 234234</td>
</tr>
<tr>
<td>Cardiff &amp; Vale University Health Board</td>
<td></td>
<td>Dr John Ingram</td>
<td>029 2074 7747</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scotland</th>
<th>NHS Grampian: Aberdeen Royal Infirmary</th>
<th>Dr Tony Ormerod</th>
<th>01224 681818</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Grampian: Aberdeen Royal Infirmary</td>
<td>NHS Lanarkshire: Monklands Hospital</td>
<td>Dr Chris Evans</td>
<td>01236 748748</td>
</tr>
<tr>
<td>NHS Lanarkshire: Monklands Hospital</td>
<td></td>
<td>Dr James Vestey</td>
<td>01463 704000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>N. Ireland</th>
<th>Craigavon Area Hospital Health &amp; Social Care Trust</th>
<th>Dr Rosemary Black</th>
<th>028 383 3444</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ireland</td>
<td>Cork University Hospitals</td>
<td>Dr Johnny Bourke</td>
<td>021 492 6100</td>
</tr>
</tbody>
</table>

By referring patients for possible inclusion into the trial you are contributing to the world literature on PG and helping patients with this rare disease in the future. Further information about the trial (including patient information leaflets) can be found at www.stopgaptrial.co.uk.

This article presents independent research commissioned by the National Institute for Health Research (NIHR) under its Programme Grants for Applied Research funding scheme (RP-PG-0407-10177). The views expressed in this publication are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health.
The Department of Health (DH) has committed to working alongside the NHS to support the phased roll out of extended patient choice through the Any Qualified Provider (AQP) platform.

Operational guidance to the NHS setting out plans to deliver the Government’s commitment to extending patient choice of provider has been published.

In developing this guidance the DH has engaged with clinicians, providers, commissioners, patient groups and voluntary organisations on how best to extend patient choice of provider. The Department has talked to these groups about which services should be subject to patient choice, how qualification criteria for providers can help to reduce bureaucracy and assure quality, and how the procurement process for extending choice of provider should operate. The approach to implementation has been developed in response to what they have listened to and from the delivery of the Future Forum Report (DH 2011a).

The goal is to enable patients to choose any qualified provider where this will result in better care. Choice of provider is expected to drive up quality, empower patients and enable innovation. Importantly, extending choice of AQP provides a vehicle to improve access, address gaps and inequalities and improve quality of services where patients have identified variable quality in the past.

A phased approach to providing these services is being adopted and commissioners are being asked to engage locally to determine where choice of any qualified provider best meets the demands of their patients, and is expected to deliver quality improvements. The DH will work with the NHS to ensure lessons are learned from each stage of the rollout. Commissioners will continue to control both contracts and prices, and to challenge providers to deliver services of the highest quality.

Key principles of an Any Qualified Provider approach

The following principles govern an AQP approach to contracting for services:

- Providers qualify and register to provide services via an assurance process that tests providers’ fitness to offer NHS-funded services.
- Commissioners set local pathways and referral protocols which providers must accept.
- Referring clinicians offer patients a choice of qualified providers for the service being referred to.
- Competition is based on quality, not price. Providers are paid a fixed price determined by a national or local tariff.

(DH 2011b)

In undertaking a phased implementation of patient choice of Any Qualified Provider, 2012/13 will be treated as a transitional year, starting with a limited set of community and mental health services. Based on discussions with national patient groups and an assessment of deliverability, the DH has identified a list of potential services for priority implementation as follows:

- Musculo-skeletal services for back and neck pain
- Adult hearing services in the community
- Continence services (adults and children)
- Diagnostic tests closer to home such as some types of imaging, cardiac and respiratory investigations to support primary assessment of presenting symptoms
- Wheelchair services (children)
- Podiatry services
- Venous leg ulcer and wound healing
- Primary Care Psychological Therapies (adults)

(DH 2011b)
What it means for patients
In the future, patients will be offered a wider choice of providers when they are referred for some treatments by a healthcare professional.

The goal is to enable patients to choose from any qualified provider where this will result in better care. Commissioners and the NHS Commissioning Board will have a duty to promote choice. It will be down to commissioners to ensure that their patients are aware of the choices available to them. Informed choice is highly dependent on the relevance, quality and accessibility of information about the type and quality of available services. There is the recognition that information to support choice will require significant investment over coming years, together with increasing patient and public awareness of the choices available.

AQP allows patients to choose, where appropriate, from a range of qualified providers who are licensed to provide safe care and treatment, and select the one that best meets their needs. The AQP model is intended to lead to an increasing focus on choice and competition as the drivers of a fully functioning, patient centred NHS that delivers effective and efficient services.

The DH operating framework (DH 2010) clearly identifies the requirement for the involvement of patients and the public when planning services, allowing them to understand how and where their money is being spent and offering greater choice and control of services. The key is shared decision making, summed up by the phrase “no decision about me without me.” Integral to this, is how the quality and productivity challenge will be met; securing re-investment to meet the demand and improve quality and outcomes.

What it means for providers
All healthcare providers – including NHS and independent organisations, charities and social enterprises, which meet the qualifying requirements will be able to deliver some NHS services.

From the end of this year and subject to the results of testing, local commissioners will start to work with patients, healthcare professionals and providers, making decisions about which services in their local community will benefit from extended choice of provider. For 2012 they will then invite new and existing providers to qualify and register to provide services to patients.

There will be clear referral protocols and thresholds. This means that providers will treat patients within a set of criteria in line with clinical best practice. The volume of patients any provider sees and is paid for will be entirely dependent on patient choice.

Providers will need to focus on offering responsive, high quality services and ensuring patients and GPs have accurate and comprehensive information on their service offered.

With commissioners controlling both contracts and prices, and challenging providers to deliver services of the highest quality, offering patients choice of Any Qualified Provider will help the NHS meet the QIPP agenda (Quality, Innovation, Productivity and Prevention) (DH 2010).

Choice of provider is expected to drive up quality, empower patients and enable innovation

Healthcare providers and commissioners will be expected to meet the quality agenda through cost savings while not being detrimental to patient care.

All providers will need to be qualified to provide services and will need to accept NHS prices. The DH expects that a national qualification process for Any Qualified Provider would minimise bureaucracy and reduce transaction costs for providers and commissioners. Patient safety is paramount. Qualification would also ensure that a provider who is registered in one locality does...
not have to go through a full qualification process again for that service in another locality.

Commissioners will set local care pathways, and will have the flexibility to ensure services are fully integrated and responsive to local needs. Providers will agree final contracts with PCT clusters or, in future, Clinical Commissioning Groups. After agreeing contracts and prices, providers will then be ready to receive patients, and the payment that follows. Commissioners cannot refuse to accept providers once they have qualified, unless they are unwilling or unable to meet any of the qualification requirements.

**What it means for commissioners**

Whilst the system appears simple from a provider and a patient point of view, it does raise important issues for commissioners. How to ensure that the new system does not lead to unplanned increases in costs is one such issue. This will require effective clinical referral protocols and treatment thresholds.

Careful consideration also needs to be given to both ‘currency’ for services and to the need for local pricing where national pricing does not exist. Experience from the current Payment by Results policy operated by the Department of Health (DH 2010) shows that these are technically challenging tasks. It is likely to be advisable for commissioners to collaborate rather than try to address these at an individual primary care trust (PCT) or commissioning group level. Clarity will be needed as to where different responsibilities sit.

It is important to be clear what might constitute ‘proportionate’ local standards. It could prove extremely burdensome to providers (particularly those covering more than one area) if local commissioners develop very variable or very complex local standards. This should be avoided unless there are sound objective grounds and evidence that this would either:

- *raise standards*
- *ensure that specific needs of the local population are met.*

**Discussion and Conclusion**

As part of the ongoing work on the AQP implementation task teams for each service area, highlighted above, have been brought together. It is these task teams’ responsibility to support the ‘roll-out’ of the AQP programme and develop implementation packs for each service area and engage with the relevant stakeholders.

One key element of the task team is to ensure that the messages and definitions regarding their service area are kept clear and consistent. It is important to note that the Venous Leg Ulcer and Wound Management service area is defined as ‘venous leg ulceration and the management of that wound type’.

The challenge for this service area is to ensure that a clear and achievable service specification is developed that can be ‘rolled-out’ nationally. In addition it will be vital to ensure that the tariff that is aligned to this service area is deemed to be fair and equitable. In determining the tariff aspects of it being procedurally led and outcome specific will need to be taken into consideration.

In order for the NHS and the DH to truly embrace the corrected roll out of the AQP ideal the patients’ needs must be at all times considered as central to the implementation. Only by assessing the variables of choice from a patients view point can this new model of care be achieved and hold true to the government mantra of “no decision about me without me”.

**References**


On the 1st of August 2011 we set off on our week-long campaign to raise awareness of leg problems. This was a week of public awareness sessions in shopping centres, staff training and cycling to the different venues, which started in Liverpool and ended in Hull on Friday the 5th of August.

This was an idea cultivated by my colleague Simon Barrett, Tissue Viability Nurse from Humber NHS Foundation Trust. During discussion I know I was very enthusiastic about such an event but my enthusiasm was about the need to raise awareness – somewhere along the way it developed into a charity cycle ride across the country, and I am still not sure at what point I actually agreed to do the cycling. Julie Carr, Helen Tankard and Alison Turner from Activa Healthcare had been equally inspired by Simon’s idea in that they were very keen to support the event. They did this by advertising, booking venues, organising the public awareness days and not least by providing excellent support vehicles for the cyclists.

So it was I found myself travelling to Liverpool on Sunday evening the 31st of July feeling very nervous, as I was still unsure if I would actually be able to do much of the cycling. My old bike had not seen light of day for well over five years and a quick cycle down my road, all of 500 yards, about two months before the planned event left me in no doubt that I was not at all fit and in no shape to cycle five miles never mind 150.

I had been told that the problem may be my old mountain bike and that I needed a hybrid; no, not a type of rose bush, I discovered, but a town and trail bike. I went along to our local bike specialist shop and came away the proud owner of a hybrid and went on a ten-mile bike ride which took me a couple of days to recover from. I managed to cycle once a week until the charity bike ride but the furthest I cycled was only 12 miles, so I hardly felt prepared.

Monday morning the 1st of August started with a public awareness session at the Quaker Meeting house in Liverpool, and Simon and I were booked to present to local staff in the afternoon. Subjects covered included the aetiology of leg ulcers and assessing lower leg oedema. Once I was speaking the thought of the bike ride went out of my head till five minutes before the end of my session when Simon opened the door and he was already in his cycle gear! Then panic set in again – would I be able to keep up? What if I got lost? I had no idea of the route, but not least would I survive?

We had been joined by seven others keen to take part in the charity bike ride these included ‘Squadron Leader’ Mike Carr (Julie’s husband, so not sure if self-volunteered or conscripted by Julie), given this title for his work in planning the route and his motivation to keep people going; Sarah, Julie’s daughter, who made cycling look so effortless; Nick Heys, Regional Manager for Coloplast who had volunteered to take part, and also ‘Mountain Goat’ Al McCann, his name earned by being the only one who managed to cycle up the steepest hill I have ever seen and no, it wasn’t the Snake Pass! Al, who works for Molnlycke Health Care, is a keen cyclist and had already planned to cycle from Lands End to John...
O’Groats alone at the end of August. These four along with Simon and me were the ones who completed all three legs of the cycle ride across the country. For the Liverpool to Manchester leg we were joined by Rob Holder and Rob Morton (both from Activa Healthcare), along with Justin Clark from CCD Public Relations.

We left Liverpool at about 5pm (rush hour!) and did well but unfortunately with only five miles to go there were some moments of panic – a couple of falls from bikes (managed to get a bit of wound care practice in), a puncture and a loose bike chain – but we all managed to get to the hotel in about two hours and fifty minutes. Fortunately we did not have any staff training to do in Manchester, but there was a public awareness in the Trafford centre on the Tuesday. I did not intend to cycle at all on the Tuesday (I was still revelling in the fact that I had completed the first leg which was 39 miles), but got talked into cycling to the Trafford Centre in our ‘Your Legs Matter’ t-shirts to try and raise some interest and donations. If you need an entertaining story, ask Simon how he talked security into letting us stay in the centre with our bikes, which was classed as a health and safety hazard. The Trafford Centre had the record for the number of people who attended for advice on their legs, the local nurses seeing a total of 83 people – a very tiring day.

Wednesday the 3rd of August had some excellent highlights but some very low periods as well. This was the day we cycled from Manchester to Sheffield. Much debate had been had in the bar the night before on which would be the best route, and finally it was decided that it would be best to go via the Snake Pass. The day was one of the hottest of the year and we set off with great enthusiasm. We had a new rider for this leg – Kim Drewery, Tissue Viability Nurse from Sheffield Teaching Hospital Community team. Kim had given up her time to cycle, using a borrowed bike, (many thanks to the cycling touring club CTC), hers having fallen from the back of her car the previous week when going out to have a practice – what dedication! That dedication soon waned when approaching the Snake Pass – what Kim thought was a cloud was actually the summit.

The views from the summit of the Snake were breathtaking – or perhaps that was the effect of cycling up there, but it was certainly worth a photo shoot. Then the cycle up seemed worth it for the ten miles of downhill right to the Lady Bower Inn where we stopped for lunch. The mood was giddy; we were all elated and ready for the estimated 18 miles left to get to the hotel at Tankersley where Simon and I were booked to do another teaching session at 6.30pm. What we didn’t account for was the last 18 miles was up and down the dales of Sheffield. Riding down into Lower Bradfield was exhilarating but the climb up out of the valley to High Bradfield was a really low point for everyone.

There was even worse to come with ‘Jaw Bone Hill’ out of Outibridge. I did wonder at the bottom of the hill why painted on the road it said ‘no pain no gain!’ I soon realised why. We eventually reached Tankersley Manor at about twenty-five to six with very little time to freshen up before the training. We were beginning to think we had set ourselves too big a challenge, as the next day Thursday the 4th we were due to cycle to Hull and again deliver a teaching session at 6.30pm.
The Sheffield public awareness day also took place on the Thursday on the Moor in Sheffield city centre with Kim (our extra rider on Wednesday) and Lesley Butcher (Tissue Viability Nurse). In stark contrast to the weather on Wednesday, Thursday was very wet. A quick text from Kim on the morning put me in the picture “It’s wet, it’s raining, I am stood on the Moor and I want to see my job description!” Therefore, big thanks to Kim and Lesley who gave up their time to see members of the public who presented with leg problems in Sheffield.

We were joined on the Sheffield to Hull leg by Becki Carter, Account Executive for Coloplast. Becki had been and bought a bike the previous week, had never really cycled before and had not practiced at all but made a fantastic effort and completed the 62 miles to Hull. The sight of the Village Hotel where the training session was booked was we all agreed, one of the best ever. Special thanks also to Chris Hall, 2010 Productions, who did a sterling job setting up all the venues, but more importantly sponsoring the cyclists and providing champagne on arrival in Hull. Recounting the journey in the bar that night was indeed one of the highlights of the week, but the journey had still not finished as on Friday there was the final public awareness day in St Stevens shopping centre in Hull, where I helped Simon, Helen Small and Kath Williams (both from Humber NHS Foundation Trust) to see over 50 members of the public.

In all, over 150 miles were covered, in excess of £1700 was raised for charity, over 60 nurses attended the training sessions and 233 members of the public were seen and given advice about their legs. Amongst those seen were people with Lymphoedema – one 35 year-old lady in Hull had been told by her GP a few years ago that she would have to live with it (the swollen leg) as there was nothing that could be done. There were also many with varicose vein problems, leg swelling and leg pains. In Sheffield, 29 people are to be booked into the assessment clinic prior to fitting with hosiery.

We are now already thinking about ‘Your Legs Matter 2012’ – not sure where this will take us, but we have more people keen to be involved. However, I might just be a bit more cautious about what I say yes to this time!

BK
The LUF
word search

Caroline Dowsett
RAL
Protease Modulator
Parliament
House of Commons
House of Lords
Biomechanics
Case Study
Treatment and prevention
Hosiery
Compression
Community leg ulcer service
Reduced rand of motion
Gastrocnemious muscle
Neuropathy
Ambulatory
Any qualified provider
Gait abnormalities
Biopsy

C I S 0 L A T P 0 N C A P G A I T N A
H I R N C M H R A L L D E G A R D E B
R A C M E N M O D U L A T O R V E U N
D P O K Y A R T E C L T H S O H D R O
N E D B I O M E C H A N I C S O N O R
T L O T C P A R L I A M E N T E P M
C C S E L D U S L O X N L E A A L A A
H O S I E R Y E J T C S E D I C S T L
S M I S T R E C S E S D S E N U S H I
U P C E R A S S O C I A T E D L S Y T
C R E D U C E D H O U S E T O N U A I
O E Y S T V A H R M C E S S I V E M E
M S W R A N G E T M E R U U N L L B S
M S L O F P G E G O F R O Q H E N U F
U I D M V U R I C N S E H I E P H L O
N O Y O E L O R D S I S U T R R A A R
V N E T C C F S U T R E A M E N T O
A N Y I M E Q U A L I F I E D V D O U
Y T H O O R A L D D T A Y C P E N R R
L Y R N E A E D G O A C O N R N I Y N
Q U R E N T A U T W U M N R O T E A B
V E E N U I S I N S R A S O V I E R K
E E C A R O L I N E E O N A I O T E D
L J L I Q N A L E T Y E O M D N I F E
H Y U N R T E T S T U D Y U E S E M H
E B I O P S Y O A N A I R S T T R C
D O R S E R V I C E R C U C A T I R Y
C O M M U N I T Y I N G V L R C B O L
S L E G I G A S T R O C N E M I O U S
Ask LUF

Q I would like to ask you for your expert opinion on the use of topical steroids directly on wounds. This particularly relates to Trimovate which in my area has escalated significantly.

I have been concerned about this practice, as without a protocol or any sort of guidance nurses are able to get it prescribed by the GP and use it whenever they want. When questioning other TVNs in the area about why they may use it, depressingly they say “well, it works doesn’t it?”. I’m afraid that with ever-increasing scrutiny by clinical governance that is not good enough in my opinion.

A In conjunction with our dermatology colleagues we sometimes use topical steroids and I have to say have very good results. Mild topical corticosteroids (1% hydrocortisone) can be used to reduce overgranulation, but evidence for this is limited. They should be applied daily for a maximum of seven days and will require a secondary dressing. Please be aware that using an occlusive dressing will increase absorption of the steroid. As the steroids are used off-licence I ask the consultants to write the prescription. We have found that exudate levels reduce and indolent ulcers (which have failed to progress despite appropriate compression and wound care products) are progressing to healing. The patients report a reduction in pain. We normally use Betnovate RD or Daktarin. It is never used as first line treatment.

We currently do not have any clinical guidelines, as they are only used on specialist/consultant advice. However, its use has to be exercised with caution as it is not licensed for use in this area. The side effects of using topical steroids for extended periods include skin atrophy and striae (linear stretch marks), easy bruising due to loss of collagen, telangiectasia (if used on the face) due to individually dilated blood vessels, and rebound phenomenon causing a worsening of the original problem when the treatment is stopped (Ashton and Leppard, 2008).

Reference

Q I have a rheumatology patient who has calcinosis to both shins which has now broken through the skin and is exudating. Has anyone had any experience with this kind of thing and/or any advice on how to manage the wound? It continues to be open and we are trying to keep it infection-free as much as possible although the patient has had two oral antibiotic courses already.

A It can be a very difficult condition to manage, but it is useful to try and determine the cause. There are four main causes – please see the information on the Dermatology NZ website. Sometimes called Calciphylaxis a type of Metastatic Calcinosis Cutis. Metastatic Calcinosis Cutis occurs in the setting of abnormal calcium and phosphate metabolism and is often associated with hypercalcaemia and/or hyperphosphataemia. The cause for your patient is probably dystrophic, due to RA and the drug therapy but it would be worth checking the serum calcium levels to check on the patient’s level of calcium in case of other systemic disorders which may then respond to some medical treatment.

In the case of dystrophic calcinosis cutes the serum calcium level would be normal. A plain x-ray of both legs would show how much calcification of the underlying tissue has taken place. Often the calcification is so widespread that surgery would be impossible, at that point obvious loose areas may be removed surgically. Otherwise it is a case of conservative management, but with an emphasis on prevention of infection as these areas are considered to be...
high risk, not least because the barrier function of the skin is impaired. Even when removed they often return.

**Further information**
http://dermnetnz.org/systemic/calcinosis.html

Q Are there any National Guidelines for when and where toe pressures are used? We currently use them as an adjunct if ABPI’s are above normal limits, to assess whether it would be appropriate for a trial of compression bandaging. In our clinic they are also used when ABPI’s are 0.7, to assess whether appropriate for reduced compression. Any ideas for what to do if toe pressures are greater than 300 and systolic equals 180. Is it still safe to compress?

A There are currently no National Guidelines. Toe pressures can be recorded using various methods, the reliability of which can be questionable. The results can be affected if the optimal cuff size is not utilised, and if the cuff is incorrectly placed on the digit (Varatharajan et al, 2006).

Toe pressures correlate with the chances of healing of skin lesions, and with the risk of amputation in relation to diabetic foot ulceration (Sawka and Carter, 1992). The results can be affected by the temperature of the toe, giving falsely low readings, and also by the temperature of the cuff itself. In ‘Effect of temperature on digital systolic pressures in lower limb arterial disease’ Varatharajan et al (2006) advise that a single recording of the toe pressure is of little clinical significance as there is a possibility of an isolated low reading. Serial toe pressures should be recorded to obtain a true and meaningful value. In ‘Implications of low great toe pressure in clinical practice’ (Williams et al, 2005) argue that there is no consensus on what constitutes a normal toe-brachial pressure index, and that toe pressure readings may also be influenced by neuropathy. It may also be worth seeking the advice of your local vascular surgeons as they may be able to help you.

**References and further reading**
Principles of Skin Care
Rebecca Penzer and Steven J Ersser with contributions from Julie Van Onselen, Rachel Duncan and Jean Robinson
£33.24 (on Amazon)
ISBN: 978-1-4051-7087-1

This book is a most welcome addition, as there is a dearth of Dermatology nursing books. It is aimed at all healthcare professionals who have an interest in, or work with, patients presenting with skin complaints. It focuses on the generic components of helping patients with skin conditions. The book is well laid out, broken down into clear chapters with boxed summaries of important facts/information and a useful reference section at the end of each chapter, making it a relatively easy read as well as being a useful reference book. Both authors have been recipients of the Stone Award by the British Dermatology Nursing Group for service to Dermatological nursing.

The book is split into two broad sections ‘fundamental principles of managing the skin’ and ‘principles of illness management’. The first section addresses core nursing issues that are relevant across the board of dermatological care while the latter section covers conditions most commonly seen in nursing practice, such as acne, eczema and psoriasis. There is a recurrent theme of using nursing skills to promote skin health and prevent disease, with the book describing what happens when the skin is no longer healthy.

Chapter two, the biology of the skin, which can be a dry subject, is a fascinating and well-written section, covering not only the structure and function of the skin but addressing the appendageal structures, hair and nails. In addition the author addresses skin changes that occur from pre-birth to old age, along with ethnic differences. This is followed by a chapter on assessment and planning care which offers an overview to a systematic approach to assessment, and addresses both the physical and psychological aspects. Incorporated into this chapter are assessment...
tools for both aspects of nursing care. This section provides excellent guidance on the terminology for describing skin lesions along with a table of types and definitions of skin lesions to assist those who are new to managing patients with dermatological conditions. The book addresses the psychological and social aspects of skin care, giving the healthcare professional the background knowledge to help patients cope with the psychological impact of their skin problems.

There is a further chapter on helping patients make the most of their treatments which is a rarity but most welcome chapter, especially as we are in a market where every treatment counts, and where we need to prevent patients storing up large quantities of prescribed but unused treatments in their homes.

A whole chapter has been devoted to emollients (moisturisers) because as the author stated “emollients are vital therapeutic products in the field of dermatology”. They are not just simple inert products but complicated mixture of carefully-formulated compounds with a range of impacts on the skin.

The second part to the book, based on the principles of illness management, addresses psoriasis, eczema and acne, skin cancer and its prevention, and infective skin conditions and infestations. These three chapters look at the background, followed by the biology to the condition. With the psoriasis section the diseases associated with this condition are discussed, followed by the clinical variants of psoriasis and finally a clearly set-out referral criteria for specialist services input. These are very useful tools for nurses working in Primary Care. The final chapter looks at a number of less common conditions such as blistering conditions and drug-induced photosensitisation.

Conclusion

When I first got this book, I was rather disappointed by it as I was rather hoping it was going to give me ‘how-to’ knowledge on the practical aspects of dermatology treatments such as shampoos, when and how to apply them. However, after reviewing this book I found instead it gave me excellent background and clinical information on dermatological skin conditions for my clinical practice. I suspect it will also be a useful resource for Primary Care and Community-based nurses whose main workload is linked to skin conditions.
Courses
University of Glasgow

Exit award qualifications
- CPD Certificate with or without academic credit
- Graduate Certificate/Diploma (Level 4)
- Postgraduate Certificate (Level M)
- Option to continue to PG Diploma or Masters
- Keyworker Qualification
- Casley-Smith MLD Practitioner Qualification
- Casley-Smith Specialist Updates

<table>
<thead>
<tr>
<th>Course</th>
<th>Dates offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lymphoedema: Diagnosis, Assessment &amp; Risk Reduction, 20 credits</td>
<td>Glasgow: 10th - 13th Jan 2012</td>
</tr>
<tr>
<td>Lymphoedema: Assessment &amp; Management, 20 credits</td>
<td>Glasgow: 28th - 30th March 2012</td>
</tr>
<tr>
<td>Managing Complicated Lymphoedema (Casley-Smith DLT), 40 credits</td>
<td>Pt 1: 24th-27th Jan 2012</td>
</tr>
<tr>
<td></td>
<td>Pt 2: 6th-9th March 2012</td>
</tr>
<tr>
<td></td>
<td>Pt 3: 6th-8th June 2012</td>
</tr>
<tr>
<td>Managing Oedema due to Advanced Disease, 20 credits</td>
<td>20th - 23rd September 2011</td>
</tr>
<tr>
<td>Lymphoedema: Specialist Service Development, 20 credits</td>
<td>14th - 17th Feb 2012</td>
</tr>
<tr>
<td>Lymphoedema: Casley-Smith Update Course (£295)</td>
<td>6th to 8th June 2012</td>
</tr>
</tbody>
</table>

2011/2012 Lymphoedema Opportunities

“every time I come here for a course or part of a course, I leave feeling more confident”
Carol Brailsford
Macmillan Clinical Specialist Lymphoedema/Chronic Oedema

Further information
Please contact Emma Fisher or Margaret Sneddon
T: 0141 330 2072/2071
E: lymph@glasgow.ac.uk
W: www.gla.ac.uk/departments/nursing/

Please note that the closing date for applications is 6 weeks prior to start of courses.

The University of Glasgow: Ranked in the top 1% of universities in the world and voted best campus in Scotland by the Times Higher Education Supplement.

Rated FIRST in the UK for Nurse Education in the National Student Survey (NSS) 2010, The 2010 NSS results show that 100% of our BN undergraduate students are satisfied with their experience.

RAE 2008: 60% of our Nursing & Health Care research is world leading or internationally excellent, and a further 30% is of international quality.
Leg Ulcer Courses
University of Hertfordshire

Leg Ulcer Theory and Practice
6NMH0017 Level: 6, Credit: 15

Who should attend this course?
Registered Healthcare Professional working in a healthcare environment with access to leg ulcer service provision.

Course Aims
This module aims to enable students to achieve competence in the assessment and management of people with leg ulcers and a greater understanding of the issues involved in delivering effective leg ulcer services. You will need to have access to a clinical area where people with leg ulcers are managed and you will need a suitable Practice Assessor as this is a competency based module.

Module Content
You will study the aetiology of leg ulcer development and the theoretical principles underpinning the assessment and management of people with leg ulcers and related conditions.

Assessment
• Coursework: a report on service provision and the extent to which it meets patient needs
• Completion of Practice Portfolio
• Demonstrate competence in Doppler assessment and compression bandaging

Where is the module taught and by whom?
The module is taught at the College Lane Campus and is facilitated by lecturers with expertise in the area from the University and invited external speakers.

When does this module run?
Wednesdays in Semester B (February – May): 12 study days.

Cost
To find out information about the fees visit go.herts.ac.uk/cpffees

Complexities in Leg Ulcer Management
7NMH0003 Level: 7, Credits: 30

Who should attend this course?
Registered Healthcare Professionals working in the healthcare environment who manage people with leg ulcers and related conditions. You will already be competent and experienced in Doppler assessment and compression therapy. Previous students on this module have been Tissue Viability Nurses, Leg Ulcer Specialist Nurses and those aspiring to a specialist role. You will wish to advance your skills to plan and deliver a more comprehensive care package. This module forms part of the postgraduate degree award or can be undertaken independently depending on previous and current clinical experience

Course Aims
Students will develop existing skills to encompass advanced assessment and clinical management of people with ulceration of the lower leg and associated conditions. Students will be enabled to develop in depth knowledge of strategies to promote evidence based care, prevention strategies and partnerships with patients with leg ulcers and associated conditions

Module Content
This module focuses on the complexities of managing patients with leg ulcers from a clinical and service delivery perspective.

Assessment
You will plan a new service or develop an existing service based on a needs analysis of your clinical area.

When does this module run?
This module runs in a block format with 8 study days between February 2012 and May 2012

Course enquiries
For further information about these modules, please contact Module Leader:
Irene Anderson
t: 01707 285233
i.l.anderson@herts.ac.uk

Booking enquiries
CPD Short Course Office
t: 01707 284956
f: 01707 285814
cpdhealth@herts.ac.uk
Epidemiological studies suggest that up to 2% of the population will suffer from leg ulcers at some point in their lives with two thirds of these occurring in elderly people. Demographic data predicts a rise in the numbers of elderly people into the next century, which will clearly indicate an increase in the numbers of leg ulcers and as a consequence increase health care costs. During the last decade the management of leg ulcers has changed dramatically with more emphasis now focused on using effective evidence based treatments.

This module has been designed to meet the learning and development needs of practitioners in relation to individuals with leg ulceration and to facilitate the delivery of holistic care derived from an evidence base. It will focus on the effective multidisciplinary assessment and management of the patient’s physical and psychosocial needs.

### Assessment:

Assignment and Seminar

### Further Information

For information please go to [www.worcester.ac.uk](http://www.worcester.ac.uk) and click on courses and departments, then course search and the CPD Framework leading to a BSc (Hons) in Applied Health Sciences is in the A-Z of courses list.

### To enrol or to check availability

Please contact Registry Admissions, Team C on tel: 01905 855111 or e-mail: admissions@worc.ac.uk

### General Module Enquiries

Please contact: Allied Health Sciences Administrator
Tel: 01905 855546
Fax: 01905 855589
Email: cpdinfo@worc.ac.uk

---

**Module Leaders** Julie Day

**Credits**

Level 6, 20 Credits

**Dates**

14, 21, 28 September 2011
5, 12, 19, 26 October 2011
9, 23, 30 November 2011
1 December 2011

(09.15 – 16.15)

**How to apply**

The majority of CPD Framework modules are funded by the NHS and therefore you need to complete 2 application forms:

- A University of Worcester Application Form
- Study Leave Form

**University of Worcester Application Form**

Please click on the following link to apply:  
[http://www.worc.ac.uk/courses/howtoapply/774.html](http://www.worc.ac.uk/courses/howtoapply/774.html)

**Study Leave Form**

All students employed by a Worcestershire or Herefordshire NHS Trust have to complete a study leave form if they want (a) to study in works time, or (b) want the Trust to fund or part fund the course, or both. The Strategic Health Authority has asked that we only accept applications which are accompanied by a copy of an authorised study leave form.

Please ensure that funding for your study leave has been authorised by the Education lead for your Trust, before submitting your application, together with your study leave form.
22nd Conference of the European Wound Management Association

EWMA 2012
23-25 May · 2012

WOUND HEALING – DIFFERENT PERSPECTIVES, ONE GOAL

Organised by the European Wound Management Association
in cooperation with Die Österreichische Gesellschaft für
Wundbehandlung AWA (Austrian Wound Association)

Organisiert von: der Europäischen Wound Management Organisation
in Zusammenarbeit mit der Österreichische Gesellschaft für
Wundbehandlung, AWA

Bilingual:
English & German
Zweisprachig:
Englisch & Deutsch

WWW.EWMA.ORG/EWMA2012
LUF Journal sponsors

We leverage 3M technology and world-class manufacturing to provide trusted products that help promote health and improve the quality, cost and outcomes of care.

3M Health Care Ltd
3M House
Morley Street, Loughborough LE11 1EP
Tel: 01509 613021  Fax: 01509 613194
Advice Line: 0800 616066 (Answerphone)
Web: www.3mHealthcare.co.uk

Activa Healthcare works in partnership with clinicians to improve patients’ quality of life with innovative compression therapy and wound care ranges.

Activa Ltd
1 Lancaster Park, Newborough Road, Needwood Burton-upon-Trent, Staffordshire DE13 9PD
Tel: 08450 606 707 / 01283 576800
Fax: 01280 576 808
Web: www.activahealthcare.co.uk

Advancis is dedicated to the improvement of healthcare through the continuous development and production of quality medical products for the effective management of clinical conditions.

Tel: 01623 751 500  Fax: 0870 264 8238
Email: info@advancis.co.uk
Web: www.advancis.co.uk

Manufacturers and distributors of classic and innovative skin protection and woundcare products: Sorbsan, Sorbsan Silver, Sorbaderm, C-View, PolyMem, DryMax Extra, Aquaform, Mesitran and Trufoam.

Aspen Medical Europe Ltd
Thornhill Road, Redditch
Worcestershire B98 9NL
Tel: 01527 587728
Web: www.aspenmedicaleurope.com

B.Braun offers healthcare professionals products which represent ‘Extraordinary Performance and Excellent Value’ in our Askina range of dressings and Prontosan wound cleansing products

B.Braun Medical Ltd
Thornfield Park
Sheffield S35 2PW
Tel: 0114 225 9000  Fax: 0114 225 9111
Email: info.bbmuk@bbraun.com
Web: www.bbraun.co.uk

We are global leader in the healthcare market, offering a wide range of products for advanced wound care, compression garments for lymphoedema and vascular therapy.

BSN Medical Ltd
PO Box 258, Willerby, Hull HU10 6WT
Tel: 01482 670140  Fax: 01482 670111
Email: advancedwoundcare.uk@bsnmedical.com
Web: www.cutimed.com

Crawford has over 15 years experience in supplying the NHS specialist dermatology products and is now the owner of Ark Therapeutics Woundcare business.

Crawford Healthcare Ltd
Unit 1, Adams Court
Knutsford, Chesire WA16 6BA
Tel: 0800 1077 107
Web: www.woundcaresolutions.co.uk

continued…
Coloplast provide products and services making life easier for people with intimate healthcare needs. In wound care we produce solutions for all types of wounds.

**Coloplast Ltd**  
First Floor Nene Hall  
Peterborough Business Park  
Lynchwood, Peterborough PE2 6FX  
Tel: 01733 392000  Fax: 01733 392314  
Advice Line: 0800 220622  
Web: www.coloplast.co.uk

Mölnlycke Health Care is a world leading manufacturer of single-use wound care and surgical products and services for the professional health care sector.

**Mölnlycke Health Care Ltd**  
The Arenson Centre  
Arenson Way  
Dunstable  
Beds LU5 5UL  
Tel: 0800 7311 876  
Email: info.uk@mymolnlycke.com  
Web: www.molnlycke.co.uk

H&R Healthcare represents world class companies in Advanced Wound Management (Sorbion Sachet S and Sorbion Sana, MIST Ultrasound), Compression Hosiery (Carolon), and Infection Control.

**H&R Healthcare Ltd**  
Melton Court  
Gibson Lane, Melton  
Hull HU14 3HH  
Tel: 01482 638472  Fax: 01482 638485  
Web: www.hrhealthcare.co.uk

We are committed to the advancement and implementation of clinically cost-effective wound care throughout the country. Providing therapy based Formulary Services and accredited educational programmes.

**Smith and Nephew Healthcare Ltd**  
Healthcare House  
Goulton Street  
Hull HU3 4DJ  
Tel: 01482 222 200  Fax: 01482 222 211  
Web: www.smith-nephew.com

Huntleigh Healthcare’s Dopplex range of world leading vascular Dopplers has been expanded to include the revolutionary Dopplex Ability Automatic ABPI system.

**Huntleigh Healthcare Ltd**  
35 Portmanmoor Road  
Cardiff CF24 5HN  
Tel: 029 2048 5885  Fax: 029 2049 2520  
Email: sales@huntleigh-diagnostics.co.uk  
Web: www.huntleigh-diagnostics.com

Urgo offers a range of clinically proven, innovative dressings and compression bandages, improving quality of life for patients and meeting the needs of healthcare professionals.

**Urgo Ltd**  
Sullington Road  
Shepshed  
Loughborough LE12 9JG  
Tel: 01509 502051  Fax: 01509 650898  
Web: www.urgo.co.uk

Medi are the leading global manufacturer of RAL quality medical compression garments. Available in Hospital and on Community Prescription FP10

**Medi UK Ltd**  
Plough Lane, Hereford HR4 0EL  
Tel: 01432 373500  Fax: 01432 373510  
Web: www.medicuk.co.uk
Once you have decided to write an article for the Leg Ulcer Forum Journal, make sure the content is appropriate for the readers. The following gives guidelines for authors.

**Format**

- **Front page**
  - Title of article
  - State author’s name/s, qualifications, position, and place of work. Name, address and contact telephone number of the author responsible for correspondence.

- **Introduction**
  - This should be approximately 30 words in length. It should introduce the reader to the areas covered in the article.

- **Headings**
  - Headings are useful to break up the text; they also help to organize the main points of the article.

- **Conclusion**
  - Should summarize the article, identify gaps in knowledge and suggest recommendations for future practice.

You can either send your article in hard copy addressed to the editor or it can be emailed for the attention of the editor (see below). Both should be presented on A4 with wide margins and double-spaced. Please type in upper and lower case – do not use ‘all capitals’ anywhere. Do not forget to keep a copy. Please send any charts, diagrams and photos as separate files.

The journal welcomes articles of interest. This could include a literature review, research project that you have been a part of, any innovations you feel would benefit our readers. Case studies are an invaluable source to practitioners, particularly when complex situations have successfully been addressed. Colour photographs and tables can be included to complement the text (the client must give written permission before publication of photographs).

All manuscripts should be between 1,000 and 2,000 words. However if you wish to submit a short report then 500 words would be acceptable. Larger manuscripts are at the discretion of the editor.

**References**

Please reference the manuscripts using the Harvard system. If you need further details of this, contact the editor.

*Articles should be sent to:*

Susan Knight  
Editor  
The Leg Ulcer Forum  
PO Box 641  
Huntingdon PE29 1GU  
OR by email (for the attention of the editor) legulcerforum@btinternet.com

"Care studies are an invaluable source to practitioners, particularly when complex situations have successfully been addressed."
Supporting the professionals

Providing a forum for nurses working within the field of leg ulcer management and wound care

• Facilitating discussion, debate and reflective practice in which all members are encouraged to participate

• Disseminating new research and identifying and supporting areas of good practice

• Providing support to specialist nurses involved in establishing leg ulcer services

• Encouraging continuous professional development

THE LEG ULCER FORUM
PO Box 641 Huntingdon PE29 1GU
legulcerforum@btinternet.com
www.legulcerforum.com