# CA1 Enhanced Supportive Care for Advanced Cancer Patients

| Scheme Name | **CA1 Enhanced Supportive Care (ESC) Access for Advanced Cancer Patients** |
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| QIPP Reference | QIPP 16-17 S23- Cancer |
| Eligible Providers | Cancer Centres (Centre level providers of specialised oncology services - Chemotherapy and Radiotherapy).<br><br>**Note*: This scheme at this stage is not appropriate for all secondary care providers of oncology – it is specifically for roll out to Cancer Centre level providers. |
| Duration | April 2016 to March 2018. It may be extended to new providers and patient groups in subsequent years. |
| Scheme Payment<br>(% of CQUIN-applicable contract value available for this scheme) | CQUIN payment proportion [Locally Determined] should achieve payment of c. £500 for each patient targeted to receive ESC within the agreed scope of the scheme.<br>Target Value: Add locally<br>CQUIN %: Add locally |
| **Scheme Description** | |
| The scheme seeks to ensure patients with advanced cancer are, where appropriate, referred to a Supportive Care Team, to secure better outcomes and avoidance of inappropriate treatments.<br><br>There is growing evidence that good supportive care provided early to patients with advanced progressing cancer can improve quality of life, possibly lengthen survival and reduce the need for aggressive treatment near the end of life. (See references, below.)<br><br>This scheme will expand the implementation of the Enhanced Supportive Care approach which has been piloted at the Christie NHS Foundation Trust, alongside adoption of best practice to optimise the use of chemotherapy in patients with advanced progressing disease. This scheme will be targeted at addressing more fully the needs of patients on active anti-cancer treatment who have a diagnosis of incurable cancer. In 2014, 60,000 patients were recorded through the SACT Database as commencing chemotherapy for “palliative intent”. This will be an under-representation of total numbers of patients within this definition due to incomplete data collection.<br><br>The behavioural change sought is the adoption of the enhanced supportive care approach (as outlined in the NHS England Guidance document available on the PSS CQUIN webpage in support of this scheme). This involves a number of recommended steps to establish (1) earlier involvement of the supportive care team with the oncology team, including (2) an ESC team with the right mix of disciplines and MDT meetings to discuss complex patients, (3) a positive rather than a reactive approach to early identification of the patients for whom ESC should be made available [for the CQUIN this means those with diagnosis of incurable cancer], (4) evidence based practice in | |

supportive care, (5) IT to improve patient oversight, including remote monitoring, (6) best practice in chemotherapy care. A guidance document has been developed, building on the Christie Pilot that has been approved by the NHS England Chemotherapy Clinical Reference Group and Cancer Programme of Care Board.

These improvements in care will require costs to be incurred in raising the standard of care to that of the ESC model, and in reaching more patients. Elements (4) and (6) in particular will require more intensive MDT input into patient care to personalise the care of each patient, whilst (5) may require system and technology investment.

The use of CQUIN monies will be individual to each provider. Costs may be incurred to increase the capacity of existing palliative / supportive care teams to promote the development of an Enhanced Supportive Care service and in communications systems and technology to allow remote oversight.

The local CQUIN used in the North West was for three years as it incentivised the development and piloting of the scheme. As the concept is now better understood and will be implemented with the help of Christie personnel, it is likely that the CQUIN will be needed for 2 years and, in some cases, only one year.

The CQUIN Payment proportion is set at (N*500)/Z, where

- N is the estimated number of eligible patients (additional to those who would receive it under any existing ESC service), designated by the category of cancer (by site) in which it is agreed that ESC should be implemented, and the diagnosis of incurable cancer, and
- Z is the estimated CQUIN applicable contract value.
- A deduction from the £500 per patient payment is made for any activity payment that the ESC implementation would attract (e.g. an Outpatient appointment payment.)

N is not expected to exceed 800 – if a larger number is proposed, an exception needs to be agreed with NHS England.

Note that if it is agreed with the commissioner to introduce or to scale up enhanced supported care in some specialities but not others, the appropriate CQUIN payment should be scaled by the number of patients intended to benefit. Scaling may be determined by the scale of CQUIN payment available and/or by capacity constraints in the development of the ESC service. (E.g. at the Christie it has been targeted with Breast, Upper GI, skin/melanoma and Hepatobiliary Cancers).

**Measures & Payment Triggers**

1. Audit is established, baseline data collected and a Clinical Champion for Enhanced Supportive Care nominated.
2. Clinical Champion engages with national peer group and processes in place to provide ESC to patients in target group.
3. Proportion of patients within the payment group receiving ESC.

## Definitions

For Trigger 3:
Numerator: Number of patients who are referred to a Supportive Care Team at the point of diagnosis of incurable disease, Relative to
Denominator: Total number of new diagnoses of incurable disease in those disease group areas where the ESC initiative is being focussed, subject to any cap on the number of ESC patients in this scheme agreed with the commissioner.
Where a provider is already funded to provide ESC for some patients, then the trigger, i.e. the denominator for trigger 3, should be set as the additional patients meeting the eligibility criteria to whom the service will be extended.

## Partial achievement rules

Given significant set up costs and time, in the first year 20% payment is made for achieving payment trigger 1, and 20% for payment trigger 2, with the remaining 60% paid according to trigger 3, the proportion of the actual number of such patients who actually receive ESC during the second half year.

## In Year Payment Phasing & Profiling

| | Rules for in year payment and partial payment |
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| **Q1** | 20% of whole-year CQUIN value awarded if the audit is established, baseline data collected and a Clinical Champion for Enhanced Supportive Care nominated. |
| **Q2** | 20% of whole-year CQUIN value awarded if locally agreed Q2 target of improvement from baseline achieved and Clinical Champion engages with national peer group. Q2 target must be set as soon as possible after Q1 ends using data from Q1 |
| **Q3&Q4 Combined** | Maximum of 60% of whole-year CQUIN value available according to proportion of eligible patients receiving ESC. |

## Rationale for inclusion

Enhanced supportive care has developed through recognition of what specialist palliative care can offer – as a cost-effective and life-extending approach to treatment of patients with incurable cancer, but also from recognition of the barriers to achieving earlier involvement of palliative care expertise within the cancer treatment continuum. These barriers may be largely due to the perception of palliative care by the public, patients and many health professionals - in particular the association with care at the very end of life. The excellent care that is provided for patients, who are nearing the end of life, needs to be extended to support them earlier on in the cancer pathway.

## Data Sources, Frequency and responsibility for collection and reporting

Trusts should be collecting referrals to the supportive care team (the trigger 3 numerator) through the national Electronic Palliative Care Co-Ordination Systems (EPACCS) initiative. Diagnosis of incurable cancer (the trigger iii denominator) should be registered in SACT – roughly as those receiving Chemo with palliative intent on SACT.

There are a number of suggested outcome measures within the ESC Guidance document. All Trusts need to measure patient experience, utilising a patient questionnaire, patient mortality within 30 days of chemotherapy (through the national SACT data submission), and impact on Emergency Hospital admissions. Baseline levels of performance need to be assessed within the 1st quarter of the 1st year of this scheme.

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| Baseline period/ date & Value | Base year provision of ESC if any to be quantified by provider. |
| Final indicator period/date (on which payment is based) & Value | Provider to supply to commissioner in line with submissions to EPACCS (for the numerator of Trigger 3) and to SACT (for the denominator). |
| Final indicator reporting date | Month 12 Contract Flex reporting date as per contract |
| **CQUIN Exit Route**<br><br>*How will the change including any performance requirements be sustained once the CQUIN indicator has been retired?* | This scheme transforms the way in which care is delivered. It will be maintained through clinical engagement and acceptance of the benefits to patients. The initial incentive is required to kick-start the process for changing long established clinical practices and potentially to support adjustments to staffing levels/ staff utilisation. The benefits of the scheme to patients and reduced health-care costs will create a very strong case for the continuation of the Enhanced Supportive Care service once the CQUIN investment closes. Any additional net costs incurred will be reflected in future prices for cancer patient care. This will be addressed during the course of the first year of the scheme. |

**Supporting Guidance and References**

"Enhanced Supportive Care"(ESC) is a new term for existing palliative care services and other services that support cancer patients, better to suit the changing landscape of cancer care. It is based around six principles:

- early involvement of supportive care services,
- supportive care teams that work together,
- a more positive approach to supportive care,
- cutting edge and evidence-based practice in supportive and palliative care,
- technology to improve communication,
- best practice in chemotherapy care.

It is intended to introduce ESC in a phased way, starting with those patients who are diagnosed with incurable cancer. Subsequently, ESC may be made available to those patients living with curable cancer, or living with cancer as a chronic illness, as well as cancer survivors.

Whilst the experience of the Christie and elsewhere is that this intervention is cost-saving over all, it will be important that it is adequately funded to ensure that gains for patients and for the system are realised. Adopting this model will impact on a number of outcome areas but in summary the key outcomes expected are:

- improvement in patient and carer experience
- reduced need for aggressive interventions in the last days / weeks of life
- improved survival

The evidence base and the initial findings from the Christie pilot suggests reduced health care costs through a focus on earlier access to supportive care. In particular,

the Christie pilot suggests reductions in emergency admissions, a reduction in 30-day mortality and optimisation of the use of chemotherapy at the end of life.

*References:* Temel et al 2010; Bakitas 2015; Greer 2012