Transforming Wound Care Technical Report 3: Staff interviews and focus groups

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This technical report along with accompanying technical reports provides a full account of all data sources for the evaluation of the Transforming Wound Care programme and should be read in conjunction with the full evaluation report of that programme.

Summary

The following report provides a description of the approach to collecting and analysing staff interview and focus group data, along with the main messages that arose from analysis of the data.

Key points

- Sixteen interviews and four focus groups with key staff from each Test and Evaluation Site (TES) were conducted.
- The Transforming Wound Care (TWC) programme's key enablers of implementation i.e. people (patients and staff), processes, and technology and data, were used to broadly organise the coding of the interview transcripts.
- Following coding, thematic analysis was carried out to derive key categories from the data.

Successes

- Staff expressed enthusiasm and commitment to the aims of the TWC programme to start patients in compression earlier and ensure consistent pathways.
- The need for staff expertise to deal with the complicated field of wound care was acknowledged and training to upskill those delivering care was being delivered across all sites.
- Staff reported feeling confident that patients are getting better care, and that this is leading to faster healing, improved outcomes, and fewer staff contacts with patients.
- Staff anticipated environmental net zero benefits resulting from the new pathways e.g. fewer appointments for district nurses, fewer miles travelled etc and cited some efficiency savings.
- With regards to technology and data, staff recognised that high-quality data could answer important questions about service delivery.
- Positive comments relating to wound management digital systems included improved quality of images, ability to upload images straight to patients' notes, and faster referral processes.

Challenges

- **Patient factors**. Lifestyle and general health factors that can work against healing and treatment adherence (such as co-morbidities, obesity, low literacy) as well as resistance to strong compression for reasons of discomfort or lack of belief it will work. This resistance can be mitigated by building trust over time in the nurse-patient relationship.
- **System challenges**. These included challenges related to engagement and involvement with the wider system beyond the immediate TES, staffing, supply of dressings, and financially challenged systems with competing priorities.
- **Technology and data**. These challenges focused on difficulties related to the collection of metrics and the implementation of wound management digital systems.

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1. Introduction

This report provides a description of the main messages that arose from the coding of the staff interviews and focus groups. This analysis contributed to the development of themes from the overall dataset, and the narrative as presented in the TWC programme report.

2. Methods

The Health Innovation Wessex Insight team (the evaluators, hereafter referred to as 'we') conducted 16 interviews and four focus groups with key staff from each TES. We aimed to understand staff views and experiences of implementing the TWC programme and any challenges or facilitators encountered. Staff represented a variety of roles including clinical, project management, business intelligence and those with strategic functions.

The number of interviews and focus groups conducted with each TES is shown in **table 1** below. Whilst we originally intended to conduct interviews and focus groups during site visits, timings and availability of staff meant that this was not always possible. A number were therefore carried out remotely via Microsoft (MS) Teams.

Table 1 Number of interviews and focus groups by TES

TES	Data collected	Face-to-face/online
Bromley Healthcare	1 x focus group	Face-to-face at site visit.
CLCH	3 x interviews	Via MS Teams.
Cornwall	1 x small focus group (2 members of staff) 1 x interview	Focus group face-to-face at site visit. Interview via MS Teams.
Yateley	3 x interviews	Via MS Teams.
Lincolnshire	3 x interviews	Face-to-face at site visit.
Locala	2 x interviews	Via MS Teams.
Norfolk and Waveney	1 x focus group 3 x interviews	Face-to-face at site visit.
Sussex	1 x focus group 1 x interview	Via MS Teams.

Interviews and focus groups lasted between 30 minutes and one hour. We used a discussion guide to facilitate the conversations, which were recorded and transcribed by an external transcription company (GoTranscript). Audio files were uploaded to GoTranscript via a secure platform.

We anticipated using rapid analysis techniques to analyse the data; however, because of its richness we decided instead to employ a thematic analysis approach[1] and conducted detailed coding within NVivo R14. We used a team approach to coding frame development and coding (the process by which

[1] Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101.

key messages, or categories, are identified within the data). One member of the team initially coded a small sample of transcripts which were simultaneously read for key messages by two other team members. Following discussion of the initial coding, the remainder of the coding was conducted by an individual evaluator (with transcripts read and re-read, codes created, merged, or discarded as key issues of importance became apparent). Once the coding frame was well developed it was tested, and finalised, by a third member of the team.

Following the coding of all transcripts, the team held a synthesis meeting where key themes from all qualitative data sources were identified.

3. Findings

We used the TWC programme's key enablers of implementation i.e. people (staff and patients), processes, and technology and data, to broadly organise our coding of the transcripts. In the following section, we use these headings to organise the thematic categories, and the data it represents. This summary draws out findings related to the aims, context, challenges, facilitators, and early benefits of implementation, as opposed to the approach to implementation used by each TES. The approaches to implementation are described in the individual TES case reports and the TWC programme report.

3.1. People - patients

With regards to patients, two categories were created i.e.,

- General health, lifestyle and living conditions.
- Patient engagement with advice and treatment.

3.1.1. General health, lifestyle and living conditions

This group of comments related to the general demographic characteristics served by the TESs, as well as more specific details regarding patients' living conditions and general health. Demographics of populations served varied across TESs, from affluent to deprived and a mix of both. Specific issues faced by the populations served included alcohol and substance misuse, people with learning disabilities, refugees, homelessness, social isolation, being housebound, co-morbidities, social deprivation, low literacy, and old age.

3.1.2. Patient engagement with advice and treatment

Staff identified a range of factors which reduced patients' ability, and willingness, to engage with treatment and advice. Factors that could delay healing included poor hygiene at home, lack of literacy/engagement with explanations, and not turning up at appointments,

> *"You can do lots of educative programs and things on the internet, but realistically, our patients aren't accessing these things."* Norfolk and Waveney interview 1

Some examples were given of patients obstructing their own healing because nurse visits were a positive experience for the patient who may otherwise experience little personal contact day-to-day,

> *"If they don't heal, we'll be coming in for longer. We do have some people that will scratch or cut the dressings down."* Norfolk and Waveney Interview 3

Staff explained that patients may find it difficult to tolerate compression because it can be uncomfortable, they may not like how it looks, and they may not feel confident it would improve their condition. This could delay healing and lead to deterioration post-healing (illustrated with reference to compression hosiery in the extract below from the Norfolk and Waveney focus group),

> *"There's only one of my TWC patients that actually didn't get on with it and couldn't tolerate it, an elderly lady and the wound was minor anyway… she said 'I couldn't stand it anymore'. She took it all off, cut it off."* Lincoln interview 3

> *"You discharge, you get everybody's legs lovely, and creams and everything, and they go off on their merry way, and two weeks later, they're back knocking on the door because they haven't put them on."* Norfolk and Waveney focus group

Nursing staff highlighted the importance of building relationships with patients, and of providing consistency of care, in overcoming some of the challenges encountered with compression. This allowed them to build trust with patients which ultimately could lead to them trying, and persevering with, compression,

> *"A lot of the patients have now got to know us so there's a lot of continuity going on, which they love."* Locala interview 2

> *"We had a lady that's got quite severe dementia in one of our care homes. She'd had two leg ulcers…and she would not tolerate any dressings. She was removing all the dressings every day. We did a lot of work with her. I increased her visits to build a rapport with her and gradually persuaded her…she's now in hosiery."* Norfolk and Waveney interview 2

> *"There's a lot around the patient, and engagement of the patient, and preparing the patient, and persuading the patient."* Lincoln interview 3

3.2. People—staff

The following categories were created concerning staff training:

- Need for professional skills, judgement and confidence (due to the complexity of wound care).
- System-wide training needs.

3.2.1. Need for professional skills, judgement and confidence

Staff with clinical expertise often stressed the complexity of wound care. This complexity required that nurses possess a range of skills e.g. to rule out red flags, give advice to patients on the importance of compression and consider lifestyle factors. Importantly, nurses must be confident to start mild graduated compression ahead of a Doppler test. A clinician from the Bromley focus group explained that with knowledge and experience nurses can tell a lot by just looking at the leg, and that a Doppler test is just one part of the process. There was also mention of the need to retrain longstanding staff to think differently about compression, and to change their practice, which could be a challenge.

3.2.2. System-wide training needs

This category recognises that training needs for wound care exist within other parts of the health system, beyond the immediate TES. Issues can arise when new wound care pathways interact with

staff (e.g. GPs, care home staff and private carers), who may not be working with the same level of understanding and knowledge. Staff stated the need for training colleagues in these intersecting parts of the system, but engagement could be challenging due to issues such as time and capacity. The quote below shows that practice nurses, for example, may not be aware of new guidance without access to relevant training,

> *"I think the old guidance used to be it was a leg ulcer after eight weeks of non-healing, and it's now changed to two. I'm not necessarily sure whether they know that or if the practice nurses are given any kind of-- They're in charge of their own training and stuff, aren't they? I don't know if they know about getting them into compression early or referring on early."* Norfolk and Waveney interview 1

> *"Because I think we've got something like 60 plus care homes, plus 57 GP surgeries. Literally two people, it's just impossible for them to go out and train every single one. What we want to try and do is bring the people to us, but it's that engagement that's been a little bit tricky."* Cornwall focus group

3.3. Processes (implementation)

We created several categories related to different aspects of the processes (implementation) heading. These were:

- Aims of implementation (comprised of sub-categories 'earlier compression' and 'clear, consistent, and equitable pathways').
- TES-specific enablers and existing expertise.
- Facilitation and contribution of the TWC programme.
- Systems working (comprising the sub-categories 'Interaction and engagement from wider system' and 'systems pressures, capacity and resource').
- Early benefits/outcomes (sub-categories are 'improved patient care and outcomes', 'benefits related to net zero' and 'staff efficiencies').

3.3.1. Aims of implementation

Earlier compression

Staff agreed that the key driver of the NWCSP Lower Limb Recommendations was to apply compression to lower leg wounds at an earlier stage to aid venous leg ulcers. This quote from the Bromley focus group reflects this as the overarching aim *("We know that lower leg wounds, apart from the ones with red flags need to be in compression."*) and alludes to the need to get treatment started while the wound is still in an acute stage. The quote also highlights patient-related factors that can delay healing despite best practice *("the health of that patient and their lifestyle massively influences the outcome."*) and reinforces the need for highly skilled staff (*"the more knowledge you've got about that, then the more you can do something about that."*),

> *"The more acute a wound is - the newer a wound is, the faster it will heal if they're in the right treatments. We know that lower leg wounds, apart from the ones with red flags…need to be in compression... All these patients that have had wounds for years on end, at some point that will have been an acute wound. The faster you get them into treatments… There's always the influences of, you can never have tunnel vision on a wound because the health of that patient and their lifestyle massively influences the outcome. There's always those elements to it, and those elements*

that actually prevent healing. The more knowledge you've got about that, then the more you can do something about that." Bromley focus group

Clear, consistent, and equitable pathways

Several staff mentioned the creation of clear, consistent, and equitable wound care pathways as a driver for their TES. This was also seen as a way to overcome inequalities in service and ensure that everyone has access to excellent care,

"To try to get everybody singing from the same songbook and heading down the same pathway." Frimley interview 1

"I think inequalities wise; it's levelling up best practice so that we won't see people who might be ulcerated for years because they're not receiving best practice. Slightly differently, possibly from how we would normally look at health inequalities." Frimley Interview 3

3.3.2. TES specific enablers and expertise

This category describes aspects of care delivery and skills that pre-existed the pathway and act as facilitating factors for delivery and implementation. This includes, for example, existing use, and recurrent funding, of a WMDS at CLCH, existing tissue viability expertise, and established and positive relationships,

"I think we had a really good foundation we're really fortunate…I think your team, although there's some learning and some changes, we already have the leg ulcer service, the structure of the clinics, and the support that you do provide to primary care when they reach out to the nursing teams." Bromley focus group

3.3.3. Facilitation and contribution of the TWC programme

There was a small number of comments relating to the facilitation of the TWC programme by the Health Innovation Network, both in terms of local support and from the TWC Central Team. Positive comments related to support to drive wound care forwards, encouraging best practice, making links, mentoring, providing challenge, and funding,

"I have been able to raise wounds and lower limb as an area of where we should really be concentrating our work, looking at reduction in, how we make savings, best practice, patient experience, and I think having it from an ICB perspective, I've been able to bring wound care, lower limb, up the agenda." Frimley interview 3

"We are now doing what we were supposed to do in the first place, that we've always supposed to do. The difference is now we've got the time, or we are allowed the time to do the assessments that are required." Lincoln interview 1

Staff reflections on challenges related to lack of clarity around metrics, too much emphasis on digital solutions, and too many project meetings.

3.3.4. Systems working

This category relates to the new pathway's place in the wider healthcare system, how it interacts with other parts, and with what effects.

Interaction with and engagement from the wider system

This sub-category focuses on difficulties experienced with spreading good practice to other parts of the system, for example GPs or hospital nurses, which can have a detrimental effect on patient care. This category is linked to the sub-category 'System-wide training needs', described above,

> **Interviewee:** *"I think as well, if they're going to the doctor surgery and they're not highlighting the need for compression--*
> **Interviewer:** *They're not reinforcing, so you haven't got that backup and reinforcement from primary care. That is quite a big challenge.*
> **Interviewee**: *I don't think it's because they don't want to. I just don't think they know about it. They've got so much other stuff to deal with, it's not on their priority list, is it?"* Extract from Norfolk and Waveney interview 1

> *"Well, lower limb in the hospital doesn't really happen because they don't have the nurses to do the compression. Even the TVNs [tissue viability nurses] in the hospital don't really do the compression."* Lincoln interview 2

3.3.5. Systems pressures, capacity, resource

This category reflects pressures within the system that can work against successful implementation. Issues raised include financial pressures (and competing priorities for scare resource), staffing pressures, and time pressure,

> *"We are in a trust that is financially very badly hit, and the priority for the trust at the moment is to fund services that are being provided but not funded. We aren't first in the queue."* Cornwall Interview 1

> *"The only thing is, I think sometimes it's getting that full assessment within the allocated time. If you've got staff off sick, if you've got weeks full of appointments and you can't physically fit them in to do that full-leg assessment within the allocated time, can sometimes be a little tricky. We try our very best to do it."* Frimley interview 2

Staff also identified availability of dressings and equipment as one of the wider challenges. If dressings are not available on time, this could disrupt the timelines for care and threaten healing, although the quote from Lincoln interview two indicates that staff are usually able to work around prescription delays,

> *'We ordered this amount of X weeks ago, please can you trace this? Because this is part of this patient's wound care…the wound is breaking down because we need X."* Norfolk and Waveney interview 2

> ***Interviewee:*** *"That sometimes can take two weeks and then you're waiting for somebody to get their hosiery. It's not ideal. If you gave them their hosiery, then at least then they've started that therapy.*
> ***Interviewer:*** *Does that create a delay in the 14-day treatment?*
> ***Interviewee:*** *No, because hopefully if you haven't got the stock on shelves, you would bandage. You could just put them in a bandage."* Lincoln interview 2

3.3.6. Early benefits and outcomes

There were encouraging comments about the early benefits that staff reported already seeing from the implementation of the TWC programme. These relate to improved patient care and outcomes, benefits related to net zero, and staff efficiencies.

3.3.7. Improved patient care and outcomes

Staff reported now feeling confident that patients are getting better care, and that this is leading to faster healing, improved outcomes, and reduced contacts,

> *"In September, there was a practice nurse meeting and one of our clinical admin team shared some information about the coding. It says that so far, 50 patients have had the full assessment since April, and out of those 50, 23 now have a healed leg ulcer."* Frimley interview 2

> *"Everyone's been pretty hot on trying to get something done quickly for the patient. At the end of the day, it helps them, and it helps us not having to see them as often."* Norfolk and Waveney interview 2

3.3.8. Benefits related to net zero

Staff expressed the sense that there will be environmental net zero benefits resulting from the new pathways e.g. fewer appointments for district nurses, reduced use of dressings, fewer miles travelled etc. Having a treatment plan for dressings was also identified as helpful for district nurses in guiding what equipment they need to take for wound care patients, which in turn saves repeat trips and use of inappropriate materials,

> *"We're working with (name of WMDS) to look at a benefits analysis really. That's not just cost, that's also working towards net zero, less use of bandaging, those sorts of things, less visits to the clinics if we're seeing them less frequently, that's less CO2 emission. It's a holistic view of what we're trying to achieve from the app."* Bromley focus group

> *"it's such a saving to get somebody in hosiery because it lasts for such a longer period than a new bandage twice a week."* Lincoln interview 2

Staff efficiencies

Staff efficiencies can result from the use of compression garments rather than bandages – these are quicker to use and can be applied by a wider range of staff. The extract below suggests that staff capacity can be released for other tasks,

> *"Certainly, in our clinics we're using more garments, and I've covered clinic the last two weeks and it makes a difference…It was bliss, it was absolutely bliss that I even managed to do a few emails in between each session because I was so timely on the appointments, makes a huge difference."* Bromley focus group

> *"Also, it means that we have certain banding [the level of pay and responsibility in an NHS job] that can put the compression bandages on, and certain bandings that they're allowed to put the garments on. That relieves the bandage-trained nurses to actually go and see some other people, and we can push it out to the wider team to manage them as well."* Norfolk and Waveney Interview 1

3.4. Technology and design – Metrics

This category of comments focuses on a myriad of challenges associated with collecting the metrics data. Representatives of some TESs acknowledged the potential usefulness of collecting data, and the learning which has sprung from being involved in the project.

3.4.1. Value of collecting data

Staff recognised that high quality data could answer questions about service delivery, for example whether self-care is being offered to the right people, or whether people are given assessments within project timescales. It also allows comparison across providers,

> *"I can appreciate that perhaps some of this data might be useful when you are looking across lots of different providers and you say, well this trust had, say we get 30 new referrals for lower leg care next quarter, this trust received 30 new referrals they were treating in line with the recommendations and this was the average healing rate, then they might have other data to compare that to. I can see that being valuable."* CLCH Interview 2

Quality data can also showcase improvements to healing rates that may encourage staff and primary care networks/GP practices to take a more active part in the project e.g. by releasing staff for training,

> *"She just developed some pie charts that she was showing the growth of the number of patients in compression, and what that meant in time and number of visits. It was quite significant and had quite an impact on their nurses being able to see actually what delivering the right care does."* Bromley Focus Group

Involvement in metrics and the related discussions helped CLCH interviewee two to understand best practice guidance so that the TES can build it into their approach,

> *"It's actually been very productive being involved in this though, for me to get to know the ins and outs of what these new standards are, what we should be doing, and as a trust, it's going to help us."* CLCH Interview 2

3.4.2. Metrics related challenges

The following issues were raised by staff as challenges of metrics collection.

- **Accuracy of reporting**: Questions over accuracy of data entry, and level of confidence sites can have in it. This is linked to data collection at the point of care which depends on staff ticking the right boxes and introduces a margin for error.
- **Definition**: Need for clarity around how metrics are defined and the meaning of terms. Definitions were not fully fixed at the start of the project and work has been ongoing to do this.
- **Baseline**: Historic service delivery and geography can mean that there are multiple approaches, templates, and systems that need to be co-ordinated to ensure consistent practice – this becomes a very big job (CLCH).
- **Interoperability**: Challenges with interoperability resulting from different systems in use in different parts of the care pathway. The following quote shows that whether patient data is captured depends on their referral pathway. For example, a community nursing referral would result in data being recorded, whereas a GP referral may not because of the different systems in use,

> *"…if we've got a patient that comes in through the normal pathway, so comes, refers them to community nursing and that gets referred into us, that's quite a simple pathway. If that patient is coming from a GP surgery, it never hits community nursing sometimes, so therefore, we're probably not capturing that data. We may do that patient assessment within a timeframe, but it won't be recorded because it's not gone through that community nursing channel. It's things like that we've picked upon that we need to look at."* Locala interview 1

- **Automation for collection**: No useful pre-existing tools or relevant data capture (e.g. Bromley, CLCH, Sussex) which necessitates manual metrics collection (e.g. CLCH) – which has time, resource, and 'human error' implications. Template development requires substantial effort and must be approved at several levels (and may need to suit more than one team/area – see interoperability above). Yateley mentions using an Ardens template initially.
- **Competing priorities**: Wound care is not the only priority for clinical systems adjustments,

> *"Our clinical systems team already have a backlog of other jobs they're doing."* CLCH interview 3

Implicit in the list above is the time and effort required to collect data against metrics and the complexity that sits behind what might outwardly appear to be a simple task,

> *"It's a slog to get the data, input the data, make sure… the data is speaking to Rio and vice versa. Interoperability is just a massive, a massive issue."* Cornwall small focus group

> *"It's not easy, but it's a long-term thing that will pay dividends, so it does take time."* Sussex focus group

3.5. Technology and design – Wound management digital systems (WMDS)

Most comments in relation to WMDS concerned perceived limitations of these systems and challenges to their adoption.

3.5.1. Limitations with WMDS and adoption challenges

Several challenges were raised by staff:

- **Interoperability challenges**:

> *"We're using a different system, so a lot of our work and written work and assessment is all done on SystmOne and they don't communicate. We often end up having to do it twice because we don't have a proper record here on the (name of WMDS) website."* Norfolk and Waveney focus group

> *"We did look at (name of WMDS) app at one point, but our phones weren't compatible with it."* Locala interview 1

- **Cost**: Several sites raised concerns about the cost of using WMDS suggesting that they could not justify this as an expense in the current climate. Cornwall Interview 1 added that it should not be a priority of the project in the same way as other aspects,

> *"At the moment, with the finances, I can't even put in cases for invest[ment] to save because there isn't the finance there."* Frimley interview 3
>
> *"Again, just talking generally about the wound management digital systems, far too much emphasis has been placed on this. This is not the focus for trusts who are in financial recovery."* Cornwall Interview 1

- **Difficulties with functionality**: e.g. WMDS can only measure one wound, nurses need to input everything while they are with the patient before the WMDS will let them take a photo, not simple to take a photo, it is time consuming.
- **Lack of engagement or uptake**: in some quarters, due to the above factors. Those interviewed also mentioned staff sickness and absence as reasons for lack of engagement. Added to this, staff from Frimley and Norfolk and Waveney stated that either they did not use or had not been offered the use of WMDS.

3.5.2. Positive comments and benefits of WMDS

Staff identified the following as benefits of WMDS:

- Improved quality of images.
- Images can be uploaded straight to patients' notes.
- Speeds up the referral process - useful for members of the wider team, e.g. podiatry or tissue viability to be able to see the wound, and give advice, without necessarily needing to see the patient,

> *"It went from something like 20 days to two days, something like that in terms of, you know, speed of tissue viability, nurse, viewing a reliable visual representation of the wound and being able to give virtual advice or saying actually I think I need to come and see that and then make it a priority to go and see it."* CLCH Interview 1 *(WMDS already implemented pre-pilot)*

- Reduced need for face-to-face contact (important especially in care homes during covid).
- Standardising care including the way photos are taken and measured and prompting actions,

> *"The app (name of WMDS) we're using to standardise what we see, measurements, photography. We've been quite lax with photographs and wound photography so it's really something that's come at the right time for us as well. We're not just taking pictures, the app will help with measurement, with making sure that everyone is doing the same thing and standardising that measurement we can use it to produce our notes as well and again that will give us prompts."* Bromley focus group

- Shows progress of wound.
- Responsive communications from companies providing WMDSs.

4. Conclusions

Staff feedback in the interviews and focus groups reflects the differing contexts and starting points of the TESs in terms of pre-existing enablers and expertise. While not developed in this report, it is clear

in the individual TES case and TWC programme reports that the scale and scope of the implementation projects across TESs also differ considerably due to the differing contexts and drivers at each TES. Nevertheless, common messages were very apparent. Our findings revealed enthusiasm and buy-in for the aims of the TWC programme (described by staff as the need to start patients in compression earlier and to ensure consistent and equitable pathways). Many staff reported early indications of benefits in terms of improved patient care and outcomes, net zero benefits, and staff efficiencies.

Similarly, there were common messages about the factors that challenge implementation and successful wound healing. These included patient factors and systems challenges. In the former category, nursing staff described patients' resistance to strong compression, and the need to build a rapport with them over time to engender trust and a willingness to engage based upon informed choice and respect for patient autonomy. Systems pressures related to challenges of staffing, supply of dressings, and difficulties of engaging with areas of the system, outside the immediate TES, that impinge on wound care pathways. Staff also reported a set of challenges related to the metrics collection and integration of digital systems to support wound management.

In the TWC programme report, we draw together data from all sources to create an overview of 'counterbalancing implementation factors' including the significant efforts that have pushed implementation forward, and the 'push back factors' that have caused constraint.

Version Control

Version	Status	Key Changes	Authorised by
V1 October 2024	Circulated for comment.		
V2 November 2024	Live	Final amendments completed.	Philippa Darnton

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