





QUALITY IMPROVEMENT: GOAL SETTING

Ask the three questions:

| What are we trying to accomplish? By answering this question, you will develop your goal for improvement. | | |
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| To increase the number of our active patients aged 50 that participate in bowel cancer screening by 10% by XXXX | | |
| 2. How will we know that a change is an improvement? By answering this question, you will develop measures to track the achievement of your goal. | | |
| Via PEN CS we will be able to identify the number of active patients aged 50 who have not had an FOBT result recorded. An improvement will be measured by reviewing this data over a X month period. As we are focusing on patients who are aging into the bowel screening program, we are aware that over this period there may be an increase in the number of patients. | | |
| 3. What changes can we make that can lead to an improvement? List your ideas for change. By answering this question, you will develop the ideas you would like to test towards achieving your goal. Use the SMART approach when developing ideas (specific, measurable, attainable, realistic, timebound). E.g. By March 2020, complete 100% of HbA1c tests for all eligible (have not had a test in the past 6 months) active patients. | | |
| ldea 1. | Using PEN CS identify patients who are aged 49 and send personalised letters from their GP encouraging participation in the National Bowel Cancer Screening Program. | |
| ldea 2. | Include bowel cancer screening and other preventative health measures to health assessment and GP Management Plan templates. | |
| ldea 3. | Create preventive health alerts in patients files, to remind the clinical team to discuss and encourage the uptake of bowel cancer screening. | |













CHEALTH NETWORK

QUALITY IMPROVEMENT: PLAN, DO, STUDY, ACT CYCLE

| Idea being tested: From page 1: Idea 1,2,3 or 4 | Using PEN CS identify patients who are aged 49 years 10 months and send personalised letters from their GP encouraging participation in the National Bowel Cancer Screening Program. |
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| $\textcircled{\baselinetwidth}$ | Plan Who? When? Where? Data predictions? Data to be collected. |
| \ <u>`</u> / | Who: Practice Manager When: xx/xx/2021 Where: General Practice Data to be collected: Number of active patients aged 49. Data predictions: Approximately 50% of eligible patients will go on to complete FOBT kit. |
| = | Do Was the plan executed? Any unexpected events or problems? Record data. |
| ~// | Yes, plan executed without problems arising: CAT 4 data extracted by Practice Manager correctly National Bowel Cancer Screening Program letter template was personalised and sent to patients |
| | Study Analysis of actions and data. Reflection on the results. Compare to predictions. |
| | [insert number] of letters were sent to eligible patients [insert number] of patients completed the FOBT kit. |
| | Act What will we take forward; what is the next step or cycle? |



PRIMARY CARE



PRIMARY HEALTH NETWORK



Embed QI activity into standard reminder system to encourage patients to commence and continue participation in the National Bowel Cancer Screening Program.