The changing face of the National Health Service

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Over the past 10 years, there have been some significant changes in the NHS, with improvements in access to services, improvement in patient safety, progress in managing long-term conditions and a drive for high quality care for all. The quality agenda and the emphasis on increased patient choice (NHS Scotland, 2010; Department of Health [DH], 2011; NHS Wales, 2012) has led to a drive for more care being delivered out of hospital and closer to home that meets patients expectations and also reduces cost.

As part of the Quality Innovation Productivity and Prevention (QIPP) programme, the NHS has a target for cost-efficiency savings of £20 billion by 2015 (DH, 2010). This has led to clinicians and organisations looking at innovative ways to deliver high-quality care with reduced resources. More recently, there has been a growing emphasis on capturing the patient's experience as an outcome of care, and many areas now report on patient-reported experience and outcome measures (DH, 2009).

We have seen a clear shift in government policies towards reducing inequalities in health outcomes and putting patients first (DH, 2010). In addition, patients have greater choice and control over their care and treatment and the introduction of Any Qualified Provider has led to some services, including venous leg ulcer services, being offered under this model (DH, 2011).

The government has created more locally accountable services through the introduction of foundation trusts and social enterprises, and has sought to introduce partnership working, competition and value for money in terms of service provision. In theory, these reforms should allow patients to choose the best services with the best outcomes, encouraging poorer quality services to improve in order to compete for patients and funding, thereby driving up standards across the NHS.

Alongside these policy drivers, funding for services has been reduced and services have had to drive up quality, while at the same time reducing costs under the QIPP agenda. It is worth remembering, however, that poor-quality care costs more. A good example of this is pressure ulcers, as demonstrated through the High Impact Actions for Nursing and Midwifery, such as Your Skin Matters (Dowsett and White, 2010).

Reform and service transformations will always impact on the way in which we deliver care and wound care is no exception. Over the past decade, we have moved from counting the number of patients we see with wounds to the challenge of demonstrating the difference we as clinicians are making. The focus on safe, effective and personalised care has led us to collect data on reduction in harm from pressure ulcers, healing rates, symptom control, and improvements to patients' quality of life and their experience of care as a result of our interventions.

Typically, the cost drivers in wound care are the frequency of dressing changes requiring nursing time, the duration of treatment and managing wound complications (Posnett et al, 2009). Treatments that improves the wound bed, facilitate wound healing and reduce nursing time are high on the agenda of wound care service providers and those who commission services.

Wound management practices have made rapid advances over the past 10 years in an ever-changing healthcare environment. We have increased our understanding of the biology of chronic non-healing wounds and this advancement is likely to continue with developments in wound diagnostics, tissue engineering, stem cells and gene therapy for achieving wound closure. The principles of wound bed preparation have become a focus for advancing technologies and wound care practice utilising the TIME framework (tissue management, infection prevention and control, exudate management

and wound edge advancement and healing; Leaper et al, 2012). There have been considerable developments in the means of facilitation wound healing with the use of technologies such as hydrosurgery, negative pressure wound therapy (NPWT), laser, and ultrasound. NPWT has become more widely available, including single-use devices so patients can be managed in their own homes.

Our knowledge of wound infection has developed with a growing understanding of the role of biofilms in wound infection. However, clinicians should not neglect the basics of good wound care and the principles of wound bed preparation to ensure maximum benefits from new technologies. We must also remember to keep the patient at the centre of care, ensuring care is delivered with care and dignity, compassion and respect (NHS Commissioning Board, 2012). WUK

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