Commissioning for Quality and Innovation target for wound assessment – is it working?

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The Burden of Wounds (BoW) study (Guest et al, 2015) identified that many patients were not receiving a proper wound assessment or appropriate care and that their wounds, therefore, were failing to heal. In response, NHS England introduced and implemented a Wound Assessment Commissioning for Quality and Innovation (CQUIN) Target for 2017–2019 (NHS England, 2018). This target aimed to increase the number of full wound assessments carried out within the community setting for wounds that had failed to heal within 4 weeks. NHS England state that failure to complete a full assessment can contribute to ineffective treatment and potentially delay in wound healing, which could have significant consequences for patients both in terms of quality of life and finances. To support the CQUIN implementation, a minimum data set (Coleman et al, 2017) was designed and published against which wound assessments would be audited. The BoW study (Guest et al, 2015) identified that much of the challenges occurred across primary and community care. The CQUIN target, however, has only been applied to community care — a workforce that is stretched to capacity and struggling to recruit, and where wounds are only one of its many priorities. For many, the documentation of wound assessments is bound to have a lower priority than delivering care that is more tangibly linked to improving the patients' quality of life. *Jacqui Fletcher*

1. The CQUIN for wound assessment has focussed activity in the community on documenting wound assessment, do you think the focus of the CQUIN (i.e. 4 weeks and community care) is appropriate?

HS: Following Guest et al's publication (2015), we were made aware that the majority of patients with a wound were being cared for in general practice (30,561,273 visits with 64% of these being with the practice nurse); with community nursing being the second largest (10,932,199 visits). The nursing costs of delivering this care, however, are higher in the community nursing cohort (£682,382,518 versus £256,760,021). Guest et al (2015) highlighted that wound assessment and differential diagnosis were lacking. It makes sense to assume that poor assessment and diagnosis will lead to poor wound healing and outcomes for the patient. Taking this view, it is understandable why NHS England have decided to target wound assessment for improvement. Despite general practice seeing the larger number of people with wounds, the costs are higher to community nursing and driving improvement in wound assessment is easier to achieve through the larger NHS organisations providing community nursing services. The communication infrastructure is better supported. A timeframe of 4 weeks seems reasonable given that we might expect many wounds to heal within this period. Consideration also needs to be given to the fact that community nursing services are under huge pressure (Maybin et al, 2016) and a shorter timeframe would be unrealistic to achieve.

MH: I would have liked to see it focussed for a longer period of time and also not just in community care, as a vast amount of my patients are transferred from other care settings, especially the hospital. In terms of equitable and transparent care, I would have liked to have seen the CQUIN address the locations where the wound assessment is undertaken. I am, however, an absolute fan of focussing nationally on wound assessment and tissue viability in its entirety and look forward to leg ulcers being addressed at a national level.

BCH: The CQUIN is ensuring essential documentation is in place to improve wound care for patients. Whilst patients with wounds are cared for in all areas of the health economy, the majority of wound care practice is undertaken in the community setting and is nurse-led (Guest et al, 2015). Therefore, it is appropriate to focus on this area. The Guest et al study (2015) highlighted that wide variations existed in terms of assessment, leading to lack of diagnosis and fragmented management, which further endorses a need to examine practice, identify the reasons for these gaps and develop solutions to resolve them. Four weeks is a good timeframe for identifying chronicity and may prompt some practitioners to develop pathways to facilitate earlier diagnosis of underlying aetiology. However, the demographic changes of an aging population with associated multiple

comorbidities does pose a challenge in terms of recognising the potential for a chronic wound as early as 2 weeks in some patients.

AS: There is an identified need for more focus on wound care and getting the right care first time. The BoW study (Guest et al, 2015) highlighted the growing issue around all wound types and the vast costs to the NHS, which is growing yearly. This CQUIN has been aimed directly at district nurses (DNs) as they have the highest proportion of wound care contacts in the health service; so, yes, it is an appropriate start point. All patients with a wound should have a full holistic assessment on first contact; this should encompass the full TIMES framework to form the planning of treatment. The CQUIN requires nurses to make a full wound assessment and identify wounds that have been present for 4 weeks. This should be standard activity but it has been highlighted that there are variations from Trust to Trust. Implemeting the CQUIN should result in an improvement in the quality of care.

SP: What would make the biggest difference in improving the quality of care to promote the healing wounds? I ask myself after 24 years of tissue viability experience: acting promptly and knowledgeably upon good holistic assessment. What does this depend upon? The knowledge of the staff undertaking the assessment: knowing how to treat patients holistically, and identifying and removing the underlying cause of the wound and impediments to wound healing if possible. This standard has been a stipulation in wound care policies, procedures and teaching for many years, so to have it reinforced and measured is good to ensure standards are being met. However, it has to be added that all wounds should be reassessed on change of their condition and also that this time period is appropriate for chronic slowly healing wounds, such as leg ulcers, but is not appropriate for some acute wounds and other wounds that are encountered in primary care that can rapidly change appearance. There are gaps in services for patients with some wound types in primary care and for chronic wounds such as leg ulcers in secondary care. Therefore, outcomes for some are not achievable without reviewing access to services available, which would improve healing across the board not just for those covered by our services being measured by CQUIN.

2. Many organisations have devoted extensive amounts of time to reviewing, amending and updating their electronic patient record templates, do you feel that this should have been done at a national level or do you prefer to have your own design for the template?

HS: Whilst doing this at a national level might be idyllic, it would likely not be possible. Organisations are using a wide variety of patient record systems be that paper or electronic, so no one template would fit. The minimum data set (Coleman et al, 2017) was designed nationally and provides guidance as to what needs to be considered for inclusion. For me personally, reviewing and redesigning our templates (SystmOne) was a valuable experience and an opportunity not only to enhance our current assessment templates, but also to get out there, meeting the teams and talking to them about the changes.

MH: The updating of the template has been extremely time consuming. I knew when the CQUIN was released that the areas for improvement wound be aim: quality of life. This was positive as it is always good to show improvement. What actually transpired was nothing but a nightmare to obtain the data. Although our electronic system is used in various UK settings, it appears my system was bespoke built, thus no read codes behind data extraction, so all 150 patients had to be audited individually. Ideally, a national template prior to the CQUIN release, at least 6 months or so, would have made the process simpler.

BCH: Whilst it is the Government's intention to introduce a comprehensive system of electronic health records in England by 2020, there are currently many organisations that are reliant or partially reliant on paper systems. Wound assessment is one document that tends to be paper-based for many healthcare organisations. Also, there are over one hundred commercial suppliers of electronic health record software, which may give rise to issues around compatibility for a national template. Whilst a national-based design would be an opportunity to standardise the assessment process, it's possibly too early to introduce this at present.

AS: There was initial confusion in Trusts as to what changes were required in capturing the wound assessments. Not all had electronic systems in place, so paper records had to be used for audit, which is very time consuming. In my Trust, we use SystmOne for electronic patient records with a wound assessment template. It did not cover all of the minimum data set details and I updated this with IT personnel. Every point and section must comply with the Read code, so this sometimes had to be adapted to ensure we covered all points. For the purpose of standardising practice and having the CQUIN, I feel that a national tool would have been useful. A lot of teams updated after the first audit; I provided training sessions to DN teams in how to use the new template. Tissue viability nurses/teams took on most of the workload to implement and make changes. In my opinion, it seems that Trusts and Clinical Commissioning Groups (CCGs) have not been fully understood what is required yet.

SP: We reviewed our SystmOne template, which had originally been amended from the national template, and added the recommended categories but not all organisations use this system of documentation. This was not the most time-consuming or difficult aspect of achieving the CQUIN for us, and, as each organisation has SystmOne set up differently with different links, it is probably better to do your own. Generally, I tend to favour standardisation, however, getting agreement for a national standard could possibly have

taken longer. Even though we think we are looking for the same thing, more holistic factors delaying healing can lead to duplication in documentation, such as smoking, and where that is recorded. I prefer to have it all in one place for wound assessment but some people outside the speciality do not see the need for this as it can be found elsewhere but staff do not always have time to look. The most time-consuming aspect of CQUIN for us was conducting the audit, which the Tissue Viability Service carried out assessing SystmOne records individually.

3. Do you believe that the introduction of the CQUIN will result in improved assessment of patient's wounds and, therefore, improved outcomes?

HS: Quite simply I do believe this, yes. It's not easy. Our dedicated community nurses struggle on a daily basis to do all they need for their increasingly complex and frail patient population. However, they can do it, they have the desire to do it and they recognise that better assessment early on will improve outcomes and therefore reduce their time commitment to some of their patients. Our full wound assessments improved from 2.3%–50.3% with the introduction of the new assessment templates.

MH: I would like to think the CQUIN will have a huge impact on wound assessment and patient outcomes as the template becomes embedded in the organisational electronic system. At ground level most community nurses have no idea what a CQUIN is thus the "How to Guide" (Wounds UK, 2017) has helped. It is imperative as lead clinicians that we keep the focus on what the CQUIN is designed to do, thus improving patient care rather than focussing on the financial gain.

BCH: Yes, and we have been able to demonstrate a 45% improvement rate in the number of fully completed wound assessments from audits undertaken in Quarter 2 (2017) and Quarter 4 (2018). However, whilst the CQUIN, House of Lords debate and related work assist in giving focus to the burden of chronic wounds in the UK, the estimated rise in the number of patients with chronic wounds over the next 10 years versus the increasing shortfall of community nurses does pose some concerns regarding sustaining this improvement.

AS: I believe there will be initial improvement, I believe, in wound assessments due the CQUIN. We are very good at ensuring that we hit the targets when they are in place. However, I think there has to be education to support how and why we do an in-depth wound assessment; looking at treatment choices, monitoring incidence and healing rates with all wounds, not only pressure ulcers (PUs) as we are now well versed in them. To sustain it after the CQUIN also is essential. In my Trust, for example, training for leg ulcers is mandatory now; all wound types need the same profile as PUs receive. The new Nursing and Midwifery Council (NMC, 2018) "Standards of Proficiency for Registered Nurses" are more detailed and has a section for assessing and planning of care. It also touches on wound care procedures. Going forward, the national strategy for wound care should also ensure that all wounds get equal attention and more standardisation in practice.

SP: Referring back to Question 1: Does filling in an assessment improve outcomes? Only if the person assessing and caring for the wound understands how to interpret the assessment findings and in turn treats the patient and wound appropriately. Therefore, assessment alone does not necessarily improve outcomes. However, with the assessment tool, we have introduced a wound assessment guide based on the TIMES model and additional training in how to use the tool so it should have prompted an increase in knowledge and awareness. We also audited how many patients had had an initial assessment as reassessments need comparing to previous assessments to evaluate the effectiveness of treatments, it is also a communication tool but can be somewhat subjective, therefore, photographs with wound assessment are very beneficial as is continuity of care where possible. To accompany assessments and in order to improve outcomes investment, is required to support Tissue Viability services to deliver educational strategies and for staff to know when further referral is needed.

4. Do you think the CQUIN should be extended to cover acute and primary care, and why?

HS: Given the number of patients being seen in general practice with a wound (Guest et al, 2015), I think this area needs to be targeted next. It might seem easier to target the acute sector because of the infrastructure of the NHS but it won't make sense when the bigger problem is elsewhere. General practice nurses (PNs) and doctors, in my experience, often don't use a wound assessment template at all so driving an improvement here might lead to improved outcomes for the patients living with a wound and being cared for by (PNs).

MH: I firmly believe that the CQUIN should be extended to both acute and primary care. Primary care is a forgotten area of practice and having seen the standard of record keeping and wound assessment often due to 10-minute patient appointments there is a clear case for change. Many of my patient referrals have been treated for prolonged periods of time for "trauma wounds" to the lower leg that have required a full holistic wound assessment and compression. I would like the CQUIN somehow to address acute hospital discharge with wounds, as the original wound assessment never follows a patient into the community and I am keen that we adopt the "no buildings" concept to ensure equitable care across all settings. Care homes are also a huge area of discovery, being private businesses they tend to adopt their own standards of practice. I would like to see a national wound assessment template or form adopted by the Care Quality Commission (CQC) to ensure that all care homes also undertake a full comprehensive wound assessment.

BCH: Variation in practice is not confined to the community but exists in other areas. It is a whole health economy issue and concentrating on pockets is not going to make a difference. Therefore, it would be useful to extend the CQUIN to other areas and ideally include primary care, community in- and out-patients, the acute sector and nursing homes. Wound assessment is strongly affiliated with the NMC's Code of Professional Standards including "Practice Effectively and Preserve Safety", which reinforces the need to apply the CQUIN to other settings.

AS: Primary care has the highest contacts with wounds with PNs after DNs. We all know *Betty's story* of experiencing an optimal and sub-optimal pathway with regards to leg ulcer diagnostics, treatment and recurrence (NHS RightCare, 2017). I believe that if we don't focus on primary care, we can never move forward, and never close the circle of the BoW. GPs need to come on board and invest in the education of PNs, releasing time or providing more chronic wound type clinics or leg ulcer clinics. Acute care would have to have specific CQUINs, e.g. a surgical wound assessment. With regards to PUs, once identified and reported, do we look at the patient journey from that point onwards? I notice staff lacking in wound management education in acute Trusts and an inequality in the assessment and care of patients admitted with a leg ulcer, oedema or lymphoedema.

SP: Yes, I think it should be extended to acute care, but a 4-weekly reassessment is not appropriate in secondary care where acute wounds can change more quickly and patients do not stay in hospital for more than a few days. It would need to be much more frequent for acute wounds: at first dressing change then, change of condition and minimum weekly. Chronic wounds are also not likely to be admitted for 4 weeks, so again the wound to be assessed on admission, on change of condition and weekly. All wounds should be reassessed prior to discharge, and this final assessment should be shared with the service so that continuity of care can be promoted post-discharge.

5. Do you feel the CQUIN has allowed you to refocus on wounds other than PUs?

HS: Not really, yet. It has provided focus on assessment of all wounds, be that leg ulcer, PU or surgical wound. It has given us an opportunity to gather some data and understand our patient population, which in turn will help us realise more improvements on assessment and management as we move forward. However, the reporting and investigations of PUs are still receiving more time and attention from tissue viability nurses (TVNs), certainly in our area.

MH: I see the CQUIN as part of the PU agenda, as all PUs are assessed using the template, as are leg ulcers along with a comprehensive leg ulcer assessment form. The issue I have found on discussion with other colleagues in the UK is that the organisations have appeared to have outstanding results have employed project nurses to oversee and embed the concept within their areas of practice. My difficulty has been to raise the profile at every opportunity, sadly, this is on top of the day job. I know the template meets the specification of the CQUIN; the battle has been in getting staff to complete it.

BCH: Yes, we feel that the national focus on PUs for a number of years has led to staff overlooking other wounds and not performing good quality assessments to enable a timely diagnosis. Wound care is more than just PUs, and the wound assessment CQUIN has recognised this.

AS: I lead a tissue viability service across acute and community settings and there are different focuses. In the community, yes, we do now consider all wound types much more than before: a new skin tear pathway was developed, the leg ulcer training updated and an new algorithm based on the "How to Guide: CQUIN Targets: Improving the Assessment of Wounds" was put in place (Wounds UK, 2017). The BoW study (Guest et al, 2015) was a catalyst for me and we need to raise the profile of wound care higher up the ladder to the leaders in the NHS in our own Trusts, so they give it as much importance as other conditions, such as obesity. The CQUIN is in place yes, audits run, TVNs are working hard to ensure it is embedded into practice, but it doesn't feel as if it's fully understood yet and why it is there in the first place. In the acute sector, PU prevention is still dominant: analysing data, campaigning and continued focus on reduction. However, The future looks promising: a political focus on wound care and the CQUIN to improve wound assessment is, indeed, a good place to start.

SP: It has changed the focus slightly but that is only because it is being measured, PUs still very a high focus, other wounds are not ignored but do not present such a high patient safety risk unless they have a serious infection, therefore, precious Tissue Viability resources are steered in the direction of prevention of PUs. I think the CQUIN missed an opportunity to separate out leg ulcers for leg ulcer assessment rather than wound assessment as wound assessment on a leg ulcer is not particularly meaningful without a full leg ulcer assessment to determine treatment, and this is a very high proportion of wounds in community nursing. As a result, we added whether a leg ulcer assessment had been carried out on leg wounds in the CQUIN audit. An improved outcome for leg wounds cannot be achieved without assessment and treatment of the underlying cause, and appropriate treatment and referral. WUK

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