CA3 – Optimising Palliative Chemotherapy Decision Making

Scheme Name	*CA3 – Optimising Palliative Chemotherapy Decision Making*
Section A. SUMMARY of SCHEME	
QIPP Reference	*[QIPP reference if any]*
Duration	April 2017 to March 2019

Problem to be addressed

Systemic Anti-Cancer Treatment (SACT) can play an important role in extending life in patients with advanced disease, acknowledging also that the beneficial and harmful effects of treatment must be carefully balanced and regularly reviewed.

All decisions regarding the starting and continuation of chemotherapy for patients with advanced cancer with/without a poor performance status cannot practically be taken back to the full multi-disciplinary team meeting to discuss, review and endorse. However, such decisions can often be close to the boundary between overall patient benefit and harm.

To ensure optimal care it is therefore appropriate that, in specific groups of patients, decisions to start and continue further treatment should be made in direct consultation with peers and then as a shared decision with the patient.

This scheme is integral to the overall development of chemotherapy services and, as such, is complementary, but not dependent, to both Dose Banding and Enhanced Supportive Care (ESC) CQUINs.

Change sought

That documented peer discussion takes place when making decisions regarding the commencement or continuation of chemotherapy (irrespective of the funding arrangements for the chemotherapy agent, i.e., CDF or routinely commissioned) for patients that fall within the following groups (acknowledging that such decisions cannot practically be taken back to the full multi-disciplinary team meeting to discuss, review and endorse):

a. Commencement or continuation of chemotherapy in any patients with a performance status (PS) of 2-4 (PS2: up and about >50% of waking hours; PS3:confined to bed or chairs >50% of waking hours; PS4: totally confined to bed or chair)
b. Commencement of 2nd, 3rd, 4th line and beyond treatments in patients being treated with non-curative intent who have demonstrated outright disease progression on the previous line of therapy (ie those patients whose only response to that line of therapy has been progression of disease)

Peer discussion does not require a full MDT, but peer opinion needs to be sought and documented from the Team involved with the care of the patient e.g. specialist nurse, palliative care team member, oncology colleague.

Chemotherapy providers are asked formally to review existing practice in relation to such decisions and put in place procedures to allow for effective and documented peer discussion

where not currently in place.

This scheme will strengthen current shared decision making and informed consent practices. Providers are asked to review local practices in order to incorporate the output of the MDT / peer discussion and improve the information that individual patients receive about the the benefits and disbenefits of treatment options.

Providers are asked to ensure that the requirements relating to the monitoring, review and reporting relating to 30 day mortality following chemotherapy set out within the chemotherapy service specification are adhered to. In addition, providers are asked to ensure that consultant level 30 day mortality data is regularly sent to individual consultants to enable continued professional development.

This scheme will bring about a change in practice within oncology teams and better support clinicians and patients to make treatment decisions. This is different to ESC, which enables early contact with supportive and palliative care teams (at the point of diagnosis of terminal disease); it is considered that where both schemes are in operation there may be synergies as clinicians and patients may feel better able to decline chemotherapy (following MDT / peer discussion) because there are effective ESC arrangements in place. However, this scheme can also be offered where ESC is not in place, as it facilitates change within oncology teams.

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.)	2017/18, 2018/19 *[Adjust locally]* One/two years *(Adjust locally)* *[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 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:		
Trigger 2:		
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, 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: FOR UNIVERSAL UPTAKE

This scheme is appropriate for all providers of chemotherapy services, irrespective of whether ESC is also being delivered.

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.)	The cohorts of patients, meeting criteria listed in section A, to be included in the scheme.

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, target CQUIN payment of <£35,000 plus (£40 times the number of

patients commencing treatment meeting the criteria listed in Section A in the last full year available from SACT data).>

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:	Review of current practice in relation to peer decision making and shared decision making in the patient cohorts defined in section A above.	Progress against targets set in year 1 Trigger 3.
Trigger 2	Review of current practice in relation to 30 day mortality reviews ensuring that monthly 30 day mortality review meetings are in place to review all deaths within 30 days of chemotherapy and that consultant specific 30 day mortality data is feedback on a regular basis to individual consultants.	
Trigger 3	Documented improvement plan against all aspects of triggers 1 and 2 agreed and shared. Including % targets set for improvement in relation to number of cases where a documented peer discussion takes place prior to commencement of continuation of treatment within the patient cohorts defined above.	
Trigger 4	Review audit against improvement plans, including review of % of patients within defined cohorts with a recorded peer discussion	

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	First Year of	Second Year

Target Payment per Trigger	scheme	
Trigger 1	25%	100%
Trigger 2	25%	
Trigger 3	25%	
Trigger 4	25%	
TOTAL	100%	100%

Partial achievement rules

% of final payment delivered to be agreed with local commissioner in line with extent of improvement delivered. Full payment should be made where there is demonstrable evidence of implementation of all aspects of the Trusts improvement plan – resulting in quantifiable improvement in the % of patients with documented evidence of peer discussion.

During Year 1, a greater proportion of payment is related to the system development work required to improve outcomes; in Year 2, the payment should relate more to achievement of a substantially higher proportion of patient care decisions appropriately reviewed.

Definitions

Not Applicable

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

Reporting of Achievement against Triggers

Review of SACT / Trust level data to identify all patients that fall within the 2 defined cohorts:

i) Patients treated with chemotherapy who have a performance status (PS) of 2-4 (PS2: up and about >50% of waking hours; PS3:confined to bed or chairs >50% of waking hours; PS4: totally confined to bed or chair)

ii) Patients treated with non -curative chemotherapy at 2nd, 3rd, 4th line and beyond

And review of Notes to baseline and audit improvement in % of cases where a documented peer discussion takes place prior to commencement of continuation of treatment within the patient cohorts defined above.

Review of SACT data to baseline and audit whether all patient deaths within 30 days of chemotherapy are reviewed.

Reporting Template requirement A reporting template will be developed.

C6. Supporting Guidance and References

N/A

Section D. SCHEME JUSTIFICATION

D1. Evidence and Rationale for Inclusion

Evidence Supporting Intervention Sought

30 Day Chemotherapy mortality can be a useful indicator of avoidable to harm to patients from SACT. The recent Public Health England published report "Trust-level 30-day mortality after systemic anticancer treatment for breast and lung cancer in England" found that 30 day mortality is:

- Higher than expected based on findings from previous RCTs in patients receiving curative systemic anticancer therapy for both breast and lung cancer.
- Higher for breast and NSCLC patients treated with the intent of relieving symptoms and extending lifespan ('palliative) compared with curative intent
- Is higher for those that had a worse performance status score of 2-4 (symptomatic patients requiring any amount of bed rest during the day, or who were completely bed bound)
- Varies significantly between Hospital Trusts.
- The report recommends that Trusts with higher than average 30-day mortality should, as a priority, recheck their own mortality data and encourage treating teams to reflect on practice and service provision in team meetings, audit, mortality and morbidity meetings and through any other established governance processes they have.

Rationale of Use of CQUIN incentive

CQUIN is being used to incentivise all providers of chemotherapy to review and audit their approach to decision making for the cohorts of patients described above, agree an improvement plan and deliver this. This will involve additional time and effort for oncology teams and audit departments to review and discuss their practice in this area.

D2. Setting Scheme Duration and Exit Route

This is a two year CQUIN scheme. The implementation costs of the shift in practice required are expected to be of a magnitude as can be absorbed within existing payments, once the new practice has been systematised over the course of the CQUIN.

D3. Justification of Size of Target Payment

The value of the scheme has been based on a cost per patient of £23, which has been set using the cost of a telephone consultation as a benchmark, and noting that this conversation may be somewhat more involved than normal. The normal CQUIN uplift has been applied to yield £40 per patient CQUIN payment.

In addition an allowance has been made for overhead costs associated with setting up and implementing the scheme.

Significant improvements in outcomes for patients, and avoidance of inappropriate chemotherapy drug utilisation, are expected to result, far outweighing the costs incurred.

D4. Evaluation

Evaluation

Data collection associated with the scheme should allow assessment of outcomes relative to existing practice, using a before and after comparison for the patients recorded on the SACT database as fitting into the categories described above in Section A.