Proposed Cancer CQUIN Intentions 2016/17

Provider Details: (*Royal Liverpool, Aintree, Liverpool Womens LHCH, Walton, Clatterbridge, Southport and Ormskirk, St Helens and Knowsley, Countess of Chester*).
CQUIN Proposal Number: (1)

Description of Goal	Holistic needs assessment and care planning
Indicator Weighting	50% of financial allocation
Description of Indicator	All newly diagnosed cancer patients will receive a holistic needs assessment, from which a supportive care plan is generated. This care plan will be shared with both patient and GP and will cover all aspects of the patient's needs including: • Physical concerns, • Practical concerns, • Family/relationship concerns, • Emotional concerns, • Lifestyle or information needs The HNA and care plan will be generated using a validated tool as described in the National Cancer Survivorship Initiative:http://www.ncsi.org.uk/wp-content/uploads/Holistic-Needs-Assessment-practical-guide.pdf
Numerator	Total number of Care Plans generated and shared with patient and GP as a result of Holistic Needs Assessment for newly diagnosed patients by tumour type
Denominator	Total number of **ALL** newly diagnosed cancer patients by tumour type (after agreed exclusions*)

The HNA should be carried out at an agreed milestone within the pathway, **after diagnosis and before commencement of treatment** for patients on an elective pathway (patients presenting and being treated as emergencies are excluded)
Patients whose first definitive treatment is specialist palliative care only are also excluded as bespoke assessments are made as part of SPCT process already.
All exclusions to be reported and justified in recording template*

Rationale for inclusion	Undertaking holistic needs assessment with the patient enables them to be more fully engage in their care and facilitates choice. It enables the patient to take greater control of what happens to them and supports them to self-manage their condition. By helping patients identify their concerns, teams will know where best to concentrate their effort and they will be able to develop a care plan that is tailored to an individual patient's needs. The importance of understanding the need for physical, psychological, social, spiritual and financial support for people with cancer and their carers was recognised in the NICE guidance devoted to improving supportive and palliative care for adults with cancer in 2004. It was reiterated in the Cancer Reform Strategy in 2007 and by the All Party Parliamentary Group in their report on inequalities in cancer published in December 2009. The 2015 Strategy for Achieving World Class Outcomes in Cancer recommends that each patient receives: A holistic needs assessment and a written individualised care and support plan at key points across the pathway. The patient should agree with and own this plan which should be shared with their GP or other designated local healthcare professional. It should take in to account social circumstances, mental health needs, and any co-morbidities. Across Merseyside and Cheshire a range of initiatives are taking place to implement holistic needs assessment and care planning however this is not consistent between trusts and tumour groups.

The Macmillan eHNA tool is in use across a number of sites, in those without access to this tool, an editable electronic version of the HNA should be used (example attached). Hand written copies of the care plan should be avoided as these do not copy well. The completed care plan should be printed and given to the patient, a copy saved to the Trust medical record, and a copy faxed to the GP in the same manner as the serious diagnosis forms

Example electronic HNa and care plan LV

Consequences of non-inclusion	Continued inequity of implementation and quality of holistic needs assessment for people affected by cancer. Limited assurance for commissioners that the recommendation that all patients with cancer receive HNA and an individual care plan
Details of Milestones	Q1. Each trust to baseline current delivery of HNA and care planning by trust and by tumour type Q2. Each trust to develop protocol for measurement and reporting (via agreed regional approach) Q3. % improvements agreed upon baseline. Q4. Improvements delivered by trust and tumour type/ team
What does "good" look like– What will be achieved at year end	Each trust to have a clear baseline of performance by team and a plan for improvement corporately and by team/ tumour type Increased % of newly diagnosed cancer patients will receive a HNA and care plan (by tumour type). Ambition 50% all newly diagnosed cancer patients receive HNA and care plan in year 1.
Suggested approach to measurement	A Cheshire and Merseyside survivorship programme has been set up to bring improvements and consistency. As part of this programme a regional dashboard is currently in development to monitor across Cheshire and Merseyside. This will include measurement of HNA and care plans.
Can performance be measured from 1st April 2016	Yes

The Somerset Cancer Register is used in all participating Trusts (except Clatterbridge Cancer Centre). The denominator (number diagnosed cancer patients) is extracted from Somerset. The numerator (number of completed HNA and Care plans for this cohort) can also be recorded within Somerset or extracted from the reporting function of the Macmillan eHNA tool.
This must be backed up with audit of evidence that care plan is present in patient record.

There may be some tumour types for example skin cancer, when the treatment takes place before the diagnosis, and these patients should be excluded from the count of pre-treatment HNA. However, these MDTs should show evidence of their actions to support implementation of HNA for appropriate patients

How does this proposal link with CCG Strategic Plan – Healthy Liverpool Programme	Directly contributes to the cancer work programme; cancer survivorship Contributes directly to the aims and design principles of Healthy Liverpool, in particular person centred care, eliminating avoidable variation in the quality of care, promoting a proactive approach, increasing self-care and empowerment and effective care planning.
Is there scope for this proposal to be a joint or collaborative CQUIN? If yes then provide the relevant detail.	Yes. Has been discussed with commissioners across Cheshire and Merseyside. Regional cancer survivorship programme is promoting this CQUIN. Also scope to include consideration of how specialised commissioning can support in their role as commissioners of specialised services. Proposed CQUIN has been discussed at cancer network primary care meeting, lead nurse and cancer managers forums. It has also been discussed at the regional cancer survivorship programme board and provided to the Macmillan GP in each CCG for comment.
Are there any rules for partial achievement of the indicator at the final indicator period / date?	See Table 1.

Table 1. Milestones and Payments

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter One	• Establish project team • Agree baseline methodology • Provide PID and methodology • Undertake scoping/ baseline exercise (including staff training needs) • Provide findings of scoping/ baseline exercise and identified actions to enable Q3-Q4		25%
Quarter Two	• Develop protocol for recording and audit • Provide protocol and audit schedule • Develop and provide implementation plan • Provide assurance of successful implementation of reporting and audit mechanisms • Staff training compliance plan • Submit baseline data via agreed mechanism		25%
Quarter Three	• Develop and provide improvement plan • Agree improvement trajectory based on baseline and improvement plan (50% by end of Qtr 4) • Staff training compliance report • Submit performance data via agreed mechanism		25%
Quarter Four	• Monitor delivery against agreed improvement plan and trajectory • Submit performance data via agreed mechanism • Submit further improvement plan and trajectory for agreement		25%

CQUIN Proposal Number: (2)

Description of Goal	Cancer treatment summaries
Indicator Weighting	50% of financial allocation
Description of Indicator	All patients completing any anti-cancer treatment at your Trust will have an extended appointment at which the likely consequences, both short term and long term, of their treatment will be discussed. A treatment summary will then be generated which includes at least the following information: Diagnosis Diagnosis Date Tumour staging Summary of Treatment Treatment aim Possible toxicities and/or late effects Symptoms that require referral back to specialist team Contact point for referrals or queries Details of other referrals made Ongoing management at Trust and stratified/ surveillance pathway choice Actions required by GP and relevant read codes Summary of information given to patient Additional information regarding lifestyle/support needs A copy of the treatment summary will be given to the patient for their own records, a copy will be sent to the GP, preferably within 24 hours but always within 14 days, of being issued to the patient, and a copy will be placed in the hospital case notes. Example template: http://www.ncsi.org.uk/what-we-are-doing/treatment-summary/

Request has been made to EMIS for READ code Cancer Treatment Summary

Numerator	Total number of patients receiving a treatment summary at reporting Trust on completion of anti-cancer treatment (by tumour type)
Denominator	Total number of patients completing anti-cancer treatment at reporting Trust (by tumour type)
Rationale for inclusion	The treatment summary has been shown to improve the communication between cancer services and primary care. It provides important information to the GP and other primary care professionals about the possible treatment toxicities and/or late effects of treatment. The patient also receives a copy to enhance their understanding of their condition and to enable self-management where appropriate. A copy of the treatment summary in the case notes is useful for medical staff to see should the patient be admitted as an emergency at a later date. The 2015 strategy to Achieve World Class Cancer Outcomes recommends that on completion of treatment a patient should receive • Information on likely side-effects of treatment and how best to manage these, including those that might appear after some months/years. • Potential markers of recurrence/secondary cancers and information on what to do in these circumstances. • Key contact point for rapid re-entry if recurrence markers are experienced or if serious side effects become apparent. Treatment summary completed at the end of every phase of acute treatment, sent to the patient and their GP

Consequences of non-inclusion	Continued inequity of implementation and lack of standardisation. Limited assurance for commissioners that the recommendation that end of treatment summaries are produced
Details of Milestones	Q1. Each trust to baseline current delivery of treatment summaries and care planning by trust and by treatment type Q2. Each trust to develop protocol for measurement and reporting (ideally via regional dashboard) Q3. % improvements agreed upon baseline. Q4. Improvements delivered by trust and treatment type/ team
What does "good" look like– What will be achieved at year end	All patients receiving a treatment summary at the end of acute treatment All treatment summaries provided to GP within 24 hours of being issued to patient Ambition 50% all cancer patients receive cancer treatment summary in year 1.
Suggested approach to measurement	A Cheshire and Merseyside survivorship programme has been set up to bring improvements and consistency. As part of this programme a regional dashboard is currently in development to monitor across Cheshire and Merseyside. This will include measurement of treatment summaries
Can performance be measured from 1st April 2016	Yes

The Somerset Cancer Register is used in all participating Trusts (except Clatterbridge Cancer Centre). The denominator (number patients with a recorded definitive treatment at the participating Trust) is extracted from Somerset. The numerator (number of completed cancer treatment summaries for this cohort) may require manual monitoring and as such staff resource must be factored in. This must be backed up with audit of evidence that treatment summary is present in patient record.

An inclusive list of all diagnoses and treatments carried out at the participating Trust will be formulated as part of Q1/2 project scoping. This will be the final denominator for the CQUIN.

How does this proposal link with CCG Strategic Plan – Healthy Liverpool Programme	Directly contributes to the cancer work programme; cancer survivorship Contributes directly to the aims and design principles of Healthy Liverpool, in particular person centred care, eliminating avoidable variation in the quality of care, promoting a proactive approach, increasing self-care and empowerment and effective care planning. Also provides an opportunity to strengthen communication and relationships between primary, secondary and tertiary care services.
Is there scope for this proposal to be a joint or collaborative CQUIN? If yes then provide the relevant detail.	Yes. Has been discussed with commissioners across Cheshire and Merseyside. Regional cancer survivorship programme is promoting this CQUIN. Also scope to include consideration of how specialised commissioning can support in their role as commissioners of specialised services. Proposed CQUIN has been discussed at cancer network primary care meeting, lead nurse and cancer managers forums. It has also been discussed at the regional programme board and provided to the Macmillan GP in each CCG for comment.
Are there any rules for partial achievement of the indicator at the final indicator period / date?	See Table 2.

Table 2. Milestones and Payments

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter One	• Establish project team • Agree baseline methodology • Provide PID and methodology • Undertake scoping/ baseline exercise (including staff training needs) • Provide findings of scoping/ baseline exercise and identified actions to enable Q3-Q4		25%
Quarter Two	• Develop protocol for recording and audit • Provide protocol and audit schedule • Develop and provide implementation plan • Provide assurance of successful implementation of reporting and audit mechanisms • Staff training compliance plan • Submit baseline data via agreed mechanism		25%
Quarter Three	• Develop and provide improvement plan • Agree improvement trajectory based on baseline and improvement plan (50% by end of Qtr 4) • Staff training compliance report • Submit performance data via agreed mechanism		25%
Quarter Four	• Monitor delivery against agreed improvement plan and trajectory • Submit performance data via agreed mechanism • Submit further improvement plan and trajectory for agreement		25%