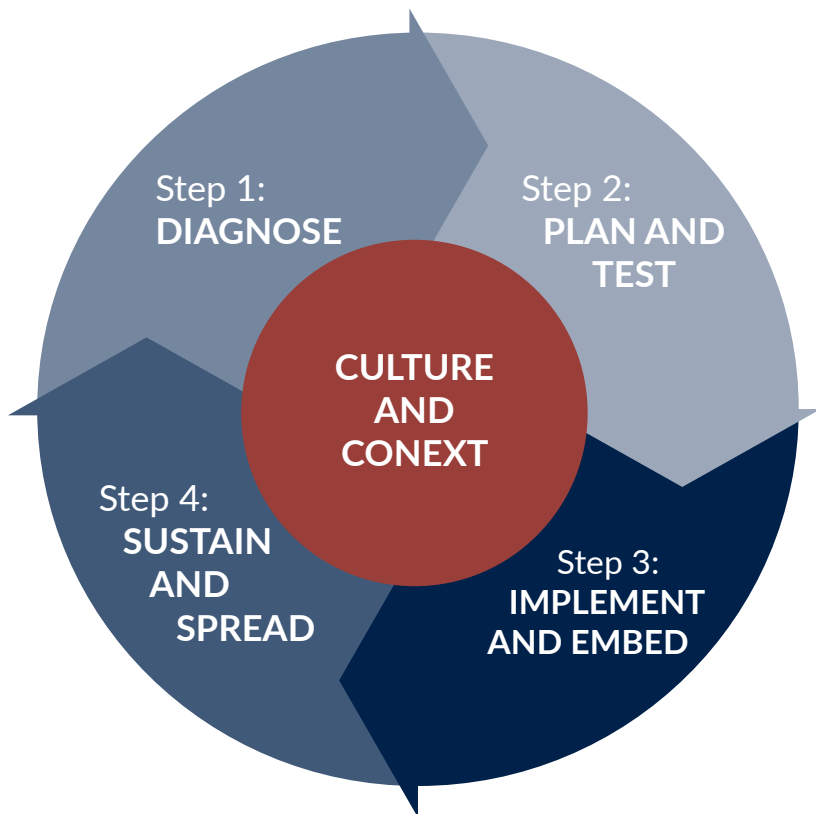# QOF QI Early diagnosis of cancer case study: Bowel cancer screening

Practice details: 6,500 patients, 2.8 WTE GPs (1 partner), inner-city practice – lower quartile deprivation index.

Step 1: DIAGNOSE

Step 2: PLAN AND TEST

CULTURE AND CONEXT

Step 4: SUSTAIN AND SPREAD

Step 3: IMPLEMENT AND EMBED

The project team focused on ways to improve the uptake of cervical screening, using evidence-based interventions.

They used the RCGP QI wheel for general practice (available in RCGP's How to get started in QI guide for advice).

👁 Culture and context:

In preparation for the QOF QI domains, 2 GPs, 2 administrators and the HCA had undertaken online QI learning modules. The practice had also elected to take up the offer of QI training offered by the CCG. The senior administrator and a salaried GP took on the lead clinical and non-clinical roles.

At a weekly practice meeting, on the background of a recent late bowel cancer diagnosis and death, the project team invited the room to undertake a brief SWOT (strengths, weakness, opportunities and threats) analysis in relation to both cancer diagnosis and screening. It was recognised that cervical screening rates had gone up over the past 5 years – coinciding with a local enhanced service. They realised that having weekly clinical meetings meant that certain equivocal cases were often held over and discussed there, and sometimes led to delays in referral. A low uptake of the national bowel cancer screening programme uptake was recognised as a key area for attention.

💙 Diagnose:

The practice used searches found in Macmillan's Quality Improvement Toolkit, along with Fingertips data. They identified the practice as being in the lowest decile nationwide.

✓ Plan and test:

Plan and test: The project team then used this data to inform their next actions and set a clear plan. They agreed a SMART outcome aim (what the project wanted to achieve and by when), a measure (how they will know if anything is changing), and the change itself (what will people do differently):

Aim:

The practice team aimed to increase the uptake of patients who default on bowel screening by 5% over the next 12 months, (and thereby to move out of the lowest decile).
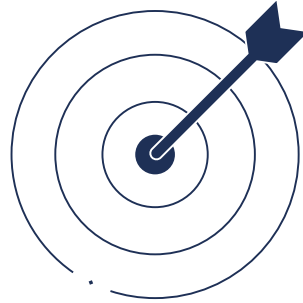
Measure:

The project used relatively limited information held within GP registers – subject date of birth and screening result codes. The lead administrator created searches and measured monthly:

a. The percentage of eligible non-participants at four months who were contacted by letter and telephone

b. The proportion of eligible subjects receiving opportunistic discussion with the GP

Change:

The team participated in an initial peer review meeting with their Primary Care Network colleagues, where practice data was shared, ideas for measurements and changes generated, and learning from each other took place. They undertook the following changes:

a. Letters were sent from the practice and telephone calls made to those subjects who had not returned their gFOBt or FIT kit within four months of the BCSP invitation

b. Opportunistic discussion of bowel screening for those patients consulting their GP for other reasons, who had not been screened within the past two years, was undertaken - including coding on the practice operating system (8CAY READ code / XaPyB - "Advice given about bowel cancer screening programme").

Implement & embed:

The GP had recently attended a GP Cancer Update Course, and this included several proposals for improving the uptake of patients who default or decline bowel screening. The proposals included increasing awareness amongst all clinicians – including the project team and practice staff – and actively seeking out the target population to encourage uptake by direct contact from the practice. These actions are in process at present and bowel screening uptake will be monitored at practice level and through PHE's Fingertips tool to evaluate impact in future.

Outcome:

The practice was able to show a small improvement on their internal searches. They placed a run chart on the wall of the practice and used it to display the progress of uptake against their SMART aim. It was updated monthly and used to check that they were on track to meet their goal when full (annual) data would be available. They found it helpful to visualise both the increase in communications from the practice, and numbers of additional opportunistic discussions, also using run charts.

Sustain and spread:

The practice also now has a heightened awareness and management plan for all clinicians, i.e. upon notification of a 'declined' bowel screening invitation, a pathway has been devised whereby these are highlighted and reviewed, and appropriate decisions are made on an individual basis. The project lead attended the 2nd peer review meeting with colleagues from the local Primary Care Network (PCN) to share the team's progress and raise suggestions for next year's focus. The practice, along with others in the PCN, is now looking for patient champions to encourage enhanced uptake of screening through patient activation and intends to use an expert patient to move forward with this process.

What the practice did next:

There is evidence that the strategy of additional GP-based reminders for those not participating by four months is effective. Approximately one additional person was estimated to participate for every 7 successful DNA telephone calls. In addition, the project team intends next year to initiate letters and telephone calls direct from the practice promoting bowel screening for those subjects approaching their 60th birthday, with details of when the first invitation by the BCSP would be sent.

What evidence did the practice provide for qof payment:

The contractor completed the annual QOF QI domain self-declaration. They kept a copy of the QI monitoring template and clinical audits for future payment verification if needed, as well as evidence for future CQC inspections.

7 Successful DNA telephone calls

One additional person