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Inequalities in pressure ulcer care will not be solved by cuts to frontline nursing services

Jacqui Fletcher, Karen Ousey

Not to put too fine a point on it, but the UK is facing a nursing crisis. In the next 10 years, 200,000 nurses are due to retire and according to the Royal College of Nursing (RCN, 2010) there are insufficient newly registered nurses entering the profession to replace those retiring. This is especially true of community nursing services, which have a markedly older age profile than other groups of registered nurses, meaning that the impact of these retirements will hit the community sector earlier and harder.

Unfortunately, the bad news does not stop there. NHS employers (2009) reported that in 2008/9 more than 11,000 qualified nurses requested verification of their UK registration as part of the process of applying for a job in another country — most commonly in Australia.

As if all that was not enough, in May 2010 a Department of Health (DH) report suggested an overall cut of one in 10 NHS jobs in England was required, with clinical services, including nursing, being part of the reduction that included 10 nurses per 300 clinical staff (DH, 2010a). These savings are not confined to England either — in June 2010, the Northern Ireland Health Minister announced that a two per cent saving needed to be made on NHS staffing costs (Health Workforce Bulletin, 2010). In the same month, the Scottish

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Government projected that reductions to staff in NHS Scotland would reach 2.8 per cent between April 2010 and April 2011, including 1,500 nursing and midwifery posts (BBC News, 2010). Added to this is the reduction in pre-registration nurse education places of approximately six per cent in 2010/11 (Snow, 2010).

But what does this mean for tissue viability nurses (TVNS) and services? The previous Labour administration and the current coalition Government have publicised the NHS efficiency savings needed to improve quality services, including the most recent, *The Operating Framework for the NHS in England 2011/12* (DH, 2010b), which identifies the challenges set out in *Equity and Excellence: Liberating the NHS* (DH, 2010c).

The Government has stated that the Operating Framework needs to be viewed in the context of three inter-related themes:

- ▶ Transition and reform: the steps that need to be taken in 2011/12 to realise the challenges set out in the White Paper
- ▶ Transparency and local accountability: more involvement of the public and patients allowing them a better understanding of how and where their money is being spent
- ▶ Service quality: securing improvement in those areas where additional funding has been made available and taking more responsibility for working together with local authorities (DH, 2010b).

The importance of tissue viability clinicians being able to meet the demands

of this agenda is as important now as it was following the DH (2008) review. Tissue viability clinicians must achieve savings while providing a quality service despite the reduction in the nursing workforce. Therefore, it is vital that we promote ourselves as a speciality that is essential to achieving the outcomes laid out in these documents.

The Government has also announced that there will be a pay freeze for all public sector workers, including nursing staff, earning basic salaries of more than £21,000 for the years 2011/12 and 2012/13 (DH, 2010b). For those staff earning less than £21,000, there will be a commitment to uplift salaries by a minimum of £250 per year.

According to the DH (2010b) 40% of NHS staff are on basic pay of £21,000 or less, including unqualified nurses and healthcare assistants (98% of whom are paid £21,000 or less a year), administrative and clerical staff (63%), and maintenance/works staff (46%).

This salary freeze reflects the need to make efficiency savings and reduce the deficit as pay has been identified as one of the most significant cost pressures for the NHS, accounting for 40% of NHS revenue expenditure and around 60% of hospital and community health services expenditure (DH, 2010b).

Tissue viability provision

The Patients Association (2010) has identified the inequities in service provision across the UK in relation to tissue viability and pressure area care. In a large survey (95% of acute and primary care trusts were surveyed with 150

organisations responding), the Association demonstrated that not only is there an 'astounding lack of available information', but also that the information is held in such a wide variety of formats that comparison is almost impossible.

Although the information presented in the document is possibly not news to those working in the field, it is very powerful to see such information presented in such an objective way from an unbiased and clearly patient-focussed source. Key messages from the document include:

- ▶▶ That there is huge variability in the provision of tissue viability services in relation to the population size or activity levels, with a tenfold increase in activity levels being apparent between areas employing one whole-time equivalent
- ▶▶ Monitoring of pressure ulcer occurrence varies hugely, making comparison almost impossible and many areas (26% of acute trusts and 64% of PCTs) were unable to produce any useful, recent data
- ▶▶ Less than a third (29%) and only a quarter of primary care trusts could provide data about how many patients were seen by their tissue viability services and most were unable to differentiate between new cases and follow up visits
- ▶▶ There is an inverse relationship between the cost of pressure ulcers and the number of TVNs employed, compared to the costs of healthcare-associated infections (HCAs) and the number of infection prevention and control nurses (IPCNs) employed — overall in acute care, there are more than three times as many ICPNs employed as TVNs (the average number of ICPNs is 5.2; the average number of TVNs is 1.6)
- ▶▶ The complete absence of comparable information makes it impossible for patients to make informed choices about services and also for the NHS or other agencies to recognise variations in performance.

The conclusion of the report recognises the work that has been put in since that data was collected through the drive of the High Impact

Actions (HIAs) (NHS Institute for Innovation and Improvement, 2010) and the Pressure Ulcer Calculator (DH, 2010d), but highlights that these are voluntary systems. Finally, the Association recommends that there is a need for 'mandated, standardised monitoring of service provision, performance and outcomes to be used across the NHS... this is not only feasible but can act as a powerful driver for service improvement' (The Patients Association, 2010).

At a time when quality is high on the Government agenda and it is intending through the White Paper (DH 2010c) to reduce mortality and morbidity, increase safety and improve patients' experiences, it seems nonsensical that information on the occurrence of pressure ulcers and standardised practice is not in place.

Even where data does exist, it is not being used in a meaningful way. Hospital Episode Statistics (HES) for 2008/9 identified 51,594 coded pressure ulcers in the NHS in England. However, it is likely that this was a significant underestimation of the true number, as the data only refers to in-patient episodes. Similarly, pressure ulcers are only coded if the correct term is entered in the medical notes and many are never brought to the attention of medical staff so do not even enter the system (Foster and Bolger, 2010).

To improve the inefficient reporting of pressure ulcers, systems that gather information intelligently need to be developed to help fully identify the scale and spread of the problem. However, in order to do, this definitions and reporting mechanisms need to be set and agreed, both of which are complicated tasks. Service provision across the UK needs to be reviewed and revisited and tissue viability needs to be seen as a clearly demarcated speciality with an important role to play in achieving targets. Otherwise, all the rhetoric about cutting budgets while saving frontline services may fall on deaf ears. **WUK**

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