20,000 reasons why we can't ignore wounds any more

Jacqui Fletcher
Independent Consultant (Chair)

Jacqui Hughes
Senior Health Outcomes Manager, Smith+Nephew

Bernadette McGlynn
Service Lead for Tissue Viability, Birmingham Community Health

Key words
- Non-healing wounds
- Big data
- Deprivation
- Coronavirus disease-19

This article reports the key findings from a dataset of over 20,000 wounds, presented in a symposium session at the Wounds UK Annual Conference on Monday 10th November 2025. The key aim of the session was to share this extensive data and explore how data can be used to drive system awareness, improvements and better outcomes for clinicians and patients alike. The symposium and this report were supported by an educational grant from Smith + Nephew.

Jacqui Hughes opened by stating that working in nursing can often mean facing many barriers, which can feel like a brick wall: lack of time, overstretched resources, competing priorities and – sometimes – the feeling that, no matter how hard we work, the barriers are unable to be overcome. The 'brick wall' in front of us isn't moving.

In wound care in particular, behind every dressing change or wound assessment, there are many challenging and competing pressures, targets and staffing issues. Patients are often more complex than ever before, but additional time and resources to care for them are not available.

Over time, these pressures can add up and take their toll. We are seeing many talented and compassionate nurses are leaving the profession. However, it is important to remember that these structural challenges can be addressed, dismantled and rebuilt. Using data and building the right partnerships can begin to make a difference, reshaping services in a way that supports rather than blocks us.

Setting the scene

Using 'big data' to make a difference is a key theme, and the aim of this session was to harness this to facilitate change at all levels, benefiting wound care patients and clinicians on a day-to-day basis. This can help to make practice more sustainable and fit for the future, and help clinicians to feel more fulfilled again on a personal level in their clinical practice.

The audience were asked to contribute by answering the question: do you think it's possible to change the 'hitting a brick wall' feeling in nursing today? This question could be addressed from a wound care perspective or otherwise. The vast majority – at 85% – voted 'yes', believing that this is possible.

Box 1. Summary of key findings, pre- and post-COVID

Pre-COVID
- 47% of patients have wounds that are non-healing (defined as being present for 6 weeks or longer and showing clinical signs of failure to heal)
- 36% of wounds are static or deteriorating
- 9% of wounds were infected, representing a drop in infection levels through successful care measures

Post-COVID
- 8 out of 10 patients aged 65 and over, representing an overall ageing population
- 7 out of 10 patients have one or more comorbidity
- 1 in 5 patients live in an area of deprivation

20,000 wounds

A massive dataset of 20,000+ wounds represents possibly the largest dataset for this type of study to date. Other studies focussing on wound care, such as the work of Guest and colleagues (Guest et al, 2020) have been based on information from the THIN database, predominantly obtained from GP records. This wound dataset was taken entirely from community nursing services. This data has been collected over the past 7 years, from across the UK and Ireland. The number of patients and wounds included is now closer to approximately 24,000, set to rise to approximately 25,000 by the end of 2025.

The size of the dataset means it really gives an in-depth insight into services and patients. The number of wound care patients has grown exponentially and these patients are often more complex; there have also been changes to clinician demographics. Post-COVID, we are seeing that more healthcare support workers are undertaking routine care.

Disparities in care faced by patients are clearly highlighted. This both gives us an insight into current care and how this is likely to develop, as well as aiming to use the data to shape care going forward.

The numbers

Box 1 provides a summary of key findings, both pre- and post-COVID. The COVID pandemic caused the numbers to change slightly, which had been anticipated, with different trends

Declarations
The symposium and report were supported by Smith+Nephew.

and patterns emerging within the wound care patient population.

Post-COVID, disparities between individuals and communities in our patient populations became more pronounced than ever. There were patients who recovered well from COVID and those who unfortunately didn't. It was also observed that, within an ageing population, patients are living longer due to advances in treatments and technologies; however, while patients are living longer lives, they are not necessarily living with more healthy years, with quality of life affected.

The life expectancy gap is still an issue. This is also shown in the increase in patients living with wounds in addition to multiple comorbidities, which has massive implications for services. Patients living in geographical areas of deprivation also tend to have poorer outcomes across healthcare services, including wound care.

Health inequalities and the wider determinants of health can be identified from the data and from patient circumstances and outcomes, showing the links between health and socioeconomic and psychosocial factors [Figure 1].

Effect on systems and services

The factors affecting the wound care patient population can render them 'invisible'. Patients with multiple comorbidities may be fractured across services, lacking continuity of care.

To engender systemic change, it is vital to have robust data to back up the change we need to see. For example, data can be used to make the case for changes to resource allocation. There is often a lack of process transparency, with no 'blueprint' for communication with different departments and levels, which has historically been a barrier for change that needs to be addressed.

There has also been a lack of governance to provide structured support within wound care for data to be produced and used effectively, creating a lack of accountability for data-gathering and progress. This could, in fact, be seen as a positive, because it means there is scope at a nursing level for this to be improved and developed. However, it currently does mean that – when extra support or resource is needed – it cannot be accessed as there is no accountability for supplying this.

Structural complexity can be an issue, with every system and department called something different, or with a different way of operating, creating barriers to access and development.

What does this data mean in practice?

In a sense, this information is not 'new' – we well know that our patients are complex and often facing a lot of challenges. However, knowing this information is not enough. We need to develop the data on a wider level. Anecdotal evidence or a small dataset does not have the same impact.

The data is needed to change the hearts and minds of people who are not necessarily clinicians, to drive change at a high level. This means policy change and change at the highest possible level. Creating as large a possible dataset gives us a powerful voice.

Historically, significant change has been made at a national level through data. See Table 1 for some examples of how data has driven national change.

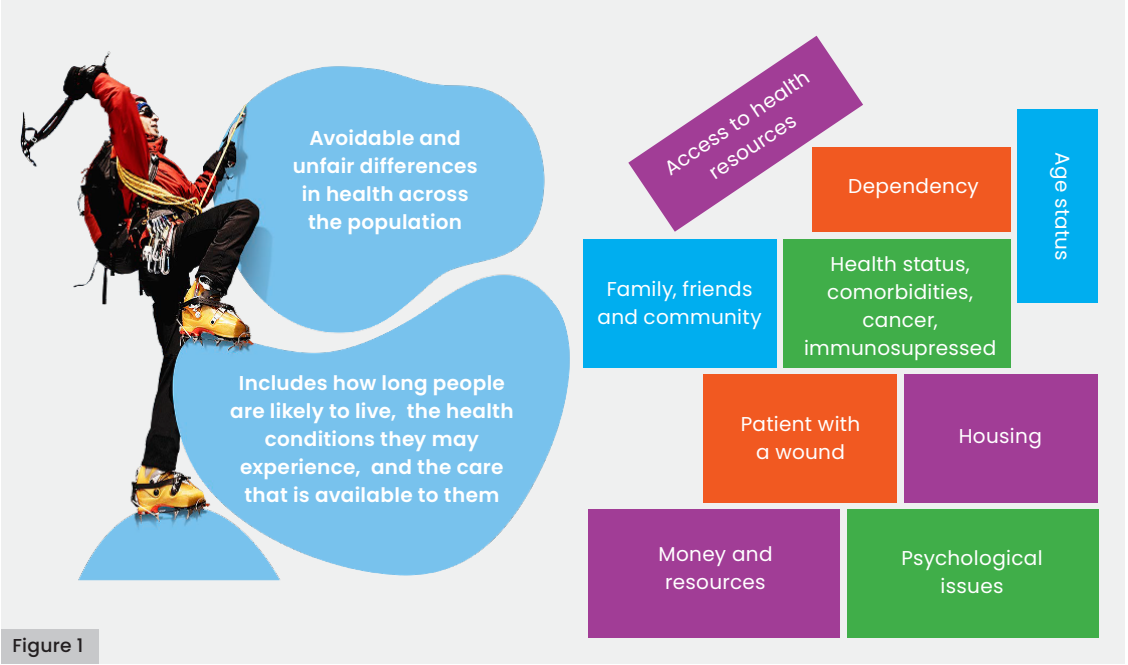

Figure 1

Figure 1: Health inequalities and the wider determinants of health

Table 1. National impact of previous studies using data		
Study	Data gathered	Impact
PINCER (prescribing safety; Avery et al, 2012)	Data used to flag hazardous prescribing	Large reductions in high-risk prescribing
QRISK (cardiovascular risk; Hippisley-Cox et al, 2007)	QResearch (millions of General Physician sugrery records)	Improved prediction of cardiovascular disease risk (deprivation, ethnicity, comorbidities)
Hospital Episode Statistics (HES; NHS England, 2025a)	National dataset of all NHS hospital activity	Used to plan services, allocate resources, redesign urgent care pathways
Mid England (NHS England, 2025b)	Fully linked dataset across health/social care	Population health management approach: 58% reduction in emergency department attendance; 3:1 return on investment

What's next?

In 2026, a statistical analysis of the data is expected to be published yeilding wound prevalence and progression outcomes, with variations noted across regions.

Jacqui returned to the image of the brick wall, but with an emphasis on how this could be dismantled with the right tools and the right conversations. We need to work to get wound care to where it needs to be, not at the bottom of a long priority list, by highlighting our work and our patients.

Implications on a local level

Bernadette McGlynn continued the session by discussing the implications for practice on a local level, explaining why health inequalities are so important in local wound care. Bernadette's practice in Birmingham is part of a huge Trust and the issues in local wound care are significant.

Using the Guest et al (2020) study as a starting point, the data was scaled up to illustrate wound care in the Birmingham area, to assess this against resources and support. When we investigate the data we can see that it does not work at a local level.

Recording data

An issue is that more detailed data needs to be recorded. Wounds are often recorded as either simple or complex when more information is needed for data purposes. Factors such as comorbidities and social isolation also need to be recorded.

Recording data around health inequalities is particularly important. Health inequalities are defined as unfair and avoidable differences in health outcomes and experiences across a population and between different groups within society. These differences can be seen in factors like life expectancy, disease prevalence, and access to healthcare.

Local information

Health inequalities clearly influence outcomes for patients, so they need to be understood. If we are aware and understand the challenges our patients may be facing, we can potentially make a difference to their experience and outcomes.

Using Birmingham as an example, there are clear areas of deprivation. Birmingham is one of the 20% most deprived districts in England; of the 69 wards, a staggering 43 are in the top 20% most deprived.

The top three most deprived wards in Birmingham are

- Sparkbrook & Balsall Heath East
- Bordesley Green
- Lozells.

The highest proportion of children aged 0–15 living in income-deprived families is in Kings Norton South (40.9%); the ward with the highest proportion of people aged 60 years or over who experience income deprivation is Lozells (67.5%).

How do health inequalities affect patients?

The effects on patients can be seen through factors (which affect or intersect with wound care patients), such as:

- A high infant mortality rate
- High rates of coronary vascular disease (strokes, blood pressure issues, diabetes)
- High rates of cancers and late presentation affecting outcomes
- Low health literacy, due to literacy and language barriers
- High levels of obesity
- Older population likely to experience social isolation and loneliness.

These may be influenced by factors such as:

ethnicity and cultural background; language barriers; patients' faith and beliefs; disabilities; and sexuality. All of these may minoritise patients and affect their access to healthcare and – ultimately – life expectancy.

What we can do to address inequality

Care and information need to be tailored to the individual. This may mean pitching education at the correct level for reading comprehension, or not using digital platforms that may not be accessible (e.g. not assuming the patient has a mobile phone or can access the internet).

In recent years, there has been a general push towards self-care, which not all patients may have capacity for. We need to consider the individual – their capacity, willingness and level of support available to them – at every stage.

We can use data to improve our understanding of patients and their needs, and use this to drive appropriate services that meet patients' needs and address inequalities. Data can be used to make the case and drive change, saving money and improving services. This will ultimately improve outcomes for individuals. ●

References

Avery AJ, Rodgers S, Cantrill JA, et al (2012) A pharmacist-led information technology intervention for medication errors: PINCER: a multicentre cluster randomised controlled trial and cost-effectiveness analysis. *The Lancet* 10.1016/S0140-6736(12)60078

Guest JF, Fuller GW, Vowden P (2020) Cohort study evaluating the burden of wounds to the UK's National Health Service in 2017/2018: update from 2012/2013. *BMJ Open* 10(12): e045253

Hippisley-Cox J, Coupland C, Vinogradova Y et al (2007) Derivation and validation of QRISK, a new cardiovascular disease risk score for the United Kingdom: prospective open cohort study. *BMJ* 335(7611): 136

NHS England (2025a) Hospital Episode Statistics (HES). Available at: https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics (accessed 8.12.2025)

NHS England (2025b) A system wide population approach. Available at https://www.england.nhs.uk/long-read/linking-data-and-embedding-a-single-system-wide-population-health-management-approach (accessed 8.12.2025)