ENHANCED SUPPORTIVE CARE CQUIN 2016/17

Summary of Results for LTHT

CQUIN Description

- 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.
- LTHT were involved in a CQUIN scheme targeted at addressing more fully the needs of patients on active anti-cancer treatment who had a diagnosis of incurable cancer.

Principles of the CQUIN

- (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

Baseline data

Baseline Data relates to: January 2015-December 2015

Cancer Tumour Site	Total number of new diagnosis of incurable disease	Total Number of Patients offered referral to a Supportive Care Team* at Point of Diagnosis of incurable disease	% of Patients in Disease Group offered referral to a supportive care team at point of diagnosis of incurable disease	% of Patients in Disease Group having a HNA at point of diagnosis of incurable disease
Lung	171	24	14.0	52.6
Oesophago-Gastric	45	4	8.9	66.7
HPB	36	4	11.1	66.7
TOTAL	**252**	**32**	**12.7**	**57.1**

Results

Cancer Tumour Site	1. Have been identified as having incurable disease			
	Q1 Baseline	Q2	Q3	Q4
Lung	89.1%	100.0%	100.0%	100.0%
Oesophago-Gastric	100.0%	100.0%	100.0%	100.0%
HPB	100.0%	100.0%	100.0%	100.0%

Results- Prognosis

Cancer Tumour Site	2. Have been given the opportunity to discuss their prognosis			
	Q1 Baseline	Q2	Q3	Q4
Lung	73.9%	57.1%	75.9%	33.3%
Oesophago-Gastric	57.1%	55.5%	75.0%	50.0%
HPB	90.9%	83.3%	50.0%	50.0%

Results – Management Plan

	3. Have documented evidence that they have been given the opportunity to be involved in decision making about their individual management plan.			
Cancer Tumour Site	**Q1 Baseline**	**Q2**	**Q3**	**Q4**
Lung	82.6%	100.0%	100.0%	100.0%
Oesophago-Gastric	71.4%	88.9%	100.0%	100.0%
HPB	81.8%	100.0%	100.0%	100.0%

Results – Referral to SPCT

	4. Be offered referral to a supportive care team			
Cancer Tumour Site	**Q1 Baseline**	**Q2**	**Q3**	**Q4**
Lung	26.1%	25.0%	34.5%	51.9%
Oesophago-Gastric	28.6%	22.2%	0.0%	33.3%
HPB	100.0%	66.6%	50.0%	75.0%

Results – GP Comms

	5. There is evidence of communication with GP around these standards			
Cancer Tumour Site	**Q1 Baseline**	**Q2**	**Q3**	**Q4**
Lung	87.0%	100.0%	100.0%	100.0%
Oesophago-Gastric	28.6%	100.0%	100.0%	100.0%
HPB	63.6%	100.0%	100.0%	100.0%

Results -HNA

	6. Did they have a holistic needs assessment documented?			
Cancer Tumour Site	**Q1**	**Q2**	**Q3**	**Q4**
Lung	63.4%	78.6%	58.6%	81.5%
Oesophago-Gastric	100.0%	55.5%	100.0%	100.0%
HPB	90.9%	100.0%	100.0%	100.0%

Results – other referrals

Cancer Tumour Site	7. Did they have a referral to another ESC service?			
	Q1	Q2	Q3	Q4
Lung	56.1%	78.6%	65.5%	81.5%
Oesophago-Gastric	71.4%	77.8%	75.0%	50.0%
HPB	72.7%	83.3%	100.0%	50.0%
	61.0%	**79.1%**	**68.6%**	**73.0%**

Baseline 30 day mortality

Cancer Tumour Site	Total Number of Patients Receiving Chemotherapy Treatment within Baseline Period	Total Number of Deaths Occuring within 30 Days of Chemotherapy Treatment	Proportion of Deaths within 30 days of Chemotherapy
Lung	167	18	10.8%
Oesophago-Gastric	85	10	11.8%
HPB	77	9	11.7%
TOTAL	**329**	**37**	11.2%

16/17 30 day mortality

16/17 Performance - 30 Day Chemotherapy Mortality

Cancer Tumour Site	Total Number of Patients Receiving Chemotherapy Treatment within Period	Total Number of Deaths Occurring within 30 Days of Chemotherapy Treatment	Proportion of Deaths within 30 days of Chemotherapy
Lung	163	12	7.4%
Oesophago-gastric	51	3	5.9%
HPB	84	4	4.8%
TOTAL	**298**	**19**	6.4%

ENHANCED SUPPORTIVE CARE CQUIN

Summary of Results

Hull

Baseline for 2017

Cancer Tumour Site	Total number of new diagnosis of incurable disease	Total Number of Patients offered referral to a Supportive Care Team* at Point of Diagnosis of incurable disease	% of Patients in Disease Group offered referral to a supportive care team at point of diagnosis of incurable disease
Breast	9	6	66
Lung	21	17	81
Gynae	13	5	38
Brain and CNS	1	1	100
Upper GI	23	21	91
TOTAL	67	50	75%

Identified as having incurable disease

Cancer Tumour Site	Q1 Baseline	Q2	Q3	Q4
Breast	90%	55%		
Lung	90%	93%		
Gynae	92%	78%		
UGI	73%	64%		
Brain	100%	50%		

Have been given the opportunity to discuss their prognosis

Cancer Tumour Site	Q1 Baseline	Q2	Q3	Q4
Breast	44%	44%		
Lung	80%	60%		
Gynae	76%	71%		
UGI	76%	88%		
Brain	100%	0%		

Have been offered referral to a supportive care team

Cancer Tumour Site	Q1 Baseline	Q2	Q3	Q4
Breast	66%	50%		
Lung	80%	80%		
Gynae	38%	50%		
UGI	95%	65%		
Brain	100%	50%		

Have been given the opportunity to be involved in decision making about their management plan

Cancer Tumour Site	Q1 Baseline	Q2	Q3	Q4
Breast	77%	66%		
Lung	71%	86%		
Gynae	84%	78%		
UGI	73%	76%		
Brain	0%	50%		

There is evidence of communication around these standards to GP

Cancer Tumour Site	Q1 Baseline	Q2	Q3	Q4
Breast	100%	66%		
Lung	90%	100%		
Gynae	100%	100%		
UGI	70%	100%		
Brain	100%	100%		

HNA

Cancer Tumour Site	Q1 Baseline	Q2	Q3	Q4
Breast	33%	0%	0%	
Lung	52%	45%	25%	
Gynae	8%	0%	0%	
UGI	0%	0%	0%	
Brain	100%	100%	100%	

Issues with data

- Baseline for mortality difficult to obtain with the systems used
- CQUIN changed to compliance against the principles and cohorts changed so difficult to compare the values

1. Earlier Involvement of supportive care services	From the point of recognition of incurable disease (whether local or metastatic) all patients should be screened for supportive care needs (NICE 2004). This should include prompt identification and management of physical and psychological symptoms. This has the potential to improve the patient experience and their ability to tolerate anti-cancer treatment	How are you are offering earlier involvement of supportive care services? (with reference to actions, or specific activities undertaken and the resulting change/improvement)
		Number of patients diagnosed with incurable cancer in the quarter who have been offered ESC and demonstrate an upward trend
		Have you identified a clinical lead for ESC? Yes/No From which professional group? Describe the impact of this on developing ESC locally If 'no' explain your rationale for not identifying a clinical lead.
		Describe how your approach to identifying patients is proactive, and how this has impacted on ESC, patients and other services.
		How are you poviding efficient referral pathways to allow prompt access to supportive care?
		What changes have been made through your ESC service to enable it to be 'available' to provide advice to oncology, by phone and face to face?
		Do your ESC patients having access to an advice line – for issues relating to pain / symptom control / complications of treatment?
		Have you developed joint clinics? If yes, with whom and what is the impact? - for patients, ESC and other professions

Principle 2; Supportive care teams that work together	Aim: Cancer patients should have access to a comprehensive range of support services, which run alongside their anti-cancer treatments. These supportive care services should work together, ideally under one umbrella, and have recognition in their centres as a core part of the business – being regarded as the "4th pillar of cancer care	Describe the range of professionals involved with the ESC caseload across this quarter, and how you demonstrate a joined up approach, to your ESC patients
		Describe your approach to ESC MDT - e.g. frequency of meeting, model, documentation.
		Describe how you are working with your community palliative care services, and the impact on your service, their services and the ESC patients. E.g. - has this resulted in improvements in efficiency and referrals/access?
		Number of patients referred to benefits advisor as a result of ESC, for whom this would not otherwise have taken place yet?
		Is your ESC service involved with joint working on projects – research and audit – to enhance clinical outcomes and care
		Does your ESC model provide of one-stop supportive care outpatient clinics – with multiple supportive care specialties available within the clinic to help patient complementary, OT, physiotherapy).
		Number of patients referred to other palliative care services e.g. day therapy as a result of ESC, for whom this would not otherwise have taken place yet

Principle 3; A more positive approach to supportive care	Aim: Excellent supportive care should offer patients a positive experience, help them to maintain hope, and even have the potential to extend survival. This approach should be adopted throughout the continuum of cancer care. In particular, for patients in whom further chemotherapy is unlikely to offer any benefit, provision of ongoing high quality supportive care should be seen as a 'real' and robust alternative to continuation of anti-cancer treatment.	Describe how your ESC model demonstrates to patients that it is maintaining appropriate hope and presenting a positive approach to care.
		How have you rebranded existing services to create ' ESC' and what is the title of your ESC service model?
		Does your ESC model enable 'automatic' referral to supportive care teams at the point of diagnosis of incurable disease? If 'no' how are you progressing towards this? eg building rapport, relationships and regular review throughout treatment and beyond.
		Where your ESC service is receiving additional referrals for access to ESC from non-palliative care professionals, ie individual consultants (or their teams) please record number of referrals received.

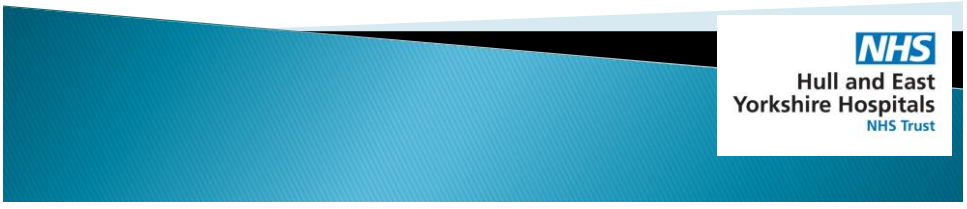
Principle 4; Cutting edge and evidence-based practice in supportive and palliative care.	Aim: Supportive care teams should commit to ensuring that the care they provide is cutting-edge, with awareness of the latest available pain and symptom control treatments used in different stages of cancer care.	Describe the involvement of your ESC model or patients in ESC related research
		Describe how you tailor your treatments for managing pain and symptoms, for patients who are earlier in their cancer trajectory / on active cancer treatment
		Are you more involved in managing the adverse effects of cancer treatments, as a result of ESC?
		Are you referring for pain interventions more frequently as a result of ESC?
		Describe how ESC has impacted on patients in your centre/Trust who are living with 'chronic cancer' .
		Have you extended your ESC service more widely than just for patients with incurable cancer? (eg curable disease, non-cancer, survivorship)?
		Describe any involvement of your ESC model or patients in ESC related research

Principle 5; Technology to improve communication	Aim: Incorporating technology to facilitate better communication between the hospital and community services, especially for patients with progressing cancer.	Describe how your ESC service is using technology to improve communication with other professionals. E.g. number of ESC patients added to the Electronic Palliative Care Coordination System.
		Describe how your ESC service is using technology to improve communication with patients at home e.g. remote monitoring / electronic patient reporting systems.
		Number of ESC patients completing an electronic Holistic Needs Assessment (eHNA)

Principle 6; Best practice in chemotherapy care.	Aim: Cancer patients should be offered appropriate treatment, delivered to a high standard. All chemotherapy treatment regimens and associated supportive care offered should be based on the results of national and international research and audit.	Does your ESC model support shared decision making between patients and oncologists regarding treatment options and continuation of treatment?"
		How does your ESC model support patients to cope with the burden of treatment?
		How does your ESC model support patients to self care?
		Can you demonstrate an impact on decision making regarding appropriateness of treatment? Is there any evidence of an impact on 30 day chemotherapy mortality?

Enhanced Supportive Care

Hull Experience



Learning from the CQUIN

- Echoes the findings from Leeds
  - Increasing numbers; multiple treatment options
  - Lack of capacity within SPCT
  - Is referral timely?
  - Signposting and support post treatment
- Raised more issues than anticipated
  - Best Supportive Care patients
  - ACP opportunities
  - SS CNS not alerted following admission or patient deteriorating
  - Lack of HNA recorded.

Data analysis

- Difficult to obtain from multiple hospital systems
- Reduced number of referral to a Supportive Care Team (SCT) when the CNS team were not based within the Cancer Centre.
- Referrals were predominantly made following an emergency admission and were therapy based

Initiatives

- Electronic HNA on hospital admin system.
- Best Supportive Care pathway review.
- Sage and Thyme implemented within the Trust.
- 7 day SPC implemented
- Education sessions by SPC for CNS teams
- Rapid access consultant clinic/ SPC

- Cancer Assessment Unit
- CNS ‘catch up’ meetings.
- Dying Matters workshops
- Nursing model to follow the whole of the patient journey where possible
- Implementation of the AOS nurse service has greatly improved pathway for patients away from the cancer centre

Future implementation

- End of Treatment summary to be undertaken by CNS.
- IPOS to be implemented by the SPCT within SPC clinics.
- Embedding Recovery Package and Living With and Beyond Cancer into patient pathways.
- Respect implementation evaluation.

- ACP clinics and joint tool with the community.
- Metastatic breast service review
- Cancer care co-ordinators
- CNS review of patient on palliative intent chemotherapy
- Closer working with therapies to identify patients back to the CNS teams.

The Issue

- Increasing number of patients receiving palliative chemotherapy
- SPCT does not have the capacity to see patients without SPCT needs
- Some evidence that those with SPCT needs are being referred although in some cases this could be earlier
- Group of patients who are finishing palliative treatment who could benefit from early intervention and signposting

Data

- Data considered from 2017 looking at patients in Q2 receiving palliative chemotherapy – then looked at what happened in next quarter:
- Had further chemo and died – very small numbers
- Died in quarter 3 – small numbers and predominantly referred to SPCT
- Had no further chemo and still alive – about a quarter of patients
- Had further chemo in quarter 3 – over half of the patients

New Initiative

- Considering focusing on the patients who are coming to the end of palliative treatment
- Aim would be for patients to feel satisfied with their plan of care and symptom control at the end of oncology treatment and know how to access services as they required them
- This would be done through a nurse led supportive care clinic where patients underwent a HNA and subsequent care planning around issues identified

Scope of Project

- This would be a pilot project to look at the feasibility of a supportive care clinic which would look to:
- Identify if this is the appropriate cohort of patients?
- Who else would be required to run the clinic eg AHP's/medical staff?
- Is the Acute setting the right place for such a clinic?

Questions

- This pilot project is still in the planning stages and as such is open to ideas to shape it
- Do you deliver any SPCT/supportive care outpatient activity?
- Do you feel this is the right group of patients to focus on?