Friday, 14 January 2022

FAQ for the CQUIN for Lower Leg Wounds (CCG11)

Which services does this CQUIN apply to?

1. **Can organisations choose if they want to do the Lower Leg CQUIN?**
   The CQUIN Guidance states that "All national indicators must be adopted where the relevant services are in scope for each contract" (p7) and that this CQUIN is applicable to "All providers of community nursing services" (p14). This means that if a provider offers a community nursing service then the Lower Leg CQUIN **must** be adopted **unless** "more than 8 indicators apply to a given contract" in which case the "commissioners and providers should agree the most relevant 8 indicators across the services in scope for each contract" (p25). Further information can be found within the CQUIN Guidance.

2. **Is the CQUIN just for community nursing services or does it apply to GP practices?**
   The CQUIN is just for community nursing services. CQUINs don't apply to General Practice where there are different levers for quality improvement. Conversations have started about how such levers might be used to improve wound care in General Practice.

Are the criteria applicable to all people with lower leg wounds?

3. **Does the CQUIN apply to all patients with a leg wound? For example, we would not usually routinely do an ABPI assessment or offer compression to someone who has a laceration to the lower leg from playing football.**
   The CQUIN covers all patients with a leg wound and this is based on the rationale that if a patient is presenting to a community nursing services clinician, this is usually because healing is problematic, or anticipated to be problematic. However, as the CQUIN is payable at 25% - 50% achievement, this should allow for the CQUIN to still be achievable, given those patients for whom it is judged that an ABPI or compression is not appropriate.

4. **What about exclusions? e.g. Patients with oedema who can't be 'Dopplered' until the oedema is reduced?**
   The essential criteria allow 4 weeks for completion, by which time, with elevation and some level of mild compression, Doppler might be achievable. However, as the CQUIN is payable at 25% - 50% achievement, this should allow for the CQUIN to still be achievable, given those patients for whom it will not be possible to achieve all the criteria.

5. **What is meant by 'being diagnosed with a leg ulcer'?**
   For the purpose of this CQUIN, a leg ulcer is being defined using the NHS definition of "a long-lasting (chronic) sore that takes more than 2 weeks to heal".

6. **Should foot ulcers be included in this CQUIN**
   No. This CQUIN only relates to leg ulcers.

7. **Are we expected to refer all leg ulceration for a vascular consultation?**
   The CQUIN criteria cover all lower leg wounds since most leg wounds that are slow to heal will be due to either venous or arterial insufficiency which will potentially benefit from a vascular referral. Since the CQUIN is payable at only 25% - 50% achievement, this allows for the CQUIN to still be achievable given those patients for whom a vascular referral would be inappropriate (e.g. a slow-to-heal wound obviously not related to venous or arterial insufficiency, a patient unsuitable for surgical intervention due to infirmity or a patient who declines referral etc). The NWCSP is currently developing guidance on vascular referrals and this will be shared as soon as possible. Those who would like early sight of the draft and to participate in the consultation surveys are encouraged to sign up to the NWCSP stakeholder forums: https://www.nationalwoundcarestrategy.net/get-involved/

8. **Our local acute services are not currently commissioned to accept referrals for venous leg ulcer surgical interventions, only for arterial. Please could you confirm whether you would be happy for us to monitor the arterial referrals only for this CQUIN?**
   This CQUIN is based on the current NICE Clinical Guideline for Varicose Veins and the NHS England Evidence-Based Interventions: Guidance for CCGs both of which advise that patients with venous leg ulceration should be referred for a vascular consultation. Therefore, the CQUIN would not be achieved if only people with arterial problems are referred.

9. **Is it acceptable to refer leg ulcers to the tissue viability service instead of referring for a vascular consultation?**
   No. There is good evidence in favour of endovenous ablation for healing venous leg ulcers and preventing recurrence and this has been recommended in the NICE Guideline for Varicose Veins since 2013. Unless the tissue viability service offers endovenous ablation or other vascular surgical services, a referral to tissue viability services cannot meet this requirement.

How to undertake the audits

10. **The CQUIN applies to both new and existing caseload patients. We estimate we have over 1000 patients but the time period in which they were admitted for care of their lower leg wound will vary. Would the CQUIN expect us to review all 1000 patients or just focus on a time period/start date for the CQUIN?**
    The denominator is the "total number of patients treated in the community nursing service with a wound on their lower leg" (regardless of when they came onto the caseload) and the CQUIN Indicator Specifications state (p8) that for this CQUIN, the period in scope is the whole year (i.e. Q1-Q4). Therefore, the CQUIN applies to all patients receiving care for slow-to-heal lower leg wounds between Q1 and Q4 and a sample of 100 from this cohort should be audited for CQUIN compliance.

    Some patients will have received care that meets the CQUIN criteria, but there may be some patients already receiving care that has not yet met the CQUIN criteria. In order to meet the CQUIN criteria, such patients should receive all CQUIN criteria care either

    - within 28 days of referral to service or,

- for a patient already receiving care from that service, within 28 days of a non-healing leg wound being identified and recorded, or within 28 days of the start of the CQUIN (i.e. 1st April 2020).

11. Can we select a sample of 100 patients who had come onto caseload more than 4 weeks previously and audit them?

The CQUIN Indicator Specifications describes how quarterly data should be collected (p12)

a. Where a list of records matching both the denominator and the numerator can be identified and extracted from systems (e.g. PAS, EPR or other local systems), and performance assessed without the need for case note auditing then all records must be used to calculate performance for each quarter in scope.
b. Where a list of records (broadly or exactly) matching the denominator can be identified (e.g. from PAS, EPR or other local systems), but not the numerator, then a minimum sample of 100 records (or all records where there are less than 100 records) are required from each quarter, and random sampling should be used to obtain this sample from case notes.
c. In exceptional circumstances, where neither the denominator nor the numerator can be readily identified then a minimum sample of 100 records (or all records where there are less than 100 records) are required from each quarter, and quota sampling should be used to obtain this sample from case notes.

For the leg ulcer CQUIN, options b and c are most likely. Clear instructions on how to undertake random sampling and quota sampling are described on p13-14 of the CQUIN Indicator Specifications.

12. Does every element of the lower limb assessment essential criteria need to be recorded to be compliant?

The assessment criteria are based on a minimum data set so there should be 100% compliance. Therefore, the assessment should indicate a response for each element, even if that response simply confirms the absence of an element. (For example, if there is no 'undermining/ tunnelling then recording 'No' indicates that the assessment has included consideration of this element and so demonstrates that the assessment has considered all the minimum criteria.)

13. Why is the diagnosis and treatment time within 28 days of a non-healing leg wound being identified and recorded, not 14 days, as per the NWCSP Lower Limb Recommendations for Clinical Care (2020)?

Although the NWCSP recommendations state a person presenting with a leg wound should be assessed (including vascular assessment of arterial supply) within 14 days of original presentation, the CQUIN is more generous to allow more organisations to succeed.

14. To meet the 25% – 50% target, do you have to meet all three sections of the Numerator?

To achieve the CQUIN, 25% - 50% of patients audited must have achieved ALL the clinically relevant steps described within the indicator specification. Missing any one of these constitutes a failure.

The following examples may be helpful:

1. If a patient has been audited, and they have had a CQUIN compliant lower limb assessment (TICK 1), *and* they are receiving greater than 40mmHG compression therapy as necessitated by their adequate ABPI result (TICK 2) *and* they have been diagnosed as having a leg ulcer (using the NHS definition of "a long-lasting (chronic) sore that takes more than 2 weeks to heal") and have been referred to vascular services (TICK 3), then this audit is fully compliant and receives a **PASS** rating.

2. If a patient has been audited, and they have had a CQUIN compliant lower limb assessment (TICK 1), *and* they are receiving greater than 40mmHG compression therapy as necessitated by their adequate ABPI result (TICK 2) *but* they don't have a leg ulcer so no referral is necessary, then this audit is fully compliant and receives a **PASS** rating.

3. If a patient has been audited, and they have had a CQUIN compliant lower limb assessment (TICK 1), *and* they are not receiving greater than 40mmHG compression therapy as necessitated by their adequate ABPI result (FAIL 1) *but* they do have a leg ulcer and have been referred to vascular services (TICK 2), then this audit is not fully compliant and receives a **FAIL** rating.

So, to achieve the CQUIN, 25% - 50% of cases must be 100% compliant (rather than achieving 25% - 50% for each of the three requirements, independent of each other).

To translate this into provider quarterly audit results might look like this:

1. Provider A audited 100 cases and found that 45 had received a satisfactory lower limb assessment, appropriate compression therapy AND an appropriate vascular referral where they had a leg ulcer. Therefore, this provider achieved **45%**

2. Provider B audited 100 cases and found that whilst 100 had received a satisfactory lower limb assessment, and 60 were receiving appropriate compression therapy, only 20% of patients with a leg ulcer had the necessary vascular referral. Therefore, this provider achieved **20%**

15. **Will there be additional information regarding a possible proforma or set standards for data collection for the CQUIN audits?**
    A data collection audit pro-forma can be found on the NHS Futures CQUIN site. All criteria must be addressed to achieve 100% compliance.

16. **As the CQUIN requires a quarterly audit, it won't be possible to report on the first quarter until the second quarter to allow for the 28 days. For example, if the quarter ends on the 30th June, it would only be possible to audit those with a non-healing leg wound up to the 2nd June otherwise they would not have had the wound 28days to audit against.**
    The end of is Q1 is 30th June. Therefore, in order to audit the care of patients admitted from 2nd June onwards the audit for Q1 should not commence until 28th July.

17. **Why is the diagnosis and treatment time within 28 days of a non-healing leg wound being identified and recorded, not 14 days, as per the NWCSP Lower Limb Recommendations for Clinical Care (2020)?**

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