

Getting it right first time

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To succeed in today's NHS, it is essential that tissue viability services align their objectives with current national healthcare priorities. Wound care expenditure is said to exceed £5.3 billion per annum (Guest et al, 2015) and the number of patients living with a wound is also rising with healing rates for chronic wounds at a year after commencement of intervention being reported as little as 50% in some studies (Guest et al, 2017). The wound care CQUIN (Department of Health, 2016) has challenged community services to audit practice against the published minimum data set (MDS) for wound assessment. It is likely that results from these quarter-one baseline audits will be soon published alongside the proposed action plans and steps taken to improve compliance with the MDS. It could be argued that most NHS services currently operate to a minimum data set, in that they have existing wound care assessment tools in use. These are tools that we as tissue viability services have been teaching people to use as part of ongoing local education programmes. Recent conversations I have had with fellow tissue viability nurses suggest that the difficulty is not having certain tools but rather compliance with their use. I am hopeful that the CQUIN will bring standardisation, local organisational focus and will help improve outcomes for patients by simply reducing variation in the care they currently receive.

Nevertheless, this does not address all the challenges currently facing services. In her editorial over the page, Jemell Geraghty urges us to look at patient self-care models. This is aligned with the recently published call to action (World Union of Wound Healing Societies (WUWHS) (2017), which suggests that the patient should be an active participant in their wound care team, if they are able.

Arguably, the logical companion of patient-centred care is the introduction of shared decision-making, however, the process of enabling both patients and professionals to make informed decisions about care is not easy. Wound healing is often heralded as the optimum and most desired outcome. However, we do have to ask ourselves if this is realistic and achievable. In doing so we must focus on our interactions with patients to ensure that they understand their prognosis and have a better understanding of the benefits and risks associated with the treatments offered. It is unlikely, given the ageing population, that the healing rates associated with studies published decades ago are relevant to the population with complex wounds accessing services today.

Perhaps the answer lies in the importance of seeking answers to the simple but emotionally challenging questions posed by Atul Gawande (2014) in his book, *Being Mortal*. He urges us to ask our patients 'What do you understand about your illness now?', 'What matters most to you thinking about the future?' and 'What does good look like?'. This approach was referred

to by Scotland's chief medical officer as 'introducing realism into health care' (NHS Scotland, 2015) or in Wales it is referred to as 'the four principles of prudent health care' (patient engagement, prioritising those in the most need, doing only that which is needed and no harm while reducing variation by using evidence-based interventions) (NHS Wales, 2015).

The key to using these techniques successfully in practice lies with strong leadership of teams, that enables the challenge of both patient and practitioner beliefs and values in the right way to ensure we get it right the first time, every time for our patients (NHS Improvement, 2017).

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