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IM1 Reducing Cardiac Surgery Non-elective Inpatient Waiting

Scheme Name	IM1 Reducing Cardiac Surgery Non-elective Inpatient Waiting
Eligible Providers	Providers providing semi-urgent Coronary Bypass Surgery with scope for improvement in this dimension.
Duration:	April 2016 – March 2018 (depending upon achievable stretch per provider)
Scheme Payment (% of CQUIN-applicable contract value available for this scheme)	CQUIN payment proportion [Locally Determined] should achieve payments of £10,000 (Payment 1) plus £150 for each targeted reduction in days' waiting beyond 7 (Payment 2) Target Value: Add locally CQUIN %: Add locally based on (Payment 1+ Payment 2) value / CQUIN-applicable contract value

Scheme Description

The scheme aims to ensure that patients referred for coronary artery bypass grafting (CABG), semi urgently, have CABG as an inpatient (with or without transfer) within **seven** days of an angiogram (wherever that takes place) or within seven days of transfer to a non-elective pathway (whichever is the later).

The scheme seeks to realise clinical benefit to patients, but by reducing length of stay can additionally provide a QIPP opportunity for the respective commissioner (CCG or NHS England) by reducing the length of stay.

Costs will be incurred in setting up the data systems and in designing pathway improvement at scheme initiation. Costs will further be incurred in monitoring waiting and in ensuring capacity – continuously. The justification of the extra effort to reduce waiting times is in reduced VTEs, infections etc, as well as reduced Length of Stay.

The baseline should be reviewed in each specific centre and a realistic but challenging target set.

Measures & Payment Triggers

1. Payment 1. Reporting and set-up. The provider will be required to provide administrative and clinical support to ensuring that the data monitoring for this scheme is completed in a timely way and is accurate. The reporting requirements quarter by quarter are set out in the profile section.

2. Payment 2. Performance. The baseline number of bed days in excess of seven days per quarter will be agreed; together with an aspiration reduction in bed days in excess of seven (the denominator). Payment will then reward reduction in number of days waiting beyond seven (the numerator) relative to the aspiration.

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Definitions
For the Payment 2 performance measure (both numerator and denominator) the definition of a day waiting beyond seven is as follows. Days waiting beyond seven for all patients* referred and accepted who are non-elective urgent in-patients accepted for coronary artery bypass grafting including patients waiting in other Trusts who have been accepted for transfer following angiogram, where the seven day count starts at point of angiogram or transfer to non-elective pathway, whichever is the later. *The clinical exceptions to this would be: ▪ Those with abnormal blood results which need investigation and management. ▪ Those with other inter-current illness such as sepsis or uncontrolled diabetes ▪ STEMIs who are referred for surgery ▪ Those who present with a NSTEMI and have had an acute stent inserted *Exception reporting not to exceed 20%. Baseline performance – except when the commissioner stipulates otherwise locally, will be outturn waiting times beyond seven according to the above definition for 2014/15 excluding clinical exceptions. (See data sources.)
Partial achievement rules
Payment 2: achieved reduction in waiting as a proportion of aspiration. E.g. A provider with a relevant caseload of 300 patients per annum, of which it is estimated that 280 wait beyond seven days for an average of 8 days each. There are then 2,240 wait days beyond seven to be reduced, 560 per quarter. The aspiration is set to reduce these by half during quarters 2-4, i.e. to reduce wait days beyond seven by 280 per quarter. This would justify a CQUIN payment of 3x280x£150=£126,000. NOTE: it will be essential to agree baseline bed days waiting beyond seven before contract finalisation, default being 2014/15 data, and also to agree the aspiration for reducing that number in quarters 2-4, so that an appropriate CQUIN payment amount and CQUIN payment proportion can be set.
In Year Payment Phasing & Profiling
1. Reporting requirements – to yield Payment 1 *Quarter 1 –50% of Payment 1 CQUIN monies to incentivise baseline work* *Quarter 2- 20% of Payment 1 in line with milestones – see below* *Quarter 3- 20% of Payment 1 in line with milestones – see below* *Quarter 4 –10% of Payment 1 Final year payment based on agreed milestones – see below:* **Reporting requirements to attract Payment 1 (as per Payment Guidance)** **Quarter 1** A. Report produced to present baseline data on all the non-elective urgent inpatient waiting times for coronary artery by-pass surgery including those patients waiting to be transferred from other centres and internal referrals.

Exceptions recorded with rationale on why all those patients waited 7 days and above.

B. Establish a working group within the clinical network to review current pathway of care for this group of patients including the pathway for those patients requiring transfers between hospitals. Suggested agenda items:
   - identify blocks and challenges to the system,
   - ensure system is fit for purpose to electronically record all referrals regardless of source,
   - agree clinical acceptance criteria including guidance for dual anti-platelet therapy modification and aspirin as per the service specification.

C. Agree trajectory for reduction with regional team consistent with other units in the area.

Quarter 2 and 3

A. Review trajectory and performance within the working party.
B. Identify blocks to improvement and identify resources to support the delivery of these including highlighting serious issues to commissioners.
C. Report Quarterly performance to commissioners in line with agreed trajectory.

Quarter 4

A. Review trajectory and performance within the working party.
B. Develop improvement plan to address the blocks highlighting serious issues to commissioners.
C. Report quarterly and full year performance to commissioners in line with agreed trajectory.
D. Agree with all commissioners the scope for further development during the next financial year including where relevant for inclusion in commissioning intentions. This should include incorporation of the regular monitoring into business as usual practice and using the baseline data develop a service improvement proposal that can be costed and quantify the expected quality and productivity benefits.

2. Performance to determine Proportion of Payment 2-(as per Payment Guideline) to be paid at end of quarters 2-8.

Reduction in number of bed days of waiting beyond 7 days (defined as above) as a proportion of aspiration reduction in bed days waiting beyond 7 days (defined likewise).

Rationale for inclusion

Over the last few years there has been a stabilisation in the numbers of patients being operated upon so that in 2012 the number of heart operations performed was 34,174[1] The ratio of elective vs non-elective has changed so that with the implementation of new acute coronary syndrome guidelines there has been an increase in non-elective referrals for coronary revascularisation. This can result in a long length of stay for patients. This leaves such patients at risk as all will have an

[1] http://www.bluebook.scts.org

<table>
<tr><td colspan="2">unstable syndrome thereby are at increased risk of death from myocardial infarction. Such patients also occupy many beds in district and teaching hospitals so that the flow of acute medical patients is disrupted in all acute hospitals. In addition they undergo an increased risk of acquired hospital infection and complications.
Capacity problems exist within the cardiac non-elective pathway when delays to treatment occur, which has a dis-benefit to the referring centre by causing a delayed transfer of care, and in the cardiac surgical unit once the patient is fit for transfer.</td></tr>
<tr><td colspan="2">Data Sources, Frequency and responsibility for collection and reporting</td></tr>
<tr><td colspan="2">Electronic referrals database – local resource used by providers. Use of this system to track non-elective referrals can generate the required reporting for the scheme.

Providers will be required to work with their referring organisations and internally to ensure that all referrals for semi-urgent coronary bypass surgery are entered onto the database. Where a provider does not have access to an electronic system, they should agree a local database with commissioners that provides consistent reporting measures. Many of these patients move between NHS organisations on a non-elective basis; HES data does not provide a platform to collect the relevant information.

Reporting frequency: Quarterly.

Providers will be required to maintain the database on a real-time basis as this will inform the referral process. This will then generate the reporting for this scheme.</td></tr>
<tr><td>Baseline period/ date & Value</td><td>Baseline performance and aspiration to be agreed before contract signature, in order to set the CQUIN payment proportion. SUS data may be used to source or to validate estimates. This is available for 2014/15, which can serve as baseline, in the file available at the CQUIN website alongside this document. See <IM.i CABG waiting CQUIN Baseline data></td></tr>
<tr><td>Final indicator period/date (on which payment is based) & Value</td><td>Achieved drop in waiting beyond 7 days in Q4</td></tr>
<tr><td>Final indicator reporting date</td><td>Month 12 Contract Flex reporting date as per contract</td></tr>
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CQUIN Exit Route *How will the change including any performance requirements be sustained once the CQUIN indicator has been retired?*	Costs incurred in performing surgery to reduce waiting times will be recouped through normal payment mechanisms. This scheme supports profiling of cardiac surgery capacity within a centre for elective and non-elective work, providing the incentive to continue work to maintain efficiencies and to avoid delays to surgery. Shorter lengths of stay reward providers within trim point, as do avoiding costs of caring for exacerbations. The 7 day wait standard (LOS from trigger to surgery of 95th centile patient per year at or below 7 days) will be included in the Quality Schedule in the second year of the scheme as a permanent change, with information requirements included in the information schedule.

Supporting Guidance and References

There have been multiple national and local improvements programmes to review this issue over the last decade. NHS Improvement completed a national audit of inter-hospital transfers and identified delays and blocks to care which included, lack of dedicated resource to co-ordinate referrals, balance of managing elective waiting list, transport, clinical criteria.

Cardiovascular networks continued this work and undertook local work to agree the blocks, local pathways and a trajectory for a reduction in waiting times for patients. The implementation of an electronic referral system which could also monitor waiting times for transfer supported the progression of this work.

The cardiac surgery clinical reference group recognise that this remains an issue and with no central monitoring of status there remain perceived and real waiting time issues for non-elective patients. This scheme seeks to review and address the current situation, and to establish the monitoring process

There is clinical and financial cost to the NHS of hospital acquired infections and complications such as VTE.

This scheme needs to be considered in line with elective waiting times and commissioners and providers need to work together to agree a complementary plan which supports both aspects of this patient pathway.