FAQ for the CQUIN for Pressure Ulcer Risk Assessment (CCG12)

Based on v1.1 6th January 2023

These FAQs only address questions about the clinical aspects of this particular CQUIN. For any other queries about CQUINs, please contact the CQUIN team directly at e.cquin@nhs.net

If you can't find the answer to your question, please email: NatWoundStrat@mft.nhs.uk

Which services does this CQUIN apply to?

1. Can organisations choose if they want to do the pressure ulcer risk assessment CQUIN?

The CQUIN Guidance sets out the requirements for all providers of healthcare services that are commissioned under an NHS Standard Contract (full-length or shorter-form version) and are within the scope of the Aligned Payment and Incentives (API) rules, as set out in the National Tariff and Payment System. These requirements take effect from 1st April 2023.
By default, commissioners and providers should include all relevant quality indicators within their CQUIN scheme. All providers commissioned to deliver the services to which these indicators apply will be required (as mandated by NHS Digital through information standards notices and/or approved collections) to report their performance via the national collection. Further information can be found within the CQUIN Guidance (page 13 onwards) and in the CQUIN Indicator Specifications (page 8).

The CQUIN Guidance (page 14) states that "all providers in scope for CQUIN will be required (as mandated by NHS England through information standards notices and/or approved collections) to report their performance against all indicators to the relevant national bodies where they deliver the relevant services, irrespective of whether the indicator is included within their CQUIN scheme".

2. Is the CQUIN just for hospital in-patient services? Does it apply to community nursing services, or GP practices?

This CQUIN is just for acute and community hospital in-patient services. Other services have different levers for quality improvement.

Which patients should be included?

3. Do we have to include every patient within our service?

Yes, all patients who have a length of stay more than 24 hours within the dates specified should be included. The specification document (page 26) states "All acute and community hospital spells (including those starting before 1 April 2023 and those unfinished by 31 March 2024), for patients aged 18+ admitted to bedded units/wards with length of stay greater than 24 hours.".

4. What is a 'patient spell'?

A patient spell is the **total continuous stay of a PATIENT** using a Hospital Bed on premises controlled by a Health Care Provider during which medical care is the responsibility of one or more CONSULTANTS, or the PATIENT is receiving care under one or more Nursing Episodes (https://datadictionary.nhs.uk/nhs_business_definitions/hospital_provider_spell.html).

5. Can you clarify the exclusion criteria?

The exclusions are listed as "Hospital spells where the admission was before 1 April 2023 and the discharge was before 1 June 2023."

Please could you clarify:

- whether any patient admitted on 31 March 2023 (one day before 1 April 2023) and discharged on 1 June 2023 would be excluded, and
- a patient admitted on 1 April 2023 and discharged on 31 May 2023 (day before 1 June 2023) would also be excluded.
- Please also clarify whether this is one single exclusion criteria (i.e., patients admitted and/or discharged before 1 April and/or 1 June 2023) or
- they are two distinct exclusion criteria (i.e., patients admitted before 1 April 2023 OR discharged before 1 June 2023)?

A patient discharged on 1 June 2023 would be included (the exclusion refers to patients discharged *before* 1 June).

A patient admitted on 1 April and discharged on 31 May would be also included, as patients admitted to hospital on or after 1 April should have their first pressure ulcer risk assessment within 24 hours.

The exclusion criterion "where the admission was before 1 April 2023, and the discharge was before 1 June 2023" is a single exclusion criterion. The purpose is to ensure that patients already under hospital care do not miss out on these valuable interventions, whilst allowing providers extra time to "catch up" on providing this care for existing patients if they are not already doing so.

6. Is maternity included within the denominator?

Yes, maternity is included but patients would need to meet the criteria stated including a length of stay greater than 24 hours.

7. For an integrated organisation, will you be requiring 100 randomised patients from both the Acute & Community or will it be 100 cases combining both sites?

It would be a minimum of 100 randomly selected patients across the whole Trust / FT. Ideally the proportions would reflect the number of patients seen in each site, e.g. if the community site(s) saw approximately 80% of patients in scope for the Trust/FT as a whole and the acute sites saw 20%, approximately 80% of those audited should be from the community site and 20%

from the acute site(s) but appreciate that it may not be possible to be as precise as this. It is important that all sites in scope are represented in the sample though.

8. **How do we count IP spells into the quarterly cohorts? Is it by admission or discharge date? Or a combination of both? How do we handle blank discharge dates, i.e. patients still in hospital?**

   They are both relevant but you may find it helpful to look at the admission date first, as the rules are different for patients admitted before the start of the financial year. Patients admitted on or after 01/04/2023 can be included in the denominator from 24 hours after their admission, as they must receive the care set out in the numerator within 24 hours (and then every 30 days of the inpatient spell thereafter), but patients admitted before 01/04/2023 should only be included in the denominator if they remain inpatients on and after 01/06/2023 (as they have until 1 June to receive the care set out in the numerator for the first time). This has been written into the criteria in order so as not to exclude patients admitted before the start of the financial year from receiving this important care, whilst allowing providers to "catch up" and not be penalised for activity not undertaken prior to the start of the financial year.

9. **May we have details of how the cases admitted before 01/04/2023 are handled? I know they must have been discharged on or after 01/06/2023 in order to be included, which suggests we look at discharge date. Indeed, this allows us to submit patients who were admitted prior to 2023/24, which makes us think we should be basing this around discharge date.**

   Patients admitted before 01/04/2023 have until 01/06/23 to receive the care set out in the numerator, whereas patients admitted on or after 01/04/2023 should receive this care within 24 hours.

10. **What about patients who straddle quarters? We would expect to count each IP spell only once, which again leads us to believe the allocation to quarters would be by discharge date.**

    Correct – patients should only be audited once per inpatient "spell" – so a patient who was part of the sample in Q1 and remains an inpatient in Q2/3/4 should be excluded from the denominator (NB if the patient has been discharged and then readmitted this would be a new inpatient spell, so the patient could be counted but this would only be with reference to the care they have received during the second inpatient spell).

11. **Plus, you will only know if a patient is in for the >=30 days - for criteria 4 - if you wait and see when they were discharged. The guidance states that admission has to be by 31/03/2024, which suggests looking only at admission date. But what then about patients still in hospital at the end of 31/03/2024, who are discharged in 2024/25? Even if the submission for Q4 is say May 2024, there will probably be some patients admitted in 2023/24 who will still be in hospital by then. What would happen with them?**

    The CQUIN only looks at care within the financial year, so if the patient remains an inpatient on 31/03/2024 they will have 'passed' the CQUIN provided their most recent repeat of the care set out in the numerator was on or after 01/03/2024 (and no more than 30 days before that for the review before etc).

Risk Assessment

12. **Our organisation uses the Braden scale which does not include skin status. Does that mean we are not required to capture this information?**

    Skin status is a key element of risk assessment. If your chosen risk assessment scale does not assess skin status, it must be assessed and documented separately.

13. **We currently use Waterlow for our pressure ulcer risk assessment which contains the criteria mentioned in the specifications; mobility, skin, nutritional status, continence and sensory perception. If we asked if the Waterlow assessment was completed, would this pass the measure or would we have to be specific and ask for all 5 of the criteria individually?**

    Waterlow does indeed address all of the five elements requested in the specification. You would however need to ensure that each element had been considered as the tool is often poorly completed. This may depend on how your Waterlow is presented and if it is paper or EPR, for example, you would need to consider if you are able to view that something has been recorded in each section rather than simply being able to view the total final risk score to evidence that each element has been considered.

14. **We are planning to switch over to Purpose T at some point this year meaning that not all 5 of the criteria for part 1 will be met for patients who are assessed as 'No pressure ulcer, not currently at risk'. For these patients, only mobility, skin status and clinical judgement will be assessed and then they would move on to the 'green' pathway. If Purpose T is classed as a 'validated scale' according to the specifications, why would we fail by using it in the correct way? Are we saying that Purpose T is not in line with NICE guidance and we should be documenting the other criteria elsewhere?**

    PURPOSE T is slightly different in that it has a screening component which the other tools do not have so the criteria don't fit as precisely.

    If you are using PURPOSE T and screen them as green (not at risk) it would be acceptable to say the criteria have been met, if you complete screening and need to proceed to full assessment then they are adequately covered in the tool.

15. **We have a patient who has refused skin inspection, the staff have clearly documented within the required time scale that they have attempted to do the assessment and the patient has refused. There is also evidence that they tried on several occasions, would we be penalised for not completing the skin inspection element?**

    If it is clearly documented that the skin assessment has been attempted within the required time scale but the patient has not given consent then the criteria would have been met. It is important to ensure that subsequently this is not taken as the norm and that attempts to perform the skin assessment continue as part of the review process.

16. **Mobility. The requirement is to record any deficit in mobility and indicate whether it is temporary or permanent. With regards to conditions such as a stroke, where a patient may be acutely affected by immobility but then possibly rehabilitate how would clinicians record the status of their mobility deficit, since it is potentially transient and not yet known if it is temporary or permanent?**

    Temporary in this context is referring to situations such as a period in theatre where there is a defined period of temporary immobility, so a general acceptance that it will return to normal 'quite quickly'. Generally, temporarily also refers to something we have done to a patient, anaesthetised them, given them an epidural, administered some form of sedation etc, but may also refer to something such as a fall including fall with a long lie, that they will be moved from. For patients who have had a stroke, there is a strong likelihood that the impact will be permanent or long lasting, although it may resolve (fully or partially) it can take several days or weeks and therefore the impact on the tissues is greater, the outcome is not predictable so should be classed as permanent.

Care Planning

17. **Please can you clarify whether the numerator requirement is for a documented pressure ulcer risk assessment to take place within 6 hours or 24 hours of admission?**

    The requirement is for the risk assessment (including skin assessment) to be completed within 6 hours as per the NICE standard. There is 24 hours to complete all of the actions listed.

18. **Should every patient have an individualised care plan to identify how risk will be managed?**

    No, only patients who are at risk should have a care plan. However, those assessed as not at risk should have documentation that records their risk assessment, the rationale for that risk status and a review date this could be taken to be the care plan.

19. **Should there be a care plan for all comorbidities, or should comorbidities be noted in the Pressure Ulcer Prevention care plan?**

    Where patients have comorbidities that contribute to risk and are modifiable, they should be noted in the Pressure Ulcer Prevention care plan.

20. **In relation to the minimum criteria to include in the pressure ulcer care for the CQUIN, why have those elements been included?**

    Where the patient is deemed to be at risk, the items to be considered within the plan of care are based on the NICE Guidelines key priorities for implementation.

21. **When developing the individualised care plan, do we have to meet the NHS England and Improvement five criteria for a personalised care plan?**

    While it is recommended that an individualised care plan should meet these criteria, this is not part of the requirement for this CQUIN.

22. **Where the patient does not express any particular individual needs or preferences, how do we measure against the criteria?**

    Whilst many patients do not express any preference, we would expect to see evidence that this question has been asked, there should be something in the box, even if it is just 'no preferences'.

23. **The guidance states every patient needs to have care plan but only patients that are deemed at risk actually need the care plan so are we please able to exclude the patients that don't require the care plan/haven't scored as high risk?**

    The expectation is that those at risk would of course have a full care plan (or similar document e.g. SSKIN bundle) those deemed to be not at risk should have a care plan which documents the not at risk status and when the risk should be reviewed.

How to collect the data for the CQUIN audit

24. **Can we select a sample of 100 patients from the specified time span?**

The CQUIN Indicator Specification describes how quarterly data should be collected (Section 13 p 5 and 6).

> a. Where a list of records matching both the denominator and the numerator can be identified and extracted from systems (eg 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.
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> 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.
>
> b. 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 Pressure Ulcer CQUIN, organisations that use point of care electronic systems (such as Wound Management Digital Systems), may want to work with their system supplier to ensure their system is capable of collecting the required CQUIN data as part of routine clinical practice (based on the criteria listed in the Data Collection Tool) - so they can report on every patient. Organisations using electronic patient record systems (such as SystmOne, EMIS or RIO) may want to develop templates to support the electronic collection of the CQUIN data as part of routine clinical practice and be able to report from these systems either on an all patient or sampling basis.

If, however, your organisation is still using a paper-based patient record, you will have to collect data manually by printing off the Data Collection Tool.

Clear instructions on how to undertake random sampling and quota sampling are described on p 7 - 7 of the CQUIN Indicator Specification

25. Our organisation uses a mixture of electronic and paper-based records – how many do we need to include?

As you have some records that are EPR, you would be expected to include all of those (as per points 17a and 17b). If the count is at least 100, you would be deemed to have met the criteria, if not you would need to make the count up to a minimum of 100. You should however consider fair representation of your organisation and what learning you may take from the audit and even if your electronic records number 100 you may also wish to consider including a percentage of paper records.

Personally, I would want to ensure that I had covered each of my sites though so I would definitely sample from the sites that use paper.

26. Does every element of the pressure ulcer risk assessment criteria need to be recorded to be compliant?

The assessment criteria are based on a minimum data set so all elements must be met to achieve the CQUIN. 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 deficit in mobility then recording 'No' indicates that the assessment has included consideration of this element and demonstrates that the assessment has considered all the minimum criteria.)

27. To meet the 70 – 85% target, do you have to meet all four sections of the Numerator?

To achieve the CQUIN, 70 – 85% 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:

a. If a patient has had:

- A CQUIN compliant pressure ulcer risk assessment (TICK 1), *and*
- They are deemed to be at risk *and* they have a CQUIN compliant care plan (TICK 2) *and*
- Actions as described in the care plan have been documented (TICK 3), *and*
- Their length of stay is more than 30 days and they have had a review of all of these (TICK 4) then this audit is fully compliant and receives a **PASS** rating.

b. If a patient has had:

- A CQUIN compliant risk assessment plan (TICK 1), *but*

- They are not at risk but do have a documented risk assessment, skin assessment and if they have not been in for more than 30 days, a date set for review or if they have been in for 30 days a review has taken place (TICK 2).

  They do not require a prevention care plan, so this audit is fully compliant and receives a **PASS** rating.

c. If a patient has had:
   - A CQUIN compliant pressure ulcer risk assessment (TICK 1), *and*
   - They are at risk, but their skin assessment is not documented (FAIL 1) *but*
   - They do have a CQUIN compliant care plan (TICK 2),

   then this audit is not fully compliant and receives a **FAIL** rating.

So, to achieve the CQUIN, 70 - 85% of cases must be 100% compliant (rather than achieving 70 – 85% for each of the three requirements, independent of each other).

To translate this into provider quarterly results, they might look like this:

- Provider A reviewed 100 cases and found that 75 had received a satisfactory risk assessment, an appropriate care plan AND actions were documented and where the patient had been present more than 30 days risk had been re-evaluated. Therefore, this provider achieved **75%**

- Provider B reviewed 100 cases and found that whilst 100 had received a satisfactory risk assessment, and 60 had a compliant care plan with evidence of actions, only 20% of patients who had a length of stay of greater than 30 days had had a reassessment of risk. Therefore, this provider achieved **20%**

28. Why has the target been increased from 40 – 60% to 70 – 85%?

In 2022 / 2023 the target for community hospitals was 40 – 60%. The results for that year suggest that the targets were easily achievable therefore they have been slightly increased this year. Consideration was given to existing data around acute hospitals and based on the national pressure ulcer prevalence audit in 2018 / 2019 the targets were felt to be also relevant to acute services.

29. Is there a proforma for data collection for the CQUIN data capture?

A data collection pro-forma can be found on the National Wound Care Strategy Programme website.

30. How should we address the issue that as the CQUIN requires a quarterly data capture, it won't be possible to report on the first quarter until the second quarter to allow for the 30 days? (For example, if the quarter ends on the 30th of June, it would only be possible to review those with an inpatient stay up to the 2nd of June, otherwise they would not have had a length of stay greater than 30 days to audit against.)

The end of 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 31st July.