A step towards getting wound care right — first time

Here, a focus group of tissue viability specialists (Box 1), look at the GIRFT programme and how by working together, clinicians and industry can help to prevent variations in wound care.

Getting It Right First Time (GIRFT) is a national programme designed to improve medical care within the NHS by reducing unwarranted variations in practice. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies, such as the reduction of unnecessary procedures and costs (https://gettingitrightfirsttime.co.uk/what-we-do/).

The GIRFT programme is well established across the NHS and being implemented in many clinical settings. With a continuous squeeze on healthcare budgets in 2017, the King's Fund produced a report which looked at how the GIRFT initiative had impacted its objectives, primarily reducing variance and improving quality care at a lower cost. The report, *Tackling Variations in Clinical Care*, explains how data sets can be used to influence practice to meet clinical needs, but also demonstrates that improvements across varied clinical areas have not specifically tackled the variances in wound care.

WHY DOES WOUND CARE NEED SPECIFIC ATTENTION?

The standard of wound care is still considered to be variable and plagued by myths, misconceptions and rituals. It has also been described as high risk, high volume, high cost and unreliable (O'Brien et al, 2011; Brown, 2018; Gray et al, 2018). This was supported by Guest et al (2015), where the first of a series of papers consisted of a retrospective cohort analysis of patients' records in The Health and Improvement Network (THIN) database. The aim of the studies was to estimate the prevalence of wounds, wound types, examine patterns of care, healthcare resource used, and the annual costs incurred by the NHS in managing wounds. Guest et al (2015) estimated that the annual cost of wound care to the NHS was greater than £5 billion, and subsequently wound care was debated in the House of Lords (Hansard, 2017).

Common areas of mismanagement have been identified as dressing choice, exudate management, diagnosis, compression therapy, cleansing, debridement and surgical wound management (Cryer, 2015; Vowden and Vowden, 2016).

WHY IS GETTING WOUND CARE RIGHT A COMPLEX CHALLENGE?

A chronic wound can be described as a wound that has not proceeded through the normal stages of wound healing in a timely fashion, generally within 12 weeks. More recently, this has reduced to where the wound has not made significant progress to healing within four weeks (Järbrink et al, 2016). With an ageing population, more patients with obesity and diabetes, the number of wounds within the population is growing. Wound healing is also further complicated and delayed by the normal process of growing older, senescent cells, reduced cell proliferation and a decline in the expression of growth factors. Inappropriate treatment can also delay healing indefinitely. Recently, these wounds have been termed complex, static or non-healing and may require a multidisciplinary approach due to the extent of associated comorbidities. They include, but are not limited to, leg (venous and arterial), diabetic and pressure ulcers (Frykberg and Banks, 2015; Gupta et al, 2017).

The identification, assessment and treatment of a complex/chronic and non-healing wound continues to pose a management challenge in all healthcare settings (Nunan et al, 2014).

Wound healing is impacted by comorbidities, both intrinsic and extrinsic. These comorbidities have been well documented but are so varied that, in the group's clinical experience, developing a wound care strategy to encompass all barriers to healing may be an impossible task. Various initiatives have been developed in leg ulcer care, pressure ulcer prevention, diabetic ulcer management and surgical wound management (i.e. Your Legs Matter, development of a wound care generic minimum data set, Procuring for effective wound management, NHS Safety thermometer, diabetes transformation metrics). However, these strategies still require a full holistic assessment of the patient in a timely manner.

Over the past few years, the Commissioning for Quality and Innovation (CQUINs) has developed a framework for reducing pressure ulcer occurrence and improving wound assessment (NHS England, 2017a). More latterly the 'Legs Matter' campaign has called for better education and care for patients with lower leg problems (Geraghty, 2018). Despite this increase in raising awareness around wound care, care pathways and best practice guidelines, variability between care settings in tissue viability service provision continues (White, 2010; Stephenson, 2017).

NHS England's national wound care strategy has been commissioned to promote collaboration to try and standardise services in wound care, unite other focus groups/schemes, and drive improvements (Adderley, 2019).

'It aims to achieve this through developing pathways of care for priority clinical issues, improving the supply and distribution of wound care products, developing appropriate education for all involved in wound care and developing robust national data information sets to measure performance' (Adderley, 2018).

It is hoped that this strategy will place the GIRFT initiative within tissue viability services' remit. Any data sets already collected by various organisations (such as the Lindsay Leg Club, Wound Care for Heroes) involved with wound care could be used to form a basis for a reduction of variance and an increase in concordance for the national wound care strategy.

To consistently improve standards it is worth considering who currently delivers wound care to patients and where. Clinically, the wound care patient group has changed over time, with patients now presenting with more complex needs, which increases the demand for informed care in the community. These increased demands are coupled with changes to community nursing staff structures, and possibly a reduction in available expertise, which may be attributed to retiring staff, or changes to roles where general practice nurses and healthcare assistants are required to take extra wound care management responsibilities as part of their roles (O'Brien et al, 2011; Chamanga, 2016; Gray et al, 2018).

Milne (2017) highlights the need for tissue viability services to work with the NHS agenda and also consider working in partnership with patients and patient self-care models. For example, adopting a patient-centred approach where perhaps the objective of 'healing' the wound is not always the primary focus, but rather considers the impact of an ageing population and increased comorbidities, and introduces realism into healthcare'. This promotes the move towards integrated care and the whole ethos of supporting the person/patient to self-manage and make decisions about their own care, leading towards a more independent life.

The NHS has always encouraged partnerships with industry, charities and social enterprises, etc. These partners have often provided a forum for education and support, particularly in clinical areas that use their products and/or services, both for staff and patients. Education and training vary in wound care across the UK, and it is difficult to assess how much is provided by trusts/tissue viability services routinely, how much they rely on partners to provide, or what is accessed by individuals through universities and e-learning modules.

In the current climate of reducing budgets, education and training is an area that has been hit. Increasingly, nurses find it difficult to get time away from the clinical arena to access training and relevant courses (Purkiss and Gabb, 2013). With the current challenges and increased awareness of wound care, this may be an ideal time for industry to support education and training in a different way.

It has already been established that improvements in dressing selection could enhance wound healing outcomes and reduce overall wastage (Denhartog and Hallman, 2015). Appropriate dressing selection can be further hampered by the wide variety of available wound dressings, and lack of access to appropriate wound care-related education for healthcare professionals.

With this clinical need for better selection and more appropriate use of wound care dressings identified, an educational grant was made available from Farla International for a group of tissue viability specialists (Box 1) to discuss possible solutions. Their remit was also to consider how to work with industry promoting the GIRFT strategy from the outset, as demonstrated in Betty's Story (NHS England, 2017b). The group considered which areas of variation in practice could be overcome by simple standardisation, which could be easily utilised by a diverse group of practitioners, with different levels of clinical expertise and education.

A consortium of clinical specialists, including podiatry and procurement, met informally for the day and were kindly chaired by Wound Care People and supported by Farla Medical Healthcare Ltd. The remit was to discuss areas within wound care where changes could be supported by industry with a focus on unmet clinical needs.

The objectives were based around the work started by the NHS Clinical Evaluation Team (NHS CET) and current healthcare priorities. The aim of the NHS CET is clinical quality, safety and value in reducing wastage.

Box 1: Members of the focus group of tissue viability specialists

Elaine Bethell, tissue viability lead nurse, The Royal Orthopaedic Hospital Birmingham

Rosie Callaghan, tissue viability nurse specialist, Worcestershire Health and Care Trust

Gemma Davies, clinical lead, Telford Wound Healing Service, Shropshire Community Health NHS Trust

Sian Fumarola, senior clinical nurse specialist in tissue viability, University Hospitals of North Midlands NHS Trust; NHS Supply Chain

Nicky Griffiths, lead tissue viability nurse, University Hospitals Birmingham NHS Foundation Trust; Queen Elizabeth Hospital Birmingham

Lisa Hill, lead nurse, tissue viability, Worcestershire Acute Hospitals NHS Trust

Adele Linthwaite, tissue viability lead and continence advisor (trust wide inpatients), Birmingham and Solihull Mental Health NHS Foundation Trust

Stefanie Mahan, palliative care clinical lead and TVSN, Palliative Care Coordination Centre, Bradwell Hospital

Joy Tickle, tissue viability specialist nurse, Shropshire Community NHS Trust

The CET reports are based on the evaluation of products against NHS user requirements and are aimed as a basis for clinical decision-making and to influence standards for the future. Through discussion, the focus group reached a set of proposals for future practice, namely:

1. Identifying key products for the wound care market that met essential clinical needs.
2. Appropriate evidence and information to support the use of products in a safe and cost-effective way.
3. Governance of new product introductions that ensures compliance with legal and ethical considerations.
4. Evaluation of packaging to meet clinicians'/users' requirements.
5. Ways to ensure availability at point of care and reduce waste.
6. Simplifying education and training and making it easier and more appropriate to access across all healthcare settings.

The above constitutes six steps towards GIRFT in wound care.

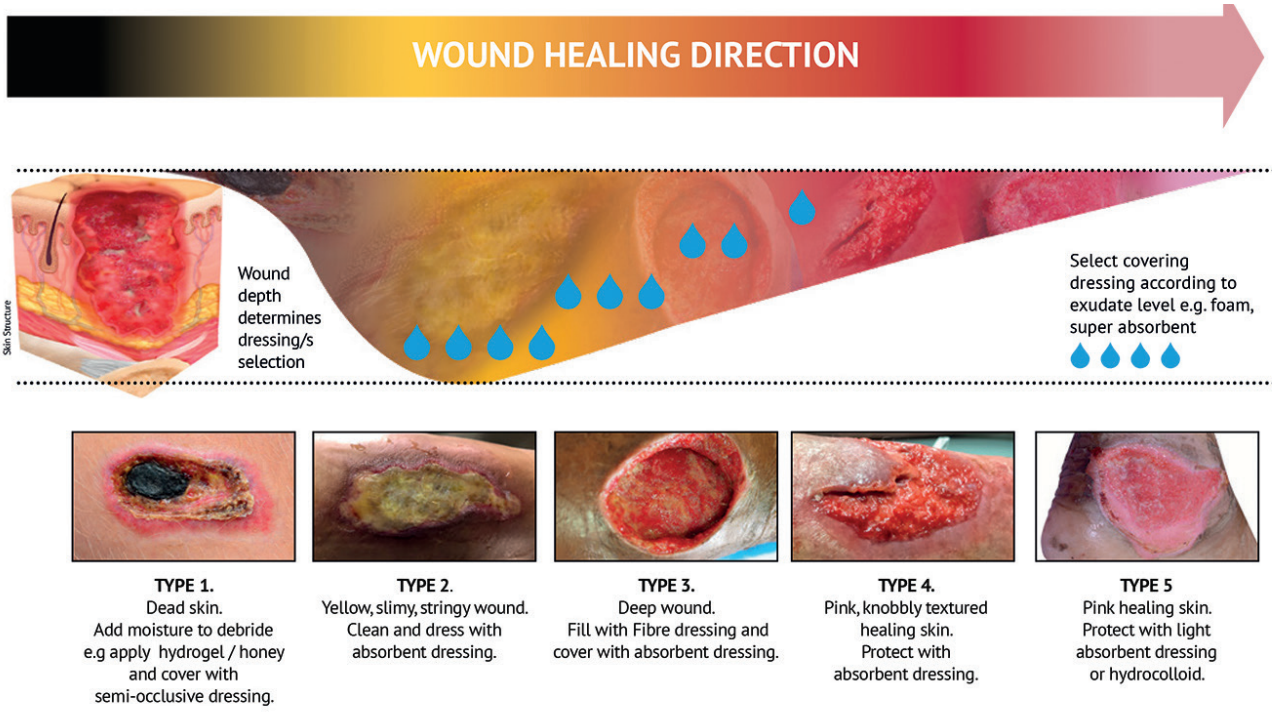
It was hoped by the group that not only would this information be of value to practitioners, but would also enable industry to deliver what the clinicians and users require based on sound research and development.

The main themes to evolve from the focus group's discussions were:

- A need to work in collaboration with industry, as industry provides access to education, training and support. This collaboration should be respectful and ethical to both clinicians, companies and users
- To keep things simple — consider clinical terminology appropriate to non-specialist staff and users including names, product codes, branding
- To look at point of care access and different methods of supply and stock management
- To consider all involved with wound care when developing products, packaging and education, including patients and carers, and nurses of all grades
- To develop innovative Eco-friendly packaging and assist different end users to make the right decisions
- To develop tools to support seamless care through a patient's journey, e.g. care pathways, decision guides and patient passports
- To ensure clinical evaluations with realistic assessment criteria, which are able to demonstrate patient benefits and cost savings without any compromise on quality or outcomes
- Clinical evidence needs to align with best practice statements.

With the above guidance in mind, an approach could be developed across all healthcare settings, supported by industry and agreed nationally, that would simplify and inform dressing choice. This should be supported by clear, simple educational tools suitable for all levels of staff and users. These would be:

- Colour-coded packaging aligned with the stages of wound healing (continuum), which would fit the criteria for assisting all users with decision-making and therefore minimising waste
- Clear instructions understood by all users in patient-friendly language
- Patient information sheets to assist with self-care
- Simple care pathways to enable correct choice, with a step-up/step-down approach



This work has been supported by an unconditional education grant from Farla Medical Healthcare Ltd.

Figure 1.
Dressing selection.

- An innovative approach to packaging to improve dressing selection and reduce wastage.

Such an approach is intended to allow clinicians, carers and patients to choose the right dressing for the patient first time. By following this, clear objectives can be set, thereby minimising errors and wastage. It is also hoped that a patient-centred approach will be easier to sustain, enabling true partnerships and less 'non-concordance'.

CONCLUSION

The delivery of wound care is changing, dressings are now classed as everyday healthcare consumables and are found in most healthcare settings (CET reports 2017). There is still variance across practice, and recognition that dressings can be misused, overused and wasted is prevalent. In a market sector that is crowded with wound care companies, an attempt is being made at shifting the emphasis from the dressing itself, which should be of an agreed quality and standard as indicated in the CET reports, to a pioneering approach in support, supply and delivery of wound care products, education and training.

The supply of dressings at point of care lends itself to innovative thinking in respect of how to get the right dressing to the right patient at the right time. Methods developed can be used by healthcare settings closer to the patient (care closer to home) and link to transformational programmes involving potential new care settings, such as pharmacies, urgent care centres, etc. A link to a patient-orientated approach that will achieve NHS objectives is also being sought. Pilot work has been started in some pharmacies — an area where industry could support and be of value both with products and training.

The first phase of this initiative, involving working with industry on a pilot scheme aligning with some of the key principals of the wound care GIRFT strategy, is nearly complete. Next steps will look at improving knowledge, thereby empowering clinicians making day-to-day wound care decision to make the right choices, reduce wastage and improve healing rates. **JCN**

REFERENCES

Adderley U (2018) Our vision for the National Wound Care Strategy Programme. *Wounds UK* 14(5): 13

Adderley U (2019) The National Wound Care Strategy Programme. *Wound Care Today*. Available online: www.woundcare-today.com/journals/issue/february-2019/article/national-wound-care-strategy-programme

Brown A (2018) Dispelling some myths and misconceptions in wound care. *J Community Nurs* 32(6): 24–32

Chamanga E (2016) Wound Assessment and Treatment in Primary Care. *Independent Nurse* 21 March. Available online: www.independentnurse.co.uk/clinical-article/wound-assessment-and-treatment-in-primary-care/116877/

Cryer S (2015) Improving the selection of wound dressings in general practice. *Nurse Prescribing* 13(7): 336–42

Denhartog L, Hallman L (2015) Strategies to reduce wound dressing waste. *Winter* 70(4): 20–1

Frykberg RG, Banks J (2015) Challenges in the treatment of chronic wounds. *Adv Wound Care* 4(9): 560–82

Geraghty J (2018) Placing our best leg forward: preventing lower leg conditions for our workforce and the general public. *J Community Nurs* 32(2): 12, 14

Gray TA, Rhodes S, Atkiknson RA, et al (2018) Opportunities for better value wound care: a multiservice, cross-sectional survey of complex wounds and their care in a UK community population. *BMJ Open* 8(3): e019440

Guest JF, Ayoub N, McIlwraith T, et al (2015) Health economic burden that wounds impose on the National Health Service in the UK. *BMJ Open* 5: e009283. Available online: https://bmjopen.bmj.com/content/bmjopen/5/12/e009283.full.pdf

Gupta S, Andersen C, Black J, et al (2017) Management of chronic wounds; diagnosis, preparation, treatment and follow-up. *Wounds* 29(9): S19–S36

Hansard (2017) *NHS: Wound Care*. Available online: https://hansard.parliament.uk/Lords/2017-11-22/debates/6C57E65A-A04D-449B-82E9-C836F088A696/NHSWoundCare

Jarbrink K, Ni G, Sonnergren H, et al (2016) Prevalence and incidence of chronic wounds and related complications: a protocol for a systematic review. *Syst Rev* 5(1): 152

King's Fund (2017) *Tackling variations in clinical care: assessing the Getting It Right First Time (GIRFT) programme*. King's Fund, London. Available online: www.kingsfund.org.uk/publications/tackling-variations-clinical-care

O' Brien ML, Lawton JE, Conn CR, Ganley HE (2011) Best practise wound care. *Int Wound J* 8(2): 145–54

Milne J (2017) Getting it right first time. *Br J Nurs* 126(20): S3

NHS England (2017a) *Commissioning for Quality and Innovation (CQUIN). Guidance for 2017–19*. Available online: www.england.nhs.uk/wp-content/uploads/2016/11/cquin-2017-19-guidance.pdf

NHS England (2017b) *NHS RightCare scenario: The variation between sub-optimal and optimal pathways. Betty's story: Leg ulcer wound care*. Available online: /www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/01/nhs-rightcare-bettys-story-narrative-full.pdf

Nunan R, Harding K, Martin P (2014) Clinical challenges of chronic wounds: searching for an optimal animal model to recapitulate their complexity. *Dis Model Mech* 7(11): 1205–13

Purkis N, Gabb CA (2013) Online learning for professional development. *Nurs Times* 109(51): 16–18

Stephenson J (2017) Coroner raises patient safety concerns over lack of Bedfordshire tissue viability nurses. *Nurs Times* 24 February. Available online: www.nursingtimes.net/news/community/exclusive-coroner-warns-of-tissue-viability-nurse-shortage/7015967.article

Vowden P, Vowden K (2016) The economic impact of hard-to-heal wounds: promoting practice change to address passivity in wound management. *Wounds Int* 7(2): 10–15

White R (2010) Tissue viability can tackle the financial burden of wounds. *Nurs Times* 106(16): 24