Evidence-based practice: Role of service evaluation in wound care

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- Assessment
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Service evaluation has become an integral part of contemporary healthcare practice, yet it remains variably understood and inconsistently applied. In an era characterised by increasing demand, constrained resources, and a growing emphasis on outcomes and value, the expectation is clear: clinicians and services must not only deliver care but also demonstrate its effectiveness. Nowhere is this more pertinent than in wound care, where high prevalence, significant cost burden and well-documented variation in practice are evident. Fundamentally, a service evaluation seeks to answer a straightforward question: *what are we doing and how well does it work?* Unlike research, it does not aim to generate new generalisable knowledge, and unlike clinical audit, it does not measure practice against predetermined. Instead, it focusses on understanding current care within a specific context. This article seeks to explain the principles of a robust and meaningful service evaluation.

Why service evaluation matters in wound care

The value of service evaluation lies in its ability to demonstrate improvement in patient outcomes, identify variations in care as well as supporting evidence-based practice (EBP) (Backhouse and Ogunlayi, 2020). Applying this to wound care, a service evaluation could be used to identify variation in healing outcomes, time to treatment and dressing, and intervention choices, all of which directly affect patient-reported outcome measures (PROMS), patient-reported experience measures (PREMs) and quality of life measures.

Taking the management of individuals with leg ulcers as an example of where service evaluation might be useful think about the variability in the use of compression therapy. Compression therapy is widely recognised as the cornerstone of venous leg ulcer management; however, it remains underused in routine practice despite strong evidence of its effectiveness (Hopkins and Samuriwo, 2022). Evidence has shown that delays in initiating compression therapy are associated with poorer healing outcomes, demonstrating how variation in care processes can directly affect patient outcomes (Hopkins, 2023). Additionally, recent service evaluation evidence from an acute hospital setting demonstrated that early specialist Tissue Viability Nurse involvement at the point of admission supported more timely vascular assessment and initiation of compression therapy, while improving care coordination and reducing variation in practice (Pagnamenta et al, 2026).

Hence service evaluation provides the mechanism to identify gaps in care, quantify their impact and highlight priorities for improvement. Service evaluation can also help identify inequalities in care and outcomes. For example, Baldridge et al (2025) undertook a cross-sectional evaluation of one district nursing team's caseload and identified considerable variation in leg ulcer assessment and compression therapy provision despite adherence to guidance for pressure ulcer and postoperative wound management. The evaluation highlighted gaps in assessment, delays in implementing evidence-based interventions and inconsistencies in care delivery, demonstrating how service evaluation can reveal unwarranted variation and identify priorities for service improvement. Examining variation across patient groups via evaluation approaches can help healthcare services determine whether differences represent clinically justified variation or potentially inequitable care requiring targeted improvement.

Importantly, service evaluation should underpin data-driven decision-making and is increasingly central to commissioning, workforce planning and service redesign (NHS Evaluation Toolkit, 2026). This is particularly important in wound care where there are currently no nationally mandated wound outcome metrics or reporting requirements, limiting visibility of service performance and variation across healthcare systems (Wood et al, 2026). For Tissue Viability Services, a service evaluation offers a way to demonstrate value, justify resource allocation, and support collaborative care across primary and secondary settings (Dunning et al, 2026). Service evaluation can also inform workforce planning. For example Hallas-Hoyes et al (2021) demonstrated that a self-care pathway reduced healthcare professional contact time by more than 90% while maintaining healing outcomes, illustrating how evaluation data can support decisions regarding service capacity and resource allocation.

What defines a high-quality service evaluation?

A reliable service evaluation begins with clarity of purpose (Skills for Health, 2025). The aim should be focussed, relevant, and grounded in a genuine service and patient need as well as national guidance where appropriate - whether that is improving healing rates, reducing unwarranted variation, or understanding delays in care. Poorly defined or overly broad objectives will weaken the methodology and consequently the findings and the potential impact.

Service evaluation is inherently based in real-world practice as it is essentially examining current practice and whether it's working. Common methods include retrospective reviews of clinical records, prospective observational approaches, and before-and-after comparisons following a service change. Hopkins and Samuriwo's (2022) multi-site prevalence audits to identify variation in compression therapy provision and workforce activity across services, demonstrated how routinely collected real-world data could be used to inform improvement priorities. Similarly, Pagnamenta et al (2026) used a descriptive service improvement evaluation to examine the implementation of an early Tissue Viability intervention model for inpatients with venous leg ulcers, focusing on feasibility, care processes, referral patterns and workforce development within routine clinical practice.

The selection of measures for a service evaluation is critical. In relation to wound care, these should include both *outcome measures* - such as time to healing, infection rates, or hospital admission as well as PROMs, PREMs and quality of life measures. Furthermore, process measures, such as time to initial assessment or adherence to care pathways are important. The most effective service evaluations also consider *balancing measures*, recognising that changes in one area may have unintended consequences elsewhere, such as increased workload or service pressure. For example, Hallas-Hoyes et al's (2021) evaluation provided a more comprehensive assessment of service impact than healing outcomes alone.

Data quality remains one of the greatest challenges in service evaluations. The challenges associated with incomplete, inconsistent and non-standardised wound data have been highlighted at a national level, with concerns that poor surveillance and variation in reporting systems continue to obscure the true burden of wounds and hinder improvement efforts (Wood et al, 2026). Primarily, service evaluation relies on routinely collected data, which may be incomplete, inconsistently recorded, or lacking in standardisation. This highlights the importance of robust documentation practices and, increasingly, the role of digital wound assessment systems in improving data capture (Adderley, 2023). Without reliable data, even the most well-designed service evaluation will fail to produce meaningful conclusions. Equally important is the use of appropriate analytical methods. Service evaluations commonly rely on descriptive analyses to examine activity, outcomes and variation, although trend analysis and before-and-after comparisons may also be useful when assessing the impact of service changes (NHS Institute for Innovation and Improvement, 2010). The chosen analytical approach should align with the evaluation objectives and be sufficiently transparent to allow readers to understand how conclusions were reached.

A further methodological expectation is appropriate interpretation. Service evaluation is observational and context-specific; it is not designed to establish causality (Twycross and Shorten, 2014). Claims that an intervention has "caused" an improvement should therefore be viewed with caution unless supported by a more rigorous design. Instead, a service evaluation should describe patterns, associations and variation, while acknowledging their limitations. Context is also particularly important when interpreting service evaluation findings. Outcomes are often influenced not only by the intervention itself but also by factors such as staffing levels, workforce expertise, patient demographics, organisational culture, digital infrastructure and available resources. Consequently, an approach that appears successful in one setting may not achieve the same results elsewhere. Describing context allows readers to assess the transferability of findings and identify the adaptations that may be required in their own service.

Appropriate governance arrangements should be considered at the outset of any service evaluation. Although service evaluations do not usually require research ethics committee approval because they do not seek to generate generalisable knowledge, they should normally be reviewed and registered through local organisational governance processes. Those responsible for reviewing proposals for a service evaluation should ensure compliance with information governance requirements, including the secure handling of patient data and adherence to relevant data protection policies. Clear documentation of registration, approvals and governance oversight enhances transparency and provides assurance that the evaluation has been conducted appropriately.

Finally, a high-quality service evaluation must be actionable. The purpose is not simply to describe current practice, but to inform change.

Evaluations that end at data collection, without translating findings into recommendations or service improvement, fall short of their potential. A range of freely available tools and resources are available to support clinicians undertaking service evaluation and quality improvement (QI) projects [Box 1].

What are the markers of a good service evaluation?

It is important to be able to distinguish a service evaluation from research and a clinical audit to understand the context and therefore implications for clinical practice. If the study introduces a new intervention, randomises patients or seeks to establish causality, it is research (Health Research Authority [HRA], 2022). Authors would need to discuss the process for ethical approval of the study. Clinical audit is a quality improvement process that systematically reviews patient care against explicit, evidence-based standards to identify areas for improvement and implement changes to enhance outcomes and service quality (Twycross and Shorten, 2014). The key question an audit examines is: *Does this service meet a predetermined standard?* This differentiates it from a service evaluation which is examining what standard does this service achieve.
One way of judging this is to ask yourself: *would patient care have been the same if the evaluation had not taken place?* If the answer is yes, the work is likely a service evaluation. Other features of a service evaluation include the use of routinely collected data, a pragmatic observational design, and conclusions that are framed within a specific clinical context rather than presented as widely generalisable. There should be a clear statement about the governance of the service evaluation i.e. evidence that it has been registered as a service evaluation project.

Understanding these methodological differences are important as the conclusions are context specific but can be used as a framework for undertaking a similar project in a different location/setting. High-quality service evaluations engage relevant stakeholders from the outset. Patients, carers, clinicians, service managers and commissioners may all provide differing perspectives on service performance and priorities for improvement. Involving stakeholders in defining questions and interpreting findings increases both relevance and likelihood of implementation.

The Standards for Quality Improvement Reporting Excellence (SQUIRE 2.0) (Goodman et al, 2016) were designed to ensure QI work is reported in a complete and transparent manner, and can be used to evaluate the

Box 1. Practical resources to support service evaluation and quality improvement in wound care.

Scan the QR codes to access the resources.

NHS Evaluation Tool Kit

Skills for Health article

Table 1. Abbreviated SQUIRE V.2.0 checklist.

✓	Question
	Is the improvement problem clearly defined?
	Are the evidence base and rationale explained?
	Are aims explicit and measurable?
	Is the context described?
	Can a reader understand what was implemented?
	Are measures and analytical methods described?
	Are ethical issues addressed?
	Are results reported with enough detail to understand implementation and impact?
	Are contextual influences and unintended outcomes considered?
	Are limitations discussed honestly?
	Are conclusions supported by the findings?
	Are funding sources declared?

rigour of a service evaluation. SQUIRE V.2.0 is a set of 18 items/statements. **Table 1** provides an abbreviated checklist which can be used to both report a service evaluation and evaluate a published project.

Service evaluation as a quality improvement approach

Service evaluation should not exist in isolation; it is an important component of wider QI approaches which represent a cycle of understanding, designing, testing and refining change (Backhouse and Ogunlayi, 2020). Undertaking a service evaluation can be that vital first step to establish a baseline and identify where improvement is needed. For example, repeated cross-sectional service evaluations using standardised data collection tools have been used to monitor wound prevalence, healing status, referral patterns, hospital admissions and treatment interventions across large community populations. Wood et al (2026) analysed nearly 20,000 wounds collected over an eight-year period, providing insights into service performance, wound outcomes and resource utilisation. Another good example is the evaluation by Hallas-Hoyes et al (2021) where findings demonstrated maintained healing outcomes alongside substantial reductions in healthcare professional contact time and costs. The evaluation supported ongoing implementation of the redesigned pathway and informed wider service development.

Service evaluation also has a role in the testing phase of a QI cycle allowing clinicians to assess whether interventions have had the desired impact. Hence, service evaluation and quality improvement are interdependent. Without evaluation, improvement efforts risk being misdirected or unjustified. Without improvement, evaluation risks becoming descriptive rather than transformative. A service evaluation may identify delays in referral to specialist services; a QI initiative may then introduce a revised pathway or triage system; subsequent evaluation could then be used to determine whether access has improved and outcomes have changed.

Dunning et al (2026) provide a good example of evaluation through implementation of a revised leg ulcer care algorithm the results of which showed that this prompted earlier intervention and reduced delays in accessing appropriate treatment. This iterative process is central to delivering sustained improvements in care. Pagnamenta et al's (2026) service evaluation findings suggested that earlier specialist assessment supported timely compression initiation, strengthened multidisciplinary collaboration and reduced unwarranted variation in leg ulcer management. For further real-world examples of wound care quality improvement initiatives please refer to the resources in **Box 2**.

Box 2. Wound care QI initiatives.

Scan the QR codes to access the resources.

Society of Tissue Viability posters

NHS Tissue Viability Leg Ulcers

Service evaluation as a basis for impact

Measuring the success of a service evaluation is more than the quality of the reporting, it should also demonstrate the potential (understanding) and actual (testing) impact on practice. Effective service evaluation should make visible impacts that might otherwise remain hidden. For example, Wood et al (2026) identified that over one-fifth of wounds were associated with hospital admission and nearly half required referral to specialist services, demonstrating the wider system consequences of poor wound outcomes. Furthermore Hallas-Hoyes et al (2021) demonstrated how a service evaluation can move beyond description to measurable impact. Their evaluation found that wound healing outcomes were maintained while healthcare professional contact time and overall treatment costs were substantially reduced, leading to adoption of the self-care model as routine practice.

The impact of a service evaluation is maximised when findings are reviewed collaboratively with stakeholders, including patients and members of the multidisciplinary team. This process helps ensure that improvement priorities are relevant, feasible and aligned with the needs of those delivering and receiving care. Therefore, the findings of a service evaluation need to be shared with clinical teams, subsequently these need to integrate into governance structures, and ultimately be used to inform change. Re-evaluation is equally important, ensuring that interventions deliver the intended benefits and enabling further refinement. In wound care, this might include redesigning referral pathways to reduce delays, standardising dressing selection through updated formularies or introducing

early intervention services to improve healing outcomes. In lower-limb wound care, evaluation findings have been used to highlight the relationship between suboptimal compression therapy use, increased nursing activity and poorer healing outcomes (Hopkins, 2023), demonstrating the potential impact of service evaluation on workforce planning and service redesign.

As healthcare systems continue to evolve, for example the shift to community care provision (NHS England, 2025) service evaluation will become increasingly important. The push for the NHS to integrate digital technology (NHS Alliance, 2025) offer opportunities for more consistent data collection, real-time monitoring and integration across care settings. For wound care, this presents a significant opportunity to address long-standing challenges related to data quality and fragmentation. However, the fundamental expectations remain unchanged. Service evaluation must be purposeful, methodologically sound and focussed on improvement. It should provide insights that are not only credible, but also actionable.

Conclusion

Service evaluation is a powerful tool, but only when used effectively. In wound care, where variation in practice and outcomes remains a persistent challenge, its importance cannot be overstated. Clinicians and services should expect more than data collection; they should expect clarity, rigour and impact. Ultimately, service evaluation should not be viewed as an optional add-on, but as an integral part of delivering high-quality care. By raising expectations of what service evaluation can and should achieve, clinicians can support a system where measurement consistently leads to meaningful improvement, and where patients with wounds receive the timely, evidence-based care they deserve.

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