National Wound Care Strategy update: lessons from implementation

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A mantra that I often find myself reflecting on as the National Wound Care Strategy Programme (NWCSP) has progressed from strategy to implementation is:

> *"If it was easy, then it would have already been done".*

Of course, writing recommendations is the relatively easy part — but implementing them in practice is the real challenge.

Working with the First Tranche Implementation Sites (FImpS) has proven just that. Recruited from each NHS England (NHSE) region, the seven FImpS are implementing the NWCSP Lower Limb Recommendations (NWCSP, 2020a) and testing assumptions of the supporting Implementation Case (NWCSP, 2020b). As a national programme, it has given us valuable insight into the complexities, challenges and key enablers. This allows further refinement of our recommendations and strategy. While for the FImpS this has resulted in some challenging work, they are already reporting benefits. Early provisional results show improved assessment timeframes, faster healing rates, a reduction in non-elective admissions, reduced wound care spend, reduced infection rates, increased workforce productivity, improved data and information and high patient satisfaction scores. The FImpS achievements are very much supporting the predictions of the Implementation Case, suggesting that it can be done.

Many organisations will be pleased to know that the work of the FImpS will inform case studies and blueprint(s) for national roll out, providing step-by-step guides to enable others to transform lower limb services more quickly and cost-effectively. This is important because since the start of the FImpS in April 2021, we have learned, perhaps unsurprisingly, that in practice recommendations are both interpreted and delivered differently. This can lead to continued unwarranted variation, despite good intentions. I am sure this is the case for many guidelines produced and is very much a symptom of the way in which existing healthcare services are structured, often working in silos. But the value of working in partnership with the FImpS is that the frequent dialogue between the national and local teams has enabled both to parties to listen, challenge, learn and work together to find solutions. As a result, additional national work has begun to shape what the NWCSP recommended delivery models are for the lower limb clinical pathway — i.e. moving from the 'what' to the 'how.'

Ultimately, our vision is for the delivery of care via dedicated lower limb services that span ambulatory, homebound and inpatient populations. Interestingly, a recent study found that many community-based nurses perceived the absence of such to be a significant barrier in providing optimal care for patients with venous leg ulcers (Perry et al, 2022). Other organisational barriers, including rising workload pressures and a lack of knowledge, skills and training provision were also reported to contribute (Perry et al, 2022). So, even with the addition of recommended delivery models, there are still some challenges yet to overcome.

Current local commissioning arrangements can negatively impact on the ability of organisations to fully implement the NWCSP Lower Limb Recommendations. Similarly, it also has consequences on important parts of our evidence-based recommendations, such as onward referral to vascular services for the assessment of and, where appropriate, interventions for venous disease. Nonetheless, as the benefits of improving wound care become more apparent through our FImpS, it is starting to have a high profile within other health and care provider organisations and also healthcare policy makers. This creates an opportunity for the national programme, the FImpS and wider stakeholders to collectively tackle the challenges together and make a difference.

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And so, we have been doing just that. From recent collaborative work on referral templates (NWCSP, 2022) with the Royal College of Surgeons (RCS) and the Vascular Society (VS) to enable more appropriate and timely referrals to vascular services, ongoing conversations with NHSE regarding support for national policy and commissioning changes. By understanding what helps and hinders in clinical practice, we can take steps to try and address these issues so that the changes we aspire to achieve are more achievable and sustainable.

As we move into the new landscape of Integrated Care Systems, we are hopeful that this will support the NWCSP vision of delivering wound care services and solutions that move seamlessly between acute, primary and community care providers. Working more corroboratively to ensure that patients get the right care, at the right time from the right service will not only improve wound and care outcomes, but support health professionals to deliver high-quality care, ensure better use of resources and provide improved job satisfaction. WUK

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