The quality and productivity challenge

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The publication of the new government's White Paper *Equity and Excellence: Liberating the NHS* (Department of Health [DH], 2010a) heralds significant change for the NHS and, indeed, other providers of health services. It sets out an agenda which puts patients and the public first and focuses on achieving health outcomes that are among the best in the world. Of course there is a lot of detail to go along with these two ambitions, but as matters of principle they are exactly what we as nurses strive to achieve: we have always held patients' needs as central to our values and want to do our best for them.

To address increasing demand for care and services in the context of a diminishing income and economic crisis, the NHS was asked to find £15–20 billion savings over four years to be reinvested so that the burgeoning care deficit can be addressed. This initiative gained momentum by being talked about as the need to improve quality — that is safety, effectiveness and the patient's experience — through innovation, productivity and prevention. The shorthand for this became known as QIPP, however, the acronym was also transformed into the quality and productivity challenge. Although this is now embedded in the lexicon of managers and many professionals, there is an anxiety that the elements of innovation and prevention will be overlooked in the clamour to save money while sustaining quality.

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Nurses, in all care settings, are particularly well placed to suggest how to be innovative, to do things differently, not necessarily using a new invention or new technology, but by examining processes critically and redesigning services by cutting out duplication and waste. Similarly, nurses could be more instrumental in implementing preventative measures, not just by cutting out waste and duplication, but by being much more involved in managing long-term conditions, especially in the community, so that people can be as independent as possible and avoid being admitted to hospital because services are more available to them at home. Promoting health and well-being will need to become more central to planning and implementing care in all parts of the healthcare system.

It is the government's intention through the White Paper to reduce mortality and morbidity, increase safety and improve patients' experiences and outcomes. To do this, it advocates a new system of commissioning services: a system which will devolve the power and responsibility for commissioning services to the healthcare professionals closest to patients. In this system, nurses need to exhibit their leadership strengths and get involved in commissioning so that their clinical voices are heard, not just as advocates for patients, service users and their communities, but by using evidence to drive best practice to improve outcomes.

From policy to practice

This new policy direction is not just rhetoric. It will be subject to legislation to go through Parliament later in the year and will make a substantial difference to how services are delivered in the future. However, it is important to recognise that whatever the system of commissioning services and the structure of the NHS, there are very real and practical initiatives to be taken to address the challenges of QIPP. One of these is changing the attitude to pressure ulcers.

Pressure ulcers present a major health challenge: they affect large numbers of people, resulting in considerable health expenditure

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(Bennett et al, 2004; International Guidelines, 2009). The impact is not only in cost to the health systems but the pain, disability and unnecessary deaths that occur due to largely preventable skin damage. Pressure ulcers are a painful, debilitating and potentially serious outcome associated with a failure of routine medical and nursing care.

What we know

There is evidence to suggest that between 4 and 10% of patients admitted to an acute district general hospital in the UK will acquire a pressure ulcer and that many of these pressure ulcers are preventable (Royal College of Nursing [RCN] and National Institute for Health and Clinical Excellence [NICE], 2005). However, limited data are available to state the position across the NHS.

Hospital Episode Statistics (HES) for 2008/9 show that there were 51,594 coded pressure ulcers in the NHS in England (*Table 1*). In 2007/8 this figure was 42,995. While this is a 20% increase, this is likely to be due to better reporting and better coding. Fewer than 10% of these patients were admitted to hospital because of their pressure ulcers. The majority were coded with pressure ulcers which were secondary to the condition causing their admission.

However, reliance on HES data is a problem because there is likely to be a significant underestimation of the true number of pressure ulcers, as the data refer to in-patient episodes only.

Of real concern is that pressure ulceration is often only associated with the elderly, but given what we can tell from HES data, the spread of pressure ulcers occurs across the ages. Although not evenly spread, the data suggest that patients with pressure ulcers are most commonly over 65 years old (75%), with those under 16 affected in 1% of all cases with a HES coded pressure ulcer (which means that 297 children had pressure ulcers in this period) (*Table 1*).

Death due to pressure ulceration ranges between 252 and 274 patients a year, and has remained relatively stable based on the last four years' available data. While these figures appear low, this is as a proportion of the primary reason for admission (*Table 2*). Pressure ulcers are also associated with a 2–4-fold increase in risk of death in older people in intensive care units (RCN and NICE, 2005).

Costs

A research report in 2004 (Bennett et al, 2004) suggested that pressure ulcers are estimated to cost the NHS across the UK between £1.4bn and £2.1bn a year in treatment costs. The National Institute of Health and Clinical Excellence (NICE) also estimated a similar range in their work on pressure ulcers in 2005 (RCN and NICE, 2005).

Pressure ulcers with complications such as critical colonisation, cellulitis and osteomyelitis are very costly. It is estimated that pressure ulcers with critical colonisation can cost nationally approximately £15m per annum, cellulitis similarly £15m per annum and £42m per annum for those with osteomyelitis — all these costs on top of normal healing (Bennett et al, 2004).

The NHS Litigation Authority advises us that there have been 224 claims for pressure ulcers between 1st April 2004 and 31st March 2009. The largest claim was £650k and the majority of these claims (201) were under £100k.

To help quantify this further, the Department of Health developed a tool which indicates potential costs of pressure ulcers based on a UK research study and uplifted to 2008/9 costs (available online at: www.dh.gov.uk/cno).

Although the costs are unclear, it is evident that there are potential savings to be made not only in nursing time, treatments and complications extending lengths of stay, but also in compensating those who have suffered. However, these savings need to be considered in relation to the health economy, not just the care setting or provider.

Guidance and best practice

A clinical guideline was developed jointly by the RCN and NICE in 2005, and is well established across the NHS, but more can be done through nursing leadership to diminish the number of pressure ulcers. If nurses are not going to rise to this challenge, no one else will.

Table 1
Spread of 2008/09 pressure ulcers (HES coded by FCEs)

Pressure ulcers FCEs 2008/09

Age	Total FCEs	% of total
Under 16	297	0.6%
16–24	353	0.7%
25–49	2,621	5.1%
50–64	5,296	10.3%
65–79	15,237	29.5%
80+	27,639	53.6%
Unknown	151	0.3%
Total	51,594	100.0%

Table 2
Deaths due to pressure ulcers. Underlying causes — deaths by ICD 10 code; L00–L99 Disease of skin and subcutaneous tissue; L89 Deubitus ulcer

		L00–L99	L89	All causes	L89 as % of L00–L99
2007	Male	591	68	240,787	12%
	Female	1231	185	263,265	15%
	Total	1822	253	504,052	14%
2006	Male	583	67	240,888	11%
	Female	1229	197	261,711	16%
	Total	1812	264	502,599	15%
2005	Male	597	74	243,324	12%
	Female	1191	200	269,368	17%
	Total	1788	274	512,692	15%
2004	Male	518	68	244,130	13%
	Female	1152	184	268,411	16%
	Total	1670	252	512,541	15%

In 2002 the Department of Health developed a pressure ulcer benchmark within the document *Essence of Care* (DH, 2002). As a widely used benchmarking tool, it supports best practice. The aim of this document was to provide clinical staff with a tool, which would enable them to provide a formal and focused approach to share good practice.

As a consequence of trying to keep pressure ulcers high on the agenda, the Department of Health have aligned the definition of pressure ulcers in line with the international definitions and classifications of pressure ulcers by using the European Pressure Ulcer Advisory Panel (EPUAP) definitions as part of the national nurse sensitive outcome indicators (EPUAP/National Pressure Ulcer Advisory Panel [NPUAP], 2009). This will equip the NHS with a standardised definition and measuring approach which allows comparison across the majority of care settings. It will allow pressure ulcer incidence data and improvements to be included in quality accounts, which are a legal requirement in England.

Although much is said about preventing hospital-acquired pressure ulcers, it is timely to start thinking about how to prevent pressure ulcers in any setting. In the authors' view it is not acceptable for hospital staff to be complacent about skin damage acquired in the community (in any care setting) as not their problem. This is borne out by the experience in NHS Newham, which invested in expanding the tissue viability service to focus on pressure ulcer prevention and management in the local nursing home population (Dowsett, 2010). Local systems should be developed to work across organisational barriers — as a whole and united nursing community — to spread best practice and help each other prevent skin damage.

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There is growing awareness of the High Impact Actions (HIAs) initiative which was developed following an initiative led by the SHA Nurse Directors in partnership with DH and NHS Institute for Innovation and Improvement. This has resulted in eight HIAs (NHS Institute, 2009, 2010) to help address the QIPP agenda in nursing, and one of these features pressure ulcers.

Essence of Care 2010 (DH, 2010b), has been refreshed to include an updated section on prevention and management of pressure ulcers. As a well established benchmarking toolkit supporting fundamental aspects of care, it is used in a variety of care settings to support best practice. It is one of the many approaches that nurses can use to demonstrate their effectiveness and contribution to care as highlighted in *Quality Roadmap for Nursing* (DH, 2009), which outlines the tools and approaches supporting quality measurement.

Suggested next steps

The next steps need to focus on broad awareness that nurses intend to develop zero tolerance to avoidable pressure ulcers and will take steps to ensure that no needless skin breakdown

occurs. This needs to be built on a pathway approach across primary, secondary and tertiary care focusing on prevention and reduction of pressure ulcers, as well as remedy and treatment. This is not just about hospital-acquired pressure ulcers. This approach needs to align with other aspects of care such as nutrition and other health and care issues. By identifying those with nutritional, mobility or other health issues such as depression, pressure ulcer incidence will be diminished and, thereby, associated acute hospital admissions. Indeed, part of the Institute for Healthcare Improvement's (IHI) skin bundle recognises the link between nutrition and hydration and skin integrity. In addition, mood and motivation impact on an individual's ability to manage self-care. Part of the national nurse sensitive indicators being agreed by the NHS will include further indicators for nutrition and hydration, both of which are key to maintaining skin integrity.

By reducing the incidence and in particular the severity — the category — of the pressure ulcer, there is a consequent effect on other risks such as associated infections, surgery to repair the ulcer and extended lengths of stay in hospital.

Nurses need to take a professional stance and be clear in organisations locally about declaring pressure ulcers as 'never events' or focusing on 'zero tolerance' rather than elimination. Both are extremely challenging, but zero tolerance is more about developing a culture of working towards as low an incidence as possible, rather than an unrealistic expectation of elimination. This does not imply complacency but acknowledges that the best care can, in an extremely compromised patient, lead to pressure damage.

Intelligent systems to gather information need to be developed. These will assist commissioners, providers and patients/users in understanding the spread and scale of pressure ulcers, and support the many other policy areas such as patient choice, commissioning and preventative agendas.

We need to be aware that putting a focus on pressure ulcers means that the true extent of the problem is likely to emerge. This should not be interpreted and misunderstood as a sudden increase in incidence. This will need management and explanation to the public and others. However, as these and other strategies are developed, there should be a positive improvement (demonstrated as a reduction following the peak) in incidence.

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Conclusion

Regardless of the political imperative to reduce costs, eliminate waste and avoid duplication, there is a clear role for nurses in helping to address the quality and productivity agenda. It is best the profession seeks out possibilities for itself rather than have the priorities of others imposed on it. This is unequivocally demonstrated by the arguments to generate zero tolerance towards pressure ulcers, along with the pain and distress they cause.

This might seem daunting in your individual sphere of practice, but there is commonly a network of professionals with you. The use of evidence is of course powerful, but so too is the story which lies behind that evidence. Patients are individual people, they should not suffer skin damage through pressure. The story of this needless harm to them can be used to move others to act and move ever closer to the worst pressure ulcers being eliminated. WUK

Key points

- Nurses are particularly well placed to suggest how to do things differently.
- Promoting health and well-being will become central to all parts of the healthcare system.
- Between 4 and 10% of patients admitted to an acute district general hospital in the UK will acquire a pressure ulcer.
- The occurrence of pressure ulcers is spread across the ages.
- Nurses will take steps to ensure that no needless skin breakdown occurs.

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