

# **QOF Quality Improvement domain 2020/21 – Early diagnosis of cancer**

NHS England and NHS Improvement



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## Introduction

NHS England and GPC England have worked with the Royal College of General Practitioners, NICE and the Health Foundation to develop the topic specific guidance included here. This guidance sets specific objectives for each topic which contractors are expected to work towards and provides advice on potential quality improvement actions.

Within the parameters set out in this guidance, contractors are encouraged to understand where they have the potential to make quality improvements and then to design and implement bespoke quality improvement plans, including improvement targets to address these. There are no deadlines given for the completion of the diagnostic activities, the subsequent plan or the network meetings. However, contractors are advised that they are expected to be working on these improvement activities throughout the QOF year.

The two topic areas identified for 2020/21 are Supporting people with learning disability and early diagnosis of cancer. These topics will change on an annual basis.

Through practice engagement with these and future modules we expect to see measurable improvement in the quality of care and patient experience at a national level against the areas of focus described in the individual modules. The focus of the indicators and associated points is on contractor engagement and participation in the quality improvement activity both in the practice and through sharing of learning across their network. This is to recognise that not all quality improvement activity will be successful in terms of its immediate impact upon patient care. If a contractor does not achieve the targets which they have set themselves this would not in itself be a reason to withhold QOF points and associated payments, unless they have also failed to participate in the activities described in the guidance.

## Indicators

The two QOF indicators included in the Early Diagnosis of Cancer module are:

- QIECD005 - The contractor can demonstrate continuous quality improvement activity focused upon early cancer diagnosis as specified in the QOF guidance.
- QIECD006 - The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on early cancer diagnosis as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings.

## Rationale for inclusion

Cancer has a huge impact both in numbers of people affected and on the individual and those close to them. More than 300,000 people received a first treatment for cancer in the UK in 2018 ([NHS England 2019](#)). Although cancer outcomes have improved significantly with 10,000 more patients surviving for at least 12 months after diagnosis than compared with five years earlier ([NHS England 2019](#)), international studies have demonstrated that the UK can make further improvements.

Other benefits from early diagnosis include relief of symptoms ([NICE 2017](#)). For most cancers survival is much greater at both one and five years if detected at stage one – highlighting the need for early diagnosis ([Hawkes 2019](#)).

General practice plays a crucial role in the timely diagnosis of cancer, with almost 68% of people with cancer first reporting their symptoms at their GP surgery ([Swann et al. 2018](#)). Use of the NICE guideline on suspected cancer ([NG12](#)) may increase appropriate referrals for suspected cancer and reduce the number of presentations before referral ([NICE 2018](#)).

In addition, whilst other providers deliver screening services for bowel and breast cancer, actions taken in general practice can increase uptake of national cancer screening programmes ([Hewitson et al 2011](#)). Cancer screening programmes have been shown to improve patient outcomes:

- Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by over 16% ([UK NSC 2018](#)).
- Deaths from cervical cancer have decreased by around 60% since the introduction of the national cervical screening programme ([UK NSC 2015](#)).
- Evidence suggests a 20% reduction in deaths from breast cancer in women invited for breast screening ([UK NSC 2013](#))

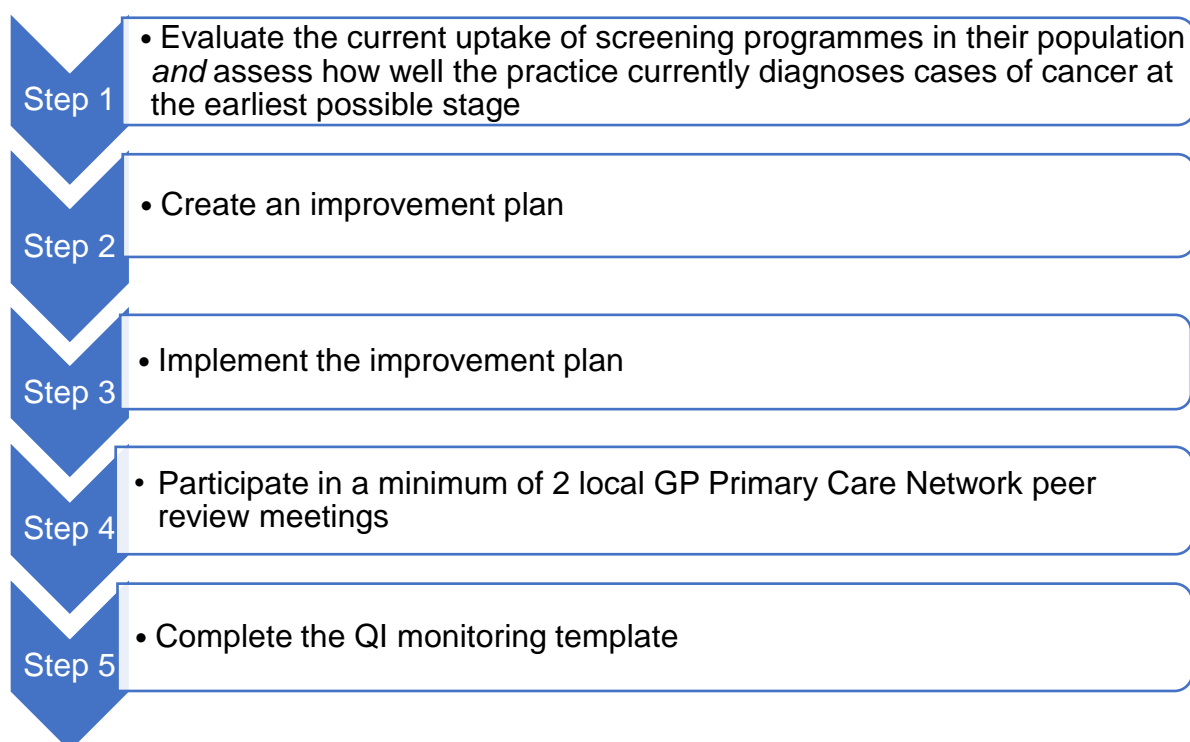
[The NHS Long Term Plan](#) sets out an ambition that by 2028 the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients. NHS England estimate that achieving this will mean that, from 2028, 55,000 more people each year will survive their cancer for at least five years after diagnosis.

## Overview of the QI module

The overarching objective of these QI indicators is to contribute to improvements in relation to the following aspects of care:

- 1) Participation in national breast, cervical and bowel cancer detection and prevention screening programmes among a practice's registered population.
- 2) Referral practices for patients suspected of having cancer; including use of guidelines, professional development, safety netting of those referred on suspected cancer pathways and shortening of diagnostic intervals.

Practices will need to undertake the following steps:



The following section includes further detail on the types of things practices could do to deliver this module. These are suggestions and recommendations only and the decision about what to include in the QI plan and which QI methodologies to use should be made by practices and shared with their peers through the network meetings.

**Practices are expected to undertake quality improvement activity in *both* screening and early diagnosis. This quality improvement activity will support existing efforts of local public health commissioning teams and Cancer Alliances and will contribute to the success of STP and NHS Long Term Plan commitments.**

## Detailed contractor guidance

### 1.1 Identifying areas for improvement

All practices should start with an assessment of the current quality of care they provide. This should include:

1. An assessment of practice screening programme uptake rates compared to local or national baselines. [PHE fingertips](#) has an easy to use tool to compare cancer indicators by practice to quickly identify areas for more in-depth audits. Cancer Research UK have a helpful “expected vs actual” tool for screening uptake and there are searches in the [Macmillan Quality Improvement Toolkit](#) which will also support this work. Practices may wish to focus upon inequalities in screening, particularly for those at risk and with low uptake.

2. An assessment of current referral practice through:
  - i. Participation in the National Cancer Diagnosis Audit or other retrospective audit of recent cancer diagnoses (See Appendix 1 for examples of other retrospective audits). Data could be collected, e.g. on the route to diagnosis; referral pathways used; time from first presentation of symptoms/signs in primary care to referral and investigations. Practices should either audit a minimum of 20 consecutive cancer diagnoses or a randomly selected sample of at least 20 cases from the previous 12 months. Practices may want to focus in more depth on cancers such as lung where there is often more unmet need. Practices may find the Quality Improvement Toolkit for Early Diagnosis of Cancer helpful in identifying ways to use their audit findings to inform their quality improvement activity. <https://www.rcgp.org.uk/cancer>
  - ii. From the patients identified in the audit, practices may find it helpful to undertake a more in-depth learning / significant event analysis around a patient where the referral or diagnosis process could have been better as a way to further identify areas for quality improvement. The RCGP and Macmillan have a helpful toolkit for this type of analysis [www.rcgp.org.uk/seatoolkit](http://www.rcgp.org.uk/seatoolkit)

Practices could also, or alternatively, audit and review the current system in place for safety netting around suspected cancer diagnoses as their early diagnosis activity. Practices who do not have a demonstrably robust practice-wide system for safety netting suspected cancer patients should consider implementing one as part of their quality improvement activities. [Macmillan's safety netting and coding module](#) could support this activity and the Macmillan Quality Improvement Toolkit can also provide some structure to improve this area (Module 2, question 8).

It is anticipated that practice QI activity will dovetail with both local priorities and wider cancer activities. The work is intended to align with existing efforts of local public health commissioning teams and cancer alliances. GP network peer group meetings will provide a forum to establish and agree on allied priorities.

Practices are encouraged to seek the views of patients and carers where this will help with quality improvement activity. This could be done through engagement with a patient participation group and/ or a survey of patients.

Practices may also find it useful to undertake a reflective group meeting and complete a 'SWOT' (strengths, weaknesses, opportunities and threats) analysis. Guidance as to how to do this can be found in the RCGP guide [How to get started in QI](#).

## 1.2 Creating an improvement plan

Following the diagnostic phase above, practices should focus their QI activities on outcomes such as:

1. An increase in the follow-up and informed consent/refusal of screening for cervical, breast or bowel cancer.

2. A reduction in inequitable uptake of screening in population groups identified by the practice.
3. An increase in the proportion of cases where cancer diagnoses are reviewed and learnt from.
4. A decrease in the time from presentation to referral.
5. An increase in the proportion of suspected cancer referrals where a demonstrably robust practice-wide system for safety-netting is used.

These outcomes will be used at a national level to assess the impact of the module and practices should consider how they measure improvement when choosing aims for their projects. *The above have been designed as process-based measures as the time lag for national screening and diagnosis outcome data is too long to assess in a year of improvement.*

Practices may wish to use both data collected during the National Cancer Diagnosis Audit and the ensuing bespoke improvement report provided (by the NCDA) as aids to identify change ideas. Macmillan's Quality Improvement Toolkit for Cancer Care in Primary Care also includes searches that have been integrated into the three main GP IT systems (EMIS Web, TPP SystemOne, INPS Vision) within England to support the identification of areas for quality improvement around screening and early diagnosis.

Once practices have identified their area/s for improvement they should be clear about:

- **The aims** of the project – what will be achieved and by when. These aims should be SMART (specific, measurable, achievable, relevant, and time-bound).
- **The measures** – what data will be collected to know if the aims have been met. Measurements to assess the effectiveness of changes made should be straightforward for teams to collect regularly. Practice project measures could be stratified into:
  - Process, e.g. proportion of patients screened for x cancer
  - Outcomes, e.g. level of confidence of a team member to opportunistically raise screening at reception (then book a smear appointment)
  - Balancing, e.g. the average waiting time for a routine appointment (at the expense of extra smear clinics)
- **The changes** – what different ways of doing things will be tested.

Practices should choose their own quality improvement activities and set their own targets for improvement based upon their baseline audit or search results. These should be challenging but realistic and recognise that it may be easier to make larger improvements when starting from a modest baseline. These should be validated by network peers as part of the initial network review meeting. Multiple small tests of change are recommended. Practices should aim to find a way to ensure improvement is continuous and that quality improvement around early cancer diagnosis becomes routine. See Box 1 for examples of SMART aims.



### **Box 1. Examples of SMART aims**

**Area for improvement 1:** Baseline analysis identifies x% of people eligible for screening for y cancer have not responded to invites.

**SMART aim:** The practice aims to contact z% of non-responders over the next 6 months providing additional information to support informed decision making about screening.

**Area for improvement 2:** Baseline analysis identifies only x% of eligible patients with a learning disability have responded to their screening invite.

**SMART aim:** The practice aims to contact y% of non-responders with a learning disability over 6 months and provide appropriate support to make informed decisions or best interest decisions as appropriate.

**Area for improvement 3:** Baseline analysis identifies only x% of new cancer diagnosis cases are reviewed and learnt from.

**SMART aim:** The practice aims to increase the % of new cancer diagnosis cases which are reviewed and learnt from, by y% to z%, over 6 months.

**Area for improvement 4:** Baseline analysis identifies an average of x days from initial presentation to date of referral.

**SMART aim:** The practice aims to decrease the time from initial presentation to referral to under y days over the next 6 months. *(This may not be an ideal choice for smaller practices or where high-quality audit data is not available)*

**Area for improvement 5:** Baseline analysis identifies the proportion of suspected cancer referrals with systematic safety netting to check they are seen in secondary care as x%.

**SMART aim:** The practice aims to increase the proportion of referrals with systematic safety netting to y% over the next 6 months.

### **1.3 Implementing the plan**

Practices should implement the improvement plan they have developed to support the objectives they have identified. It is recommended that these plans and associated improvement activities should involve the whole practice team and practices are encouraged to engage with colleagues outside the practice where practical, for example public health and the screening service if addressing screening, or secondary care or other local practices when addressing early diagnosis in order to share learning.

Where possible, patients should be involved in quality improvement activity, at the most basic level this would involve discussion of planned activity with the practice's patient participation group but could involve surveys and or focus groups where this would be practical and relevant for the planned activity.

## **1.4 GP network peer review meetings**

A key objective of the network peer review meetings is to enable shared learning across the network. The first meeting should aim to validate and agree meaningful QI activity plans and to share baseline information. The second should focus on shared learning from the quality improvement process and change activities undertaken. It is also intended to provide a forum for practices to identify wider system issues impacting upon care quality which may require a collective response.

Whilst these meetings would usually be face to face, networks are able to explore other mechanisms to facilitate real time peer learning and sharing including virtual meetings. Practices can choose the most appropriate members of the team to attend. The peer review group will usually be the Primary Care Network of which the practice is a member. Suggested discussion points for these meetings are made in Box 2. The network clinical director or their nominated deputy or a clinical lead should facilitate these meetings and maintain a record of attendance. It is for the network to determine the timing of these meetings, but it is recommended that the first meeting takes place early in the QI activity at the stage of deciding on what quality improvement activities to undertake and the second towards the end to share outcomes and learning from these activities.

Contractors should participate in a minimum of two network peer review discussions unless there are exceptional and unforeseen circumstances which impact upon a contractor's ability to participate, more meetings maybe beneficial to the process.

## Box 2. Suggested peer review meeting discussion points

The **first** peer review meeting should take place early in the QI activity and focus on:

- Sharing the outputs of the audit and search baseline work to understand the issues for each practice, compare screening rates and share significant event analyses. Accounting for outlier practices, QI focus should ideally be on worst uptake of screening programmes at network/ 'local' level.
- Validation of practice improvement plans and targets.
- Alignment with the wider cancer activities and local priorities

Discussion points could include:

1. What relevant evidence-based guidance / quality standards can the group use?
2. What data has each practice used to inform its review of current performance? How timely and robust is this data?
3. Has the right focus been chosen by each practice based on their current performance?
4. Has each practice set a clear aim with a challenging but realistic local target, and agreed an appropriate measurement to monitor impact?
5. What ideas for changes is each practice planning to try in an improvement cycle?
6. How are practices ensuring that the whole practice team (including other clinical colleagues and patients and carers) are engaged in the proposed QI activity?
7. The awareness and adoption of referral support technology to reduce variability, e.g. ['C the signs'](#)

The **second** peer review meeting should take place towards the end of the QI activity and focus on:

- Celebrating success and sharing of key changes made in practice.
- Encouraging a compassionate, no-blame and active learning culture.
- How these changes have been embedded and will be sustained.

Discussion points could include:

1. What results have each practice seen in their QI activity testing?
2. What changes have been adopted in each practice?
3. How will these changes be sustained in the future?
4. What new skills have staff developed and how can they be used next?
5. What further QI activity in cancer screening and early diagnosis is planned in each practice?
6. What further actions may need to take place (e.g. at network or CCG level) to support the changes in practices?
7. Not all changes are improvements, what has been tried and failed/ had unintended consequences?

## 1.5 Reporting and verification

The contractor will need to complete the QI monitoring template in relation to this module and self-declare that they have completed the activity described in their QI plan. The contractor will also self-declare that they have attended a minimum of two peer review meetings as described above, unless there are exceptional and

unforeseen circumstances which impact upon a contractor's ability to participate. In these circumstances' contractors are expected to make efforts to ensure alternative participation in peer review.

Verification - Commissioners may require contractors to provide a copy of the QI monitoring template as written evidence that the quality improvement activity has been undertaken. Commissioners may require the network clinical lead to provide written evidence of attendance at the peer review meetings. If a contractor has been unable to attend a meeting due to exceptional circumstances, then they will need to demonstrate other active engagement in network peer learning and review.

## Appendix 1 – Alternative audits

**Option 1** (taken from Macmillan's Quality Improvement Toolkit for Cancer Care in Primary Care)

Review the patient notes for all new cancer diagnoses within your practice from the past 6 months. This can be done through a review of your practice list and if the level of coding within your practice allows, by running searches 13 and 17.

- a) Using the results of the above searches alongside information contained within patient notes, what proportion of these new cancer diagnoses were referred using the urgent suspected cancer (two week wait) referral route?
- b) Using the results of the above searches alongside information contained within patient notes, what proportion of these patients were diagnosed following an emergency presentation?
- c) Using the results of the above searches alongside information contained within patient notes, what proportion of these patients were diagnosed following a routine referral?

Significant Event Analysis (SEA) can be an effective way to identify problems in a patient journey that have led to a delay in a diagnosis of cancer and to provide solutions to ensure similar problems do not affect other patients.

- a) Identify a recent cancer diagnosis where the patient presented either as an emergency or encountered potential delays in the diagnosis.
  - Use the RCGP and Macmillan SEA template to carry out a high-quality SEA ensuring that this is robustly anonymised.
  - Discuss this SEA with your practice team at the next clinical meeting, ensuring that appropriate reflection is made and any suggested actions are taken forward.
- b) Recommendation 25 of the National Cancer Strategy dictates that an SEA should be carried out on all patients diagnosed with cancer following an emergency admission. As a team, agree a plan to use the RCGP and Macmillan SEA toolkit to conduct a case review on all emergency cancer presentations going forward, and agree a forum for discussion of these cases.

Outline a summary of this plan.

Once diagnosed with cancer, patients may need rapid access to appointments.

- a) How easy is it for someone who has received a cancer diagnosis, or who is going through treatment for cancer to book an urgent appointment?
- b)** How might you ensure that practice support staff are made aware of the importance of rapid access to appointments for patients with a cancer diagnosis to support them to prioritise appropriately?

## **Option 2**

This [template](#) includes the data items captured in the National Cancer Diagnosis Audit and may be used in your practice if you wish to audit cancer diagnoses.

## Appendix 2 - Quality Improvement and Early diagnosis of cancer resources available to support practices

**RCGP Cancer Resources** – a host of resources including the RCGP QI Toolkit for Early Diagnosis of Cancer and other tools, guidance and eLearning modules to support with screening and early diagnosis. Available at [www.rcgp.org.uk/cancer](http://www.rcgp.org.uk/cancer)

**RCGP QI Ready** – a host of resources including access to the RCGP QI Guide for general practice, and a series of easily downloadable one or two-page quick guides covering a large range of QI tools, techniques and documents suitable for beginners to experts. There is also a programme of eLearning (3x15minute introduction to QI learning modules), an online learning network to share ideas and QI case studies, and a self-accreditation process for practices to become QI Ready. Free to RCGP members and their teams. Available at [www.rcgp.org.uk/qi](http://www.rcgp.org.uk/qi)

**National Cancer Diagnosis Audit** - Practices may wish to take part in the National Cancer Diagnosis Audit which looks at primary and secondary care data relating to patients diagnosed with cancer. It helps practices to understand pathways to cancer diagnosis, what works well and where improvements could be made. Available at [www.cancerresearchuk.org/ncda](http://www.cancerresearchuk.org/ncda)

**Cancer Research UK Bowel Screening Hub** - An online one-stop hub of evidence-based information, resources, and case studies relating to bowel screening uptake including resources and information on how to carry out activities aiming to increase bowel screening uptake. Available at [www.cancerresearchuk.org/health-professional/screening/bowel-screening-evidence-and-resources](http://www.cancerresearchuk.org/health-professional/screening/bowel-screening-evidence-and-resources)

**Macmillan** – a wealth of free online resources including toolkits, top tips, guidance documents and online training modules to support GPs connect with cancer patients from early diagnosis through to after treatments. Available at [www.macmillan.org.uk/about-us/health-professionals/resources/resources-for-gps.html](http://www.macmillan.org.uk/about-us/health-professionals/resources/resources-for-gps.html)

**Cancer Research UK** – a host of resources including access to professionals' tools and information for increasing the early diagnosis of cancer. Available at [www.cancerresearchuk.org/health-professional/diagnosis](http://www.cancerresearchuk.org/health-professional/diagnosis)

**Gateway C** – an online cancer education platform for primary care professionals which aims to improve cancer outcomes by facilitating earlier and faster diagnosis and improving patient experience. Available at [www.gatewayc.org.uk/](http://www.gatewayc.org.uk/)