Viewpoints

Reflections on the Wounds UK Awards ceremony

George Cherry has been in charge of the wound healing programme in Oxford since 1982. He is a member of the Faculty of Clinical Medicine, Oxford and Honorary Professor to the Trauma Center Postgraduate Medical College and 304th Hospital, Beijing, China

The Wounds UK Awards initiative was launched in 2005. The underlying rationale of this award ceremony is to celebrate work of all healthcare professionals working in wound care and to share their accomplishments with others in the field.

I was fortunate to be given an award of recognition at this year's event. I had attended the ceremony once before, and, like then, was impressed by the quality of the work of those receiving awards as well as their enthusiasm for research.

Listening to the presentations of the winners and reading their abstracts made me think of my own career in the field of wound healing. Many of the questions that we were addressing in the sixties concerning pathophysiology and various forms of treatment are similar to those being addressed today. Despite more sophisticated research techniques in studying pathophysiology and measuring outcome, particularly utilising evidence-based medicine, these questions still exist.

In fact, the famous nineteenth century French neurologist Jean-Martin Charcot (Charcot's joint) is said to have commented on this in describing his philosophy of the teaching of medicine which went along the following lines. He intended first to show some cases from the outpatient department that he had not seen before and to share his thoughts with his students. The reason for this was threefold. First, to understand the difficulties that beset any blind diagnosis. Next to be clear that close visual scrutiny and steady observation are the keys to making a successful diagnosis. Lastly, that it is the continuing contact with the patient and his symptoms that will allow much more than theories dreamed up in universities or far from the bedside of the unfortunate patient.

This philosophy by Charcot is still very applicable to the assessment and treatment of wounds and has been stated by many in all fields of research. You may prove or disprove a clinical hypothesis, but what you really achieve by clinical or basic research is the discovery of new questions that lead to further exploration.

We should all keep in mind that the problem of improving wound healing care is not only confined to developed countries but is a major health problem in developing countries, and recognition of people working in this field could be part of this annual ceremony.

An award system such as the one Wounds UK has started leads to the encouragement of continued questioning in a similar way to which Charcot approached patient management in the 19th century.

Specialist wound care units and the tissue viability nurse

Martin Butcher, Independent Tissue Viability and Wound Care Consultant; Richard White, Professor of Tissue Viability, University of Worcester; Andrew Kingsley, Clinical Manager Infection Control and Tissue Viability, Northern Devon Healthcare Trust

The editorial by Mike Salter (*Wounds UK* 5[3]) raises a number of interesting points about the relationship of tissue viability within the UK healthcare community, and about its future as a predominantly nurse-led speciality.

Firstly, the initiative in Southend should be applauded for its efforts in raising the profile of wound care as a trust-wide, indeed healthcare-wide, issue which has ramifications for patient care and health economics. The team has shown that by standardising treatment practices, introducing appropriate research-based/research-linked practice, and developing a clinical centre of excellence in wound care, significant improvements have been made in patient outcomes, reductions in in-patient stays and cost-savings. However, without wishing to disparage these achievements, we have concerns about how this was achieved, and about the message it sends out to the wider tissue viability community.

Tissue viability in the UK is unique. It enjoys the privilege of having a true multidisciplinary, multi-agency background, but unlike elsewhere in world health care, its key practitioners have emerged from a predominantly nursing background, whether that be education, research, vascular medicine, dermatology, plastic surgery, stoma therapy or community nursing. These clinicians have pooled their experience and knowledge to provide a rounded, diverse approach to patient care. This multidisciplinary background gives the speciality its strength, but also its weakness, as it generally lacks a medical framework.

It is noted that the government states it is keen for non-medical staff to develop their skills, practice and responsibility. Recently, Health Minister Ann Keen MP, who chairs the Prime Minister's Commission on the Future of Nursing and Midwifery, pledged to put nurses 'at the centre of the healthcare team'. Indeed, she continues: 'We need to break down the traditional barriers and give nurses the confidence and freedom to practise to the best of their knowledge level, directing healthcare teams while staying in control of the quality and safety agendas that drive patient care', (Lomas, 2009). However, there has been little evidence to support this to date. Nurses now have

the ability to prescribe independently, perform certain surgical procedures, order or undertake specific diagnostic tests, manage their own waiting lists and even use the term 'consultant'. Yet, when it comes to strategic multidisciplinary initiatives, evidence suggests that they are forced to rely on the 'beneficent paternalism' of their medical colleagues in order to bring about fundamental change.

In his article, Mike Salter describes how the wound management team was able to develop in Southend by the amalgamation of the vascular nursing team with the tissue viability team, of which Mike took the lead clinical role as vascular surgeon. Is this really an amalgamation of services or a medical staff take-over of the tissue viability service? Mike was already clinical director, and, as a consultant vascular surgeon, would have been the lead clinician in control of the vascular nurses team. By assimilating the tissue viability team, the independence of the lead tissue viability nurse (TVN) is usurped, substituting it with that of the clinical director. This is an appropriate outcome if the skills brought to the service are superior and aimed at raising the service to a new level. Cynically, however, it could be argued that an independently run clinical service has been seized by (or surrendered to) a 'rival' service.

In defence of this action, Mike states that 'the presence of the consultant clinical lead allows for a fast track to theatre when needed, and other procedures and investigations as necessary'. While this might be the case within his trust, it is not necessarily correct for all healthcare arenas. An appropriately empowered nurse consultant in tissue viability would have been able to achieve the same outcome. In a truly supportive healthcare environment, an appropriately qualified nurse would be able to refer to a surgeon if it was indicated, just as a physician refers to a surgeon when that is the best course of action for the patient. This demonstrates a lack of knowledge or appreciation of the role of tissue viability specialists.

The issue here is the recognition of expertise. In surgery, the junior doctor would not refer a patient to another team without discussion with a senior (consultant) colleague, as this might be inappropriate (based on their relative experience) and would be a breach in protocol. Similarly, nurses would not refer to another team unless they were assured that such a referral was clinically indicated. Instead, they would seek additional review and opinion. They would, therefore, ensure the relevance of that action or proposal.

As yet, there is no guarantee that [tissue viability] will be given due representation in the forthcoming Framework for Quality Accounts (DoH, 2009). Without this recognition, the speciality will not prosper and develop as we wish.

It would appear that health care in the UK operates a double standard; while doctors refer patients to specialist nurses, it is not generally accepted that nurses refer patients to doctors. This appears to indicate that because a wound care specialist comes from a nursing background their level of expertise is considered less than that of their medical colleagues, and yet, a high percentage of doctors admit that they know little about wound care. Surely, in a healthcare system where true expertise is recognised and acknowledged there should be no need for a 'fast-track' system, the presence of which implies that without the 'surgical seal of approval' a referral is treated with scepticism — in other words, the expertise of the TVN is not recognised?

Mike indicates that when his team was set up it was found that wound care was seen as a 'low priority' and that there were 'variable standards of practice' across the trust. For any working within the field this is not unique. We have all struggled to raise the profile of wound care within our respective clinical environments and have struggled to achieve research-based/linked care approaches. The 'no-brainer' concept of centralising wound care patients in a dedicated ward has been raised by many TVNs but to date has had little success nationally, as medical staff have been unwilling to support the concept, and without support even 'no-brainers' cannot succeed.

The success and acclaim that this group has achieved must be recognised and applauded, but how much of this has been because of Mike's personal dynamism, position and enthusiasm, rather than through the implementation of a novel, innovative approach to wound care delivery?

The Southend initiative worked because it had hospital management backing. This was probably made much easier because of the personal attention of Mike, a vascular surgeon who happened to be clinical director, heading up the project. One wonders how successful the project would have been if the trust's clinical director was from a different clinical background?

The amalgamation (or take-over, depending on your perspective) of the TV service and vascular nursing service at Southend has brought about positive change for patients in that area, which is of prime importance. But what has it actually done for tissue viability as a speciality, and what does this say about the way the speciality is viewed by the wider healthcare community? While the pragmatic approach adopted at Southend has worked, is this a real model for change or a case of pulling rank in which team dynamics and sustainability is sacrificed for a quick-fix solution?

Tissue viability is at a crossroads; while it was not mentioned in the first report by Darzi (Darzi, 2008), some acknowledgement was given in the second (Darzi, 2009) — noticeably without authoritative specialist input (White and Cutting 2009a, b). As yet, there is no guarantee that it will be given due representation in the forthcoming Framework for Quality Accounts (Department of Health [DoH], 2009). Without this recognition, the speciality will not prosper and develop as we wish.

Those involved in tissue viability have long argued that it has not enjoyed the profile that it deserves — on cost grounds as well as from the impact on patients. The quality indicators have been identified and the future direction recommended (Ousey and Shorney, 2009). While the development of tissue viability in the UK has been largely attributable to the enthusiasm, perseverance and skill of nurses, how much further can it go? Can nurses actually gain a voice on the government agenda and therefore raise its profile in healthcare management issues, or is it time to change the way we think?

We maintain that the speciality of tissue viability can develop without a medical lead, but only if allowed to do so by the medical profession. Wound care is an area that interacts with all clinicians (regardless of profession), and there will always be areas where interprofession friction occurs. Tissue viability is not unique in this, even well developed and established professions such as physiotherapy and psychology have faced similar issues. Due to inter-professional politics, and the power and influence the medical profession has, is nursing the right profession to tackle the issues and move the speciality forward?

The current situation appears to indicate that 'partnerships' with a medical specialty are required in order to achieve the required national profile (White, 2008). However, is this the best option, and will such partnerships be one of equality? Ann Keen MP has stated, 'Healthcare is a complex area that requires joint learning and shared experiences, and the medical profession need to ensure they value nurses' knowledge and expertise' (Lomas, 2009). Changing the prevailing attitudes among the medical profession, healthcare management and the government may make such 'partnerships of equals' possible and so facilitate the development of best service provision, regardless of professional background. Otherwise, it may be the case that to move tissue viability forward we will need to consider a new lead profession. In so doing, those involved will need to accept that the unique structure, composition and autonomy that tissue viability in the UK has established, will be sacrificed. Does the end justify the means?

Further reading

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Second Darzi report: mixed messages for tissue viability

Martin Butcher, Independent Tissue Viability and Wound Care Consultant, Director, Squirrel Medical

I read with great interest the comment paper in the last issue of Wounds UK, 'Second Darzi report: mixed messages for tissue viability' (White and Cutting, 2009). The authors highlighted a number of key issues within the realms of the politics of healthcare. Like them, I was disappointed by the seeming disinterest, lack of knowledge and lack of insight displayed by the Darzi document.

The authors were right in saying that wound care is a central function of primary care services, as can be witnessed by the amount of district nursing time spent dealing with them. I am also fully supportive of their statement that this is 'fundamental care' (not 'basic' with all the connotations that are linked to that term). What has to be asked then is why is this not recognised, not only within the report but by the government itself? Could it be that this pivotal role has been side-lined simply through ignorance, or are there more suspicious forces at work? While being an old-fashioned sceptic, I am always eager to see the good in folk and with that in mind will start by assuming that governments overlook the specialty of wound care/tissue viability simply because they do not know of its existence. A lot has been done to raise the profile of tissue viability but this is an ongoing process. It was once said that politicians' memories are very short, lasting from one election promise to the next. Personally, I think it more likely they last from one Parliamentary crisis to the next, and in a year when there have been so many (Iraq, Afghanistan, MPs' expenses, global financial crisis, etc), is it any surprise that tissue viability has been overlooked. The sad fact is that unless those involved in wound care shout about their field with the same passion they demonstrate in treating patients, little notice will ever be taken of them.

What stands out in Darzi's report is that he and his advisors are so far removed from what clinicians are dealing with every day. I think it is fair to criticise the report for its focus on four-layer bandaging and vacuum assisted closure as being evidence-based and the authors are correct in questioning where Darzi got his evidence. However, I also think it

fair to say, 'where are the government-appointed tissue viability advisors?' This speciality has so many great clinicians from all academic and professional backgrounds, so many professionals with passion and such great inspirational, eloquent speakers, and yet no-one seems to be there waving the flag to the media, the electorate or the politicians. Just as 'you won't find a fever unless you take the patient's temperature', how can we expect governments (regardless of political persuasion) to understand problems unless we tell them about it?

If we look at government initiatives in health care over the last few years we see a recurring theme; politicians act when the voters say 'enough is enough'. However, I do not hear people shouting about wound care outside of the specialist journals.

With the current financial issues we have seen every political party say there will need to be financial cuts in public service spending. Regardless of the assurances of those in power, we all know that those cuts will include the NHS. The specialty of tissue viability deserves more than the 'crumbs from the table'. Unless we act, and act soon, the Darzi reports' views on tissue viability will be accepted and recognition for the hard work put in by all those involved in tissue viability, providing quality care and the relief of suffering, will be little more than a tick box exercise.

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Quality compliance and partnership: a new dawn

Deborah Glover, Independent Advisor and Writer, London

Over recent months, Members of Parliament in the United Kingdom have been in an uncomfortable position over 'expenses'. While many have asserted that they acted 'within the rules of the system' (albeit one open to abuse), there has been a clear loss of individual moral awareness and accountability, culminating in a loss of public trust and confidence.

While such practices may seem a long way from wound care, there are in fact similarities in terms of perceptions of accountability and trust. Patients and colleagues trust wound care practitioners to advise on and guide best practice and appropriate dressing use. But can they be sure that this advice is based on evidence rather than the best corporate hospitality or sponsorship?

Patients and colleagues trust wound care practitioners to advise on and guide best practice and appropriate dressing use. But can they be sure that this advice is based on evidence rather than the best corporate hospitality or sponsorship?

The relationship between wound care practitioners and industry is unique but complex, in part due to the relatively 'young' nature of the discipline. Out of necessity, practitioners and industry have forged dynamic working relationships to develop new products. The companies provide the funding and/or resources for formal research or product evaluations, the outcomes of which are published or publicised through local and national study events. Indeed, many practitioners are paid by companies to present the results of the work they have undertaken.

These continued working relationships are critical for future research and development of new and enhanced products that ultimately lead to improved patient outcomes (Rashid et al, 2009). Therefore, it is vital that these interactions between healthcare professionals and industry are at all times transparent and visible for all.

Fortunately, there are frameworks within which practitioners and the industry can work to ensure that all legal, moral and accountability issues are addressed. Smith and Nephew Healthcare are committed to 'ethical trading' and ensuring that they work with their clinical partners within these frameworks in order to ensure that both practitioners and the patient are confident that all obligations are fulfilled, and that the effective management approaches are utilised. In addition to their internal code of conduct and business principles, they work within the following frameworks to ensure that the principles relating to business courtesies, training, education and company sponsored attendance at conferences are adhered to.

Surgical Dressing Manufactures Association

Three main principles of the Surgical Dressing Manufactures Association's (SDMA) Code of Conduct apply. Principles 3.2 and 3.8 relate to business courtesies such as meals, social events, travel and living expenses (SDMA, 2007) and conferences/exhibitions. The SDMA Code states that expenses should not 'exceed a level normally associated with the customer's lifestyle'. Essentially, this prevents the 'jollies' often associated with drug companies such as 'educational events' that may be little more than an exotic holiday with an hour or two of lectures. Thus, practitioners should not be expecting to be wined and dined at the sponsoring company's expense, and that any hospitality is secondary to education and training (Shorney, 2006). Smith & Nephew Healthcare, in underwriting the costs of conferences, have outlined clear boundaries centred on this which ensures that the educational event itself, and the associated networking and inter-professional communication is the focus for the attendees they have sponsored (Shorney, 2006).

Eucomed

Eucomed (European Medical Technology Industry Association, Brussels, www.eucomed.org) represents 4,500 designers, manufacturers and suppliers of medical technology used in the diagnosis, prevention, treatment and amelioration of disease and disability (Eucomed, 2009). Members are required to adhere to its Code of Business Practice, which in acknowledging

the importance of the contribution of healthcare practitioners to the advancement of medical technology, safe and effective use of such technology and research and education, provides a set of key principles:

- Separation: interactions between industry and professionals should not influence purchasing decisions, nor should any interaction be dependent on purchase or recommendation of company products. In other words, the company should not expect you, for example, to use or recommend their products if they sponsor you to attend a conference or suchlike
- Transparency: all interactions have to comply with local or national laws and professional codes of conduct, and the purpose clearly stated
- Equivalence: if you as a healthcare professional are engaged (paid) by the company to perform a service, for example, undertaking a product evaluation or presenting at a conference, any fee or remuneration should be commensurate with your normal services. In other words, as a nurse, you should not be expected to receive more than your normal 'hourly rate'
- Documentation: for any interactions, a written agreement outlining the purpose, content, services and remuneration is required. This ensures that both parties are happy with what is expected/required and how such an interaction will be conducted. This is particularly important in relation to, for example, ownership of information obtained from research and how this may be disseminated.

In essence, the Eucomed code reflects the principles outlined in the SDMA code and those in the Nursing and Midwifery Council Code (NMC, 2008).

The Code

The Nursing and Midwifery Council has developed and produced a plethora of documents that help guide practice and professional conduct. The Code specifically outlines expected behaviours in relation to advertising and sponsorship. It states that:

- You must be open and honest, act with integrity and uphold the reputation of your profession
- You must ensure that any advice you give is evidence-based if you are suggesting healthcare products or services
- You must ensure that your professional judgement is not influenced by any commercial considerations.

Essentially, they are not saying that you cannot work with companies for financial gain, but that if you do so, it must be open and transparent, which again, is reflected in Smith and Nephew's approach to working with practitioners.

Similarly, sponsorship by companies is not frowned upon, whether in relation to funding of posts or attendance at conferences, but it is beholden on the practitioner to ensure that their choice of product is not influenced by this, rather than professional judgement.

In addition to the company and professional codes of practice, quality indicators and clinical governance, if applied appropriately can be used by both parties to facilitate ethical partnerships.

Wound care quality indicators

Based on 2005–2006 prices, Posnett and Franks estimated the cost of wound care to the NHS to be in the region of £2.3–£3.1 billion per annum (Posnett and Franks, 2007). Clearly, as this represents a fair portion of the NHS budget, it would make sense for healthcare professionals and companies to explore ways of reducing this. While it may not seem obvious for the latter to do so in terms of profit margins, morally and ethically, it is the right thing to do. As a further driver, the Department of Health (DoH) will require both quality and financial accounts from healthcare professionals from 2010 (DoH, 2008, p.11) — these will be quality indicators. Thus, providing quality, cost-effective health care is imperative.

Quality and cost-effective care can be delivered if appropriate and timely education is delivered. Smith and Nephew are already committed to providing practitioners with education and, where possible, evidence-based practice on all aspects of wound care delivery, from products to business acumen. In addition, they are wholly supportive of the notion of working within 'clusters' or partnerships between them and NHS, universities and practitioners. This will facilitate new models of care which encompass both theoretical and practical approaches.

Conclusion

Ethical practice is an imperative both for industry and healthcare practitioners. Working within guidelines, codes and frameworks will ensure that partnerships between industry and practitioners are mutually beneficial, professional and, ultimately, patient-focused.

Smith and Nephew believe that they are conducting their business in this way. Please feel free to discuss any aspect of this with your local representative, or Richard Shorney, Professional Development Manager. WUK

This viewpoint was commissioned by Smith & Nephew Healthcare.

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