

The Quality Agenda: what does it mean for tissue viability?

The NHS quality agenda has been discussed, debated, explored and highlighted over the past year in an effort to meet the challenges laid down by the Department of Health (DH). The terms quality accounts, innovation, productivity and prevention (QIPP), and the Commissioning for Quality and Innovation (CQUIN) payment framework should by now be familiar to most clinicians.

The CQUIN framework aims to place quality improvement and innovation at the heart of negotiations between commissioners and providers to ensure that local quality improvement priorities are discussed at board level. The CQUIN payment framework also stipulates that a proportion of the income paid to healthcare providers is conditional on quality and innovation. This will help to create an NHS where quality is the organising principle, as set out in High Quality Care for All (DH, 2008).

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There are in excess of 200 new indicators that make it essential for tissue viability clinicians to benchmark their work against that of their peers. Each strategic health authority (SHA) has identified quality initiative schemes and indicators based around four sectors — acute, community, mental health and ambulance services. The Chief Nursing Officer for England has produced eight high impact action themes for nursing and midwifery, including: 'Your skin matters: no avoidable pressure ulcers in NHS-provided care.'

Additionally, the Leg Club social model, which has been designed for use in patients with leg ulcers, has been identified by the DH as an area of good practice for its approach to quality care.

The DH document NHS 2010–2015. From Good to Great (DH, 2009) clearly states that there will be 'safer care for patients, who can be confident that they will be protected from avoidable harm'. It highlights pressure ulcers as an area that needs to be addressed and insists that the tariff payment system will not reward poor quality or unsafe care. Penalties can be applied to those areas that do not meet quality or patient satisfaction outcomes, and there is an expectation that over time up to 10% of trusts' income could be dependent on patient experience and satisfaction.

However, tissue viability is not always recognised as a speciality and clinicians need to ensure that it is seen as a discipline that impacts on other areas, such as nutrition, pain management, infection and medicines management. In the future NHS, quality is going to be paramount, but what support will tissue viability practitioners receive in meeting these targets and indicators? KO

How do we raise the profile of tissue viability?

SP: I have been involved in the development of tissue viability services for 16 years and have been reasonably successful in securing funding for new posts. However, this has only been achieved through local primary and secondary care services working together to identify problem areas and overcome any barriers that may prevent service development.

The fragmentation of trusts is making collaboration even more difficult, and tissue viability is rarely prioritised over other more essential services until an 'incident' or complaint brings it to the attention of NHS managers.

The recent national guidance does help and forces managers (some of whom have no medical experience) to find out more about tissue viability. However, what exactly it is that constitutes a tissue viability service is not always clear to the outsider.

As the NHS changes and different specialties provide different services, tissue viability clinicians need to be clearer about the specialist skills that they bring to patient care. If necessary, this should involve a national strategy, which is clearly communicated with standardised service specifications and improved quality measures.

Some areas of tissue viability do have a high profile, for example *From Good to Great* (DH, 2009) raises the issue of preventable pressure ulcers

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and methicillin-resistant *Staphylococcus aureus* (MRSA) infections in a section entitled 'safer care'. As such conditions can be fatal and the compensation risks to trusts are high, these areas often receive a lot of attention from managers. However, many other wound types are also seriously debilitating and this is why the speciality as a whole needs to develop a unique voice.

SB: The profile of tissue viability services in the NHS can be raised by demonstrating the value of these services and the contribution they can make to patient care. There are various ways to do this, for example:

- ▶ Demonstrating a reduction in patient risk through reporting prevalence and incidence data to trust boards (infection control teams do this regularly)
- ▶ Demonstrating an improvement in patients' experiences through reporting different patient cases and their outcomes to trust boards
- ▶ Compiling annual reports that clearly define the numbers of patients treated, the costs of equipment and a breakdown of prevalence/incidence data to trust boards.

RS: It is imperative that tissue viability aligns itself to the national quality agenda. Tissue viability leads around the country need to continue to engage with key NHS stakeholders in order to raise the awareness of their speciality. Endorsement needs to be sought from the highest level and evidence provided as to the quality of local tissue viability services.

Engaging directly with the relevant people in the DH should be part of a project plan that aims to raise the awareness of tissue viability services.

Importantly, the correct language and terminology needs to be used when attempting to engage with non-clinical colleagues in the NHS. Hard facts and figures are needed to express precisely how tissue viability can align itself to the three main domains of the quality agenda — patient safety, clinical effectiveness and patient satisfaction.

What support do nurse directors offer to develop the indicators and raise the profile of tissue viability?

SP: This depends upon the nurse director and how other targets can be linked to tissue viability. Initiatives such as Productive Wards and Essence of Care have both contributed to raising the profile of tissue viability in primary and secondary care, and have encouraged more staff, such as ward managers and tissue viability link nurses, to become active and involved. They also help services to prioritise delivery targets.

However, it is an unfortunate truth that adverse events often demand the most attention, resulting in service reviews, policy development, education and further training. Extra resources that enable all of this to be put in place are not usually forthcoming unless cost savings have been made elsewhere.

Our service has been involved in providing evidence for the

NHS Litigation Authority (LA) risk management standards for primary care trusts and these are now being replaced by Quality Care Commission standards. Demonstrating these standards can make tissue viability services more robust and fit for purpose.

However, all of this is only possible by having good links with governance teams and other specialist services, as well as the support of an administrative team. Also, if clinicians can produce examples of good service delivery, this may result in a trust director championing their tissue viability service and support will then follow naturally.

SB: The nurses in a tissue viability service should endeavour to report directly to the trust's nurse director in order to build a sound working relationship. This will ensure that tissue viability issues are recognised and supported within the trust.

What are the societies doing to promote and develop this agenda?

SP: The various societies need to work towards the common goal of establishing and promoting tissue viability as a specialty. There is a never-ending list of projects that need to be pushed forward, however any new initiative should be part of an over-arching plan to establish a clear strategy for tissue viability.

Working with colleagues in the British Dermatological Nurses Group (BDNG) demonstrated to me just how successful cohesion can be.

SP: Commissioners want evidence of quality provision via patient feedback and experience and monitoring this will help tissue viability services find a way forward.

SB: Quite simply, if companies do not support tissue viability clinicians, then the entire specialty will suffer, including the commercial interests of industry.

The BDNG is recognised as the main consulting body on national dermatology issues, represents the specialty in parliament, and runs its own conference which is integrated with that of the British Association of Dermatologists (BAD).

SB: The societies associated with tissue viability support and disseminate developments in practice and research, both through journal publications and at conferences and study days. They also develop and publicise measurement tools, for example, those that facilitate audit and prevalence data collection. These are all useful in demonstrating the value of tissue viability.

RS: The specialty as a whole needs to ensure that any messages about the quality agenda are communicated clearly and consistently across all of the various tissue viability societies. Some groups have realised the importance of using their events to promote the quality agenda, for example at the next Leg Ulcer Forum conference, Gerry Bolger, Programme Director of Quality in Caring at the DH, has been invited as a guest speaker and will help to outline the quality agenda to everyday clinicians.

When the indicators are in place how will they be measured and what penalties will occur should they not be met?

SP: It is difficult to predict what measurements will be acceptable in the future and if the current methods will continue, or whether each patient outcome will be monitored

on a case-by-case basis and reported via a different mechanism, i.e. clinical incident reporting. This is a complicated area as not all of the pressure ulcer grades are classed as clinical incidents.

It would be interesting to know exactly who is advising the DH on this policy, as this is where tissue viability clinicians should have a level of influence. If a pressure ulcer represents a 'never event', it will have to be determined whether the event was considered preventable or not — but who is to decide this?

Similarly, when investigations into an event are being completed, trying to determine whether or not it was preventable can be difficult, despite other practice-related issues, i.e. adequate documentation being flagged up.

SB: Measuring patient outcomes is generally a positive move, which should enable services to develop and improve. Tissue viability is being recognised as an important aspect of patient care, which is what many of us have been advocating for a long time.

However, it is important that the sanctions or penalties used to discourage inadequate care do not negatively impact on the reporting of tissue damage.

The principles of clinical governance revolve around a 'no blame' culture and engendering an atmosphere of learning. Initiatives such as the *Safer Patient Initiative* (Institute for Healthcare Improvement [IHI]

and the Health Foundation, 2004), 1,000 Lives campaign (www.wales.nhs.uk/sites3/home.cfm?orgid=781) and *Transforming Care at the Bedside* (TCAB) (Robert Wood Johnson Foundation and IHI, 2003) have been effective in improving clinical practice and patient outcomes.

RS: Although the Chief Executive of the NHS, Sir David Nicholson, has stated that all secondary care providers will have to publish quality accounts this year, there is still no real national consensus on what they should look like. Part of the difficulty is that there is no agreement on who will be accountable for the content. However, this should not be an excuse to be complacent or tentative.

These quality accounts are going to happen and we should see them as an opportunity not a threat. After all, they could raise the awareness of tissue viability in the NHS.

It is important that tissue viability clinicians develop a small number of good quality metrics, rather than trying to measure a wide range of variables.

The most obvious place to start is with pressure ulcer management, which clearly falls under the remit of patient safety. The DH has suggested that grade 3 and 4 pressure ulcers will be identified as never events and penalties and incentives will be assigned accordingly. This provides clinicians with an opportunity to properly measure and report pressure ulcer prevention and management.

When measuring quality, clinicians need to be looking for improvement, rather than just performing measurements as an end in themselves. Clear objectives need to be set and ideal outcomes identified before any measurements are conducted. Indicators and metrics are vital as they ensure that a service like tissue viability can demonstrate its quality.

The DH identifies success in the national operating framework as having two main areas:

- ▶▶ Providing more services closer to home with a reduction in activity and investment in the acute sector
- ▶▶ An identifiable, clear quality of service across all standards and patient pathways.

One of the biggest opportunities for quality and productivity in tissue viability services is at the interface of primary and secondary services, where clinicians can ensure that care is seamless and always in the patient's best interest.

Caring for vulnerable skin and prevention of ulcers is a basic element of care, yet the CQUIN did not identify this as a priority. Why do you think this was not recognised?

SP: CQUIN is a general framework for commissioning quality and innovation, therefore no specific area is mentioned as we have to fit our ideas into a proposal that will be locally agreed. This means that once again tissue viability will be competing for priority against other services.

It is also recommended that any area, such as the prevention of pressure ulcers, is measured by demonstrable patient outcome. The East Midlands has now produced its framework and pressure ulcers feature in the community sector, with the objective: 'To measure, monitor and reduce the incidence of grade 2 and higher pressure ulcers.'

Improving data collection and ensuring that standards of care are in place should fit with CQUINs aims as data collection is specifically mentioned as a way of reducing pressure ulcers – without good initial data, a reduction cannot be robustly demonstrated.

Our trust collects incidence and prevalence data and has a reasonably low incidence of grade 3 and 4 pressure ulcers, but it has always been a concern of mine that data collection methods are not standardised nationally. There is a clinical incident report and investigation for each full thickness ulcer that develops in our trust. This is an area we are still learning about in order to improve care and monitor the type of issues that arise.

Commissioners want evidence of quality provision via patient feedback, and monitoring this will help tissue viability services find a way to improve quality in the future.

The reward for achieving the CQUIN targets will be extra funding, but this is non-recurrent and paid gradually dependent on any improvements being quantified.

SB: As I work in Wales and we do not have this system, I feel unable to comment accurately.

Does industry have a role to play in updating clinicians' knowledge on national healthcare policy??

SP: Educating clinicians is imperative, but often the interpretation placed on new guidance is seen as having a 'hidden agenda', especially if the information is provided by companies.

However, if employers do not provide updates about new guidance and clinicians do not regularly attend conferences, it can be difficult for them to access information. Reading about guidelines does not always provide an accurate idea of how they should be implemented in practice.

I think industry can help fill this void, especially if they recruit impartial and experienced speakers. However, even these can only provide an overview as interpretation at local level can be quite different. This is one area where clinicians can work together to develop ideas for proposals and secure funding to improve tissue viability practice.

SB: Yes, industry does have a role as it has a proven track record of providing and funding generic education, which is not product- or company-focused.

Some companies have put on workshops and study days for TVNs on topics related to their role as a specialist, including how to deal with

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RS: *In the future, tissue viability groups and societies need to work together to offer clear and consistent messages on quality.*

organisational change in the NHS and leadership and management. Other companies provide generic education for nurses working in clinical practice in subjects such as pressure ulcer prevention, wound and patient assessment, documentation and patient evaluation.

Industry can help by updating clinicians and inviting independent speakers to workshops and study days. A broad range of presentations of educational materials are available, from group teaching and workshops through to web-based materials and programmes.

Those managing clinicians' education should liaise with those companies that provide unbiased education, as well as using the materials provided by the associations. This will provide a balanced approach to education.

RS: Yes, industry does have a role to play here, but importantly the rationale for offering education must be clearly identified to refute any suspicion of commercial bias.

As cost is becoming such an important driver for clinical decision-making in the NHS, it is imperative that tissue viability services provide evidence on the rationale and cost-effectiveness of any advanced wound care products used. Moreover, industry can support clinicians by offering economic evidence on the value of products used.

In this current climate, where the need for productivity and efficiency

savings are highlighted at every possible opportunity, accurately measuring and reporting quality in tissue viability services is more important than ever.

Who is the national voice of tissue viability?

SP: I wish I could answer this question with a definitive answer because it is imperative that the specialty has a powerful voice. There are influential individuals in tissue viability, but the societies should be responding to policymakers on their members' behalf. Due to the dissolution and merger of various societies, we have to refocus and work together to ensure a cohesive approach to raising the profile of the specialty.

Established regional networks exist and these need to communicate via a national centre in order that tissue viability information is consistently disseminated. This kind of information sharing is vital, especially if the views of clinicians are to be sought.

SB: Unfortunately, there is no one, national voice. Because of the UK's political system the trend is towards devolvement, thereby health services can be fragmented across the various countries.

But do we need one voice, or is the plethora of associations a positive thing, allowing for a diversity in focus and differing yet complementary ways of providing tissue viability information? I belong to several

associations and each give me something different and useful.

In return, I have been privileged to sit on some of the committees and contribute to the work the associations carry out. Having one single voice would, in my view, inhibit the growth of the specialty and engender a culture of infighting among the various tissue viability associations.

RS: At present there does not seem to be one national voice for tissue viability. In the future, tissue viability groups, societies and forums need to work together to offer clear, consistent messages on quality and other important national issues. A national communication platform also needs to be developed in order to disseminate messages and information. **WUK**

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If you have an idea for a debate, please email blinkie.mais@wounds-uk.com