The future of tissue viability

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As we all attend the annual Wounds UK event in Harrogate, it is probably an ideal time to reflect on the changes over the last twelve months and tissue viability as a specialty service. Is there a future for tissue viability, or will the speciality be subsumed into the role of the generalist practitioner?

The publication of 'Operational Guidance to the NHS: extending patient choice of provider' (Department of Health [DH], 2011a) has clearly stated that the Government will increase choice of services to patients in NHS funded care that include venous leg ulcer and wound healing. How will this look, who will provide this service, can we be confident that the providers will be specialist in tissue viability? More importantly, will any qualified provider be able to offer a quality service to patients with both simple and complicated wounds? Questions we need to consider, but we should also see this as an opportunity for tissue viability practitioners to raise awareness of the complexities of this service and how it impacts on all types of health care and works as part of the multidisciplinary team. The field of tissue viability sees no age boundaries, with specialists offering advice, care and education to paediatric and adult patients.

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There are challenges ahead, but we must take up the challenge and be heard, we need to ensure that we are providing audit of services, cost analysis of treatments used, metrics of care, education programmes for pre and post registration practitioners that reflect the realities of practice, and providing a quality service within the confines of available resources.

Healthcare areas continue to demonstrate that they are offering value for money, being productive, innovative, preventing harm to patients and, above all, offering a quality service. Yet, the Safe Care Workstream (DH, 2011b) states that approximately 10% of patients are harmed during a hospital stay.

To this end, the Safe Care Workstream has established a quality improvement programme called 'Safety Express', to help the NHS develop safer system in hospitals and community settings. It will work towards the shared aim of dramatically reducing harm from:

- Hospital- and community-acquired pressure ulcers
- Blood clots (deep vein thrombosis [DVT] and pulmonary embolism)
- Urinary tract infections in patients with catheters
- Falls in care settings.

Their ambition is to eliminate harm from these conditions in 95% of patients by 2012.

There is evidence that much good work is being done across the country to achieve these ideals — witness some of the excellent posters available at the conference, clearly evidencing how tissue viability practitioners are stepping forward and meeting the challenges of the quality agenda. Yet, what seems to be missing is the sharing of these efforts. Practitioners continue to work either in isolation or with their local/regional groups and work either does not, or is slow to transfer to other areas.

One of the aims of the journal and, indeed, the next conference in 2012, will be to showcase this excellent work and to act as a way of sharing good practice across the UK. This becomes more imperative as we are increasingly driven to meet CQUIN targets and other quality standards which are yet to be written. These standards need to have clinician involvement and engagement, and the only way that this will be achieved is to be seen as a united force with a strong opinion and unified voice. It is clear that a quality standard for pressure ulcers is on the way. This was mentioned, but not discussed in detail, at the NICE Pressure Ulcer guideline stakeholder meeting. However, it is not clear what clinical representation there will be on this most important group, information on how these are developed can be found online at: www.nice.org.uk/media/6F6/2B/.

References

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