Continuous Quality Improvement

WORKBOOK FOR GENERAL PRACTICE

PIP QI Ten Measures

EDITION 1 | JULY 2020

phn
NORTH WESTERN
MELBOURNE

An Australian Government Initiative

A new model for general practice improvement

Our aim is to strengthen primary care to deliver integrated person-centred care that is comprehensive, accessible, safe and coordinated. Our new model has three modules of engagement. Your level of engagement will depend on your needs.

Practice Improvement

Continuous Quality Improvement

Intensive Quality Improvement
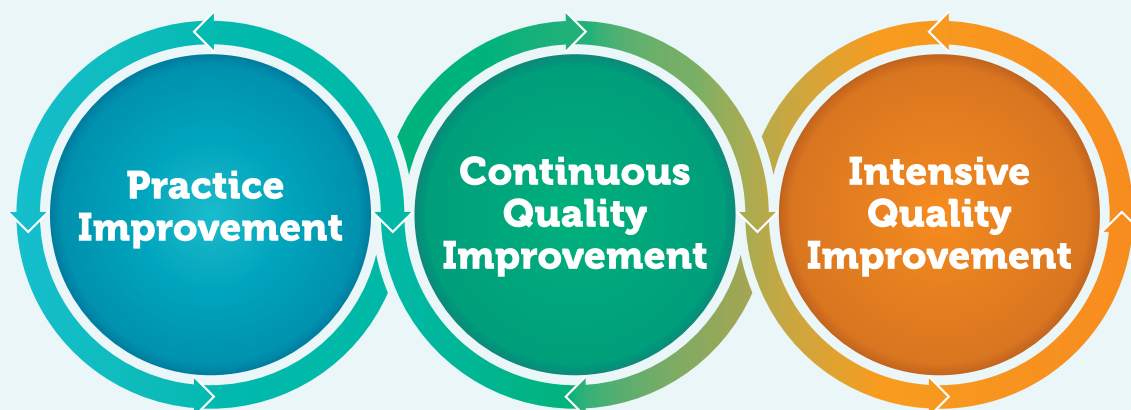
Focused on developing systems for quality improvement.

Focused on data-driven improvement. For accredited practices that share data and are new to quality improvement, or confident to implement quality improvement at their own pace.

A time-limited intensive facilitated quality improvement project for practices who want to further improve patient, clinical and whole of practice outcomes.

N20 0002 v.1

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Acknowledgements

About this workbook

This workbook is created as an interactive PDF. You can complete the tables in the book for your Priority 1 activity. Templates in the Appendix can be used for subsequent Priorities.

To complete this workbook, you will ideally use Adobe Acrobat or a similar compatible program to fill out the forms. If you add more content than what will fit in the text box, the text box will allow scroll for additional content to be added. Additional text will be shown with a + on the bottom of the panel. Please note that this additional content will not appear, however, if you print the document.

Your answers use only simple text formatting. You can paste into the text areas.

Contents

From little things, big things grow

This workbook will show you how to do the 'little' on the way to achieving the 'big'.

It's a clear, four-step guide that draws on a proven approach, the Model for Improvement, with activities and resources specific to the PIP QI Ten Measures.

The four steps are:

Step 1: Understand the PIP QI Ten Measures

Step 2: Analyse data, set goals and brainstorm potential improvements

Step 3: Create a plan and act on it, following the 'plan, do, study, act' cycle

Step 4: Evaluate and celebrate.

These steps are complemented by links to resources and a comprehensive set of Appendices (p. 42) covering:

- quality improvement and RACGP Standards (5th ed.)

- sample goals

- 'Plan, do, study, act' worksheet sample and template

- CAT4 'recipes'.

Using the Model for Improvement, you'll start small with your changes. You will then systematically review, refine and re-test your ideas as necessary before broader implementation. You'll find samples in Appendix 3 🔧 and a template for this system in Appendix 4 🔧.

It's a low-risk, high-return approach, and you'll have solid data to prove your achievements. But be warned—it's likely the process won't end there for your practice. Quality improvement can be a hard habit to shake.

"a healthy community, a healthy system"

Quality improvement (QI) workbooks

This workbook is part of a collection created by North Western Melbourne Primary Health Network (NWMPHN) to help general practices undertake self-directed quality improvement in a particular area of work, type of clinical practice or population group.

The workbooks have been created **by** general practice, **for** general practice, with input from NWMPHN teams and subject-matter experts, and through consultation with the community and the broader primary care sector.

They are designed to meet the particular needs of providers, patients and priority populations in the NWMPHN area. Links to appropriate local referral pathways are also included.

See a full list of QI workbooks on the NWMPHN website.

Before you start

The workbooks are designed to supplement the Quality Improvement Guide and Tools, **which we recommend reading first**. We've also included a primer about the Model for Improvement (MFI), to refer back to while using the workbook.
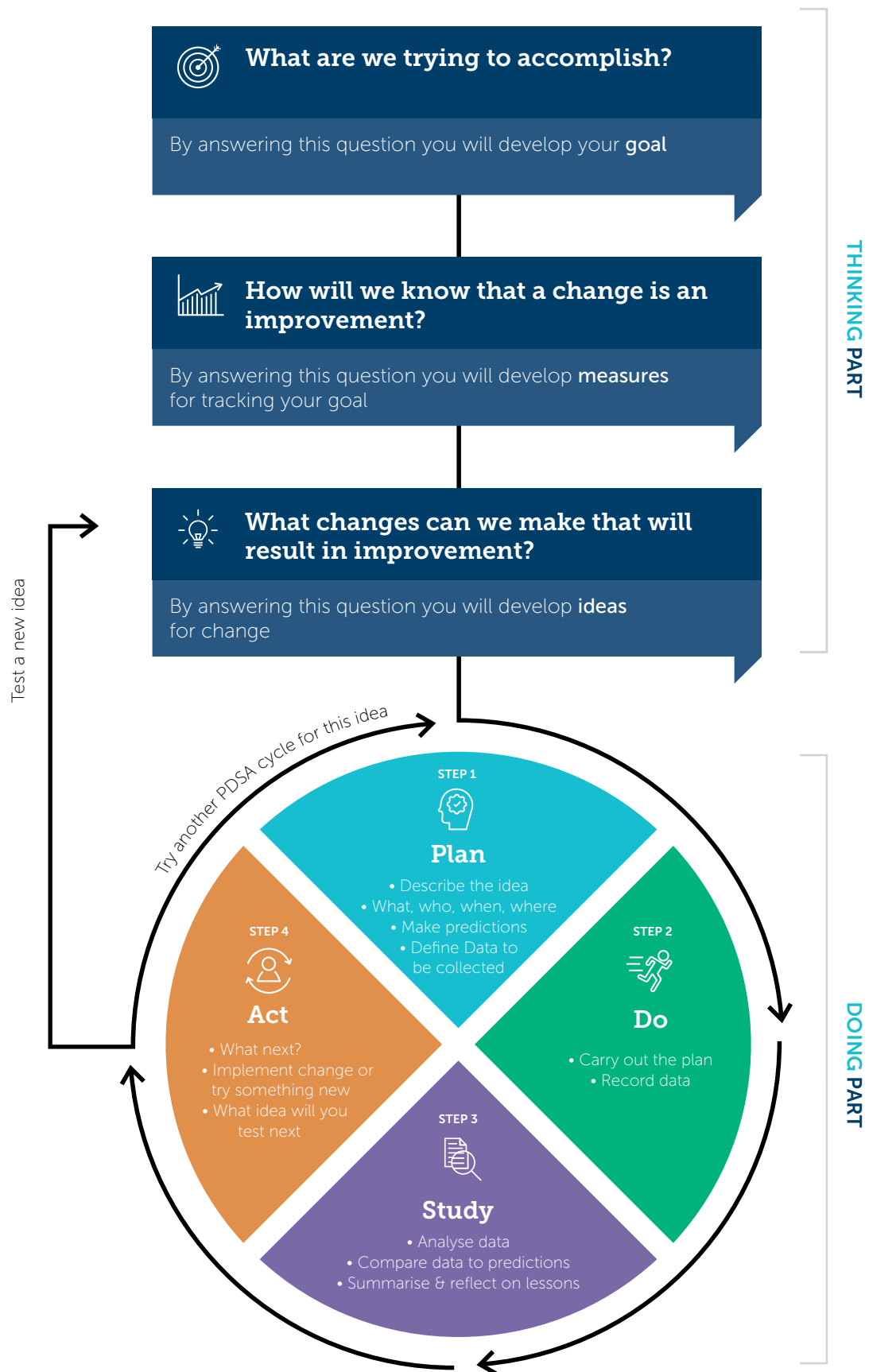
The Model for Improvement (MFI)

This is an evidence-based approach endorsed by leading health bodies, including the Royal Australian College of General Practitioners (RACGP) and the Institute for Healthcare Improvement (IHI).

It's easily applied and requires no specialist skills or background. It also has the advantage of encouraging creativity, and collegiality and collaboration.

Starting small is key, with change broken down into manageable pieces. This not only helps to reduce risk, but also to foster unity and avoid resistance to change. Proven changes can then be implemented more widely, while refined or new ideas can also be run through the mill.

As illustrated in Figure 1, MFI comprises a 'thinking part' and a 'doing part'. In the 'thinking part', you step through 'Goal', 'Measure' and 'Idea' (GMI). The 'doing part' consists of the 'Plan, Do, Study, Act' (PDSA) cycle. It's not a linear process—the idea is to cycle back and forth through both parts as often as required. (See Videos on the Model for Improvement in this workbook.)

Figure 1: The Model for Improvement and the Plan, Do, Study, Act cycle

What are we trying to accomplish?

By answering this question you will develop your **goal**

How will we know that a change is an improvement?

By answering this question you will develop **measures** for tracking your goal

What changes can we make that will result in improvement?

By answering this question you will develop **ideas** for change

THINKING PART

Test a new idea

Try another PDSA cycle for this idea

STEP 1

Plan
• Describe the idea
• What, who, when, where
• Make predictions
• Define Data to be collected

STEP 2

Do
• Carry out the plan
• Record data

STEP 3

Study
• Analyse data
• Compare data to predictions
• Summarise & reflect on lessons

STEP 4

Act
• What next?
• Implement change or try something new
• What idea will you test next

DOING PART

General practice considerations

Quality improvement in general practice can address one or more of the following:

- **Safety** – Avoiding harm to patients

- **Effectiveness** – Providing evidence-based care and only providing services likely to be of benefit

- **Patient-centricity** – Providing care that is responsive to individual patient's preferences, needs and values

- **Timeliness** – Reducing waiting times for care and avoiding harmful delays

- **Efficiency** – Avoiding waste

- **Equity** – Providing care of the same quality regardless of personal characteristics such as gender, ethnicity, location or socio-economic status.

Benefits and outcomes of QI in general practice are often categorised into four areas, as shown in Figure 2. Change that results in benefits across all four areas are said to have met the 'quadruple aim' – a useful target to keep in mind when developing your ideas.

Figure 2: The 'Quadruple Aim'

Improved Patient Experience	Improved Provider Experience	Population health	Sustainable Cost
Better care: safe, quality care	Increased clinician and staff satisfaction	Better health outcomes	Efficient and effective services
Timely and equitable access	Leadership and teamwork	Reduced disease burden	Increased resources for primary care
Patient and family needs met	Quality improvement culture in practice	Improvement in physical and mental health	Commissioning effectively

Links with PIP, accreditation and professional development

This workbook can be used by practices and individual professionals as evidence for:

- Practice Incentive Payment Quality Improvement (PIP QI)

- RACGP accreditation standards

- Continuous professional development points.

Appendix 1 🔧 has detailed information about how quality improvement activities included in this workbook can be used as evidence for continuing professional development (CPD) points for GPs and RACGP accreditation, including requirements relating specifically to the PIP QI Ten Measures.

Support from NWMPHN

For further support on implementing continuous quality improvement activities at your practice, contact your relationship manager at NWMPHN on (03) 9347 1188 or email primary.care@nwmphn.org.au

The use of the CAT4 data extraction tool

CAT4 is a data extraction tool that extracts and summarises key information about your practice population. It is compatible with a number of medical software systems and the PHN provides general practices with free access to the tool. This workbook uses CAT4 as a primary source of data, however you can still undertake quality improvement if you don't have CAT4. There may be opportunities to extract the same data (or a modified version of it) directly from your clinical system. If you need assistance, contact your NWMPHN relationship manager.

Your four steps to improvement

Step ① Understand PIP QI Ten Measures

General practices can now qualify for an Australian Government payment for their work to improve patient care and outcomes.

The Practice Incentives Program—Quality Improvement Incentive (PIP QI) started in August 2019 to reward quality improvement in general practice.

The program has defined **10 improvement measures** to help mitigate Australia's most prevalent chronic conditions. These measures are designed to improve the:

1 Proportion of regular patients with
diabetes with a current HbA1c result recorded in the last 12 months

2 Proportion of regular patients with
a smoking status recorded in the last 12 months

3 Proportion of regular patients with
a BMI recorded in the last 12 months

4 Proportion of regular patients
aged 65 and over who were immunised against influenza

5 Proportion of regular patients with
diabetes who were immunised against influenza

6 Proportion of regular patients with
COPD who were immunised against influenza

7 Proportion of regular patients with
an alcohol consumption status recorded in the last 24 months

8 Proportion of regular patients with
the necessary risk factors assessed to enable CVD assessment

9 Proportion of regular
female patients with an up-to-date cervical screening

10 Proportion of regular patients with
diabetes with a blood pressure result recorded in the last 6 months

Do we need to focus our quality improvement initiatives on the 10 improvement measures?

No, they are recommendations, not prescribed targets. Practices can choose to undertake quality improvement activities on any area where they have identified a need for improvement.

Note, however, that this workbook is for practices choosing to focus on one or more of the 10 Improvement Measures. It's designed to help practices review their data in relation to the 10 measures, identify priority areas, and then set specific targets, based on their current performance.

See a underlined full list of QI workbooks on the NWMPHN website.

Qualifying for PIP QI

General practices enrolled in PIP QI commit to:

1 Participating in continuous quality improvement activities in partnership with their local PHN

2 Sharing the PIP Eligible Data Set with their local primary health network (PHN) each quarter.

The 'Eligible Data Set' is data collected in relation to the 10 Improvement Measures.

Want to learn more?

For more information, visit the PIP QI page on the Australian Department of Health website.

Use HealthPathways Melbourne to research PIP QI topics

HealthPathways Melbourne (melbourne.healthpathways.org.au) is an online resource that gives clinicians up-to-date, localised clinical and referral information.

HealthPathways Melbourne provides clear, concise guidance for assessing and managing patients with particular symptoms or conditions, as well as outlining the most appropriate referral pathways.

How do I access HealthPathways Melbourne?

You will need a username and password. Request access online or complete this form to request automatic login.

To receive the monthly HealthPathways Melbourne Bulletin, email info@healthpathwaysmelbourne.org.au

Access is limited to health professionals in the North Western and Eastern Melbourne PHN catchments.

We recommend reviewing the following pages:

1   **Diabetes** (PIP QI measures 1, 5 and 10)

HealthPathways Melbourne has 14 pages of local (NWMPHN) information about diabetes, including pages on diagnosis, management, referrals and patient education.

Screening

• Screening and Detection of Diabetes and Pre-diabetes

• Eye Disease Screening in Diabetes

• Foot Screening in Diabetes

• Renal Disease Screening in Diabetes

Treatment and management

• Managing Type 2 Diabetes

• Newly Diagnosed Type 1 Diabetes - Adults

• Diabetes in Pregnancy

• Diabetes Medication Management

    • Glycaemic Control

    • Hypoglycaemia

    • Insulin

    • Self-Monitoring Blood Glucose (SMBG)

Recording HbA1c, influenza status (annually) and blood pressure are key process measures to help manage diabetes, and are the specific target of PIP QI measures 1, 5 and 10.

Also see the Diabetes QI Workbook.

2   **Smoking** (PIP QI measure 2)

There are many clinical pages with smoking as a key risk-factor. Go to HealthPathways Melbourne and use the search term 'smoking'. Key pages include:

• Smoking cessation advice

• Nicotine replacement therapy

• Tips and resources in adolescent health

• Lung cancer—suspected

3   **Weight** (PIP QI measure 3)

Like smoking, weight is a risk-factor in many clinical pathways. Obesity is a key risk-factor—and consequence—of many chronic diseases, while being severely underweight can also be a risk-factor for disease, or indicate an eating disorder or poor nutrition.

Go to HealthPathways Melbourne and use the search term 'weight' or 'obesity'. Key pages include:

• Weight management in children

• Weight management in adults

• Weight management in older adults.

4 **Influenza** (PIP QI measures 4, 5 and 6)

You're at greater risk of contracting influenza if you are diabetic, over 65 or have chronic obstructive pulmonary disease (COPD), so vaccination is recommended annually. HealthPathways has three relevant pathways:

- Influenza
- Immunisation—Influenza
- Comprehensive Medical Assessment for RACFs.

5 **Alcohol consumption** (PIP QI measure 7)

Excessive alcohol consumption is linked to conditions including liver disease, cardiovascular disease and mental ill health. In some cases it may result from alcohol dependence. The following pages are most likely to be relevant:

- Alcohol withdrawal
- Alcohol use and dependence
- Low-risk alcohol and drug treatment assessment
- LGBTI alcohol and other drugs
- Tips and resources in adolescent health.

Also see the Alcohol and Other Drugs QI Workbook.

6 **Risk factors assessed to enable CVD assessment** (PIP QI measure 8)

Cardiovascular disease (CVD) assessment for patients aged 45 and older (or 30 and older for Indigenous Australians) is made once the following information is recorded: tobacco smoking status, diabetes status, systolic blood pressure, total cholesterol and HDL cholesterol levels, age and sex. (See Medicare Benefits Schedule Item 699.)

See the HealthPathways Melbourne page Absolute Cardiovascular Disease Risk Assessment and the Australian absolute CVD risk calculator.

7 **Cervical screening** (PIP QI measure 9)

Appropriate cervical screening ensures that more women with precancerous abnormalities can have these detected and treated, thereby reducing mortalities and the incidence of cervical cancer.

See the Cervical Screening page on HealthPathways Melbourne.

See the Cancer Screening QI workbook on the NWMPHN website.

Step 2 Work as a team to collect data and develop goals

Now you've done your background research, it's time to establish a brains trust and start examining ideas. By the end of this section, you'll be able to answer these key questions:

Goal
What are we trying to accomplish?

Measure
How will we know that a change is an improvement?

Idea
What changes can we make that will result in an improvement?

Team up

Evidence shows that improvement is most likely when all staff support change, so adopt a whole-of-team approach from the outset.

Form a QI project team

Your project team should include representatives from your whole-of-practice team. It might include your practice manager, reception and other administrative staff, nursing staff, GPs and allied health practitioners.

For each project, you will need at least two project leads:

1 A lead GP to inform any clinical content

2 Another person in your team capable of managing the project, who will be given protected time to complete the work required.

As your practice becomes more experienced with quality improvement, you may consider including a patient in your project team – they can provide great insight from a patient perspective, particularly if the focus of your QI activities includes measuring and improving patient experience. Page 15 of the Quality Improvement Guide and Tools provides more ideas on how to include patients in your QI activities.

Download the NWMPHN Team Health Check PDSA* and Improvement Foundation's Team Health Check Score Sheet* to help you assess your team culture and identify roles and responsibilities. Along the way, you might also identify team members who might resist change, as well as potential issues or matters to address before your project begins.

*Documents will download directly from the links

Collect baseline data

There is a saying that 'what gets measured gets done.' So collect and collate as much relevant data as you can. This will help you accurately assess the current situation and pinpoint exactly where you want to improve. It will also give you a 'baseline' against which success (and failure) can be measured objectively.

Some baseline data is straightforward, such as clinical data retrieved from CAT4 searches. By contrast, information such as 'staff knowledge' or 'patient experience' is harder to measure but may be no less important. (See Videos on the Model for Improvement on p. 41.)

Baseline data may include, but is not limited to:

- CAT4 data

- practice system audits

- environment audits

- measurement of patient experience

- measurement of staff experience

- measurement of current staff knowledge and confidence.

Note too, that NWMPHN will also send quarterly reports to practices on their performance in relation to the Improvement Measures, and in relation to the aggregated performance of other NWMPHN general practices. This information may also be useful in establishing your baseline data.

Stop and 'cleanse' your data

'Clean' data going in means 'clean' data coming out. Guides for undertaking a 'data cleanse' include:
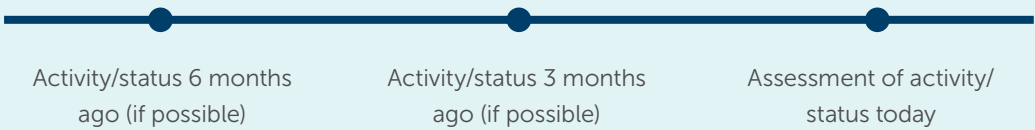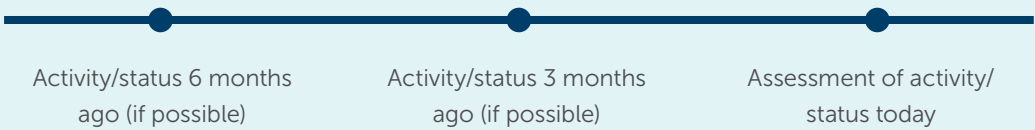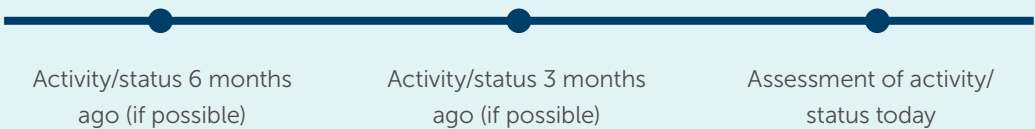
- CAT4: Pen CS Data Cleansing Guide

- Medical Director: Data cleansing in Medical Director (Sydney North Health Network)

- Data cleansing in Best Practice: Best Practice's data clean up guide or Sydney North Health Network's Best Practice Data Cleansing Guide

- A Quality Improvement activity: Data Cleansing QI Activity (North Western Melbourne PHN).

Activity Table 1 on the next page, will help you collate your baseline data.
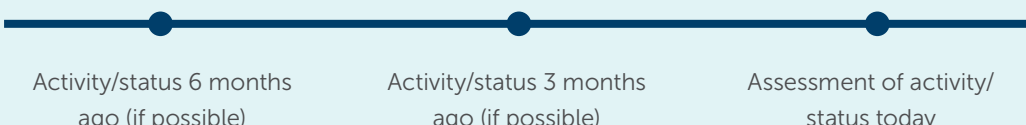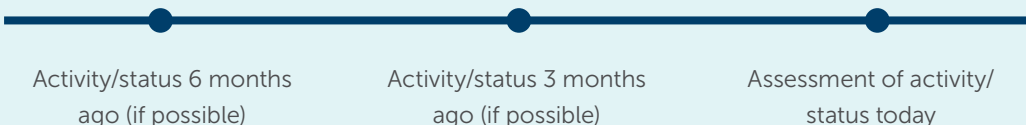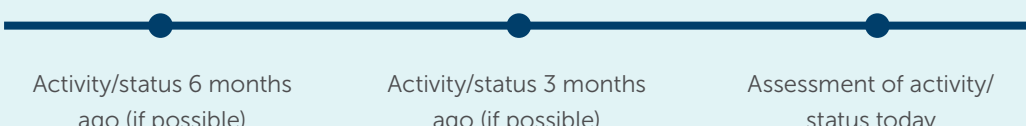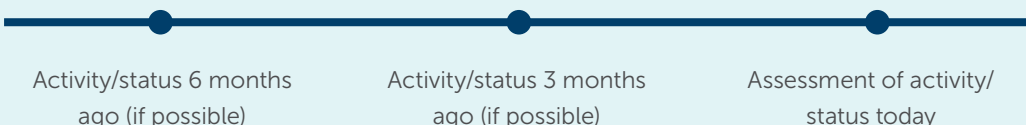
CAT4 is your data source for Activity Table 1. CAT4 has been well set up to enable you to extract all the data you need for each of the 10 measures. Refer to the PEN CS guide Using CAT4 and Topbar for PIP QI activities for help on collecting your baseline data using CAT4.

See your most recent CAT4 quarterly report from your PHN for the current PHN averages. Reports periods are marked in each PIP QI measure on Activity Table 1.

Activity Table 1: Collating baseline data

| 1 | **Proportion of patients with diabetes with a current HbA1c result recorded in the last 12 months** |
| | Activity/status 6 months ago (if possible) · Activity/status 3 months ago (if possible) · Assessment of activity/ status today |

| 2 | **Proportion of patients with a smoking status recorded in the last 12 months** |
| | Activity/status 6 months ago (if possible) · Activity/status 3 months ago (if possible) · Assessment of activity/ status today |

| 3 | **Proportion of patients with BMI recorded in the last 12 months** |
| | Activity/status 6 months ago (if possible) · Activity/status 3 months ago (if possible) · Assessment of activity/ status today |

| 4 | **Proportion of patients aged 65 and older who were immunised against influenza** |
| | Activity/status 6 months ago (if possible) · Activity/status 3 months ago (if possible) · Assessment of activity/ status today |

| 5 | **Proportion of patients with diabetes who were immunised against influenza** |
| | Activity/status 6 months ago (if possible) · Activity/status 3 months ago (if possible) · Assessment of activity/ status today |

Activity Table 1: Collating baseline data (continued)

6

Proportion of patients with COPD who were immunised against influenza

Activity/status 6 months ago (if possible) — Activity/status 3 months ago (if possible) — Assessment of activity/ status today

7

Proportion of patients with an alcohol consumption status recorded in the last 24 months

Activity/status 6 months ago (if possible) — Activity/status 3 months ago (if possible) — Assessment of activity/ status today

8

Proportion of patients with the necessary risk factors assessed to enable CVD assessment

Activity/status 6 months ago (if possible) — Activity/status 3 months ago (if possible) — Assessment of activity/ status today

9

Proportion of female patients with an up-to-date cervical screening

Activity/status 6 months ago (if possible) — Activity/status 3 months ago (if possible) — Assessment of activity/ status today

10

Proportion of patients with diabetes with a blood pressure result recorded in the last 6 months

Activity/status 6 months ago (if possible) — Activity/status 3 months ago (if possible) — Assessment of activity/ status today

* Add any other measures you think are relevant including any patient feedback you already have in hand – this is valuable baseline data!

Reflect on the data

Reflect on the information you've compiled. You might consider the following questions:

- How does your performance compare to benchmarks and standards?

- Does any data surprise you?

- How does the data compare from year-to-year? Can significant differences be explained?

- Are there clear areas for improvement that could form the basis of your QI project?

Based on this discussion, identify and prioritise key areas for improvement using Activity Table 2 ✎.

Remember – You don't need to improve in all areas at once. You might decide to concentrate on one measure at a time. How you do this is up to you. You can pick and choose ideas in this workbook to suit the approach that best meets your practices needs.

Activity Table 2: Analysing baseline data

Item	✎ Identified area for improvement	✎ Number each in order of priority for improvement (i.e. 1, 2, 3, etc.)
1		
2		
3		
4		
5		
6		

✎ Completed by:	✎ Date:

Set a goal

Now that you have identified the top priority area for your practice, the next step is to work together to set a goal for this area. Goals should be 'SMART', so ask if each goal is:

- **Specific** – Does the goal say exactly what we want to achieve?

- **Measurable** – Have we included a measurable target, such as 'increase cervical screening rates among appropriate women by 50 per cent'?

- **Achievable** – Is it likely our practice will be able to accomplish the goal?

- **Relevant** – Does the goal align with our practice's broad vision and aims?

- **Time-based** – Do we have a clear deadline for achieving our goal? (Deadlines should be challenging but realistic.)

Group Improvement Measures together where possible

Improvement Measures that address the same condition or presentation can be neatly grouped under a single goal.

For example, consider addressing all three diabetes-related Improvement Measures at once, to avoid double-ups when addressing each separately. Table 1 provides samples of goals that address multiple Improvement Measures. (See Appendix 2 🔧 for more PIP QI sample goals.)

Table 1: Sample goals that address multiple Improvement Measures

Sample Goal	PIP QI measures addressed
Influenza: To increase the number of active patients immunised against influenza to 80 % for each of the following categories—65 and older, diagnosed with diabetes, and diagnosed with COPD—by the end of October 2020 (that is, the conclusion of the extended flu season).	4, 5 and 6
Diabetes: To record HbA1c and blood pressure for at least 90 % of active patients with diabetes by 31 December 2020. Also ensure that all diabetic patients seen during flu season are offered an influenza vaccination.	1, 5 and 10
Lifestyle factors: To record smoking, weight, and alcohol consumption information for 80 % of our patient population by 30 September 2020.	2, 3 and 7

Describe your goal

Once you have established your first goal, describe it in more detail in Activity Table 3.
(This table will also be used for any subsequent goals.)

Activity Table 3: Set a goal for the top priority area

✎ Our priority for improvement is:	✎ Our target population is:
✎ Our goal is to:	✎ Check that the goal is: Specific　　Measurable　　Achievable Relevant　　Time-based

✎ We will use the following measures to know if we've been successful:

Measure:	Source:
Measure:	Source:
Measure:	Source:
Measure:	Source:

Etc. (Add more as appropriate)

✎ We want to achieve our goal by:	✎ We will collect our measures every: e.g. 1st of the month, two months, quarter, six months.

Brainstorm ways to achieve your goal

Now use Activity Table 4 to prioritise activities that your practice can undertake to achieve its goal or goals. Activities might include, but are not limited to:

- staff training and education
- system changes
- workplace/environmental changes
- regular reviews/audits/meetings.

There is no minimum or maximum number of activities. As a guide, we have provided room to record six.

See brainstorming tools for identifying a change idea, recommended by IHI, including:

- Affinity Tool
- Five Whys
- Driver Diagram
- Flow Chart
- Cause and Effect (Fishbone)

Activity Table 4: Brainstorm of ideas for implementing change

Idea no.	✎ Activity	✎ Expected outcomes
1		
2		
3		
4		
5		
6		

✎ Completed by:	✎ Date:

Sample activities for PIP QI

Adjust these sample activities to suit your needs, strike-off those you've already done, or develop your own activities.

General

These activities could apply to any goal:

- Introduce the new QI project at the next all-staff meeting, and discuss it at regular meetings. Talk about rationale, targets, activities, and roles. Invite ideas for any other activities which may help achieve the goal.

- Discuss the new QI project at the next clinical meeting, to address clinical-specific issues and tactics. Add it to regular meeting agendas.

- Have relevant staff complete education/online training/online learning modules by a specified date.

- Develop a poster for the waiting room/consulting rooms on the area of focus.

- Source patient information about your area of focus in English and other appropriate languages. See the Victorian Government's Health Translations and Better Health Channel websites.

- Develop a reminder sticker for GPs' and nurses' computers to remind them about the area of focus.

- Add an update to the staff newsletter about the project, its aim and starting position, as well as updates on outcomes in subsequent newsletters.

- Ensure Topbar is installed on every workstation and fully operational if compatible with medical software. This useful application can assist you to see where data is missing.

Diabetes

- Ensure all active patients with diabetes are 'coded' correctly, as either Type I or Type II. (See the Pen CS guide on this topic.)

- Review all patients with indications for diabetes but no diagnosis recorded and code them either as diabetic (Type I or II) or not diabetic. (See the Pen CS guide on this topic.)

- Send out a recall SMS and/or letter to all patients on the Type I or Type II diabetes register who have not had a blood pressure or HbA1c or both measured in the past 12 months. Repeat every quarter to capture new patients or existing patients now eligible for recall. Revise the plan for patients who did not respond to the original SMS and/or letter. (See the Pen CS guide on this topic.)

- Consider sending a pathology form to patients prior to their appointment, either by post or email, to streamline the appointment. Most patient management software will allow a nurse to generate a pathology form and handwrite the GP's name and provider number, for approval and signing by the GP.

- Create a prompt in Topbar so that clinicians are reminded to follow up eligible patients during any type of consultation. (See the Pen CS guide on this topic.)

Recording lifestyle information

- Change practice procedures so that nurses can take the opportunity to see patients prior to GP appointments to collect height, weight and waist measurements, blood pressure, and smoking and alcohol consumption status.

- Routinely ask new and returning patients to complete (or update) a brief patient information form in the waiting room, providing their height, weight, smoking status and weekly alcohol consumption, and checking contact details (address, phone number), next-of-kin and emergency contact details.

- Create a prompt in Topbar so that clinicians are reminded to complete smoking status, weight classification and alcohol consumption for relevant patients during any type of consultation. (See the Pen CS guide on this topic.)

Influenza immunisation

- Ensure you have cleansed your data (prior to doing Activity 1). Make sure this includes:

    - reviewing all patients with indications for diabetes but no diagnosis recorded, and coding them either as diabetic (Type I or II) or not diabetic

    - reviewing all patients with indications for COPD but no diagnosis recorded, and confirming them as 'diagnosed COPD' or 'no diagnosis'

- Ensure all active patients with diabetes are 'coded' correctly, as either Type I or Type II. (See the Pen CS guide on this topic.)

- Confirm the practice's system for convenient influenza vaccination. For example, scheduling nurse-led clinics on certain days/times. (Brisbane South PHN's Flu Vaccine QI Toolkit has useful information about this.)

- Send out a recall SMS and/or letter to the following groups of patients who have not received an influenza immunisation in the past 15 months:

    - patients 65 and older

    - patients with Type I or Type II diabetes

    - patients with COPD.

- Repeat annually to capture new patients or existing patients eligible for recall. Revise the plan for patients who did not respond to the original SMS and/or letter. (See the Pen CS guide on this topic.)

- Send out a recall letter via mail merge to all patients on the Type I or Type II diabetes register who have not had an influenza vaccine in the past 15 months. Repeat every quarter to capture new patients or existing patients eligible for recall. Revise the plan for patients who did not respond to original letter.

- Create a prompt in Topbar so that clinicians are reminded to follow up with eligible patients about influenza vaccinations during any type of consultation. (See the Pen CS guide on this topic.)

- Ensure there is a standard process for recording information so that clinicians:

    - update influenza vaccine recalls to next year if the current year has been done

    - document if flu vaccines have been done at a patient's workplace (not by practice)

    - code correctly in medical software.

CVD risk-factor assessment (basic)

- Hold a clinical meeting on CVD risk assessments and ensure all clinical computers have access to a risk assessment tool such as the Australian absolute cardiovascular disease risk calculator.

- Send out a recall SMS and/or letter to all patients missing CVD risk-factor information. Repeat or revise the plan every quarter for patients who did not respond to the original SMS and/or letter. (See the Pen CS guide on this topic.)

- Send out a recall letter via mail merge to all patients who are missing CVD risk-factor information. Repeat or revise the plan every quarter for patients who did not respond to the original letter.

- Create a prompt in Topbar so that clinicians are reminded to collect eligible patients' risk-factor information during any type of consultation. See the Pen CS guide on this topic.

CVD risk-factor assessment (intermediate)

- Prepare information for clinicians about the appropriate referrals and information on the Medicare Benefits Schedule (MBS) Heart Health Item Number 699 to help patients to improve their lifestyles to reduce CVD risk. (See the Australian absolute cardiovascular disease risk calculator and the Heart Foundation's Heart Health Checks.)

- Prepare patient information about appropriate services, lifestyle changes, activities and medications to reduce CVD risk.

- Create a list of all patients (in CAT4) with a >15 per cent risk of a CVD event (such as a heart attack or stroke) in the next five years (high risk) and give to GPs to review clinically. Recall these patients by SMS or letter. (See the Pen CS guide on this topic.)

- Create a list of all patients (in CAT4) with a 10 to 15 per cent risk of a CVD event (such as a heart attack or stroke) in the next five years (medium risk) and give to GPs to review clinically. Recall these patients by SMS or letter. See the Pen CS guide on this topic.

- Create a prompt in Topbar so that clinicians are reminded to collect eligible patients' risk-factor information during any type of consultation. (See the Pen CS guide on this topic.)

Cervical screening

- Send out a recall letter and an SMS and/or voice message, to all patients eligible for a cervical screening test (women aged 25–74 who have not had a hysterectomy and have not had an Human Papillomavirus (HPV) test since 1 December 2017 and within the previous five years). Repeat every quarter to capture new patients and existing patients eligible for recall. Revise the plan every quarter for patients who did not respond to the original SMS and/or voice message. (See the Pen CS guide on this topic.)

- Create a prompt in Topbar so that clinicians are reminded to follow up with eligible patients during consultations. (See the Pen CS guide on this topic.)

- For patients who are unsure about their cervical screening history, use the National Cancer Screening Register to retrieve information.

Step 3 Plan, Do, Study, Act – time to get 'cycling'

You're now ready to take action, using a 'Plan, Do, Study, Act' (PDSA) cycle for each activity you've decided to implement.

To get started, take the activities you've listed and prioritised in Activity Table 4 ✎ and assign a responsible person/persons, and intended due dates, to keep the activities moving along. Use Activity Table 5 ✎, and regularly check in on your team's progress. This is part of the 'plan' part of the cycle. (You may also want to review the explanation of PDSA under The Model for Improvement heading in the introduction to this workbook.)

Activity Table 5: Timeframes and responsibilities

1	✍ **Activity**
	✍ **Person responsible**　　　　✍ **By when**
	✍ **Expected outcomes**

2	✍ **Activity**
	✍ **Person responsible**　　　　✍ **By when**
	✍ **Expected outcomes**

3	✍ **Activity**
	✍ **Person responsible**　　　　✍ **By when**
	✍ **Expected outcomes**

Activity Table 5: Timeframes and responsibilities (continued)

4	**Activity** **Person responsible**　　　　　**By when** **Expected outcomes**
5	**Activity** **Person responsible**　　　　　**By when** **Expected outcomes**
6	**Activity** **Person responsible**　　　　　**By when** **Expected outcomes**

Next, create copies of this PDSA table and fill one out for **each activity**. This will help you to break your project down into manageable chunks, allocate responsibilities more easily, and accurately assess what's working and what's not. Ensure that each PDSA table includes details of who is doing what, and by when, to keep your project on track.

Note that you can run more than one PDSA at a time. This will depend on the change you're making, and the time it's likely to take before any measurable improvement. If results are likely to take longer (more than a month, for example, or a year), running separate, sequential PDSAs for each activity would mean the project would take too long.

PDSA cycle template

You've got your plan and are now ready for the 'doing'—that is, to start 'cycling' through PDSAs. Use Activity Table 6. See also Appendix 3: PDSA worksheet samples 🔧 on page 51 for samples of completed forms.

Activity Table 6: PDSA cycle template

✍ Priority area number	✍ Priority area goal
✍ Activity number	✍ Staff member responsible
✍ Date started	✍ Date completed

Plan

Plan the test, including a plan for collecting data

Describe the brainstorm idea you are planning to work on. (Idea)

What exactly will you do? Include what, who, when, where, predictions and data to be collected.

Idea (activity)

What (step-by-step)

Who

When

Where

Prediction

Data to be collected

Baseline

Do

Run the test on a small scale

Carry it out, and describe how you went (Action)

Was the plan executed successfully?

Did you encounter any problems or difficulties?

Study

Analyse the results and compare them to your predictions

Does the data show a change? (Reflection)

What does the data say?

Did you meet your predictions, or did you fall short?

Act

Based on what you learned from the test, plan for your next step

Do you need to make changes to your original plan? (What next?) OR Did everything go well?

If this idea was successful you may like to implement this change on a larger scale or try something new.

If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.

Repeat Step 2 for other ideas. What idea will you test next?

Tip: Do your first lot of activities for your first priority then proceed to manage and monitor your progress/success. Begin again on page 20 (setting a goal section) when you're ready to tackle the process again for your next priority area.

Manage and monitor your project

Now you're in the swing of things, ensure you monitor the project regularly, with an eye on your 'baseline data'.

Ensure each PDSA template for each project activity is completed as the activity is completed. As soon as practical, reflect on how the activity went, and any obstacles, and decide whether to continue with the change, or amend it and try it again.

Look back at the data you collected in Activity Table 1 ✎, as well as any other measures you decided to collect as part of your project.

Now collect the same data again and complete Activity Table 7. As you do, assess whether there's any improvement since the last measurement. If not, consider why not. Is it too early to see change, or is an extra effort needed to push performance along? And what might be the best activity to tackle next?

Manage and monitor — tips for successful PDSA

- Allocate 'protected time' so that those responsible can effectively implement the changes.

- Set dates in the project team's calendars **now** for reviewing the project. Use the PDSA due dates as a guide, and also set regular review periods (perhaps monthly or quarterly). Regular monitoring is important so that the team can support and encourage each other to complete activities.

- Keep your project team and other practice staff well-informed.

- Catch-up with staff about their PDSAs and offer support where needed.

- Conduct regular check-ups, both to help encourage staff, and to iron-out issues.

Activity Table 7: Measure and monitor

1	✎ **Measure**
	✎ **Source of data**
	6 months before project · 3 months before project · Start of project · 3 months into project · 6 months into project

Activity Table 7: Measure and monitor (continued)

2

✍ **Measure**

✍ **Source of data**

| 6 months before project | 3 months before project | Start of project | 3 months into project | 6 months into project |

3

✍ **Measure**

✍ **Source of data**

| 6 months before project | 3 months before project | Start of project | 3 months into project | 6 months into project |

4

✍ **Measure**

✍ **Source of data**

| 6 months before project | 3 months before project | Start of project | 3 months into project | 6 months into project |

Activity Table 7: Measure and monitor (continued)

5	✎ **Measure**
	✎ **Source of data**

| 6 months before project | 3 months before project | Start of project | 3 months into project | 6 months into project |

6	✎ **Measure**
	✎ **Source of data**

| 6 months before project | 3 months before project | Start of project | 3 months into project | 6 months into project |

* Copy the relevant data results from Activity Table 1 ✎, but note the order of columns
are different here.

Step 4 Evaluate and celebrate

Evaluation is, of course, a regular and integral part of the PDSA process. But it's also important to conduct broader evaluations of the overall project, which is what Step 4 is all about.

Once you have completed all activities for a priority area, reflect on the process, and complete Activity Table 8 on the next page, as a team.

Celebrate and share

Celebrating your success doesn't just feel good—it will help you capitalise on your quality improvement efforts. Under the Model for Improvement, quality improvement is a 'virtuous cycle'. Each benefit has a positive effect on the next, leading to a 'snowball' of improvement.

By celebrating your 'wins', you'll engage your practice team more deeply with your QI project, enhance morale and foster a culture where striving for improvement is as integral as payroll— or lunch!

Depending on the stage and scale of your success, you could share results at staff meetings, hold a celebratory lunch, post your achievements in the waiting area, or even in local media or online.

Has your practice completed a quality improvement activity or project that you'd like to share?

Submit your case study, resources or photos to primarycare@nwmphn.org.au

What's next?

Now that you have completed these activities for priority one, it is time to tackle your next priority. Head back to Activity Table 2 ✏ on page 19 to identify the next priority area for your practice and work through the activities again. You can use the sample templates in Appendix 3 🔧.

Activity Table 8: Evaluate achievements

✍ **Did you achieve your goal?**

✍ **What are you most proud of?**

✍ **What were the things that helped you?**

✍ **Were there any barriers?**

✍ **How did you overcome these?**

✍ **What were the changes for: • Patients • Staff/Clinicians • Population • Business?**

✍ **What would you have done differently?**

✍ **What are your next steps for the changes that were made?**

Education and training in PIP QI Ten Measures

Diabetes

RACGP and Diabetes Australia both offer eLearning, education and clinical management resources. Some modules are for health professionals generally, others are specifically aimed at nurses.

RACGP

View a list of RACGP General Practice eLearning activities.

The gold standard for clinical management of diabetes in primary care is the RACGP General Practice Management of Type 2 Diabetes.

Diabetes Australia

Diabetes Australia has links to various eLearning and courses including:

- 'Diabetes Qualified' courses (12 hours)
- International Diabetes Federation (IDF) free online course (1 hour)
- APNA 'Diabetes Management in the Primary Care Setting' (26 hours)
- Diabetes Academy (Melbourne University) 'What's new in diabetes?' (20 hours).

See Diabetes Australia Tools and eLearning, as well as updates and workshops for health professionals.

Lifestyle information and risk factors

Quit offers online support for GPs in how to have quit-smoking conversations with patients. The site includes links to free 'brief advice' training and PDSA training.

RACGP also has a useful document: Smoking, nutrition, alcohol, physical activity (SNAP): A population health guide to behavioural risk factors in general practice.

Also see the Alcohol and Other Drugs QI workbook for more education and training information.

Influenza immunisation

See the Immunisation QI Workbook for education and training information.

Cervical screening

The Cancer Council has information about nurse cervical screening provider training, including information on certification. Scholarships for nurses to become cervical screening providers are also available.

Tools and resources to build your confidence and skills

PIP QI areas

Diabetes

- [Diabetes Australia](#) and [Diabetes Victoria](#) offer a range of information for health professionals and patients, as well as running events listings.

- Diabetes Australia also publishes [best practice guidelines](#).

- Also see the [Diabetes QI Workbook](#) and check HealthPathways Melbourne for further resources under specific diabetes areas, such as foot care and renal screening.

Lifestyle and risk factors

Smoking

- [Quit's website](#) offers information and support for people who want to stop smoking.

- Quit's site includes the number for Quitline (13 78 48), a smoking cessation phone-counselling service.

- Quit also has [resources designed for GPs](#).

Lifestyle: general

- See [HealthPathways Melbourne](#) for details about local services related to smoking cessation, exercise and fitness, and community health and wellbeing.

- The [Life! program](#) is a free Victorian healthy lifestyle program that helps you reduce your risk of Type II diabetes and cardiovascular disease. Run by expert health professionals, the program is delivered as a group course or a phone health coaching service. (Also see the [HealthPathways page about the Life! program](#).)

Influenza immunisation

- See the Victorian Government's information about seasonal flu vaccine.

- Melbourne Vaccine Education Centre publishes annual influenza vaccine recommendations.

- Also see the National Centre for Immunisation Research and Surveillance and the Australian Immunisation Handbook (online version).

- The following CAT4 'recipes' will help you identify vulnerable patients:

    - at risk of influenza in relation to ethnicity and age

    - at risk of influenza due to pre-disposing conditions

    - aged 65 and older.

- Brisbane South PHN has created this excellent tool to guide practices through influenza immunisations, including how to set up clinics.

- Better Health Channel's influenza page is the full 'why and how' for patients.

- Also see the Immunisations QI Workbook.

- NWMPHN's Immunisation page for primary care providers.

Cardiovascular disease resources

- See the Australian CVD guidelines and risk calculator.

- The Heart Foundation and the National Stroke Foundation have a range of excellent resources.

Cervical screening resources

- The Australian Department of Health's website has information about the National Cervical Screening Program:

    - for health professionals

    - for patients.

- The Cancer Council also has cervical screening resources.

General

Patient information

- The Victorian Government's Better Health Channel website has patient-appropriate information in English about various conditions.

- The government's Health Translations website also has resources in English and other languages on various topics, reviewed and approved for clinical accuracy.

Nurse clinics

- For guidance on setting up a nurse-led clinic at your practice, see the Hunter New England and Central Coast PHN Nurse-Led Clinics Toolkit.

- Australian Primary Health Care Nurses Association (APNA) offers tips, tools and resources for starting nurse clinics in general practice.

PIP QI and CAT

- See the Australian Department of Health website for information about PIP, eligibility and requirements.

- Pen CS has an excellent step-by-step guide to extracting CAT information for each of the 10 PIP measures. This will help with your initial data collection but also your ongoing project monitoring. The guide also explains how to 'cleanse' your data to improve its quality, so your results are more meaningful.

- Pen CS also has these step-by-step 'recipes' that show you how to get more out of CAT4 and Topbar in relation to quality improvement and the 10 Improvement Measures.

- Also see the Pen CS advice on functionality for sending a recall SMS, voice message or letter, and for creating Topbar prompts to remind clinicians to take the opportunity to follow up with patients about certain information, such as organising a vaccination.

Videos on the Model for Improvement

Short videos are available at IHI website. In particular, see:

- Model For Improvement – Part 1 (2 min. 54 sec.) – IHI – MFI – Part 1
- Model For Improvement – Part 2 (3 min.) – IHI – MFI – Part 2
- Plan Do Study Act – Part 1 (4 min. 45 sec.) – IHI – PDSA – Part 1
- Plan Do Study Act – Part 2 (3 min. 48 sec.) – IHI – PDSA – Part 2.

Case Studies

Local examples of quality improvement success, as well as sample PDSA cycles, can be found on the NWMPHN primary care pages.

North Western Melbourne Primary Health Network
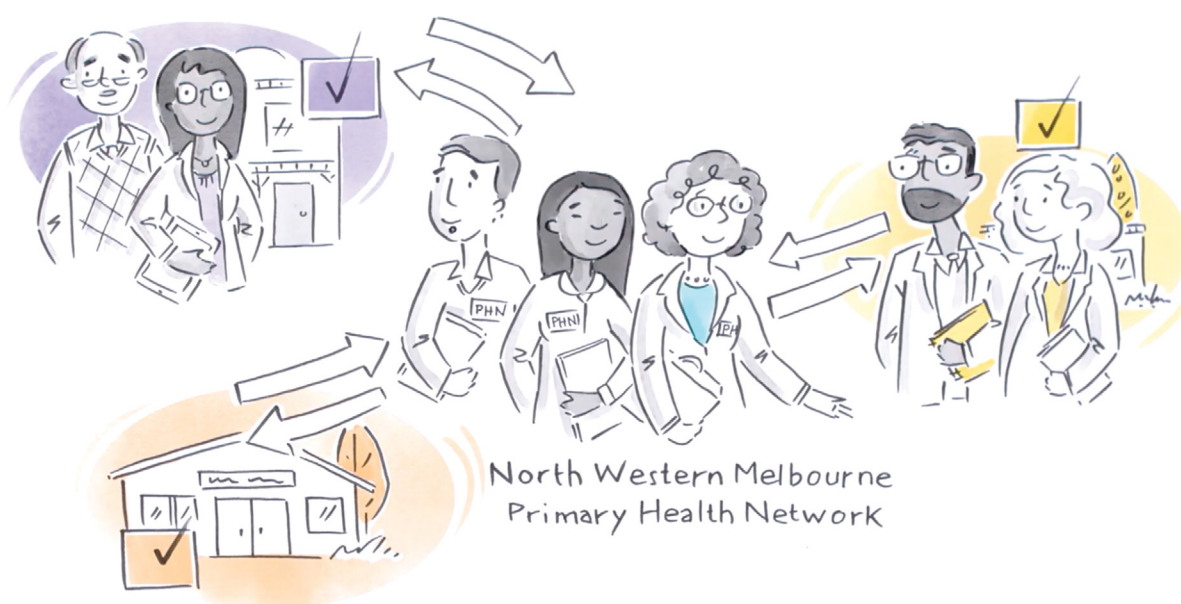
Appendices

Appendix 1: Quality Improvement and RACGP accreditation

RACGP's Standards for general practices (5th edition) now includes several QI requirements. Undertaking a QI activity helps demonstrate that a practice can meet or exceed the following:

* Indicator (> Denotes indicator is mandatory)

Criterion QI1.1: Quality improvement activities

Indicators

QI1.1>A Our practice has at least one team member who has the primary responsibility for leading our quality improvement systems and processes.

QI1.1>B Our practice team internally shares information about quality improvement and patient safety.

QI1.1>C Our practice seeks feedback from the team about our quality improvement systems and the performance of these systems.

QI1.1>D Our practice team can describe areas of our practice that we have improved in the past three years.

Claiming RACGP Continuing Professional Development Points

GPs who complete activities in this workbook may be eligible to accumulate 40 CPD Accredited Activity points. Speak to one of our Workforce, Education and Training team members about requirements before starting your activities. For more information email education@nwmphn.org.au or call (03) 9347 1188.

The Standards also include a range of requirements relating to PIP QI Ten Measures. Undertaking PIP QI Ten Measures activities will help demonstrate that a practice can meet or exceed the following indicators:

Criterion C1.3: Informed patient decisions

Indicators

C1.3>A   Our patients receive information about proposed investigations, referrals and treatments, including their purpose, importance, benefits, and risks.

C1.3>B   Our patients receive information to support the diagnosis, treatment, and management of their conditions.

Criterion C1.4 – Interpreter and other communication services

Indicators

C1.4>A   Our practice endeavours to use an interpreter with patients who do not speak the primary language of our practice team.

C1.4>B   Our practice endeavours to use appropriate communication services to communicate with patients who have a communication impairment.

C1.4C   Our patients can access resources that are culturally appropriate, translated, and/or in plain English.

Criterion C3.4 – Practice communication and teamwork

Indicators

C3.4>A   Our practice team has the opportunity to discuss administrative matters with the principal practitioners, practice directors, practice management, or owners when necessary.

C3.4>B   Our practice encourages involvement and input from all members of the practice team.

C3.4>C   Our clinical team discusses the practice's clinical issues and support systems.

Criterion C4.1 – Health promotion and preventive care

Indicator

C4.1>A   Our patients receive appropriately tailored information about health promotion, illness prevention, and preventive care.

Criterion C5.1 – Diagnosis and management of health issues

Indicators

C5.1>A   Our clinical team is able to access relevant current clinical and other guidelines that help diagnose and manage our patients.

C5.1>B   Our clinical team supports consistent diagnosis and management of our patients.

Criterion C7.1 – Content of patient health records

Indicators

C7.1>G   Our patient health records contain, for each active patient, lifestyle risk factors.

Criterion QI1.3 – Improving clinical care

Indicators

QI1.3A   Our practice team uses a nationally recognised medical vocabulary for coding.

QI1.3>B   Our practice uses relevant patient and practice data to improve clinical practice (e.g. chronic disease management, preventive health).

Criterion QI2.1 – Health summaries

Indicators

QI2.1>B   Each active patient health record has the patient's current health summary that includes, where relevant:

- adverse drug reactions
- current medicines list
- current health problems
- past health history
- immunisations
- family history
- health risk factors (e.g. smoking, nutrition, alcohol, physical activity)
- social history, including cultural background.

Criterion GP2.2 – Follow-up systems

Indicators

GP2.2D   Our practice initiates and manages patient reminders.

Criterion GP3.1 – Qualifications, education and training of healthcare practitioners

Indicators

GP3.1>A   Members of our clinical team: ... actively participate in continuing professional development (CPD) relevant to their position and in accordance with their legal and professional organisation's requirements.

Appendix 2: Sample SMART goals for PIP QI Ten Measures

Note that these are samples only: practices should amend dates, percentage targets and other variables so that goals are achievable (but still challenging) in relation to current performance.

Diabetes (PIP QI measures 1, 5 and 10)

✎ **Our goal is:**

To record HbA1c and blood pressure for at least 90% of our active diabetic population by 31 December 2020. If an active diabetic patient is seen during flu season, they will be offered an influenza vaccination.

✎ **Our target population is:**

Active patients who have a diagnosis of diabetes (Type I or II)

✎ **Check that the goal is:**

☑ Specific ☑ Measurable ☑ Achievable
☑ Relevant ☑ Time-based

✎ **We will use the following measures to know if we've been successful:**

Measure:

Proportion of active patients with diabetes with a current HbA1c result in the past 12 months

Source:

CAT4 data extraction tool

Refer to our guide Using CAT4 and Topbar for PIP QI activities.

Measure:

Proportion of active patients with diabetes with a blood pressure result in the past 12 months

Source:

CAT4 data extraction tool

Refer to our guide Using CAT4 and Topbar for PIP QI activities.

Measure:

Proportion of active patients with diabetes who were immunised against influenza in the past 15 months

Source:

CAT4 data extraction tool

Refer to our guide Using CAT4 and Topbar for PIP QI activities.

✎ **We want to achieve our goal by:**

31 December 2020

✎ **We will collect our measures every:**

1st of the month

Recording lifestyle information (key risk factors for chronic disease) (Improvement Measures 2, 3 and 7)

✍ **Our goal is:**

To achieve the following rates of recording for all active patients aged 15 years and over:

- smoking status recorded within last 12 months: 80%
- BMI classification as obese, overweight, healthy or underweight, recorded within the last 12 months: 50%
- alcohol consumption level recorded: 50%

To also offer cessation and lifestyle advice as appropriate.

✍ **Our target population is:**

All patients aged 15 and over.

✍ **Check that the goal is:**

☑ Specific   ☑ Measurable   ☑ Achievable

☑ Relevant   ☑ Time-based

✍ **We will use the following measures to know if we've been successful:**

Measure:	Source:
Proportion of active patients with a smoking status recorded in the past 12 months.	CAT4 data extraction tool Refer to our guide Using CAT4 and Topbar for PIP QI activities.
Proportion of active patients with a weight classification of obese, overweight, healthy or underweight recorded within the past 12 months.	CAT4 data extraction tool Refer to our guide Using CAT4 and Topbar for PIP QI activities.
Proportion of active patients with an alcohol consumption status recorded (at any time)	CAT4 data extraction tool Refer to our guide Using CAT4 and Topbar for PIP QI activities.

✍ **We want to achieve our goal by:**

31 December 2020

✍ **We will collect our measures every:**

1st of the month

Influenza immunisation (Improvement Measures 4,5 and 6)

✍ Our goal is:

By the end of the flu season, to increase the number of active patients immunised against influenza in the past 15 months to 70% for each of the following categories:

- 65 years and older
- diagnosed with diabetes
- diagnosed with COPD.

✍ Our target population is:

Patients aged 65 and older, all diabetic patients and all patients with COPD

✍ Check that the goal is:

☑ Specific   ☑ Measurable   ☑ Achievable
☑ Relevant   ☑ Time-based

✍ We will use the following measures to know if we've been successful:

Measure:	Source:
Proportion of patients aged 65 and older immunised against influenza in the past 15 months	CAT4 data extraction tool. Refer to our guide Using CAT4 and Topbar for PIP QI activities.
Proportion of patients with diabetes who were immunised against influenza in the past 15 months	CAT4 data extraction tool. Refer to our guide Using CAT4 and Topbar for PIP QI activities.
Proportion of patients with COPD who were immunised against influenza in the past 15 months	CAT4 data extraction tool. Refer to our guide Using CAT4 and Topbar for PIP QI activities.

✍ We want to achieve our goal by:

31 December 2020

✍ We will collect our measures every:

1st of the month

CVD risk-factor assessment (Improvement Measure 8): Basic level

✍ Our goal is:

To improve our recording of CVD risk factors for all active patients aged 45 to 74 by 20%.

✍ Our target population is:

All patients aged 45 to 74.

✍ Check that the goal is:

☑ Specific ☑ Measurable ☑ Achievable

☑ Relevant ☑ Time-based

✍ We will use the following measures to know if we've been successful:

Measure:

Proportion of patients with the necessary risk factors assessed to enable CVD assessment

Source:

CAT4 data extraction tool

Refer to our guide Using CAT4 and Topbar for PIP QI activities.

✍ We want to achieve our goal by:

31 December 2020

✍ We will collect our measures every:

1st of the month

CVD risk-factor assessment: Intermediate level (Improvement Measure 8)

The next level of work follows on from improving recording of the risk factors to managing those deemed to be at medium or high risk of CVD in the next five years.

✐ Our goal is:

To follow up 70 % of the active patients on our CVD event risk register who have been rated as having a medium or high (>15 %) risk of having a heart attack or stroke in the next five years.

(The aim of this is to provide intervention options, such as advice on lifestyle changes or medication intervention, to reduce CVD risk.)

✐ Our target population is:

Active patients who are rated as being at medium or high risk of having a CVD event in the next five years

✐ Check that the goal is:

☑ Specific   ☑ Measurable   ☑ Achievable
☑ Relevant   ☑ Time-based

✐ We will use the following measures to know if we've been successful:

Measure:

Number of patients who are on the CVD register as having a medium or high risk (>15 %)

Source:

CAT4 data extraction tool

Refer to our guide Using CAT4 and Topbar for PIP QI activities.

Measure:

Number of patients on the list who have attended an appointment to discuss their CVD risk or a CVD event in 2020

Source:

Manual audit of patient records in medical software

✐ We want to achieve our goal by:

31 December 2020

✐ We will collect our measures every:

On the first day of alternate months

Cervical screening (Improvement Measure 9)

✎ **Our goal is:**

To improve the proportion of active eligible patients with an up-to-date cervical screening result from 55% to 75%.

✎ **Our target population is:**

All women between 25 and 74 who have not had a hysterectomy and who have not had a cervical screening test after 1 December 2017 and within the previous five years.

✎ **Check that the goal is:**

☑ Specific ☑ Measurable ☑ Achievable
☑ Relevant ☑ Time-based

✎ **We will use the following measures to know if we've been successful:**

Measure:

The proportion of active female patients between 25 and 74 who have not had a hysterectomy or had cervical screening result (HPV) since 1 Dec 2017 and within the past five years.

Source:

CAT4 data extraction tool

Refer to our guide Using CAT4 and Topbar for PIP QI activities.

✎ **We want to achieve our goal by:**

31 December 2020

✎ **We will collect our measures every:**

1st of the month

Appendix 3: PDSA worksheet samples

You will have noted your ideas for testing when you worked through earlier activities. Here are three samples of how to complete the PDSA template (provided in <u>Appendix 4</u> 🔧 on page 59) to test each new idea.

PDSA worksheet sample 1

✍ Priority area number	✍ Activity number
1	1

✍ Goal
To record the following information for all active patients aged 15 years and over: • smoking status recorded within the past 12 months: 50%   • BMI classification as obese, overweight, healthy or underweight recorded within the past 12 months: 50%   • alcohol consumption level recorded: 80%   To also offer cessation/lifestyle advice as appropriate.

✍ Staff member responsible

✍ Date started	✍ Date completed

Part 2: The doing part – Plan, Do, Study, Act

Plan

Plan the test, including a plan for collecting data

Describe the brainstorm idea you are planning to work on. (Idea)

What exactly will you do? Include what, who, when, where, predictions and data to be collected.

Idea (activity)

Regular meetings to get practice staff on board

What (step-by-step)

1   Add agenda item to next all-staff meeting and to each meeting every three months until year end.

2   Add agenda item to next clinical meeting and alternate clinical meetings until year end.

3   PM and Dr Brown meet to discuss approach (message, staff roles, what do we want people to contribute at meeting?)

4   Dr Brown to lead meeting discussion, PM to take minutes.

Who

PM

When

1 June – 31 Dec 2020

Where

Dr Brown's office on Wednesday afternoons before each meeting

Prediction

Improved anecdotal interest and buy-in from staff

Data to be collected

Minutes at each meeting – we can review discussions and any feedback from staff.

Baseline

No baseline data needed here.

Do

Run the test on a small scale

Who is going to do what? (Action)

Was the plan executed successfully?

Did you encounter any problems or difficulties?

A couple of meetings were cancelled during year due to illness and public holiday, so we sent written email updates to staff instead. We think this worked well.

Allocated 15 mins to initial meetings – in retrospect we needed 30 minutes at the initial meetings and then 15 mins for subsequent ones, due to flow of ideas and discussion.

Meetings are only 1-hour long. Can be too much to talk about apart from the project. Need to consider other ways of updating.

Part 2: The doing part – Plan, Do, Study, Act (continued)

Study	Does the data show a change? (Reflection)
Analyse the results and compare them to your predictions	What does the data say? Did you meet your predictions? If you fell short, suggest why.

Meeting discussions were valuable if structured well and if we had clear aims about what we wanted. If time allows, interactive work is most engaging, rather than just an update, but sometimes an update is all that's possible. Meetings allow some discussion and feedback though.

Written updates are quick, but there's no guarantee people will read them, and there is less opportunity for dialogue about the project.

However, the project got a good reception and it helped us to organise who would do what, and how we could work as a practice towards this goal, from administrative through to clinical staff.

It also enabled people to volunteer for certain tasks such as updating the new patient information sheet and making a poster for reception.

Staff members reported that it was nice to know how the project was going (even if they were not directly part of it) and encouraging to hear that we were improving.

In three out of five meetings, we were able to come up with a solution to a problem that a staff member had encountered.

Act	Do you need to make changes to your original plan? (What next) OR Did everything go well?
Based on what you learned from the test, plan for your next step	If this idea was successful, you may like to implement this change on a larger scale or try something new. If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.

This is the first time we've calendared regular communication about a project. Putting it in the calendar at the start of the project helped us keep discussion and feedback regular and helped us organise what information we'd share. It gave people enough information without overwhelming them. We will ensure we do this for future projects and combine meetings and written updates where appropriate.

Repeat Step 2 for other ideas. What idea will you test next?

PDSA worksheet sample 2

✍ Priority area number	✍ Activity number
1	2

✍ Goal

To achieve rates of recording of the following information for all active patients aged 15 and older:

- smoking status recorded within past 12 months: 50%
- BMI classification as obese, overweight, healthy or underweight, recorded within the past 12 months: 50%
- alcohol consumption level recorded: 80%.

To also offer cessation and/or lifestyle advice as appropriate.

✍ Staff member responsible

✍ Date started	✍ Date completed

Part 2: The doing part – Plan, Do, Study, Act

Plan	✍ Describe the brainstorm idea you are planning to work on. (Idea)
Plan the test, including a plan for collecting data	What exactly will you do? Include what, who, when, where, predictions and data to be collected.

✍ Idea (activity)

Education and training for clinicians

✍ What (step-by-step)

1 Each clinician to register for training

2 PM to develop short knowledge and confidence questionnaire by 20 June; check with Dr Brown who is skilled at quit-smoking discussions (aim to see if knowledge/confidence improves as result of training)

3 PM to timetable 2 hours per staff member to complete training

4 Staff to complete pre-questionnaire

5 Staff to complete training

6 Staff to complete post-questionnaire.

7 PM to review results.

✍ Who	✍ When
PM	Begin 1 June until 30 August

Part 2: The doing part – Plan, Do, Study, Act (continued)

✍ Where	✍ Prediction
N/A	Improvement of knowledge and confidence comparing pre- and post-questionnaires.

✍ Data to be collected

Percentage of GPs and nurses that have completed education. The results of the pre- and post-questionnaires (for comparison)

✍ Baseline

2 clinicians have completed education in the past. This leaves 6 to do training under this project.

≡🏃 **Do**	✍ Who is going to do what? (Action)
Run the test on a small scale	Was the plan executed successfully? Did you encounter any problems or difficulties?

Two staff members have already completed other quit-smoking training, so we decided they did not need to complete this online training.

Despite providing 'protected time', it largely got eaten up by other tasks. Next time, ensure that people are given off-site time to ensure it is truly protected.

Three staff members were unable to complete the training by 30 August. More protected time was given to these three staff members. All training has been completed by 30 September 2020.

🔍 **Study**	✍ Does the data show a change? (Reflection)
Analyse the results and compare them to your predictions	What does the data say? Did you meet your predictions? If you fell short, suggest why.

- Four out of six clinicians said their knowledge of the consequences of smoking improved
- Six out of six said that their confidence in having a brief quit-smoking discussion with a smoker improved
- Six out of six said that they had more knowledge about where to refer a person for support.

We therefore think that the training has been highly successful in providing our staff with more skills and confidence around smoking cessation support.

Part 2: The doing part – Plan, Do, Study, Act (continued)

Act	Do you need to make changes to your original plan? (What next) OR Did everything go well?
Based on what you learned from the test, plan for your next step	If this idea was successful, you may like to implement this change on a larger scale or try something new. If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.

Our next cycle is to explore whether any staff members would like to undertake further enhanced training in smoking cessation.

We will also investigate training in relation to having discussions with patients about weight management and alcohol consumption.

Repeat Step 2 for other ideas. What idea will you test next?

PDSA worksheet sample 3

Priority area number	Activity number
1	3

Goal
To achieve rates of recording of the following information for all active patients aged 15 and older: • smoking status recorded within past 12 months: 50% • BMI classification as obese, overweight, healthy or underweight, recorded within the past 12 months: 50% • alcohol consumption level recorded: 80%. To also offer cessation and/or lifestyle advice as appropriate.

Staff member responsible

Date started	Date completed

Part 2: The doing part – Plan, Do, Study, Act

Plan

Plan the test, including a plan for collecting data

✎ **Describe the brainstorm idea you are planning to work on. (Idea)**

What exactly will you do? Include what, who, when, where, predictions and data to be collected.

✎ **Idea (activity)**

To add a Topbar reminder about recording smoking status, alcohol consumption and weight classification so it 'pops up' during a consultation when the information is missing.

✎ **What (step-by-step)**

1 Make sure Topbar is installed and functional on all desktop computers in all rooms

2 Add a Topbar smoking status reminder

3 Add a Topbar alcohol consumption reminder

4 Add a Topbar weight classification reminder

5 Test that pop-up reminders work

6 Discuss effect on clinicians at alternate clinical meetings – do they take notice of pop-up, is it annoying, how long does it take to record info, have the reminders led to positive discussions with patients, have there been any technical issues, have there been any other issues?

✎ **Who**	✎ **When**
Receptionist (Sam)	Begin 1 June to 15 June to put reminders on. Discuss impact on clinicians in meetings until end of year.

✎ **Where**	✎ **Prediction**
N/A	Increase in the number of our patients who have all three factors recorded. We are aiming for the targets set out in our goal above.

✎ **Data to be collected**

Feedback from clinicians at meetings. We also collect overall goals measures each month (i.e. % of patients who have the factors recorded). This should directly contribute to improved recording rates.

✎ **Baseline**

Smoking status for 45%, Alcohol consumption for 62%, weight classification for 42%

Part 2: The doing part – Plan, Do, Study, Act (continued)

Do	✍ **Who is going to do what? (Action)**
Run the test on a small scale	Was the plan executed successfully? Did you encounter any problems or difficulties?

Sam did not have great knowledge of Topbar. CAT4 provided a training session. Reminders were delayed by 2 weeks to allow for this upskilling.

Sam now has a greater understanding of the use of Topbar and can implement other Topbar notifications in future.

Doctors reported that they sometimes did not have time to fill in the information in consultations for complex needs.

Study	✍ **Does the data show a change? (Reflection)**
Analyse the results and compare them to your predictions	What does the data say? Did you meet your predictions? If you fell short, suggest why.

As of the end of September, the recording rate has improved as follows:

- smoking status recorded: up by three percentage points
- alcohol consumption recorded: up by three percentage points
- weight classification: up by two percentage points

We found that this was positive, but still less than we were hoping for.

Act	✍ **Do you need to make changes to your original plan? (What next) OR Did everything go well?**
Based on what you learned from the test, plan for your next step	If this idea was successful, you may like to implement this change on a larger scale or try something new. If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.

We will continue to have the Topbar reminder running so people can still be 'caught' during consultations.

But we will now test whether it would be better for a nurse or admin staff member to help us update this information – i.e. nurse to take opportunities to see people prior to seeing the GP for their appointment.

We will also update our new patient registration sheet to include these questions so we can improve information on new patients from the start. Admin or nurse can input the information, taking pressure off GPs.

Repeat Step 2 for other ideas. What idea will you test next?

Appendix 4: PDSA worksheet template

This is a blank PDSA worksheet that you can use to test each new idea.

✍ Priority area number	✍ Activity number
✍ Goal	
✍ Staff member responsible	
✍ Date started	✍ Date completed

Part 2: The doing part – Plan, Do, Study, Act

🧠 **Plan**	✍ **Describe the brainstorm idea you are planning to work on. (Idea)**
Plan the test, including a plan for collecting data	What exactly will you do? Include what, who, when, where, predictions and data to be collected.

✍ Idea (activity)	
✍ What (step-by-step)	
✍ Who	✍ When
✍ Where	✍ Prediction

✎ **Data to be collected**

✎ **Baseline**

🏃 **Do**

Run the test on a small scale

✎ **Carry it out, and describe how you went (Action)**

Was the plan executed successfully?

Did you encounter any problems or difficulties?

📄 **Study**

Analyse the results and compare them to your predictions

✎ **Does the data show a change? (Reflection)**

What does the data say?

Did you meet your predictions, or did you fall short?

Part 2: The doing part – Plan, Do, Study, Act (continued)

Act	Do you need to make changes to your original plan? (What next?) OR Did everything go well?
Based on what you learned from the test, plan for your next step	If this idea was successful you may like to implement this change on a larger scale or try something new.
	If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.

Repeat Step 2 for other ideas. What idea will you test next?