Second Darzi report: mixed messages for tissue viability

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The recent report from Lord Darzi (Darzi, 2009), 'Transforming community services' is the second to be authored by Ara Darzi and follows in the wake of his review of the NHS in England last year (Darzi, 2008).

This latest report is to be welcomed by those who provide care in the community setting. For staff who are involved in tissue viability (including wound care) it has long been known that the predominant wound care workload is in primary care. However, little has been done to provide the necessary resources or acknowledge the vital role that community staff have to play. It is also important to emphasise that the commissioners of care (PCTs) should give due recognition to the fact that tissue viability care covers a broad spectrum of interventions from 'basic/fundamental' through to highly specialised care, including preventive measures to avoid skin and soft tissue damage, vascular assessment, diagnosis of wound infection, and sharp debridement, all of which require specialised clinical skills (White, 2008). The report stresses the importance of 'getting the basics right — every time'. An admirable sentiment, but how does Darzi address this in his report?

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First, tissue viability does get a mention but sadly it amounts to no more than 100 words in this lengthy report. One might be forgiven for regarding this as disproportionate, especially as in community nursing wound care is one of the top 10 purposes for visits and accounts for 66% of the total available community nurse resource (Posnett et al, 2009). Second, Darzi does emphasise the need for clinical skills and competent care, highlighting the need for assessment, intervention and treatment. These components of quality care have been top of tissue viability collective priorities for decades. Third, Darzi provides examples of 'evidence-based practice', but does this by mentioning two specific (and in one instance branded) therapies. It is perhaps pertinent to remember at this point that Darzi was made a Minister of Health, with a responsibility for health policy, by a Labour Government who wanted to promote trust and respectability and to deliver a market-based healthcare system. In such a system services are provided by a diverse range of independent providers who, in turn, compete for business in a market supposedly governed by consumer choice.

It is therefore surprising, if not downright controversial, that specific therapies have been used as examples of so-called evidence-based practice, namely four-layer bandaging (4LB) and vacuum assisted closure (VAC therapy). The use of a specific trade name (VAC®, KCI) is disappointing in a Department of Health report, particularly when other forms of topical negative pressure (TNP) are available. The evidence base for TNP has been recently reviewed in a Cochrane systematic review (Ubbink et al, 2008). The outcome of this exercise was that 13 randomised control trials (RCTs) were included in the review. Trial quality was considered to be 'moderate' overall. One study reported a significant increase in the median time to complete healing. In two studies where wound preparation time before surgery was assessed, a statistically significant reduction of 10 days was reported in one, and a non-significant reduction of one day in the other. In three studies on diabetic wounds, one showed no significant difference between TNP and control in mean healing time. Of two studies assessing measures of reported wound area reductions in TNP-treated groups, one was statistically significant. One study reported a significant reduction of four days in the wound preparation time before surgery. Trials in skin grafts and pressure ulcers showed inconclusive and conflicting evidence as to the efficacy of TNP. The authors' conclusions being, 'There was little evidence to support the use of TNP in the treatment of wounds'. The conclusions of the Cochrane group are corroborated by a review conducted by a panel of experts in the USA (Agency for Healthcare Research and Quality [AHRQ], 2009).

While we do not know where, and from whom, Darzi obtained his evidence, it is reasonable to assume that the Cochrane database was consulted. On the basis of these conclusions, Darzi has little foundation for recommending VAC in particular, or generic TNP to primary care practitioners. The stance taken by

Darzi also draws into question his insight into reimbursement, the wider availability of TNP, and the numbers of clinical staff properly trained to use it in primary care. The authors feel that this aspect of his report is ill-considered and superficial. What of alternative dressing-based therapies as advocated by Ubbink et al (2008)? These may well offer equivalent clinical efficacy at a fraction of the cost. Should they not also be considered?

With respect to advocating four-layer bandaging (4LB), the report is found wanting. With reference to Cochrane, we find that in a recent systematic review the authors concluded that, 'compression increases ulcer healing rates compared with no compression. Multi-component systems are more effective than single-component systems. Multi-component systems containing an elastic bandage appear more effective than those composed mainly of inelastic constituents.' This does not extol 4LB *per se*. Other recent evidence suggests that cohesive short-stretch bandaging also has great potential in the management of venous leg ulcers (Franks et al, 2004), and a recent review of the relevant literature states that, 'current research demonstrates that the use of short-stretch compression bandages is as effective as a four-layer compression bandage system in the treatment of adult patients with venous ulcers' (Castonguay, 2008).

So, what should we make of Darzi's legacy to tissue viability in primary care? Are these *faux pas* indicative that his advice and direction are now discredited? This is an important consideration, particularly as his resignation from his ministerial post on 15 July quickly followed the publication of his second report, prompting the question: what value may be placed upon the report? Darzi does state that, 'investment in tissue viability specialists to promote and lead should be a priority'. This does, however, have far-reaching implications for fundamental care provision. It has, for example, been established that 'better general education and better specific training in wound care could lead to better wound care' (Dugdall and Watson, 2009). The government has already pledged to 'liberate the talents of nurses', but a demonstrated lack of collaboration between healthcare professionals has led to clinical nurse specialists being 'constrained' (Austin et al, 2006a). Are we to assume that the promotion and leadership of specialists will solve the problem, or is this too facile a solution?

Clinical nurse specialists are central to practice development and must be provided with the framework in which they can bring about changes in practice (Austin et al, 2006b). The development of a published written directory of local services/resources would encourage scrutiny of local provision and promote their improvement and design: examples include screening and preventive services, out-of-hours accessibility and targeting services to specific demographic needs.

Tissue viability desperately requires recognition of the therapeutic value that expert care can bestow on patients, and at the same time have a positive impact on cost-effectiveness, as well as the authority to enact changes in practice. What it does not need are vague recommendations from 'on-high' where there are potential commercial overtones, lack of firm commitment to training and resources, and, where the supportive evidence is insufficient to convince practitioners committed to evidence-based care.

Could this report finally be the stimulus for the government to make tissue viability a priority by consulting openly with those directly responsible for tissue viability service provision, or, yet another misrepresentation?

Lord Darzi is a surgeon but has written this from a 'generalist' perspective. This report demonstrates that health care in the UK, including central administration (Department of Health), continues to ignore the fact that tissue viability has emerged as a specialty in its own right. The report would have benefited from specialist tissue viability input, which would have achieved two goals. First, recognition of the intrinsic value of tissue viability to patient care (not as an add on), and second, avoidance of the *faux pas* indicated through having 'informed' input. **WUK**

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