1. **Introduction**
   Dr Mike Burrows, National Coordination Director: AHSN Network

2. **The Case for Change**
   Dr Una Adderley, Director: National Wound Care Strategy Programme (NWCSP)

3. **Data for QI**
   Professor Ann Jacklin, Lead: Data and Information Workstream, NWCSP

4. **Implementing the Recommendations**
   Dr Mike Burrows, National Coordination Director: AHSN Network

6. **Questions**
1. Introduction

Dr Mike Burrows
National Coordination Director:
AHSN Network

Interested in wound care? Sign up at: www.nationalwoundcarestrategy.net

Twitter: #NatWoundStrat
2. The Case for Change

Dr Una Adderley
Director: NWCSP
2018 – NHS E & NHS I commissioned AHSN to develop a national wound care strategy for England that focuses on improving care relating to:

- Pressure ulcers (7%)
- Lower limb ulcers (42%)
- Surgical wounds (18%)
• Data and Information
  • Key data items to inform quality improvement
  • Wound Management Digital Systems - WMDS (‘apps’)
  • National Wound Product Classification System

• Education and Workforce
  • MSc level education for advanced practice
  • Free to access, online education modules
  • 4-day curriculum for clinicians working in leg ulcer services
  • NWCSP Core Capability Framework

• Supply and Distribution
The current situation in England

**Foot Ulcers**
- Diabetic foot ulceration
- Foot ulceration
- No diabetes
- Same estimated point prevalence
  - at least 60,671 – 75,838\(^1\) (2017)
- 45% of amputations\(^2\)
- Dedicated DFU services

**Leg Ulcers**
- No diabetes
- 55% of amputations\(^4\)
- Most due to peripheral arterial disease
- No dedicated services

4% increase per annum predicted due to:
- Poor healing rates (due to inappropriate care)
- High recurrence rates (due to inadequate preventative care)
- Ageing population

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The Challenge

Betty’s story: Wound care

Proposed Innovation

Model of Care Provision
Moving care to dedicated services staffed by clinicians with appropriate time, knowledge and skills and established referral routes to specialist services.

Data and Information
Support clinical care and quality improvement through effective data capture and reporting.

Evidence-based Care
Increase delivery of clinical and cost-effective care that delivers better health outcomes at a lower cost.

Education for clinicians delivering chronic lower limb wound care
Roll-out of dedicated chronic lower limb wound care services
Education and materials to support self care

Roll-out of point of care NHS-compliant mobile digital technology.
Establishment of information feedback systems to inform business and clinical needs.

Education for clinicians delivering chronic lower limb wound care
Access to materials and equipment for delivery of compression therapy
Agreed funding and pathways for referral for vascular services/ podiatry/ dermatology
Improving care

### Foot ulcers

- Delays in accessing appropriate care are associated with poor limb-salvage outcomes\(^5\)
- Access to ‘at risk’ foot clinics appear to significantly reduce the risk of major lower limb amputation at 12 months\(^6\)

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Impact of implementing NWCSP recommendations

Within 5 years
• 30% annual reduction in leg ulcer prevalence
• 15% annual reduction in cost of leg ulcer care

By 2030
• 23% less time spent on leg ulcer care
• 30% less spent on prescriptions
• 11% fewer hospital admissions for leg ulcers

Estimated savings have been calculated in line with treasury guidance and include:
• Costs of implementation
• 30% optimism bias

£9.8 of financial benefit for every £1 invested
Estimated results per ICS/STP

- 2 year implementation period NPV: 433m
- Benefit cost ratio: 10.0
- Payback period: 5 years
- 9% net cash releasing savings (annual, inc. implementation costs)

### Annual savings (%), To-be vs Baseline

<table>
<thead>
<tr>
<th>Year</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-cash releasing</td>
<td>£0.00</td>
<td>£0.00</td>
<td>£4,292,668.70</td>
<td>£6,207,745.53</td>
<td>£7,485,420.87</td>
<td>£8,353,601.18</td>
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<tr>
<td>Cash releasing</td>
<td>£0.00</td>
<td>£0.00</td>
<td>-£2,977,181.75</td>
<td>£2,901,169.19</td>
<td>£6,776,304.70</td>
<td>£9,366,773.93</td>
</tr>
<tr>
<td>Total benefits</td>
<td>£0.00</td>
<td>£0.00</td>
<td>£1,315,486.95</td>
<td>£9,108,914.72</td>
<td>£14,261,725.57</td>
<td>£17,720,375.11</td>
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<tr>
<td>Implementation costs</td>
<td>-£1,732,767.97</td>
<td>-£2,923,104.96</td>
<td>-£2,390,203.05</td>
<td>-£2,216,475.54</td>
<td>-£2,131,590.68</td>
<td>-£2,105,283.51</td>
</tr>
<tr>
<td>Net benefit</td>
<td>-£1,732,767.97</td>
<td>-£2,923,104.96</td>
<td>-£1,074,716.09</td>
<td>£6,892,439.18</td>
<td>£12,130,134.90</td>
<td>£15,615,091.60</td>
</tr>
</tbody>
</table>
# Estimated local investment profile per ICS / STP

(Based on average STP/ICS population of 1.2 million and assuming implementation over 2 years)

<table>
<thead>
<tr>
<th>Costs</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set up costs for clinics</td>
<td>£14,251</td>
<td>£0</td>
<td>£0</td>
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<tr>
<td><em>(Assumed that existing Doppler equipment will be used for new service)</em></td>
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<td></td>
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<tr>
<td>Clinic running costs – Staff and clinical space</td>
<td>£790,932</td>
<td>£1,651,282</td>
<td>£1,721,119</td>
</tr>
<tr>
<td><em>(Assuming that existing staff will be redeployed to new service)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social care model running costs</td>
<td>£174,667</td>
<td>£364,664</td>
<td>£380,087</td>
</tr>
<tr>
<td>Clinicians attending education and training</td>
<td>£106,955</td>
<td>£109,393</td>
<td>£8,392</td>
</tr>
<tr>
<td><em>(Education provided by organisation’s own specialist clinicians)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hardware purchase for data capture (imaging cameras for clinics)</td>
<td>£26,051</td>
<td>£26,546</td>
<td>£0</td>
</tr>
<tr>
<td>Software costs (apps for clinicians)</td>
<td>£135,119</td>
<td>£275,373</td>
<td>£280,605</td>
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<tr>
<td>Programme Support</td>
<td>£484,793</td>
<td>£495,846</td>
<td>£0</td>
</tr>
<tr>
<td>Monitoring and evaluation costs</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td><strong>Total per annum</strong></td>
<td><strong>£1,732,768</strong></td>
<td><strong>£2,923,105</strong></td>
<td><strong>£2,390,203</strong></td>
</tr>
</tbody>
</table>
Workforce productivity gain and cash releasing savings

**Workforce productivity gain**
- Reduction in proportion of staff time spent on wound care

**Cash releasing savings**
- Drug prescriptions,
- Hospital admissions,
- Wound care products
Patient benefits

• Improved well being and quality of life for people with lower limb wounds
  • Greater mobility
  • More time for work and leisure activities
  • Less social isolation
  • No smell
  • Less pain
  • Better sleep
  • Less anxiety

• Improved morale and job satisfaction for clinicians
Exemplars from practice

Kent Community Health NHS Trust
The Wound Medicine Centres are already achieving better healing rates than other services, despite caring for people with more complex conditions, justifying the investment in the data and information system.

Accelerate CIC Tower Hamlets Project
99% of people diagnosed with a venous ulcer are in compression of which 65% are healed by 12 weeks and 91% are healed at 24 weeks.

The Adams Surgery Leg Club®
Healing rates have been greatly improved with some patients finding their ulcers that normally took a couple of years to heal were healed within three to six months.

North Lincolnshire and Goole NHS FT
An audit of 30 patients referred from general practice found that the average time to healing was 59 days from starting the pathway. Many of these patients had lived with their ulcer for much longer before being referred to the wound clinic.

Manchester Amputation Reduction Strategy (MARS)
Appropriate referrals for vascular surgical input have increased (from 61% to 93%) and there is now easier movement of patients between services, reduced duplication of care and a growing culture of multi-professional collaboration.

Leeds CHCT
“Thank you for turning me into a human being with normal legs. I’ll never forget your hard compassionate and competent work and for not giving up on me.”

Leicester Vascular Limb Salvage (‘VaLS’) clinic
Since the VaLS clinic was implemented, the rate of major amputation has reduced from 19.4% to 9.5% and amputation-free survival at 12 months has increased from 60.7% to 74%.

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• One stop - once only assessment clinic
• Staffed by Vascular Nurse Specialist & community staff
• New ulcers only
  • Complete vascular assessment (ABPI and beyond)
  • Assess for need of venous surgical/ endovenous interventions
  • Diagnosis
  • Set treatment plan
  • Start compression
  • Promote/enable self-supported management
  • Provide supplies to patient
  • Onward referrals as needed
Presentation
• Immediate and necessary care
• Within 24 hours, refer to

Ongoing Care
• Assessment
  • Foot – 48 hours
  • 14 days - legs
  • Diagnosis
  • Treatment
  • Commence compression
  • Supply dressing materials
  • Referrals

Immediate care
• All clinical providers

Assessment

Care providers
• HCA/Self/family

Care reviewer
• Registered Professional

Specialist Clinic
• Specialist/consultant

Week 4
• Review by registered community nurse

Week 8
• Review by registered community nurse

Week 12
• Review by registered community nurse
Results

- 116 referrals in 3 months
- Average time from referral to assessment: 4.3 days (range: 0-12)
- Mostly venous
- 90% of venous leg ulcers in strong compression
- Only 28% in compression bandaging
- Only 8% requiring regular registered nurse input
- Only 5% referred to vascular

Ongoing Compression Therapy

- Bandage: 28%
- Hosiery Kit: 25%
- Wrap: 5%
- Tubgrip: 42%

Ongoing Care

- Discharged: 45%
- Escalated: 22%
- Selfcare: 14%
- HCA: 8%
- DN: 1%
Impact

- 87 patients requiring regular registered nurse visits
- 37% healed in 4 weeks
- High patient satisfaction

The Mid Yorkshire Hospitals NHS Trust

4 Week review

- Self: 37%
- RN: 29%
- HCA: 12%
- Healed: 22%

87% extremely likely to recommend service
No responses expressing negative opinion
3. **Data for QI**  
Professor Ann Jacklin  
Lead: Data and Information Workstream, NWCSP
Purpose of Data

**Patient data**
- Patient age, gender
- Referrals
- Diagnosis
- Activity volumes
- Outcomes

**Workforce data**
- Staff involved

**Product data**
- Wound care products
- Equipment

**Business**
- Commissioning & contract management
- Service Management
- Business case development
- Performance management

**Clinical**
- Point of Care
- Continuity of care
- Decision support
- Audit
- Improvement
  - To identify unwarranted variation
  - To support improvement programmes

*Underpinning principle:*
*Data collection to be secondary to operational practice*
Use of Data at different levels

- **National / Regional**
  - Highly aggregated patient / workforce / product

- **Integrated Care System**
  - More detailed across sectors/pathways
  - Potential for patient linking
  - Service commissioning
  - Audit / Improvement

- **Local provider**
  - Service management / improvement
  - Contract management
  - Audit / improvement

- **Clinician**
  - Continuity of care
  - Clinical decision support
  - Audit / Improvement

HES = Hospital Episode Statistics
LHCR = Local Health Care Record
ICS = Integrated Care System
CSDS = Community Services Data Set
EPR = Electronic Patient Record
Data & Information Priorities 19/20

Examine existing HES/SUS and CSDS

- Highly aggregated and lacking in detail
- Not previously looked at for wound care - data quality likely to be poor and require iterative improvement
- Need to standardise clinical problem SNOMED CT coding in community and primary care

Wound Management Digital Systems (WMDS)

- more granular data capture for both business and clinical purposes
- Point of care data capture and clinical continuity
- High level Functional Overview specification - consultation closed 2 October

For the 2020/21 First Tranche Implementation sites

- To have or adopt WMDS
- To lead on data quality, SNOMED CT
- To develop LHCR / ICS level reporting
- support development of Quality Improvement Metrics blueprint for Model HealthCare System (previously known as Model Hospital NHS E&I)
4. Implementing the Recommendations

Dr Mike Burrows
National Coordination Director:
AHSN Network
Recap

Where we are now, what next?

- National funding in place ✓

- Business case for lower leg pathway demonstrating the patient outcome and financial benefits ✓
  - Combination of:
    - service improvement
    - use of digital innovation
    - data analytics

- Local template to enable local case to be generated ✓

- Need to commence implementation work
Achieving the vision : The Plan

2020- 2021

1st tranche implementation sites will be recruited to:

• Test the assumptions of the business case
• Develop a blueprint for implementation
• Evaluate implementation

2021 onwards

Policy levers from NHS England and NHS Improvement to support widespread implementation

• CQUIN
• Steer to commission in line with NWCSP Lower Limb Recommendations
The Invitation

• NHS organisations are invited to send in expressions of interest in becoming sites for the 1st tranche of implementation to make early progress in implementing the recommendations of the National Wound Care Strategy relating to lower limb care.

• We are seeking up to 3 sites to become part of this initial implementation cohort.
Requirements
Proposals will be expected to demonstrate:

1. A commitment and readiness to implementing the strategy recommendations

2. Full commitment to developing an implementation case that describes resourcing, timelines and planned outcomes (from both a provider and patient perspective)

3. Full support from all relevant local partners including commissioners, provider organisations and Primary Care Networks ideally with full ICS/STP support

4. Adoption of a recognised service improvement programme management methodology with a supporting timeline and support from the local AHSN partner

5. Commitment to release front line staff to undertake training and education
Requirements
Proposals will be expected to demonstrate:

6. Implementation of digital tools including the use of mobile technology to support the provision of evidence-based care and its measurement

7. Active engagement of service users

8. How early implementation of strategy recommendations addresses health inequalities

9. Commitment to work as part of an implementation collaborative group

10. Commitment to evaluation of implementation work

11. Commitment to developing a blueprint for implementation for other NHS organisations
<table>
<thead>
<tr>
<th></th>
<th>Detail</th>
<th>Weighting Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Name of Applicant</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Applicant’s Organisation</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Applicant’s email address</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Applicant’s phone number</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>In which NHS region are you based?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Midlands West</td>
<td></td>
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<tr>
<td></td>
<td>Midlands East</td>
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<tr>
<td></td>
<td>North East and Yorkshire</td>
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<tr>
<td></td>
<td>North West</td>
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<td></td>
<td>London</td>
<td></td>
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<tr>
<td></td>
<td>South East</td>
<td></td>
</tr>
<tr>
<td></td>
<td>South West</td>
<td></td>
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<tr>
<td>6.</td>
<td>Where is your locality numbered in the English Indices of Deprivation 2019?</td>
<td></td>
</tr>
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</table>
### Expressions of Interest Form

<table>
<thead>
<tr>
<th></th>
<th>Partnership Working</th>
<th>Yes/No</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td>Does your organisation operate within a defined ICS (Integrated Care System) or STP (Sustainability and Transformation Partnership)? <em>(If so, please give the name of that organisation)</em></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>8.</td>
<td>Successful implementation will require collaboration between the local health care providers and other health care organisations in your area. Please indicate which of these have agreed to support this proposal: <em>(If possible, please attach written confirmation of support to this application)</em></td>
<td></td>
<td>15</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Community Nursing Services</th>
<th>Verbal</th>
<th>Written</th>
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<tbody>
<tr>
<td>Podiatry</td>
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<td>Vascular services</td>
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<tr>
<td>General Practice</td>
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<tr>
<td>Commissioners</td>
<td></td>
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<tr>
<td>Local Academic Health Science Network (AHSN)</td>
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<tr>
<td>Local Care Homes</td>
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<tr>
<td>Other <em>(please state)</em></td>
<td></td>
<td></td>
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</tbody>
</table>

<p>| 9.| The NWCSM will provide some project and programme support management resource but participating organisations will also be expected to contribute. Is your organisation willing to commit to this? | Yes/No | 10 |</p>
<table>
<thead>
<tr>
<th>Implementation of the NWCSP Lower Limb Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. <strong>With regard to implementing the NWCSP Lower Limb Recommendations, please describe progress in your organisation.</strong> <em>(If implementation has not yet begun, are your organisation and partners willing to do so using a recognised service improvement programme management methodology with a supporting timeline?)</em></td>
</tr>
<tr>
<td>11. <strong>Does your organisation commit to releasing front line staff to undertake necessary training and education to implement the Lower Limb Recommendations?</strong></td>
</tr>
<tr>
<td>12. <strong>Does your organisation and partners agree to contribute to development of a blueprint for national implementation that describes resourcing, timelines and planned outcomes?</strong></td>
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<td>17.</td>
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<tr>
<td>18.</td>
</tr>
<tr>
<td>19.</td>
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</tbody>
</table>

**Total Weighting Score**: 100
Expressions of Interest

• Expressions of Interest should use the template and must be submitted to NatWoundStrat@yhahsn.com no later than 5pm 20th November 2020.

• Tuesday 24th Nov - Short listing of Stage 1 applications

• Wednesday 25th Nov – inform applicants of outcome and invite short listed applicants to submit more detailed application
What support is being offered?

• 1x implementation site in 3 different NHS England regions

• Each 1st tranche implementation site will receive the support of:
  • 1.0 WTE senior implementation lead
  • 0.5 WTE NWCSP admin support
    Fully funded for 9 months then 50% funded for a further 15 months

• Organisations that sign up as 1st tranche implementation sites will be required to commit to a minimum of 2-year contracts for these implementation posts.

• As the implementation project rolls out, this funding pattern will be replicated for the remaining 4 NHS England regions.

  There may be room for differing approaches within this funding envelope.
Why are we encouraging involvement with the AHSNs?

Pathway Transformation & Innovation incorporating Digital/Technology

Model of Care Provision
Moving care to dedicated services staffed by clinicians with appropriate time, knowledge and skills and established referral routes to specialist service

Data and Information
Support clinical care and quality improvement through effective data capture and reporting

Workforce Productivity

- Reduction in proportion of staff time spent on wound care

Workforce productivity gain
Questions.....