National Wound Care Strategy Programme

Key Messages

Working in partnership with

Health Innovation Network

NHS

Introducing the document

Purpose of key messages and summary of programme

What is the purpose of the key messages?

PROGRAMME CLOSE	The National Wound Care Strategy Programme will come to a close in March 2025.
RECOGNITION OF VALUE	The value of this work has been recognised by a wide range of stakeholders, who want to see this work continued.
A SMOOTH TRANSITION	Together with NHS England, the programme team is ensuring a smooth transition of workstreams.
ENABLING UNDERSTANDING	The key messages play a crucial role in this, by allowing stakeholder to gain a quick, **comprehensive grasp of the programme's approach, the journey and outputs of each workstream and they key recommendations for future work to be undertaken.**

Who are the key messages for?

1

NHS England

To ensure a smooth transition and continuation of work

2

Future teams/regional leads

Building on the programme successes

NHS colleagues and staff

Interested in understanding the core aspects of the programme

Public and patients

Eager to learn more about wound care and the clinical pathway

4

3

Why was there a need for this programme?

No national strategic framework

Lack of data and information

Poorly organised services

No standardised education

PATIENT SUFFERING

~ 3.8 million people living with a wound[1]

EXORBITANT COSTS

Wound care in England costs approximately £8.3 billion per annum

UNPRODUCTIVE USE OF STAFF TIME

Wound care accounts for 50% or more of community nursing time[3].

TREATMENT LOTTERY

There is unwarranted variation in the treatment of wounds, with underuse of evidence-based practice and overuse of ineffective interventions.

TREATMENT NOT PREVENTION

Non-healing or delayed healing is a major factor in care costs and many of these wounds could be prevented or healed more quickly.

Clinical workstreams of the NWCSP

THE PROBLEM	THE OBJECTIVE
LOWER LIMB WOUNDS **37% of all wounds and 71% of NHS spend on wound care[1]**	To ensure **equal access to evidence-based lower limb and wound care** through **integrated pathways, skilled teams, and consistent data sharing**. To **empower healthcare professionals, improve patient outcomes, and streamline care to address the root causes of delayed healing**.
SURGICAL WOUND COMPLICATIONS **14% of all wounds and 7% of NHS spend on wound care[1]**	To **advance the understanding, prevention, and management** of surgical wound complications through **standardised assessments, consistent data collection**, and **improved education.** To equip healthcare professionals with the **tools and knowledge to reduce complications and improve patient outcomes**.
PRESSURE ULCERS **5% of all wounds and 7% of NHS spend on wound care[1]**	To reduce the occurrence of pressure ulcers by **eliminating unwarranted variation in care**. We aim to create and **implement a standardised, evidence-based pathway across the NHS**, ensuring **consistent adherence to clinical guidelines and reducing the burden on healthcare providers while improving patient outcomes**.

Enabling workstreams of the NWCSP

SUPPLY AND DISTRIBUTION

To **standardise wound management product naming, coding, and grouping across all supply routes**, ensuring **clinical input drives the development of comparable product groups**. We aim to **improve data visibility on product spend and adapt to rapid changes in product portfolios driven by innovation**, mergers, and discontinued products, ultimately **enhancing patient care and operational efficiency.**

DIGITAL, DATA AND INFORMATION

To **enhance wound care data and information** by **identifying and optimising existing national datasets, coding systems, and IT infrastructure**.

To establish **comprehensive measurement standards across all healthcare sectors** to **drive better outcomes and informed decision-making**.

EDUCATION AND WORKFORCE

To equip every patient-facing healthcare practitioner with **consistent wound care knowledge and skills through accessible**, national education resources. We aim to **foster flexible learning and enhance the digital literacy of the healthcare workforce**, ensuring high standards of wound care are delivered across all levels of care.

What has the programme achieved?

Strategic Alignment

- Integration of wound care priorities into national NHS plans and frameworks.
- NHSE recognition of wound care as a priority and need to continue this work post programme completion.

Data and Information

- Improved data collection, classification, and use for better wound care management.
- Collaboration with organisations to enhance consistent data flows and integration.

Service Improvement

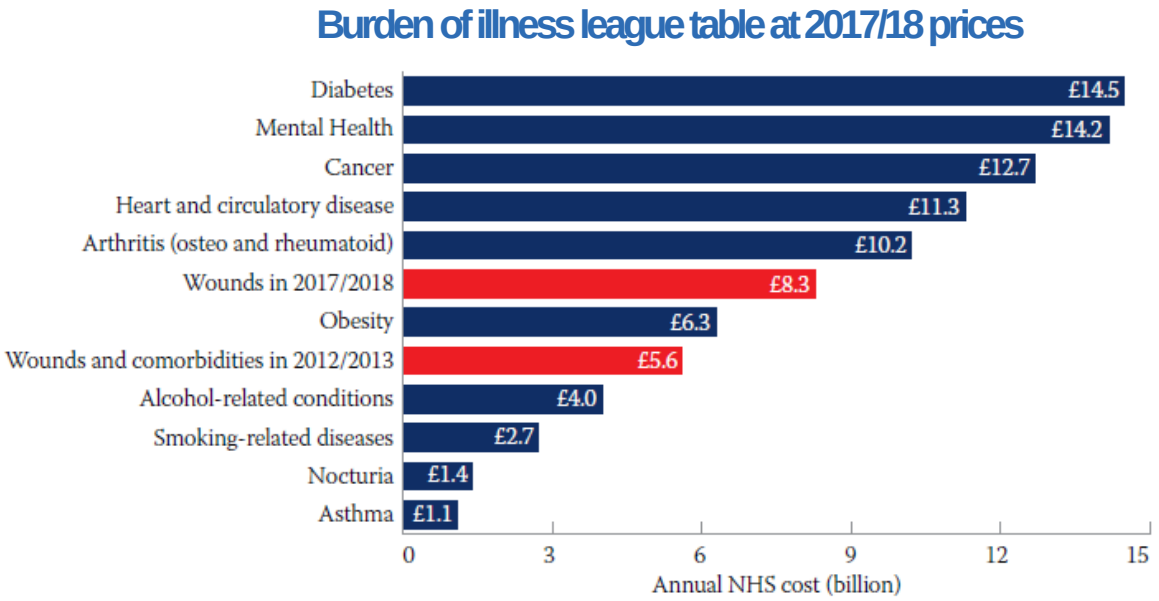
- Developed clear clinical pathways, recommendations and best practice standards to enhance care quality.
- Cooperation with organisations providing NHS services to implement effective service models.

Workforce and Education

- Established standardised training and resources for healthcare professionals.
- Created accessible, patient-friendly educational materials in multiple languages.

Background

- There are estimated to be 3.8 million people living with a wound[1], many experiencing long-term pain, discomfort and poor quality of life related to their wound.
- Wound care in England costs approximately £8.3 billion per annum - the third highest expense for the NHS after cancer and diabetes[2].
- Most wound care takes place in the community - accounting for 50% or more of community nursing time[3].
- There is unwarranted variation in the treatment of wounds, with underuse of evidence-based practice and overuse of ineffective interventions.
- Non-healing or delayed healing is a major factor in care costs and many of these wounds could be prevented or healed more quickly.



1. Guest JF, Fuller GW, Vowden P (2020), Cohort study evaluating the burden of wounds to the
UK's National Health Service in 2017/2018: update from 2012/2013, BMJ Open https://bmjopen.bmj.com/content/10/12/e045253

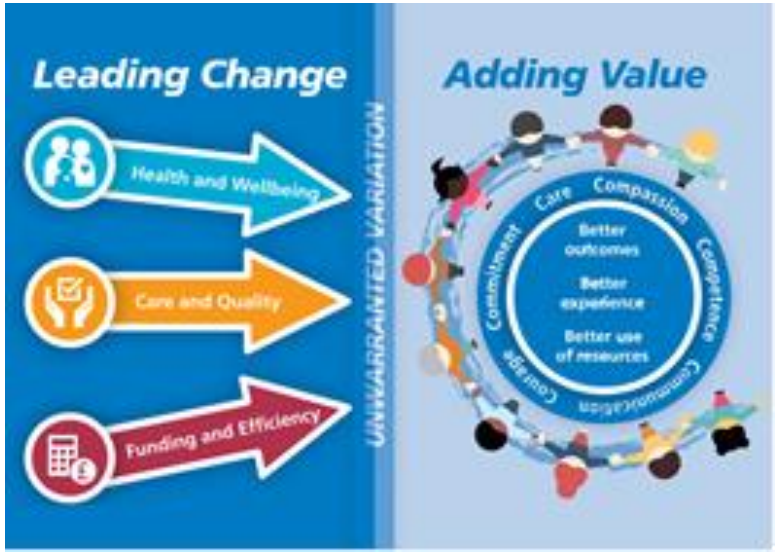
2. Guest, J. F. (2020). "Burden of wounds to the NHS: what has changed since 2012/13?" Wounds UK **17**(1): 10-15.

3. NHS Benchmarking Network (2021) Generic Community Services Report 2020/21

Growing consensus on the need for change

2016 Leading Change Adding Value (2016)

- *Chronic wound care recognised as a priority*



2017 House of Lords debate (Dec 2017)

- *Discussion on development of strategy for improving standards of wound care in the NHS*

2018 House of Lords meeting (May 2018)

NHS E & NHS I Visioning Session (4th May 2018)

The National Wound Care Strategy Programme (NWCSP) is commissioned by NHS England

- Established in 2018 to address:
  - the **unwarranted variation** in wound care services
  - lack of **robust wound care information**
  - inadequate levels of wound care knowledge and skills across the health workforce

  and help systems to:
  - improve wound healing
  - prevent harm and **reduce patient suffering**
  - increase **staff productivity**
  - deliver **financial savings** to the NHS

  focusing on:
  - lower limb wounds
  - pressure ulcers
  - surgical wound complications.

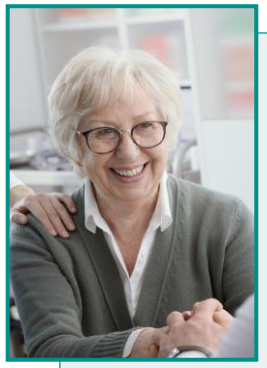
Lower Limb Wounds 37% of all wounds and 71% of NHS spend on wound care[1]

Pressure Ulcers 5% of all wounds and 7% of NHS spend on wound care[1]

Surgical Wounds 14% of all wounds and 7% of NHS spend on wound care[1]

1. Guest, J.F., G.W. Fuller, and P. Vowden, *Cohort study evaluating the burden of wounds to the UK's National Health Service in 2017/2018: update from 2012/2013.* BMJ Open, 2020. **10**(12): p. e045253.

Improving wound care significantly benefits all



Patients

The current **healing rate for lower leg wounds is only 32%** at 12 months, with **recurrence rates high at 46%** at 12 months.

Inequality

Leg ulcers and pressure ulcers are more common in older people, those from lower socio-economic backgrounds and women. People experiencing homelessness and those with addictions and substance misuse problems are more susceptible to leg ulcers.

Healing rates are lower, and recurrence rates are higher in more deprived areas.

Leg ulcers and pressure ulcers are a major precipitating factor for frailty.

Workforce

Most wound care occurs in community settings and accounts for **50% or more of community nursing** capacity and time.

Cost

Wound care is costly. For example, there are estimated to be **739,000 leg ulcers in England** (primarily due to venous disease), with estimated **healthcare costs of £3.1bn per annum**.

NWCSP Approach

Problem	Solution
NO NATIONAL STRATEGIC FRAMEWORK • Wound care not recognised as a national priority. • No framework to support improvements in the quality of wound care services. • No focus on impact on wound care on sustainability and net zero. • NWCSP identification of health inequalities.	• NWCSP funded as a 5-year programme. • NWCSP included in the NHS Long Term Plan. • Development of CQUIN's to drive local quality improvement initiatives and encourage new patterns of care. • Inclusion of wound care in the NHSE Enhanced Health in Care Home Framework. • Best practice leg ulcer care included within the NHSE Priorities and Operational Planning Guidance 2024/25.
POORLY ORGANISED SERVICES • Lack dedicated services. • Inequality in access to evidence-based care. • Variation in access to skilled Multidisciplinary Team (MDT). • Silo working.	• NWCSP Clinical Recommendations and pathways. • Collaborating with organisations and systems to understand best models of implementation. • Best Practice Bundles/Standards – for systems.
POOR USE OF DATA & INFO • Organisations unable to review total spend on wound management products from different routes of supply. • Data not inputted in a consistent way and doesn't flow through systems. • There is no quality assurance of data. • Data is not used to inform quality improvement and demonstrate impact.	• Development of a wound product classification system and hierarchy to group clinically comparable products • DAPB4086: Wound Care Information Data Standard. • Collaborating with organisations and ICB's to understand wound care coding and data flows into national data sets.
LACK OF (STANDARDISED) EDUCATION • From pre-reg to practicing clinicians. • Wound care seen largely as a nursing responsibility. • Lack of NHS-provided standardised education • Lack of universally informed patient information resources • Accessibility to patient information	• Standardisation: National Wound Care Workforce Framework for England - for the multiprofessional workforce. • Free to access NHS provided eLearning resources for the multiprofessional workforce. • Co-production of patient led information resources (available in 13 languages).

Lower Limb Wounds

Key messages

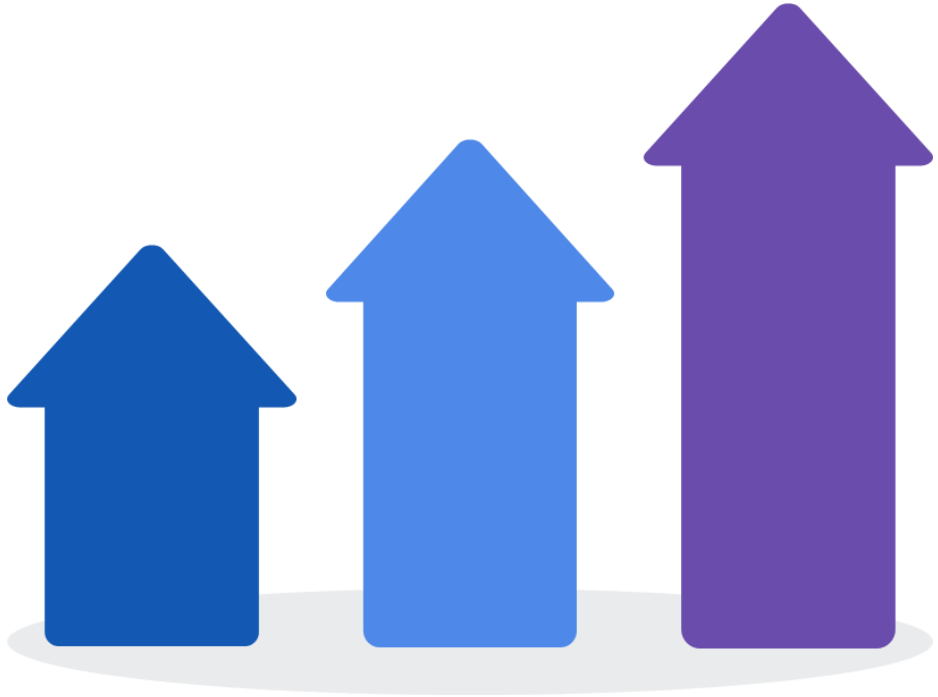
Introduction

Lower limb wounds – account for 37% of all wounds and 71% of NHS spend on wound care[1].

Between 2019 and 2021:

- Leg ulcer healing rate decreased by 42% and the time to heal increased by >85%
- 1% of patients had VLU related sepsis
- 0.2% developed gangrene
- Up to 0.6% underwent an amputation on part of the foot or lower limb[2]

All of this equates to patient harm.



1. 1. Guest, J.F., G.W. Fuller, and P. Vowden, *Cohort study evaluating the burden of wounds to the UK's National Health Service in 2017/2018: update from 2012/2013*. BMJ Open, 2020. **10**(12): p. e045253.
2. Guest, J.F. and G.W. Fuller. Cohort study assessing the impact of COVID-19 on venous leg ulcer management and associated clinical outcomes in clinical practice in the UK. BMJ Open, 2023.

Myth Busting

Myth: the health and care workforce is skilled in wound care and are managing lower limb wounds well.

Reality: The available data demonstrates that unfortunately this is not the case. Mobile patients commonly receive wound care from practice nurses in general practice while the housebound receive care from community nursing services. Despite the high numbers of patients, this often translates into a low volume of lower limb wound care per nurse and wound care is squeezed by competing priorities such as palliative care or respiratory care. As a result, the quality of care varies widely, and many patients never receive appropriate evidence-based care or experience significant delay in receiving the correct care.

Myth: People with diabetes and foot wounds pose the biggest risk.

Reality: there are at least as many people with foot ulcers but without diabetes, as there are people with diabetic foot ulcers, and more than half of all major lower limb amputations are in people that do not have diabetes. The principles of caring for these ulcers is the same as for diabetic foot ulcers (i.e. off-loading, infection control, debridement and early revascularisation) which makes the current inequity of care unacceptable.

Myth Busting

Myth: training all practitioners to do lower limb assessments (including doppler) will result in lower limb wounds being assessed and managed better.

Reality: Wound specialists have been teaching the workforce on this topic for many, many years. Attempting to deliver best practice lower limb care against other demands of a generalist service, within a limited visit/appointment time and with a lack of access to the right equipment leads to unnecessary delays in assessments and therefore treatment.
The implementation of the NICE Guideline for diabetic foot problems, which recommends the establishment of multidisciplinary diabetes foot care teams in hospitals and foot protection teams in community, has improved care for people with diabetic foot ulceration. This approach should be mirrored for those with lower limb wounds and without diabetes – i.e. practitioners working within a dedicated service who are able to develop and maintain their skills, and with the necessary equipment and protected time to deliver quality care.

Myth: Setting up lots of separate dedicated clinics will help solve the issues we have in lower limb wound care.

Reality: An ICSs approach is required to ensure that pathways cover all health and care settings as part of a person's journey. This should include local treatment pathways, pathways into dedicated services and those for onward referral to specialties such as vascular, dermatology and lymphoedema services. All providers should engage in wider networks to understand current pathways and contribute to the development of revised ones. Elements of best practice should not be implemented locally in isolation and providers should consider what implications or opportunities implementing the bundle presents for ways of working. For example, having a dedicated service offers the opportunity for direct referrals to Vascular services and/or joint community diagnostic clinics.

Lower Limb Workstream Progress

Problem	Solution
• Inequality in access to evidence-based care. • Variation in access to skilled MDT. • Silo working. • Pathways within leg and non-diabetic foot ulceration management are unclear across the patient journey. • Lower limb and wound care is often viewed as a separate clinical issue which is not integrated into the care of underlying co-morbidities that cause or contribute to wounding and delayed/non-healing.	• NWCSP suite of Lower Limb Recommendations (leg and foot ulcer clinical recommendations). • An NHSE Finance approved national Lower Limb Implementation Business Case. • A final evaluation of seven First Tranche Implementation Sites (FImpS) (to test the assumptions of the Lower Limb Implementation Business Case and resources produced). • A synthesis of learning and implementation advice: NWCSP Leg Ulcer Best Practice Bundle (NWCSP website). • Lower limb wound care is integrated into NHSE policy e.g.: - Publication of Leg Ulcer Best Practice Bundle as an NHSE policy document. - Inclusion of best practice leg ulcer service models in NHSE Priorities and Operational Planning Guidance 2024/25. - Inclusion in Enhanced Health in Care Homes Framework.
• There is an inconsistent approach to the capabilities and education required by the workforce responsible for undertaking lower limb wound assessment and management.	• Standardisation through National Wound Care Workforce Framework for England - for the multiprofessional workforce. • Development of Educational Resources for Lower Limb wound assessment, diagnostics and management.
• There is an inconsistent approach to data collection and information sharing across integrated care systems and reporting at a national level.	• DAPB4086: Wound Care Information Standard (how to record the clinical assessment, observations and treatments delivered for the management of wound care) and an Implementation Toolkit. • Defined Lower Limb Metrics.

Leg Ulcer Best Practice Bundle

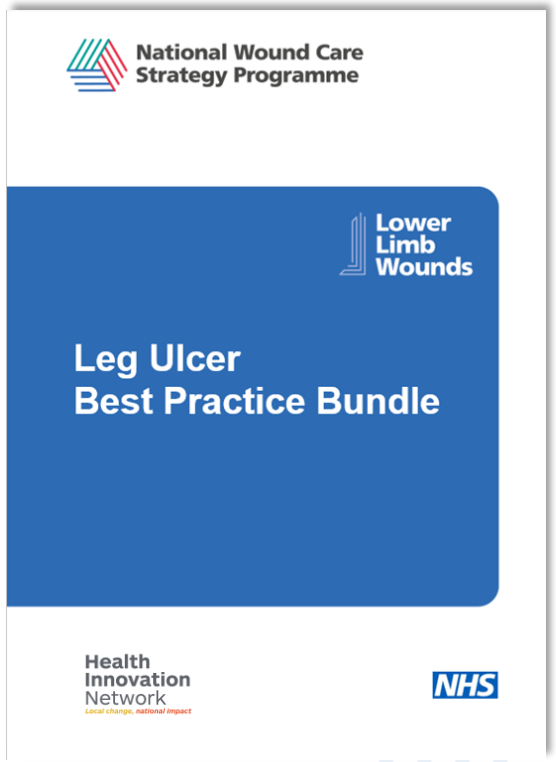
Key recommendations:

- Describes **system changes** required
- **Dedicated services** and **specialist clinical leadership** to drive change.
- Early recognition of red flag symptoms - **patient safety** and **admission avoidance**.
- Promotion of **supported self-management**/care.
- Having dedicated services enables **direct referrals** to specialist services (e.g. Vascular, Dermatology, etc.) **- removing burden from GPs** in primary care.
- Use of **NHS eReferral Service** and **Advice & Guidance** in dedicated services = improved quality and more **appropriate referrals** and **reducing waiting lists**.
- Integrated working – e.g., joint community **diagnostic clinics** (Vascular & dedicated clinic).
- Opportunities for **patient initiated follow up**.

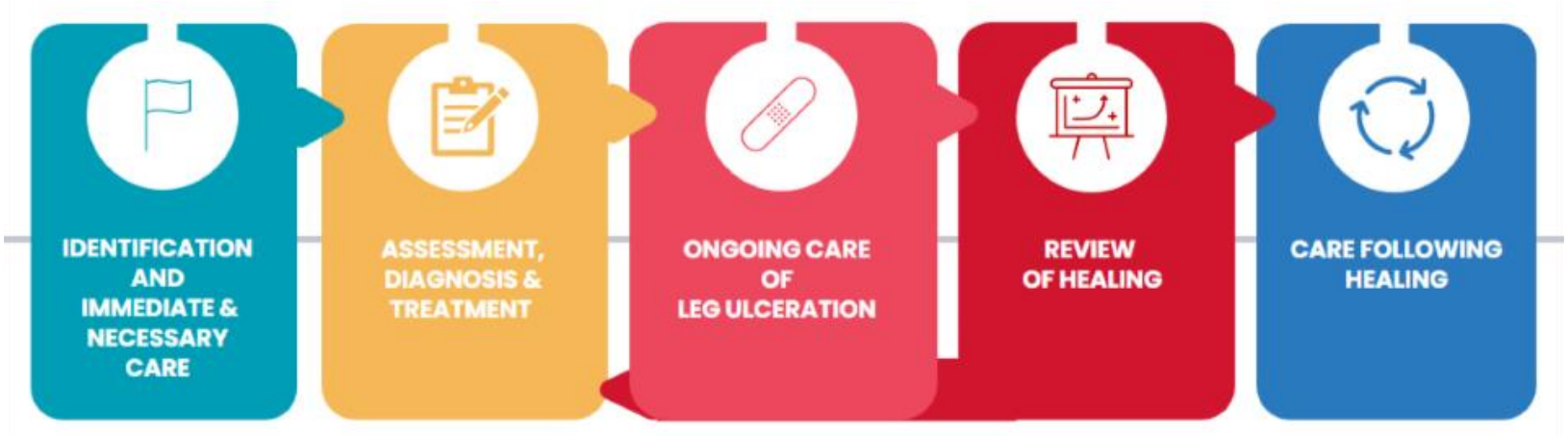
Leg Ulcer Best Practice Bundle

- The purpose is to outline interventions that are fundamental to supporting providers, commissioners and professionals in making a difference for people with leg ulcers in terms of:
  - Improving healing rates.
  - Reducing recurrence rates.
  - Reducing the overall burden of wounds.

- It is not intended to replace the clinical NWCSP Leg Ulcer Recommendations, but instead ‘encourage’ ICBs to implement the most impactful changes by directing the providers at a place-based level.



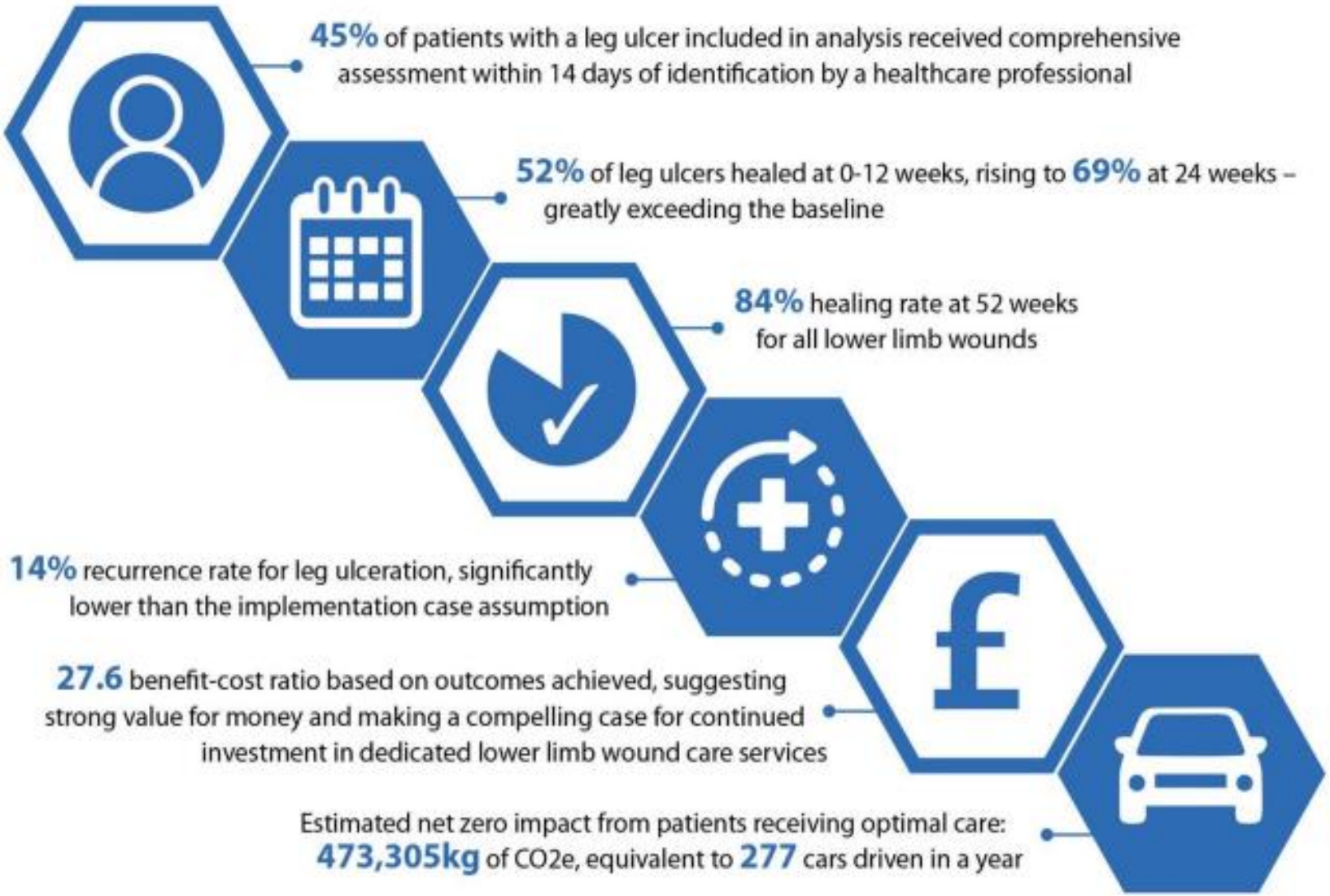
Leg Ulcer Best Practice Bundle



Five key elements:

- Most impactful interventions (from NWCSP Leg Ulcer Recommendations & pilot)
- Rationale
- Implementation Guidance
- Impact Metrics: Process and Outcome indicators
- Continuous Learning
- Supporting Resources

Implementation of the NWCSP Lower Limb Recommendations: Key Outcomes



For full outcomes see the Evaluation Report

Lower Limb Workstream: Key Recommendations

Data Collection and Standardisation

Data collection should focus on five core aspects of wound care, including total caseload, comprehensive assessment, treatment, healing rates and recurrence. This standardisation will enable identification of unwarranted variation and targeted improvement efforts at both National and Regional levels. Mandate this data collection by ensuring explicit inclusion in the NHS operational planning guidance 2025/26

Commissioning and Service Implementation

ICBs should commission dedicated leg ulcer services at place level, requiring providers to report on agreed, standardised metrics. Implementation of the leg ulcer best practice bundle should be harnessed to achieve widespread adoption.

System-Wide Transformation

ICBs should give prominence to wound care as a transformation programme across the system.

Provider Prioritisation of Wound Care

Providers should give prominence to wound care as a transformation priority, on the strength of the clinical outcomes, value for money and positive staff and patient feedback as evidenced in the Lower Limb Recommendations.

Equity in Service Provision

Equity of service provision should be addressed for diabetic and non-diabetic foot ulcer services.

Digital Integration for Automation

Digital systems used to augment wound care services should demonstrate full integration with existing Electronic Patient Record systems, ensuring data collection is automated and captured in relevant national datasets - such as the Community Services Datasets - to avoid placing burden on clinicians to manually record metrics.

Surgical Wound Complications

Key messages

Background

- Surgical wounds are commonly associated with acute organisations.
- However, although most surgery occurs in secondary care, it is estimated almost half (48%) of the NHS cost of caring for these patients is incurred in community services and primary care[1] due to surgical wound complications (SWC).
- It is estimated that a fifth (21%) of surgical wounds fail to heal within 12 months leading to considerable patient suffering and NHS cost[1].
- In the UK, the number of people having surgery is growing and so too is the complexity of the operations.
- In addition, the push towards day case surgery, particularly post Covid, means that the burden of SWCs now mostly falls on primary and community services[2].
- Currently Model Hospital demonstrates day case rates are between 60-85% of all surgical procedures across England, and this continues to grow. The aim is for 85% of all surgery to be completed as day cases[3].
- **The true size and scale of surgical wound complications is currently unknown - and is likely to continue to increase.**

1. Guest J.F., Ayoub N., McIlwraith T., Uchegbu I. Health economic burden that different wounds types impose on the National Health Service in the UK. International Wound Journal . 2016, Vol. 14, 2, pp. 322-330.https://bmjopen.bmj.com/content/10/12/e045253
2. NHS England & NHS Improvement (NHSE & I). Same day elective care - treat day surgery as the norm. https://www.england.nhs.uk/wp-content/uploads/2021/12/qsir-same-day-elective-care.pdf. 2021.
3.NHSE. 2023/2024 priorities and operational planning guidance. https://www.england.nhs.uk/wpcontent/uploads/2022/12/PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf. 2023.

Myth Busting

Myth: surgical wound care is commonly associated with acute organisations.

Reality: Surgical wound complications and care predominantly takes place in the community setting.

Myth: all surgical wound complications are caused by an underlying infection.

Reality: infection is one of the causes of surgical wound complications. There are many causes of surgical wound dehiscence including technical, mechanical, etc.

Myth: most surgical wounds are simple wounds and require no follow up.

Reality: any surgical wound that dehisces can quickly become complex.

Myth: surgical teams do not need to review surgical wound dehiscence.

Reality: all people with surgical wound dehiscence and a suspected implant or prosthesis infection should be referred to the surgical team[4].

Myth: data is routinely collected and available on the prevalence of surgical wounds and complications.

Reality: reporting of complications is currently only mandatory for orthopaedic surgery via the UKHSA Surgical Site Infection Surveillance Service (SSISS) and only relates to complication caused by infection. This system is optional for all other surgical specialties i.e. there is no surgical wound complication surveillance system.

4. British Orthopaedic Association. 2024. BOAST - Acute Management of Peri-Prosthetic Joint Infection

NWCSP Progress

Problem	Solution
• Historical misunderstanding of the problem with surgical wounds	• NWCSP defines "Surgical Wound Complications" as the specific area of focus.
• Lack of widespread understanding regarding prevention and management of surgical wound complications.	• NWCSP Surgical Wound Complications Recommendations. • NWCSP Surgical Wound Complications Pathway. • NWCSP Surgical Wound eLearning Education Modules. • Patient led patient information leaflets.
• No standardisation for the clinical assessment of surgical wounds.	• Working group of clinical experts established to co-produce/build on the existing Wound Care Minimum Data Set[5] criteria for the assessment of wounds to ensure that it is applicable to surgical wounds.
• Lack of consistency in the clinical recording of data and information relating to surgical wound complications.	• Inclusion of surgical wound specific criteria in the DAPB4086: Wound Care Information Data Standard.
• Lack of standardised education on surgical wounds	• Development of eLearning modules and a decision tree to guide clinical decision making.

5. Coleman S, Nelson EA, Vowden P, Vowden K, Adderley U, Sunderland L, Harker J, Conroy T, Fiori S, Bezer N, Holding E, Atkin L, Stables E, Dumville J, Gavelle S, Sandoz H, Moore K, Chambers T, Napper S, Nixon J; Improving Wound Care Project Board, as part of NHS England's Leading Change Adding Value Framework. Development of a generic wound care assessment minimum data set. J Tissue Viability. 2017 Nov;26(4):226-240. doi: 10.1016/j.jtv.2017.09.007. Epub 2017 Sep 18. PMID: 29030056.

Surgical Wound Complications Workstream: Key Recommendations

Integrate Surgical Wound Parameters into Point-of-Care Tools
Establish key surgical wound complication parameters within point-of-care tools used across all NHS services.

Scale Remote Monitoring for Post-Discharge Wound Management
Launch pilot programmes in community and primary care settings to implement remote monitoring solutions for surgical wounds, collecting data to evaluate effectiveness and scalability.

Establish a Surveillance Tool for Surgical Wound Complications
Work with NHS partners to create a standardised point of care surveillance tool for surgical wound complications within the Model Health system, piloting it in select regions.

Conduct a National Study on Surgical Wound Complication Prevalence
Launch a prevalence study on surgical wound complications across surgical specialities, using findings to guide future management strategies.

Expand Surgical Wound Management Training Using NWCSP Modules
Recommend the use of NWCSP's eLearning modules and patient information leaflets in community care settings to ensure consistent training in surgical wound management.

Implement the NWCSP Surgical Wound Complications Pathway
Develop an implementation programme for the Surgical Wound Complications Pathway across primary and community healthcare providers, with clear referral points to connect patients to surgical teams when necessary.

Surgical Wound Complications Best Practice Bundle
Develop a Surgical Wound Complications Best Practice Bundle collating a risk stratification tool, standards of care and implementation and surveillance tool.

4. Coleman S, Nelson EA, Vowden P, Vowden K, Adderley U, Sunderland L, Harker J, Conroy T, Fiori S, Bezer N, Holding E, Atkin L, Stables E, Dumville J, Gavelle S, Sandoz H, Moore K, Chambers T, Napper S, Nixon J; Improving Wound Care Project Board, as part of NHS England's Leading Change Adding Value Framework. Development of a generic wound care assessment minimum data set. J Tissue Viability. 2017 Nov;26(4):226-240. doi: 10.1016/j.jtv.2017.09.007. Epub 2017 Sep 18. PMID: 29030056.

Pressure Ulcers

Key messages

Background

- Pressure ulcers continue to feature as one of the most common causes of harm for patients being cited within the ‘top ten’ harms reported within the national reporting and learning system (NRLS).
- They have a significant impact on an individual’s quality of life and may result in increased mortality and morbidity.
- In older people they are associated with a fivefold increase in mortality with hospital mortality reported at 25% to 35%.
- Pressure ulcers can result in longer lengths of stay in hospital from an additional four days to an additional 10 days for those over 75 years and, it is estimated that their care costs the NHS in the region of £571 million per annum.
- There is considerable variation in the care that is delivered across NHS England including in the assessment of risk, the delivery of preventative care, and the categorisation, recording and treatment of the pressure ulcer once it occurs.
- The expected outcomes for a patient with a pressure ulcer in the NHS are largely unknown as they are not reported.
- Over the last 30 years there has been significant investment and improvement activity to reduce the harm from what is considered a largely preventable disease.

Myth Busting

Myth: **the health and care workforce have access to standardised and high levels of wound care education**

Reality: *The available data demonstrates that unfortunately this is not the case, many patients particularly in their own homes are only in receipt of social care where staff have limited access to education. Whilst a core curriculum for pressure ulcer prevention has existed since 2018 there have been no standardised resources available until 2023 and the lack of standard tools (for example for risk assessment) has made shared education complex.*

Myth: Pressure ulcers only occur in bed

Reality: Pressure ulcers occur primarily due to immobility so they can occur wherever the patients is, for example in a chair or wheelchair, or if they fall and lie on the floor for a period of time. They can also be caused by devices such as masks, plaster casts or urinary catheters which are held immobile against the skin.

Myth: 95% of pressure ulcers are preventable.

Reality: Whilst we know that many pressure ulcers are preventable with appropriate care, equally many are not due to the complexity of the patient's underlying medical condition, their need for multiple medications and sometimes life saving procedures or use of lifesaving devices. The percentage that are preventable is variable but in reality is much lower than 95%. Some patients present to health care settings already having developed a pressure ulcer in their home where the only care they have received is from a family member or friend, or possibly they have been self caring.

Myth: Pressure ulcers only affect the older population

Mythbusting: Pressure ulcers can occur at any age from the most premature of babies through to the oldest in our population. They occur across all care settings including, physical and mental health, women's health (including maternity units) paediatrics, learning disability and mental health settings.

Myth: Pressure ulcer is seen as responsibility that falls under nursing

Reality: Pressure ulcer prevention is everyone's' business. Every healthcare professional that comes into contact with a patient should be aware of the risk of pressure ulcers occurring and how they can either initiate preventative care or who they should escalate concerns to.

Progress

Problem	Solution
• Inequality in access to evidence-based care. • No standardised pathway for pressure ulcer diagnosis and treatment	• Development of the Pressure Ulcer Clinical Recommendations and Clinical Pathway.

• No national system of data capture for pressure ulcers
• There is an inconsistent approach to data collection and information sharing across integrated care systems and reporting at a national level
	• Together with NHS England:
	  • Development of a point of care pressure ulcer surveillance tool for both acute and community care.
	  • Work with multiple pilot sites to test the data quality of the surveillance system
	  • Improve flow and visibility of pressure ulcer occurrence data into the Model. Hospital and Model Community systems based on information directly derived from the clinical records.

• Existing categorisation tools open to interpretation	• Development of new pressure ulcer categorisation tool .
• Lack of standardised implementation processes across NHS organisations for pressure ulcer diagnosis and treatment	• Implementation of one single risk assessment tool. • Implementation of single bundle of care framework (aSSKINg). • Development of a report synthesising learning from collaboration with an ICS and NHS England, which will lead to development of standards of care and a national implementation package. • Review of existing methodologies and evidence-base via a systematic literature

Pressure Ulcer Workstream: Key Recommendations

Establish and Implement Pressure Ulcer Standards Across the NHS

Roll out pressure ulcer standards for diagnosis, surveillance, reporting, and treatment across all NHS organisations and other care providers to ensure consistent and effective care.

Develop and Launch a Pressure Ulcer Implementation Programme

Introduce a comprehensive implementation programme to embed the clinical pathway in practice , including the risk assessment tool, aSSKINg care framework, standardised categorisation tool and standards of care, to drive consistent practice across all care settings.

Deploy a National Pressure Ulcer Surveillance Tool

Roll out the pressure ulcer surveillance tool across NHS organisations to enable consistent data capture, analysis, and reporting of pressure ulcer cases nationwide.

Implement a Standardised Pressure Ulcer Categorisation Tool

Implement the pressure ulcer categorisation tool across NHS organisations to reduce variability in classification and improve accuracy in reporting and treatment planning.

Develop a suite of outcome measures for patients with pressure ulcers

By developing a suite of outcome measure for patients with pressure ulcer, we can increase our collective understanding of what influences the outcomes for patients with pressure ulcer. Improving local and national data gathering, we can better tailor our care for this patient population.

Enhance Wound Care Education and Training for All Care Providers

Expand access to standardised wound care education, ensuring that all staff involved in patient care—including those in social care settings—are trained in pressure ulcer prevention and management.

Supply and Distribution

Key messages

Background

There are several existing systems that group wound care products, but none are comprehensive and able to support the following two requirements:

(a) the **business functions** of the NHS for the selection, supply, and distribution of wound care products and able to consistently merge and report data across all routes of supply,

and

(b) to underpin **clinical decision support** (CDS) for wound care product selection within digital systems

The NHS needs to be able to report (from any clinical system or supply system) some basic grouping of products, to use as the basis for analysis outputs.

These groupings need to be **clinically relevant** so that clinical staff can interpret and use data for product review and quality improvement initiatives.

NWCSP Progress

Problem	Solution
• Lack of consistency in naming, coding and grouping wound management products across different routes of supply	• Development of a new repository which lists all wound management products, codes and attributes • Alignment established (where possible) with Global Medical Device Nomenclature Codes, Terms and Definitions • Development of a new wound product hierarchy to establish clinically comparable groups of wound management products
• Lack of clinical input regarding development of clinically comparable groups for wound management	• Clinical experts have been engaged in review of key attributes for wound management products (dressings) that enable grouping within the classification hierarchy • Work ongoing for bandages with task and finish group
• Lack of visibility of data on wound product spend in provider organisations from different routes of supply	• When implemented the new classification system will enable visibility of spend by product groups across all routes of supply
• Rapidly changing product portfolios for wound management due to innovation, supplier mergers and discontinued products	• The classification system repository of data has been quality assured by suppliers (July 2024 for dressings) but requires ongoing updates to other products groups (bandages, specialist therapies, etc.) • NHS BSA has established a DHSC-led Process for Ongoing Updates and Ownership of the Classification System

Supply and Distribution Workstream: Key Recommendations

Implement the New Wound Product Classification System Across NHS Supply Channels

Recommend that all NHS organisations involved in listing and supplying wound care products adopt the new wound product classification system to enable standardised reporting and clinical decision support.

Re-align Drug Tariff Listings to Reflect the New Classification System

Undertake the re-authoring of wound care products in the Drug Tariff to align with the new classification system as part of the Part IX DT review, ensuring consistency in product descriptions and categories.

Conduct Comprehensive Quality Assurance of GMDN Codes for Wound Products

Establish a working group between DHSC, MHRA, PIM, NHSBSA and GMDN Agency to launch a thorough quality assurance process for GMDN codes, terms, and definitions specific to wound management products, updating codes to ensure alignment with clinical relevance and accuracy.

Build Collaborative Links Between DHSC, MHRA, PIM, and Drug Tariff Review Processes

DHSC, NHSE and NHS Supply Chain should continue formal collaboration with MHRA, PIM, and the Drug Tariff review teams to ensure the new classification system is consistently integrated across regulatory, supply, and clinical guidance frameworks.

Glossary of terminologies (Supply and Distribution)

DHSC – Department of Health and Social Care

GMDN Agency – Global Medical Device Nomenclature Agency

NHSBSA – NHS Business Services Authority

DT – Drug Tariff – Wound management products are listed here for prescription on NHS

NHSSC – NHS supply chain

MHRA – medicines and healthcare regulatory agency

PIM – Product Information Management system

NHSBSA – NHS Business Service Authority

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www.nationalwoundcarestrategy.net

NatWoundStrat

NatWoundStrat@mft.nhs.uk