MH4 Discharge and Resettlement REVISED 18th Nov 2016

Scheme Name	**MH4 Discharge and Resettlement from Specialised MH In-Patient Services**
Section A. SUMMARY of SCHEME	
QIPP Reference	*[QIPP reference if any]*
Duration	April 2017 to March 2019

Problem to be addressed

Blockages and protracted delays in discharge impact 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 patient's pathway to enable patients to move on when active treatment has finished and patients are ready for discharge.

Providers will be expected:

- to establish or appropriately to enhance a system for specifying and recording estimated discharge dates (EDD) for all admissions, with commissioner and independent expert involvement, and involving and informing the service-user,
- to create a system, with funded provider resource, to plan discharge in advance of expected discharge date, building upon existing – Care Programme Approach (CPA) reviews and Care and Treatment Reviews (CTR),
- to create a system to review each delay if not resolved within the specified timeframes set out below
- to create a fund to be used to reduce delays caused by issues of minimal expenditure
- to agree an ambition for year two for reduction in bed days in excess of original expected date of discharge, based upon a detailed strategy and implementation plan, agreed with stakeholders. This will set out how the provider 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 (CUR) systems approved by the commissioner in a Mental Health context. CUR will complement discharge planning by providing evidence-based support to the judgment of whether a service user is ready for discharge. Providers taking this part of the CQUIN will be expected to procure and to implement the technology provided by one of the approved providers, and to undertake appropriate training.

Section A. 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 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 regarding payment triggers is set out in this table.

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

Provider specific triggers	2017/18	2018/19
Trigger 1: Stretch level		
Trigger 2 stretch level		
Trigger 3 Stretch level		
Trigger 4 Stretch level		
Trigger 5 Stretch level		
CUR		

	[Add rows if required.]	

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:

For each year:
<1% of Contract Value> adjusted up or down according to scale of assessed opportunity to improve discharge planning and reduce length of stay relative to central expectation of a at least a 10% reduction.

(NB Although Target Payment under this CQUIN is modulated according to expected impact upon length of stay, outturn payment relative to the Target payment is determined using a

different set of triggers – see Section C4 below.)

Setting the Target payment thus requires an anticipation of the length of stay reduction that the CQUIN will achieve. This may be difficult to forecast in advance; nevertheless an understanding must be achieved between provider and commissioner of an appropriate scale of ambition reflecting the local opportunity to use care pathway planning and redesign, as set out in section C4, to reduce average length of stay.

PLUS <cost of CUR implementation for CUR Pilot sites agreed with commissioner>times 1½.

Example:

- 20 bed service provider is:
  - Has 18 occupied beds
  - expected (on basis of 2015/16 data, adjusted for any planned expansion or contraction) to have 15 discharges in 2018/19;
  - implied average LOS is (18/15)*52=62.4 weeks.
  - is reckoned to be able to reduce length of stay by on average three weeks
  - implied %age reduction in LOS is 3/62.4=4.8%
  - CQUIN proportion for scheme can be set at 1%x(4.8/10)= 0.48%

The expected reduction in average length of stay and appropriate payment target should be negotiated with the provider, and specified in section B3, together with the CUR-specific increment if appropriate.

If CUR is being piloted, the CUR-specific increment should be valued as follows. The CUR scheme involves procurement of technology and investment in training to enable real-time monitoring of appropriateness of bed usage. The one off costs would be covered by the CUR-specific increment to the CQUIN value for ‘17/18 (plus the 50% enhancement); the second year CUR-specific CQUIN increment should reflect additional costs involved in rolling out the CUR programme to cover more wards, as well as an element to fund action to improve appropriateness of bed use. Advice on the Target Value for this element of the CQUIN should be sought from the CUR implementation team at NHS England; it should in general follow the approach taken to set CQUIN values for acute hospitals under the GE1 CUR CQUIN.

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),	Proportion of service users who pass the

	with commissioner and independent expert involvement, and involving and informing the service-user, within a maximum of 12 weeks of admission. (Shorter periods may be appropriate for some services.) 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 to employ a standard reporting template that includes Initial EDD, change to EDD and comments/reason for change in EDD.	maximum period specified in Year 1 Trigger 1 who had within that period been informed of an Expected Discharge Date that had been agreed by commissioner and independent expert.
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). Links to CTR and CPA guidance are here, and here: **CTR (October 2015)**- Care and Treatment Reviews	Reduction in bed days in excess of the agreed Initial Expected Date of Discharge, relative to agreed ambition, as per Year 1 trigger 5. For this purpose, “discharge” relates to discharge to the community or transfer into a non-specialised setting , as defined in the supporting Definitions documentation Further, a transfer to another hospital setting 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 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	Maintenance of fund as in year 1 trigger 4

	• CAMHS T4: 1 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 (monthly), and from CAMHS T4 (weekly) to report 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 Managers where applicable or alternatively to MH Supplier Managers monthly. 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 original 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 providers 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, in liaison with NHS E, manage lack of engagement of local care co-ordinators and develop internal provider strategy to resolve this critical issue. f) Strategy for readmission avoidance - CQUIN achievement payments will be moderated where increased readmissions of a provider's discharged patients, whether to the same or to another provider, offset reductions in length of stay. g) Include any other aspect that provider plans to address e.g. skills, staffing to deliver therapeutic programmes etc. For adult secure services, this would include utilisation of outcomes from PROM indicated in Local Quality Requirement to inform the strategy. It is expected that the services will develop this strategy and implementation plan in consultation with staff, service users, CCGs, LAs and NHS England, and also with New Care Model sites where applicable. (It is recognised that involvement of local commissioners is more challenging where patients are placed out of area and local teams may be situated at a distance from the specialist provider; in such cases any specific issues should be raised through the NHS England MH Case Manager.) A developed draft of the strategy should be shared with CCGs and Local Authorities and any relevant New Care Model sites by end September 2017 to give scope for planning for 2018/19 service provision improvement. The service providers will brief and engage with all stakeholders including staff/SUs /carers to explain and involve them in 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. Providers of Adult Secure services will also participate in action learning sets organised by the CRG.	

	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 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-hub or region capacity (where applicable) working as a network of provision, possibly as part of the development of New Care Models.	
CUR TRIGGERS	Additional triggers should be added for CUR pilot sites. These will relate to the procurement and implementation of the technology, to the training of the staff, to the monitoring of appropriate bed usage (with agreed frequency), and to reporting. ***Advice from the NHS England CUR support team should be sought to design this element of the CQUIN.***	Second year CUR triggers will include expansion to cover additional wards (if any), maintenance of monitoring and reporting system, and an outcome measure relating to the reduction of inappropriate bed usage.

<u>Percentages of Target Payment per Payment Trigger</u>

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%	20%
Trigger 2	20%	60%
Trigger 3	20%	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: **Full payment if September milestone met; 50% payment if complete by December; nothing thereafter.**

Year Two
Trigger 1: **strictly-proportional**
Trigger 2: **strictly-proportional**
Trigger 3: **strictly-proportional**

Definitions

DD: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.
CPA: Care Programme Approach (see link above in Year 1, Trigger 2)
CTR: Care and Treatment Review (see link above in Year 1, Trigger 2)
ED: Eating Disorder
CAMHS: Child and Adolescent Mental Health Services

Discharge: see supporting documentation.

Independent Expert: A clinician with expertise sufficient to assess EDD for the relevant patient who is not employed by the provider; the independent expert must be acceptable to the

commissioner.

Exceptions:

- Where an EDD is not given for clinical reasons, these should be set out and agreed with the commissioner. Such patients are excepted from numerator and denominator for Year 2 Triggers 1 and 2.

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. Wherever possible existing reporting mechanisms/ templates and processes will be used or strengthened (for example building upon templates for adult Eating Disorder and CAMHS leave – that are already submitted from the provider as part of monthly returns).

Reporting Template requirement A template is under development.

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 service users' experience and expectation in regards expected discharge date and 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, where relevant
- 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
- increased productivity and reduction in cost of individual patient care episodes by reduced length of stay of completed episodes of care.

Providers are encouraged to work together with commissioners from NHS England, CCGs and LAs and New Care Model sites where possible to develop innovative system solutions. . Where there are significant variations in throughput and/or LOS, providers will be expected to

consider what can be done differently. This should include an examination of the differences in practice and/or how they deliver operationally. If appropriate providers should then develop strategies to bring about change. It is recognised that there will be factors totally outside of providers' control that impact on LOS, but there will be areas of clinical and operational delivery that are under their control and/or ability to influence and it is these areas that providers will be expected to change.

Each service will be given a %age reduction of expected length of stay, based on a review of activity data for their service (and will take into account national averages for service type), to set the scale of opportunity and hence the appropriate Target Payment for this CQUIN, as illustrated in section C3. This will be agreed in discussion between service-providers and 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 their plans to reflect the impact of the recommendations as they are introduced including factoring in 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 part 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 – see NHS England Commissioning Intentions for 2017/18 and 2018/19, https://www.england.nhs.uk/wp-content/uploads/2015/12/spec-comm-intent.pdf, p.23:
"In secure mental health services, re-procurement following the current service review will enable transition to a new more recovery oriented payment approach with improved discharge and resettlement and user-led patient reported experience and outcome measures embedded in all contracts from 2017."
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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:

As currently articulated, this scheme sets an incentive for effort to expedite discharge, once readiness for discharge is achieved (including effort needed at admission, to agree expected length of stay and put in place plans for discharge).

Target payment is proposed at C3 is **<1% of Contract Value> adjusted up or down according to scale of assessed opportunity to improve discharge planning and reduce length of stay relative to central expectation of at least a 10% reduction.**
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. Clearly a 1% reward for a 10% reduction in length of stay is a reasonable benchmark given the nature of the current payment system.

D4. Evaluation

Evaluation is desirable for this scheme; information flows will be designed to support it.