

The Darzi Report and tissue viability services

Richard White, Professor of Tissue Viability at the University of Worcester, and Keith Cutting, Visiting Professor, Buckinghamshire New University, discuss Lord Darzi's most recent report and its potential impact on the tissue viability community

The recent report *Transforming community services: Ambition, Action, Achievement* (Department of Health (DH), 2009), is the second to be authored by Lord Ara Darzi and follows in the wake of his review of the NHS in England, *High Quality care for All* (DH, 2008).

This latest report is to be welcomed by all of those who provide care in the community setting. For the specialty of tissue viability, depending on what is included (White, 2008), total costs to the NHS have been calculated at between £2 and £3 billion per annum (i.e. 2–3% of the NHS budget; Vowden et al, 2009).

For staff who are involved in tissue viability (including wound care), it has long been known that the predominant workload (estimated at 80%) is in primary care, yet hitherto little has been done to provide the necessary resources, let alone acknowledge the vital role that community staff have to play.

It is also important to emphasise that the commissioners of care (PCTs) should give due recognition to the fact that tissue viability care covers a broad spectrum of interventions from 'basic/fundamental' through to highly specialised care, including preventive measures to avoid skin and soft tissue damage, vascular assessment, diagnosis of wound infection, sharp debridement, all of

which require specialised clinical skills (White, 2008).

The report stresses the importance of 'getting the basics right—every time', an admirable sentiment, but how does Darzi address this in his report?

Firstly, tissue viability does get a mention, but sadly it amounts to no more than one short paragraph in a report of 100 pages. One might be forgiven for regarding this as disproportionate, especially as in community nursing, wound care is one of the top ten purposes for visits and accounts for approximately 70% of the total time expenditure (NHS Management Executive Value for Money Unit, 1992).

Secondly, Darzi does emphasise the need for clinical skills and competent care, highlighting the need for assessment, intervention and treatment. These components of quality care have been top of our collective priorities for decades.

Thirdly, Darzi provides examples of 'evidence based practice', but does this by mentioning two specific (and in one instance, commercially branded) therapies. It is perhaps pertinent to remember at this point, that Darzi was made a Minister of Health, with a responsibility for health policy, by a Government who wanted to promote trust and respectability and to deliver a market-based healthcare system. In such a system,

services are provided by a diverse range of independent providers who, in turn, compete for business in a market supposedly governed by consumer choice.

It is, therefore, surprising if not downright controversial that specific therapies have been used as examples of so-called evidence-based practice, namely four-layer bandaging (4LB) and vacuum assisted closure (VAC therapy). The use of a specific trade name (VAC® KCI) is disappointing in a DH report, particularly when other forms of topical negative pressure (TNP) are available.

The evidence base for TNP has been recently reviewed in a Cochrane systematic review (Ubbink et al, 2008). The outcome of this exercise was summarised thus:

Thirteen RCTs were included in the review. Trial quality was considered to be 'moderate' overall. One study reported a significant increase in the median time to complete healing. In two studies where wound preparation time prior to surgery was assessed, a statistically significant reduction of 10 days was reported in one, and a non-significant reduction of one day in the other. In three studies on diabetic wounds, one showed no significant difference between TNP and control in mean healing time. Of two studies assessing measures of wound area reported reductions

in TNP-treated groups, one was statistically significant. One study reported a significant reduction of four days in the wound preparation time prior to surgery. Trials in skin grafts and pressure ulcers showed inconclusive and conflicting evidence as to the efficacy of TNP. The authors' conclusions being, 'There was little evidence to support the use of TNP in the treatment of wounds'.

While we do not know where, and from whom, Darzi obtained his evidence, it is reasonable to assume that the Cochrane database was consulted. On the basis of these conclusions, Darzi has little foundation for recommending VAC in particular, or generic TNP to primary care practitioners.

The stance taken by Darzi also begs question of his insight into reimbursement of, the wider availability of TNP, and the numbers of clinical staff properly trained to use it in primary care. We feel that this aspect of his report has been ill-considered and superficial.

TNP treatment is currently restricted in its availability, is expensive when compared with orthodox dressings, and needs training—these important considerations do not appear to have been considered by Darzi. What of the alternative dressings-based therapies as advocated by Ubbink et al; these may well be able to offer equivalent clinical efficacy at a fraction of the cost. Should they not also be considered?

With regard to the advocating of 4LB, the report is found wanting.

With reference to Cochrane, we find that in a recent systematic review the authors concluded that (O'Meara et al, 2009):

'Compression increases ulcer healing rates compared with no compression. Multi-component systems are more effective than single-component systems. Multi-component systems containing an elastic bandage appear more effective than those composed mainly of inelastic constituents.'

This does not extol 4LB *per se*, nor does it provide that high level of health economic evidence that might be expected if country-wide use in primary care is to be implemented. Given that this evidence was available at the beginning of 2009, it is surprising that the Darzi review took such an unequivocal stance on 4LB.

Other recent evidence suggests that cohesive short-stretch bandaging also has great potential in the management of venous leg ulcers (Franks et al, 2004), and a recent review of the relevant literature states that (Castonguay, 2008):

'Current research demonstrates that the use of short-stretch compression bandages is as effective as a four-layer compression bandage system in the treatment of adult patients with venous ulcers.'

So, what should we make of Darzi's legacy to tissue viability in primary care? Are these faux pas indicative that his advice and direction are now discredited? This is important, particularly so as his resignation from his ministerial post on 15 July quickly followed the publication of his second report.

It has become clear that nurses were not fully involved in the review process (Nursing Times, 2008). Indeed, only six nurses chaired regional clinical review groups, as opposed to 67 by doctors. To the best of our knowledge, none were established tissue viability experts. As tissue viability, including wound care, has been nurse-led in the UK for the past 25 years, this is somewhat surprising and goes a long way towards explaining the misconceptions in the report.

Darzi does state that, 'Investment in tissue viability specialists to promote and lead should be a priority'. This does, however, have far-reaching implications for fundamental care provision.

It has, for example, been established that 'better general education and better specific training in wound care could lead to better wound care' (Dugdall and Watson, 2009). The government has already pledged to 'liberate the talents of nurses', but a demonstrated lack of collaboration between health professionals has led to clinical nurse specialists being 'constrained' (Austin et al, 2006a).

Are we to assume that the promotion and leadership of specialists will solve

the problem, or is this too facile a solution? Clinical nurse specialists are central to practice development and must be provided with the framework in which they can bring about changes in practice (Austin et al 2006b).

The development of a published written directory of local services/resources would encourage scrutiny of local provision and promote their improvement and design. Examples include screening and preventive services, out of hours accessibility, and targeting services to specific demographic needs.

Tissue viability desperately requires due recognition of the therapeutic value that expert care can bestow on patients, and at the same time positively impact on cost-effectiveness, and, the authority to enact changes in practice.

What it does not need are vague recommendations from 'on-high', where there are potential commercial overtones, lack of firm commitment to training and resources, and where the supportive evidence is insufficient to convince practitioners committed to evidence-based care.

Could this report finally be the stimulus for the government to make tissue viability a priority by consulting openly with those directly responsible for service provision, or another misrepresentation? **BJHCM**

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