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**SMITH AND NEPHEW:
‘Invisible patients, unsustainable practice:
insights from 20 000 wounds to drive
solutions across integrated care systems’**

**MORE
INSIDE**

+ Analysing 19472
wounds over 8 years

+ Over 40% of
wounds classed as
non-healing/static
or deteriorating

+ One in five patients
required hospitalisation

+ No significant
improvement in wound
healing time and other
key factors since 2017

Smith+Nephew

Invisible patients, unsustainable practice: insights from 20 000 wounds to drive solutions across integrated care systems

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Abstract

Wound care represents a major and widespread contributor to the national health burden and NHS costs, yet this is rarely reflected in national priorities. Without urgent attention and improvement, wounds will continue to grow as an under-monitored and under-resourced pressure on the healthcare system. This report presents a data pool of 19 472 wounds, collected from January 2017 to March 2025 from community healthcare centres – to the authors' knowledge, this is the largest recent dataset of its kind.

Key findings from the analysis showed that:

- Over 40% of wounds were classed as either non-healing/static or deteriorating, despite advancements in treatments and evidenced guidelines to avoid non-healing
- Around 45% of wounds had been present for over 3 months at data capture, requiring extended periods of care to progress to healing
- There has been no significant improvement in the duration of wounds or the number progressing to healing since 2017
- Over one in five wounds required the patient to be admitted to hospital, with nearly half (46.7%) requiring referral to specialist care, reflecting the systemic impact of failing to prioritise wound care.

A joined-up, national approach to wound care is urgently required to prevent these problems from remaining hidden in the system. There are currently no nationally mandated metrics or reporting requirements related to wound outcomes at a national level, nor is there a strategic focus on non-healing wounds – this must change. Wound care represents a major area of opportunity for preventative care, and should be seen as a crucial piece of the puzzle for implementing the 10 Year Health Plan's goals of shifting from hospital to community, and from sickness to prevention.

Incremental optimisation of existing fragmented systems is insufficient. Redesigning integrated and sustainable models of care delivery that build on national priorities and bring parity with other long-term conditions is a national health imperative. The analytical, commissioning, workforce and improvement functions required to achieve this already exist within systems; they must now be coherently applied to this population of patients.

Key words: Community wound care; Healthcare service use; Integrated care boards; Non-healing wounds; Preventative wound management; Wound care data; Wound surveillance

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Introduction

The burden of wounds represents an urgent challenge that demands immediate and sustained attention from policymakers, healthcare leaders and frontline practitioners. Across the UK, there are calls for change in healthcare delivery, to create a system that preserves health, protects patients and ensures effective use of available resources. Wound care is an essential piece of this puzzle, presenting an opportunity to make a tangible difference to population health and service use. Although approximately 2.2 million people in the UK live with a non-healing wound at any given time (Life Sciences Organisation, 2018), this remains an often-overlooked aspect of healthcare delivery, with wide-reaching implications for the future success of national health goals.

In 2020, Guest et al reported that around 3.8 million people were living with a wound in the UK, costing the NHS around £8.3 billion a year. While 6% of these costs were associated with wound care products, over 70% was attributed to the demand for practitioners, including district and community nurses (29%), GP clinics (18%), healthcare assistants (17%) and practice nurses (7%) (Guest et al, 2020). For an integrated care board that serves a population of around 1 million people, this puts the cost of wound management at around £124 million per year. These figures place wound care as the third highest expense for the NHS after cancer and diabetes (Kanwal, 2024), with costs exceeding those of obesity (Guest, 2021), yet this scale of impact is rarely reflected in national priorities, performance frameworks or surveillance initiatives.

Despite its scale and cost, wound care remains structurally marginalised within the healthcare system. Systemic restrictions and fragmented commissioning pathways create inconsistencies in access to effective wound care, contributing to a lack of national benchmarking and accountability for outcomes. Clear governance structures, better visibility of outcomes and connected communication channels across healthcare organisations are vital to improving coordination in this area (Atkin et al, 2021; Public Policy Projects, 2023).

A key target for change lies in the way the healthcare system approaches non-healing wounds. Defined as wounds that do not progress to healing within 6 weeks, non-healing wounds represent a disproportionate financial, resource and human burden, comprising £5.6 billion of the £8.3 billion total wound care costs reported by Guest et al (2020). Non-healing wounds are associated with prolonged morbidity, increased risk of infections, higher mortality rates, reduced quality of life and limitations on activities of daily living (Hareendran et al, 2005; Herber et al, 2007; Mahmoudi and Gould, 2020; Mallick et al, 2020; Atkin et al, 2021).

This demonstrates how the consequences of delayed or ineffective wound care extend well beyond the wound itself. The longer a wound remains open, the longer the patient is at increased risk of complications, such as infection, which may culminate in a lengthy hospital admission. Evidence suggests that this is a common occurrence, with around 30% of patients with venous leg ulcers accessing emergency care over a 12-month period (Guest et al, 2020). This can lead to longer length of stay and costly interventions, including theatre time, placing avoidable pressure on already overstretched acute services. Protracted management of open wounds, including regular treatment and dressing with single-use consumables, as well as nurse travel time to patients' homes, also raise serious concerns regarding financial and environmental sustainability. These systemic impacts require national action to prevent avoidable demand on services and give patients the best chance of healing in the community.

Growing pressure on the healthcare system

Despite innovations in protocols and products, wound-related outcomes remain poor. Guest et al (2020) found that around half of non-healing wounds in the UK fail to heal within a 12-month period. Meanwhile, the prevalence of wounds may be increasing; in 2017–18, an estimated 2.0% of the UK population developed a wound of the lower limb, compared to 1.4% in 2013–14 (Guest et al, 2020). This increasing trend is likely being driven by changes in the national demographic, with the population getting older and experiencing more non-communicable diseases. Meanwhile, many known risk factors for non-healing wounds, including older age, type 2 diabetes, cardiovascular disease and obesity, are becoming more prevalent (Office for National Statistics, 2023; World Health Organization, 2025). Several social determinants of health also correlate with non-healing wounds, such as socioeconomic deprivation and lower educational levels. Together, these trends point to a foreseeable and preventable escalation in wound burden and cost (Atkin et al, 2021).

Prevention of disease and morbidity is one of the focus points of the 10 Year Health Plan for England (UK Government, 2025). To achieve this, steps must be taken to identify individuals at risk of non-healing and recurring wounds, and implement preventative measures. However, while the clinical links between wounds, long-term conditions and social determinants are well established, they remain underrecognised at policy, regional

and commissioning level. The systems and policies that are currently in place to coordinate treatment and prevention of wounds are fragmented and only address aspects of the wider problem.

Another central tenet of the 10 Year Health Plan is to drive a radical shift from hospital to community care (UK Government, 2025). Yet, the number of NHS community nurses fell by 43% between 2009 and 2024, with those positions largely being shifted into acute care settings (Palmer et al, 2025). The remaining community-based staff are considerably overstretched and face heightened demand from a population with increasing age and multimorbidity. As the financial and resource burden of wound care falls predominantly on community healthcare systems (Guest et al, 2020), a more in-depth understanding of this clinical area is needed to ensure that the shift away from hospital care is safe and sustainable.

Despite the substantial burden of wound care, wound-specific monitoring remains limited, with key literature (Guest et al, 2020; Urwin et al, 2022; Public Policy Projects, 2023) relying on datasets that were not originally designed for wound-specific analysis. To fill this gap, a large cohort of community services has been collecting data to describe the real-world burden of wound care in community settings, with a focus on resource use and quality of outcomes experienced under existing care processes. Between January 2017 and March 2025, data were collected from 19 472 wounds – to the authors' knowledge, this represents the largest available pool of wound-specific prevalence data in community settings. By December 2025, this dataset had surpassed 20 000 wounds, with collection still ongoing.

This evidence review presents the major findings from these data, highlighting key metrics to inform healthcare policy makers, service leaders and integrated care boards, and urge them to design appropriate governance and care structures for patients with, or at risk of, non-healing wounds.

Methods

Data collection

This community wound management inquiry used a repeated cross-sectional survey design to capture wound care activity across NHS community services, using a data capture tool created by Smith+Nephew. Community healthcare centres that were accessing (or considering use of) Smith+Nephew's auditing services were offered the data capture tool, which was initially launched in 2017 and is still in use at the time of writing. Centres with established relationships with Smith+Nephew in the Republic of Ireland, Denmark and Sweden were also given the opportunity to collect data using this tool, although implications of the findings for these countries are outside the scope of this report, which focuses on UK wound care services and policies.

Each participating centre was asked to collect data prospectively over a 1-week period, once per year, using a standardised survey delivered either as a digital form completed at the point of care, or a paper form, which was transcribed directly into a digital platform (SNAP, SnapSurveys Ltd, UK). Centres were requested to complete data entries at the point of care for every wound encountered during the chosen week. Patients and wounds seen in each week of data collection would vary year on year; therefore, the dataset represents a series of independent annual cross-sections, rather than a longitudinal cohort. To ensure accurate use of the data capture tool, clinicians from Smith+Nephew's regional teams visited participating centres before data collection began to discuss the form and ensure understanding of all items.

Participating centres were given the option to submit completely anonymous data, which precluded calculation of an exact total, but it was estimated that 166 individual community care centres had participated in the survey between January 2017 and March 2025. Each centre was provided with a unique login, and clinicians were strongly encouraged to record data of all presenting wounds at the point of care. The specific week of data collection varied between the centres according to their preference, and individual centres were not required to collect data in the same week each year. Therefore, data from 2017–24 could have been collected at any time of the year. This analysis includes all data collected up to March 2025. Future results, including data collected from April 2025 onwards, will be analysed in future work.

The data capture tool was designed to collect patient demographics, wound characteristics and treatment information. Data entry was structured so that one wound was documented per form, allowing services to capture the full range of wound types without duplication or loss of detail. Therefore, each data point presented here represents one wound, rather than one patient; individuals with multiple wounds may contribute several entries. No inclusion or exclusion criteria were applied, so any wound treated during the data collection week was valid to be included in the survey.

Additional variables were introduced in 2024 to examine health inequalities, the complexity of patient populations, clinician mileage and product disposal, thereby incorporating sustainability perspectives alongside clinical measures. In the 2025 survey, some response options were added or changed (e.g. categories of comorbidities and risk factors) to reflect the evolving healthcare landscape and national priorities. This has affected comparability with earlier years in some data categories (e.g. patient demographics, virtual appointments, quality of life). Given the variability in the number of yearly responses, readers are encouraged to refer to percentages rather than *n* values presented in these results.

Data analysis

Data analysis consisted of descriptive statistics for quantitative fields. All statistical analyses were performed using the Statistical Package for the Social Sciences (SPSS version 31.0). A two-sided significance threshold of $P < 0.05$ was applied. Associations between study year (treated as an ordinal variable) and categorical wound outcomes (leg ulcers, antimicrobial treatment, full compression, any compression, deep wounds, high exudate and infection) were primarily evaluated using Pearson's Chi squared tests of independence. Effect sizes for these associations were quantified using eta (η), appropriate for ordinal–categorical relationships ($\eta = 0$ indicates no association, $\eta = 1$ indicates perfect association). Any changes in the duration of antimicrobial treatment were assessed using Somers' D by quantifying association, reflecting both the strength and direction of monotonic trends. For weekly dressing changes, univariate analysis of variance (ANOVA) and independent *t* tests were used to assess mean differences across years, with eta (η^2 ; Cohen's D) reported as the effect size.

Given the large sample size, statistically significant *P* values may reflect minimal absolute differences; therefore, effect sizes were prioritised when interpreting findings. For categorical outcomes, associations between study year and wound characteristics were evaluated using eta (η). Values < 0.10 indicate negligible associations, $0.10–0.24$ small, $0.25–0.39$ moderate and ≥ 0.40 strong associations.

It is important that readers consider that variations in sample sizes and months covered in each year mean that annual denominators varied substantially, and fluctuations in estimates may reflect differences in data capture rather than true changes in clinical practice. Readers are therefore encouraged to avoid comparison between *n* values and *P* values alone, but refer instead to percentages (showing proportional data) and effect size. Additionally, given the nature of data collection, there are some missing data; blank fields shown in the results below indicate that information was not entered at the time of data collection, rather than showing true negative values. Data were analysed using listwise deletion because missing data patterns could not be reliably imputed. The extent of missing data varied. Readers are directed to the limitations section (Box 1) of this article for further details.

Ethical considerations

The digital platform was ISO27001-certified and compliant with General Data Protection Regulation, ensuring that all data were stored in a secure environment. To protect confidentiality, no patient-identifiable information was captured at any stage of the survey or subsequent analysis.

The Health Research Authority tool did not classify this study as research, thus formal research ethics approval was not required. In each participating centre, local consent and organisational approvals were sought and obtained where necessary. This included consent to use and publish the pooled dataset, but excluded individual centre data, hence the absence of centre-specific analysis in this report.

Key findings

Geographical and individual characteristics

A total of 19 472 wounds were collected from community settings between January 2017 and March 2025. Many participating centres chose to submit their data anonymously, particularly in the earlier years of data collection. However, in the 2023–25 datasets, a total of 8164 wounds were submitted with geographical data indicating the centre's country and region. Of these, 6574 wounds (80.5%) occurred in the UK and 1590 (19.5%) were documented by centres outside the UK. Although regional analysis or comparison were not possible with this dataset, substantial variation in participation was observed, both between regions and across years ([Appendix 1](#)), with engagement typically involving one or two trusts in each area.

The 2024 and 2025 iterations of the survey collected data on patients' ages and their risk factors or comorbidities. In both years, around 80% of documented wounds occurred in patients aged over 65 years, while 65.9–68.1% occurred in those with at least one known risk factor for non-healing. Full details are shown in [Appendix 2](#).

Wound healing metrics

Key wound healing metrics (at the point of data capture) for the whole data pool are shown in [Table 1](#), with temporal trends shown in [Figure 1](#). More detailed yearly data are shown in [Appendix 3](#).

Data on healing status were collected for 16 242 wounds, over 40% of which were classed as either static/non-healing or deteriorating. This figure remained at around 40% across all years except 2023, where just over half (53.0%) of wounds recorded were static/non-healing or deteriorating. There was no meaningful improvement over time ($\eta=0.083$).

Around 45% of documented wounds (ranging from 40.6–50.7% in 2021–23) had been present for more than 3 months at the time of data capture, meaning that they were failing to progress along normal wound healing trajectories. Differences between years were also not clinically meaningful ($\eta=0.059$), indicating a lack of improvement in wound healing since 2017.

Across all years, the most common wound types were leg ulcers, accounting for nearly one-third (32.0%) of all wounds collected, followed by pressure ulcers (15.0%). Although there was some variation between years, there were no meaningful differences in the proportions of wounds of different aetiologies ($\eta=0.079$). There were also no differences in the severity of wounds, represented by depth ($\eta=0.089$) and exudate levels ($\eta=0.143$), between years. While non-diagnoses were not measured as part of the survey, these may have come under 'other', comprising 13.6% of wound types across all years.

Resource burden of wounds

Community nursing teams

Data related to the time burden faced by community nursing teams were captured for 2024 and 2025 ([Table 2](#)). The resource burden of wound care was generally high, but the amount of time required to care for a patient's wound during each appointment varied significantly. Most wounds required 20–30-minute appointments, but more complex wounds took up to 1 hour per appointment to manage. Time and costs were exacerbated by travel to patient homes, with clinicians covering an average distance of 3–4 miles per wound. Care tended to involve over two visits per patient per week, up until the point of wound healing. Achieving wound healing could be a lengthy process, with nearly half of all wounds lasting longer than 3 months, without indication of progress to healing ([Figure 1a–b](#)). The survey did not assess the appropriateness of wound care delivery, so time to care does not necessarily represent the quality of care.

Wider healthcare system

Hospital admissions and referrals added to the resource burden of non-healing wounds. Across the whole sample, over 20% of wounds seen by participating centres resulted in the patient being admitted to hospital, with this figure exceeding 30% in some years ([Table 2](#)). The admission rate for 2025, covering January–March only, was notably lower at 8.9%. However, internal observations of data collected from April–December 2025

Table 1. Key wound healing metrics across all years (2017–25)

Characteristic	Category	n (%)
Wound duration (n=18 802)	6 weeks or less	7305 (38.9)
	>6 weeks–3 months	2917 (15.5)
	>3–6 months	2437 (13.0)
	>6–9 months	1285 (6.8)
	>9–12 months	1070 (5.7)
	>12 months	3788 (20.1)
Wound healing status (n=16 242)	Improving	9553 (58.8)
	Deteriorating	1398 (8.6)
	Non-healing/static	5291 (32.6)
Wound type (n=18 701)	Burns/traumatic	1377 (7.4)
	Diabetic foot ulcer	1138 (6.1)
	Fungating	294 (1.6)
	Haematoma	150 (0.8)
	Leg ulcer	5975 (32.0)
	Lymphoedema	467 (2.5)
	Pilonidal sinus	205 (1.1)
	Pressure ulcer	2796 (15.0)
	Skin tear	1588 (8.5)
	Surgical wound	2163 (11.6)
	Other	2548 (13.6)
Exudate level (n=17 366)	Low	9429 (54.3)
	Moderate	4696 (27.0)
	High	1111 (6.4)
	None	2130 (12.3)
Wound depth (n=14 759)*	Deep	3546 (24.0)
	Superficial	11213 (76.0)

*Excludes data from 2025 due to survey change

(excluded from this analysis due to time constraints) indicated that the overall admission rate for that year was over 20%. This suggests that the lower rate seen in January–March 2025 was related to seasonal factors—such as increased strain on acute services leading to hospital avoidance, or higher strain on staffing resulting in missed documentation of community-linked admissions—rather than sustained reduction in wounds requiring inpatient care. Similarly, the proportion of admissions dipped in 2020 to 16.7%, possibly because of COVID-19 pandemic-related restrictions, then increased back up to 25.3% in 2021, remaining over 20% from 2022–24.

Wound management services

Patients being treated in the community were seen in a variety of settings and by a range of healthcare professionals (Table 2). The proportion of patients referred for further specialist treatment varied between years, ranging from 38.7% in 2021 (possibly affected by the

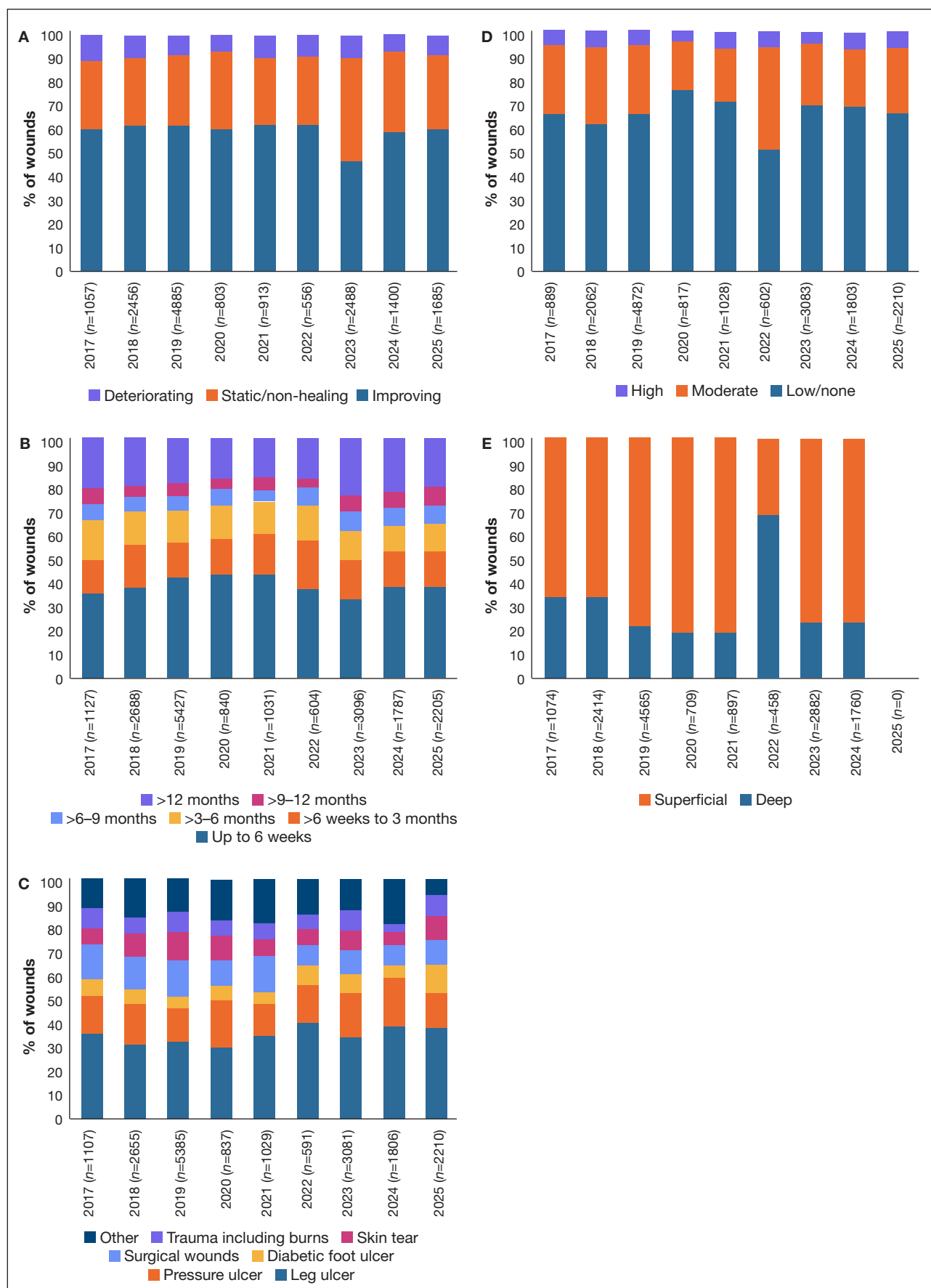


Figure 1. Key wound healing metrics: a) wound healing status; b) wound duration; c) wound type; d) level of exudate; e) wound depth, 2017–25. $P < 0.05$ for each comparison; however, effect sizes were negligible ($\eta^2 < 0.10$); $n = 18\,370$.

Table 2. Resource burden associated with wound care, 2017–25

Category		All years	2017	2018	2019	2020	2021	2022	2023	2024	2025	P, effect size*
Treatment location, n (%)	Total	18927	1110	2698	5513	851	1040	611	3088	1806	2210	-
	Patient's home	10919 (57.7)	680 (61.3)	1696 (62.9)	2810 (51.0)	597 (70.2)	481 (46.3)	412 (67.4)	1802 (58.4)	1188 (65.8)	1253 (56.7)	$P<0.001$, $\eta=0.166$
	Outpatient clinic	3717 (19.6)	275 (24.8)	460 (17.0)	969 (17.6)	53 (6.2)	392 (37.7)	157 (25.7)	566 (18.3)	259 (14.3)	586 (26.5)	
	Nursing home	2733 (14.4)	139 (12.5)	419 (15.5)	724 (13.1)	146 (17.2)	81 (7.8)	39 (6.4)	546 (17.7)	295 (16.3)	344 (15.6)	
	Hospital	279 (1.5)	4 (0.4)	5 (0.2)	73 (1.3)	0 (0)	40 (3.8)	0 (0)	78 (2.5)	56 (3.1)	23 (1.0)	
	GP practice	1120 (5.9)	1 (0.1)	97 (3.6)	838 (15.2)	46 (5.4)	38 (3.7)	0 (0)	92 (3.0)	5 (0.3)	3 (0.1)	
	Other	159 (0.8)	11 (1.0)	21 (0.8)	99 (1.8)	9 (1.1)	8 (0.8)	3 (0.5)	4 (0.1)	3 (0.2)	1 (0.0)	
Attending clinician, n (%)	Total	19256	1174	2783	5629	859	1045	614	3136	1806	2210	-
	Nurse	14537 (75.5)	1024 (87.2)	2105 (75.6)	4495 (79.9)	571 (66.5)	871 (83.3)	471 (76.7)	2255 (71.9)	1234 (68.3)	1511 (68.4)	$P<0.001$, $\eta=0.162$
	Healthcare assistant	3717 (19.3)	61 (5.2)	504 (18.1)	742 (13.2)	200 (23.3)	84 (8.0)	102 (16.6)	756 (24.1)	571 (31.6)	697 (31.5)	
	Podiatrist	93 (0.5)	3 (0.3)	0 (0)	3 (0.1)	0 (0)	32 (3.1)	0 (0)	52 (1.7)	1 (0.1)	2 (0.1)	
	Other	909 (4.7)	86 (7.3)	174 (6.3)	389 (6.9)	88 (10.2)	58 (5.6)	41 (6.7)	73 (2.3)	0 (0)	0 (0)	
Hospital treatment for wound care in previous 12 months, n (%)	Total	18267	1128	2605	5232	816	1004	586	2880	1806	2210	-
	Hospital admissions, n (%)	4246 (23.2)	374 (33.2)	806 (30.9)	1189 (22.9)	136 (16.7)	254 (25.3)	121 (20.6)	807 (28.0)	363 (20.1)	196 (8.9)	$P<0.001$, $\eta=0.162$
	Hospital admissions, mean (SD)	-	0.8 (1.6)	0.7 (1.5)	0.4 (0.9)	0.3 (0.7)	0.5 (1.3)	0.3 (0.7)	0.6 (1.5)	0.3 (0.7)	- [†]	$P<0.001$, $\eta=0.139$
Referrals, n (%) [‡]	Total	19256	1174	2783	5629	859	1045	614	3136	1806	2210	-
	Any referral	9002 (46.7)	847 (72.1)	1497 (53.8)	2329 (41.4)	372 (43.3)	404 (38.7)	397 (64.7)	1446 (46.1)	1338 (74.1)	372 (16.8)	$P<0.001$, $\eta=0.162$
	Vascular	3012 (15.6)	380 (32.4)	597 (21.5)	741 (13.2)	93 (10.8)	142 (13.6)	107 (17.4)	455 (14.5)	360 (19.9)	137 (6.2)	$P<0.001$, $\eta=0.168$
	Tissue viability	4523 (23.5)	290 (24.7)	842 (30.3)	1228 (21.8)	231 (26.9)	161 (15.4)	295 (48.0)	830 (26.5)	522 (28.9)	124 (5.6)	$P<0.001$, $\eta=0.200$
	Dietitian	534 (2.8)	165 (14.1)	84 (3.0)	95 (1.7)	28 (3.3)	5 (0.5)	53 (8.6)	40 (1.3)	52 (2.9)	12 (0.5)	$P<0.001$, $\eta=0.197$
	Plastic surgery	790 (4.1)	140 (11.9)	130 (4.7)	212 (3.8)	28 (3.3)	55 (5.3)	49 (8.0)	97 (3.1)	61 (3.4)	18 (0.8)	$P<0.001$, $\eta=0.122$
	Podiatrist	1739 (9.0)	96 (8.2)	271 (9.7)	523 (9.3)	48 (5.6)	92 (8.8)	57 (9.3)	296 (9.4)	231 (12.8)	125 (5.7)	$P<0.001$, $\eta=0.064$
	Dermatologist	1063 (5.5)	92 (7.8)	158 (5.7)	333 (5.9)	33 (3.8)	70 (6.7)	19 (3.1)	191 (6.1)	110 (6.1)	57 (2.6)	$P<0.001$, $\eta=0.059$
	Infection control	413 (2.1)	34 (2.9)	130 (4.7)	63 (1.1)	4 (0.5)	20 (1.9)	9 (1.5)	33 (1.1)	112 (6.2)	8 (0.4)	$P<0.001$, $\eta=0.129$
	Diabetologist	356 (1.8)	33 (2.8)	57 (2.0)	104 (1.8)	20 (2.3)	15 (1.4)	27 (4.4)	55 (1.8)	43 (2.4)	2 (0.1)	$P<0.001$, $\eta=0.061$

*Expressed as η , η^2 or Cohen's D; [†]The 2025 survey collected data on whether or not patients were admitted into hospital, but did not include the number of admissions per wound; [‡]Respondents could select more than one referral type; '-' indicates data were not collected, due to changes to the questionnaire which occurred to ensure relevant data were gathered; SD=standard deviation

Table 2. Resource burden associated with wound care, 2017–2025 (continued)

Category	All years	2017	2018	2019	2020	2021	2022	2023	2024	2025	P, effect size*
Time spent on wound treatment per appointment, mean minutes (SD)	-	-	-	-	-	-	-	-	20.0 (11.4)	30.1 (14.6)	$P<0.001$, $\eta=0.170$
Miles travelled by clinician to patient, mean (SD)	-	-	-	-	-	-	-	-	4.1 (4.5)	3.5 (4.6)	$P<0.001$, Cohen's $D=15$

*Expressed as η , η^2 or Cohen's D ; †The 2025 survey collected data on whether or not patients were admitted into hospital, but did not include the number of admissions per wound; '-' indicates data were not collected, due to changes to the questionnaire which occurred to ensure relevant data were gathered; SD=standard deviation

COVID-19 pandemic) up to 74.1% in 2024. Across all wounds with available data in this category, 46.7% ($n=9002/19\,256$) required the patient to be referred to a specialist service. A variety of services were accessed via referral, the most common being vascular, tissue viability, dietetics and plastic surgery, demonstrating the broad impact of wound management.

The human burden of wounds

In 2025, an additional category on quality of life was added to the data capture tool to assess the human burden of wounds. The most common issue reported was wound-related pain, affecting 27.7% of the cohort, followed by reduced engagement in socialisation, leisure or personal activities (19.1%) and limitations on activities of daily living (17.5%) (Figure 2).

Wound care interventions

Dressings

The survey results showed treatment changes in community practice over time (Table 3). A decrease in the mean number of dressing changes per week was observed ($P<0.001$, $\eta^2=0.008$), ranging from a mean of 2.5 dressing changes per week in 2018 to 2.1 in 2025, aside from a spike in 2024 (mean of 2.5 dressing changes).

Infection and antimicrobial products

Infection was measured based on symptoms rather than use of antimicrobials, as these could be administered for issues unrelated to the wound, leading to over-estimation. Similarly, when indicating whether antimicrobial products (such as dressings or topical creams) had been used, centres were asked to exclude antibiotic drugs, to ensure that all recorded treatments were directly related to the wound, rather than other infections.

The survey results showed that the incidence of wound infection ranged from 6.0% in 2025 to 10.9% in 2018 (Table 3). Overall, the proportion of wounds with infection significantly declined between 2017 and 2025 ($P<0.001$; $\eta=0.048$). However, no corresponding decrease in the use of antimicrobial products to manage wound-related infection was observed ($\eta=0.104$).

Statistical analysis revealed an association between presence of infection and wound healing status and duration (Table 4), with infected wounds being more likely to exhibit delayed healing or to remain unhealed.

Compression therapy

The proportion of patients with leg ulcers (typically the wound type suitable for compression therapy) did not change meaningfully over time ($\eta>0.05$). Similarly, no meaningful change in the proportion of patients who received any type of compression ($\eta=0.062$), or full compression ($\eta=0.106$) was observed (Table 3). Compression use was recorded for all wound types, not only leg ulcers.

Virtual appointments

In 2024 and 2025, survey respondents were asked to identify whether it would be appropriate for patients to interact with their clinician via virtual appointments, as a

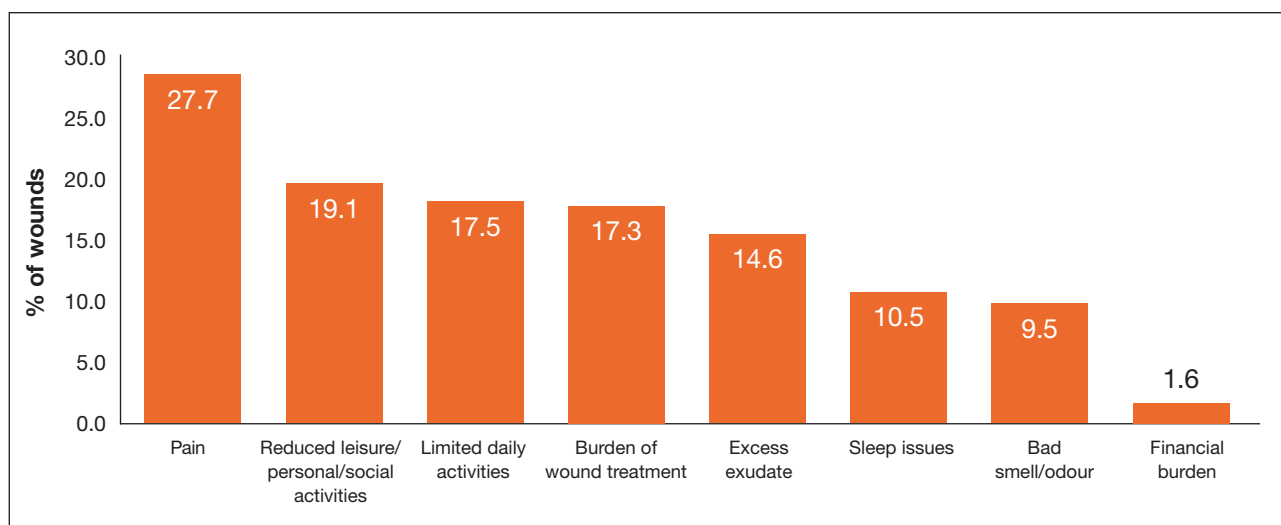


Figure 2. Impact of wounds on patient wellbeing, 2025. Representing 2437 responses relating to 2210 wounds documented in 2025; it was possible to select multiple responses per wound.

Table 3. Use of treatment interventions over time, 2017–25

Intervention		2017	2018	2019	2020	2021	2022	2023	2024	2025	P value, effect size†
Dressing changes total, n		1132	2682	5406	830	1035	603	3085	1806	2210	-
Number of dressing changes per week, mean (SD)		2.3 (1.5)	2.5 (1.7)	2.4 (1.7)	2.3 (1.6)	2.1 (1.4)	2.3 (1.4)	2.2 (1.4)	2.5 (1.8)	2.1 (1.4)	$P<0.001$, $\eta^2=0.008$
Antimicrobials total, n		1174	2783	5629	859	1045	614	3136	1806	2210	-
Use of antimicrobials, %	Wounds with infection	10.2	10.9	8.5	8.5	8.7	10.6	8.4	8.1	6.0	$P<0.001$, $\eta=0.048$
	Wounds treated with antimicrobials	31.7	34.5	25.5	30.3	20.3	30.3	33.0	32.9	37.7	$P<0.001$, $\eta=0.104$
Compression* total, n		1034	2385	4488	687	892	504	2952	1716	2047	-
Use of compression	Leg ulcers	33.8	29.5	29.9	28.0	33.2	36.9	32.4	35.3	35.2	$P<0.001$, $\eta=0.054$
	Wounds treated with any type of compression	37.3	26.6	22.5	14.0	30.6	31.9	34.6	25.9	36.5	$P<0.001$, $\eta=0.062$
	Wounds treated with full compression	23.1	18.4	13.5	7.4	21.7	22.0	20.3	19.3	22.6	$P<0.001$, $\eta=0.106$

*Types of compression included reduced, full or hosiery; † η or η^2 ; SD=standard deviation

Table 4. Statistical relationship between infection with healing status and duration, 2017–25

Category	P	Cramér's V*
Wound infection vs wound healing status	<0.001	0.293
Wound infection vs wound duration	<0.001	0.039

*Cramér's V is a statistical measure of association between two variables, ranging from 0=no association to 1=perfect association

Table 5. Suitability of virtual appointments for the management of wounds, 2024 and 2025

Item	Response	2024 (n=1805)	2025 (n=2210)
Able to cope with virtual appointment? n (%)	Yes	441 (24.4)	527 (23.8)
	No	1364 (75.6)	1683 (76.2)
Reasons for not coping, n (%)*	Does not have family/carer support	102 (5.7)	212 (9.6)
	Not mentally capable to do the dressing change	273 (15.1)	447 (20.2)
	Not physically able to do the dressing change	1086 (60.2)	1459 (66.0)
	Wound is too complex	319 (17.7)	350 (15.8)

*More than one reason could be selected per patient

means of self-care with virtual support. Participating clinicians believed that in over three-quarters (75.6% and 76.2% in 2024 and 2025, respectively) of cases seen, the patient would not cope with virtual appointments (Table 5), with the principal reason being the patient's physical inability to attend to their own wound (60.2% and 66.0% in 2024 and 2025, respectively). Other reasons included lack of mental capability (15.1–20.2%), the wound being too complex (15.8–17.7%) and lack of carer support (5.7–9.6%). These results indicate that around one-quarter (24.4% and 23.9% in 2024 and 2025, respectively) of the community case load of wounds could be appropriate for a virtual support approach.

Implications for care

Achieving real improvement

This survey of nearly 20 000 wounds demonstrated a consistently high proportion of non-healing wounds, with a lack of improvement since 2017. Notably, almost half of all wounds (45%) documented by participating centres had persisted beyond 3 months at the time of data entry, likely requiring considerable time and healthcare resources for their ongoing management. The proportion of wound types associated with non-healing (leg ulcers, pressure ulcers and foot ulcers) and the severity of wounds (depth and exudate level) remained relatively unchanged from 2017–25, despite treatment developments in this time.

Although these data represent a snapshot of the burden of wounds at a single timepoint and did not capture whether these wounds progressed to healing, the wound duration and status clearly demonstrate poor outcomes, with no improvements in the overall proportion of non-healing wounds over the 8-year period of data collection. This has major implications for wound care, both in terms of human burden and the wider healthcare system.

The evidence-based recommendations required to deliver improvements in wound care are already available, published within the guidelines of national bodies such as the British Lymphology Society (2019), National Wound Care Strategy Programme (2025) and Society of Tissue Viability (2026). Of particular note is the National Wound Care Strategy Programme (2023) resource, which has set out a uniform approach to wound management – data from the first sites to implement these guidelines as part of a pilot assessment have shown positive

results. Key findings included faster healing rates for venous leg ulcers, reduced rates of ulcer recurrence and a cost–benefit ratio of 27.6, showing strong value for money based on the outcomes achieved (National Wound Care Strategy Programme, 2023; Lee, 2024).

Despite the availability of these tools, the lack of improvement seen in the data presented here highlights barriers to their integration into practice. Addressing clinical inertia, lack of training and diagnostic delays could be key to overcoming these challenges and achieving real progress.

Relieving the burden of wound care

Community and hospital resources

Stagnating wound outcomes ultimately contribute to a high resource burden on healthcare systems, including strain on community nursing teams, hospital resources and overall healthcare costs. From 2017–25, most wound care appointments lasted 20–30 minutes, but more complex cases took up to 1 hour per appointment. Additionally, community nurses were travelling an average distance of 3–4 miles to treat patients in their homes, involving at least two visits per patient per week. This not only represents a significant temporal burden on community nurses, an already stretched staffing resource, but also additional cost, product use and travel emissions.

Failure to deliver timely wound healing increases the risks of complications, some of which may require more intensive and expensive intervention. For wounds with available admission data, the average hospitalisation rate across the whole sample was 23.2%. This means that more than one in five wounds required the patient to undergo an inpatient admission, increasing to almost one-third in some years. This demonstrates the high contribution of wounds to inpatient admissions, likely contributing to cost, time and staffing burdens in the acute sector. The human cost also cannot be overstated, with avoidable admissions increasing the risk of nosocomial infections, functional decline and emotional trauma in an already-vulnerable individual (Schattner, 2023).

To achieve the 10 Year Health Plan's ambitions to shift care from hospital to community, the multi-faceted impact of wounds on the population and healthcare system must be reflected in policy, with systemic change to support community-based wound care.

Product use

This survey revealed a reduction in the mean number of dressing changes per week. There may be various reasons for this, one possible explanation being greater use of high-absorbency or advanced dressings with longer wear times. Survey data also showed an overall reduction in wound infection rates between 2017 and 2025, although this trend was inconsistent from 2019 to 2024 and was not accompanied by a reduction in antimicrobial use. This may indicate increasing use of topical antimicrobials to address early or covert signs of infection, potentially preventing progression to overt infection. The observed association between wound infection, healing status and wound duration highlights the importance of effective infection control. Antimicrobials should therefore be used in an informed and targeted manner, alongside preventative strategies, while remaining aware of antimicrobial resistance.

The proportion of wounds receiving full compression remained lower than the proportion of leg ulcers, indicating limited progress in optimising compression use among eligible patients. The National Wound Care Strategy Programme (2023) recommends first-line use of at least mild compression for the majority of lower-limb ulcers, with avoidance only in defined high-risk situations. Persistent variation in compression use may reflect ongoing barriers, such as limited clinician expertise, patient discomfort, low health literacy and physical constraints (Stevenson et al, 2024). Urgent attention is needed to address this variation and ensure that patients receive guideline-recommended care as early as possible, to prevent progression to non-healing.

Costs

The costs associated with wound treatment interventions are substantial but often invisible to commissioners and budget holders, who tend to focus on short-term consumables costs that mainly impact isolated budgets. The disparate commissioning landscape further contributes

to a lack of clear wound care expenditure. Interventions may be managed across multiple budgets, including being locally funded or part-funded through the integrated care board, making it difficult to track the holistic costs associated with wound care (Public Policy Projects, 2023).

There are currently few incentives or drivers to explore and understand the holistic costs to the system, despite national evidence from integrated care boards and provider organisations of the operational and financial benefits of adopting direct supply and digital wound systems (Phillips, 2025; Phillips and Robinson, 2025). The impacts of delayed healing, avoidable complications and repeated interactions with urgent and emergency care are not always captured in headline performance indicators, but have a substantial effect on patient outcomes and system efficiency. Instead, the focus is often on the relatively small amount of expenditure on consumables, which earlier research has suggested account for only 6% of the total cost of wound care (Guest et al, 2020). This is reflected by the current national drive to focus on unit cost of wound dressings rather than treatment costs, which is arguably distracting from greater waste reduction opportunities that exist in the system.

Holistically, greater savings could be made through improved adherence to evidence-based care and, ultimately, reduced incidence of non-healing wounds, which contribute a major proportion of the total cost of wound care – substantially greater than the cost of consumables (Guest et al, 2020). Furthermore, while more efficient use of existing resources, such as freeing up clinician time to manage other cases, may not directly contribute to short-term cost savings, it could expand clinical workload, ultimately reducing waiting times and improving patient outcomes. This challenge will remain if there continues to be an absence of subjective leadership and visibility at senior levels of provider organisations and integrated care boards.

It follows that improving the time to achieve healing has the potential to drastically reduce the overall resource burden associated with care. Any additional costs associated with a more effective treatment leading to faster healing could potentially be offset by the avoided future costs (Lindholm and Searle, 2016). Advanced and clinically effective treatments can be more cost effective overall (Lindholm and Searle, 2016), even if they are more expensive on a unit-by-unit basis compared with standard care. This has been seen for other advanced wound management devices (Guest et al, 2018; Kerivan et al, 2025).

Human burden

Previous literature has identified factors with the greatest impact on quality of life for this population, including wound pain, functional limitations, sleep impairments and disappointment with treatment (Hareendran et al, 2005; Herber et al, 2007; Mallick et al, 2020; Atkin et al, 2021). These factors were well represented in the 2025 cohort in this data pool, with the most common effects being wound-related pain, reduced socialisation and limitations on activities of daily living. The chronic pain associated with non-healing wounds can further disrupt social roles, undermine personal identity and reduce participation in work and community life (Herber et al, 2007). These issues can significantly affect patients' quality of life and lead to feelings of isolation and hopelessness (Renner and Erfurt-Berge, 2017). Mental health problems are also common in this population, with around 30% of patients with a non-healing wound showing signs of depression or anxiety (Renner and Erfurt-Berge, 2017).

This highlights both the human impact of non-healing wounds treated in the community and the potential implications for other areas of the healthcare system, such as mental health services and frailty pathways. Efforts must be made to increase the visibility of these impacts across the system, as improvement initiatives in wound care could potentially reduce the pressure on other high-demand NHS services.

Tackling system inefficiencies

Joining up wound management services

Although most day-to-day wound care takes place in the community, supporting services are fragmented across primary, community, acute and specialist settings. Non-healing wounds have been deprioritised and are often managed within the scope of other long-term health conditions, meaning that there is no unified approach to wound management and

these patients can become ‘hidden’ in the system. Wound management frequently falls between service lines and, contrary to evidenced best practice, patients often do not have access to multidisciplinary care pathways (Atkin et al, 2021). This differs from other well-defined long-term conditions, such as diabetes and heart failure, where patients benefit from targeted investment, national registries and well-established models of care with coordinated multidisciplinary teams (Atkin et al, 2021).

This fragmentation was evident in this dataset. Patients being treated in the community were seen in various settings and by a range of healthcare professionals. Most patients were seen by registered nurses (75.5%) and/or healthcare assistants (19.3%), with a significantly lower proportion having access to wound care specialist nurses (4.7%) and podiatrists (0.5%). This split in access may point towards a lack of specialist care and/or limited staffing and investment in wound services.

In contrast, diabetic foot ulcers are managed within well-established multidisciplinary team models, bringing together diabetology, podiatry, vascular surgery, orthopaedics, microbiology and specialist nursing (National Institute for Health and Care Excellence, 2019). This multidisciplinary approach has been shown to reduce fragmentation and improve access to specialist interventions, and is associated with better outcomes, including reduced amputation rates and improved healing (Yousuff et al, 2025). Given the success of multidisciplinary team-led diabetic foot care in improving provision, access and outcomes, there is a strong case for applying a similar coordinated, multidisciplinary model to the wider wound care population to address current system fragmentation and inequity (Palladino et al, 2022).

The causes of fragmented wound management are varied but typically stem from a lack of defined systemic governance structures and strategic focus on non-healing wound care at a national level. There are currently no nationally mandated metrics or reporting requirements related to wound outcomes (Public Policy Projects, 2023), and metrics at the national, regional and institutional level are typically poor. However, change may be coming: the 10-Year Health Plan has recommended a shift, over time, from block payments to year of care payments, which changes the focus from funding based on a fixed, lump sum for a broad service to an outcomes-focused model designed to incentivise preventative, integrated care for people with long-term conditions (NHS Confederation, 2025).

Remote care

It may be possible for select patients to perform self-care with access to healthcare professionals if required, or in some cases with remote advice (e.g. via phone or video call). Such initiatives have the potential to reduce the resource burden of routine and straightforward wound dressing changes, freeing up community nurses’ time to focus on more complex cases.

Several variables must be considered to determine patient suitability for remote, digitally-supported care, including their physical and mental capacity to conduct dressing changes, the nature of the wound, availability of family/carer support and whether more complex treatment is required. In this dataset, clinicians felt that most patients would not be able to cope with virtual appointments, with the main reason being the individual being unable to attend to their own wound. However, this suggests that one-quarter of the community case load of wounds could be eligible for remote, supported self-care (24.4% and 23.9% in 2024 and 2025, respectively). There is a growing understanding of self-management, but if nursing teams are not trained to consider this at first contact and given access to the correct resources, this will remain an under-used option for care. While virtual appointments could benefit capacity and workforce planning, its implementation requires a paradigm shift in the community nursing sphere, one that should be seriously considered.

Future care strategies

Preventative care

In both the 2024 and 2025 cohorts, over 65% of wounds occurred in individuals with other health conditions. Key contributors included diabetes, cardiovascular disease, hypertension, obesity and poor nutrition, all of which are considered modifiable risk factors in a substantial

proportion of cases. The National Wound Care Strategy Programme's (2023) guidance emphasises early risk identification and preventative care, including nutritional support and management of underlying conditions, as critical to improving outcomes. However, several disparities in the wound population have been identified, particularly those associated with social determinants of health, such as socioeconomic status and social capital (Costa et al, 2022; Sen, 2025). Each provider organisation should monitor local demographics and tailor the design of healthcare services to address future trends in population needs.

There is a need for more preventative and proactive treatment of non-healing wounds, including earlier interventions and strategies to alleviate systemic burdens. Currently, wounds are often addressed as a standalone issue, rather than as an important part of the patient's holistic health status and, often, a symptom of a long-term condition. This means that efforts to prevent non-healing wounds are undervalued and underprioritised in the healthcare system.

One exception to this is the shift in attitudes towards pressure ulcers over the last 20 years. Now often seen as a preventable harm, many institutions have invested in education, training and the adoption of evidence-based protocols to reduce the risk of pressure ulcer formation. These efforts have been effective in acute care settings, but formal prevention protocols are less well integrated in community settings (Aloweni et al, 2024). In the present dataset, no decrease in the proportion of pressure ulcers was found (Figure 1c), with this wound type consistently representing around 15–20% of the wounds being managed in the community since 2017. This suggests that more work is needed to support wound prevention in community settings across all indications. Innovative solutions, such as classifying a poorly managed lower limb condition as a harmful event, need to be explored and implemented in order to resolve the current wound crisis.

The neighbourhood health model may further improve preventative care, as the model emphasises place-based, multidisciplinary working to proactively address population health needs before significant deterioration (Morris et al, 2025). In community wound care, this approach could support earlier identification of risk factors, enabling preventative interventions, continuity of care and long-term condition management (NHS England, 2025a).

Data as a driver of change

Many centres that participated in this initiative chose to submit their data anonymously. While having this option likely encouraged engagement, it meant that regional- and country-specific analyses were not possible. Collecting comprehensive geographical data of this kind for wound care would likely require a coordinated approach, driven from within the NHS, with clear targets and incentives for completion. That said, the data collection initiative discussed here is ongoing, and regional analysis with these data may become possible in the coming years.

The 8164 wounds submitted with geographical information suggest a UK-wide reach over a number of years, but with activity remaining modest relative to the population and organisational coverage of each region. There were considerable variations in participation, both between and within regions across time. This likely reflects the reliance of wound care data collection on local, short-term initiatives, which are vulnerable to time, funding and staffing changes. This contributes to the ongoing invisibility of patients with wounds, and particularly those with non-healing wounds, within broader population health frameworks. Where participation has occurred, it may reflect the commitment of individual clinicians rather than a sustainable, coordinated regional or national mandate. This locally driven pattern risks reinforcing existing inequalities in wound care visibility, investment and workforce prioritisation. Further limitations of the present data analysis are shown in Box 1.

This inconsistency highlights the need for systematic approaches to wound surveillance and improvement in the UK, focusing on regional coordination through integrated care boards and strategic clinical networks, aligning local audit participation with population-based commissioning objectives (Public Policy Projects, 2023). Strengthening regional oversight would not only improve data completeness but also ensure that the burden of non-healing wounds is more accurately represented in policy and service planning.

Box 1. Limitations of this data analysis

The survey aimed to provide a 'snapshot' overview of the state of wound care in community centres, with centres contributing wound data from just 1 week per year; although not every centre contributed to the dataset every year. Furthermore, each centre was able to choose which week of the year to complete the survey in. This means that confounding variables may have affected the comparisons made between years and wound- or patient-related factors. For example, seasonal variation may have affected the quantity and characteristics of wounds that presented, as healing is typically slower in colder weather. Additionally, although clinicians were actively encouraged to collect data at the point of care, some may have done this retrospectively, introducing recall bias. Similarly, clinicians may have been less likely to complete the survey during busy periods, possibly affecting the results.

The dataset did not provide equivalent coverage for each study year; some years contained data that spanned all 12 months, while others represented only a few months, and the 2025 dataset was incomplete at the time of analysis. Consequently, annual denominators varied substantially, and fluctuations in estimates may reflect differences in case capture rather than true changes in clinical practice. The period covering the COVID-19 pandemic and its immediate aftermath (2020–22) was associated with a marked reduction in survey responses. These years were included in the primary analysis because they reflect real-world system pressures, but the reduced case counts may have skewed estimates relative to other years.

Around one-fifth of the data with geographical information available were sourced from non-UK countries (*Appendix 1*), but the representation of these countries across the whole dataset is unknown. This would have influenced the findings and potentially the themes discussed in relation to the UK healthcare system. Furthermore, all data were collected from centres that had an existing relationship with Smith+Nephew, which could have biased the results. Although it was not feasible to calculate this sample as a proportion of the total number of wounds present across the UK, it cannot be assumed that this sample is representative of all UK wound characteristics.

The survey instrument was not wholly consistent throughout the study period, with new categories and/or response options introduced in 2024 and 2025. Occasionally, terminology varied between years. This was done to reflect changes in national and local healthcare influences, but presents limitations in comparison of the data across years. Data collection is still ongoing, so future data will allow more in-depth comparison with the 2024 and 2025 datasets in years to come. It is also important to note that risk factor and comorbidity data were combined in the survey, with risk factors including characteristics that would not be classified as comorbidities (e.g. ethnicity, deprivation). Therefore, these results cannot accurately represent multimorbidity. Additionally, each point of data represents a single wound, rather than a single patient, so multiple data entries would have been made for a single patient with multiple wounds, possibly skewing results.

Data were missing across several indicators, leading to varied denominators by indicator and year, and outcomes may be underestimated where data entry was incomplete. Very low case counts in certain categories required exclusion from statistical testing, limiting comparability across the full data collection period. Although the results have some inconsistencies, this is due to the broad scope of the data—spanning multiple years, healthcare centres and wound indicators—enabling temporal and real-world analysis that extends well beyond the scope of previously published wound-care datasets.

A community currency approach has gained traction in recent years, as a means of grouping individuals with similar clinical characteristics together to plan support, funding and resources into a bundle of care, based on standardised assessments (NHS England, 2025a). Before implementation of this, or other data-driven approaches, can become a reality, standardised data need to be widely and rigorously collected. Currently, inconsistent reporting means that wound care lacks a reliable evidence base. There is variation in how non-healing wounds are defined and classified across institutions, regions and healthcare systems, as well as differences in how data are collected and reported. Even standardised terminology has not been comprehensively adopted; in some regions, any lower-limb wound in a patient with diabetes is automatically categorised as a 'diabetic foot ulcer', even if it may actually be a pressure injury or other condition. This lack of parity in reporting make it difficult to collate or compare data between different systems, which in turn limits the development of effective care protocols or sharing of best practice between institutions or regions. Standardisation of data recording thus has the potential to unlock systemic change for patients receiving wound care.

Future models of care

A more integrated, uniform and holistic approach to the treatment of non-healing wounds is needed for effective prevention (Harding and Queen, 2019). In order to achieve better outcomes, innovations in services, systems and processes associated with wound management may be equally as important as treatment innovations (Harding and Queen, 2019). There

is an opportunity to leverage existing local and national priorities and policies, such as the 10-Year Health Plan's shifts from treatment to prevention and from hospital to community (NHS England, 2025b). Across the system, there is a call to address fragmentation, poor communication, siloed working and suboptimal care through an integrated response.

The persistent burden of non-healing wounds seen here, and the absence of improvement in healing duration over 8 years of data collection, highlight the need for redesigned models of care rather than further optimisation of existing fragmented practice. Clinicians should prioritise early expert assessment, as delays of up to 57 days to correct diagnosis have been reported (Ahmajärvi et al, 2022), contributing to prolonged chronicity, infection risk and avoidable hospital admissions.

Evidence from the Manchester Amputation Reduction Strategy (MARS) demonstrated that system-level organisation—specifically, rapid access to podiatry and vascular expertise, clear escalation pathways and multidisciplinary triage—can result in markedly improved outcomes, including a 46% reduction in major amputation prevalence over 6 years (Ahmad et al, 2024). Applying similar multidisciplinary team-based pathway standards to all lower-limb wounds could significantly shorten healing time and reduce the downstream resource burden on already stretched community services.

Change efforts should also focus on freeing up clinical capacity within existing resources. Using extended-wear and evidence-based dressings, increasing appropriate compression use and activating supported self-care for suitable patients can reduce the number of district nursing visits required (National Wound Care Strategy Programme, 2020). Value-based procurement principles could further support clinicians by ensuring that product choices are linked to outcomes rather than unit price, enabling access to advanced treatments that are more cost effective across the whole pathway (Lindholm and Searle, 2016).

Addressing inequalities through systematic risk identification, consistent adoption of diagnostic bundles and neighbourhood-level intervention is essential. Patients with multimorbidity, frailty and socioeconomic disadvantage have poorer healing outcomes, reinforcing the importance of structured, preventative and multidisciplinary care to improve system efficiency, equity and patient quality of life.

In the current system, failure to define an appropriate coding and reporting structure has led to fragmented services, where care is shifted and not shared, with cases hidden in complex commissioning arrangements. The drive for neighbourhood health provision with locally delivered services offers an opportunity to implement a benchmarking structure that is fit for the future, driving higher standards of care, with an aim to decrease the proportion of non-healing wounds and reduce the financial burden. A structured and mandated approach to the delivery of shared care records across health and social care could enable consideration of each patient across service boundaries, ultimately reducing variations in care.

Meanwhile, implementation of nationally defined benchmarking is becoming increasingly urgent, as geographical and regional variations continue to widen, given stagnation in community care. Local healthcare leaders and managers must prioritise reducing handovers and increasing access to care in community service delivery. Care systems must urgently implement change in order to support a reduction in the overall wound care burden in the future.

Steering the change

The changes recommended in this report are as urgent as they are ambitious, and will require coordinated leadership to ensure effective, sustainable implementation across the healthcare system. Establishing strategic steering groups at integrated care system level is a key step to achieving these aims. Membership of each region's steering group should reflect the multi-faceted presentation and impact of wounds on the population and healthcare services, as shown in **Figure 3**. The key purpose of the steering group should encompass:

- Providing strategic leadership for wound care across the integrated care system
- Setting and measuring performance metrics (healing rates, variation, activity/cost, inequalities etc)

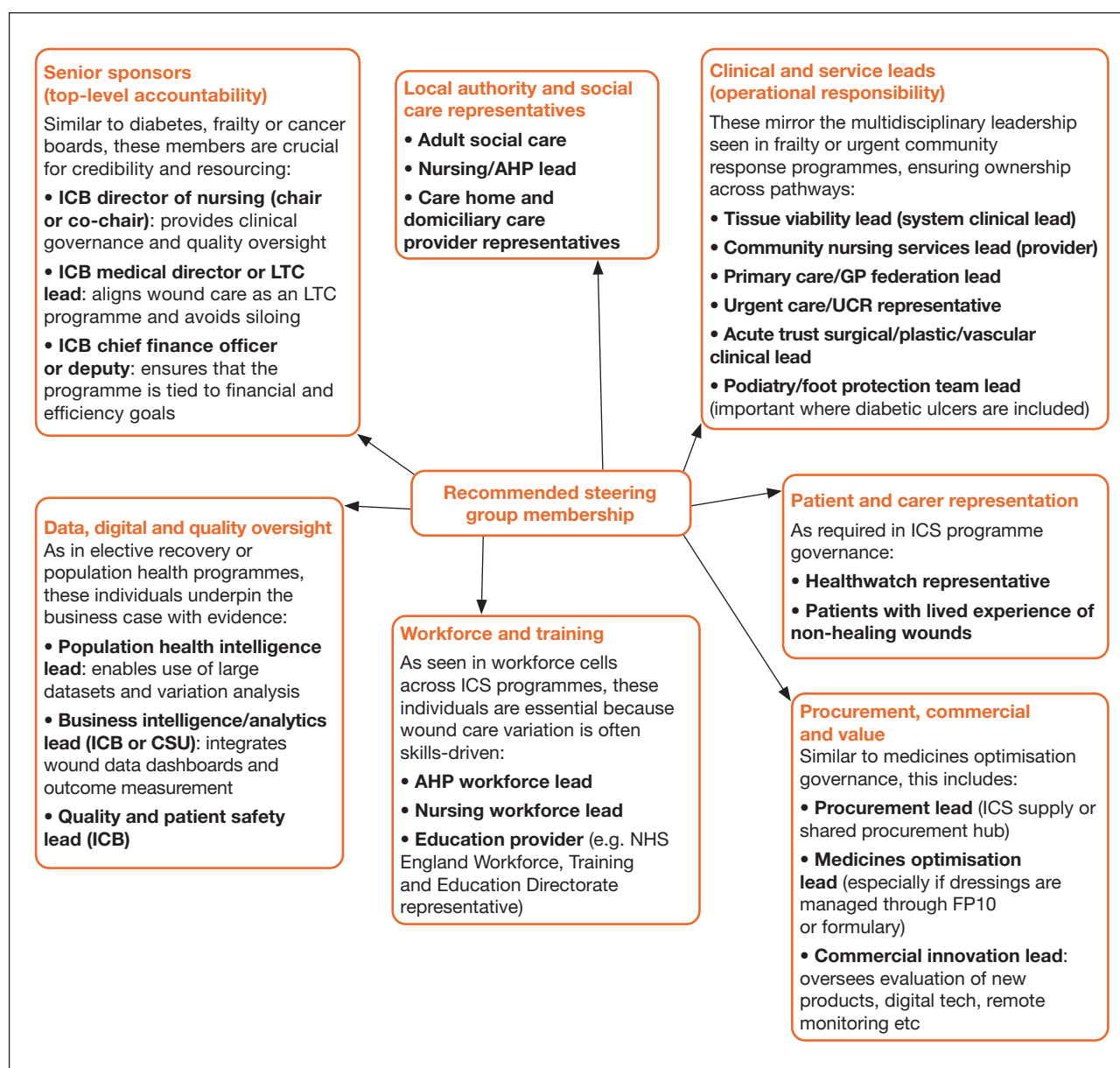


Figure 3. Recommended membership for wound care strategic steering group. AHP=allied health professional; CSU=commissioning support unit; ICB=integrated care board; ICS=integrated care system; LTC=long-term conditions; UCR=urgent community response.

- Overseeing pathway redesign and commissioning intentions
- Aligning workforce, data, procurement and digital workstreams
- Ensuring that wound care becomes, and remains, a system priority, not solely a community nursing issue.

Conclusions

The 8 years of data presented in this report demonstrate that best practice wound care is still not consistently implemented and that meaningful improvements in outcomes have failed to materialise, despite advances in treatments and development of more effective care processes. This prolonged stagnation is not coincidental; it reflects a systemic failure driven by fragmented and poorly integrated wound care services, inconsistent commissioning and funding arrangements, and an absence of clear responsibility and accountability for outcomes at a system level.

Non-healing wounds represent a significant and growing population health challenge, associated with avoidable harm, widening health inequalities and escalating demand on services. This is a population whose risk is both identifiable and modifiable. Reducing harm, preventing deterioration and intervening earlier in groups at higher risk are precisely the circumstances for which integrated care systems were designed. The analytical, commissioning, workforce and improvement functions required to address this issue already exist within systems, yet they have not been coherently applied to this population of patients.

Addressing this requires a concerted and urgent effort at governmental, national and local levels to establish clear ownership of these patients, prioritise risk stratification, prevention and early intervention, and ensure consistent implementation of evidence-based care across all pathways. Without decisive action, poor outcomes for people living with non-healing wounds will continue to be a tolerated reality in the UK—despite the scale of the problem, and despite systems being explicitly designed to prevent exactly this type of failure.

Investing in structured, data-driven wound care pathways offers a major opportunity to improve patient outcomes while alleviating pressure across primary, community and acute care settings. Further monitoring of wound care could support increased funding, as seen with other long-term conditions, such as diabetes and heart failure. Effective wound care is not only a matter of clinical quality, but also a marker of system efficiency, safety and value. Recognition at national level is key to changing the lived experiences of patients with non-healing wounds and reducing the system-wide waste within this population.

The persistent burden of non-healing wounds and lack of improvement in outcomes over time demonstrate that incremental optimisation of fragmented services is insufficient. Redesigned, integrated models of care that are aligned with national priorities for prevention and community-based delivery are urgently required. Implementing multidisciplinary, system-level approaches—supported by national benchmarking, shared care records and neighbourhood health teams—offers a sustainable route to reducing variation, improving healing outcomes and alleviating the growing clinical and financial burden of wounds.

To find out more about this data collection initiative, readers are encouraged to contact Jacqui Hughes at jacqui.hughes@smith-nephew.com.

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Key points

- This report presents a data pool of 19472 wounds, collected from January 2017 to March 2025. This initiative is ongoing, with the total dataset now surpassing 20000 wounds.
- Wound care outcomes showed stagnation, with no significant improvement in the proportion progressing to healing within expected timeframes, and fairly consistent hospital admission rates of over 20%.
- A national approach to wound care is urgently required to address these, included mandated reporting requirements and a strategic focus on non-healing wounds, which represent a disproportionate cost and resource burden on the NHS.
- It is time that policymakers and healthcare leaders see wound care as an important area of opportunity to redesign models of care and enable the strategic shifts from sickness to prevention, and hospital to community care.

Conflicts of interest

The development of this article was sponsored by Smith+Nephew. Authors NA, GW and HS received honoraria for their contributions. Author JH is an employee of Smith+Nephew.

References

- Ahmad N, Ravenscroft R, Sharpe A et al. Amputation inequalities across a large metropolitan area of England and effect of a 'high-risk' rather than 'diabetes-only' multidisciplinary approach to lower-limb wound care 2015/16 to 2021/22. *Diabet Foot J.* 2024;27(1):20–27
- Ahmajärvi K, Isoherranen K, Venermo M. Cohort study of diagnostic delay in the clinical pathway of patients with chronic wounds in the primary care setting. *BMJ Open.* 2022;12(11):e062673. <https://doi.org/10.1136/bmjopen-2022-062673>
- Aloweni F, Lim SH, Gunasegaran N, Ostbye T, Ang SY, Siow KCE. Community-acquired pressure injuries: prevalence, risk factors and effect of care bundles-an integrative review. *J Clin Nurs.* 2024;33(12):4618–4634. <https://doi.org/10.1111/jocn.17431>
- Atkin L, Hopkins A, Gardner S et al. Making legs matter: a case for system change and transformation in lower-limb management. *J Wound Care.* 2021;30:S1–28. <https://doi.org/10.12968/jowc.2021.30.Sup11.S1>
- British Lymphology Society. Assessing vascular status in the presence of chronic oedema prior to the application of compression hosiery: position document to guide decision making. 2019. <https://legsmatter.org/wp-content/uploads/2020/04/Assessing-Vascular-Status-in-the-presence-of-Chronic-Oedema.pdf> (accessed 12 January 2026)
- Costa D, Ielapi N, Caprino F et al. Social aspects of diabetic foot: a scoping review. *Social Sciences.* 2022;11(4):149
- Guest J. Burden of wounds to the NHS: what has changed since 2012/13? 2021. <https://wounds-uk.com/wp-content/uploads/2023/02/68803cd147c4d81a02b9cc56823f19a1.pdf> (accessed 12 January 2026)
- Guest JF, Singh H, Rana K, Vowden P. Cost-effectiveness of an electroceutical device in treating non-healing venous leg ulcers: results of an RCT. *J Wound Care.* 2018;27(4):230–243. <https://doi.org/10.12968/jowc.2018.27.4.230>
- Guest JF, Fuller GW, Vowden P. Cohort study evaluating the burden of wounds to the UK's National Health Service in 2017/2018: update from 2012/2013. *BMJ Open.* 2020;10(12):e045253. <https://doi.org/10.1136/bmjopen-2020-045253>
- Harding K, Queen D. Innovation and inertia in wounds. *Int Wound J.* 2019;16(5):1079. <https://doi.org/10.1111/iwj.13229>
- Hareendran A, Bradbury A, Budd J et al. Measuring the impact of venous leg ulcers on quality of life. *J Wound Care.* 2005;14(2):53–57. <https://doi.org/10.12968/jowc.2005.14.2.26732>
- Herber OR, Schnepf W, Rieger MA. A systematic review on the impact of leg ulceration on patients' quality of life. *Health Qual Life Outcomes.* 2007;5:44. <https://doi.org/10.1186/1477-7525-5-44>
- Kanwal B. Rising costs, hidden risks: the unseen epidemic of wound care. 2024. <https://integratedcarejournal.com/rising-costs-hidden-risks-unseen-epidemic-wound-care/> (accessed 12 January 2026)
- Kerivan LT, Vilain KA, Hill TM, Guidry CA. Closed incisional negative pressure wound therapy is cost-effective at reducing superficial surgical site infections. *Surg Infect (Larchmt).* 2025;26(6):413–419. <https://doi.org/10.1089/sur.2024.286>
- Lee R. A system approach to lower limb wound care. *Wounds UK.* 2024;20(4):8–9
- Life Sciences Organisation. Advanced wound care: develop new treatments in the UK. 2018. <https://www.gov.uk/government/publications/advanced-wound-care-develop-treatments-in-the-uk/advanced-wound-care-develop-new-treatments-in-the-uk> (accessed 12 January 2026)
- Lindholm C, Searle R. Wound management for the 21st century: combining effectiveness and efficiency. *Int Wound J.* 2016;13(Suppl 2):5–15. <https://doi.org/10.1111/iwj.12623>
- Mahmoudi M, Gould LJ. Opportunities and challenges of the management of chronic wounds: a multidisciplinary viewpoint. *Wound Care.* 2020;7:27–36
- Mallick S, Sarkar T, Gayen T, Naskar B, Datta A, Sarkar S. Correlation of venous clinical severity score and venous disability score with dermatology life quality index in chronic venous insufficiency. *Indian J Dermatol.* 2020;65(6):489–494. https://doi.org/10.4103/ijdr.IJD_485_20
- Morris L, Baird B, Charles A. What is neighbourhood health? 2025. <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-is-neighbourhood-health> (accessed 12 January 2026)
- National Institute for Health and Care Excellence. Diabetic foot problems: prevention and management. 2019. <https://www.nice.org.uk/guidance/ng19/chapter/Recommendations> (accessed 12 January 2026)

- National Wound Care Strategy Programme. Lower limb recommendations. 2020. <https://thehealthinnovationnetwork.co.uk/wp-content/uploads/2020/10/@NWCSP-Lower-Limb-Recommendations-13.10.20.pdf> (accessed 12 January 2026)
- National Wound Care Strategy Programme. Pressure ulcer recommendations and clinical pathway. 2023. <https://www.oxfordhealth.nhs.uk/wp-content/uploads/sites/51/2025/01/NWCSP-PU-Clinical-Recommendations-and-pathway-final-24.10.23.pdf> (accessed 12 January 2026)
- National Wound Care Strategy Programme. National Wound Care Strategy Programme: improving wound care for people with leg and foot ulcers, surgical wounds and pressure ulcers. 2025. <https://thehealthinnovationnetwork.co.uk/our-programmes/wound-care/national-woundcare-strategy-programme/> (accessed 12 January 2026)
- NHS Confederation. Ten-year health plan: what you need to know. 2025. <https://www.nhsconfed.org/publications/ten-year-health-plan-what-you-need-know> (accessed 12 January 2026)
- NHS England. Neighbourhood health guidelines 2025/26. 2025a. <https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/> (accessed 12 January 2026)
- NHS England. 2025/26 Priorities and operational planning guidance. 2025b. <https://www.england.nhs.uk/publication/2025-26-priorities-and-operational-planning-guidance/> (accessed 12 January 2026)
- Office for National Statistics. Profile of the older population living in England and Wales in 2021 and changes since. 2023. <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/profileoftheolderpopulationlivinginenglandandwalesin2021andchangessince2011/2023-04-03> (accessed 12 January 2026)
- Palladino R, More A, Greenfield G et al. Evaluation of the North West London diabetes foot care transformation project: a mixed-methods evaluation. *Int J Integr Care*. 2022;22(2):4. <https://doi.org/10.5334/ijic.5956>
- Palmer B, Dodsworth E, Julian S. District nursing: understanding the decline and mapping the future. 2025. <https://www.nuffieldtrust.org.uk/research/district-nursing-understanding-the-decline-and-mapping-the-future> (accessed 12 January 2026)
- Phillips K. Regional integrated care board: system-wide, collaborative, improvement-led delivery to reduce variation and increase cost-effective wound care procurement products. *Wounds UK*. 2025;21(3):20–26
- Phillips K, Robinson H. Developing wound care formularies that can be brought to life to simplify use and increase accessibility. *Wounds UK*. 2025;21(4):16–23
- Public Policy Projects. Going further for wound healing: assessing unmet needs and proposing transformational reform of UK wound management. 2023. <https://publicpolicyprojects.com/wp-content/uploads/2023/10/PPP-Wound-Healing-Report-1023.pdf> (accessed 12 January 2026)
- Renner R, Erfurt-Berge C. Depression and quality of life in patients with chronic wounds: ways to measure their influence and their effect on daily life. *Wound Care*. 2017;4:143–151
- Sen CK. Human wound and its burden: updated 2025 compendium of estimates. *Adv Wound Care (New Rochelle)*. 2025;14(9):429–438. <https://doi.org/10.1177/21621918251359554>
- Schattner A. The spectrum of hospitalization-associated harm in the elderly. *Eur J Intern Med*. 2023;115:29–33. <https://doi.org/10.1016/j.ejim.2023.05.025>
- Society of Tissue Viability. Society of tissue viability. 2026. <https://societyoftissueviability.org/> (accessed 12 January 2026)
- Stevenson EM, Coda A, Bourke MD. Investigating low rates of compliance to graduated compression therapy for chronic venous insufficiency: a systematic review. *Int Wound J*. 2024;21(4):e14833
- UK Government. Fit for the future: the 10 year health plan for England. 2025. <https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future> (accessed 12 January 2025)
- Urwin S, Dumville JC, Sutton M, Cullum N. Health service costs of treating venous leg ulcers in the UK: evidence from a cross-sectional survey based in the north west of England. *BMJ Open*. 2022;12(1):e056790. <https://doi.org/10.1136/bmjopen-2021-056790>
- World Health Organization. Health data overview for the United Kingdom of Great Britain and Northern Ireland. 2025. <https://data.who.int/countries/826> (accessed 12 January 2025)
- Yousuff M, Htwe N, Joumah A, Jayan J, Vasukutty N. Improving diabetic foot care through a multidisciplinary clinic: experience from pilgrim hospital, UK. *Cureus*. 2025;17(10):e95480. <https://doi.org/10.7759/cureus.95480>

Appendices

Appendix 1

Appendix 1. Geographical distribution of wounds with non-anonymous data from 2023–25

Region	2023, <i>n</i>	2024, <i>n</i>	2025, <i>n</i>	Total, <i>n</i> (%)
England Central	360	1063	0	1423 (17.4)
England North East	1110	274	1236	2620 (32.1)
England North West	101	0	0	101 (1.2)
England South East	153	205	0	358 (4.4)
England South West	54	0	203	257 (3.1)
Northern Ireland	128	0	0	128 (1.6)
Scotland	167	206	584	957 (11.7)
Wales	124	606	0	730 (8.9)
Non-UK countries	1409	0	181	1590 (19.5)
Total, <i>n</i> (%)	3606 (44.2)	2354 (28.8)	2204 (27.0)	8164 (100.0)

Appendix 2

Appendix 2.1. Patient demographics: age, 2024–25

Age	2024 (<i>n</i> =1805)	2025 (<i>n</i> =2180)
<65 years, <i>n</i> (%)	342 (18.9)	461 (21.1)
>65 years, <i>n</i> (%)	1463 (81.1)	1719 (78.9)

Appendix 2.2. Patient demographics: risk factors, 2024

Risk factor (<i>n</i> =1805)	<i>n</i> (%)
Total cases with risk factors	1230 (68.1)
Cardiovascular disease	385 (21.3)
Peripheral vascular disease	50 (2.8)
Chronic obstructive pulmonary disease	101 (5.6)
Chronic pain	73 (4.0)
Diabetes	455 (25.2)
Immunosuppression	85 (4.7)
Obesity	228 (12.6)
Malnutrition	216 (12.0)
Tobacco/nicotine use	105 (5.8)
Intravenous drug use (illicit)	4 (0.2)
Other	271 (15.0)

Appendix 2.3. Patient demographics: risk factors, 2025

Risk factor (n=2210)	n (%)
Total cases with risk factors	1456 (65.9)
Alcohol dependency	38 (1.7)
Cancer/malignancy	189 (8.6)
Cardiovascular disease	392 (17.7)
Peripheral vascular disease	140 (6.3)
Chronic obstructive pulmonary disease	123 (5.6)
Chronic kidney disease	220 (10.0)
Diabetes	503 (22.8)
Hypertension	417 (18.9)
Immunosuppression	34 (1.5)
Obesity/high body mass index	320 (14.5)
Malnutrition/undernutrition	174 (7.9)
Tobacco/nicotine use	167 (7.6)
Mental health disorder	188 (8.5)
Lack of social/carer support	147 (6.7)
Socioeconomic deprivation	129 (5.8)
Ethnic minority	7 (0.3)
Other	12 (0.5)

Appendix 3**Appendix 3. Key wound healing metrics, 2017–25**

Characteristic	All years	2017	2018	2019	2020	2021	2022	2023	2024	2025	P value, effect size*
Total	18802	1126	2688	5427	840	1031	604	3096	1787	2203	
Wound duration, n (%)											P<0.001, $\eta^2=0.059$
6 weeks or less	7305 (38.9)	398 (35.3)	1026 (38.2)	2290 (42.2)	359 (42.7)	447 (43.4)	229 (37.9)	1028 (33.2)	686 (38.4)	842 (38.2)	
>6 weeks–3 months	2917 (15.5)	159 (14.1)	471 (17.5)	789 (14.5)	128 (15.2)	165 (16.0)	118 (19.5)	496 (16.0)	269 (15.1)	322 (14.6)	
>3–6 months	2437 (13.0)	183 (16.3)	376 (14.0)	719 (13.2)	117 (13.9)	140 (13.6)	86 (14.2)	381 (12.3)	180 (10.1)	255 (11.6)	
>6–9 months	1285 (6.8)	75 (6.7)	153 (5.7)	331 (6.1)	59 (7.0)	54 (5.2)	47 (7.8)	248 (8.0)	143 (8.0)	175 (7.9)	
>9–12 months	1070 (5.7)	70 (6.2)	130 (4.8)	266 (4.9)	29 (3.5)	56 (5.4)	22 (3.6)	215 (6.9)	113 (6.3)	169 (7.7)	
>12 months	3788 (20.1)	241 (21.4)	532 (19.8)	1032 (19.0)	148 (17.6)	169 (16.4)	102 (16.9)	728 (23.5)	396 (22.2)	440 (20.0)	

Appendix 3. Key wound healing metrics, 2017–25

Characteristic		All years	2017	2018	2019	2020	2021	2022	2023	2024	2025	P value, effect size*
Wound healing status, <i>n</i> (%)	Total	16242	1057	2456	4885	803	913	556	2488	1400	1684	<i>P</i> <0.001, η =0.083
	Deteriorating	1398 (8.6)	110 (10.4)	234 (9.5)	394 (8.1)	55 (6.8)	83 (9.1)	48 (8.6)	232 (9.3)	102 (7.3)	140 (8.3)	
	Improving	9553 (58.8)	640 (60.5)	1507 (61.4)	2999 (61.4)	484 (60.3)	566 (62.0)	347 (62.4)	1169 (47.0)	827 (59.1)	1014 (60.2)	
	Non-healing/static	5291 (32.6)	307 (29.0)	715 (29.1)	1492 (30.5)	264 (32.9)	264 (28.9)	161 (29.0)	1087 (43.7)	471 (33.6)	530 (31.5)	
Wound type, <i>n</i> (%)	Total	18701	1107	2655	5385	837	1029	591	3081	1806	2210	<i>P</i> <0.001, η =0.079
	Burns/traumatic	1377 (7.4)	97 (8.8)	168 (6.3)	439 (8.2)	50 (6.0)	74 (7.2)	34 (5.8)	264 (8.6)	63 (3.5)	188 (8.5)	
	Diabetic foot ulcer	1138 (6.1)	70 (6.3)	155 (5.8)	241 (4.5)	47 (5.6)	45 (4.4)	45 (7.6)	216 (7.0)	87 (4.8)	232 (10.5)	
	Fungating	294 (1.6)	15 (1.4)	51 (1.9)	61 (1.1)	14 (1.7)	10 (1.0)	15 (2.5)	59 (1.9)	31 (1.7)	38 (1.7)	
	Haematoma	150 (0.8)	11 (1.0)	29 (1.1)	48 (0.9)	4 (0.5)	7 (0.7)	1 (0.2)	16 (0.5)	22 (1.2)	12 (0.5)	
	Leg ulcer	5975 (32.0)	374 (33.8)	784 (29.5)	1609 (29.9)	234 (28.0)	342 (33.2)	218 (36.9)	998 (32.4)	637 (35.3)	779 (35.2)	
	Lymphoedema	467 (2.5)	16 (1.4)	44 (1.7)	111 (2.1)	30 (3.6)	22 (2.1)	20 (3.4)	72 (2.3)	67 (3.7)	85 (3.8)	
	Pilonidal sinus	205 (1.1)	8 (0.7)	21 (0.8)	73 (1.4)	9 (1.1)	10 (1.0)	8 (1.4)	28 (0.9)	33 (1.8)	15 (0.7)	
	Pressure ulcer	2796 (15.0)	170 (15.4)	416 (15.7)	663 (12.3)	150 (17.9)	130 (12.6)	87 (14.7)	539 (17.5)	329 (18.2)	312 (14.1)	
	Skin tear	1588 (8.5)	67 (6.1)	250 (9.4)	574 (10.7)	85 (10.2)	69 (6.7)	36 (6.1)	238 (7.7)	85 (4.7)	184 (8.3)	
	Surgical wound	2163 (11.6)	153 (13.8)	337 (12.7)	748 (13.9)	83 (9.9)	144 (14.0)	46 (7.8)	283 (9.2)	145 (8.0)	224 (10.1)	
	Other	2548 (13.6)	126 (11.4)	400 (15.1)	818 (15.2)	131 (15.7)	176 (17.1)	81 (13.7)	368 (11.9)	307 (17.0)	141 (6.4)	
Exudate level, <i>n</i> (%)	Total	17366	889	2062	4872	817	1028	602	3083	1803	2210	<i>P</i> <0.001, η =0.143
	Low	9429 (54.3)	587 (66.0)	1268 (61.5)	2708 (55.6)	447 (54.7)	557 (54.2)	239 (39.7)	1573 (51.0)	877 (48.6)	1173 (53.1)	
	Moderate	4696 (27.0)	248 (27.9)	649 (31.5)	1362 (28.0)	155 (19.0)	220 (21.4)	255 (42.4)	780 (25.3)	427 (23.7)	600 (27.1)	
	High	1111 (6.4)	54 (6.1)	145 (7.0)	297 (6.1)	38 (4.7)	75 (7.3)	40 (6.6)	171 (5.5)	139 (7.7)	152 (6.9)	
	None	2130 (12.3)	0 (0.0)	0 (0.0)	505 (10.4)	177 (21.7)	176 (17.1)	68 (11.3)	559 (18.1)	360 (20.0)	285 (12.9)	
Wound depth, <i>n</i> (%)	Total	14759	1074	2414	4565	709	897	458	2882	1760	-	<i>P</i> <0.001, η =0.089
	Deep	3546 (24.0)	370 (34.5)	603 (25.0)	1013 (22.2)	139 (19.6)	179 (20.0)	158 (34.5)	680 (23.6)	404 (23.0)	-	
	Superficial	11213 (76.0)	704 (65.5)	1811 (75.0)	3552 (77.8)	570 (80.4)	718 (80.0)	300 (65.5)	2202 (76.4)	1356 (77.0)	-	

‘-’ indicates data were not collected, due to changes to the questionnaire which occurred as a means of ensuring relevant data was gathered; η =effect size; *P*<0.05 for each comparison; however effect sizes were negligible (η <0.10); *n*=18 370

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