Utilisation of Additional Reimbursement Roles for Cancer Care in Primary Care

HEE SE Funded project

- 18 Months Duration
- Working closely with other WCA Programmes:
  - Personalised care
  - Primary care
  - Education
  - Early diagnosis
- Working closely with other Cancer education programmes:
  - ACCEnD
  - ProsPer
  - Macmillan

Project Output

- Primary Care ARRS Workforce Toolkit
- Evaluation of: new, upskilled roles and innovative models of care in proof of concept sites
- Promoting employment Cancer Care Coordinators

This toolkit will provide the links to education, tools, patient material and asset mapping to support and assist ARRS postholders to develop their cancer knowledge and skills.

In addition, WCA will support with development of new innovative cancer specific roles and/or cancer patient pathway improvement within Primary Care Networks.

The Additional Roles Reimbursement Scheme (ARRS) is designed to expand the primary care work force and enable more proactive, personalised and integrated health and social care.

The toolkit will help primary care understand the potential and opportunities to employ and develop existing ARRS to:

- Support the delivery of cancer priorities of the DES GP Contract
- Support achievement of Quality Outcome Framework (QoF) Indicators
- Provide personalised care planning throughout the cancer pathway, as stated in NHS Long Term Plan

ADDITIONAL REIMBURSEMENT ROLES

Support Roles

- Care Coordinator
- Social Prescriber
- Health and Well-being Coach

Assistive Roles

- Nursing Associate
- Pharmacy Technician

Clinical Roles

- Physician Associate
- Dietician
- Occupational Therapist
- Paramedic
- FCP Physiotherapist
- Mental Health Practitioner
- Clinical Pharmacist

Drivers

Primary Care

People affected by Cancer

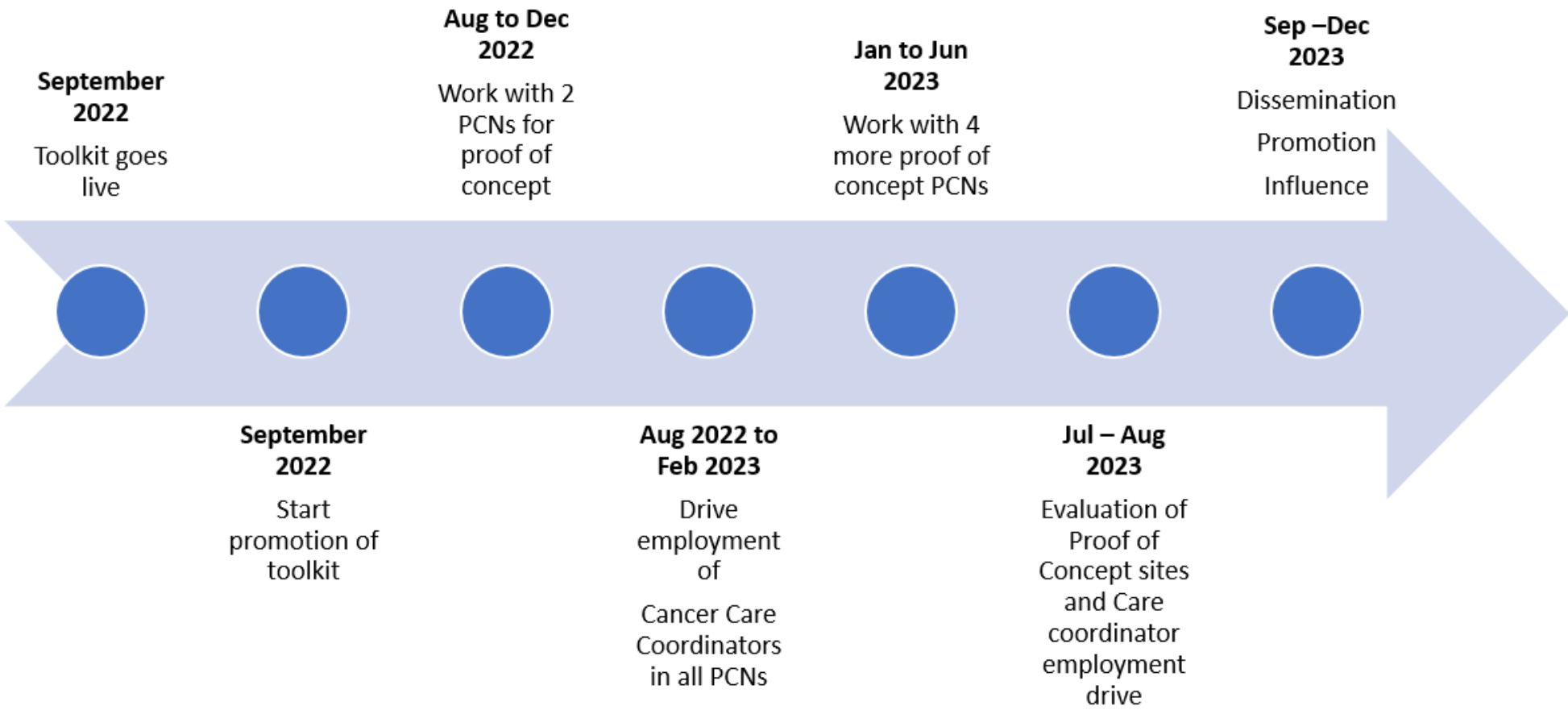
ARR Postholders

Integrated Care

Tackling Health Inequality

Health Education England

Timeline



What is the toolkit?

A resource for Additional Reimbursement Roles to support learning and development and support roles new to post.

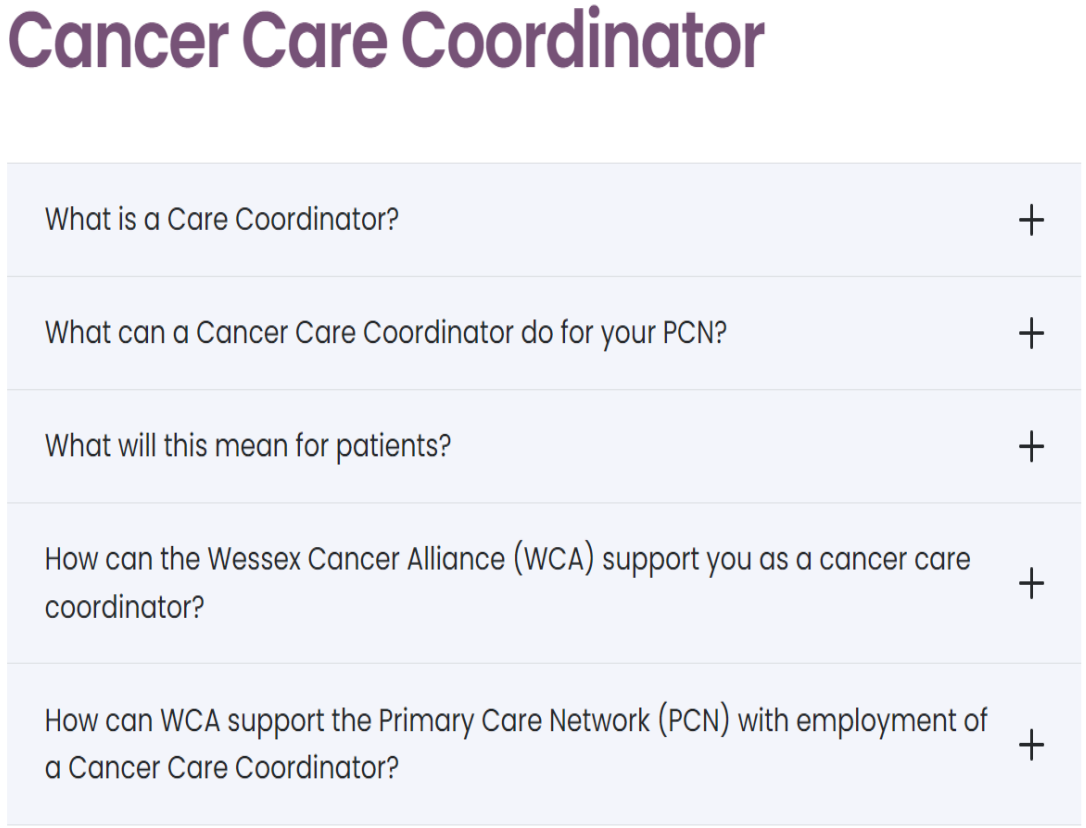
A resource for employers to understand the potential of these roles and how they can be utilised to meet the responsibilities of Primary Care and the universal personalised care model. It provides recruitment support documents.

Enables Wessex Cancer Alliance to share learning opportunities, best practice, communicate what is new and learn about workforce needs.

ARRS Toolkit Update: This is now live on the Wessex Cancer Alliance website: [Additional Roles Reimbursement Scheme - Welcome to Wessex Cancer Alliance]

This includes a 'button' for each role:

Once you click on the button it will take you to a page where there are 5 drop downs to enable quick access to information and support



Cancer Care Coordinator

Wessex Cancer Alliance are promoting the role of Cancer Care Coordinators, if you would like to discuss support and employment for this role or join our Community of Practice please contact Tamzen Hogben at: Tamzen.Hogben@nhs.net

NHS Wessex Cancer Alliance

Cancer Care Coordinators:

- Support the delivery of cancer priorities of the Network Contract DES
- Support achievement of Quality Outcome Framework (Qof) Indicators
- Provide personalised care planning throughout the cancer pathway, as stated in NHS Long Term Plan

Wessex Cancer Alliance will support you as a PCN by providing:

- Job Description
- Induction package
- Insight into the potential utilisation of this role.

Wessex Cancer Alliance will support your Cancer Care Coordinators by providing:

- Induction Package
- Education and Training
- Tools to help patients
- Community of Practice

There are many points in the cancer patient pathway a Cancer Care Coordinator can be utilised:

Prevention	Screening	Safety Netting	Personalised Care

• Identify at risk populations Obesity, Smoking.
• Signpost to health and well-being services
• Coding
• Health promotion media within PCN
	• Identify:
	  • low screening rates,
	  • non-responders,
	  • low participation groups
	• Contact patients to provide information and support to encourage uptake of screening
		• Arranging follow-up appointments,
		• provide information and leaflets to patients.
		• Follow up patient groups that may not attend appointments.
		• Monitor completion of FiT with 2WW referrals
		• Monitor 2-week wait referral and clinic appointments and escalate breaches.
		• Champion decision support tools within the practices
			• Co-ordinate care for anyone diagnosed with cancer in the practice signposting to internal and external services at any point in the pathway
			• Support Holistic Needs Assessment prior to Cancer Care Review
			• Palliative care register and GSF Meetings

PRIMARY CARE 10 TOP TIPS

For Social Prescribing

The Personalised Care Institute (PCI) is accountable for setting the standards for evidence-based training in personalised care in England and has developed the first ever personalised care curriculum.

The PCI is a collaborative organisation with more than forty partners across health and care and works together with these partners to develop, accredit and deliver high quality personalised care training, aligned to the personalised care curriculum.

Via a dedicated virtual training hub, the PCI offers health and care staff across all sectors to access the very latest in personalised care training and development.

For more information and to access the training hub, please visit www.personalisedcareinstitute.org.uk

This edition: March 2021
Next planned review: March 2022

1. Social prescribing can be an essential way to support people living with cancer (PLWC) in the community, from the time of their diagnosis right through their cancer experience.
2. Social Prescribers should be considered a vital member of the Primary and Community care teams, linking regularly with the GPs, Nurses and admin staff.
3. PLWC have described feeling like they have 'fallen off a cliff' when they're discharged from regular follow up. Having the opportunity to be seen by such a key role working in Primary Care can provide the support they need.
4. We know that **almost a quarter** of PLWC are suffering from loneliness as a result of their cancer. Social prescribers can help people identify community groups, activities or support that may alleviate this. **The Macmillan Online community** can also be a way for people to connect with others who've had the same experience.
5. Over **70%** of PLWC need emotional support, with 2 in 5 people suffering from depression and 1 in 10 troubled by anxiety. Social prescribers can contribute to identifying these needs, asking what matters to the person and signposting/ referring to appropriate support, such as identifying sources of support in the community or referring the individual back to their GP/CNS where appropriate.
6. **4 in 5** PLWC experience a negative financial impact as a result of their cancer, with the average PLWC being £570 a month worse off. Social prescribers can ensure PLWC are getting the financial support they are entitled to. It is also possible for PLWC to speak to a Macmillan welfare rights adviser by calling **0808 808 00 00**.
7. Getting back to work after a cancer diagnosis can be difficult, but we know that **87%** of PLWC who were employed at the time of diagnosis would like to return to work. Over half of PLWC don't know where to go to get help with this; a social prescriber could provide vital support. Get Macmillan's **'Work Support Route'** guide and **Top Ten Tips for Primary Care Professionals to help** with these discussions.
8. Appropriate advice and support regarding physical activity can be essential for PLWC from the time of being diagnosed, through treatment and recovery, and to prevent effects of treatment or recurrence of cancer. Social prescribers can signpost PLWC to services that are available locally. Further information can be found **here**.
9. PLWC can have multiple physical consequences of their cancer and its treatment that may need medical intervention. Having a close relationship with the Primary Care Team and understanding and developing links back into and from secondary care can ensure these problems are identified early, and that people are offered appropriate support.
10. Over 70% of PLWC will be living with at least one other co-morbidity. We are already seeing how social prescribers can help Primary Care teams provide individual personalised care to meet people's physical, social and practical needs.

In partnership with

Personalised Care Institute

MACMILLAN CANCER SUPPORT

(Macmillan, 2019)

Project

Primary Care Drivers:

Long Term Plan/10 year Cancer consultation

Network Contract DES

- Early Diagnosis
- Safety Netting
- Screening
- EHCH

Quality Outcomes Framework

- CCR
- Palliative care
- Screening
  - FiT/Cervical
  - Prostate

Prevention

- Obesity
- Smoking

NHS Outcomes Framework

- All Domains (but particularly 1-4

NCPES 2020

- GP satisfaction
- Support during and after treatments

Cancer QoL Survey 2021

- QoL symptom scores
- Severity of problems

RBY/Wessex Voices Patient Engagement 2019

- Regional Patient Need
- Support through whole journey
- Signposting

Output

OUTPUTS

- Primary Care ARRS Workforce Toolkit
- Job Descriptions and Person specifications
- Testing Innovative new roles in PCN
- Training (Links/New)
- Asset Mapping (improved – access)
- Community of Practice (support/new)
- Case Studies
- Proof of Concept

Benefit

BENEFITS

- Number of ARRS roles recruited due to Toolkit/WCA projects
- Number of ARRS upskilled and providing cancer care
- Number of referrals of cancer patients to ARR
- Increased ARR attendance at cancer training
- Increased CCR completed by ARR
- Increase in screening uptake
- Increase in screening uptake in a target population
- Increase in signposting to cancer services
- Increase in QoL scoring of cancer patients
- Increase QoL symptom score pre-post treatment
- Improve cancer patient GP services satisfaction scores
- Increase job satisfaction and opportunity

Outcome

OUTCOMES

- Improved cancer care provided within Primary Care
- Wider workforce able to support cancer patients within primary care
- Improved pathways for cancer patients
- Improved rates of self-management
- Improved knowledge skills and attributes to manage cancer patients
- Growing a cancer workforce
- Opportunities for careers and career progression
- Reduce health inequality
- Proof of concept for innovative roles

Feedback

What do you want from Primary Care?

Developing Allied Health Professional First Contact Practitioner (FCP) and Advanced Clinical Practitioner (ACP) roles in cancer care in Wessex

Proof of Concept

Aim

0.2 WTE in a PCN

- Physiotherapist
- Dietitian
- OT
- Paramedic

Barriers

- Unsettled workforce
- T & C
- Management sign off
- Current workload
- Small workforce

Advanced Clinical Practitioner in Cancer Care

The role seeks to be involved at any point in the cancer pathway to manage symptoms, reduce health and social inequalities and provide seamless care. Holistic, patient centred and patient directed. Self-referral encouraged.

NHS Wessex Cancer Alliance

Symptom Management

- Anorexia/Cachexia (including weight management/taste changes)
- Breathlessness
- Communication
- Continence (including sexual dysfunction)
- Dysphagia
- Gastro-intestinal symptoms (nausea, vomiting, constipation, diarrhoea)
- Lymphoedema
- Medication review
- Metastatic spinal cord compression
- Mobility
- Musculoskeletal Conditions (including skin and soft tissue management)
- Neurological system
- Pain (acute and chronic)
- Palliative care
- Prehabilitation/Rehabilitation
- Psychological Distress (including anxiety/depression)

Professional Collaboration with:

- GPs
- Practice Nurses
- CNS/Secondary Care Team
- Cancer Support Workers
- Social Prescribers
- AHPs including physiotherapy/ OT/ Radiographers/ SALT/ dietitians
- Frailty teams
- Palliative care teams
- Specialist rehabilitation services incl community rehabilitation teams
- Social Services
- Charity organisations

Diagnosis/ Prehabilitation

Development of relationships and optimisation of health to ensure best outcomes of treatment and personalised care

Rehabilitation

Identifying, supporting and optimising abilities

Shared care and collaboration with acute and specialist services – working across boundaries during treatment and beyond through to palliative care and end of life

Late Effects

Identifying and treating the long term consequences of cancer and its treatments.

Risk stratification, follow-up of treatment summary, Cancer care reviews

Outcomes

To identify, treat and promote self-management of common consequences of cancer and its treatments throughout the treatment pathway, in a place closer to home, in collaboration with other sectors and organisations to maximise rehabilitation potential.

This will help to increase efficiency within the NHS, reduce admissions and improve quality of personalised care through:

Introducing
Tracy Gallacher
ACP
Shore Medical PCN