EDITORIAL

Absurd funding decisions obstruct optimal care

Dai Harvard MP

My constituency in Wales has one of the highest incidences of chronic disease and ill health in the UK so I naturally have a keen interest in improving health provision and practices. I have focused my efforts in parliament on arguing for the early and consistent adoption of modern medical treatments and technologies to drive greater efficiency and quality of care in the NHS. Recently that effort has centred on tissue viability and the prevention and treatment of wounds.

I had the privilege to host the first parliamentary reception for the Tissue Viability Nurses Association in October 2005 to raise the profile of this diverse area. Following that I sent a letter to all the trusts in England enquiring about tissue viability services. The responses have illuminated the problems that staff in this area are up against (see p13).

The incidence and prevalence of pressure ulcers is worryingly high and one thing that struck me when reading the responses to my letter was the inconsistency in the way data is collected. It is vital for the development of better evidence-based care that data is coordinated and effective. National documentation of pressure ulcer prevention and care, including the implementation of the 2005 NICE guidance, is urgently needed.

It is clear that in the hospital setting the potential initial cost of replacing traditional beds with modern beds with pressure-relieving mattresses would be more than recovered by the savings made through the prevention of pressure ulcers. Chelsea and Westminster Hospital NHS Foundation Trust is one example of a trust employing good practice and this could easily be replicated by others. It is replacing older beds as part of its investment in wound prevention and will send them to Iraq for those in more acute need.

Another problematic issue surrounds the transfer of patients from the hospital to the community setting. This is especially evident where patients are receiving therapy that relies on newer technology such as topical negative pressure. Many NHS trusts have noted a specific problem in gaining access to such treatments, primarily due to funding barriers at primary care level. Patients are being prevented from leaving hospital when they are medically able to do so, and this places an unnecessary burden on the hospital and also places patients at a greater risk of contracting a hospital-acquired infection. Again, the initial costs of the treatment appear to be the main barrier, but when considered in conjunction with the faster healing rates and the reduction in nursing time it is clear that modern treatments are the most efficient and effective way to improve the patient's quality of life.

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The problems seem to have nothing to do with medical and social care or indeed the safety of the patient and everything to do with dysfunctional transfer charges and accounting. It is an absurdity that a PCT 'pays' for an expected four-week stay in a hospital for a given patient but with the use of modern treatments the patient would be able to leave two weeks earlier. Instead this is discouraged by some trusts because to discharge a patient 'early' would somehow mean them paying for the same bed twice. These accounting barriers are often compounded by the inability to account for loaned capital equipment and the consumable costs of such treatments. We have put men on the moon but it appears that the construction of a flexible accounting and costing model in the NHS still alludes us.

We need a much greater understanding of the impact of wound treatment regimens, particularly for patients with chronic conditions. Significant improvements in medical treatments are meaning that more conditions are being considered chronic, and the long-term management of the patient is becoming more important. In recognising these changes, a mechanism for primary and secondary care professionals to work together to prevent patients unnecessarily entering hospital — as well as allowing them to leave as soon as possible — is critical.

It is clear that tissue viability staff are committed to providing the best possible care for a diverse set of patients. The problem is that they are often hindered by 'silo budgeting' (where budgets are not allowed to be transferred between departments) and an unwillingness or inability to look at the broader value of their work.

These issues need to be raised and I will continue to do so in the House of Commons to challenge these barriers and increase awareness of tissue viability services and the vital role it plays. WUK

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