phn BRISBANE SOUTH
An Australian Government Initiative

QUALITY IMPROVEMENT TOOLKIT FOR GENERAL

Prevention

Cancer screening and prevention (cervical, breast & bowel)

MODULE

Version 2

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In partnership with

CANCER PREVENTION – CERVICAL, BREAST AND BOWEL

Introduction

The Quality Improvement (QI) toolkit

This QI toolkit is made up of modules that are **designed to support your practice to make easy, measurable and sustainable improvements to provide best practice care for your patients**. The toolkit will help your practice complete QI activities using the Model For Improvement (MFI).

Throughout the modules you will be guided to explore your data to understand more about your patient population and the pathways of care being provided in your practice. Reflections from the module activities and the related data will inform improvement ideas for you to action using the MFI.

The MFI uses the Plan-Do-Study-Act (PDSA) cycle, a tried and tested approach to achieving successful change. It offers the following benefits:

- A simple approach that anyone can apply
- Reduced risk by starting small
- It can be used to help plan, develop and implement change that is highly effective.

The MFI helps you break down your change implementation into manageable pieces, which are then tested to ensure that the change results in measurable improvements, and that minimal effort is wasted.

There is a bowel cancer screening example using the MFI and a blank template for you to complete at the end of this module.

If you would like additional support in relation to quality improvement in your practice please contact Brisbane South PHN on support@bsphn.org.au.

Due to constant developments in research and health guidelines, the information in this document will need to be updated regularly. Please contact Brisbane South PHN if you have any feedback regarding the content of this document.

This icon indicates that the information relates to the ten Practice Incentive Program Quality Improvement (PIP QI) measures.

Acknowledgements

We would like to acknowledge that some material contained in this toolkit has been extracted from organisations including the Institute for Healthcare Improvement; the Royal Australian College of General Practitioners (RACGP); the Australian Government Department of Health; Best Practice; MedicalDirector, CAT4 and Train IT. These organisations retain copyright over their original work and we have abided by licence terms. Referencing of material is provided throughout.

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Brisbane South PHN would like to acknowledge the contribution of Queensland Health Cancer Screening Unit in the production of this QI toolkit.

Brisbane South PHN, 2021

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CANCER PREVENTION – CERVICAL, BREAST AND BOWEL

Background

Cancer currently places the largest and a growing burden on patients, families and the health system in Australia. Over 100,000 new registered cancer cases are diagnosed every year. [1]

Cancer is potentially one of the most preventable and treatable of all diseases. Almost one-third of all cancers may be avoidable, with more than a quarter attributable to just three risk factors: smoking, alcohol misuse and obesity. Other risk factors are poor diet, insufficient physical activity, infectious diseases and exposure to ultraviolet radiation. The risk of many cancers can be modified by individual lifestyle changes.

This toolkit will focus on cervical, breast and bowel cancer as there currently are screening programs for these cancers. Simple screening tests look for particular changes and early signs of cancer before it has developed or before any symptoms emerge.

Cervical cancer

Cervical cancer is the growth of abnormal cells in the lining of the cervix. The most common cervical cancer is squamous cell carcinoma, accounting for 70 per cent of cases. Adenocarcinoma is less common and more difficult to diagnose because it starts higher in the cervix.

Estimated number of new cases of cervical cancer diagnosed in 2020

933 females

Estimated % of all new female cancer cases diagnosed in 2020 - 1.4%

Estimated number of deaths from cervical cancer in 2020

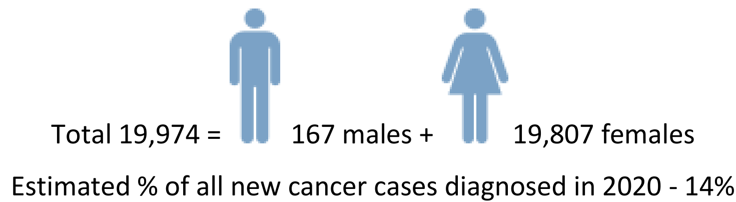
238 females[2]

[1] https://www1.health.gov.au/internet/main/publishing.nsf/Content/cancer
[2] https://cervical-cancer.canceraustralia.gov.au/statistics

Breast cancer

Breast cancer occurs when abnormal cells in the breast grow in an uncontrolled way. Breast cancer can develop at any age. It is most common in women but also affects a small number of men each year.

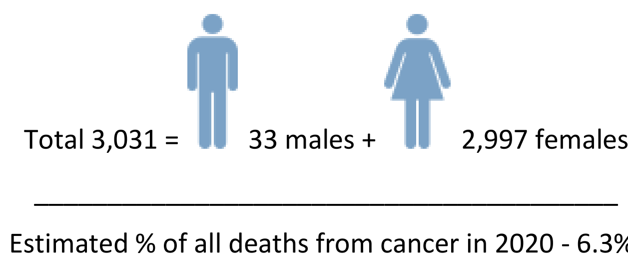
Estimated number of new cases of breast cancer diagnosed in 2020



Total 19,974 = 167 males + 19,807 females

Estimated % of all new cancer cases diagnosed in 2020 - 14%

Estimated number of deaths from breast cancer in 2020



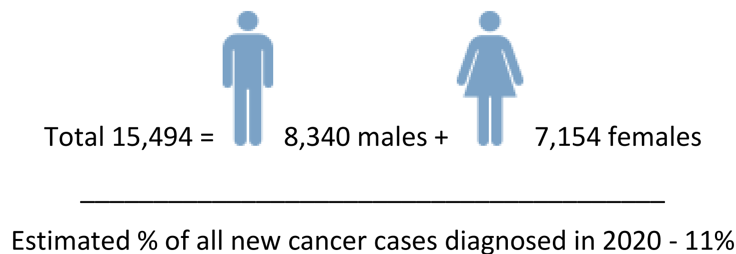
Total 3,031 = 33 males + 2,997 females

Estimated % of all deaths from cancer in 2020 - 6.3%[3]

Bowel cancer

Bowel cancer (also known as colorectal cancer) occurs when abnormal cells in the wall of the large bowel grow in an uncontrolled way. Bowel cancer is one of the 10 most common cancers in both men and women in Australia.

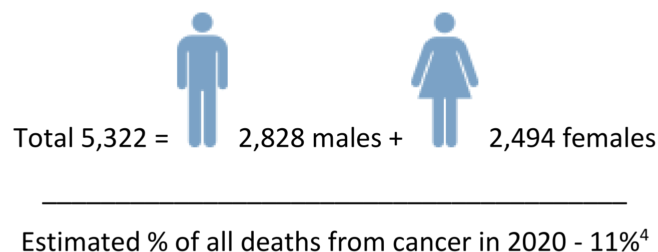
Estimated number of new cases of colorectal cancer diagnosed in 2020



Total 15,494 = 8,340 males + 7,154 females

Estimated % of all new cancer cases diagnosed in 2020 - 11%

Estimated number of deaths from colorectal cancer in 2020



Total 5,322 = 2,828 males + 2,494 females

Estimated % of all deaths from cancer in 2020 - 11%[4]

[3] https://breast-cancer.canceraustralia.gov.au/statistics
[4] https://bowel-cancer.canceraustralia.gov.au/statistics

Australian cancer screening programs

Cancer prevention and early detection practices, including screening, play an important role to reduce the prevalence of cancer and cancer-related deaths and diseases in Australia. Cancer screening programs aim to reduce cancer causing illnesses and deaths through a public health approach of early detection of cancer and pre-cancerous abnormalities and follow-up treatment. Australia has three cancer screening programs:

- National Cervical Screening Program (NCSP)
- BreastScreen Australia
- National Bowel Cancer Screen Program (NBCSP).

Who is eligible for the national cancer screening programs?

The eligibility criteria for the national cancer screening programs and recommendations for each program are outlined below:

Program	Eligibility	Test type and frequency	More information
The National Cervical Screening Program (NCSP)	The program promotes routine screening with cervical screening test. People are eligible for a subsidised cervical screening test if they are: • aged between 25 and 74 • sexually active or ever have been • a woman or person with a cervix. Women aged 70 to 74 will be invited to have an exit test. Please refer to the pathology test guide for cervical and vaginal testing for more information.	HPV test every five years (*this may vary depending on the patient's history)*.	For information about the cervical screening test, go to the National Cervical Screening Program.
BreastScreen Australia	BreastScreen Australia targets women aged 50-74, although women aged 40-49 and > 75 years are able to attend for screening	Mammogram every two years	For more information visit BreastScreen Australia
National Bowel Cancer Screening Program (NBCSP)	Available to all people aged between 50 and 74	Faecal Occult Blood Test (FOBT) every two years	For more information regarding screening for bowel cancer visit the National Bowel Cancer Screening Program website

Frequency of conducting cervical screening

On 1 December 2017, the NCSP changed from two yearly cervical cytology testing to five yearly HPV testing for women aged 25–74 years. An HPV test every five years is more effective, just as safe, and is expected to result in a significant reduction (24%-36%) in incidence and mortality from cervical cancer in Australian women, compared with the program it replaces, which is based on two yearly pap smears.

Frequency of conducting mammogram

BreastScreen Australia targets women aged 50 to 74 years as 75 per cent of all breast cancers occur in women over the age of 50 years.

- Screening mammograms are often less reliable for women under 40 years of age. The density of breast tissue in younger women often makes it difficult to detect cancers on mammograms.
- All women aged 40 to 49 years who have no breast symptoms also have free access to the BreastScreen Australia program should they choose to a have a screening mammogram.
- All women aged 50 to 74 years are encouraged to have a free mammogram every two years through BreastScreen Australia.
- Women aged 75 and over who have no breast symptoms also have free access to the BreastScreen Australia program. They should discuss whether to have a mammogram with their doctor.

Frequency of conducting bowel screening

National Health and Medical Research Council (NHMRC) approved guidelines recommend FOBT testing every 2 years from 50-74 years for those at average risk and without symptoms. People in this age range are sent a free home test kit (an FOBT) by mail to complete at home and send back to a laboratory for analysis. Test results are sent directly to the participant and their nominated doctor.

Screening and managing patients at higher risk

Some patients will be at a higher risk of cancer and may need to be screened at different timeframes. The RACGP have outlined screening guidelines for higher risk patients in the Guidelines for preventive activities in general practice.

- Cervical cancer identifying risk - RACGP
- Breast cancer managing risk – RACGP
- Colorectal cancer – identifying risk - RACGP

Encouraging patients to be aware of their body

Treatment can be more effective when cancer is found early. If patients are **not eligible** for the cancer screening programs or are **in between screening**, encourage them to look for signs such as:

- lumpiness or a thickened area in their breasts, any changes in the shape or colour of their breasts, unusual nipple discharge, a nipple that turns inwards (if it hasn't always been that way) or any unusual pain
- a lump in the neck, armpit or anywhere else in the body
- changes in toilet habits that last more than two weeks, blood in a bowel motion
- unusual vaginal discharge or bleeding especially after menopause
- unexplained weight loss.[5]

[5] https://www.cancer.org.au/cancer-information/causes-and-prevention/early-detection-and-screening

Toolkit aim - to identify patients from your practice who are eligible to participate in the national cancer screening programs.

To achieve this goal, there are a number of activities below which have been broken down into small achievable steps that may be completed.

How to use this toolkit

There are checklists included below that will guide you and your practice.

- identify a sample group of patients by reviewing data measures from your practice population
- use this toolkit to guide you along the journey
- set yourselves timelines to achieve your goals
- consider potential internal or external factors that could impact the activity and factor these into your planning e.g. accreditation preparation, staff leave (planned or unplanned), global pandemic, influenza vaccination season
- review your progress regularly

If you find your process is not working and you are not seeing improvements, then review your process and start again.

For more support

support@bsphn.org.au 1300 467 265

Activity 1 – Cervical screening

Cervical cancer is one of the most preventable cancers. Routine cervical screening is one of the most effective ways to prevent cervical cancer or detect it earlier. Early detection and treatment can significantly improve cervical cancer survival.

The new screening program is also designed to work together with the HPV vaccination program. The cervical screening test is expected to protect up to 30 per cent more women. The cervical screening test detects infection with HPV. Guidelines for the cervical screening test include:

- a HPV test with partial genotyping should be undertaken every 5 years
- cervical screening should commence from 25 years of age
- people should have a cervical screening test between 70 and 74 years of age
- people with symptoms (including unusual or persistent vaginal bleeding (post-coital, unexplained inter-menstrual or any post-menopausal), discharge (offensive and/or blood stained) or deep persistent dyspareunia) can have a cervical test at any age and require further investigation.[6]

Activity 1.1 – Data collection from CAT4 – cervical screening

The aim of this activity is to collect data to determine the number of patients eligible for the National Cancer Cervical Screening Program and also identify any patients who have not met the suggested guidelines for screening.

Note - Instructions on how to extract the data are available on: cancer screening **or** identify eligible female patients for cervical screening

	Description	Total Number	Patient %
1.1a	Number of active female patients aged between 25 and 74 years		
1.1b	Number of active female patients aged between 25 and 74 years with HPV recorded ≤5 years		
1.1c	Number of active female patients aged between 25 and 74 years with a HPV result > 5 years		
1.1d	Number of active female patients aged between 25 and 74 years with NO cervical screening (including PAP smear) recorded		
1.1e	Number of active female patients aged between 25 and 74 years ineligible for cervical screening		

Please note: you may wish to change you search criteria to include all female patients. Active patients will identify people who have visited your practice 3 times in the past 2 years. If you have a patient who only attends the practice for their 5 year cervical screening test or an annual influenza vaccination, they will not appear in the active patients report.

[6] http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/healthcare-providers

Activity 1.2 – Identifying number of eligible patients with no cervical screening

The aim of this activity is to review the number of eligible patients with no cervical screening.

Description	Action to be taken
After completing **Activity 1.1** note how many female patients are aged between 25 and 74 years with NO cervical screening (including PAP smear) recorded?	Number: ____ % of active patient aged between 25 and 74 years: _______ *(To work out %, take total number from 1.1 and divide by 100 (make a note of this figure). Then divide total number of not recorded by the figure you have taken note of. For e.g. If your total female population is 2209 divide by 100 = 22.09 and your total not recorded is 734, then 734 divide by 22.09 = 33%).*
Is the percentage of not recorded patients low (less than 20%) or high (greater than 40%)?	☐ Low ☐ High
Is there an explanation as to this result?	(*E.g. loss or gain of female GP/s, influx of patients, screening done elsewhere, data entry etc.*):
How does your practice's cervical screening rates compare to other practices in the Brisbane south region? *(Refer to your monthly benchmark report).*	☐ Similar ☐ Lower ☐ Higher
Is there an explanation as to this result?	(*e.g. Our practice has a lower/higher female population than others in the region*)
After reviewing your patient cervical screening rates, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	Yes, refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success. No, you have completed this activity.

HPV vaccination

The HPV vaccine is funded for both males and females in the year 7 school program and catch-up up to 19 years of age. The HPV vaccine is given as a 2-dose schedule (with an interval of at least 6 months between doses). If a person is immunocompromised or between 15 to 19 years of age, they need to receive a 3-dose schedule (at 0, 2 and 6 month intervals). The vaccine is most effective when all doses have been given. Missed doses should be given as soon as possible. The vaccine protects against those types of HPV that cause 70 per cent of cervical cancer cases among women.

Immunisation against HPV is recommended as part of the Queensland School Immunisation Program.

Activity 1.3 – Data collection from CAT4 – HPV vaccine

The aim of this activity is to collect data to determine the number of patients eligible for the HPV vaccine and also identify any patients who may have not completed their schedule.

Note - Instructions on how to extract the data are available on: adolescent immunisations.

	Description	Total Number	Patient %
1.3a	Number of active patients aged between 11 and 14 years		
1.3b	Number of active patients aged between 15 and 19 years		
1.3c	Number of active patients aged between 11 and 14 years with one HPV dose		
1.3d	Number of active patients aged between 11 and 14 years with two HPV doses		
1.3e	Number of active patients aged between 11 and 14 years with three HPV doses		

Please note: the majority of these vaccines are completed during a school program, so information may need to be obtained from Australian Immunisation Register (AIR).

Activity 1.4 – Understanding the HPV vaccination rates

The aim of this activity is to increase your understanding of the number of eligible patients with a completed HPV vaccination schedule.

Description	Status	Action to be Taken
After completing **activity 1.3** are there any unexpected results with your practice's HPV vaccination status?	☐ Yes, **see action to be taken.** ☐ No, continue with activity.	Please explain: (*e.g. lower recording of HPV vaccination than expected).* How will this information be communicated to the practice team?
After reviewing your patient HPV vaccination rates, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see action to be taken to help set you goals.** ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Important changes to the NCSP clinical guidelines pathway

Changes to the NCSP's guidelines came into effect from 1 February 2021. Women with a 12-month follow up HPV (not 16/18) result with a negative liquid-based cytology (LBC) prediction, and possible low-grade squamous intraepithelial lesion (pLSIL) or low-grade squamous intraepithelial lesion (LSIL), will be recommended under the updated guidelines to undertake a further follow up HPV test in 12 months, instead of being referred directly for colposcopy.

It is now recommended that:

- Women with a 12-month follow up HPV (not-16/18) result with a negative LBC prediction, pLSIL or LSIL (intermediate risk result) should be recommended to undertake a further HPV follow up test in 12 months' time following their previous HPV test instead of referral to colposcopy.

Some groups of women may be at higher risk of harbouring a high-grade abnormality and should be referred to a colposcopy if HPV is detected at 12 months, regardless of the LBC result. These include:

- Women 2 or more years overdue for screening at the time of the initial screen
- Women who identify as being of Aboriginal or Torres Strait Islander
- Women aged 50 years or older.[7]

[7] https://www.health.gov.au/news/important-changes-to-the-national-cervical-screening-programs-clinical-guidelines-pathway-for-women-at-intermediate-risk

There is a revised cervical screening pathway from 1 February 2021.

CERVICAL SCREENING PATHWAY

Activity 2 – Breast screening

Activity 2.1 – Data collection from CAT4

The aim of this activity is to collect data to determine the number of patients eligible for the NBCSP and also identify any patients who have not met the suggested guidelines for screening.

Note - Instructions on how to extract the data are available on: cancer screening **or** find a patient who have not had a mammogram recorded.

	Description	Total Number	Patient %
2.1a	Number of active female patients aged between 50 and 74 years		
2.1b	Number of active female patients aged between 40 and 49 years		
2.1c	Number of active female patients aged between 50 and 74 years with a mammogram recorded in the past 2 years		
2.1d	Number of active female patients aged between 50 and 74 years with a mammogram between >2 years and 3 years ago		
2.1e	Number of active female patients aged between 50 and 74 years with a mammogram between >3 years and 4 years ago		
2.1f	Number of active female patients aged between 50 and 74 years with a mammogram >4 years ago		
2.1g	Number of active female patients aged between 50 and 74 years with NO mammogram recorded		
2.1h	Number of active female patients aged between 50 and 74 years ineligible for mammogram (e.g. bilateral mastectomy)		

Activity 2.2 – Identifying number of eligible patients with no mammogram results

The aim of this activity is to review the number of eligible patients with no mammogram results.

Description	Action to be taken
After completing **Activity 2.1** note how many active female patients are aged between 50 and 74 years with NO mammogram recorded?	Number: ________________________________ % of active patients aged between 50 and 74 years: __________ *(To work out %, take total number from 1.1 and divide by 100 (make a note of this figure). Then divide total number of not recorded by the figure you have taken note of. e.g. If your total female population is 2209 divide by 100 = 22.09 and your total not recorded is 734, then 734 divide by 22.09 = 33%).*

Description	Action to be taken
Is the percentage of not recorded patients low (less than 20%) or high (greater than 40%)?	☐ Low ☐ High
Is there an explanation as to this result?	(*E.g. loss or gain of GP/s, influx of patients, data entry, limited mammogram services in the area etc.*):
Is there a similar trend with cervical screening? (from **Activity 1.2**)	☐ Yes ☐ No Please explain:
How does your practice's mammogram results compare to other practices in the Brisbane south region? *(refer to your monthly benchmark report)*	☐ Similar ☐ Lower ☐ Higher
Is there an explanation as to this result?	(*E.g. our practice has a lower/higher female population than others in the region*).
After reviewing your patient breast cancer screening rates, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	Yes, refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success. No, you have completed this activity.

Some risk factors that may increase your risk of breast cancer include:

- increasing age
- family history
- inheritance of mutations in the genes BRCA2, BRCA1 (more common with Ashkenazi Jewish heritage) and CHEK2
- exposure to female hormones (natural and administered)
- a previous breast cancer diagnosis
- a past history of certain non-cancerous breast conditions.

Lifestyle factors that can also slightly increase the risk of breast cancer in men and women include:

- being overweight
- not enough physical activity
- drinking alcohol.[8]

[8] https://www.cancer.org.au/cancer-information/types-of-cancer/breast-cancer

Activity 3 – Bowel cancer screening

Activity 3.1 – Data collection from CAT4

The aim of this activity is to collect data to determine the number of patients eligible for the NBCSP and also identify any patients who have not met the suggested guidelines for screening.

Note - Instructions on how to extract the data are available on: cancer screening **or** identify under screened population for bowel cancer.

	Description	Total Number	Patient %
3.1a	Number of active patients aged between 50 and 74 years		
3.1b	Number of active patients aged between 50 and 74 years with NO FOBT recorded		
3.1c	Number of active patients aged between 50 and 74 years who are ineligible for FOBT (e.g. colonoscopy surveillance due to high risk or follow up)		
3.1d	Number of active patients aged between 50 and 74 years with FOBT recorded in the past 2 years		
3.1e	Number of active patients aged between 50 and 74 years with FOBT recorded >2 years to 3 years ago		
3.1f	Number of active patients aged between 50 and 74 years with FOBT recorded >3 years to 4 years ago		
3.1g	Number of active patients aged between 50 and 74 years with FOBT recorded >4 years ago		

Activity 3.2 – Identifying number of eligible patients with no bowel screening results

The aim of this activity is to review the number of eligible patients with no bowel screening results recorded.

Description	Action to be taken
After completing **Activity 3.1** note how many patients are aged between 50 and 74 years with NO bowel screening recorded?	Number: ______________________________ % of active patient aged between 50 and 74 years: ________ *(To work out %, take total number from 1.1 and divide by 100 (make a note of this figure). Then divide total number of not recorded by the figure you have taken note of. (E.g. If your total population is 2209 divide by 100 = 22.09 and your total not recorded is 734, then 734 divided by 22.09 = 33%).*
Is the percentage of not recorded patients low (less than 20%) or high (greater than 40%)?	☐ Low ☐ High
Is there an explanation as to this result?	(*E.g. loss or gain of GP/s, influx of patients, data entry etc.*):

Description	Action to be taken
Is there a similar trend with cervical screening and/or breast screening?	☐ Yes ☐ No Please explain:
How does your practice's bowel screening rates compare to other practices in the Brisbane south region? *(Refer to your monthly benchmark report).*	☐ Similar ☐ Lower ☐ Higher
Is there an explanation as to this result?	*(E.g. Our GPs are very proactive about bowel cancer screening).*
After reviewing your patient bowel screening rates, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	Yes, refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success. No, you have completed this activity.

Activity 4 - Receiving and incorporating cancer screening results into the patient's file

The aim of this activity is to identify all the avenues where cervical screening (including PAP smear), breast screening and bowel screening results are completed. It is also to ensure that the results are incorporated into the correct section of the patient file to ensure the results are part of any extraction performed.

In **activities 1.1, 2.1 and 3.1**, you identified the number of eligible patients who did not have any screening (cervical, breast and/or bowel) recorded. This could be for a variety of reasons including screening done at another practice, performed with specialist or hospital etc. Some of the time, the patient's GP will receive notification of this. It is important that the information is included into the patient file, using the appropriate menus and fields in your practice's clinical software.

Activity 4.1 – Patient screening results

The aim of this activity is to identifying your practice's system for incorporating results into patient's notes.

Description	Status	Action to be taken
Are relevant practice team members aware of the importance of quality data (avoiding free text)?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Communicate to relevant practice team members the importance of data quality in your clinical software.
Are practice team members aware of how to enter cervical screening results into the relevant section in your clinical software?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	See instructions: Entering Cervical Screening Results. How will you communicate this information to relevant practice team members? (Please explain).
Are practice team members aware of how to enter mammogram results into the relevant section in your clinical software?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	See instructions: Entering Mammogram results. How will you communicate this information to relevant practice team members? (Please explain).

Description	Status	Action to be taken
Are practice team members aware of how to enter bowel screening results into the relevant section in your clinical software?	☐ Yes, continue with the activity. ☐ No, **see action to be taken.**	See Instructions: Entering Bowel Screening Results. How will you communicate this information to relevant practice team members? (Please explain).
After reviewing your system for incorporating results into your clinical program, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see action to be taken.** ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Practice decision point

It is recommended that you meet either in your established micro-team or at a practice meeting to create a process for ***recording cancer screening information*** *into patient's records. This will ensure the practice has an accurate cancer screening database.*

Please use the below table to guide you through this process.

Activity 4.2 – Reviewing process for recording screening into patient records

Based on the review of the number of eligible patients with no record of cervical screening, breast screening and/or bowel screening complete the following table.

Questions to consider	Status	Action to be taken
What is the current process of receiving and recording cervical screening at your practice?	Please explain: Are results currently imported into the cervical screening section? If yes, please explain:	

Questions to consider	Status	Action to be taken
What is the current process of receiving and recording breast screening (mammogram) results?	Please explain:	
What is the current process of receiving and recording bowel screening (FOBT) results?	Please explain:	
After reviewing the number of female patients or women with NO cervical screening reported at **Activity 1.1e,** will your practice implement changes to the way results are recorded?	☐ Yes, **see action to be taken.** ☐ No, continue with activity.	Please explain: What action will you take? Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success. How will you use this information to increase the number of cervical screening recorded in your practice?
After reviewing the number of females with NO breast screening (mammogram) reported at **Activity 2.1g**, will your practice implement changes to the way results are recorded?	☐ Yes, **see action to be taken**. ☐ No, continue with activity	Please explain: What action will you take? Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Questions to consider	Status	Action to be taken
		How will you use this information to increase the number of mammograms recorded in your practice?
After reviewing the number of patients with NO bowel screening reported at **Activity 3.1b,** will your practice implement changes to the way results are recorded?	☐ Yes, **see action to be taken.** ☐ No, continue with activity.	Please explain: What action will you take? Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success. How will you use this information to increase the number of FOBT recorded in your practice?

Activity 5 – Lifestyle risk factors

A risk factor is any factor associated with an increased likelihood of a person developing a health disorder or condition, such as cancer. Having one or more risk factors does not mean a person will develop cancer. Many people have at least one cancer risk factor but will never get cancer, while others with cancer may have had no known risk factors.

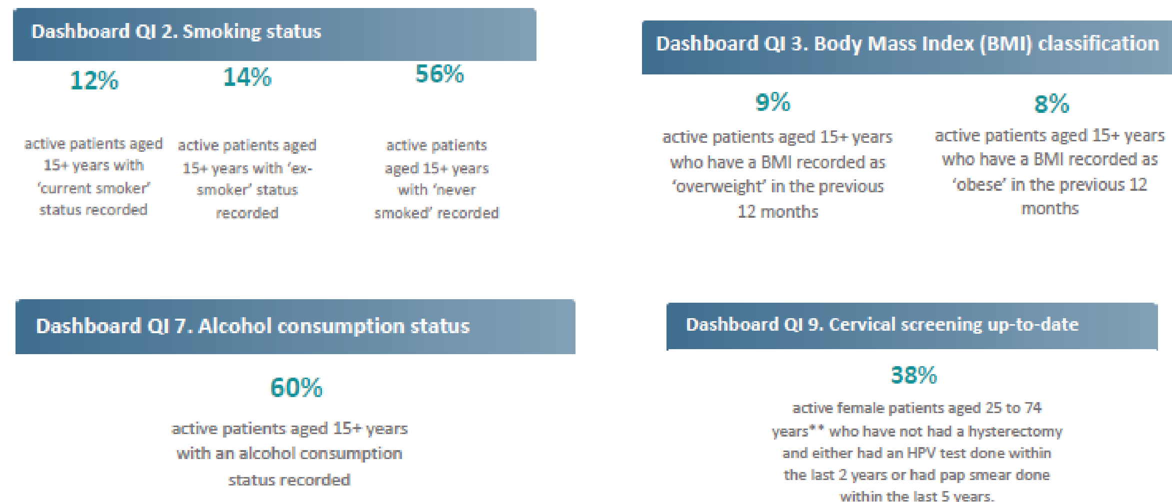
However, there are a number of modifiable lifestyle factors that increase the risk of cancer.

- tobacco smoking
- overweight and obesity
- physical activity and sedentary behaviour
- diet
- alcohol
- UV radiation
- infections.[9]

It is important to review practice data to identify patients who may not have these measures completed, however, this should be seen as an opportunity to engage patients with regard to their behavioural, modifiable risk factors. This should be accompanied by conversations addressing relevant issues to address these risk factors across the board.

PIP QI Measures

As part of the PIP QI measures, practices are to report on body mass index (BMI) classification, smoking and alcohol status. See a snapshot on how your practice is going with reporting this information from your latest benchmarking report provided by Brisbane South PHN.



[9] https://canceraustralia.gov.au/publications-and-resources/position-statements/lifestyle-risk-factors-and-primary-prevention-cancer/lifestyle-risk-factors

Activity 5.1 – Data collection from CAT4

The aim of this activity is to collect data to determine the number of patients who have their BMI status, smoking, alcohol and physical activity recorded.

Complete the below table by collecting data from your CAT4 Data Extraction Tool or benchmark report provided by Brisbane South PHN.

Note: Instructions on how to extract the data is available from the CAT4 website:

Add weight, height and waist measurements to patient records **OR** smoking status **OR** alcohol status

	Description	Total Number	% completed
5.1a	Number of active patients aged 15+ years who have their smoking status recorded PIP QI		
5.1b	Number of active patients aged 15+ years who have their smoking status recorded as current smoker PIP QI		
5.1c	Number of active patients aged 15+ years who have their smoking status recorded as ex-smoker PIP QI		
5.1d	Number of active patients aged 15+ years who have their smoking status recorded as never smoked PIP QI		
5.1e	Number of active patients 15+ years who have their alcohol status recorded PIP QI		
5.1f	Number of active patients who have their physical activity recorded		
5.1g	Number of active females aged between 25 and 74 who are up to date with their cervical screening		
5.1h	Number of active patients aged 15+ years who have their smoking status recorded PIP QI		
5.1i	Number of active patients aged 15+ years who have their smoking status recorded as current smoker PIP QI		
5.1j	Number of active patients aged 15+ years who have their smoking status recorded as ex-smoker PIP QI		
5.1k	Number of active patients aged 15+ years who have their smoking status recorded as never smoked PIP QI		

Please note*: for this activity, we have selected active patients (3x visits in 2 years), you may choose to select a different patient population.*

Activity 5.2 – Understanding your practice lifestyle risk factors

The aim of this activity is to increase your understanding of your practice's population regarding BMI, smoking, alcohol and physical activity status.

Description	Status	Action to be Taken
After completing **activity 5.1** are there any unexpected results with your practice's patient BMI, smoking, alcohol or physical activity status?	☐ Yes, **see action to be taken.** ☐ No, continue with activity.	Please explain: (*e.g. low recording of BMI, excellent smoking status recorded*): How will this information be communicated to the practice team?
After reviewing your PIP QI measures from your latest benchmark report, are you happy with your results?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Please explain: (*e.g. we have a lower % of patients with alcohol status recorded*). How will this information be communicated to the practice team?
Are your practice patient measures similar to other practices in the Brisbane south region (compare information from benchmark report)?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Outline the differences: (*e.g. we're awesome at recording smoking status, other practices do better at alcohol status*) How will this information be communicated to the practice team?
After reviewing your patient lifestyle risk factors, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see action to be taken to help set you goals.** ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

BSPHN quality patient records QI toolkit

You may wish to refer to Brisbane South PHN Quality patient records QI toolkit. This toolkit is designed to assist you and your practice to maintain quality patient records.

Activity 6 – Strategies for improving participation in the cancer screening program/s

GPs are key to discussions around cancer screening, to promoting both informed choices in screening and increased participation.[10] The following primary care activities may lead to higher participation rates:

- Having a GP endorse an invitation to take a screening test.
- Utilising benchmark and trend reports provided by Brisbane South PHN.
- Using recall and reminder systems.
- Incorporate conversations about cancer screening tests as part of Medicare Benefit Schedule (MBS) health assessments (e.g. 45-49 year old health assessment, Aboriginal and Torres Strait Islander assessment).
- Identify if your practice cares for populations that are more vulnerable to missing out on their preventive health screening (e.g. some people from First Nations or culturally and linguistically diverse backgrounds may be less likely to participate in routine screening programs). Determine whether you have the necessary health promotion resources to better assist these populations. Refer to the patient populations QI toolkit for assistance with identification of patient demographics.
- Using programs and decision supporting tools (such as Topbar) to provide prompts if patient has not had screening completed.
- Including other team members to assist with identifying and promoting cancer screening.
- Participation in quality improvement programs incorporating audit and feedback on screening.

MBS health assessments

There are time-based MBS health assessment items: 701 (brief), 703 (standard), 705 (long) and 707 (prolonged). These are available for people between the age of 45 and 49 (inclusive) who are at risk of developing a chronic disease.

There is also an Aboriginal and Torres Strait Islander health assessment (MBS item number 715).

Ensure the template that is used to complete these assessments at your practice includes conversations about cancer screening.

Using Topbar to provide prompts for cancer screening

Pen CS have developed Topbar as an adjunct to the GP Clinical Desktop System to deliver useful tools and decision support information for the primary care sector at the point of care.

Topbar is designed to provide prompts and relevant information to all clinic staff based on the patients being seen and also those who are on the waiting list for the day. The user interface is minimalistic and allows the users to focus on the patient details and clinical information but provides important additional tools and information. Complete and accurate patient records are a key component of primary health care and Topbar assists all staff with this important aim.

[10] https://www1.racgp.org.au/newsgp/clinical/survival-rates-improving-through-cancer-screening

Activity 6.1 – Using Topbar to improve your practice data

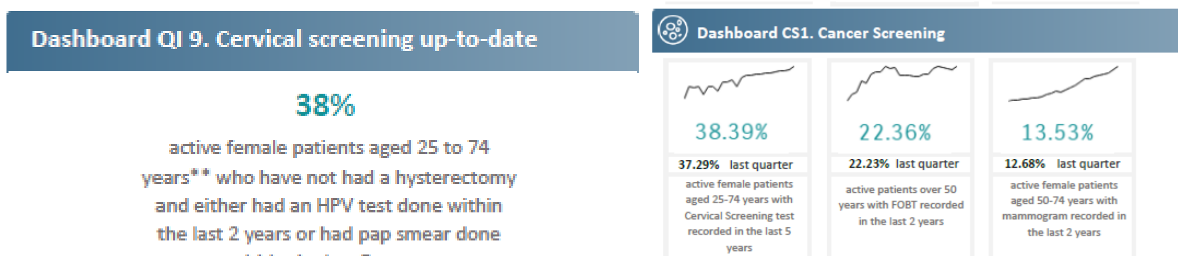
The aim of this activity is to ensure relevant team members have access to and use Topbar.

Description	Status	Action to be taken
Is Topbar installed on all workstations at your practice?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Follow the Running Topbar resource, or Follow the Topbar installation guide.
Have relevant team members been set up as a Topbar user?	☐ Yes, continue with activity. ☐ No, **see action to be taken**.	Follow the Managing Topbar users resource.
Have relevant Topbar users been set up with appropriate access rights?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Follow the Topbar access rights resource.
Do relevant team members understand all the Topbar apps?	☐ Yes, you have completed this activity. ☐ No, **see action to be taken.**	Refer to Topbar flip guide.
After reviewing your practice's Topbar use, are there any changes with the management of your patients you would like to implement over the next 12 months.	☐ Yes, **set goals and outline in actions to be taken**. ☐ No, continue with activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Activity 6.2 – Cancer screening measures on benchmark and trend reports

The aim of this activity is to review your practice's data dashboard and cancer screening table on the monthly benchmark and trend reports provided by Brisbane South PHN.

You will need your practice's benchmark and/or trend report to complete this information.



Cancer Screening **Preventative Health**

Figure PH2. Cancer screening graph

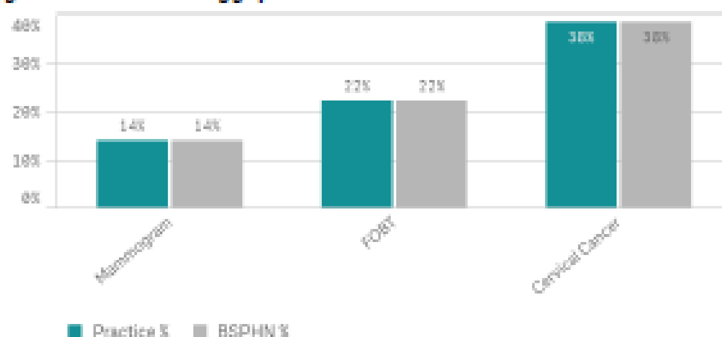


Table PH2. Cancer Screening table

Cancer Screening	-	- %	BSPHN	BSPHN %
Mammogram – Eligible Population*	188,301	-	188,301	-
Mammogram Recorded	26,106	14%	26,106	14%
Mammogram – Ineligible population	7,130	-	7,130	-
FOBT – Eligible Population**	364,709	-	364,709	-
FOBT Recorded	80,555	22%	80,555	22%
Cervical Cancer Screening – Eligible Population***	463,721	-	463,721	-
Cervical Cancer Screening Recorded	178,241	38%	178,241	38%
Cervical Cancer Screening – Ineligible population	23,969	-	23,969	-

	Description	Percentage current quarter	Percentage last quarter
6.2a	Active female patients aged 25-74 years with HPV test recorded in the last 5 years		
6.2b	Active patients 50 years and over with FOBT recorded in the last 2 years		
6.2c	Active patients aged 50-74 years with mammogram recorded in the last 2 years		

Activity 6.3 – Reviewing your practice benchmark and trend reports

Complete the checklist below which reviews your practices benchmark and trend reports.

Description	Status	Action to be taken
After completing **activity 6.2** are there any unexpected results with your cancer screening measures on your practice's benchmark and trend reports?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. only 20% of eligible patients have had an FOBT completed).* How will this information be communicated to the practice team?
Is your practice's data from your benchmark report similar to other practices in the Brisbane south region?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Outline the differences – (e.g. *our practice's recording of FOBT is higher than other practices).* How will this information be communicated to the practice team?
After reviewing your practice's benchmark and trend reports, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see action to be taken.** ☐ No: you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Successful Teams

Engaged and effective practice teams are the foundation for achieving sustainable improvements.

Consider how your team currently operates. Is your team working together effectively and efficiently? To achieve sustainable improvement, you will likely need to do some work on achieving a whole of team approach to cancer screening.

There are a range of responsibilities for the effective management of cancer screening within a health service. Documented role clarity is important to ensure efficiency and accountability. Below is an example of how responsibilities could be shared across the team. As there is a great deal of diversity between practices, consider what will work best for your team.

General Practitioners (GP)

- Respond to recall/reminder systems and engage in opportunistic discussions to encourage participation with eligible patients.
- Support eligible patients to participate in screening, including addressing potential barriers to screening (e.g. fear, embarrassment, lack of knowledge, access etc.).

- Identify patients eligible for self-collection of cervical screening test and discuss this option with those patients.
- Perform cervical screening tests and/or work with practice nurses to do so.
- Assess and support patients with follow up care following a positive result. Additionally, for bowel cancer screening, assist by reporting referrals for further investigation back to the NCSR.
- Work in accordance with clinical guidelines, including managing patients at increased risk of breast, bowel or cervical cancer: NHMRC approved guidelines.
- Maintain RACGP Standards for General Practice - Criterion GP2.2 - Follow up systems.
- Send MBS billing recommendations to reception.

Practice nurse

- Works with reception staff to promote the screening programs.
- Responds to recall/reminder systems and engages in opportunistic discussions to encourage participation with eligible patients.
- Supports eligible patients to participate in screening, including addressing potential barriers to screening (e.g. fear, embarrassment, lack of knowledge, access, cultural, linguistic barriers etc).

- Explains to patients how to use the bowel screening test kit.
- Performs cervical screening tests (if appropriately trained).
- Refers patients of any age with cancer symptoms or a family history to a GP for further investigation.
- Enters any screening results received, and an appropriate re-screen reminder, into the clinical software.
- Contacts and provides support to patients following a positive result and arranges a GP appointment.
- Follows up patients who did not attend a GP and/or colonoscopy appointment(s), addresses potential barriers to participation (e.g. fear, embarrassment, lack of knowledge, access etc).

Practice manager

- Maintains up to date cancer screening registers.
- Undertakes screening audits of practice records to identify eligible patients due for screening as well as targeting those never screened, under screened and/or specific vulnerable groups.

- Establishes and oversees recall/reminder systems.
- Supports GPs with the flow of information to and from the program register.
- Supports and manages reception staff responsibilities.
- Manages succession planning.
- Documents policy and procedures for cancer screening.
- Monitors progress against cancer screening goals and measures.

Reception staff

- Promotes the screening programs within the practice ensuring messaging is culturally safe and effective.
- Orders and maintains supplies of program resources.
- Displays brochures, flyers and posters.
- Responds to recall/reminders opportunistically when a patient phones for an appointment and/or by handing relevant resources to patients in the waiting area.
- Sends GP signed recall/reminder letters (and/or text messages and phone calls) to eligible (or soon to be eligible) patients to encourage participation.
- Provide resources and support information in alternative languages as needed.

Activity 6.4 – Practice team roles in cancer screening activities

Based on the example above, identify the person responsible for each part of the process required to complete cancer screening in general practice. Document each person's responsibilities in the table below.

Tasks for (insert QI Activity Name)		
	Name	**Responsibilities**
GP		
Practice Nurse		
Practice Manager		
Receptionist		

Activity 6.5 – Review task allocation

The aim of this activity is to review task allocation for team members in your practice.

Description	Status	Action to be taken
After completing **activity 6.4** have you considered how the patient bookings will be made?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Please explain: (*e.g. receptionist will phone each patient to make the appointment or patient will be sent a reminder letter and they will need to contact the practice to make an appointment).* How will this information be communicated to the practice team?
Have you considered how long to allocate for each appointment (for GP and nurse time)?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Consider holding a team meeting to decide on the length of time for each clinician – will this be on the same day or separate days? How will this information be communicated to the practice team?
Have you included how all the practice team (admin, nurse & GP) will be able to identify the nature of the appointment in the appointment book?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Please explain: (*e.g. our practice will use appointment icons to identify patient attending for a reminder or we will type in the appointment comments what the appointment is for*). How will this information be communicated to the practice team?

Description	Status	Action to be taken
Have you included who will update the patient reminder system to ensure continuity of care for the patient?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Outline who has the responsibility to update reminder system – is it GP, practice nurse, manager or receptionist (*consider a backup for when the main person is on leave)*. How will this information be communicated to the practice team?
Do all team members understand their roles and responsibilities?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Provide training to individuals or groups within your practice.
After reviewing your practice roles and responsibilities for managing cancer screening at your practice, are there any changes you would like to implement over the next 12 months?	☐ Yes, **see action to be taken to help set you goals**. ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Activity 7 - Cancer screening and recalls and reminders

As part of the RACGP accreditation standards, it is a requirement that practices provide health promotion, illness prevention, preventive care and a reminder system based on patient needs and best available evidence.

Brisbane South PHN have a comprehensive toolkit to assist you to review your practice recall and reminder systems, however, the aim of this activity is to assist with cancer screening specific recall and reminders.

You can also access other QI tools via medical software modules that will assist your practice to merge duplicate recall/reminder lists in your practice's clinical software. These modules are:

- Module 7 – Recalls, Reminders and Screening using MedicalDirector
- Module 8 – Recalls, Reminders and Screening using Best Practice

You can access these modules via DiscoverPHN.

National Cancer Screening Register

The National Cancer Screening Register (National Register) enables a single electronic record for each person in Australia participating in cervical and bowel screening.

The three main functions of the National Register are to:

- send invitation and reminder letters to participants
- provide a safety net for when a person is at risk
- provide a history of screening results.

Healthcare providers can also support participants to complete requests to the National Register, such as requesting to defer their next screening date. Patients will automatically be placed on the register.

Accessing the National Register

The following healthcare providers who provide cervical or bowel screening services may have access to the National Healthcare Provider Portal, including:

- general practitioners (GPs)
- nurses trained in cervical or bowel screening
- specialists such as gynaecologists and gastroenterologists
- Aboriginal and Torres Strait Islander health practitioners.

All healthcare providers will need to have a PRODA account. The portal allows access to patient screening history, due date for next screening, notification of referral and options to order a new FOBT kit. More information can be found: Quick Start Guide for Healthcare Providers.

The National Register has introduced an online portal for participants, accessed via myGov. Participants can update their personal details, manage their participation, nominate a healthcare provider, view previous correspondence, view screening status and request a bowel screening home test kit.

BreastScreen Queensland Register

The Queensland Health BreastScreen Queensland Register is a state-wide confidential patient information database that stores the number and characteristics of women screened, information about women recalled to assessment, number and size of breast cancers detected and treatment outcomes.

Activity 7.1 – Reminder system

The aim of this activity is to review your practice's reminder system for cervical, breast and bowel screening.

Description	Status	Action to be taken
Does your practice have a routine reminder for cervical screening (five years)?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	For instructions on creating a reminder in Best Practice or MedicalDirector.
Does your practice have a routine reminder for breast screening (mammogram) (two years)?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	For instructions on creating a reminder in Best Practice or MedicalDirector.
Does your practice have a routine reminder for bowel screening (FOBT) (two years)?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	For instructions on creating a reminder in Best Practice or MedicalDirector.
Do relevant team members know how to access the National Register?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to Healthcare providers accessing participant data through the National Register.
Do clinicians know how to initiate a patient reminder within clinical software?	☐ Yes, continue with activity. ☐ No, **see action to be taken**.	Education to be provided to relevant team members on creating and managing patient reminders.
Is there a system for ensuring patients recently eligible for screening are incorporated into the reminder system (*e.g. female turns 25 is now eligible for cervical screening)?*	☐ Yes, policy is working. ☐ Yes, policy is not working, **see action to be taken**. ☐ No policy, **see action to be taken.**	Revise policy. Practice policy on reminders to be implemented.
Does the recall and reminder system take into consideration patients with low English proficiency?	☐ Yes, policy is working. ☐ Yes, policy is not working, **see action to be taken**. ☐ No policy, **see action to be taken.**	Revise or implement practice policy. Letters and voice phone messages can be confusing for patients with limited or no English. Using the Translating and Interpreting Service to call the patient or sending text messages can be more effective. Consider using the online Appointment Reminder Translation Tool.

Description	Status	Action to be taken
After reviewing your practice recall and reminder system, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see action to be taken to help set you goals**. ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Activity 8 - Cancer screening resources for General Practice

SpotOnHealth Pathways

SpotOnHealth HealthPathways provides clinicians in the greater Brisbane south catchment with web-based information outlining the assessment, management and referral of over 550 conditions.

It is designed to be used at point of care primarily by general practitioners but is also available to specialists, nurses, allied health and other health professionals.

You can search for a particular topic and under each topic there is a range of information available that may include:

- information specific to Aboriginal and Torres Strait Islander peoples
- information specific to culturally and linguistically diverse communities
- assessment tools and pathways
- management steps according to the latest guidelines
- requests/referral pathways
- clinical resources
- patient information
- references.

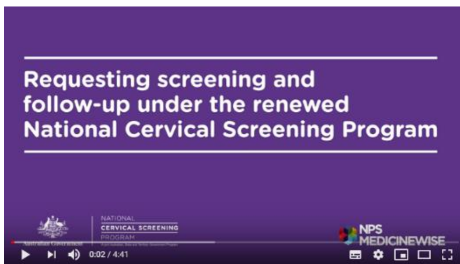
Resources for health professionals

- Understanding the National Cervical Screening Program Management Pathway: A Guide for Healthcare Providers
- Quick Reference Guide – Clinician collected cervical screening tests
- Pathology Test Guide for Cervical and Vaginal Testing
- Guidelines for preventive activities in general practice 9th edition (RACGP red book)
- HPV vaccine information for GPs and other health professionals
- National Cancer Screening Register Transition Quick Start Guide
- Cancer screening education for general practitioners – True relationships and reproductive health
- Cancer Council Australia:
- Advice about familial aspects of Breast Cancer – National Breast and Ovarian Cancer Centre
- Familial Risk Assessment tool (FRA-BOC) – Cancer Australia
- Clinical practice guidelines for the psychosocial care of adults with cancer – Cancer Australia
- Breast Cancer Clinical Guidelines – The pathology reporting of breast cancer (3rd edition 2008)
- Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer: A Guide for Patients, their families and friends
- National Bowel Cancer Screening Program – Guide for nurses working in general practice.

Cancer screening videos

Queensland Health have a suite of animated videos for screening, promoting screening and for patients needing diagnostic follow up, in relation to bowel and cervical screening. These can be used in reminder letters/SMS to patients to encourage screening or for those needing follow up tests.

- Bowel screening – Queensland Health
- Cervical screening - Queensland Health
- Colonoscopy – Queensland Health
- Colposcopy – Queensland Health



Video outlining the cervical screening test (warning: it contains clinical images).

NPS MedicineWise - video on requesting screening and follow-up under the renewed NCSP.

You may also wish to watch a cancer screening webinar from Pen CS.

Abnormal results guidelines

- National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities and investigation of abnormal vaginal bleeding
- Investigation of a new breast symptom – a guide for general practice
- Clinical Practice Guidelines for Surveillance Colonoscopy
- Screening strategies for people with a family history of colorectal cancer
- Guidelines for preventative activities in general practice – Colorectal cancer
- Guidelines for preventative activities in general practice – Breast cancer
- Family history assessment – Breast and Ovarian Cancer.

Health professional education modules

- Online training modules for clinicians covering the cervical screening changes from NPS MedicineWise
- Cancer Council Australia cervical cancer education modules (e-learning)
- Cancer screening education for general practice - True
- PDSA cycle for implementation of the National Cervical Screening Program – Self Directed Learning Activity for RACGP
- GP Online learning – Bowel Cancer – Cancer Council
- National Bowel Cancer Screening Program (GPs) – RACGP
- National Bowel Cancer Screening Program (Nurses) – APNA.

Patient resources

- National Cervical Screening test patient resources
- The National HPV Vaccination Program for parents and teens
- Cervical Screening for Aboriginal Women
- Multicultural patient information brochures
- Your Risk and Breast Cancer – Calculate your risk – online calculator for patients
- Request for Cancer Support – Cancer Council Queensland
- Mammogram – Cancer Council Australia
- Bowel Cancer resources.

Example PDSA for cancer screening

See below for suggested goals related to the cancer screening you may wish to achieve within your practice:

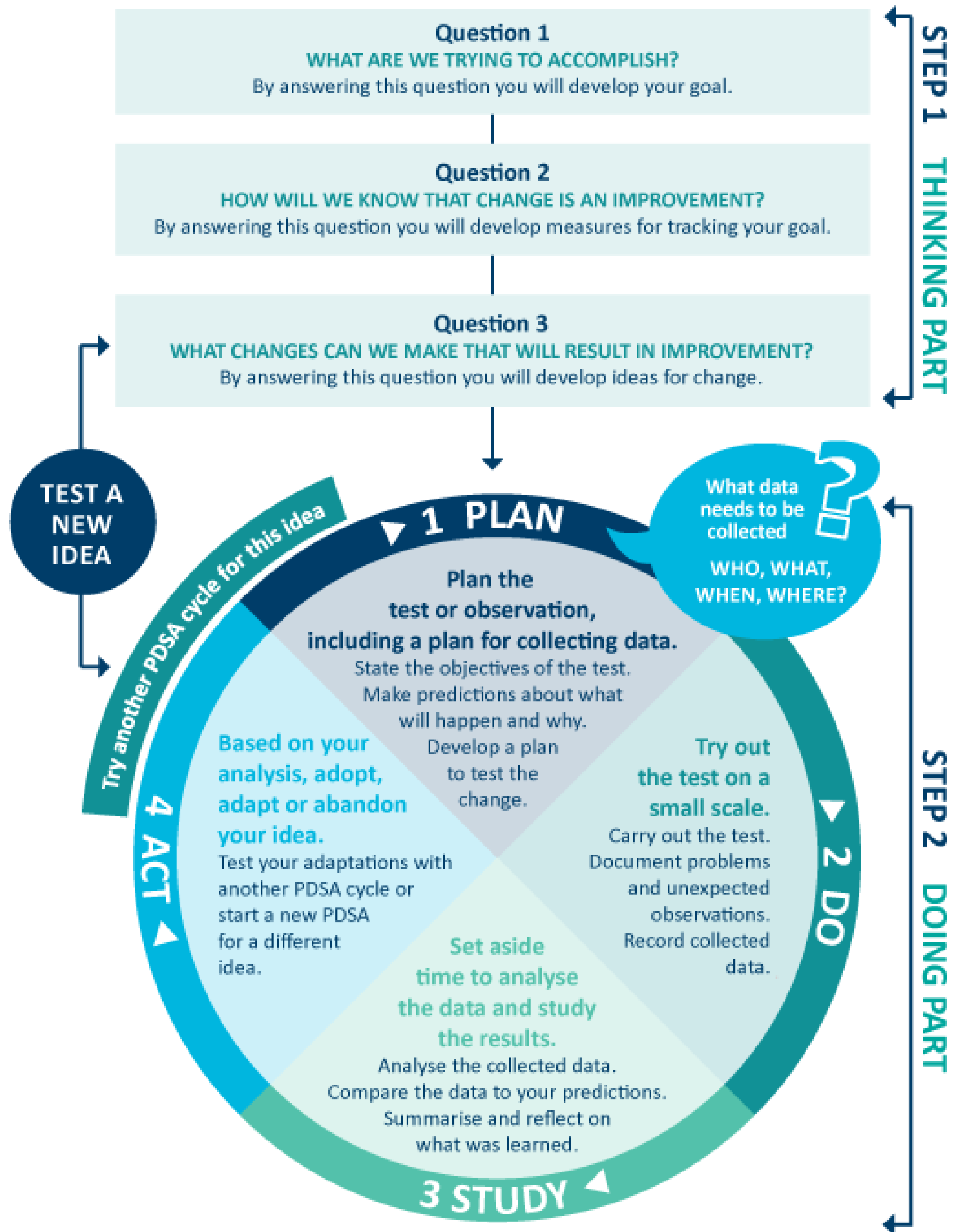
GOAL	HOW YOU MAY ACHIEVE THE GOAL
Increase the cervical screening of the number of eligible female patients by 10%.	Refer to CAT4 recipe: eligible for cervical screening
Increase the number of FOBT recorded on eligible patients by 15%.	Refer to CAT4 recipe: find patients who do not have a FOBT recorded.
Increase the number of mammograms recorded by 20%.	Refer to CAT4 recipe: find patients who have not had a mammogram recorded.

Other ideas for improving cancer screening measures

It is suggested that you meet in your practice team to discuss how at your practice you can improve cancer screening measures. Some suggestions you may consider include:

- ask the practice nurse to opportunistically see patients prior to their GP appointment to review cancer screening results and due dates
- ensure cancer screening prompts are included in 45-49 year old and Aboriginal and Torres Strait Islander health assessment templates
- actively contact patients who do not have measures recorded e.g.: proactively contact patients who are due and/or overdue for cancer screening
- ensure Topbar is installed on every workstation and fully operational.

Model for Improvement diagram



Source: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

MFI and PDSA template EXAMPLE

Step 1: The thinking part - The 3 fundamental questions

Practice name:	**Date:**
Team members:	
Q1. What are we trying to accomplish? (Goal)	
By answering this question, you will develop your GOAL for improvement. Record this as a S.M.A.R.T. goal (**S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime bound).	
Our goal is to: Increase the number of people who undertake bowel cancer screening. This is a good start, but how will you measure whether you have achieved this goal? The team will be more likely to embrace change if the goal is more specific and has a time limit. So, for this example, a better goal statement would be: *Our S.M.A.R.T. goal is to* increase the proportion of our patients aged 50 (first timers) that participate in bowel cancer screening by 15% by 31 December.	
Q2. How will I know that a change is an improvement? (Measure)	
By answering this question, you will determine what you need to MEASURE in order to monitor the achievement of your goal. Include how you will collect your data (e.g. CAT4 reports, patient surveys etc.). Record and track your baseline measurement to allow for later comparison.	
We will measure the percentage of active patients aged 50 years that participate in bowel cancer screening. To do this we will: A) Identify the number of active patients aged 50 years. B) Identify the number of active patients aged 50 years with a FOBT result. B divided by A x 100 produces the percentage of patients aged 50 years who have a FOBT result recorded. *This is a good measure, however, please note that as you measure this over time, some people who were included in earlier results will have turned 51 and will not be included. In later measurements, people who have just turned 50 will be included.* BASELINE MEASUREMENT: 27% of active patients aged 50 years have a FOBT result DATE:	
Q3. What changes could we make that will lead to an improvement? (List your IDEAS)	
By answering this question, you will generate a list of IDEAS for possible changes you could implement to assist with achieving your S.MA.R.T. goal. You will test these ideas using part 2 of this template, the 'Plan, Do, Study, Act (PDSA)' cycle. Your team could use brainstorming or a driver diagram to develop this list of change ideas.	
IDEA: Identify patients aged 49 by completing a search on CAT4. Contact these patients via letter, phone, SMS etc. to encourage participation in the bowel screening program. IDEA: Contact eligible patients aged 50 years and 6 months who have not had an FOBT recorded to discuss options for testing. IDEA: Add bowel cancer screening to templates for chronic disease management and 45-49 year old health assessments. IDEA: Clinical team develop a system for flagging eligible patients and addressing screening opportunistically. IDEA: Source and provide endorsed patient education resources (in waiting rooms, toilets etc.). IDEA: Run an awareness campaign for bowel cancer awareness month in June.	

Note: Each new GOAL (1st Fundamental Question) will require a new MFI plan.
Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

MFI and PDSA template

Step 2: The doing part - Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the 3rd fundamental question in step 1. You will use this template to test an idea. Ensure you communicate the details of the plan to the entire practice team.

IDEA	Record the change idea you are testing
Which idea are you going to test? *(Refer to Q3, step 1 above)*	
Contact eligible patients aged 50 years and 6 months who have not had an FOBT recorded to discuss options for testing. .	
PLAN	**Record the details of how you will test your change idea**
Plan the test, including a plan for collecting data	What exactly do you plan to do? Record who will do what; when they will do it (day, time etc) and for how long (1 week, 2 weeks etc); and where (if applicable); the data to be collected; and predictions about the outcome.
WHAT: John to use Sue's office to conduct search on CAT4 and identify active patients aged 50 years who have not had a FOBT result recorded. Searches will be conducted on CAT4 to identify the number of active patients aged 50 years who have not had a FOBT result recorded. Lists of patients will be provided to each GP for review. A Topbar prompt will be created for eligible patients for the vaccine. WHO/WHEN/WHERE: Who: Receptionist. When: 17 November. Where: Dr Brown's office. DATA TO BE COLLECTED: Number of active patients aged 50 years and the status of their FOBT result.	
DO	**Run the test, then record your actions, observations and data**
Run the test on a small scale	What did you do? Were there any deviations from the original plan? Record exactly what you did, the data collected and any observations. Include any unexpected consequences (positive or negative).
Done – completed 17 November – while the test went smoothly, the receptionist needed to contact PHN for support with the Pen CS search and the export function. A Topbar prompt was created which assisted the practice team identify patients who did not have a FOBT result recorded when they attended for an appointment. John contacted patients via SMS who did not have a FOBT results recorded, which resulted in 5 people making an appointment to see their GP.	
STUDY	**Analyse the data and your observations**
Analyse the results and compare them to your predictions	Was the plan executed successfully? Did you encounter any problems or difficulties? What worked/didn't work? What did you learn on the way? Compare the data to your predictions. Summarise and reflect on what was learned.
At the end of the focus on FOBT testing, 38% of patients aged 50 years have had a FOBT result recorded. This has resulted in an 11% increase in results which is 4% lower than our goal. Results have been shared with the whole practice team. Whilst we didn't achieve our goal, we can see the benefit in discussing this with eligible patients. John has been commended for his work in identifying eligible patients. *Communicate the results of your activity with your whole team. Celebrate any achievements, big or small.*	

ACT	Record what you will do next
Based on what you learned from the test, record what your next actions will be	Will you adopt, adapt or abandon this change idea? Record the details of your option under the relevant heading below. *ADOPT: record what you will do next to support making this change business as usual*; ADAPT: *record your changes and re-test with another PDSA cycle; or ABANDON: record which change idea you will test next and start a new PDSA.*
ADOPT: The practice will regularly monitor FOBT rates via the monthly benchmark report supplied by Brisbane South PHN to ensure the rates are increasing. John will ensure a Topbar prompt has been created for all patients aged 50 years and 6 months who do not have a FOBT result recorded. ADAPT: ABANDON:	

Repeat step 2 to re-test your adapted plan or to test a new change idea

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