NHS
Wessex
Cancer Alliance

APPENDIX 9: ARRS CANCER AND PRIMARY CARE RESPONSIBILITIES

Utilisation of Additional Roles Reimbursement and Primary Care Contract Responsibilities and Drivers

This document maps the roles and responsibilities stated in the:

- **GP Network Contract DES**
- **Quality Outcomes Framework**
- **Long Term Plan**

To potential activities and patient care that can be completed by the ARRS workforce.

Prevention (QoF)

- **OB002. The contractor establishes and maintains a register of patients aged 18 years or over with a BMI ≥30 in the preceding 12 months (based on NM143)**
- **OB 002.1 Rationale The register includes all patients whose BMI has been recorded by the practice as part of routine care. It is expected that this data will inform public health planning and support onward referral to weight management services.**
- **SMOK002. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (NICE 2011 menu ID: NM38**
- **SMOK004. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months (based on NM40)**
- **SMOK005. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers 25 56–96% 21 who have a record of an offer of support and treatment within the preceding 12 months (NICE 2011 menu ID: NM39)**

Patient Care	Activity	Roles
Making Every Contact Count	Very Brief Advice	All Roles

	Signposting	All Roles
Using Population Health Data	Target populations	Care Coordinator Health and Well Being Coach
Health Promotion within PCN	Posters/leaflets Media	Care Coordinator
	Healthy checks	Nursing Associates Pharmacy Technicians
	Behaviour Change Coaching	Health and Well-being Coach
Signposting	Referral to local services, exercise, smokestop, IAPT, support groups	All Roles

Early Diagnosis (Contract DES)

8.4. Early Cancer Diagnosis

8.4.1. A PCN is required to:

a. review referral practice for suspected cancers, including recurrent cancers. To fulfil this requirement, a PCN must:

i. review the quality of the PCN's Core Network Practices' referrals for suspected cancer, against the recommendations of NICE Guideline 1260 and make use of:

ii. clinical decision support tools;

iii. practice-level data to explore local patterns in presentation and diagnosis of cancer; and

iv. where available the Rapid Diagnostic Centre pathway for people with serious but non-specific symptoms;

v. build on current practice to ensure a consistent approach to monitoring patients who have been referred urgently with suspected cancer or for further investigations to exclude the possibility of cancer ('safety netting'), in line with NICE Guideline 12; and

vi. ensure that all patients are signposted to or receive information on their referral including why they are being referred, the importance of attending appointments and where they can access further support; and

vii. in undertaking section 1.1.1.a.i to 1.1.1.a.vi identify and implement specific actions to address unwarranted variation and inequality in cancer outcomes, including access to relevant services;

b. contribute to improving local uptake of National Cancer Screening Programmes. To fulfil this requirement, a PCN must:

i. work with local system partners – including the NHS England and NHS Improvement Regional Public Health Commissioning team and Cancer Alliance – to agree the PCN's contribution to local improvement plans which should build on any existing actions across the PCN's Core Network Practices. This must include at least one specific action to engage with a group with low participation locally, with agreed timescales; and

ii. support the restoration of the NHS Cervical Screening Programme by identifying opportunities across a network to provide sufficient cervical screening sample-taking capacity; and c. establish a community of practice between practice-level clinical staff to support delivery of the requirements set out in sections 8.4.1.a to 8.4.1.vii. A PCN must, through the community of practice: i. conduct peer to peer learning events that look at data and trends in diagnosis across the PCN, including cases where patients presented repeatedly before referral and late diagnoses; ii. engage with local system partners, including Patient Participation Groups, secondary care, the relevant Cancer Alliance, and Public Health Commissioning teams; and iii. identify successful improvement activity undertaken by constituent practices in support of the Quality and Outcomes Framework requirements on early cancer diagnosis. Ensure that successful practice is implemented and developed across the PCN		
Risks, Signs and Symptoms Education	Patient Non-Clinical Roles Clinical Roles	All roles at appropriate level of training
Screening **New DES 22/23 Contract** **2. Work with local system partners – including the NHS England and NHS Improvement Regional Public Health Commissioning team and Cancer Alliance – to agree the PCN's contribution to local efforts to improve uptake in cervical and bowel NHS Cancer Screening Programmes and follow-up on non-responders to invitations. This must build on any existing actions across the PCN's Core Network Practices and include at least one specific action to engage a group with low participation locally.**	Skills	Nursing Associates for Cervical Cytology
	Audit	Cancer Care Coordinators for auditing screening rates
	Uptake/contacting Non-responders	Care coordinators, Social prescribers, Nursing Associates
Safety Netting	Coding Coordination	Cancer Care Coordinator can assist with coding, appointment booking
	Use of risk assessment tools	Paramedics, FCP MSK Physiotherapists, Physician Associate roles to be developed in safety netting knowledge, skills and

		ability to use tools if in their scope of practice.
Decision Support Tools	Emis System one Cancer Research C the Signs	Paramedic, FCP MSK physiotherapists, Physician Associates to be developed in knowledge, skills and ability to use tools if in their scope of practice.
FIT with 2WW request (QoF/IFF) **CAN-10: Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral. Threshold UT: 80% LT:40% (22/23), 65% (23/24) Valuation £5.0m/ 22 points**	Completion	Referring Clinicians ACP/FCP Paramedic, Physiotherapist and potentially Physician Associates
	Monitor completion	Coordinators to follow up if FIT completed.
Care Navigation	Patient information 2WW time achieved Signposting	Cancer Care Coordinator

Personalised Care (NHS LONG TERM PLAN)

- **The** NHS Long Term Plan for Cancer **states that "where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support."**
- Cancer Alliances **are working with trusts and primary care to offer these personalised care interventions to people with breast, colorectal and prostate cancer and for other cancers by March 2022. We estimate that around 80% of cancer multidisciplinary teams (MDTs) are now offering Personalised Care and Support Planning**
- **Personalised Care and Support Planning (based on holistic needs assessments) ensures people's physical, practical, emotional and social needs are identified and addressed at the earliest opportunity.**
- **End of Treatment Summaries provide both the person and their GP with valuable information, including a detailed summary of treatment completed, potential side effects, signs and symptoms of recurrence and contact details to address any concerns.**
- **Primary Care Cancer Care Review is a discussion between the person and their GP / primary care nurse about their cancer journey. This helps the person to discuss any concerns, and, if appropriate, to be referred to services or signposted to information and support that is available in their community and from charities.**
- **Health and Wellbeing Information and Support includes the provision of accessible information about emotional support, coping with side effects, financial advice, getting back to work and making healthy lifestyle choices. This support will be available before, during and after cancer treatment.**

Personalised Care and Support Planning	Cancer Care Reviews (QoF) Care Plans **CAN001.** The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding nonmelanotic skin cancers diagnosed on or after 1 April 2003' **CAN004.** The percentage of patients with cancer, diagnosed within the preceding 24 months, who have a patient Cancer Care Review using a structured template recorded as occurring within 12 months of the date of diagnosis (NICE menu 2020 ID: NM205 **CAN005**. The percentage of patients with cancer, diagnosed within the preceding 12 months, who have had the opportunity for a discussion and been informed of the support available from primary care, within 3 months of diagnosis (based on NM204)	Development of non-clinical additional reimbursement roles to do some 3-month cancer care reviews. (**N.B training and considerable support will be needed to fulfil this in a non-clinical role.)** All clinical staff can do cancer care reviews
	Advanced Care Planning	Physician Associates Paramedics OTs Dieticians
	End of Treatment Summaries	Physician Associates Paramedics/ACPs Clinical Pharmacists
Health and well-being information support including Social Prescribing	Holistic management and rehabilitation supportive roles.	Cancer Care Coordinators Health and Well-being Coaches

	Living with and beyond cancer	Social Prescribers/ Health and Well-being Coach
	Universal prehabilitation advice	Health and well-being coach, Social Prescribers and Cancer Care Coordinators
Rehabilitation **Across the whole of the pathway**	Prehabilitation – targeted to specialist	OTs Dieticians
	Management of Late effects	OTs Dieticians Physician Associates Paramedics
	Consequences of cancer and its treatments	Mental Health Practitioners
	Back to work, return to function and activities of daily living.	
Other DES Contract Service Requirements		
Network DES 20/21 8.2. Structured Medication Review and Medicines Optimisation	Medicine: • Optimisation • Adherence • Quick access • Review	Clinical pharmacists Pharmacy Technicians
Network DES 20/21 8.3. Enhanced Health in Care Homes	Management of cancer and palliative patients in Care Homes	Paramedics Occupational Therapists Physician Associates Clinical Pharmacists and Technicians with medication management and queries
	Education of Care Home staff	As above

	Advanced care planning	Paramedics Occupational Therapists Physician Associates
	Admission avoidance	Paramedics Occupational Therapists Physician Associates
8.7. Tackling Neighbourhood Health Inequalities **New Network Contract DES 22/23** **1. Review referral practice for suspected and recurrent cancers, and work with their community of practices to identify and implement specific actions to improve referral practice, particularly among people from disadvantaged areas where early diagnosis rates are lower.** **2. Work with local system partners – including the NHS England and NHS Improvement Regional Public Health Commissioning team and Cancer Alliance – to agree the PCN's contribution to local efforts to improve uptake in cervical and bowel NHS Cancer Screening Programmes and follow-up on non-responders to invitations. This must build on any existing actions across the PCN's Core Network Practices and include at least one specific action to engage a group with low participation locally.**	Review referral practices: Data collection Uptake of screening Targeting specific populations	 Cancer Care Coordinators Care coordinators Social Prescribers Nursing Associates Physician Associates (QI) Cancer Care Coordinator Social Prescriber Nursing Associate Physcian Associate (QI project)
Significant Event Analysis	Review of late diagnosis and emergency unplanned admissions	Physician Associates could lead on audit and discussion. Cancer Care coordinator can provide the data.
Investment and Impact Fund Indicators 22/23		

Personalised Care **PC-01: Percentage of registered patients referred to a social prescribing service**	Referrals	All ARRS All roles doing cancer care reviews Cancer Care Coordinator could have great impact by referring at point of diagnosis
	Ensure snomed coding correct/used	Cancer Care Coordinator
Access **ACC-08: Percentage of patients whose time from booking to appointment was two weeks or less**	Increased workforce and skillset to reduce pressure on other members of the surgery team and freeing up appointments	All ARRS
Enhanced healthcare in care homes **EHCH-02: Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed**	Completion of Cancer Care Reviews Advanced Care Planning in this patient population	Any role involved in Enhanced Healthcare in Care homes work – most likely to be: Paramedic Physician Associate OT