TR1 **REVISED** Adult Critical Care Timely Discharge

Scheme Name	**TR1 REVISED Adult Critical Care timely discharge**
QIPP Reference	16-17 S4-Trauma
Eligible Providers	All Tier 1, 2 and 3 providers with critical care beds
Duration	April 2016 to March 2017.
Scheme Payment (% of CQUIN-applicable contract value available for this scheme)	TWO APPROACHES: APPROACH ONE (default): CQUIN payment proportion [Locally Determined] should achieve payments of respectively: £400,000 on average for Tier 1 providers, £240,000 on average for Tier 2 providers, £160,000 on average for Tier 3 providers. with payments adjusted to reflect proportion of total ACC discharges in that tier of providers. APPROACH TWO (selected trusts only): CQUIN payment proportion [Locally Determined] should achieve payment of £650 per baseline patients beyond 4 hours up to 24 hours, and £1,000 for stays beyond 24h Target Value: Add locally CQUIN %: Add locally

Scheme Description

To reduce delayed discharges from ACC to ward level care in the same hospital by improving bed management in ward based care, thus removing delays and improving flow. Discharges occurring directly to home will also be included as these are a reflection of a delay in discharge to a ward.This is to support Trusts with the Year Two QIPP scheme referenced above – to remove delayed discharges of 4 hours or more within daytime hours.

There is a national standard that all discharges from adult critical care should be made within 4 hours of a clinical decision to discharge being taken within daytime hours. Data from ICNARC shows that as of 2014/15 this target was not being met. Of the146,022 discharges in that year from critical care beds in tiers 1,2 and 3 providers, only 39% were within 4 hours of a patient being clinically ready for discharge:

	<4 hours	4-24 hours	>24 hours
Adult Critical Care Delayed Discharges 2014/15	39%	44%	16%

This CQUIN aims to support removal of delays of more than 4 hours, whilst continuing to encourage more emphatically removal of delays of more than 24 hours (these having been the subject of the corresponding QIPP and CQUIN scheme for 2015/16).

It is recognised that even with the scheme in place, providers may decide to leave patients in Critical Care when no beds are available, or when available beds are

dedicated to alternative priorities. However, it is also appropriate that patients occupying beds in Critical Care wards pragmatically in this way should not attract specific critical care payment. This CQUIN scheme has the effect of withholding (a portion of) such payment. Further, such an outcome is not satisfactory as leaving Critical Care wards full creates a risk of the need to cancel operations or discharge at night, or delayed admission to Critical Care, in order to meet the needs of new patients.

This scheme complements the CUR CQUIN scheme, which should help to liberate beds in wards to receive critical care patients.

The maximum CQUIN payment for this scheme must be set in advance using one of the following two approaches.

On Approach One, payment should be calculated as follows:
£400,000 on average for Tier 1, £240,000 on average for Tier 2, £160,000 on average for Tier 3 providers, with payment targets proportioned for each Tier according to the proportion of total ACC discharges. Thus:

- the target payment for one of the Tier 1 providers with 6% of total Tier 1 ACC discharges (44,805) would be 6% of the £7.2m targeted for the 18 Tier 1 providers (18x£400,000), i.e. £432,000.
- For a Tier 3 provider with 1.8% of the 60,361 Tier 3 ACC discharges, the payment target would be that percentage of the £14.4m targeted for 30 Tier 3 providers (30x£160,000), i.e. £259,000.

For a minority of providers (the Trial providers) a more powerful incentive will be set, and payment will be set on Approach Two, on the basis of the number of discharges above 4h in 2014/15, with a CQUIN target payment calculated as follows:

(2014/15 discharges 4-24 h x £650 + 2014/15 discharges >24 h x £1,000).

This approach may in particular be adopted for providers who have already achieved 60% or more discharges within 4 hours. (See Excel workbook on the PSS CQUIN web-page in support of this scheme where these providers are marked in yellow.)

For both approaches the CQUIN payment proportion is derived as usual by taking this sum as a ratio of the projected estimated PSS CQUIN-applicable contract sum.

Concern was expressed in provider feedback that the decision to discharge might be deferred till a bed is available. There is also concern that emptied beds will be filled from elsewhere.

However, it is thought that in most hospitals pressure on Critical Care capacity is such that these responses are unlikely.

Nevertheless, it is recommended that the CQUIN scheme should be complemented by monitoring of (i) cancelled high risk elective operations, (ii) night time discharges from Critical Care, as these tend to be symptoms of a failure to discharge timeously. Success in timely discharge should be associated with reduced problems in these dimensions. Critical Care ODNs should monitor these outcomes.

Measures & Payment Triggers

1. ~~(Reduction in)~~ The number of Critical Care ~~bed days occupied by~~ discharges of patients who have been ~~are~~ clinically ready for discharge to a ward bed in the same hospital , according to ICNARC, for more than 4 hours, but less than 24 hours. Such discharges trigger a reduction in the CQUIN payment – see Partial Achievement Rules, below.
2. ~~(Reduction in)~~ The number of Critical Care ~~bed days occupied by~~ discharges of patients who have been ~~are~~ clinically ready for discharge to a ward bed in the same hospital , according to ICNARC, for more than 24 hours or have been discharged home from critical care. Such discharges trigger a reduction in the CQUIN payment – see Partial Achievement Rules, below.
3. Achievement of a 30% reduction in the number of Critical Care bed days occupied by patients who are clinically ready for discharge to a ward bed in the same hospital according to ICNARC, for more than 24 hours, for 2016/17 as a whole compared to the 2014/15 base, **or achievement of a maximum of 5% of total critical care beddays occupied by such patients.**.

Definitions

Discharges include both Specialised and CCG funded patients.

All critical care beds are in scope; discharges are to non-critical care beds in the same hospital, as defined by ICNARC or discharged home from critical care.

Discharges exclude both deaths and discharges to other hospitals. (Both are excluded from the baseline database.)

For Trigger 3, see column M of the DAAG data tab in the Excel workbook supporting this scheme. (However note that that is by site rather than by Trust. So the number of bed days in line with the above definition has to be calculated for each provider.)

The numbers of bed days for Trigger 3 are calculated by summing the bed days utilised from 24 hours after the decision to discharge to actual discharge for each of the categories - discharged direct to the ward in the same hospital and discharged direct to home - where bed days (or part thereof) are measured in hours/minutes.

These definitions, for triggers 1, 2, 3, accord with the respective definitions of indicators ACC02di, ACC02ci, ACC02ai of the adult critical care Quality Dashboard 2016/17.

Partial Achievement Rules

Payment for the year would be the CQUIN payment amount (derived according to the guidance above) less:

Under Approach One:

Payment for the year would be the CQUIN payment amount (derived according to the guidance above) less :(2016/17 discharges 4-24 h x £325 + 2016/17 discharges >24 h or home x £500). (Triggers 1 & 2)

Under Approach Two:

Payment for the year would be the CQUIN payment amount (derived according to the guidance above) less: (2016/17 discharges 4-24 h x £650 + 2016/17 discharges >24 h or

home x £1,000). (Triggers 1&2) Under both approaches, the payment is subject to achievement of trigger 3. No payment is made if trigger 3 is not achieved.
In Year Payment Phasing & Profiling
Quarterly payment with end year reconciliation. In the out turn, quarter by quarter, the CQUIN payment would be ¼ the estimated CQUIN payment proportion times estimated contract value less Approach One: discharges 4-24 h x £325 + discharges >24 h x £500 Approach Two: discharges 4-24 h x £650 + discharges >24 h x £1,000, subject to reconciliation at end year.
Rationale for inclusion
There is evidence that patients who have a delay in their planned discharge to a lower level are more likely to experience a night time discharge or an expedited discharge to accommodate another patient. Such poorly executed discharges frequently lead to a reduced patient experience characterised by unnecessary additional hand-offs of care and the inherent risks this poses. Delays in discharge result in high occupancy rates which reduce efficiency and responsiveness of the service, increased costs for commissioners due to the unnecessary bed day costs and critical care capacity being unavailable to other patients who require admission to critical care. (The payment system for Adult Critical Care reimburses Provider Trusts at a daily rate based on total number of organs supported at any stage during the critical care stay, so efforts to meet the 4 h target will – in the absence of this CQUIN scheme or penalties – will not directly reward the Trust.)

Data Sources, Frequency and responsibility for collection and reporting	
Data source is directly from Case Mix Programme which all Providers should be submitting to ICNARC, national database for ICU. The CRG have put delayed discharges on to the Dashboard as a quarterly indicator, so this now widely available to commissioners and the full databook can also be sent directly to commissioning hubs. Data is available within 2-3 months of the previous quarter.	
Baseline period/ date & Value	N/A
Final indicator period/date (on which payment is based) & Value	As above.
Final indicator reporting date	Month 12 Contract Flex reporting date as per contract
CQUIN Exit Route *How will the change including any performance requirements be sustained once the CQUIN indicator has been retired?*	Although the national target has been in place for some years, there has been no performance management of this by commissioners. From a provider perspective the change that needs to happen is outside of Critical Care, whilst there is a perverse financial consequence of reducing the length of Critical Care stays as bed day costs are higher than ward based care. Beyond the end of the CQUIN, it is intended to restrict payment in line with this policy: i.e. no payment to be made for patients beyond 4h of daytime readiness for discharge in line with the national service specification.

Supporting Guidance and References

Specialised Commissioning reviews in South Yorkshire and Cheshire, Wirral and Merseyside have indicated that in Critical Care Units, 17% of patients did not meet the clinical criteria for continued stay, and consequentially 16% (298 beds) of all bed-days reviewed were potentially conservable. A London hospital commenting on this CQUIN reckoned that currently 13% of discharges occurred after 24 hours, whilst only 33% of patients are discharged within 4 hours.

Scale of the problem varies widely at an individual provider level and sometimes even at an individual unit level. Data has been provided to the national improving value team that outlines individual provider/unit level data for the last financial year. The ambition to move to the national target is achievable and supported by the CRG.