BHTA
British
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Pressure Ulcers

The BHTA guide to prevention and cash releasing savings

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Executive summary

The cost to the NHS of treating chronic wounds associated with Pressure Ulcers exceeds £2.6 billion per annum.[1]

Each Pressure Ulcer (PU) causes pain and discomfort and risks exacerbating co-morbidities. Pressure Ulcers were reported to have caused more than 200 deaths and contributed to 25,000 more deaths in England and Wales in 2010. Reported associated deaths related to Pressure Ulcers increased by 50% between 2001-2012.[2+3]

A focussed Wound Audit (PUWA) across NHS in-patient facilities in England identified high levels of under-reporting for all systems and highlighted data capture challenges, and the completeness of clinical records for Pressure Ulcers.[4]

This guidance identifies immediate cash releasing savings of £270m per annum are available to the NHS by adoption of the simple preventative actions repeated and highlighted in this report.

Introduction

It is estimated that one in five hospital inpatients has a Pressure Ulcer (Clark et al, 2004)[5] – this represents at least 20,000 hospital patients in the UK at any time. In the UK, around 400,000 individuals develop a new Pressure Ulcer annually. The cost to the NHS is high, primarily because prolonged hospital treatment is needed in serious cases and those at risk must be protected. The annual cost is in the range of £2.6 billion.

Some of the recommendations in the 2010 paper, "BHTA Proposals in Relation to the Elimination of Avoidable Cases of Pressure Ulcers" have been adopted and initiatives such as the 'NHS Safety Thermometer' in England[6], SKIN Bundles in Wales[7] and SSKIN Care Bundle in Scotland[8], reflect proactive improvements in monitoring and reporting of Pressure Ulcers in the NHS.

Raising awareness, improving education and adopting more appropriate preventative interventions are all necessary to achieve the elimination of these avoidable wounds. To help do this, BHTA members have over the last eight years funded a campaign called "Your Turn", which is a national movement working to reduce the number of Pressure Ulcers in the UK.

In Coventry and Rugby a community education campaign run by "Your Turn" resulted in a 20% decrease in avoidable Grade 2 Community acquired Pressure Ulcers in just six months.[9]

1 http://www.nursingtimes.net/clinical-subjects/wound-care/the-burden-of-chronic-wounds-in-the-uk/527138.fullarticle

2 http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/about-ons/business-transparency/freedom-of-information/what-can-i-request/published-ad-hoc-data/health/july-2013/number-of-deaths-from-pressure-sores--england-and-wales--2001-2012.xls

3 http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/639/639we08.htm

4 https://www.nice.org.uk/guidance/qs89

5 Clark M, Defloor T, Bours G (2004) A pilot study of the prevalence of pressure ulcers in european hospitals. In clark M (ed) Pressure Ulcers: Recent Advances in Tissue Viability. Quay Books, London.

6 https://www.safetythermometer.nhs.uk/

7 http://www.wales.nhs.uk/sitesplus/863/page/65480.

8 http://www.healthcareimprovementscotland.org/our_work/ patient_safety/tissue_viability/sskin_care_bundle.aspx

9 Your Turn – www.your-turn.org.uk

Background

"Delivering the NHS Safety Thermometer"[10] gave Pressure Ulcers a high profile. Data from the NHS Safety Thermometer pilot work demonstrated that an average reduction in Pressure Ulcer prevalence of 42% was possible. This suggests that between 30% and 50% of Pressure Ulcers can be prevented in organisations that are able to provide the right equipment at the right time, introduce regular checks and ensure adequate nutrition and hydration.

This statement is not consistent with EPUAP-NPUAP[11] consensus documents which indicate that approximately 10% of Pressure Ulcers are unavoidable.

The NICE guidance published in April 2014[12], states that if implemented throughout the NHS, this could contribute to reducing the numbers of Pressure Ulcers nationally. The guidance recognises the importance of training healthcare professionals, conducting risk assessments and skin assessments, individual care plans for at-risk patients, the use of appropriate medical devices and offloading where heel Pressure Ulcers are present.

BHTA supports the updating of NICE guidance every five years to incorporate advances in technology and research/ evidence. We are keen to work with clinicians to help clarify and implement the guidelines for all Pressure Ulcer applications.

The BHTA recognises there are issues surrounding data collection and reported prevalence levels.

The percentage of patients reported to have Pressure Ulcers fell from 4.3% to 4.1% between December 2013 and December 2014, according to the NHS Safety Thermometer: Patient Harms and Harm Free Care[13], however, information presented by The Tissue Viability Society at the 2015 European Wound Management Association conference[14], suggested that only about 50% of patients with an existing Pressure Ulcer are correctly reported as having one.

This indicates that prevalence is actually 7.1% compared with the NHS Safety Thermometer estimate of 4.7% (4.3%-4.1%) and raises concerns about the actual progress that has been made.

10 Delivering the NHS Safety Thermometer CQUIN 2013/14: http://harmfreecare.org/wp-content/uploads/2012/06/NHS-ST-CQUIN-2012.pdf

11 https://www.npuap.org/wp-content/uploads/2014/08/Updated-10-16-14-Quick-Reference-Guide-DIGITAL-NPUAP-EPUAP-PPPIA-16Oct2014.pdf

12 https://www.nice.org.uk/guidance/qs89

13 NHS Safety Thermometer: Patient Harms and Harm Free Care, England December 2013 – December 2014, official statistics, Health & Social Care Information Centre, published 07 January 2015

14 http://ewma.org/fileadmin/user_upload/EWMA/pdf/journals/Scientific_articles/Articles_October_2014/Visit_EWMA_2015_in_London.pdf

The BHTA was greatly encouraged to see that the Department of Health was using the Commissioning for Quality and Innovation (CQUIN) payment framework to guide behaviour within the NHS. We supported the approach adopted in the CQUIN guidance for 2014/15; namely that the Pressure Ulcer CQUIN should be considered in the context of all relevant health providers in a local health community, with a view to supporting joint working of organisations across a patient pathway.

In addition, BHTA believes that it is appropriate to have targets of a reduction of 50% using stronger leadership, improvement materials and integration of the goal into local change plans implemented across the health and social care sector. The BHTA has major concerns that dropping the CQUIN for Pressure Ulcers in 2015/16 may have reduced the focus and reversed much of the progress which had been achieved.

Safety Thermometer

The BHTA believes that an increase in expenditure on Pressure Ulcer prevention will be more than funded by reduction in overall NHS expenditure. The UK has established itself as a centre of excellence for Pressure Ulcer prevention, both in terms of clinical research and research and development of medical devices for prevention of them. We are keen that this is supported in order to ensure that the industry is successful and is able to create jobs in the UK and increase the export of UK manufactured products.

The BHTA Manifesto[15] published in July 2014 focussed on:

- savings and better value for public expenditure on health and social care
- supporting and enabling people who need equipment and related services
- supporting growth in the British economy

This paper is fully consistent with that overall approach.

15 BHTA Manifesto http://www.bhta.net/sites/default/files/document-upload/BHTA%20Manifesto%20-%20July%202014_1.pdf

A high priority for the NHS

The NHS Outcomes Framework 2014/15[16] showed that Pressure Ulcers remain a high priority for the NHS. Indicator 5.3 in the section on "Treating and caring for people in a safe environment and protecting them from avoidable harm" is the proportion of patients with Category 2, 3 and 4 Pressure Ulcers.

BHTA key recommendations:

1 Each healthcare setting should have policies with clear recommendations for a structured approach to risk assessment that are relevant to that healthcare setting.

These policies must show clinical areas to be targeted, the timing of risk assessment and reassessment, how the documentation is assessed, and how communication of that information is made to the wider healthcare team.

The BHTA recommend using EPUAP/NPUAP guidance on Grading, updated in 2014.[17]

2. In line with the 2014 NICE guidance[18] all Pressure Ulcers graded 2 and above should be documented as local clinical incidents and reported, particularly in secondary care. In primary and tertiary care settings, however, it seems that there is still a lot of work to be done.

The BHTA believes that if these guidelines are implemented correctly, it will lead to more accurate incidence levels of Pressure Ulcers falling within grades 2-4.

In addition, it is essential that reporting should also indicate the likely origin of the Pressure Ulcer (e.g. in the community at home, in a nursing home, an ambulance, Emergency Department, operating theatre or other secondary care setting) and that appropriate training is provided on the grading of Pressure Ulcers.

3. Regular assessments of prevalence are recommended in addition to incidence reporting. Prevalence audits should take place at least once a year at the same time in the year and data should be collected locally, reported centrally, in order that national and regional data can be collated[19]. Steps should be taken to improve the understanding of the difference between incidence and prevalence, especially in the community.

There is concern that not all Pressure Ulcer data is being correctly reported and that this may result in very significant underestimation of the scale of the problem.

16 https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015

17 https://www.npuap.org/wp-content/uploads/2014/08/Updated-10-16-14-Quick-Reference-Guide-DIGITAL-NPUAP-EPUAP-PPPIA-16Oct2014.pdf

18 https://www.nice.org.uk/guidance/qs89

19 http://nhs.stopthepressure.co.uk/docs/NHS_Midlands_East-How_to_educate_patients.pdf?v=L1WKZwh2Hpg

We believe that each healthcare setting should have policies with clear recommendations for a structured approach to risk assessment

Healthcare Professionals should receive appropriate education about how to achieve an accurate and reliable risk assessment. There are many recognised assessment tools.

The tool used should be recorded. All risk assessments (and possible photographic evidence) should be documented. These documents should be held within patient records to facilitate audit. If a patient develops a Pressure Ulcer of Grade 2 and above, the clinical incident should be investigated, and recommendations for corrective action be made by local tissue viability specialists.

4. Progress in the secondary care setting has been helped by Tissue Viability Nurses (TVNs) championing accountability. There is a need for more TVNs, particularly in the primary care setting due to the increasing vulnerable population. The NHS has experienced an increase in the Patient Risk Profile of up to 110%, driven by the ageing population, increases in incidence of diseases such as Diabetes Type 2 and in some areas increases in levels of deprivation. Where TVNs are in both primary and secondary care settings, the importance of community activity at all primary care delivery points including nursing homes must not be underestimated.

5. That along with patient safety training such as manual handling, training in Pressure Ulcers and their prevention should be mandatory for carers.

6. There should be local guidance[20] on comprehensive skin assessment coupled with clinical judgement (to include assessment of activity, diet, mental capacity and mobility) which will result in the appropriate involvement and development of:
   - Skin care teams
   - Educational programmes
   - Care protocols

7. The BHTA supports medical device regulations which require manufacturers to provide clear indications for the use of their products and to provide evidence to support those indications. Manufacturers must clearly state those indications on their device instructions for use and include the evidence in instruction manuals and other supporting materials.

8. Various tools are available to measure the amount of pressure redistribution and these have value in assisting a healthcare professional to make an appropriate choice of product for an individual patient.

   Such tools can also be useful in the training of healthcare professionals and the selection of appropriate products for inclusion in care protocols.

9. Equipment produced for the provision of pressure redistribution should be manufactured in accordance with industry approved national and international standards.

Cash releasing savings

It has been estimated that the cost of treating chronic wounds associated with Pressure Ulcers costs the NHS between £2.3 billion and £3.1 billion per annum[21] One reason may be that cash releasing savings are much harder to achieve today given that significant savings were made in the last decade but demand is accelerating. What some hospitals (i.e. Blackpool) are referring to instead are productivity gains / improvements e.g treating more than double the patients for the same spend.

It is vital that Pressure Ulcers are prevented in all settings such as an individual's own home, a nursing home, residential care, in the emergency care system or indeed in secondary care with due regard to a person's wheelchair, seating and bed/ sleeping arrangements.

20 Source: DWP February 2012: JP//Corporate Development and Engagement; Updated: June 2013 http://www.cvsbwf.org/wp-content/uploads/2013/09/Blackpool-Context-June-2013-Version.pdf

21 http://www.nursingtimes.net/clinical-subjects/wound-care/the-burden-of-chronic-wounds-in-the-uk/527138.fullarticle

The BHTA supports medical device regulations which require manufacturers to provide clear indications for the use of their products and to provide evidence to support those indications

Accurate data on incidence and place of origin are essential in ensuring that expenditure can be targeted appropriately. CQUIN historically rewarded performance, but incentives should not be restricted to acute services. It should also extend to community, mental health and ambulance services, and beyond the NHS into Social Care. Pressure Ulcers must remain an area of focus.

In the 2010 document, BHTA suggested that increased expenditure is required on awareness, measurement of incidence and prevalence and education and that this will lead to an increase in expenditure on prevention. There are potential savings of £1.5 billion per annum (based on 50% of Pressure Ulcers being prevented) and there are likely to be significant overall savings to the NHS.

Year	Overall Cost of Pressure ulcers*	Cost of Pressure Ulcer Prevention				Saving/(Cost) Measurement £
		Devices	Education	Awareness	CQUIP	
2011/12	£3,100,000	£200,000	£150,000	£100,000	£50,000	(401,000)
2012/13	£2,600,000	£300,000	£70,000	£100,000	£50,000	79,000
2013/14	£2,200,000	£350,000	£35,000	£100,000	£50,000	599,000
2014/15	£1,800,000	£375,000	£20,000	£100,000	£50,000	1,074,000
2015/16	£1,500,000	£400,000	£10,000	£100,000	£50,000	1,549,000
Accumulative savings over five years						**£2,900,000**

*http://bhta.com/sections/pressure-care-seating-positioning-2/

Conclusion

The BHTA believes that an increase in expenditure on Pressure Ulcer prevention will be more than funded by reduction in overall NHS expenditure.

The cost to the NHS of treating chronic wounds associated with Pressure Ulcers exceeds £2.6 billion per annum and if the points in this paper are carried out you will achieve cash release savings.

By following the recommendations the NHS should achieve better value for public expenditure on health and social care; support and enable people who need equipment and related services; and support growth in the British economy.

British Healthcare Trades Association
Suite 4.6
The Loom
14 Gowers Walk
London
E1 8PY

Telephone: 020 7702 2141
Email: bhta@bhta.com
www.bhta.com

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