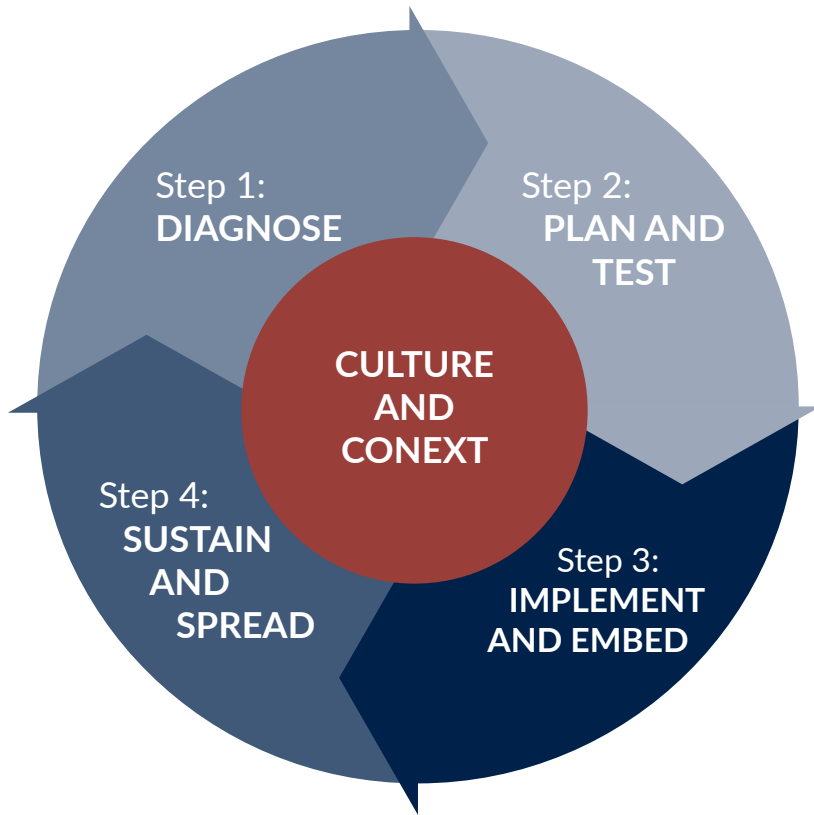# QOF QI Case study: Early diagnosis of cancer based on NCDA outcomes

Practice details: 12,000 patients, 5.5 WTEs, suburban practice

Step 1: **DIAGNOSE**

Step 2: **PLAN AND TEST**

CULTURE AND CONEXT

Step 4: **SUSTAIN AND SPREAD**

Step 3: **IMPLEMENT AND EMBED**

The team decided to focus on reducing both the primary care interval – i.e., the time in days between first presentation to referral from primary care, and the number of consultations prior to referral, to improve early cancer diagnosis.

They used the RCGP QI wheel for general practice (available in RCGP's How to get started in QI guide for advice).

Culture and context:

One of the salaried GPs had attended a regional QI training course, and a health care assistant (HCA) had completed online QI modules. A core team was created to lead the project, made up of the GP, the HCA and an experienced administrator.

A significant event analysis was undertaken at a practice multidisciplinary clinical team meeting following a complaint relating to a delayed referral. Learning from it highlighted that the patients with vague symptoms took several GP visits before referral to the correct specialty was made.

Diagnose:

The surgery had participated in the National Cancer Diagnosis Audit in the previous year, and the team reviewed the annual feedback analysis report. They recognised that they had a relatively long primary care interval (time in days between first presentation to referral from primary care) compared to local and national figures, and the median number of GP consultations prior to referral was 2 compared to the local and national figure of 1.
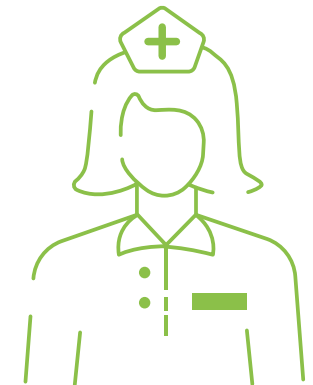
CORE TEAM
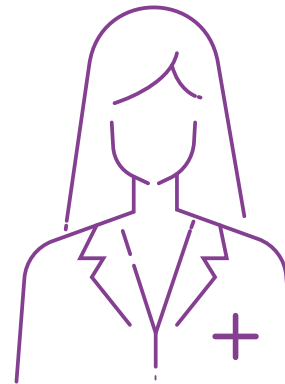

GP

Experienced Administrator

HCA

✓ Plan and test:

The project team then used this data to inform their next actions and set a clear plan. They agreed a SMART outcome aim (what the project wants to achieve and by when), a measure (how they will know if anything is changing), and the change itself (what will people do differently).

Aim:

The practice team set 2 aims:

a. To reduce the primary care interval by 25% over the next 12 months

b. To reduce the median number of consultations prior to referral from 2 to 1 over the next 12 months.
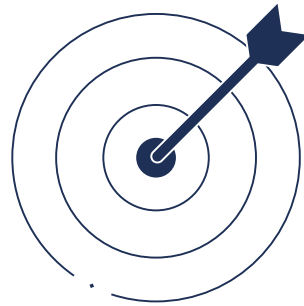
Measure:

On a monthly basis the administrator created a list of all new cancer diagnoses. The primary care interval was calculated for each new case by electronic notes review – with first presentation and referral date having been documented in the notes. The number of consultations prior to referral was counted by the HCA.

Change:

The team participated in an initial peer review meeting with their Primary Care Network colleagues and were able to share both data and ideas. Learning from their nearest practice colleagues they decided to:

a. Discuss the new cancer diagnoses at more regular intervals – by creating dedicated new multidisciplinary cancer diagnosis discussion meetings (administration team were also invited) every month. These were previously happening quarterly. They ensured dissemination of minutes across the team and invited more active feedback from colleagues.

b. Generate quarterly in-house cancer education sessions and agreed changes to the rota that allowed all GPs and practice nurses to attend at least one of the wider CCG cancer events throughout the year.

⭐ Outcome:

It was reassuring to find that the median number of consultations prior to referral had reduced from 2 to 1.5 (the new range being 0-5 compared with to 0-8 previously) over the course of the project, whereas the primary care interval showed a modest improvement of 10%. The figures were plotted on run charts in the waiting room each month so that both the whole practice team and patients could observe progress.

📦 Implement & embed:

The administrator left the practice after 2 months, providing the opportunity to retrain a new colleague in search and list creation. The HCA oversaw the primary care interval calculation. To ensure a good mix of clinical colleagues could attend, the team realised they needed to vary the day of the cancer meetings and change the frequency to 6-weekly to keep attendance high. They realised that not all the clinicians were aware of the latest changes to NG12 (*Suspected cancer: Recognition and referral)* guidelines1, so this was the focus of the first team educational session. Session changes meant that some GPs were able to attend more educational sessions than in previous years.

🔄 Sustain and spread:

By calculating and reviewing the primary care interval themselves on a monthly basis, they felt better able to visualise any changes. They found that an increasing number of the admin team attended the meetings. The project lead also attended the **2nd peer review meeting**, where they shared the team's work with colleagues from the local primary care network, wider system issues were recognised and ideas for next year's collective efforts were suggested.

➡️ What the practice did next:

They agreed that they would continue to contribute to the NCDA. Also, that the QI cancer lead would rotate between 2 of the junior GPs who both showed increased interest following the cancer education sessions. They intended to concentrate next year on safety netting 2 Week Wait referrals to ensure patients consistently receive an appointment within 2 weeks and agreed to invite members of the PPG to join in planning discussions for future QI work.

🔍 What evidence did the practice provide for QOF payment:

The contractor completed the annual QOF QI domain self-declaration. They kept a copy of the QI monitoring template and clinical audits for future payment verification if needed, as well as evidence for future CQC inspections.

MEDIAN NUMBER

2

NEW MEDIAN NUMBER

1.5

0   PREVIOUS RANGE   8

0   NEW RANGE   5

10%

PRIMARY CARE INTERVAL IMPROVEMENTS