NICE National Institute for Health and Care Excellence

Guidance assessment consultation document for HTE10048 Compression products for treating venous leg ulcers: late-stage assessment

24 April 2025

Guidance development process

NICE late-stage assessment (LSA) guidance evaluates categories of technologies that are already in widespread use within the NHS. It assesses whether price variations between technologies in a category are justified by differences in innovation, clinical effectiveness and patient benefits. This will support NHS commissioners, procurement teams, patients and healthcare professionals to choose technologies that maximise clinical effectiveness and value for money.

Find out more on the NICE webpage on late-stage assessment (LSA).

NICE is producing this guidance on compression products for treating venous leg ulcers in the NHS in England. The medical technologies advisory committee has considered the evidence and the views of clinical and patient experts.

This document has been prepared for consultation with the stakeholders. It summarises the evidence and views that have been considered and sets out the recommendations made by the committee. NICE invites comments from the stakeholders for this evaluation and the public. This document should be read along with the evidence.

The committee is interested in receiving comments on the following:

- Has all of the relevant evidence been taken into account?

- Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?
- Are the recommendations sound and a suitable basis for guidance to the NHS?
- Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex or sexual orientation?

After consultation:

- Based on the consultation comments received, the committee may meet again.
- If committee meets again it will consider the evidence, this evaluation consultation document and comments from stakeholders.
- The committee will then prepare the final draft guidance, which will go through a resolution process before the final guidance is agreed.

Note that this document is not NICE's final guidance on compression products for treating venous leg ulcers. The recommendations in section 1 may change after consultation.

More details are available in NICE's health technology evaluations: the manual and NICE's late-stage assessment interim process and methods statement.

Key dates:

Closing date for comments: 9 May 2025

Second committee meeting: 19 June 2025

1 Recommendations

1.1 When choosing compression products to treat venous leg ulcers, price variation for compression hosiery over compression bandaging is justified, provided that the hosiery is clinically appropriate and meets the needs and preferences of the person with a venous leg ulcer.

1.2 There is not enough evidence to determine whether price variation is justified for compression wraps over other compression products.

1.3 NHS trusts should provide access to a range of compression products, so that a product that is clinically appropriate and meets people's needs and preferences is available for everyone with a venous leg ulcer.

1.4 A healthcare professional and the person with the venous leg ulcer should decide together which compression product to use (see the NICE page on shared decision making). Decisions should take into account how the choice of compression product might affect the person's quality of life, including:

- ability to complete activities of daily living
- adherence with the treatment regimen
- physical health
- mental health and wellbeing
- relationships with others, including whether people have informal carer support at home.

What information is needed

More information is needed to determine whether compression wraps are clinically and cost effective compared with compression hosiery or compression bandaging. Evidence should be of sufficient sample size to detect a statistically significant difference, report details of concomitant treatments and ideally be done in a community setting in the NHS.

Key outcomes that should be captured include:

- clinical performance outcomes of compression wraps, including:
  - health-related quality of life
  - time to complete wound healing
  - duration of treatment
  - adverse events
- preferences of the person with a venous leg ulcer, including:
  - comfort
  - ease of application
  - bulkiness of the product
- resource use, including:
  - number of products prescribed
  - frequency of visits by healthcare professionals.

What this means in practice

Considerations for procurement and commissioning

- According to the National Wound Care Strategy Programme, in 2019 there were around 739,000 leg ulcers in England with estimated associated healthcare costs of £3.1 billion per year. Venous leg ulcers account for 60% to 80% of all leg ulcers.
- The price varies between and within different types of compression products.
- Many factors can influence which type of compression product is best to treat a person's venous leg ulcer. Commissioners and procurement specialists should work with healthcare professionals in NHS trusts to ensure access to a range of compression products.
- Evidence suggests the clinical effectiveness of compression hosiery and bandaging is broadly similar. Economic modelling suggests that compression hosiery, which enables self-management, is cost effective compared with compression bandaging, which relies on regular visits

from a nurse to change the dressing. Compression wraps also have the potential to enable self-management, but there is more uncertainty about their effectiveness.

- NICE's resource impact assessment estimated potential savings of £528,000 based on 2,000 people using compression bandaging, and assuming that 30% of them switch to hosiery.

Considerations for wound management formulary groups

- These recommendations are not intended to restrict choice. When developing a formulary, a range of compression bandages and other types of compression products, including both compression hosiery and compression wraps, will be needed to provide options for different clinical and patient preference scenarios.
- Aids, such as hosiery applicators or waterproof protectors, to support people using compression products should also be considered. Decision making should prioritise cost-effective options, taking into account the factors listed in recommendation 1.4.

Considerations for healthcare professionals

- These recommendations do not replace clinical reasoning. If more than one type of compression product is clinically appropriate, the choice of dressing should be based on the preferences of the person with the leg ulcer and cost effectiveness, taking into account the factors listed in recommendation 1.4.
- Additional items, such as hosiery applicators and waterproof bandage protectors, should be offered alongside the compression product if appropriate.
- Healthcare professionals should work with commissioners and procurement specialists who cover their NHS trust to ensure access to a range of compression products.

Considerations for people with venous leg ulcers

- People with venous leg ulcers should be involved when deciding which compression product to use. They should be given information on the compression product that is being prescribed and, where possible, offered options that meet their needs. People should ask for products that support the use of the compression product, such as waterproof protectors for compression bandages.
- People with venous leg ulcers should be given support if they experience any issues or wish to change to another type of compression product.

Why the committee made these recommendations

There are many compression products available to treat venous leg ulcers. This assessment aims to determine whether the differences in clinical, economic and non-clinical outcomes attributed to the different types of compression products could justify price variation.

Evidence from clinical trials shows that the clinical effectiveness of 2-layer compression bandaging, 4-layer compression bandaging and 2-layer compression hosiery is broadly similar. But there is limited evidence on the clinical effectiveness of compression wraps compared with these products.

The economic model suggests that compression hosiery is more cost-effective than compression bandaging and compression wraps over time periods of up to 1 year. It also suggests that compression wraps are most cost effective in the long term (up to 5 years). But this is uncertain because the data for compression wraps is limited. A large UK study also showed that compression hosiery was cost effective compared with 4-layer compression bandaging.

So, price variation for compression hosiery over compression bandaging is justified, but there is not enough evidence to determine whether price variation is justified for compression wraps over other compression products.

2 The technology

Strong compression products

2.1 Compression products squeeze the lower limb to reduce oedema (swelling) and help blood flow back to the heart. Compression products can vary in the level of pressure applied. Strong compression, that is compression designed to give at least 40 mmHg of pressure at the ankle, is recommended for venous leg ulcers. This can be elastic, inelastic or a combination compression system. The scope of this assessment includes only compression products which deliver at least 40 mmHg of pressure at the ankle and are used for treating venous leg ulcers. This assessment does not include compression products which are used for maintenance following ulcer healing or those used before or after surgery.

2.2 Four types of compression products are used to treat venous leg ulcers in the NHS:

- 4-layer compression bandaging
- 2-layer compression bandaging
- 2-layer compression hosiery
- compression wraps.

The focus of this assessment is the difference in clinical and cost effectiveness between the types of compression product. The variation of features within a product type (colour, marking) was expected to have less impact on their effectiveness.

2.3 At least 20 companies provide over 200 compression products (of different sizes, products and colours) to the NHS through a range of procurement routes. There are also many supplementary products, such as hosiery applicators and boots to protect bandages when showering, to support people using a compression

product. For this assessment, NICE considered compression products listed on the NHS Drug Tariff Part IX.

3 Committee discussion

The medical technologies advisory committee considered evidence on compression products for treating venous leg ulcers. Evidence was considered from several sources to determine whether price variation between types of compression products could be justified by differences in their clinical and cost effectiveness or non-clinical outcomes important to users. Full details are available in the project documents for this guidance.

The condition

3.1 The National Wound Care Strategy Programme (NWCSP) defines a leg ulcer as an ulcer between the knee and ankle that has not healed within 2 weeks. Most leg ulcers are caused by venous insufficiency. Venous leg ulcers, which account for 60% to 80% of all leg ulcers, typically present as shallow, irregularly shaped wounds with sloping edges on the lower leg (from mid-calf to above the ankle). These ulcers are frequently accompanied by other clinical signs of venous disease, including varicose veins, hyperpigmentation, hardening of the skin and subcutaneous tissues, white scarred areas and oedema.

Current practice

3.2 Current NHS clinical practice for venous leg ulcers follows a structured approach based on the NWCSP guidelines, which recommend strong compression therapy as a first-line treatment for suspected venous leg ulcers with adequate arterial supply. Current treatment options include traditional 4-layer compression bandaging systems and the newer 2-layer compression bandaging systems. Alternative options to compression bandaging are compression hosiery or compression wraps, both of which can

facilitate self-management by people or their carers. These different compression products vary in methods of application, complexity and patient suitability.

3.3 The NWCSP recommends that strong compression hosiery should be considered as first-line compression therapy choice where possible and the need for application aids should be considered. But strong multi-component compression bandaging (in preference to compression hosiery) should be offered to people with any of the following:

- chronic ankle or leg oedema that is not reduced by elevation
- abnormal limb shape
- copious exudate
- very fragile skin.

Lived experience

3.4 Eighteen people with lived experience of venous leg ulcers completed a survey. They all reported that it can have a big effect on their lives, including feeling stigma and shame, especially when the wound is leaking or has an unpleasant smell. The survey also showed that almost all participants were aware of 2-layer compression hosiery (89%), followed by 2-layer compression bandaging (78%), compression wraps (72%) and 4-layer compression bandaging (61%). In the survey, the participants were asked to rank the product-related characteristics criteria identified in the user preference workshops (see section 3.7). The criteria were ranked in the same order, with comfort, ease of use and bulkiness of the product the most important.

3.5 At the committee meeting, people with lived experience described the impact of using compression products on themselves or when caring for others. Clear instructions are needed to help people and their carers manage their treatment, as well as a consistent

approach to the support products offered that help people with self-care and to complete tasks of daily living. People and their carers should be involved in decision making about product selection and treatment options. The committee agreed that a range of compression products should be available to meet people's needs and that shared decision making should always be followed.

Healthcare professional preferences

3.6 A group of 11 healthcare professionals took part in a user preference assessment designed to explore which criteria are most important when choosing a compression product for treating a venous leg ulcer. Although shared decision making is promoted and the preferences of the person with the leg ulcer are considered, the product choice is ultimately made by the healthcare professional and is informed by their clinical reasoning and product knowledge.

3.7 The group identified and agreed 2 sets of criteria that they used when selecting a product. The first set of criteria related to clinical presentation, including wound condition and patient characteristics. These criteria were not ranked because their importance varies between individual patients and clinical situations.

3.8 The criteria in the other set were generic, independent of clinical presentation and related to product characteristics or performance. They were ranked in order of importance as follows:

- comfort of the product
- use of the product by healthcare professional, the person with the leg ulcer or their carer
- bulkiness of the product
- cost and associated costs of the compression product
- the healthcare professional's familiarity with the compression product

- visibility of the product
- impact on sustainability.

The committee noted that, apart from cost, the evidence does not capture these preferences.

Equality considerations

3.9 Many different groups of people, some of whom have protected characteristics, are at risk of developing a venous leg ulcer. Factors that increase a person's risk for developing a venous leg ulcer include pregnancy, obesity or overweight, a history of deep vein thrombosis, varicose veins, hernias, previous ulcers or previous surgery to the leg, such as hip or knee replacement. Increased age, restricted movement, a sedentary lifestyle, prolonged standing and a limited range of ankle function may also increase the risk of developing a leg ulcer. People from the most deprived areas may have longer healing times with a higher chance of the ulcer recurring. People on a low income may struggle to access appointments and people without a fixed address or in prison may struggle to access treatment. The committee also understood that smoking, dependence on alcohol, drug use and nutritional deficiencies can be contributing factors to delayed wound healing. The committee understood that people who have venous leg ulcers have individual needs and these should be considered when selecting a compression product.

3.10 The committee queried the availability of information about the use of compression products in an accessible format for people who use the products, especially those who self-apply the products. Companies confirmed they provide various forms of patient education tools, including pictorial guides, online videos demonstrating application and removal, and materials in different

languages. The committee agreed that educational and product information should be available in a range of accessible formats.

Clinical effectiveness

Evidence is available comparing the different types of compression products

3.11 The EAG prioritised 15 studies: 14 randomised controlled trials (RCTs) and 1 large UK-based retrospective cohort study comparing different forms of compression for venous leg ulcers in the context of routine NHS practice. Six studies were conducted exclusively in the UK, and 1 other study included some UK sites. Evidence covered all 4 compression products, and head-to-head RCT evidence was available that directly compared different types of product. The clinical evidence was generally considered to be high quality, but the EAG noted that the open-label studies have a higher risk of bias.

3.12 Seven prioritised studies compared 4-layer compression bandaging with 2-layer compression bandaging. These showed that 2-layer compression bandaging was at least as effective as 4-layer compression bandaging, with some evidence showing that 2-layer compression bandaging may be more effective. Both 2-layer compression hosiery and compression wraps were shown to be equivalent to 4-layer compression bandaging, but there was only 1 small US-based RCT on compression wraps for this comparison. The VenUS IV study, a UK-based multicentre RCT, compared 2-layer compression hosiery with 4-layer compression bandaging. The EAG considered the evidence available to be high quality and generalisable to the NHS. The EAG acknowledged that all the compression product types evaluated are appropriate treatment options for people with venous leg ulcers.

Evidence review included some recent VenUS 6 results

3.13 VenUS 6 was a pragmatic, parallel-group, 3-arm RCT that recruited 637 people in NHS settings across the UK. Data collection was completed in August 2024. It compared 3 types of strong compression: compression wraps, 2-layer bandaging and 'evidence-based compression'. The evidence-based compression included either 2-layer compression hosiery or 4-layer compression bandaging. People were followed up for between 4 and 12 months. The primary endpoint was time to healing. The findings of VenUS 6 were included as individual patient data in a network meta-analysis (NMA) by the VenUS 6 team. Results from the VenUS 6 NMA were shared with the EAG and committee, but are academic in confidence and cannot be reported here.

3.14 The EAG requested an additional NMA that includes the VenUS 6 data. This analysis provided by the VenUS 6 team, referred to here as the EAG NMA, was designed to align with the current decision problem and separated the evidence-based care into 2 separate interventions: 2-layer compression hosiery and 4-layer compression bandaging. The results of the EAG NMA are academic in confidence and cannot be reported here.

Limitations of the evidence

3.15 Despite the overall quality of the evidence, the committee agreed there were several important limitations. In its review of the evidence, the EAG noted that the evidence for studies that included 2-layer compression bandaging was difficult to interpret because the studies used different combinations of bandages. For example, some studies included short-stretch bandages, whereas others used 2-layer multi-component bandages. Expert advice to the committee was that short-stretch bandages and 2-layer multi-component bandages were treated as separate interventions in the NMAs from the VenUS 6 team. There was more limited evidence

for compression wraps than for the other interventions. The committee understood this was because compression wraps are a newer technology for this indication. None of the prioritised included studies presented evidence on specific patient subgroups. There was little evidence on patient-reported outcomes, such as ease of use and mobility during treatment.

The VenUS IV and upcoming VenUS 6 studies provide the most relevant evidence

3.16 The committee considered the published results of the VenUS IV study and the academic-in-confidence results from the VenUS 6 NMA. VenUS IV was a multicentre, pragmatic, open RCT in NHS settings that compared the clinical and cost effectiveness of 2-layer compression hosiery and 4-layer compression bandaging. The results from VenUS IV showed that the 2 interventions had similar time to healing, but the 2-layer compression hosiery was cost effective compared with 4-layer compression bandaging. At the time of the committee meeting, the EAG and the committee had seen only the associated NMA and not the detailed results of the VenUS 6 trial. This limited the committee's ability to take these results into account. The committee was aware that the results of the VenUS 6 trial and the associated economic evaluation are being prepared for publication. The committee agreed that the published evidence from VenUS IV and the upcoming results from the VenUS 6 trial will provide important evidence comparing the effectiveness of the compression products in NHS settings.

3.17 The committee also discussed the different results of the EAG NMA and the VenUS 6 NMA. It understood that the VenUS 6 NMA assumed equivalence between 4-layer compression bandaging and 2-layer compression hosiery, whereas the EAG NMA treated these interventions separately. The EAG explained that separating the interventions and using the 4-layer compression bandaging as

the reference introduced uncertainty in the results of the EAG NMA. Expert advice to the committee was that the different structure in the EAG NMA meant that the results for compression wraps were more uncertain because there was only an indirect link between compression wraps and 4-layer compression bandaging. But the committee understood that the EAG's NMA structure aligned more closely with the decision problem for this assessment. The committee accepted that the results from both NMAs based on the VenUS 6 data are important contributions to the evidence base and considered that the variation in their results highlighted uncertainties in the evidence base. It concluded that the time to healing from the EAG NMA was the most appropriate evidence for the economic modelling, but it noted the uncertainty associated with compression wraps.

Cost effectiveness

Model structure

3.18 The EAG used a Markov model that estimated the costs and quality-adjusted life years (QALYs) accrued for each of the 4 types of compression product. The model included 3 health states: unhealed, healed and dead. People entered the model with an unhealed venous leg ulcer when a healthcare professional applies one of the 4 types of compression product. In each cycle, a person has a probability of transitioning to the healed or dead state. While the venous leg ulcer was unhealed, people were assumed to continue treatment with the same compression product. Once the ulcer was healed the person was offered compression hosiery to provide maintenance compression. The model used a cycle length of 1 week and a time horizon of 5 years. The committee agreed that the structure of the model was appropriate.

Limitations of the model

3.19 The committee noted that the model did not consider recurrence of ulcers over the 5-year time horizon. The EAG explained that the model's focus was exploring the cost effectiveness of the different treatment options for a venous leg ulcer, rather than capturing all the occurrences of leg ulcers over a person's lifetime. Experts advised that they expect most leg ulcers to heal in a relatively short time (12 to 24 weeks), but some people have ulcers for much longer. The committee also discussed that treatment switching is not included. It heard from the experts that switching between different types of products is relatively common. The EAG believed that excluding treatment switching could bias the analysis in favour of more expensive options, such as compression hosiery and wraps. This is because their higher unit cost means that wastage as a result of switching would have a greater cost impact. The clinical experts advised that people who have compression wraps continue with this treatment in the maintenance phase and do not switch to hosiery. This is different from the model's assumption that all patients move to maintenance hosiery in the healed state.

Time to healing is the key clinical input

3.20 The key clinical input in the economic model is time to healing. The model assumed that this parameter was unaffected by leg size, BMI, comorbidities, ambulatory status or wound size. Baseline time to healing was estimated for 4-layer compression bandaging using data from the VenUS IV study. Time to healing for the other compression products was calculated by applying hazard ratios from the EAG NMA to the baseline 4-layer compression bandaging survival curve.

Costs include the compression product costs and the resource use costs

3.21 The committee noted that for each compression product type, the associated resource use costs are more than the product costs. The committee discussed assumptions about resource use and their effect on the results of the economic model. The EAG used expert advice to estimate the resource use associated with the different products. Experts confirmed that the duration of appointments is fixed in clinic settings. The EAG advised that a scenario analysis that equalised the nurse costs across the products did not affect the results of the model. The committee understood that the frequency of healthcare visits needed is the resource use driver of cost effectiveness.

Results of the EAG's economic evaluation

3.22 The results of the economic evaluation suggested that, over 5 years, the differences in QALYs accrued between the 4 compression product types were very small. But, compression wraps and compression hosiery appear to be associated with lower costs. This is the case for all ankle circumferences and whether or not the person with a venous leg ulcer is ambulatory. The committee understood that some of the difference in cost between product types is driven by the frequency of visits needed to change compression bandages. The EAG noted that the economic results should be treated with caution. It explained the results are driven by the clinical evidence suggesting broad equivalence across the product types, with some evidence favouring 2-layer compression bandaging over 4-layer compression bandaging. Compression wraps and 2-layer compression hosiery appear to be of equal clinical effectiveness and lower cost, whereas 2- and 4-layer compression bandaging are more expensive. So, the EAG results showed compression wraps and compression hosiery may offer

better value for money than 2- or 4-layer compression bandaging. The committee understood that some of the uncertainty in the EAG's economic modelling was linked to the uncertainties in the EAG NMA results, in which the evidence for compression wraps is limited.

3.23 The EAG conducted several scenario analyses that used a lower utility benefit for healed ulcers and similar nurse costs across compression products. These scenarios did not considerably affect the results, and lower costs were still associated with compression wraps and 2-layer compression hosiery compared with 2- and 4-layer compression bandaging. A scenario analysis exploring different time horizons showed that, over shorter time horizons (12 to 52 weeks), 2-layer compression hosiery is the most cost-effective product type. When the time horizon was lengthened, compression wraps became the preferred option.

Economic results from the VenUS studies

3.24 The EAG advised that the VenUS IV study reported that 2-layer compression hosiery was cost effective compared with 4-layer compression bandaging. This was attributed to its protective effect against recurrence. The committee noted the differences between the VenUS 6 economic modelling and the EAG's economic model. The VenUS 6 model was informed by resource-use data and health-state utilities collected during the study. The VenUS 6 model also adopts a lifetime time horizon and includes ulcer recurrence. The results of the VenUS 6 economic model are academic in confidence. The committee concluded that the VenUS IV and VenUS 6 economic results provided useful additional information to the EAG's results.

Resource impact assessment

3.25 Economic modelling suggests that compression hosiery, which enables self-management, is cost effective compared with compression bandaging, which relies on regular visits from a nurse to change the dressing. So, using compression hosiery (if it is clinically appropriate and meets the preferences and needs of the person with the venous leg ulcer) instead of bandaging may be cost-saving for the NHS. A resource impact assessment based on the assumptions and costs from the EAG's economic model showed that there could be potential savings from using compression hosiery instead of bandaging. These were estimated to be £528,000 based on 2,000 people using compression bandaging and assuming that 30% of them switch to compression hosiery. Any potential savings would depend on local practice and would be subject to the limitations discussed in the external assessment report. More details can be found in the resource impact assessment report.

Compression hosiery is cost effective compared with compression bandaging

3.26 The committee discussed the clinical and economic evidence, the user preference assessment and the lived experience. Taking into account the published VenUS IV results, the VenUS 6 results and the EAG economic modelling, it agreed there was enough evidence to show that compression hosiery is cost effective compared with compression bandaging. It concluded that the price difference is justified for compression hosiery compared with compression bandaging. Although compression wraps facilitate self-management and are a cost-effective option in the EAG's base case, there is considerable uncertainty in these results. The EAG NMA results for compression wraps used in the EAG economic modelling for time to healing were also uncertain. The committee

concluded that there is not enough evidence to determine whether price variation is justified for compression wraps over the other products. The committee emphasised that healthcare professionals should have access to an appropriate range of compression products to address the clinical needs and preferences of people with venous leg ulcers.

Evidence needed to show additional value

3.27 The committee noted that the additional value of compression wraps is unclear because of the uncertainties in the evidence. It asked for more evidence about the use of compression wraps that uses clearly defined clinical and cost outcomes suitable for health economic analysis. It acknowledged the upcoming VenUS 6 trial results, which may provide relevant evidence about the use of compression wraps in NHS settings. For all the compression products, the committee emphasised the importance of analysing effectiveness in subgroups of people who are at increased risk of developing venous leg ulcers. It also asked that evidence is collected on the performance of compression products against the criteria identified in the user preference assessment.

4 Committee members

This topic was considered by NICE's medical technologies advisory committee, which is a standing advisory committee of NICE.

Committee members are asked to declare any interests in the technology to be evaluated. If it is considered there is a conflict of interest, the member is excluded from participating further in that evaluation.

The minutes of each committee meeting, which include the names of the members who attended and their declarations of interests, are posted on the NICE website.

NICE also recruited clinical experts and specialist committee members for this topic.

Specialist committee members

Leanne Atkin

Vascular nurse consultant, Mid Yorkshire NHS Trust

Priti Bhatt

Tissue viability specialist nurse lead for community services, Guy's and St Thomas' NHS Foundation Trust

Jo Dumville

Professor of applied health research, University of Manchester

Mark Dunne Willows

Lay specialist committee member

Alan Leslie Elstone

Vascular nurse specialist and advanced clinical practitioner, University Hospitals Plymouth NHS Trust

Megan Leach

Lay specialist committee member

Julie Thackray

Vascular nurse specialist, Leeds Teaching Hospitals NHS Trust

Jane Todhunter

Vascular nurse practitioner, North Cumbria Integrated Care NHS Foundation Trust

Clinical experts

Hannah Blake

Tissue viability clinical nurse specialist, Livewell Southwest

Debera Drew

Tissue viability specialist nurse and senior community research nurse, Northumbria Healthcare Foundation Trust

Stacey Evans-Charles

Tissue viability lead nurse, NHS Highland

Rachael Lee

Acting programme manager, National Wound Care Strategy Programme

Nicky Morton

Supply and distribution workstream lead, National Wound Care Strategy Programme

Maria Poole

Support consultant, The Lindsay Leg Club Foundation

Beverly Wright

Tissue viability operational lead, Northumbria Healthcare NHS Foundation Trust

NICE project team

Each evaluation is assigned to a team consisting of 1 or more health technology analysts (who act as technical leads for the evaluation), a technical adviser, a project manager and an associate director.

Lirije Hyseni and Ahmed Yosef

Technical leads

Bernice Dillon

Technical adviser

Catherine Pank

Project manager

Emily Eaton Turner

Associate director

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