

# Reducing pressure ulcer incidence: CQUIN payment framework in practice

In 2008 the Department of Health published 'High quality care for all: NHS Next Stage Review'. This report includes a commitment to make a proportion of NHS providers' income conditional on provision of quality and innovation through the Commissioning for Quality and Innovation framework (CQUIN). This article discusses the principles of the CQUIN payment framework and explores its relevance and impact in reducing pressure ulcer incidence. Personal experiences of negotiating CQUIN targets, implementing a strategy to reduce pressure ulcer incidence, and monitoring outcomes to provide evidence of quality improvements will be given.

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## KEY WORDS

CQUIN payment framework  
Pressure ulcer incidence  
Quality and innovation  
Strategy

In 1992 the Department of Health produced the *Health of the Nation* report, which detailed healthcare policy for England. It was the first attempt by the government to provide a strategic approach to improving the overall health of the population (DH, 1992). Included in this report was a specific target aimed at reducing the incidence of pressure ulcers by 5–10% annually. This was one of the first recognitions that pressure ulcers were a problem in the NHS, and that patient quality of life was affected as a result. Pressure ulcers were seen to be avoidable and an indicator of the quality of patient care.

In 1998 the government developed a strategy for reorganising the NHS to create a modern service that delivered high quality services for all. A *first class service* — *Quality in the new NHS* (DH, 1998) acknowledged the need to improve quality in relation to pressure ulcer incidence and, as such, essence of care benchmarking was developed

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as a toolkit to share and compare best practice. It recognised fundamental aspects of patient care, that through a structured approach to measuring quality, outcomes could be shared and practices improved as a result.

Ten years later, Lord Darzi acknowledged the work of the NHS throughout its 60-year history in his report *High Quality Care for All: NHS Next Stage Review*, and outlined future requirements to ensure a

safe and effective healthcare service (DH, 2008). Quality was to be the organising principle and a framework has been developed with those working in the NHS to help produce a system which actively encourages organisations to focus on quality improvements and innovation in commissioning of services. The CQUIN payment framework was part of this commitment to quality and innovation. This will be discussed in more depth later in the article.

The most recent report outlining the NHS vision was published in July 2010. *Equity and Excellence; Liberating the NHS* focuses on three core beliefs:

- ▶▶ Freedom
- ▶▶ Fairness
- ▶▶ Responsibility.

It clearly details the responsibilities of healthcare providers with an emphasis on making the NHS more accountable to patients, a relentless focus on clinical outcomes and empowerment of healthcare professionals (DH, 2010a).

The NHS Institute for Innovation and Improvement is a body of the Department of Health that has been set up to assist the NHS in transforming health care for patients and the public. In collaboration with the Nursing and Midwifery Council (NMC) and the Royal College of Nurses and

Midwives (RCN), an online survey was conducted asking staff to share their ideas on how they have improved quality and innovation. As a result, eight key high impact actions were developed, of which 'your skin matters' recommends that there are no avoidable pressure ulcers in NHS care (NHS Innovation and Improvement, 2009).

Many organisations are using the high impact actions (HIAs) as measures of quality to form part of their CQUIN targets. Examples can be found online at [www.institute.nhs.uk/world\\_class\\_commissioning/pct\\_portal/cquin.html](http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html).

There has been a high profile within the NHS both in England and Scotland for the need to improve quality and safety for patients and the public since the early 1990s. Healthcare professionals are all accountable for the delivery of safe, high quality care with a commitment to continually improve the way care is delivered and develop services to meet changing healthcare needs.

### Pressure ulcers

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' (European Pressure Ulcer Advisory Panel/ National Pressure Ulcer Advisory Panel [EPUAP/NPUAP], 2009).

The majority of pressure ulcers are avoidable in NHS care, yet many NHS trusts are still experiencing higher than average incidence figures, hence the continuing initiatives and targets being introduced. It is disappointing that despite a lot of hard work by many specialist tissue viability teams over a number of years, we still have patients developing avoidable pressure ulcers. As a nation, we know that we have an ageing population who are at risk of developing multiple comorbidities. The EPUAP supported this fact and envisaged that due to an ageing population, the numbers of patients with pressure ulcers would increase (EPUAP, 1998).

Diabetes and peripheral vascular disease as well as obesity are also on the increase, and these factors can lead to an increased risk of pressure ulcer development through reduced mobility, oxygen tension in the tissues and poor blood flow.

Pressure ulcer incidence has been found to be between 4 and 10% of patients admitted to acute hospitals

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in the UK (Clark et al, 2004). They not only represent a notable burden of sickness and a reduced quality of life for patients, but also cost average district general hospitals in the region of £600,000–£3 million per year (NHS Institute for Innovation and Improvement, 2009).

Pressure ulcer prevention is not complex, nor should it be made to be. Maintaining the integrity of patients' skin is a fundamental and essential element of care, for which all healthcare professionals are accountable.

### CQUIN payment framework

The key aim of the CQUIN payment framework is to help produce a system which actively encourages organisations to focus on quality improvements and innovation in commissioning decisions. It links closely with the emphasis in the next stage review process where measuring what we do is the basis for transforming quality (DH, 2008).

The CQUIN framework is only one part of the NHS overall approach to quality and existing work being undertaken. It specifically aims to focus on improving quality of care in commissioning and contract discussions, which has the potential to open up a dialogue to promote innovation and continuous improvements in care through local negotiation.

In simplistic terms, commissioners will discuss and agree local quality targets with care providers, which, if achieved, will earn financial rewards.

For 2010/2011 the CQUIN payment framework must include the two national goals and indicators:

- ▶▶ Reducing avoidable deaths, disability and chronic ill health from venous thromboembolism
- ▶▶ Improving responsiveness to the personal needs of patients.

Other goals are set based on quality improvements that are required locally. Examples in the author's trust are 80% of staff undertake training in dementia awareness, a 10% increase in nurse-led discharges for selected elective surgery pathways, and reducing sickness absence by 0.75%.

Reducing the incidence of pressure ulcers is a target that appears to be included in many CQUIN schemes across the country for 2010/2011, as pressure ulcer prevention remains a key indicator of the quality of patient care.

The target is negotiated at a local level, therefore there are variances across the country. Examples being

- ▶▶ To reduce all grades of pressure ulcers
- ▶▶ To have no grade 4 pressure ulcers and a reduction in the percentage of grade 3 ulcers
- ▶▶ To maintain the low levels of grade 3 and 4 hospital-acquired pressure ulcers achieved in 2009/2010
- ▶▶ A year on year reduction in newly-acquired pressure ulcers of no less than 25% against the baseline
- ▶▶ A reduction in all preventable pressure ulcers.

In the author's trust, a target has been set to reduce hospital-acquired pressure ulcers of grade 2 and above by 30% at the end of the financial year.

Overall, the CQUIN payment framework is worth £3.85 million to the trust, with the pressure ulcer CQUIN worth 10% of the total, equating to £385K.

**Local negotiation of the CQUIN target**

Local negotiation with the PCT commissioners took into account work that had already been undertaken in the trust on pressure ulcer reporting, such as monitoring of pressure ulcer prevalence and incidence and what indicators were used to achieve these results. The trust had an average of between 3 and 5% of patients developing hospital-acquired pressure damage. It was acknowledged during the negotiations that this information was based on quarterly prevalence data collection and not ongoing incidence data. For many trusts it is difficult to obtain accurate incidence data, as it relies on accurate reporting of all patients developing pressure damage over a defined period of time. At times, staff struggle to find time to report pressure ulcer incidence at the time of the event and, therefore, capturing accurate data was difficult.

To determine accurate incidence data there also needed to be a robust method of obtaining activity information on which to calculate the incidence figure. In the author's trust, this process has been far from accurate in the past. Therefore, it was decided to use prevalence data which the PCT commissioners were prepared to accept. The baseline was agreed at 5%.

Although the trust had always collected pressure ulcer data on grade I damage and above, the rationale for

excluding grade I pressure damage was in relation to accurate recognition of skin changes. There have been occasions where changes in skin colour have been misdiagnosed as pressure damage, when in fact this was related to infection or dermatitis. The EPUAP classification system (EPUAP, 1998) provides clear guidance on grading of pressure ulcers and identifies that all pressure ulcers of grade 2 and above should be documented as a local clinical incident. This was also taken into account during the discussions. Despite not counting grade I pressure damage in the reporting process, the clinical staff are reminded of the importance of early interventions at this stage to prevent further skin breakdown.

As pressure ulcers are rarely found in paediatric or maternity services, it was also agreed that these areas would be excluded from the reporting process.

The CQUIN payment is based on achievement of the target quarterly. *Table 1* details the percentage of reduction required to meet the 30% total target at the end of the year.

**Strategy for achievement of the CQUIN target**

Following negotiation of the CQUIN target, it was the author's responsibility to develop a new strategy for achieving a reduction in pressure ulcer incidence.

The trust already had a well-established educational programme for the prevention and management of pressure ulceration and policies and guidelines to support staff in practice. Thus, the key objective was to raise the profile of the need to improve the quality of care for patients at risk of developing pressure ulcers once admitted to hospital, and reduce the incidence to ensure achievement of the specific CQUIN target.

The key elements of the strategy were as follows.

**Strategic statement**

- ▶▶ To demonstrate a commitment to reducing pressure ulcer incidence in

patients admitted to the trust and to manage effectively those patients who develop, or are admitted with existing pressure ulcers.

**Aim of the strategy**

- ▶▶ To ensure that all staff involved in patient care have the knowledge, skills and resources to reduce the incidence of pressure ulcers in patients admitted to care.

**Strategic criteria for action**

- ▶▶ Acknowledge at board level a commitment to reduce pressure ulcer incidence
- ▶▶ Demonstrate a commitment, through an action planning process and robust outcome monitoring to improving quality to meet the requirements of the Care Quality Commission essential standards of quality and safety outcomes 1, 4 and 11 (CQC, 2010)
- ▶▶ Highlight through action planning how this is to be achieved
- ▶▶ Promote good practice in pressure ulcer prevention and management
- ▶▶ Develop a multiprofessional-led approach
- ▶▶ Highlight educational and resource needs.

**Governance arrangements**

- ▶▶ All patients who develop pressure ulcers grade 2 and above to be reported via the incident reporting system as a clinical incident
- ▶▶ Monthly pressure ulcer audits required to monitor impact of strategy
- ▶▶ Clear reporting processes to the divisional teams and trust governance committee to be put in place.

An action plan was then developed to support achievement of the strategy (*Table 2*). Timescales and areas of responsibility were also included, but are not detailed in this article. Progress was updated before each pressure ulcer action group meeting using the action plan template.

**Detailed actions and outcomes**

**Pressure ulcer action group**

A pressure ulcer action group was

**Table 1**

**Local CQUIN target for pressure ulcer incidence reduction**

Quarter	Pressure ulcer incidence: percentage reduction required
Baseline	5.0%
1. June 2010	4.75%
2. September 2010	4.5%
3. December 2010	4.0%
4. March 2011	3.5%

Table 2

## CQUIN action plan: prevention of pressure ulcers

Objective	Action plan
To reduce the incidence of hospital-acquired pressure ulcers grade 2 and above by 30% in 2010/2011	<ul style="list-style-type: none"> <li>» Set up a pressure ulcer action group to facilitate and implement the pressure ulcer strategy and to monitor and report outcomes</li> <li>» Provide monthly education and training in pressure ulcer prevention for all healthcare staff. Promote the use of the pressure ulcer self-directed learning pack</li> <li>» Provide all staff with information on pressure ulcer prevention and provide evidence of receipt of this information. Review the pressure ulcer reporting process and further develop to meet future needs</li> <li>» Clarify the feedback process to divisional teams to ensure outcomes and actions are integrated into quality reports</li> <li>» Develop a process for root cause analysis of grade 4 pressure ulcers</li> <li>» Raise patient and public awareness</li> <li>» Identify equipment needs</li> <li>» Develop care pathways for vulnerable patient groups</li> </ul>

set up to monitor and implement the pressure ulcer prevention strategy. It comprised relevant clinical professionals; nurses, physiotherapists, occupational therapists and medical staff within the trust to ensure appropriate divisional representation. Initially the meetings were held every fortnight and outcomes formally recorded. The meetings are now held monthly, which fit in well with the feedback plan. This group has a responsibility to the organisation to provide assurance that the strategy is implemented and that actions are completed in a timely manner.

#### Education and training

Although pressure ulcer prevention education has been available for many years, the uptake by clinical staff has been poor. Although it is becoming harder for staff to be released from the clinical areas for education, it was decided to continue pressure ulcer workshops and all staff would receive an information leaflet providing

essential information on pressure ulcer prevention. The 'Pressure Points' leaflet was developed by the tissue viability lead nurse and every ward and department manager received leaflets to distribute to their staff. The pressure ulcer action group decided to place the responsibility for dissemination of information with the ward managers and they were asked to return a completed staff receipt sheet as evidence of the communication.

Pressure ulcer workshops continue to provide up to date knowledge on aetiology, assessment and treatment of pressure ulcers and, together with a pressure ulcer prevention self-directed learning pack, forms the basis of the educational resources. Promoting multiprofessional learning has been a priority and there has been an excellent uptake to the training from the therapy staff, who not only contribute to the repositioning and moving of patients but also the appropriate use of pressure-relieving

equipment, both in hospital and on discharge.

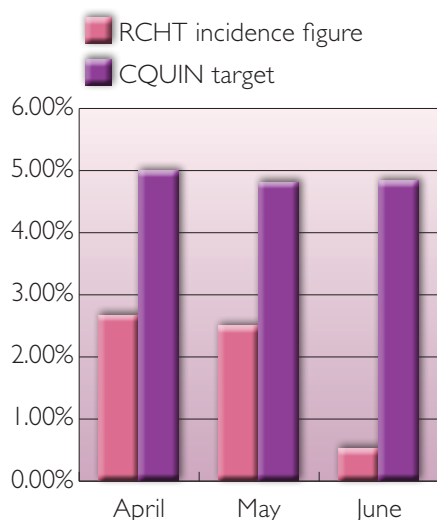
Link practitioners have also been active in their own areas providing information boards for staff, patients and relatives raising the awareness and risks associated with the development of pressure ulceration.

Maternity services are excluded from pressure ulcer reporting for the CQUIN target. However, in the past, the author has undertaken work with midwives to reduce the risk of pressure ulceration in this patient group (Newton and Butcher, 2000). A pressure points leaflet specifically for midwives has been produced which focuses on epidural risks and repositioning, as well as risks of skin damage associated with prolonged immersion in water from a birthing pool.

A pressure ulcer study day has been planned for October at the beginning of a two-week awareness campaign, which has national speakers discussing pressure ulcers and the quality agenda, good practice examples and general pressure ulcer prevention and treatment information. This provides a focus for learning, discussion and debate, which seeks to improve the way in which pressure ulcer care is delivered at the author's trust.

#### Pressure ulcer reporting

Before the strategy, the tissue viability (TV) team collected quarterly prevalence data from all of the clinical areas apart from child health and maternity services. At this stage, grade 1 pressure ulcers were collected. Wards were also encouraged to report any pressure ulcers whether they were hospital or non-hospital acquired on the Datix incidence reporting system. The numbers of patients reported on Datix was very low and it was felt by the TV team that it was not reflective of the true incidence. Pressure ulcer prevalence data collection was more accurate, especially when the forms were delivered on the day of the audit and all wards were reminded of their



**Figure 1. Percentage of patients with hospital-acquired pressure ulcers measured against the CQUIN target.**

responsibilities at the time. As part of the strategy that has been agreed with the trust's governance lead and PCT commissioners, monthly prevalence data is collected. This identifies the total number of patients with pressure damage in the hospital on one specific day, and the percentage is calculated on the total number of patients in the wards included in the audit on that day.

To provide information for the CQUIN report, three months of data is analysed and an average taken of the number of patients developing grade 2 hospital-acquired pressure damage. The author acknowledges that this is not as accurate as identifying actual incidence figures, but it is the most accurate method for the organisation and is modelled on existing work using the same methodology.

An example for the last three months is as follows:

- ▶▶ April: 14/523 patients with hospital-acquired pressure damage = 2.6%
- ▶▶ May: 13/503 patients with hospital-acquired pressure damage = 2.5%
- ▶▶ June: 2/435 patients with hospital-acquired pressure damage = 0.45% (Figure 1).

The evidence was reassuring and is reflective of the hard work that has been put in place by the clinical

staff. However, despite achieving the target for the first quarter, this level of pressure ulcer incidence must be maintained. The majority of the pressure ulcers were grade 2, with sacral ulcers being the most prevalent.

Pressure ulcers continue to be reported as a clinical incident and there has been an increase in the amount of incidents reported using this method. As confidence increases, it may be possible to stop prevalence monitoring and just have one method of pressure ulcer reporting trust wide.

#### Feedback to divisional teams

Reporting quality outcomes of clinical care and service provision lays with the trust's divisional teams. The quality and safety team support the divisions to collect and report information that is needed to be part of the communication system.

It was agreed that all information in the first instance would be reported to the pressure ulcer action group, where outcomes and actions would be discussed. There is divisional representation at this group, which ensures feedback to the divisional teams.

Quarterly data is sent to the governance team with a breakdown of information relevant to each divisional team. This can then be included in the divisional reports, as well as the report detailing outcomes for the CQUIN target.

A six-month report has been requested by the trust's divisional quality group, which will be a summary of actions and outcomes to date.

It is important that the divisional teams are aware and engaged in this activity. The decision to have senior matrons and senior therapists on the pressure ulcer action group was a way of ensuring that information was shared at the highest level. The tissue viability team, link practitioners and ward managers are responsible for communicating best practice in relation to pressure ulcer prevention and

management, and are also responsible for collecting pressure ulcer outcome data.

#### Pressure ulcer root cause analysis (PURCA)

Root cause analysis (RCA) is a method of investigating and analysing patient safety incidents so that effective ways of preventing similar incidents from recurring can be put in place, with an emphasis on improving the systems in which individuals work to improve safety (Healey, 2006). Pressure ulcers are one example of a patient safety incident, which is defined as 'any unintended or unexpected incident, which could have or did harm a patient' (National Patient Safety Agency [NPSA], 2004).

In the author's trust, and in line with the community tissue viability service who had already started to undertake work in this area, it was agreed that all patients developing grade 4 pressure ulcers would be investigated using the RCA methodology. Initially, the RCA template that was used to investigate meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemias in the trust was adapted. However, this was found to be too complicated and time-consuming. The expectation was that the investigation would be conducted by the ward managers with support from the TV team and, to ensure it was completed in a timely manner, it needed to be realistic, easy and quick. The PURCA tool uses the RCA methodology of reacting, responding and recording and also asks for details on the patient, the patient's management, the organisational environment and the practice environment. It is important that, where relevant, information is collected in all of these areas to discover and understand the issues that contributed to the incident so that they can be addressed to prevent incidents of the same nature occurring again. The tool is currently still being tested to ensure the final outcome is fit for purpose.

#### Raising patient and public awareness

As clinicians we are aware that patients, relatives and carers need to be involved in their care where possible, and the

latest government White Paper makes reference to shared decision-making becoming the norm, with 'no decision about me without me' as an underlying principle (DH, 2010a).

Pressure ulcer information leaflets have been in place for many years across the organisation, however, there has been little evidence found in patients' records to show that they have received a leaflet or have had opportunities to discuss their plan of care. This was an action that needed to be addressed quickly. Information on the leaflets and how to order them was thus provided to all clinical areas. The risk assessment section of patients' records is to be amended to provide a box to acknowledge that a leaflet has been given to any patients at risk, as part of their preventative plan.

A pressure ulcer leaflet has also been developed to give to women before giving birth at their 36-week consultation, as it was felt by the midwives that they were dealing with a vulnerable client group and wanted to raise awareness of the risks involved.

A pressure ulcer awareness fortnight is being planned by the TV lead nurse in October to raise awareness of pressure ulcer risks and what actions can be taken. Stands in public areas with information and guidance for the public will be set up, as well as notice boards in clinical areas detailing the progress and outcomes of the strategy to date.

#### Identifying equipment needs

As with many organisations, there is always a great deal of competition for the capital money allocation each year within the author's trust. Until a few months ago the TV service managed the trust equipment library, which was responsible for beds, mattresses and other pressure-relieving aids. Annual audits were routinely conducted to determine equipment needs and formed the basis of the business case for future requirements.

This year, the trust board have acknowledged the need for a recurring

revenue and capital allocation of money to meet the demand for equipment that relieves pressure and supports achievement of the quality account. This investment has meant that the author's trust are in a better position to meet the National Institute for Health and Clinical Excellence (NICE) guidelines which state that patients with grade 1 and 2 damage are to have a high specification foam mattress, and those with grade 3 and 4 pressure damage should be nursed on a dynamic mattress system (NICE, 2005). The guideline also recommends that there is 24-hour access to equipment, as, with more resources available, patients' needs will be met. The equipment library team are vigilant in their coordination activity and walk the wards routinely to ensure equipment is in the right place at the right time for patients.

A recent medical device alert (Medical and Healthcare products Regulatory Agency [MHRA, 2010]) has raised concern about the lack of inspection regimens for hospital mattress covers and, as such, has detailed guidance for their routine inspection for external damage and internal contamination. The author's trust has purchased high density foam mattresses for many years, and it is the ward staff's responsibility routinely to check the mattresses for breakdown. The ward staff contact the equipment library when a mattress is condemned, who then organise the delivery of clinical waste bags and waste disposal. A record is kept in the library of the number of mattresses condemned, however there was not enough evidence of this activity at ward level to comply with the MHRA alert.

The infection control team together with the medical device lead have developed a bed space cleaning proforma that is to be used after each patient episode. The sheet is to be filed in the patient's notes as a record that the bed space has been cleaned and the mattress checked. The condition of mattresses across the trust is important not only for reducing the potential for cross-infection, but also for

### Key points

- ▶▶ Patients now have the right to expect NHS organisations to monitor and improve the quality of health care they provide and commission.
- ▶▶ Improving the quality of care for patients is a fundamental part of professional practice.
- ▶▶ The CQUIN payment framework enables providers to receive financial benefits for improvements in quality care provision.
- ▶▶ Pressure ulcers are still seen as an indicator of the quality of care provided.
- ▶▶ Reducing the incidence of pressure ulcers is a key target for many NHS organisations.

reducing the risk of patients developing pressure ulcers.

#### Developing pathways for vulnerable patient groups

As already highlighted, the elderly are a vulnerable high risk group of patients. However, patients requiring orthopaedic interventions following a fractured neck of femur have been highlighted by the pressure ulcer action group as needing a clear pathway on admission to ensure that their risks are reduced. This work is still in progress but the key aim is rapidly to assess pressure ulcer risk and place the patient onto an alternating pressure mattress as soon after admission as possible before surgery. There is often a delay in accessing equipment, however, when the pathway is in place, patients will be prioritised. To ensure that resources are continually available, the pathway will determine when patients are stepped down off their alternating mattresses onto static mattresses.

Other pathways for development include the prevention of pressure ulcers in vulnerable children. Although this is not a CQUIN measurable target, the TV team feel that work is required so that children are accurately assessed, their risks identified and care planned to ensure that they receive quality care. As previously mentioned, work is also in progress within the maternity setting and currently the author is working on a maternity pressure ulcer risk calculator to ensure accurate assessment of women at risk.

**The CQUIN payment framework is just one example of a quality initiative which allows clinicians to be accountable for their practice and be rewarded as a result.**

Work undertaken by Dowsett (2010) in Newham relating to the reduction of pressure ulcer incidence has been recognised within the High Impact Action document (NHS Institute for Innovation and Improvement, 2009) as an example of good practice. Although the author's trust is a secondary care environment, there are similarities in outcomes with a reduction in pressure ulcer incidence and reduction of the high graded pressure ulcers. Dowsett (2010) has been able to demonstrate a reduction in costs through reducing hospital admissions, whereas in the author's trust a reduction in length of

hospital stay can be achieved. Using the pressure ulcer productivity calculator (DH, 2010b), it is anticipated that by reducing the number of pressure ulcers by 30%, the trust will save £257K. Based on last year's figures, this equates to a reduction of 50 patients developing pressure ulcers.

**Summary**

The government have clearly identified that they aim to drive the NHS quality agenda to another level, and it is the responsibility of the clinical leaders to ensure that these expectations are met. The CQUIN payment framework is just one example of a quality initiative which allows clinicians to be accountable for their practice and be rewarded as a result.

It is the responsibility of healthcare providers to provide evidence of achievement of quality and innovation within their practices to assure the public, the trusts in which they work, and the government that the NHS is safe, efficient and has its foundation in quality which underpins all that is done. **WUK**

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This year will see the introduction of the national Quality Accounts. The primary purpose of these reports is to ensure that clinicians assess quality across all services, with an eye to continuous quality improvement. They represent a challenge and cultural shift, involving managers and clinicians working together to rigorously analyse the quality of care provided. The three main domains of focus for the Quality Accounts will be patient safety, clinical effectiveness and patient experience. This offers tissue viability and those dealing with patients with wounds the opportunity to highlight the quality of service they provide. There are many unanswered questions as to how this will be done.

To respond to this challenge, Wounds UK's 'Enacting quality initiatives in tissue viability' series, supported by Smith & Nephew Healthcare, includes articles that discuss related themes, thereby serving as a toolkit for clinicians to measure service quality.

