Tissue viability: the QIPP challenge

RICHARD SHORNEY and Dr **KAREN OUSEY** discuss how the specialty of tissue viability can align with the ideals of the quality agenda. They argue that investment in tissue viability leads to improvements in quality, reduced hospital admissions and significant savings.

In the new NHS the effectiveness of care provision needs be demonstrated, with healthcare practice being aligned to priorities for quality and true measurements of care recorded. The Department of Health (DH) and both the previous Labour and present coalition Government, have identified the need to maintain and develop quality in healthcare. One key area where efficiency savings can be made is within tissue viability services. For example, the DH[1] set out its ambition to eliminate all avoidable pressure ulcers in NHS-provided care and the National Patient Safety Agency[2] selected the prevention and treatment of pressure ulcers as one of its "10 for 2010" plans to reduce levels of harm in ten high risk patient safety areas.

Efficiency savings and elements of the quality agenda, most noticeably Quality, Innovation, Productivity and Prevention (QIPP) have become synonymous with healthcare. Most recently the DH published the challenges and opportunities to health care providers and commissioners to meet the quality agenda, ensuring that efficiency savings are made to allow reinvestment.[3,4]

The DH operating framework clearly identifies the requirement for the involvement of patients and the public when planning services, allowing them to understand how and where their money is being spent and offering greater choice and control of services. The key is shared decision making, summed up by the phrase "no decision about me without me." Integral to this, is how the quality and productivity challenge will be met; securing re-investment to meet the demand and improve quality and outcomes. The Government plans to allow patients to rate hospitals and clinical departments according to the quality of care they receive. In addition there will be a focus on personalised care that reflects individuals' health and care needs, supports carers and encourages strong local partnerships. Patients will be in charge of making decisions about their care and will be able to choose which consultant-led team, GP and treatment they have.[3] Empowering patients to become involved in choosing their treatment through integrated care can help them achieve greater control.[5]

The GP Consortia will look after an £80 billion budget and by 2012 will take over responsibilities from Primary Care Trusts (PCTs), including leadership of the existing QIPP initiative. This initiative will continue with even greater urgency, but with a stronger focus on general practice leadership.

A radical new approach

The DH proposed a radical new approach to healthcare that includes protecting the population from health threats; empowering local leadership encouraging responsibility across society to improve health and a focus on key outcomes.[6] Healthcare providers and commissioners will be expected to meet the quality agenda through cost savings while not being detrimental to patient care. A major area of expenditure for the acute and primary care sectors is tissue viability, with costs being assessed by the DH in 1997[7] as being over £80 million, not including hosiery products, with that figure increasing to £95 m over a two year period.[8] Posnett and Franks[9] calculated that 200,000 people in the UK had a chronic wound with an estimated cost of treatment being between £2.3 bn and £3.1 bn per year. Additionally, wound dressings account for about £120 m of prescribing costs in primary care in England each year,[10] with prescription costs for wound dressings in primary care in England being estimated at £116 m in the year to September 2009. Interestingly, the Patient Association[11] presented results of a survey that sampled 79 Trusts and identified that there were three times more infection control nurses than tissue viability nurses employed by Acute Trusts. This was despite the fact that the Patient Association estimated the cost of treating healthcare associated infections in

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hospital to be approximately £1 bn compared to at least £1.4 bn to treat pressure ulcers. What was of more concern was that infection control nurses act in an advisory capacity, as opposed to the tissue viability nurse who has a more active clinical role.

The National Tissue Viability Society defines the specialty as "A growing specialty that primarily considers all aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and all forms of leg ulceration. However, it is not just wound management, it also covers a wide range of organisational, political and socioeconomic issues as well as professional relationships and education."

A nurse-led specialty

Tissue viability is currently a nurse-led specialty with a relatively low profile – both publicly and within the healthcare system. The problem lies with the indistinct perception of what it entails, and the variable cost to the NHS of typical disorders such as pressure ulcer prevention and treatment, leg ulceration, aspects of skin care and protecting at risk skin.[12] While there is currently no consensus on what constitutes tissue viability, areas of care covered include managing acute and chronic wounds; pressure ulcer prevention and management; infection control in wound care; and protecting skin at risk from trauma.[13]

Much of what has been published recently addresses and focuses on quality from a strategic perspective. Despite this it is important to put these theoretical models into practice and make them fit for purpose. Of equal importance is how these theoretical, national ambitions and ideals from the DH are transferred into everyday practice and, indeed, who is accountable for delivering on the metrics of quality care. Although evidence-based practice, which can be defined as an integration of the best available evidence obtained from research, clinical guidelines in conjunction with clinical expertise, does allows clinicians to justify their methods, this alone is no guarantee of quality outcomes.[14]

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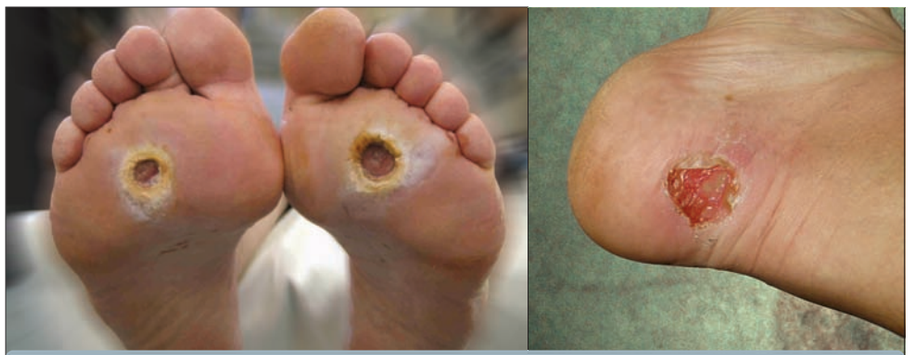
The DH white paper[3] goes some way to address this practice theory gap, but areas of best practice and actual case studies need to demonstrate how quality can and should be measured. The launch of the High Impact Actions (HIAs) for nursing and midwifery in 2009 is an example of how awareness of tissue viability services has been raised.[15] The project initially sought examples of best practice from the nursing and midwifery community that could demonstrate a response to the QIPP challenge.

Each HIA sets out the scale of the challenge and the potential opportunity in terms of improvements to quality and patient experience and reduction in cost to the NHS. Many healthcare Trusts and organisations are using the HIAs as measures of quality to form part of their CQUIN targets. The key aim of the CQUIN payment framework is to help produce a system which actively encourages Trusts and organisations to focus on quality improvements and innovation in commissioning decisions.[14] In particular, the "Your Skin Matters" HIA has highlighted how nurses have embraced this challenge.[15]

The tissue viability team at NHS Newham has been highlighted in this particular HIA, through their prevention strategies and correct management of pressure ulcers that identified how to reduce the number of people with pressure damage admitted from nursing homes to hospital. Pressure ulcers are defined as "localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear".[16] The majority of pressure ulcers are avoidable in NHS care, yet many Trusts still experience higher than average incidence figures, hence the continuing initiatives and targets being introduced. Pressure ulcer incidence has been found to be between 4% and 10% of patients admitted to acute hospitals in the UK.[17] Pressure ulcers not only represent a reduced quality of life for patients, but also cost average district general hospitals in the UK between £600,000 and £3 m per year.[15]



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Prevention strategies

Evaluation from the Newham initiative has identified a reduction in admissions from 24-45 in 2008, to 0-12 in 2009, for patients with pressure ulcers, a 50% reduction for the period April-August 2008/9. This has resulted in a cost saving of £59,100, based on admission costs of £199 per night with an average of a nine night stay.

Calculating the returns on investment for this project showed that for every £1 NHS Newham invested in their tissue viability service they generated £51.56 of benefit over a year. This figure is

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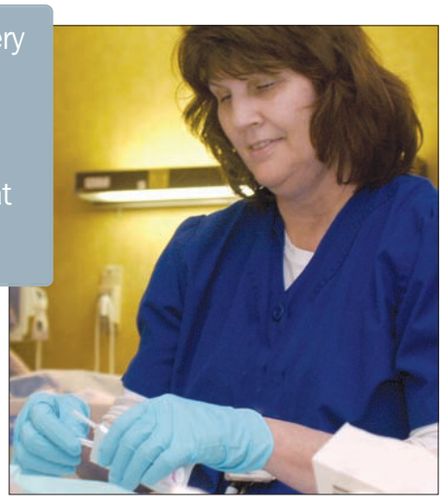

based on direct costs of setting up the project, additional employment costs of a Band 7 nurse, the cost of treating pressure ulcers, and the number of pressure ulcers prevented. The calculation does not take into account the additional quality benefits such as improvement in quality of life for elderly patients in nursing homes.

Conclusion

The DH has clearly identified that it aims to ensure the quality agenda is at the heart of the NHS care delivered. It is the responsibility of clinical leaders to ensure that these ideals and expectations are met. The HIAs are just one example of a quality initiative which allows clinicians to be accountable for their practice and show through tangible and fiscal rationale that their service is of high quality. Using examples of best practice tissue viability can and should align to the ideals of the quality agenda, positioning the service offered as both valued and of good quality.

Despite the high costs associated with tissue viability, including wound management and treatment, it is an ideal specialty for public, patient involvement and development of metrics that align to the quality agenda. It is essential that multi-disciplinary teams work in close collaboration across both the acute and secondary sector to develop measures of care that reflect evidence-based care while maintaining and developing quality within a budget that demands efficiency savings.

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It is the responsibility of healthcare providers to provide evidence of achievement of quality and innovation within their practices to assure that those that are commissioning services are aware of the value of service offered.

True investment in tissue viability can lead to improvements in quality, reduced hospital admissions and significant savings. It is important that commissioners work with their providers to commission high quality care for all, as demonstrated by NHS Newham in implementing the Your skin matters HIA.

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