Comparison of final QOF guidance to original requirements for QOF QI module for Cancer

Original guidance April 2020	Final Guidance September 2020
Following the diagnostic phase, practices should focus their QI activities on outcomes such as:	The national quality improvement actions for early cancer diagnosis are focused upon restoration of delivery of screening services with a focus on cervical screening and ensuring patients who require urgent referral are identified, supported and managed in line with NICE guidance. All the specific actions below require an understanding of the inequalities within the practice and network population for whom there may have been a disproportionate drop in activity. Further guidance on place based approaches for reducing health inequalities can be found on the NHS England and NHS Improvement website. Specifically, practices should:
1. An increase in the follow-up and informed consent/refusal of screening for cervical, breast or bowel cancer.	1. continue to focus on restoring the cervical screening programme among their registered population, and ensure appointments are offered to women who are eligible and due to be screened. Practices should actively identify women who have had their cervical screening appointment delayed or cancelled due to COVID-19 and ensure that they are offered an appointment. NHS England and NHS Improvement have produced guidance on prioritisation of patients for screening. This may be via a review of local records or final non-responder lists. Practices are encouraged to continue with innovative service developments implemented as part of the pandemic response that have supported improved equitable access;
2. A reduction in inequitable uptake of screening in population groups identified by the practice.	2. proactively engage with patients, families and carers to build confidence in primary care and take action to offer reassurance that general practice and other healthcare settings (including screening) can be accessed safely. Practices are encouraged to address inequalities and to focus on those groups who may experience barriers to accessing services and in which there might be a disproportionate drop in activity. Practices could send a text message or a letter, in various inclusive formats – easy read, plain English and translations to all patients to provide reassurance about accessing general practice. Practices may want to work with local partners to include targeted and culturally competent messages in community newsletters and local media. The key aim of this action is to ensure that all patients receive a consistent message that general practice is open and available to support them. Practices may wish to implement this at a PCN level and could work with local people, community and faith-based organisations and networks to help understand how best to engage with the diverse needs of their local population;
3. An increase in the proportion of cases where cancer diagnoses are	3. monitor their suspected cancer referral rates and assess if these are returning to their previous levels seen before COVID-19. It is understood that some aspects of the referral pathway will be outside of the

reviewed and learnt from.	control of the practice, however practices are encouraged to reflect and identify where they could improve on: a. the quality of referrals, including how far implementation aligns with guidance, and seeking to support a return to pre-pandemic levels of referral rates; b. awareness of referral and testing pathways, including the impact of any pathway changes implemented as part of the pandemic response;
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.	4. ensure they have a robust and consistent system in place for safety netting supported by high-quality, appropriate and responsive communication and patient information, for patients who: a. have been placed on an urgent referral pathway for suspected cancer, including proactive follow-up of those who do not attend any appointments; b. have not been referred due to the level of risk and or/patient concern; c. have been referred on an urgent referral pathway but have been downgraded with the consent of the primary care professional.