MH4 Discharge and Resettlement

Scheme Name	MH4 Discharge and Resettlement - Reduction of Length of Stay in Specialised MH In-Patient Services
Section A. SUMMARY of SCHEME	
QIPP Reference	*[QIPP reference if any]*
Duration	Two years
Problem to be addressed Blockages and protracted delays in discharge impacts significantly and adversely on patient quality of life and speed of recovery, and upon availability of specialised inpatient beds for others. Specialised mental health services are experiencing ongoing capacity and demand pressures for inpatient beds.	
Change sought This scheme is designed to achieve at least a 10% reduction in the current average LOS (more in some service lines). Discharge planning should commence sufficiently early in the patients pathway to enable patients to move on when active treatment has finished and patients are ready for discharge. Providers will be expected to develop a strategy for how they will implement plans for optimising the care pathway from admission to discharge and work with stakeholders as appropriate to deliver the target set for their service and speciality. For adult secure services, providers are required to utilise outcomes from PROM indicated in Local Quality Requirement to inform the strategy. Additionally the scheme seeks to fund those Trusts who are willing to pilot the use of Clinical Utilisation Review systems approved by the commissioner in a Mental Health context.	
B. **CONTRACT SPECIFIC INFORMATION** *(for guidance on completion, see corresponding boxes in section C below)*	
B1.Provider (see Section C1 for applicability rules)	*Insert name of provider --*
B2. Provider Specific Parameters. What was or will be the first Year of Scheme for this provider, and how many years are covered by this contract? (See Section C2 for other provider-specific parameters that need to be set out for this scheme.)	2017/18, 2018/19 Two years *[Other – as specified in C2]*
B3.Scheme Target Payment (see Section C3 for rules to determine target payment)	Full compliance with this CQUIN scheme should achieve payment of: *[set sum £s following the Setting Target Payment guide in section C3 for setting target payment according to the scale of service and the stretch set for the specific provider.]* Target Value: *[Add locally ££s]*

B4. Payment Triggers.

The Triggers, and the proportion of the target payment that each trigger determines, and any partial payment rules, for each year of the scheme are set out in Section C4.

Relevant provider-specific information is set out in this table.

[Adjust table as required for this scheme – or delete if no provider-specific information is required]

Provider specific triggers	2017/18	2018/19
Trigger 1: Baseline		
Trigger 1: Stretch level		
Trigger 2: Baseline		
Trigger 2 stretch		
Trigger 3		
	[Add rows to match C4 requirements.]	

B5. Information Requirements

Obligations under the scheme to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.

Final indicator reporting date for each year.	Month 12 Contract Flex reporting date as per contract. *[Vary if necessary]*

B6. In Year Payment Phasing & Profiling

Default arrangement: half payment of target CQUIN payment each month, reconciliation end of each year depending upon achievement.

[Specify variation of this approach if required]

Section C. SCHEME SPECIFICATION GUIDE

C1. Applicable Providers

Nature of Adoption Ambition: Universal Adoption

All providers of PSS MH Inpatient Services.

C2. Provider Specific Parameters	
The scheme requires the following parameters to be set for each provider in advance of contract, in order to determine precisely what is required of each provider, and/or to determine appropriate target payment (as per C3.)	1. Specific type of specialist MH service to which this applies. 2. For each service, 2015/16 number of admissions and number of discharges. Any expected change from this number for 2017/18 and 2018/19 and reason why to be specified 3. Whether CUR is being piloted.

C3. Calculating the Target Payment for a Provider

The target overall payment for this scheme (the payment if the requirements of the scheme are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm:

<Expected number of discharges [clearly based upon recent trend]> times <expected number of weeks' reduction in average length of stay> times £3000.
PLUS <cost of CUR implementation for CUR Pilot sites agreed with commissioner>times 1½.

[Given an example of the calculation.]

- 20 bed service provider is:
  - expected (on basis of 2015/16 data) to have 15 discharges in 2017/18;
  - is reckoned to be able to reduce length of stay by on average three weeks
  - CQUIN payment for 2017/18 would be
    - 15x3x£3000 = £135,000.
- If expansion is planned for 2018/19, a proportionately higher figure would be appropriate.
- If CUR is being piloted, the cost plus 50% of that implementation would be added to the scheme value.

The expected reduction in average length of stay and appropriate payment target should be negotiated with the provider, and specified in section B3.

As a default, 2015/16 discharge and admission numbers can be used for both years.

Year One:

Year Two:

See Section D3 for the justification of the targeted payment, including justification of the costing of the scheme, which will underpin the payment.

C4. Payment Triggers and Partial Achievement Rules

Payment Triggers

The interventions or achievements required for payment under this CQUIN scheme are as follows:

Descriptions	First Year of scheme	Second Year
Trigger 1:	Establish a system for specifying and recording estimated discharge dates (EDD) for all patients in service at 1 April 2017 and for all future admissions (if not already in place), with commissioner and independent expert involvement, within *[max 12 weeks – to be varied according to patient group]* weeks of admission. And for ongoing monitoring of all cases as they move through pathway phases. This baseline report will be shared with commissioners and will be updated for each service in line with the following timescales - Adult Secure - quarterly - CAMHS T4 - weekly - Adult ED – monthly - Deaf MH - monthly Note: Providers design reporting template to include Initial EDD (fixed), change to EDD and comments/reason for change in EDD.	Reduction in bed days in excess of expected date of discharge, relative to agreed ambition, as per Year 1 trigger 5. For this purpose, "discharge" relates to discharge to home or from secure into non-secure (or to prison). Further, a discharge to another hospital that results in delay beyond EDD is attributed back to all the hospitals upstream. (E.g. Hospital A determines EDD of a patient of 1st Jan '18; patient is transferred to hospital B on 1st Oct '17, receiving a revised EDD of 1st Feb '18. Patient discharged home 28th Feb '18. Then Hospital A has exceeded EDD by 31+28 days. Hospital B by 28 days.)
Trigger 2	Creation of a system, with funded provider resource, to plan discharge in advance of expected discharge date, building upon existing – Care Programme Approach (CPA) and Care and Treatment Reviews (CTR).	Maintenance of fund as in year 1 trigger 4
Trigger 3	Create system to review each delay if not resolved within the timeframes set out below. The review will include all stakeholders. Timings of these are service specific and will take place at these points beyond the expected discharge date, unless this is adjusted for clinical reasons: • Adult Secure: 4 weeks • CAMHS: 7 days from date identified as delayed week • Adult ED: 1 week • Deaf MH: 1 week	

	The format of the stakeholder review will be in the form of a teleconference in the first instance with face to face meetings held if this does not resolve issues. All delayed discharges from adult secure to report monthly, CAMHS T4 weekly to relevant MH Case Managers, with reasons for delay and actions taken or proposed to facilitate discharge. Adult Eating Disorder service to report MH case Mangers where applicable or alternatively to MH Supplier Managers weekly. Deaf MH services to report to MH Case manager or MH Supplier Manager as applicable monthly.	
Trigger 4	Creation of a fund to be used to reduce delays caused by issues of minimal expenditure which create further delay e.g. payment of rental deposit, essential items not in place (washing machine, furniture)	
Trigger 5	Agreement of ambition for year two for reduction in bed days in excess of expected date of discharge. This to be based upon a strategy and implementation plan as follows: Services to submit a strategy and timetabled implementation plan that sets out how the service plan to achieve the target reduction in excess days beyond EDD. This plan will need to describe the key areas the service will focus on over Year 1 and Year 2 to improve throughput and free up capacity for new admissions and decrease the average LOS across the service. In developing the strategy commissioners will expect services to address the following aspects and identify areas for change to be addressed in the implementation plan:	

		a) Management of pathway phases, with timeline, to include referral, decision to admit and intended outcome for admission, through assessment phase, active treatment and discharge planning. b) Bed management processes and ways to improve the discharge planning phase c) How providers will demonstrate a proactive, MDT/multi-agency approach to the whole of pathway planning d) How they propose to ensure plans for discharge commence early enough to identify potential barriers to discharge and or anticipated blockages are known (as Trigger 2) e) Consider how providers will manage lack of engagement of local care co-ordinators and develop internal provider strategy to resolve this critical issue. f) For CAMHS and adult ED, service practice in respect of management of patient leave (trial and home leave) and (if appropriate) actions to be taken to reduce. g) Strategy for readmission avoidance - CQUIN achievement payments will be moderated where readmission rises offset reductions in length of stay. h) Include any other aspect that provider plans to address e.g. skills, staffing to deliver therapeutic programmes etc.	

	It is expected that the services will develop this strategy and implementation plan in consultation with staff, service users, CCGs, LAs and NHS England. The services will brief and engage with all stakeholders including staff/SUs /carers to explain the CQUIN requirements and the benefits of optimising the care pathway. Ideas from the stakeholders, including service users, must be used be to inform the strategy. The strategy should also address the following issues to ensure that the discharge strategy is consistent with wider community goals: a) Management of referrals and reasons for refusals when units have spare capacity and to develop a strategy for reducing these occurrences b) Current waiting list management c) Repatriations in conjunction with MH Case Managers (CMs) (Secure and CAMHS Tier4 specifically but also where teams have Adult ED CMs) and as part of network discussion. d) How services ensure effective usage of in region spare capacity (where applicable) working as a network of provision.	
CUR TRIGGERS	Additional triggers should be added for CUR pilot sites.	

Percentages of Target Payment per Payment Trigger

The following table sets out the proportion of the Target payment that is payable on achievement of each of the Payment Triggers.

Percentages of Target Payment per Trigger	First Year of scheme	Second Year
Trigger 1	20%	80%
Trigger 2	20%	20%
Trigger 3	20%	
Trigger 4	20%	
Trigger 5	20%	
CUR Triggers	%age representing CUR payment [other %ages to be adjusted if applicable]	%age representing CUR payment [other %ages to be adjusted if applicable]
TOTAL	100%	100%

Partial achievement rules

Year One
Trigger 1: all-or-nothing
Trigger 2: strictly-proportional (that is payment should not exceed size of fund created)
Trigger 3: all-or-nothing
Trigger 4: all-or-nothing
Trigger 5: all-or-nothing

Year Two
Trigger 1: strictly-proportional
Trigger 2: strictly-proportional

Definitions

Delayed discharge: 'Patient will be a delayed discharge once it is agreed at CPA (and CTR where applicable) that the patient is clinically and legally ready for discharge and patient remains in the service.'
EDD: Expected Date of Discharge, is the expected date at which a patient is expected to be clinically and legally ready for discharge.

C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.

All services will be expected to establish from the start reporting mechanisms to inform MH case managers and MH supplier managers in respect of delays and use of leave. Wherever

possible existing reporting mechanisms/ templates and processes will be used or strengthened.

Reporting Template requirement A template will be available.

C6. Supporting Guidance and References

Section D. SCHEME JUSTIFICATION

D1. Evidence and Rationale for Inclusion

Evidence Supporting Intervention Sought

- ***The characterisation of the problem***

The rationale of this scheme is given by its expected outcomes, namely:

- to improve capacity and access for individuals who need a specialised inpatient mental health bed through the reduction of average LOS specifically targeting cases with significantly longer LOS and/or blockages to discharge.
- to reduce out of area placements due to improved throughput of patients within inpatient specialised mental health services
- to improve access to beds geographically closer to home
- to improve service users experience and expectation in regards to length of stay
- to deliver changes to practice across the management of the whole pathway based on care pathway review of each of the phases of the care pathway; assessment/active treatment and discharge planning including management of leave
- increased productivity and reduction in cost of individual patient care episodes by reduced length of stay of completed episodes of care
- The choice of behavioural change to remedy the problem - in terms of its cost-effectiveness.

Providers are encouraged to work together and with commissioners both from NHS England, CCGs and LAs where possible to develop innovative system solutions. Services should be working to the same service specification. Where there are significant variations in throughput and/or LOS, they will be expected to consider what is being done differently. This should include an examination of the differences in practice and/or how they deliver operationally. If appropriate they should then develop strategies to bring about change. It is recognised that there will be factors outside of providers' control that impact on LOS, but there will be areas of clinical and operational delivery that are under their control and it is these areas that providers will be expected to change.

Each service will be given a % of expected achievement target, based on a review of activity data for their service (and will take into account national averages for service type). This will be agreed in discussion with commissioners.

The recent publication of the Mental Health Task Force Five Year Forward View (Feb 2016)

and Implementation Plan (July 2016) lists several recommendations that support the consideration of optimising throughput and care pathways. Building the Right Support (October 2015) encouraged Transforming Care Partnerships to plan for their local populations in this way with emphasis being on community provision wherever possible.

Providers will need to review and refresh theirs plans to reflect the impact of the recommendations as they are introduced including factoring as applicable the impact of transformational plans to be implemented within community settings (specifically CAMHS T4 / ED/ LD and ASD populations) which may impact on capacity requirements within the specialised end of the pathway.

The overall aim of this CQUIN is the development of strategies for optimising the care pathway. This will be done by decreasing the length of time service users within specialised services spend through the pathway to achieve the outcomes expected, as agreed and described in the initial care plan prior to and at admission. There will be an expectation on admission that an *'expected discharge date'* will be set and all plans and pathway progression should be aligned to achieving this outcome in line with an x% target reduction to the average LOS set for the service.

Services will be set a target average reduction in LOS which will need to be considered by the service when designing their strategy and taking forward the CQUIN work streams to ensure they are working from the outset toward achievement.

Reference to CUR evidence from UK and overseas justifying CUR piloting in MH context is available on request.

Rationale of Use of CQUIN incentive

Payment system currently militates against investment to reduce Length of Stay. Reform is under development.

D2. Setting Scheme Duration and Exit Route

One off costs will be incurred in adopting processes to facilitate early discharge. Processes that require recurring investment that are of proven benefit can be built into prices with agreement of the commissioner from year three.

D3. Justification of Size of Target Payment

The evidence and assumptions upon which the target payment was based, so as to ensure payment of at least 150% of average costs (net of any savings or reimbursements under other mechanisms), is as follows:

Target payment is proposed at C3 is "<Expected number of discharges [clearly based upon recent trend]> times <expected number of weeks' reduction in average length of stay> times £3000.

The effort and costs that are appropriate to incur are proportionate to the reduction in excess bed days, beyond readiness for discharge that is achieved. This in turn will be proportionate to the number of expected discharges per annum. Effort is also needed at admission, to agree expected length of stay and put in place plans for discharge.

The sum that is appropriate per discharge depends upon the expected drop in length of stay consequent upon the intervention. If this is set as a fortnight, then target CQUIN payment should be scaled by around £6,000 times expected no of discharges. This assumes that costs are around £3,000 per week. However, for some services much larger reductions in LOS might be targeted, in which case a higher CQUIN value should be set.
D4. Evaluation
Evaluation is desirable for this scheme; information flows will be designed to support it.