What impact will Lord Darzi's report, 'High Quality Care for All', have on tissue viability?

Lord Darzi's report 'High Quality Care for All' (Department of Health, 2008) appears at least on the surface to continue or replicate previous rhetoric by promoting quality care and mechanisms for testing initiatives to prove that quality of care is given. The quality word has been overplayed in many White Papers, and no one would argue that we need to strive for higher standards. Yet with the service already stretched to its limits, how can all this be achieved? Over the years there have been a number of government reports which all seem to demand higher quality. However, most healthcare professionals would agree that without proper resources, these demands for high quality will be difficult to achieve. So, what is it that makes the Darzi report different? JT

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1. What does *High Quality Care for All* mean for those involved in wound care and do we need to adapt to meet the recommendations within the report?

MM: Wound care is still not 'on the map' as far as the government is concerned. Lord Darzi did not directly mention it, and we should not expect that his report will make any direct difference to patients or staff in this field. However, he alludes to 'never events' (events that should never take place) and as a result the National Patient Safety Agency has charged primary care trusts and local health boards with implementing the core list of locally defined 'never events' (e.g. wrong site surgery [NPSA, 2008]). There has already been talk of making pressure ulcers such an event. Tissue viability specialists may have already shot themselves in the foot by saying pressure ulcers are 95% preventable, and risk shooting themselves in the other by reinforcing the false idea that a pressure ulcer can be a 'never event'. We are reaping what we have sown by our sloppy thinking.

What Lord Darzi has shown is that we need to have a national report into the state of tissue viability in the UK, written by a minister of state, in order for anything to be taken seriously. I have received two requests for information on pressure ulcers from members of parliament investigating the national situation. This is progress, but the problem needs to be recognised not just by backbenchers but by the real power brokers. Given that politicians react to media-generated public pressure (such as the recent Ghurka issue), there is a real need to raise the profile, perhaps by a *Panorama*-style investigation.

PB: Darzi (2008) recommends 'Getting the basics right first time, continuing to seek improvements in safety and reductions in healthcare-associated infections'. I would interpret this as a declaration that healthcare professionals need to ensure that basic standards of care are in place, with regular risk assessments regarding nutrition, pressure damage, falls and maintaining the safety of the individual. In wound care this ensures that highest standards of universal precautions are utilised to prevent wound infection. If the patient is being looked after in primary care and the patient is at increased risk due to their home environment, this must be recognised and care adapted to minimise the risk. Regular review of any wound is necessary to ensure that optimum care is delivered, and it is important that healthcare professionals are able to recognise their limitations and be able to refer a patient on to a specialist when this is clearly indicated.

It has always been thought that most pressure ulcers occur in secondary care. Many tissue viability nurses working in both primary and secondary care can now vouch for the escalation in pressure ulcers occurring in patients' homes as well as residential and nursing homes. Pressure ulcer prevention equipment has become more sophisticated, but that does not necessarily make it available in all care settings. PCTs need to examine the needs of their population via audit and then designate an appropriate budget to encompass not only pressure-

relieving mattresses and cushions, but various orthotic devices, such as pressure-relieving boots. This budget should be managed by a TVN, but advice should be taken from both occupational and physiotherapists to ensure the patient receives the most appropriate equipment for their needs.

JF: Lord Darzi's report can be seen as a real opportunity for providers of wound care services, and for some practitioners it will mean changing their ways of working. Fundamental to the report is the requirement to provide evidence of the benefit of the service provided and also a requirement to be proactive rather than reactive, actively seeking to move care on, developing the service strategically rather than becoming bogged down in an ever increasing workload, much of which could and should be dealt with by others. Process will become as important as outcomes, with patients being given a far greater choice in where and from whom they receive care. For some clinicians, collecting and interpreting data in order to defend their role in care may prove difficult because lack of support or appropriate team sizes may mean that they have only been able to focus on delivering care, rather than providing evidence of the care they deliver.

2. One of the report's recommendations deals with improving access to health care and health promotion issues. How could you improve access to your service and could you do more with respect to health promotion for your patients?

MM: It is impossible to promote something that is not recognised or resourced. The only way to improve access to tissue viability advice is to treat the service equitably. It needs to be contracted for in the same way that a medical service is. Perhaps controversially, I would say that this will not happen unless one or more of the following occurs. First, that tissue viability specialists are all employed at consultant grade (and if these are nurses, they need the support of a registrar or senior house officer). Second, medical staff need to start calling themselves tissue viability consultants. Third, the arbitrary socio-cultural distinctions inherent in having a separate register for nurses and doctors have to be ended. If you do not believe in this divide look at page 12 of Lord Darzi's report which refers to senior doctors' awards which says: 'for senior doctors, the current Clinical Excellence Awards Scheme will be strengthened to reinforce quality improvement. New awards, and the renewal of existing awards, will become more conditional on clinical activity and quality indicators; and the Scheme will encourage and support clinical leadership of service delivery and innovation.' Surely he is not implying that money is at the heart of change? This says a great deal about where real power lies, and what is needed to get senior medical staff on side. Improved access to wound care services will undoubtedly result in health promotion and reduced costs to the NHS, but only when tissue viability is ranked alongside other medical specialities as a core service.

PB: It is vital that all TVNs audit their practice and advertise the success of their work in their own trusts so that GPs and healthcare commissioners become familiar with the advantages of a patient seeing an appropriate specialist in a timely fashion to expedite wound healing where possible, and to initiate appropriate investigations for those with complex wound needs.

Initiation of service specifications can aid the speed at which a patient proceeds through health care, for example, if a patient presents to a practice nurse with a diabetic foot ulcer, they should be referred immediately to a diabetic podiatrist. It is inappropriate for a practice nurse to lead such complex wound care management. Service specifications outline the pathway of care, time limitations and referral pathway to all service providers. They clarify wound management for all concerned — most especially, the patient.

JF: The report identifies the importance of getting the basics right first time every time, which must surely include a focus on health promotion whether through 'well leg' initiatives to prevent occurrence or recurrence of leg ulcers, or general health promotion to promote good wound healing by smoking cessation, weight reduction and other measures. Access to services could be improved considerably. The emphasis on enabling staff to lead and manage the organisations in which they work should encourage much greater participation from clinical staff who are not only close to their patients, but can also be very creative in developing patient-focused services. Many tissue viability specialists are already setting up and leading initiatives designed

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not only to improve quality of care for the patient, but also to meet the government targets on waiting lists and reducing admissions. With guidance and support these initiatives can be widely adopted.

3. With respect to improving choice for patients, how could you give patients more choice with regards to treatment and providers of treatment?

MM: Lord Darzi mentions that he had personally seen a fourfold increase in the size of his colorectal surgical team, including the employment of two full-time stoma nurses, two specialist nurses and a nurse consultant. Clearly patients can be referred to a team of experienced staff, but this is not always possible in tissue viability. Certainly not to one with comparable resources. His team crosses the primary-secondary interface too, which is also very rare in our field. When a service is properly recognised, it is likely to be properly commissioned and resourced. We seem to fight for even the most basic choice of dressing, let alone the chance to offer more complex treatment.

PB: Currently patients can be offered a choice, albeit limited, as to which surgeon their referral is made to within an area, provided their GP makes this effort. However, in regard to wound management, patients are expected to be referred to whoever is their local provider of wound care regardless of whether or not that TVN/wound/leg ulcer specialist has the capability to provide care. A similar distinction should be made between TVNs. Not all integrate leg ulcer expertise into their practice, some specialise only in pressure ulcer prevention and management, consequently it should not be expected by all trusts that their TVN has all-encompassing knowledge. If independent tissue viability consultants exist in the area why should a patient be deprived of that service? After all, the bulk of the NHS budget now lies within primary care, with the intention that the money should follow the patient.

JF: Widening the provision of service providers can be a double-edged sword — most patients would be keen to have greater flexibility over who delivers their care, and where and when they receive care, however, they would also like to be reassured that the care is delivered by an appropriately qualified practitioner working to designated standards or protocols of care. This is a major weakness in the field of wound care because there are no standards for education, training or minimum competence, regardless of clinical background, and there are very few agreed benchmark standards. Thus, a patient would have few quality indicators against which to make a reasoned choice. A decision will often be made on purely practical issues such as choosing a clinic based on its opening hours. The wound care community needs to set aside political infighting and agree what is best for their patients so that they can truly make an informed choice.

4. Darzi also recommends that patients are guaranteed to be treated with the most clinically- and cost-effective treatments available. Can this be achieved in the light of recent initiatives to reduce the NHS spend on dressings and wound care therapies?

MM: In the Bible it says 'If God be for us, who can be against us?' Darzi is neither for us nor against us, and the National Institute for Health and Clinical Excellence is not exactly fulsome in its support. We need some respected advocacy at the highest level. I detect a bit of spin in the use of the word 'guarantee'. It is a meaningless statement, though it sounds laudable. My own experience is that procurement officers and clinicians are more likely than ever to ask what the cost of a treatment is. They seem less able to ask what the cost benefit is. Patients ought to be guaranteed to have access to the most knowledgeable and experienced tissue viability practitioners. Such staff have their reputation to protect, and will do their utmost to help a patient to heal, and to do so quickly, efficiently and economically given the chance.

PB: All NHS trusts have a responsibility to spend wisely, including their wound dressings budget. However, savings can be made by examining acquisition and distribution of dressings. The majority of patients in primary care have their dressings prescribed for them which leads to a great deal of wastage in unused dressings. However, several wound dressing companies now offer a service whereby they will procure wound products from their own and other companies which can then be stored in community hospitals and nurse bases. This is cost-effective and may free the budget for purchase of some of the more expensive therapies, such as negative pressure wound therapy which is unavailable to many patients in primary care, regardless of the wealth of evidence to support its application.

JF: The feedback given to the House of Commons Select Committee (Fletcher, 2006) shows how cost-effectiveness can be achieved in many ways other than reducing spend on consumables. More recently published audit data (Posnett and Franks, 2007; Vowden et al, 2009) clearly demonstrates where cost savings can be made, with the greatest cost-efficiency being generated not by a penny pinching approach to dressings, but by ensuring delivery of appropriate care at the earliest occasion by an appropriately qualified individual. Vowden et al (2009) provide data from their local primary care trust which illustrates that only 17% of the total wound care costs were attributable to dressings and bandages. In contrast, 52% of the costs were for wound-attributable hospitalisation, accounting for 17,800 bed days in one year. They conclude that 'putting in place care pathways to avoid admission and prevent hospital-acquired pressure ulcers and wound complications are important means of reducing cost — and (incidentally) improving patient outcomes'.

5. How could you ensure consistent and measurable high quality care for your patients?

MM: The answer to this is to reduce the number of people messing about with the patient's tissues. It is assumed that chronic wounds are of low risk (compared with other conditions such as untreated cardiac problems or cancer) and are intrinsically simple to deal with. That is why nurses and not doctors are the ones looking after such patients. When I am called in to give advice, I am taken by surprise when a nurse proffers any current or useful information about a patient's wound. Nobody will own up to having seen the wound previously (at least not in secondary care). Agreement is needed on basic techniques and basic competence for 'first-responders' who should then be supported in terms of more critical assessment and treatment by nurses, doctors, or others who have at least a bachelor degree in tissue viability.

PB: Audit is an extremely valuable tool. All TVNs should be collecting pressure ulcer prevalence and incidence statistics for their primary or secondary healthcare trust, including mental health trusts, in order to demonstrate the quality of nursing care delivery. If Darzi's report (2008) is taken literally it should become mandatory for all care settings to provide meaningful statistics. However, since not all care settings have a TVN or lead person to provide such information this could prove difficult. Wound Care Alliance UK and the Tissue Viability Society have pushed mandatory reporting for several years and it would be welcomed. TVNs should also be auditing their own service stringently to ensure that patients are seen promptly, their care shared with appropriate members of the multidisciplinary team and that appropriate outcomes for particular wound aetiologies are reached. For example, the patient that is referred to a specialist leg ulcer clinic should expect to receive a high standard of care, assessment and investigation. Information should then be shared with community and practice nurses to provide continuing care, thus giving confidence to both patient and other nurses regarding the treatment plan and their roles within that plan. If the patient has a venous leg ulcer, service specifications should outline the expected time to reduce ulcer size or healing depending on the original size of the ulcer, taking into consideration comorbidities, mobility and nutritional status. If care is audited against these service specifications, it should be expected that a high standard is achieved by a TVN.

JF: The Darzi report suggests that there should be systematic measurement and publication of information about quality of care, but this would depend upon there being standards or agreed benchmarks against which the care was measured. So far, few of these exist within wound care. Where data are collected they are often in a format that is incompatible with that collected in other areas, for example it is impossible to compare the frequency of occurrence of pressure ulcers from one acute provider to the other because there is no agreement on how data are collected or, indeed, what data are collected. National standards need to be agreed which will be a considerable undertaking. To persuade clinicians to participate there has to be clear benefits for the patient and the process needs to be practical and free from red tape.

6. Apart from national procurement cost-saving initiatives, what other factors could prevent you from delivering Lord Darzi's recommendations?

JF: *Although undeniably and inextricably linked to many other conditions such as diabetes, care of the older person, long-term conditions, etc, wound care itself does not warrant a mention.*

PB: *Pressure ulcer prevention and nutritional screening training should be made mandatory in both primary and secondary care.*

MM: If tissue viability was seen as a medical consultant-led discipline, training arrangements would have to be in place for junior staff. In south-east England consultant nurses in A&E or cardiac care, for example, have the opportunity to support the development of future consultant grade nurses through monies designated for that purpose. This venture will pay dividends. But, I believe it only happens because the particular specialities have featured explicitly in national reports and targets. These opportunities need to happen in our own field.

PB: Lack of recognition of the healthcare issues facing groups of the population. The DoH show no sign of acknowledging that the increase in an older population will bring an associated escalation in comorbidities, including chronic wounds. In addition, PCTs should be increasing their numbers of community nurses to meet the demands of increasing numbers of patients being discharged from hospital with wounds, in order to facilitate the Better Healthcare Closer to Home NHS strategy (www.betterhealthcare.org.uk/). Good forward planning demands that audits are made of the numbers of patients with acute and chronic wound problems in order to provide good, continuing care, but many PCTs have failed to do so and are expecting the goodwill of community nurses to stretch a very long way.

JF: The lack of focus on wound care within any government initiative means that it is rarely a high profile subject. Although undeniably and inextricably linked to many other conditions such as diabetes, care of the older person, long-term conditions etc, wound care itself does not warrant a mention. Identifying, costing and attributing care within wound care is a complex and often unachievable goal. Commissioners appoint lead commissioners for high priority services, but wound care does not appear to be among these.

Lack of guidance and support for wound care specialists means that they are often isolated and unsupported. Many are inappropriately appointed — no other specialty would have band 6 nurses employed as specialists to design, lead and deliver a service. This unrealistic expectation by employers is the biggest stumbling block to achieving high quality care. There is no support, no team building and definitely no succession planning. Relatively junior nurses with basic clinical skills, no management skills and certainly no business skills are appointed to strategic posts where they burn out, get it wrong and actually in some cases stand their ground and make a good job of it. This is no way to deliver services.

7. The report also mentions improving education for staff to improve care standards. What educational provision would help you in your clinical practice?

MM: *High Quality Care for All* clearly states that there will be reforms of NHS education and recommends a threefold increase in preceptorship for nurses. By implication, there is a need for reform, and newly qualified nurses are uncertain in their practice.

As for tissue viability, there is a sizeable group of nurses who are frightened of wounds. Some avoid removing dressings when a patient is admitted because they are not sure what to do with the wound afterwards. This is understandable. The fact is that tissue viability is already acknowledged to be a discipline for which training beyond pre-registration is necessary. Given that a vast amount of NHS patients have wound-related problems — surgical patients can have incisions, patients with diabetes have risks of foot ulceration, smokers have circulatory impairment, older people can have leg ulcers, trauma patients have injuries, and immobilised patients have increased pressure ulcer risk — surely much more time needs to be spent on tissue viability in pre-registration training. However, potentially, the more senior one becomes in a specialty, the more boundaries could be pushed. For example, some TVNs conservatively debride wounds: what is to stop them doing surgical debridement or even flap transfers? The answer is to do with the mindset and lack of nursing opportunity to develop one's skill base. Sharing the specialty and learning opportunities with medical trainees could alleviate fears and extend the range of treatments for patients.

PB: Since the older patient is more likely to suffer problems with nutrition and possible pressure damage, it would seem prudent that pressure ulcer prevention and nutritional screening training should be made mandatory in both primary and secondary care. This would assist with risk assessment and minimise the danger to patients in all care settings.

MM: *I do not think there is anything specifically new in this report, neither has much of any lasting value or innovation been said in previous reports.*

JF: *... the strength of this report is in its directness and also the flexibility to apply it to areas of practice.*

Furthermore, with the rise in obesity and diabetes, community nurses should be trained to discuss healthcare promotion regarding healthy eating and weight reduction to enable them to adequately support patients with these problems.

JF: Agreement of a basic standard for wound care in all pre-registration training (especially nursing) would allow passionate and committed clinicians to focus on developing their skills and knowledge to manage the more complex patients who require specialist care instead of becoming general 'dressing nurses' because more and more ward and community-level nurses have become deskilled. Education needs to be targeted to the practitioners' needs. Focusing on achieving academic awards in order to cross gateways is not always in the patient's best interest, as there is a dislocation between strong clinical knowledge and academic achievement. That is not to dismiss higher-level academic skills because they are incredibly important, but there must be a good foundation of knowledge to start with. Nurses cannot be expected to learn specialist clinical skills, management and strategy and undertake a Masters degree all at the same time. A Masters programme is about higher-level thinking, developing individual knowledge and it is often very theoretical. Good clinicians should have a strong grounding in clinical practice and team working as this allows them to develop and use those higher-level skills in the best interests of the patient and their colleagues.

8. Finally, does this report bring anything new to the table or do you feel that these initiatives have been mentioned in previous reports?

MM: I do not think there is anything specifically new in this report, neither has much of any lasting value or innovation been said in previous reports. What we need is a Darzi-level ministerial review of tissue viability.

PB: Darzi (2008) states that, 'for the first time we will systematically measure and publish information about the quality of care' but the NHS Institute for Innovation and Improvement (www.productivity.nhs.uk) has been publishing NHS indicators of care since 2006 based on information furnished by NHS trusts. Certainly, the new best practice tariffs have the potential to set the cat among the pigeons and will provide the impetus to improve practice in areas which may have been dragging their heels. This will work hand in hand with the strengthening of the Clinical Excellence Awards Scheme to reinforce quality improvement, all of which can only favour the patient.

Regarding the patient's views, all trusts have been recording the patient experience via confidential surveys which are performed annually and signal those areas in which a trust can congratulate itself or identify areas of weakness which need to be addressed — which often involve pain management and nutrition.

What is different in the Lord Darzi report (2008) is that patients' experiences will have a direct impact on the way hospitals are funded. This has the potential to empower the patient. However, we have yet to see how this will be interpreted by trusts and strategic health authorities. There are clearly areas of repetition, but also some new points raised by the report. We now await its interpretation at local and SHA level.

JF: Many of the initiatives have been mentioned in previous reports, but the strength of this report is in its directness and also the flexibility to apply it to areas of practice. The statements are brief and to the point — ideal for measuring against or using to develop a case for service provision or review. WUK

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