**Early Cancer Diagnosis Improvement Planning – Template and Examples**

It is suggested that the planning templates below can be adapted to support both PCN planning or individual practice plans.

To follow is a populated plan to outline some possible examples of workstreams for PCNs and GP practices.

|  |  |
| --- | --- |
| **Supporting Early Cancer Diagnosis PCN Directed Enhanced Service 2020-21****Name of PCN:** **PCN lead for this area** : | **Constituent Practices:****Date Plan Agreed :** |

| **PCN Objective (SMART)** |  **Activities / Actions**  | **Outcome Measures**  | **Time Frames**  | **Progress** **(Interim and** **End of Year Updates)** |
| --- | --- | --- | --- | --- |
| **Cancer Screening**  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Improving Referral Practices** |
|  |  |  |  |  |
|  |  |  |  |  |
| **PCN Planning and Peer Review Meetings** |
|  |  |  |  |  |
|  |  |  |  |  |

**Example Objectives / Improvement Topics**

The following are possible examples of improvement objectives. It is not an exhaustive list nor is it suggested that all these examples are used in any given PCN or practice plan.

|  |  |
| --- | --- |
| **Supporting Early Cancer Diagnosis PCN Directed Enhanced Service 2020-21****Name of PCN:** **PCN lead for this area** : | **Constituent Practices:****Date Plan Agreed :** |

| **PCN Objective****(Specific, Measurable, Achievable, Relevant and Time-Bound)** | **Activities / Actions**  | **Outcomes / Measures**  | **Time Frames**  | **Progress (Interim and Final** **End of Year**  |
| --- | --- | --- | --- | --- |
| **PCN Wide – Peer Review Meetings**  |
| *PCN convenes three cancer early diagnosis planning and shared learning events between October 2020 and March 2021. For all constituent practices*  | **PCN – Convene First Planning Meeting** To review – PHE Cancer Data, Cancer Audits practices and outcomes (if in place), safety netting process. To inform practice plans. **PCN – Convenes midpoint shared learning** Meeting. Aim to enable practices to share progress and good practice on ED plans. Provide joint learning session with external providers/partners**PCN - Convenes End of Year Reflection and Progress Event** . Capture improvements made against improvement plans.  | PCN Cancer trends/challenges ID and discussed. Practice Plans Agreed Cancer Screening – Target Low Participation Group Agreed. Improvement Metrics captured and recorded.  | By End of October 2020 |  |
| **Cancer Screening Examples -** Reduce inequitable uptake of screening - Engage with a patient group identified as having low-participation rates.  |
| *Reduce variation in cervical screening uptake in women aged 25 – 49 years of age by x%. In 6 months. Across constituent practices.* | **Practice baselines are established** using NHS Digital data for 2019/2020. Or PHE Fingertips 2018/19Practices conduct a non – responder search for women in this age group. Using cervical screening Non -Responder Codes. Non – Clinical Cancer Champions review and consider across practices engagement approaches adopted. Practices identify three methods to engage women in this age group (access CRUK Good Practice Guide). E.g. working with social prescribers to support community engagement, text messaging, pre-invite practice “birthday letters”Support staff updates and clinical staff training / briefing to increase knowledge from CRUK Facilitators. Agree work plans at PCN Review meeting and share outcomes and practice at second PCN support meeting. | Establish baseline coverage using PHE Fingertips and NHS Digital.**Process Measures -**Variation is reduced by x% by March 2021. Proportion of previous non- responders screened. **Outcome Measure** –Staff trained and more confident in raising the issue of screening.  | Oct 2020 – March 2021 |  |
| *Practices increase the proportion of LD patients who receive easy read invitations and support to bowel screening. By sharing details of patients with a learning disability with the regional bowel screening hub by Jan 2020. (Patient consent not required).*  | All practices agree to review LD registers and share details with the bowel screening hub.Practices baseline the no. of LD patients on the practice register eligible to be screened (i.e. those aged 60 – 74yrs old). To capture number of patients that will benefit.  | The proportion of LD patients that will receive easy read invitations and support. No. of learning disability patients participated in screening for the first time.  | Oct 20 - March 21 |  |
| *All practices aim to contact x% of learning disability, non-responders to x screening, over next 6 months. And provide appropriate support for informed consent/best interest decisions.* | Practices run clinical system reports to identify non – responders. Search parameters – LD register, eligibility age for the screening programme and screening non – responder codes.  | No. of LD patients contactedNo. of LD patients contacted taking up screening offer. No. of patients supported via community LD team.  | Oct 20 - March 21 |  |
| *All PCN Non – Clinical Cancer Champions contact x% of cervical screening non – responders aged 25 – 49yrs living in high deprivation areas. To support informed decision making. By March 2020.* | Practice identify pts within this cohort. Establish baseline position.Practices initiates text messaging advice and reminder service, telephone follow – up, targeted discussions during baby imms clinics Practices engage and use Regional Screening Saves Lives materials.Practices access support from CRUK Facilitator. Practices share projects, learning and outcomes at PCN Peer Review meeting.  | No. younger of women contactedNo. of younger women contacted taking up screening offer.  | Oct 20 - March 21 |  |
| *To increase the no. of cervical screening appointments available across the PCN by x. Constituent practices will work collaboratively to set up shared extended access to cervical screening clinics (e.g. to increase evenings and weekend appts).*  | Practices scope and decide when and where and how out of hours screening services can be provided and staffed. N.B. mindful of COVID19 requirementsPractices gather patient feedback on planned changes. Women surveyed about service provided. | No. of extra appointments created% increase in women screened (compared to previous year)Feedback from patients accessing the service.Balancing outcome – % of patients report reduced waiting time for appointment.  |  |  |
| **Examples - Review and Improve Referral Practices**  |
| *Practices set up audits, reflect and share learning on new cancer cases diagnosed during emergency admission.*  | Set up retrospective audit of patient’s records (including those who have died). Patients diagnosed in the last year (or at least 20 consecutive cases)Use RCGP Significant Event Analysis Tool. Share anonymised learning with other practices in PCN during peer review.  | At PCN Level – the no. of participating No. of cases audited (increased numbers)Learning and Practice Improvements documented  |  |  |
| Reduce the no. of incomplete 2WW referral forms leaving primary care by October 2020.  | Audit completeness of referral forms. Arrange reflection and training for 2WW refers related to outcomes. Use good practice examples. In support of CPD – clinical staff to access Gateway C – e- learning module. Improving the Quality of Referral <https://www.gatewayc.org.uk/browse-free-interactive-cancer-courses/> Re - audit completeness of referral forms. Identify improvements made. | Increase in the number of fully complete referrals (against starting point baseline) | Audit notes by January 2021. Anonymised sharing by March 2021 |  |
| Practices to undertake retrospective audit of new cancer cases using National Cancer Diagnosis Audit (NCDA) Tool by 31st August 2020 .  | With support of CRUK Facilitators Practices register with NCDA before 31st July 2020. Complete case reviews .Auditors capture and share reflections as they audit. Practices access and review audit reports. Share learning and identify potential improvements  | 95 % of cases auditedAction plans and learning points from audit identified across the PCN  | Cases Audited by 31st Ausgust.Audit reports accessed October 2020.Learning and action points identified by Nov/Dec 2020.  |  |
| **Safety Netting** Practices will use the relevant SNOMED code “Delivery of safety netting for patients on urgent referral pathway for suspected cancer” from Oct 2020.  |  |  |  |  |