CA1/IM1 Enhanced Supportive Care

Scheme Name	***IM1: Enhanced Supportive Care – Non Cancer pathways*** ***CA1: Enhanced Supportive care – Cancer pathways***
Section A. SUMMARY of SCHEME	
QIPP Reference	*[QIPP reference if any]*
Duration	April 2016 to March 2019

Problem to be addressed

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. The same approach is likely to be of benefit in other disease areas.

Part A: Cancer Services
Approximately 20 Cancer Centres commenced this scheme in 2016-17. For 2017/18 and 2018/19 this scheme is a priority for these existing Cancer Centres to continue with existing patient groups, and for these providers to consider extending the programme to new cancer groups.

The scheme will involve implementation of the Enhanced Supportive Care approach originally developed at the Christie NHS Foundation Trust alongside adoption of best practice to optimise treatment in patients with advanced progressing disease (in the disease areas specified above).

Part B: Non Cancer services
Part B Scheme is also available for introduction of the scheme in centres treating complex hepatopancreatobiliary (HPB) diseases. Existing Cancer centres may also wish to participate in the IM1 scheme for this or other disease areas.

Change sought:

The scheme seeks to ensure that patients with advanced cancer and/or advanced Hepatopancreatobiliary (HPB) disease are offered early referral to a Supportive Care Team, to secure improved outcomes and avoidance of inappropriate aggressive treatment.

Implementation of the Enhanced Supportive Care approach within specified patient populations. This approach is outlined in the NHS England Guideline document (https://www.england.nhs.uk/wp-content/uploads/2016/03/ca1-enhncd-supprtv-care-guid.pdf).

This involves a series of recommended service principles: (1) earlier involvement of the supportive care team with the oncology team, (2) supportive care teams that work together, ideally under one umbrella, and have recognition in their centres as a core part of the business (3) a positive approach to supportive care, (4) cutting edge and evidence based practice in supportive and palliative care, (5) technology to improve communication.

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. The approach will require more intensive MDT input to patient care and may also require system and technology investment.

The use of CQUIN monies will be individual to each provider and available for adoption of Part A and / or Part B of the scheme. 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.

Section B. CONTRACT SPECIFIC INFORMATION *(for guidance on completion, see corresponding boxes in sections 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.)	2016/17[1], 2017/18, 2018/19 *[Adjust locally]* One/two years *(Adjust locally)* *[Other – as specified in C2: including whether Part A Part B or both parts.]*
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		

[1] I.e. scheme was contracted for first implementation in 2016/17, and this template is setting out requirements for 2nd (and perhaps 3rd) year of scheme.

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 for each part of the scheme adopted , reconciliation end of each year depending upon achievement.

[Specify variation of this approach if required]

C. SCHEME SPECIFICATION GUIDE

C1. Applicable Providers

This scheme is applicable to:

- Providers who are currently working to this CQUIN during 2016-17 should be offered the CA1 scheme as a priority, to: (i) ensure embedding and evaluation; and (ii) expand into additional cancer disease specific populations.
- Providers of Hepato pancreatobiliary (HPB) disease care to patient groups with advanced stages of those conditions should be offered the IM1 scheme.

It should be noted that the CA1 Part A scheme should not be offered to providers that are not currently working on this CQUIN during 2016-17. This is because the scheme requires further evaluation and, given that it places a high burden on palliative care teams, it is considered important to complete evaluation prior to wider rollout.

For HPB, the following is a list of eligible providers, with some marked as priority for the offer of this scheme:

epatobiliary Providers (*priority)

- *Addenbrooke's Hospital*
- Bradford Royal Infirmary
- Burnley General Hospital
- Castle Hill Hospital
- Charing Cross Hospital
- Cheltenham General Hospital

- Churchill Hospital
- City Hospital
- Derriford Hospital
- *Freeman Hospital*
- Glenfield Hospital
- Hurstwood Park Centre
- *King's College Hospital (Denmark Hill)*
- Leeds General Infirmary
- Manchester Royal Infirmary
- Musgrove Park Hospital
- Nottingham University NHS Trust - Queen's Medical Centre Campus
- Queen Alexandra Hospital
- Queen Elizabeth Hospital
- Royal Bournemouth And Christchurch NHS Trust
- Royal Cornwall Hospital (Treliske)
- Royal Devon & Exeter Hospital (Wonford)
- Royal Free Hospital
- Royal Oldham Hospital
- Royal Surrey County Hospital
- Sheffield Teaching Hospitals
- Southampton General Hospital
- Southmead Hospital
- The Royal Liverpool University Hospital
- *The Royal London Hospital*
- The Royal Marsden Hospital (London)
- University College London Hospitals NHS Foundation Trust
- University Hospital (Coventry)
- *University Hospital Aintree*
- University Hospital Bristol
- York Hospital

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.)	Patient Group(s) included, which may include: • Cancer groupings • Hepatobiliary end stage disease • Number of additional patients in each year

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:

The CQUIN payment for each part of the scheme adopted is set at (N*£600) where
N is the estimated number of total eligible patients in which it is agreed that the ESC approach

should be targeted to (in addition to those who would receive such support under existing arrangements outside of the CQUIN initiative).

A deduction from the £600 per patient payment is made for any activity payment that implementation would attract (e.g. outpatients appointment payments).

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	Third Year (where applicable)
Trigger 1:	Clinical Lead for Enhanced Supportive Care nominated.	Clinical Lead for Enhanced Supportive Care in place	Clinical Lead for Enhanced Supportive Care in place
Trigger 2	Baseline Audit undertaken and ongoing data collection arrangements in place.	Baseline Audit undertaken and ongoing data collection arrangements in place for new patient populations	Baseline Audit undertaken and ongoing data collection arrangements in place for new patient populations
Trigger 3	Improvement targets established for proportion of patients within targeted population offered referral to ESC	Improvement targets established for proportion of patients within targeted populations offered referral to ESC	Improvement targets established for proportion of patients within targeted population offered referral to ESC
Trigger 4	Delivery against agreed improvement Targets – demonstrated through return of ESC data tool to local commissioner	Delivery against agreed improvement Targets – demonstrated through return of ESC data tool to local commissioner	Delivery against agreed improvement Targets. demonstrated through return of ESC data tool to local commissioner
Trigger 5			

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	Third Year
Trigger 1	10%	10%	10%
Trigger 2	10%	10%	10%
Trigger 3	20%	20%	20%
Trigger 4	60%	60%	60%
Trigger 5	-	-	-
TOTAL	100%	100%	100%

Partial achievement rules applicable to each part of the scheme

For Trigger 4 partial achievement

60% is paid on demonstration of the proportion of the target patient population offered access to Enhanced Supportive Care in line with agreed targets for improvement. f 80% of eligible patients, for that period, have been offered referral to the Enhanced supportive Care team then that should be seen as good enough performance to generate the final 60% payment. If performance is below this level then payment is made in line with the performance achieved (e.g. the providers gets 70% of the final payment if they deliver 70% of eligible patients referred to the Enhanced Supportive Care Team.)

Definitions

For Trigger 4:

Numerator: Number of patients who are offered referral to a Supportive Care Team at the point of diagnosis of incurable disease

Denominator: Total number of new diagnosis of incurable disease in those disease group areas where the ESC initiative is being focussed. Where a provider is already receiving funding outside of CQUIN to provide ESC for some patients then the denominator should be set as the additional patients meeting the eligibility criteria to whom the service will be extended.

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

triggers.

A reporting tool has been developed to support the reporting of data for this initiative. This includes baseline data on:

Data to support achievement of the CQUIN Triggers

And evaluation data to capture the impact of this initiative on emergency referrals and 30 day mortality and patient QoL.

Information for Evaluation

Audit Data against 5 key standards of Enhanced Supportive Care.

Quality of Life impact, Chemo 30 Day Mortality Impact (or equivalent measure for non cancer disease areas), and Emergency Admissions impact.

Reporting of Achievement against Triggers

Baseline Data on the estimated number of patients in each targeted disease group.

Quarterly reporting on numbers of patients offered referral to ESC against total patient population.

Reporting Template requirement

A standard reporting template has been developed for the 16-17 CQUIN

C6. Supporting Guidance and References

https://www.england.nhs.uk/wp-content/uploads/2016/03/ca1-enhncd-supprtv-care-guid.pdf

https://www.england.nhs.uk/2016/03/richard-berman/

https://www.england.nhs.uk/2016/07/early-supportive-care/

D. Scheme Justification

D1. Evidence and Rationale for Inclusion

Enhanced Supportive Care has developed through recognition of what specialist palliative care can offer. It is a cost-effective and life-extending approach to treatment of patients with incurable cancer or other terminal disorders, but also from recognition of the barriers to achieving earlier involvement of palliative care expertise within the 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 – from the point of diagnosis with incurable disease.

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.

- Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer, Temel JS et al, N Engl J Med 2010; 363:733-742 August 19, 2010.

Early palliative care for patients with advanced cancer: a cluster-randomised controlled trial, The Lancet, Dr Camilla Zimmermann.

- Effect of early palliative care on chemotherapy use and end-of-life care in patients with metastatic non-small-cell lung cancer, Greer J A et all, Journal of Clinical Oncology, 2012.
- Nice 2004; Guidance on Cancer Services; Improving Supportive and Palliative Care for Adults with Cancer.

DH 2010; Living with and Beyond Cancer – Taking Action to Improve Outcomes (National Cancer Survivorship Initiative).

- Palliative and Supportive Care: Early Versus Delayed Initiation of Concurrent Palliative Oncology Care: Patient Outcomes in the ENABLE III Randomized Controlled Trial - Marie A. Bakitas, Journal of Clinical Oncology May 1, 2015:1438-1445; published online on March 23, 2015; DOI:10.1200/ JCO.2014.58.6362.
- Srivastava P et al. The benefits of early integration of palliative care as a part of standard outpatient oncology care. Journal of Clinical Oncology. 2014;32. [Evidence is required to support:

Rationale of Use of CQUIN incentive

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. It is suggested that the interface with supportive care services could also benefit other patient groups with life limiting diseases.

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 disease , but also from recognition of the barriers to achieving earlier involvement of palliative care expertise within the specialised 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 – from the point of diagnosis with incurable disease.

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 treatment (e.g. Chemotherapy) in patients with advanced progressing disease.

The approach is in line with recommendation 49 and section 5.7 of Achieving World-Class Cancer Outcomes - A Strategy for England 2015-2000 which references the Christie pilot.

The key high-level Impacts are summarised as follows:

- Reduction in the need for aggressive interventions in the last days / weeks of life.

The project will seek to achieve a 25-50% reduction from baseline in 30 day chemotherapy mortality within those cancer services that adopt the programme.

- Improved Patient Quality of Life – Measured through a patient questionnaire

The project will seek to achieve statistically significant improvement in Quality of Life from baseline.

- Reduction in Cost of Treatment

Reduced hospital admissions
Reduction in length of stay
Fewer intensive care hospital days
Reduced cost of therapy in patients with advanced progressing disease

Intended Benefits of this approach:

For Patients	For Commissioners	For Providers
-Coordinated and timely supportive care -Informed choice of treatment from an early stage -Involves patients in decision making about treatment -Improved patient experience and quality of life. -Optimise the use of chemotherapy and reduce the need for aggressive interventions in the last days or weeks of life	-Reduced costs through avoidance of untimely treatments and reduction in inappropriate treatment at end of life. -Delivers the right treatment to the patient at the right time -Optimise the use of therapy in advanced cancer	-Improves patient experience. -Improves communications between specialties and the different elements of supportive care services.. -Delivers the right treatment to the patient at the right time.

D2. Setting Scheme Duration and Exit Route

Provided the intended system wide benefits are being realised the approach to mainstreaming Enhanced Supportive Care needs to be developed early in 2017-18 – allowing providers who commenced the CQUIN in 2016-17 to move out of the scheme for 2018-18 with a mainstreamed approach. Mainstreaming will involve agreeing a sustainable funding mechanism and agreeing the responsibilities of non-specialised commissioners in supporting the Enhanced Supportive Care approach (building on the current funding of supportive and specialist palliative care services)

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 an estimated payment to adequately cover the costs of additional investment in supportive and palliative care teams in line with experience at The Christie NHS Foundation Trust and the first year of the CQUIN during 2016-17.

D4. Evaluation

Evaluation

Data collected through the scheme using the data-collection tool will be used to undertake a central evaluation of the scheme at the end of 16-17 and 17-18.