



Personalised Cancer Care in Primary Care Project Report





Foreword

The provision of personalised care for patients with cancer should no longer be an aspiration but a daily reality, and is a priority in the recently published National Cancer Plan for England (<https://www.gov.uk/government/publications/national-cancer-plan-for-england>). The plan sets out, amongst many other things, a vision for long term support after a cancer diagnosis with an emphasis on providing more care close to the patients' home.

Cancer Alliances, commissioners and providers are now working hard in partnership with patients and their families to ensure local personalised care is a reality for our whole population.

This report describes the approach Wessex Cancer Alliance has taken to understanding the role of the Cancer Care Review and the considerations required to successfully develop personalised cancer care in the community, with a focus on Primary Care .

I hope that readers will find its contents thought provoking, practical and challenging in equal measure.

We certainly look forward to delivering our ambitions in this regard.

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Executive Summary

1. Introduction & Strategic Context

The project examines the Cancer Care Review (CCR) as one key tool that practices, Primary Care Networks (PCNs) and Integrated Neighbourhood Teams (INTs) can use to facilitate structured, personalised conversations. However, the goal is a broader ethos change: promoting personalised cancer care in primary care from diagnosis, during treatment and in the context of longer-term care through integration with routine primary care. This approach, which normalises ongoing support in primary care from diagnosis and could see cancer care integrated into appointments for other chronic diseases, is particularly critical following the removal of CCRs from the Quality and Outcomes Framework (QOF) on 31st March 2024. The project commenced before the publication of the NHS 10-Year Health Plan for England (DHSC 2025) and the Cancer Plan for England (DHSC 2026) but concluded after their publications.

2. Key Findings

The project triangulated evidence from the 2024 National Cancer Patient Experience Survey (NHS England 2025) a local primary care survey, a patient experience focus group, and a review of work in other Cancer Alliances. Some key findings include:

- **Low Patient Awareness of Having a Cancer Care Review:** Patients are often unaware they have received a formal "CCR," even when they deeply value the contact and reassurance from their GP practice. This suggests the *relationship* and ongoing support are more important than the label of a single intervention.
- **Variable Use of the CCR:** The CCR is used inconsistently. While 67% of surveyed practices offer it, delivery varies significantly in quality, length (often 10-15 mins), and staffing (85% by GPs). This highlights that while the CCR has been delivered widely, its application is not standardised.
- **A Disconnect in Care Models:** The findings point to a system where cancer is often treated as an acute, episodic event rather than an ongoing condition. Indeed, the QOF funding model didn't incentivise this kind of integration into routine care. There is a missed opportunity to integrate cancer follow-up into existing management pathways such as long-term condition reviews.
- **Practitioner and System Needs:** Clinicians desire more time, training, and better integration with secondary care systems (e.g. access to treatment summaries) to provide effective, ongoing cancer care.
- **Funding Threat to Key Processes:** The QOF change was frequently cited in the survey as a major threat. Respondents noted that without specific funding, the capacity to use dedicated tools like the CCR were at risk, jeopardising a key opportunity for structured personalised care planning.

These findings reinforce the Cancer Plan’s emphasis on establishing consistent standards for personalised cancer support across primary and community settings.

SWOT Analysis of Personalised Cancer Care in Primary Care with a focus on the CCR as an enabling tool

SWOT Category	Points
Strengths	<ul style="list-style-type: none"> • Patients highly value the relational continuity and supportive relationship with their primary care team. • Some practices have developed robust processes and are using the CCRs effectively with dedicated staff. • Good practice with CCR could be developed to support interventions to integrate cancer care
Weaknesses	<ul style="list-style-type: none"> • There is significant variation in how personalised care is delivered; for example, over-reliance on ad-hoc or brief CCRs. • In general, the system does not yet fully treat cancer as a condition that requires long-term care and support in the way that long term conditions are managed • Some practices ceasing structured activity like CCRs post-QOF change. • Loss of the QOF Cancer Register may have a negative effect on coding which will impact on future care such as identifying consequences of cancer treatment
Opportunities	<ul style="list-style-type: none"> • To develop a model of personalised cancer care that meets the longer-term care needs of people living with and beyond cancer treatment that aligns with the NHS 10-Year Health Plan for England (the left shift) and NHS Cancer Plan. • Relational, Informational and management continuity of care could all be improved through the development of integrated teams aligned to the emerging Integrated Neighbourhood Teams (INTs). • Establish general practice nursing roles at practice or Primary Care Network (PCN) or INT level to oversee cancer care at an enhanced level of practice. The CCR could be utilised as a tool to perform an initial holistic needs assessment that supports ongoing and integrated care. This supports both the 10-year HealthPlan for England’s ambition of more community-based care and meets the need for an ambition for named neighbourhood care leads for cancer cited in the Cancer Plan. • Utilise the wider practice team (for example Care Co-ordinators) to support this work. • Integration of cancer care across secondary care to primary care and community settings. Treatment Summaries to be

	<p>optimised to facilitate personalised care through self-management and supporting shared decision making.</p> <ul style="list-style-type: none"> • Develop infrastructure that supports specialist nursing roles to work in primary care/ community settings so that specialist nursing needs are addressed – for example treatment toxicities (supporting the left shift of the 10-Year Health Plan for England and ambition to provide long term care where needed in the Cancer Plan.) • To involve patients in the design of any patient facing resources.
Threats	<ul style="list-style-type: none"> • The QOF change could reduce the emphasis on proactive cancer care in the community unless alternative models of care are developed and supported at a system level. • If cancer is not prioritised, patients may not receive planned primary care interventions related to cancer, which could result in their needs remaining unmet. • Resource constraints (time, funding) inhibit both dedicated reviews and broader integration efforts.

High-Level Recommendations for the Cancer Alliance to consider that align to the 2026 Cancer Plan and the 10-Year Health Plan for England.

1. To develop a model of personalised cancer care that enables primary care and community support from diagnosis through to the needs of people living with and beyond cancer treatment that aligns with both the NHS 10-Year Health Plan for England and the Cancer Plan.
2. Champion personalised cancer care from diagnosis to living with and beyond cancer. This requires a fundamental shift in how cancer is positioned in primary care, encouraging practices, PCNs and INTs to consider how to integrate cancer into routine care. This includes addressing cancer needs during appointments for other conditions or interventions and ensuring ongoing, holistic oversight.
3. Utilise the strategic drive to develop integrated neighbourhood teams to create system-wide capacity for personalised cancer care in primary and community settings by collaborating across systems, neighbourhoods, PCNs, and practices to establish needed infrastructure. **This would involve making the case for cancer to be seen as a priority condition.** Key actions include workforce planning, securing protected time and focused training, and improving information flow—such as timely delivery of End of Treatment Summaries—from secondary to primary care to support ongoing management. Relational, informational and management continuity of care could all be improved through the development of integrated teams.

4. Support the development of General Practice Nurses (GPN) roles at PCN level to oversee personalised cancer care working at an enhanced level of practice. Such roles will be similar in nature to current GPN roles in the system that focus on LTCs such as diabetes, or asthma.
5. Develop capacity and infrastructure to enable community-based specialist nursing roles that will support patients with complex cancer care needs such as late effects and treatment toxicities. The integration of such roles to support boundary spanning working and access to the MDT at secondary care and INT level would be essential for effectiveness.
6. At a system level provide support for emerging GPN Cancer roles – for example through [mentorship](#), a funded education offer, and exploring other opportunities to create conditions for those new roles to develop and thrive. Facilitate opportunity for peer-to-peer learning and mentorship by establishing structures such as communities of practice that cross organisational boundaries.
7. Position the CCR as a tool to support proactive personalised cancer care by supporting practices use it effectively for a comprehensive, holistic assessment at the end of treatment or at the most appropriate time for the patient. This involves:
 - Developing a standardised yet flexible protocol for conducting CCRs
 - Creating patient-facing resources that clearly explain the CCR’s purpose as the starting point for ongoing, meaningful conversations about care and support needs as part of routine primary care practice.
8. Demonstrate impact and secure sustainable support: Establish methods to collect patient experience data related to this broader personalised care approach. Use this evidence to build a case for sustainable funding and resources that support personalised cancer care in primary care and properly reflects the leftward shift of care from hospital to primary care and community.

Background

The increasing number of individuals living with and beyond cancer can be attributed to both improved survival rates and a greater number of diagnoses arising from an ageing population. Consequently, new models of care have developed to ensure that diagnostic and treatment capacities align with growing demand. Initiatives such as outpatient transformation programmes and personalised stratified follow-up have led to the transfer of care for many patients, away from specialist settings once their primary cancer treatment concludes, with most individuals diagnosed with cancer, only remaining under the direct care of their specialist team for a limited time.

Care and support after cancer diagnosis and treatment require a personalised, comprehensive approach that accounts for tumour type, cancer stage, treatment received, and the individual's health needs and preferences. This includes prehabilitation and rehabilitation, psychosocial care and support, management of treatment side effects and toxicities and the management of late effects of cancer treatment.

Careful attention to developing the necessary care and support outside of the specialist cancer setting is therefore required. Developing robust care and support in primary care settings throughout the cancer journey and beyond has become increasingly necessary.

The strategic direction set forth by 'Fit for the Future' represents a policy transition aimed at shifting care delivery from hospitals to community-based settings (Department of Health and Social Care 2025). The Royal College of Physicians emphasises that healthcare services should be designed around individuals rather than physical infrastructure (RCP 2025). There is a significant risk of unsuccessful implementation if existing hospital services are simply relocated to community environments without adaptation. Additionally, moving care to primary care and community settings requires the resource to manage that care to be shifted too. A person-centred approach is Taessential for both the conceptualisation and planning of future care delivery.

The 2026 Cancer Plan for England sets out a clear ambition for community-based care and support for people after a cancer diagnosis. Broadly this consists of personalised cancer care plans, named neighbourhood leads, living well standards and enhanced community and charity integration.

Personalised Cancer Care

Personalised cancer care in the United Kingdom has evolved through initiatives such as the National Cancer Survivorship Initiative (NCSI) and Macmillan's Recovery Package, receiving additional policy endorsement via the 2019 NHSE Long Term Plan.

Lord Darzi's 2024 recommendations highlighted the importance of enhancing personalisation within NHS cancer services by involving patients actively in shared decision-making concerning their health and measuring outcomes that matter most to them—such as appointment access, choice in care pathways, support during waiting periods, and quality of communication.

These principles are integrated into 'Fit for the Future,' and more comprehensively in the recently published Cancer Plan.

Integration of cancer care

Integral to this left shift of care to the community, is the ability of health care systems to integrate care. Whilst cancer treatment remains highly specialised, the primary care system is central to the provision of their health care. With an increasingly multi-morbid population the case for cancer care to be integrated is a strong one.

Systems need to identify the aspects of care that require highly specialised workforce and services, and aspects which could be provided by a skilled generalist workforce. How these components work together will determine the level of integration that can be achieved.

As part of this planning, the resources required to achieve this shift of care must be considered to create environments that can provide the required care. Patient stratified follow up pathways are already driving the shift but consideration needs to be given how to ensure there are resources available to support patients in primary care and community.

In order to successfully transition cancer care from specialist hospital environments to community and primary care settings, it is essential to carefully assess and plan for the resources that will be required. The creation of supportive environments depends on ensuring that the necessary infrastructure, workforce, and support systems are in place to deliver high-quality care. While patient-stratified follow-up pathways are already facilitating this shift, it is crucial to address how resources can be allocated and sustained to meet the ongoing needs of patients within primary care and community settings. This means proactively considering the availability of skilled professionals, access to appropriate facilities, and ensuring that patients receive comprehensive support throughout their cancer journey outside of the traditional specialist setting.

The recently published Cancer Plan sets out a clear ambition to support personalised care planning and improved coordination of care through neighbourhood care leads.

Systems will need to consider how these priorities will be met and allocate resources to enable them.

Cancer Care Reviews

Cancer Care Reviews (CCRs) were developed as a Quality Outcome Framework indicator for primary care as an acknowledgement of the need for primary care involvement in cancer care. They were further developed by Macmillan and the NHS in England as a means to support primary care teams in delivery of tailored personalised interventions that complement the support given by secondary care providers.

From 1 April 2003 to 31 March 2024, CCRs were funded through the Quality Outcome Framework as a primary care initiative designed to support individuals following a cancer diagnosis. This approach recognises the heightened risk of diminished quality of life – across both physical and mental health domains – that can persist for decades after diagnosis. QOF specified that the CCRs should be conducted before 12 months after diagnosis with the assumption that for many, this will be after the conclusion of active treatment, and when patients are either being discharged or having reduced contact with specialist cancer teams. The intention being, to provide patients with an opportunity to reflect on their cancer experience and discuss any outstanding needs.

As this report shows, the delivery of the CCR is variable in terms of levels of personalisation and their perceived benefit to patients. The question of whether patients receive CCRs in the future should be considered in the context of the broader question of how best to deliver personalised care to this diverse group of patients in the primary care setting. Standardising the CCR as part of wider personalised care planning supports the Cancer Plan's ambition for improved coordination through neighbourhood-level leadership.

Aim of the project

To evaluate how CCRs are currently utilised within the Wessex Cancer Alliance's (WCA) personalised care approach, and to explore opportunities for developing personalised cancer care in primary care and community settings.

Objectives

To map the current landscape: To describe the existing policies, guidelines, and service models for the delivery of CCR both across the Wessex Cancer Alliance and nationally.

To consider care integration: To examine communication and coordination between primary, secondary, and other support services during the CCR process.

To evaluate how the CCR might support the core principles of personalised care, such as:

- a holistic and personalised approach to assessing needs.
- The co-creation of Personalised Care and Support Plans.
- The practice of shared decision-making.
- Support for self-management.

To understand patient experience:

To explore the perspectives of people who have received a Cancer Care Review or have been eligible for one, focusing on their perceived value in addressing their physical, psychological, social, and practical needs.

To identify barriers and facilitators to CCR delivery:

Identifying the key challenges, enablers, and areas of best practice in the current provision of CCR, will assist with supporting a personalised care offer in the future.

To provide actionable recommendations:

To formulate evidence-based recommendations for the Wessex Cancer Alliance to develop personalised care in the primary care setting.

Evidence

As part of this project the existing evidence to support CCRs was reviewed.

NCPES

Since 2022, patients have been surveyed regarding whether they have received a review of their cancer care by a General Practitioner (GP) or nurse. In the Wessex region, 22% of patients reported having had a CCR in 2024, compared to the national result of 24% (NHS England 2025.) Both locally and nationally, this figure has increased by 1-2% since the question was first introduced in 2022. It is important to note that this data may be influenced by the respondents' awareness of the intervention, as well as the timing of the survey, since some respondents may not have yet received the intervention. There are proposed changes to the question for following years in order to establish if these factors are impacting on the result.

Additionally, 48% (up from 45% in 2023) reported receiving adequate support from their GP practice during treatment (national result: 46.4%). Despite this improvement, the rate

remains low. Contributing factors may include system pressures affecting appointment availability and lack of digital interoperability impacting communication between secondary and primary care.

Recent Publications and Resources

The NCPES data cited above indicates a poor patient experience with the intervention. However, it is challenging to demonstrate the impact of single consultations within complex cancer journeys, and patients may not fully comprehend the term "review of cancer care." A 2023 scoping review (Gopal, Ahmad et al. 2023) identified limited evidence for CCRs, with some negative patient experiences from research conducted in the 2010s. This review highlighted themes such as continuity of care from GPs as a facilitator of positive CCR experiences, due to familiarity with diagnosis and treatment received. In the absence of these features, patients found the reviews less beneficial (Adams et al., 2011).

However, it must be noted that this refers to a period when the intervention's nature was not defined within the Quality Outcomes Framework (QOF), national holistic templates were unavailable, and the intervention required only one contact within six months of diagnosis. Therefore, it is difficult to use this data to define the current experience of CCRs. The QOF evidence review in 2020 mandated the use of a holistic template which led to the division of the intervention into 2 parts and amended the timing of the intervention which is depicted in Table 1.

Table 1. QOF requirement from 2020.

QOF Code (2020)	Timing Requirement	Focus Area
CAN005	Within 3 months of diagnosis	Support & Information: An offer of support or conversation to ensure the patient knows how to access primary care support and is aware of national/local resources (e.g., Macmillan). Ensure cancer diagnosis is coded.
CAN004	Within 12 months of diagnosis	Structured Review: A holistic conversation using a "structured template" (For example Macmillan or Ardens) to discuss treatment, side effects and create a care plan.

A 2017 Macmillan-funded Scottish project demonstrated high patient satisfaction when 13 General Practice Nurses, who had completed Macmillan’s practice nurse course (Trim 2017), conducted 246 comprehensive CCRs with allocated time for care delivery. A more recent BJGP paper (Dyer, Bhuiya et al. 2024) offered practical guidance on implementing CCRs based on the authors' clinical experience and patient feedback. It concluded that several key factors are essential for delivering a high-quality CCR:

- Patient preparation
- Scheduling dedicated appointments
- Referring to treatment summaries and clinical correspondence
- Utilising templates for proactive patient identification

Developing a care plan

Creation of care plan was not mandated as an output from the CCR as defined by QOF.

A recent qualitative study reveals that CCR can be valuable in primary care for providing ongoing support and revisiting cancer diagnoses. Positioning cancer as a condition that for many, needs longer term care and support, means an ongoing review could be normalised. Currently, the CCR has been completed only in the first year. The study highlights the importance of education in enabling practitioners to create care plans with patients collaboratively.

A London based proposal in 2016 (TCST 2016) produced a 4-point model for holistic CCR which provides a structured approach to CCR delivery but additionally aimed to integrate cancer into LTC reviews for future follow up. This model was adopted in part in some CCGs with local incentive schemes to support delivery. System wide roll out has not been achieved. The notion of integration into long term condition care is of interest.

Work in Other Cancer Alliances and by Macmillan Cancer Support

Improvement initiatives for CCRs across the country were scoped and documented in a scoping report. It demonstrated variation in delivery in general practice across the country. Initiatives aimed to standardise practice and provide guidance on how best to deliver the intervention.

Four discrete projects were identified that were focused on quality improvement at a system level. These are described in Table 2.

Table 2

Region	Key Activities/Findings	Challenges/Barriers	Measures/Outcomes	Recommendations/Actions
Greater Manchester	Standards document and flowchart; Use of shared care records for HNA and Treatment Summary; Proactive support offer; CCRs prebooked and standalone; Minimum 20-minute appointment; Preparation opportunity (concerns checklist); Clinician reviews Treatment Summary and clinic letters; Greater Manchester template developed; CCR as part of future care and annual reviews being considered	Limited patient engagement due to poor response rates and unrepresentative data	Clinician confidence; Patient engagement	Review at annual chronic disease reviews
West Sussex	Online patient survey (n=74); 82% unaware of CCR; Unclear communication; Lack of collaboration; Patients were not listened to; Only 4 aware of CCR invitation; Focus on physical symptoms; Rare preparation (5% received text/questionnaire); Patient-facing poster and leaflet created; Video link for support in primary care	Unclear communication; Lack of collaboration; Low awareness; Rare preparation	This project has been closed due to ICB head count reduced.	Promote CCRs via poster, leaflet, and video
Lincolnshire (2024)	Co-production and engagement; Variation in CCR quality and consistency; GPs report lack of guidance and training; Time pressures; CCRs mainly opportunistic	Lack of QOF guidance; Insufficient training; Time pressures	Variation in quality and consistency	Separate appointment for CCR; Invite friend/family; Send info in advance; Use checklist; Improve communication with secondary care
Harrogate and West Yorkshire CCR project	Care Coordinators and Social Prescribers upskilled to deliver non-clinical component of the CCR in a 40-minute appointment	Short term funding.	Numbers of CCR increased. Length of appointment with patient 40 minutes with CCC or Social Prescriber.	CCR resource for HCPs online. Education/ training for CCC/SPs.

Attachments

- [1. GM Personalised Care Standards for Primary Care](#)
- [2. GM Cancer Care Review Protocol](#)
- [3. Sussex Patient Leaflet](#)
- [4. Sussex Patient poster](#)
- [5. Sussex Patient Survey](#)
- [6. West Yorkshire and Harrogate CCR resource pack](#)

Survey

As part of this project, a survey was created to help gain an understanding of the current use of CCRs in primary care. A description of the methods used to create and conduct the survey is shown below in table 2. A copy of the survey is included in Appendix A.

Methods

The methods adopted to develop and disseminate the survey to practices are outlined in Table 3 below.

Table 3

Activity	Details
Survey Development	Based on a template used by the WCA Right by You Team
Pilot Survey	Conducted to sense check and test readability
Target Audience	Each practice, one reply per practice or PCN if CCR work was conducted at PCN level
Survey Period	Opened 14th February 2025, closed 31st March 2025
Response Rate	Approx. 30% with 68 responses and 4 duplicates

Results

Key Findings

Offer of support within 3 months of diagnosis (Q6) 78.9% offered this to all patients.

Reasons for not offering included coverage variability, delivery challenges, time constraints, resource availability, and training issues. Support is provided through various formats by different healthcare professionals, but majority were carried out by GPs.

Support formats Telephone consultations (43%)

- Letter 41%
- Telephone Support call 31%
- Face-to-face 31%

Most often offered by:

- GPs (55%)
- Cancer Care Coordinators (36%)
- GPNs (17%)

Practices could deliver this part of the intervention via a call from clinical or non-clinical staff, or by sending a letter with available support options for patients to access. Often more than one method offered. Some practices chose more than one type of staff when asked who completes the CCR most commonly.

A wide range of training supports this intervention.

Q8 What training or education has been undertaken by the person/people that provides the offer of support within 3 months of a cancer diagnosis.

template Wessex Cancer Alliance lead GSF meetings MacMillan use meetings online PCN Accend GP resource:
training cancer patients reviews support learning course Cancer Care
cancer care coordinator Care co-ordinator local practice nurse discussions

Responses to this question demonstrate a range of training and education utilised by the professionals who are carrying out offers of support within 3 months of a cancer diagnosis. These include those offered by Macmillan and WCA, as well as resources such as templates within clinical systems and support from other professionals.

CCR Within 12 Months of Diagnosis

- **66.67%** of respondents indicated that all patients diagnosed with cancer are offered a Cancer Care Review within 12 months.
- **20%** reported offering CCR to some but not all patients.
- **10%** are planning to offer this service in the future.
- A small percentage (**3.33%**) do not currently offer CCR.

Nominated Person for CCR (Q11)

- **66.67%** of practices have a nominated person responsible for the majority of CCRs.
- **33.33%** do not have a nominated person.

Who Completes CCRs (Q12)

- **85.42%** of CCRs are completed by General Practitioners (GPs).
- Other contributors include Practice Nurses (**12.5%**), Cancer Care Coordinators (**12.5%**), allied health professionals (**12.5%**), and Social Prescribers (**6.25%**).

Key Findings

Duration of CCR Appointments (Q15)

Most CCR appointments last between 10 to 15 minutes. Some practices tag CCR onto other consultations without additional time allocation.

Resources Used to Support CCR Completion (Q17)

Common resources include:

- Ardens/Macmillan CCR templates
- Template invitation letters
- ACCuRx Macmillan Florey mini holistic needs assessment

Confidence in CCR Process (Q18)

Practices generally rate their confidence in CCR processes between 5 and 10, with many indicating a confidence level of 8 or 9 (where 1 was not at all confident and 10 was very confident.)

Training Undertaken

Training varies widely, including internal training, Macmillan webinars, online courses, and informal learning.

Improvements suggested by participants

- Increased opportunities to share ideas and good practice
- Dedicated time for CCRs

- More systematic ways to capture CCR data
- Feedback from patients about their CCR experience

Thematic analysis of free text comments

Timing

“Sometimes 3 monthly cancer care reviews feel too soon as the patient is overwhelmed by the diagnosis, multiple hospital appointments and side effects.”

Use of tools supports personalisation

Generally, respondents agreed that use of available tools (CCR template, AccuRx, and template letters) supported a personalised approach.

“AccuRx enables (GPs) to utilise their time more effectively and discuss matters important to the patient”

Personalised approach to delivery

Appointment times were generally 10-15 minutes. Given that the majority of CCRs were being carried out by GPs it is unsurprising that there was limited time allocated to this activity. Some respondents suggested that this should be more flexible.

“Patients should be offered longer if required “

Importance of relationships

The value of primary care continuity of care is suggested in the comments. When primary care hadn't been involved in the diagnostic pathway this was a barrier to effective CCR.

“CCR more difficult to do when cancer detected through screening or private referral.”

Funding

The GP contract change came during the survey period. Several questions have raised comments regarding CCR activity, with some respondents suggesting that CCR activity may cease due to the lack of funding. Several respondents referred to the QOF change with the suggestion that CCR activity was at risk or would stop entirely.

“Challenges of QOF change- harder to prioritise cancer “

Integration

The suggestion to link more with cancer specialist nurses at the hospital highlights a critical aspect of integrated cancer care. By fostering closer collaboration between primary care providers and hospital-based cancer specialist nurses, patients can benefit from a more comprehensive and coordinated approach to their care. This partnership

could improve communication, streamline care pathways, and ultimately contribute to better patient outcomes and experiences.

“It would be really helpful to link in more with the cancer specialist nurses at the hospital to know more about what they can offer.”

Patient Experience of Personalised Cancer care and Cancer Care Reviews

A meeting of the Wessex Personalised Care Patient Advisory Group was held on the 18th March 2025. Six patients and caregivers (Dorset and Hampshire) attended. The topic of discussion was the cancer care review. There was also discussion around 2025/26 GP contract funding changes which had just been announced.

Background

Six patients and caregivers from Dorset and Hampshire participated in an online discussion about improving CCRs amid upcoming funding changes in the 2025/26 GP contract. The group discussed the purpose and timing of CCRs and considered three key themes: the impact of CCRs on wellbeing, project success criteria, and patient involvement.

Focus group findings

Several participants reported contact with their GPs following cancer treatment; however, none recalled being explicitly informed that they were receiving a CCR, nor did they receive follow-up afterward.

One participant stated, *“The GP phone call was reassuring and felt like a vital connection to medical professionals. It gave me confidence that I was not alone and that I remained under observation when I needed it most.”*

The group concurred that CCRs represent a valuable initiative for enhancing healthcare delivery, particularly for individuals managing ongoing health conditions, experiencing late effects from treatment, or who may find self-advocacy challenging, even in the absence of active cancer. The group recommended the following actions:

- Gather data on the impact of CCRs for patients and communicate the advantages to GP practices to foster engagement with reviews.
- Notify patients in advance regarding their scheduled CCR, similar to procedures used for diabetes or asthma reviews.

- Provide patients and secondary care providers with copies of review consultations and care plans, clearly outlining responsibilities and if possible, referencing end of treatment summaries.
- Integrate records across healthcare settings to minimise repetitive information sharing and enhance coordination of interventions such as routine blood tests.
- Ensure consistent practice is maintained throughout Wessex.

Success would be that patients consistently feel:

- Better supported
- They were being treated holistically
- That their care was well coordinated by everyone involved
- Confident to know who to go to with questions post treatment
- Confident in their clinical teams
- Satisfied with their CCR

Other issues raised

- The need for ongoing GP and other healthcare professional education to support early diagnosis
- Frustrations around access to primary care appointments more generally

Changes to activity since the removal of Cancer Quality Outcome Framework.

Changes to QOF were made in the 2025/26 primary care contract which meant a loss of funding for creating and maintaining a cancer register, a 3 month offer of support after a cancer diagnosis, and a cancer care review within 12 months of diagnosis. At the time of publishing this report in March 2026 early local data and national sources suggest that activity to support these activities is decreasing.

Data from Dorset shown in Tables 4 and 5 below, shows a reduction in both the offer of support and review at 12 months based on the most recent data available.

Table 4: Offer of Support at 3 months (CAN005) data from Nov 2024-Nov 2025

Month	Performance Percentage
Nov-24	80.40%
Dec-24	82.70%
Jan-25	85.60%
Apr-25	82.70%
May-25	79.0%

Jun-25	74.30%
Jul-25	72.30%
Aug-25	68.20%
Sep-25	64.60%
Oct-25	60.40%
Nov-25	56.90%

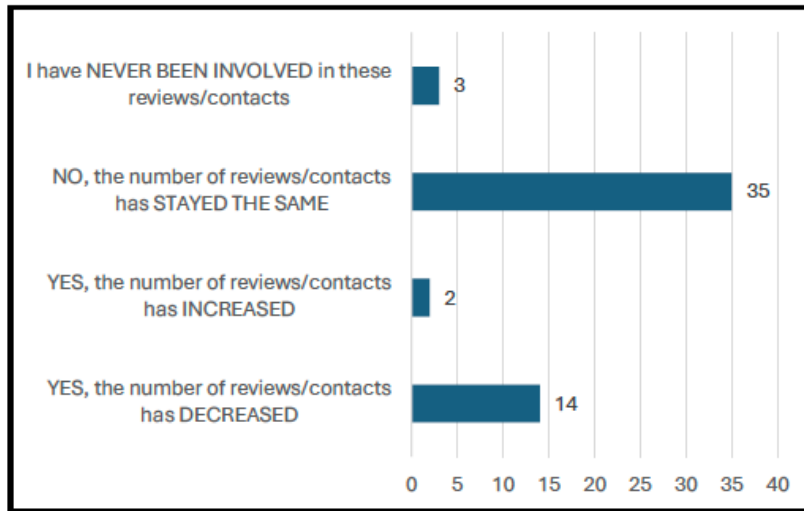
Table 5: Cancer Care Review within 12 months of diagnosis (CAN004) data from Nov 2024-Nov 2025

Month	Performance Percentage
Nov-24	80.0%
Dec-24	81.9%
Jan-25	86.9%
Apr-25	81.7%
May-25	75.4%
Jun-25	68.9%
Jul-25	66.0%
Aug-25	62.3%
Sep-25	58.7%
Oct-25	54.2%
Nov-25	51.2%

Cancer Care Coordinator National Survey

Additional data comes from a survey of 55 Cancer Care Coordinators who attended a national Community of Practice in October 2025. This demonstrated that the removal of cancer QOF is having some impact on CCR contacts with patients after a diagnosis.

Has the removal of the QOF cancer indicator specifically impacted the number of cancer care reviews or contact with patients after a diagnosis?



25% stated a decrease but with the majority (64%) stating there had been no change. However, free text comments suggest that where GPs were leading on the CCR in the past, this activity may have stopped.

Further intelligence gathering is needed to fully understand the impact of the contract changes on primary care activity.

Discussion

There are common themes observed in the patient experience focus group, National Cancer Patient Experience Survey data and CCR survey data. These can be summarised into the following themes:

- **Variable Use of the CCR Tool:** The CCR is used inconsistently. While 67% of surveyed practices offer it, delivery varies significantly in quality, length (often 10-15 mins), and staffing (85% by GPs). This highlights that while the tool exists, its application is not standardised.
- **Low Patient Awareness of Specific Interventions:** Patients are often unaware they have received a formal "CCR," even when they deeply value the contact and reassurance from their practice. This suggests the *relationship* and ongoing support are more important than the label of a single intervention.
- **A Disconnect in Care Models:** The findings point to a system where cancer is often treated as an acute, episodic event rather than an ongoing condition. There is a missed opportunity to integrate cancer follow-up into existing LTC management pathways.
- **Practitioner and System Needs:** Clinicians desire more time, training, and better integration with secondary care (e.g. access to Treatment Summaries) to provide effective, ongoing cancer care. These findings highlight persistent system barriers

that the Cancer Plan seeks to address through improved data sharing and consistent use of Treatment Summaries.

- **Funding Threat to a Key Tool:** The QOF change was frequently cited as a major threat. Respondents noted that without specific funding, the capacity to use dedicated tools like the CCR is at risk, jeopardising a key opportunity for structured personalised care planning. This is supported by early data on activity changes.

Alternative Models of Care

The 10-year Fit for the Future ‘left shift’ is a driver to move care from the hospital to community settings. This needs to be a process of reimagining those services to meet the needs of the users, rather than simply dropping old services into new community locations. The newly published Cancer Plan sets out short and longer-term targets for systems to meet in order to fulfil the ambitions of personalised care plans, neighbourhood leads, living well standards and enhanced community and charity integration.

Given the complexity of cancer, with multiple treatment modalities dependent on tumour site, type, grade and stage and the individual’s existing health and preferences, examples are used to illustrate the principles around integrating personalised cancer care into primary care as routine care.

Cancer Care Review as a personalised care tool

Examples of good practice identified in this report demonstrate that the CCR can be a useful tool to support people with cancer at the point of diagnosis and at the end of treatment. The removal of QOF points mean that this intervention can be timed to meet the needs of the individual –i.e. a CCR delivered at the end of treatment, or at another time of need identified by the patient.

To maximise the benefits of the intervention the practitioner needs access to previous HNA and care plans, and treatment summaries.

A suite of resources available to support CCRs as a personalised care intervention could include downloadable patient leaflet and videos, letters, and model protocol to be adopted by practices or PCNs

System level support to communicate to patients where the CCR fits into personalised cancer care should be considered in the **context of a wider message about primary care as the provider of ongoing care for most patients**. This would be a significant shift in messaging to patients in relation to cancer. It is consistent with the delivery model for other conditions requiring longer term care and follow up and aligns with ambitions of the 10-year health plan shift of care to community settings.

Incorporating Cancer Care Review into multi-morbidity reviews for ongoing care

Most people with cancer have another long-term condition when diagnosed. Single disease reviews are not time efficient for patients or healthcare systems. In multi-morbidity a coordinated and person-centred approach leads to better outcomes (NICE 2023.) Although funding in primary care currently is still organised around a single disease model there remains an option of combining single reviews into a multi-morbidity appointment in the context of ongoing care.

Tower Hamlets, a borough in NE London with significant socio-economic deprivation has successfully delivered an integrated long term conditions yearly review for several years as a Local Enhanced Service. A locally designed template included cancer as a heading, so that cancer could be discussed at their annual LTC review.

Utilising the evidence and resources of recent multi-morbidity primary care research (Centre for Academic Primary Care 2025) could galvanise the system to adopt a multi-morbidity model, cancer could be considered within this. Creating resources such as a template that includes cancer would support this approach.

Production with patients of a care plan for future care ensures both personalisation and an opportunity for proactive care.

This approach is sustainable and could be expected to bring efficiency savings in terms of numbers of appointments and reduced duplication of effort, compared to the current system of individual reviews for each long-term condition. There is evidence that a multimorbidity approach in long term condition care is more patient centred and improves their experience of care (Salisbury, Man et al. 2018). Embedding cancer within multimorbidity reviews mirrors the Cancer Plan's focus on recognising cancer as a long-term condition for many, requiring ongoing personalised support.

Developing new roles within primary care teams to support personalised cancer care capacity and delivery

Workforce to provide capacity and capability to deliver personalised cancer care in primary care could be grown through system support for such roles. This needs to be considered in the context of integration with a vision as to what the future cancer workforce could look like. These roles directly support the Cancer Plan requirement for neighbourhood cancer care leads and expanded community-based specialist capacity. The requirements of the Cancer Plan for systems should also be considered in this context and are referenced in the examples below.

Examples Roles

- General Practice Nurses with a specialist interest in cancer located at individual practice or PCN/INT level working at enhanced or advanced level. There are existing examples of such roles in Wessex and additional examples in long term

conditions such as diabetes. This role would provide opportunity to integrate cancer care into LTC care where possible and be an enabler to delivery of personalised cancer care including delivery of CCR. The role would work closely with GPs, and with other members of the MDT to enable safe and timely care is provided. This role would aim to create an additional resource rather than substitute for the medical workforce. The WCA provides examples of similar roles, as well as an evaluation of a current advanced-level nurse position. Such a role could potentially fulfil the role of the neighbourhood cancer care lead which is cited in the Cancer Plan as a future requirement for systems.

- Specialist cancer nurse roles focussed on specialist cancer healthcare needs – for example treatment toxicity or side effects that require specialist input. This could be an outreach role from secondary care, or a specialist nurse employed at PCN or INT level covering a larger population. These roles would continue to work closely with specialist cancer medical and AHP teams to ensure that care provided is safe and timely.
- Utilisation of current ARRS funded personalised care roles – for example Cancer Care Coordinators and Social Prescriber Link Workers. These roles need to be considered as part of the team approach to cancer care and are important in addressing social determinants of health in the context of health equity.

This workforce would form part of a wider cancer and generalist workforce who will support people with their prehabilitation, rehabilitation, and psychosocial needs. System integration processes would need to consider these wider roles to maximise potential for integration at all levels.

Conclusion and recommendations

This project's findings demonstrate a misalignment between the current model of cancer care in primary care and the needs of a growing population living with and beyond cancer. This conclusion matches that of the cancer plan which sets out a vision for long term support after a cancer diagnosis with an emphasis on providing more care in the community.

The evidence, drawn from patient experiences, practitioner surveys, and national data, consistently reveals that while the intent behind personalised interventions like the CCR is sound, its application is variable, and its purpose poorly communicated. **People with cancer do value the supportive relationship with their primary care team.** Their experience of disjointed care and unawareness of the formal CCR intervention, suggests the focus should be on continuous, integrated support rather than a single, labelled event.

The removal of the CCR from the QOF on March 31, 2024, presents a significant threat. Without dedicated funding, there is a risk that structured, proactive cancer care will be deprioritised, leaving patient needs unmet. However, this change coincides with new

policy that is moving care out of hospitals to the community and focuses on integration at a neighbourhood level and the launch of the Cancer Plan. These two strategies provide the impetus to move beyond what many perceived as a tick-box exercise of the CCR and fundamentally embed personalised cancer care into primary care with an assumption that many people will have longer term care needs.

The path forward requires the multi-faceted approach outlined in the recommendations. It is imperative to champion a cultural shift towards viewing personalised cancer care as an integral part of care delivered in primary care. The CCR should be repositioned not as a standalone task, but as one tool that supports a holistic needs assessment and initiates an ongoing, personalised care plan. **Personalised cancer care may include a CCR, but a CCR does not encapsulate the entirety of what should be delivered.**

To achieve this wider ambition to develop personalised cancer care in primary care, a systemic effort is needed to build capacity through workforce training, securing protected time for clinicians, and crucially, improving the flow of information to and from secondary care. By demonstrating the impact of this broader, integrated approach on patient experience and continuity of care, a compelling case can be made for sustainable resources. The Cancer Plan provides a national framework for justifying the investment required for this shift, ensuring that primary care teams are equipped to deliver ongoing personalised support.

Ultimately, successfully navigating this transition will ensure that after a cancer diagnosis people receive the holistic, consistent, and personalised support they need to manage their health within primary care and community as part of their ongoing care. The NHS 10-year Health Plan for England and National Cancer Plan provide the strategic impetus to make these system wide shifts that will ensure person centred community-based support available to people living with and beyond cancer.

High-Level Recommendations for Wessex Cancer

Alliance to consider

1. To develop a model of personalised cancer care that enables primary care and community support from diagnosis through to the needs of people living with and beyond cancer treatment that aligns with the ambitions of the NHS 10-Year Health Plan for England and Cancer Plan.
2. Champion personalised cancer care from diagnosis to living with and beyond cancer. This requires a fundamental shift in how cancer is positioned in primary care, encouraging practices, PCNs and INTs to consider how to integrate cancer

into routine care. This includes addressing cancer needs during appointments for other conditions and interventions and ensuring ongoing, holistic oversight.

3. Utilise the strategic drive to develop integrated neighbourhood teams to create system-wide capacity for personalised cancer care in primary and community settings by collaborating across systems, neighbourhoods, PCNs, and practices to establish needed infrastructure. **This would involve making the case to commissioners and key system leaders for cancer to be seen as a priority condition with resources made available to support the left shift to community.**

Key actions include workforce planning, securing protected time and focused training, and improving information flow—such as timely delivery of End of Treatment Summaries—from secondary to primary care to support ongoing management. Relational, informational and management continuity of care could all be improved through the development of integrated teams.

4. Support the development of General Practice Nurses roles at Primary Care Network (PCN) level to oversee personalised cancer care within their practice or PCN/INT, working at an enhanced level of practice. Such roles will be similar in nature to current GPN roles in the system that focus on LTCs such as diabetes, or asthma. These roles could fulfil the future requirement for cancer neighbourhood leads.
5. Develop capacity and infrastructure to enable community-based specialist nursing and AHP roles that will support patients with complex cancer care needs such as late effects and treatment toxicities. The integration of such roles to support boundary spanning working and access to the MDT at secondary care and INT level would be essential for effectiveness and safety.
6. At a system level, provide support for emerging GPN cancer roles – for example through the existing mentorship offer, a funded education offer, and exploring other opportunities to create conditions for those new roles to develop and thrive. Facilitate opportunity for peer-to-peer learning and mentorship by establishing structures such as communities of practice that cross organisational boundaries.
7. Position the CCR as a tool to support proactive personalised cancer care by supporting practices use it effectively for a comprehensive, holistic assessment at the end of treatment or at the most appropriate time for the patient. This involves:
 - Developing a standardised yet flexible protocol for conducting CCRs
 - Creating patient-facing resources that clearly explain the CCR's purpose as the starting point for ongoing, meaningful conversations about care and support needs as part of routine primary care practice.

8. Demonstrate impact and secure sustainable support: Establish methods to collect patient experience data related to this broader personalised care approach. Use this evidence to build a case for sustainable funding and resources that support personalised cancer care in primary care and properly reflects the leftward shift of care from hospital to primary care and community.

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Appendix One

Survey Questions