Is wraparound care the future?

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Despite the current Government's protection of the NHS budget, social services' budgets have fallen by 11% in 5 years. (Bulman, 2017). This has led to longer hospital stays for some patients as the transition to community is delayed due to a lack of services to support people at home. Secretary of State for Health and Social Care Matt Hancock has recently suggested that community care should be delivered by teams of self-governing nurses who offer 'wraparound care' to patients living at home (Department of Health and Hancock, 2018). He suggests that this would be cheaper and would result in higher quality care than current models. He cites a model pioneered in the Netherlands where a dozen nurses care for 50 patients in a neighbourhood and coordinate their care. In this model, nursing teams provide all care and patients do not need visits from multiple agencies.

Adoption of this model would not come without its challenges; the fact that it was first discussed 2 years ago in a Royal College of Nursing (2016) policy briefing highlights the problems the NHS faces in adopting change at scale and pace. In addition to this is the fact that the nursing workforce nationally is under pressure, with more than 36 000 vacancies reported in England (Lintern, 2017). Additionally, district nursing posts, which have been halved over the 5-year period 2009-2014 (Maybin et al, 2016) have, in some areas, been largely replaced by community nurses. Staff turnover and recruitment challenges have led to teams operating with less than optimum numbers of staff.

A highlight this year was the establishment of an Academic Health Science Network Wound Care Strategy Programme Director post in England, aimed at improving standards across the specialism of tissue viability. Prior to this we also saw the emergence of the Legs Matter campaign (https://legsmatter.org/). It aims to encourage patients and community staff to diagnose, manage and heal lower leg wounds. Leg ulceration is one of the most studied areas of wound care (O'Meara et al, 2012); care for these patients must focus on addressing lifestyle choices associated with diet and exercise, coupled with limb elevation, good skin care, the application of compression therapy and identification and management of local barriers to healing. Without doubt, this could all be accomplished as part of a wraparound care programme. That said, pathways of care have long been purported to be the saviour of modern health care (Panella et al, 2003). Unfortunately, the NHS remains data rich and information poor, with metrics and healing rates difficult to obtain easily (Guest et al, 2017). There can be a lack of continuity in larger teams, and a heavy workload of ageing, frail patients.

We must also look at the needs of younger patients with wounds, changing the focus of their care

to one of empowerment and using technology to help facilitate safe self-care. It is imperative that we not only listen to patient concerns, but also acknowledge them, discuss them and openly seek to address them, so that we improve the lives of those living with a wound (International Consensus, 2012). Nurses must seek to address patient concerns as a central tenet of care—it is the key to achieving patient concordance. Any management plan that fails to get patient buy-in will fail.

Many readers will be working hard to develop new tools and metrics to measure the impact of interventions. While I am excited to see the continued focus on our specialism, I urge caution and realism in order that goals are both aspirational and achievable at a grassroots level.

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