

# QOF 2020/21 QI Cases Studies

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## Purpose of this document

Since 2019/20 the Quality and Outcomes Framework included a quality improvement (QI) domain. This booklet contains three case studies developed by the Royal College of General Practitioners, National Institute for Health and Care Excellence and the Health Foundation which provide examples of how practices could approach their quality improvement activity.

## Case Study 1 – Learning disabilities

**Practice details:** 8500 patients, urban practice

The practice decided to work with their local Quality Improvement (QI) team who helped facilitate as they were new to quality improvement work. To help ensure buy-in and experience from diverse team members, a QI team was formed including a GP partner, salaried GP, GP registrar, nurse, HCA and receptionist.



The team decided to focus on uptake of the LD (learning disability) annual health check and uptake of seasonal influenza vaccination as its first priorities. They used the RCGP QI wheel for general practice available in the NHS England [An Introduction to Quality Improvement in General Practice](#) for advice.

### 1.1 Culture and context

At a whole practice meeting, the team led a SWOT analysis (strengths, weakness, opportunities and threats) on carrying out the annual health checks for patients with LD. This identified that clinicians felt the annual health check was a good opportunity to get to know patients, understand their needs and provide health promotion advice including offering flu vaccination or encouraging uptake when available. The practice manager highlighted that there was a high DNA rate for the double appointment slots with the GP or nurse for the checks. The receptionists commented that it wasn't clear who had responsibility for calling in patients and following up those who didn't attend. GPs commented that often patients would not have had up to date bloods at the appointment so would require a further appointment to review results at a later date.

## 1.2 Diagnose

The GP registrar was able to present the data on the practice DES achievement for the annual health checks for the last 4 quarters to the team, as available at <https://digital.nhs.uk/data-and-information/publications/statistical/learning-disabilities-health-check-scheme>. This showed that in the last year, they had carried out checks on 48% of patients with LD aged 14 and above, which was below their CCG average of 62% and the national average of 55%. They also were able to see that the prevalence of LD in their practice was 0.4%, below the national average of 0.47% and well below the estimated 2-2.5% of people in the general population. Practice level data also showed that uptake of flu vaccination in patients on the Learning Disability register was just 15% last year.

The local QI team facilitator helped practice staff to carry out a process mapping exercise to see how patients are booked into their annual health checks. This revealed that patients may not receive information in an accessible format and were not being reminded that bringing a carer with them was an option if helpful. It also showed patients were booked in to see the GP before they had had their bloods done.

A receptionist was appointed as the LD Champion, their responsibilities included calling patients in for their annual health checks, following the agreed pathway created after the process mapping exercise and ensuring patients were having their communication needs documented and met.

A meeting was held with patients, their families and carers to gain insight on what would help make it easier for them to attend appointments. They reported it would help if the appointment letter was in an accessible format and patients were given a reminder phone call the day before the annual health check.

The GP registrar and the practice nurse attended the first PCN peer review meeting to share their findings from the SWOT analysis, initial audit findings, process mapping and patients' meeting. Colleagues supported the practice to decide on their aim and outcome measure and provided further helpful suggestions on the interventions that could be tested, including sharing an easy-read questionnaire to send to patients prior to the health check to help focus the appointment.

## 1.3 Plan and test

The team used the free [RCGP QI Ready](#) tool to develop the following plan: They developed a SMART (Specific, Measurable, Achievable, Realistic, Time-bound) aim:

- 1) *Aim* - Increase the proportion of patients with LD receiving an annual health check (including an offer of flu vaccination) to the national target of 75% within the current financial year, they had 30 patients on the LD register aged 14+, so aimed to see 2-3 patients a month.
- 2) *Measure*- Each month a search was run to check how many annual health checks and flu vaccinations had been done. The data were compiled on to a run chart and was displayed in the staff room, so all members of the team could monitor progress.

3) *The change:*

- a) For their first PDSA (Plan, Do, Study, Act) cycle, they predicted that having an organised system for recalling patients and would increase uptake of annual health checks. The LD Champion generated a list of patients who needed to be contacted each month including chasing up patients who had not responded the previous month. They reviewed the numbers attending for annual health checks in the two months before and after the new process was initiated and noted that there was an increase in the number of patients seen.
- b) For the next PDSA cycle, they predicted providing accessible information may also increase attendance. The LD Champion provided accessible information to patients about the appointment including an easy-read letter. The team noted an improvement in the uptake of annual health checks but the levels of flu vaccination had not changed.
- c) The next change idea to be implemented was for flu vaccinations to be routinely offered at every health check appointment when available and when out-of-season, a leaflet explaining the vaccination would be shared with advice that a further appointment would be arranged in the coming months. This increased the numbers receiving a flu vaccine but they realised there were still high numbers who DNA'd their appointments.
- d) They ran another PDSA cycle, where they predicted inviting patients to bring a relative or carer may increase attendance. The LD Champion started to advise patients when booking the appointment that they can bring a family member or carer to the appointment. Clinicians reported that this made the appointment more productive but there was no change in the rate of attendance so another PDSA cycle was run, where they also provided a telephone reminder the day before the appointment. Reviewing the run chart over the next three months, there was a sustained increase in completed annual health checks. They then started a process for clinicians to send reminders to the LD Champion if someone DNA'd their appointment so they could be contacted to arrange another appointment.
- e) In subsequent PDSA cycles, the team decided to focus on improving the quality of the annual health checks, ensuring information was gathered before the appointment to enable a comprehensive review. They gained feedback from patients and clinicians on their experience to guide progress. The LD Champion would send out an easy-read pre-appointment questionnaire and ensure they were booked to see the HCA 2 weeks before the annual health check to do bloods and baseline measurements.

## **1.4 Implement and embed**

Staff attended training on meeting the communication needs of patients with LD and complying with the Accessible Information Standard. This meant all members of the team felt confident ensuring reasonable adjustments were made for patients with LD and other reception staff could support the LD Champion with the recall process.

The use of the HCA appointment and pre-appointment questionnaire helped to focus the GP appointment so that the time could be used more effectively covering issues

pertinent to the patient and patients reported they found the appointment more useful. The telephone reminder from the LD Champion reduced the DNA rate at appointments and the process for following up patients who DNA'd increased the proportion of patients who were getting their annual health check.

### **1.5 Sustain and spread**

The practice then decided to focus on identifying patients who have LD but are not identified on the register. The salaried GP ran a search for patients with codes suggesting a possible LD but not on the register and this list was reviewed by their named GPs. This identified 2 patients who were not previously being called in for reviews.

The run chart was updated each month in the staff room and a further practice meeting was held to reflect on how the process was going. This indicated that the practice were on track to have done 75% of annual health checks by the end of the year. The proportion of patients on the LD register obtaining a flu vaccine rose from 15% to 65% in the first year. The practice shared their findings at the second peer review meeting with their PCN. Another practice shared that they had increased their rates of health checks by doing an outreach visit to a residential home for patients with LD. A plan to reach a new target of 85% (for both health checks and flu vaccines) was developed which included doing an outreach visit to a local residential home for patients with LD.

### **1.6 What the practice did next**

The team decided to look at health outcome measures such as rates of cervical screening among female patients with LD and compare these to the general population. This led to a search for patients with LD who were not up to date with their cervical screening and the LD Champion led on calling patients in ensuring accessible information was provided and patients received reminders about the appointment.

### **1.7 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 and to support individual clinicians in their annual appraisal.



## Case Study 2 - Improving prescribing in Learning Disability

**Practice details:** 16,000 patients, inner city practice, diverse practice team including two prescribing pharmacists.



The practice team had met to discuss their approach to improving care for people with LD and identified that while they performed well when identifying people with LD and completing annual health checks (with 80% of patients taking up the offer), there was less evidence of comprehensive medication reviews.

### 2.1 Culture and context

The local CCG medicines management team had recently highlighted the NHS England initiative on the over prescribing of medication to patients with a learning disability that may be unnecessary and harmful ([STOMP](#)). It followed the release of research from PHE that showed as many as 35,000 adults with a learning disability (LD) are being prescribed an antipsychotic, an antidepressant or both without appropriate clinical justification. Anonymous data from all local practices to establish the scale of the issue showed that patients with LD in this CCG area appear to be (when compared to the general population):

- 6 times as likely to be prescribed an anticonvulsant
- Nearly twice as likely to be prescribed an antidepressant
- 10 times as likely to be prescribed an antipsychotic
- 7 times as likely to be prescribed an anxiolytic
- 4 times as likely to be prescribed a hypnotic

## 2.2 Diagnose

The practice-based pharmacist undertook a search in the patient records to identify whether patients with LD had had a comprehensive medication review in the last 12 months. While most had a code for medication review, there was no documentation of reasons for changing or remaining on current medication. Psychotropic medication was being prescribed to ten patients with LD. The patient record was then reviewed by the lead GP and pharmacist to see if the prescription was linked to an active problem and when the prescription had last been reviewed. A decision was made to undertake a more detailed review in all these patients, and to regularly check for new prescriptions being commenced.

## 2.3 Plan and test

Following further discussion with the wider practice team the following was agreed:

**Area for improvement** - To reduce inappropriate psychotropic medication prescribing.

1. *Aim* – After 12 months of the project, all patients on the practice LD register will have a comprehensive virtual medication review recorded in the notes, and all patients prescribed a psychotropic medication will have a face to face review.
2. *Measure* – a coded comprehensive medication review in all patients with LD at least once a year carried out by both the pharmacist and lead clinician; searches were run quarterly to ensure a regular achievement towards the practice's own target of 100% by the end of the year. Searches were also run each quarter to identify any new patients with LD who had been prescribed a psychotropic drug.
3. *The changes:*

**After an in-depth review of the current pathway for dealing with this cohort of patients:**

- a. The pharmacist and lead GP both attended a local training session on prescribing for people with LD.
- b. The process for inviting all patients for their annual health check was revised
- c. Medication reviews, conducted virtually by the pharmacist and lead GP, were introduced
- d. All patients identified with prescribed psychotropic medication were recalled for a more detailed review.

The improvement aim, measure and proposed changes were discussed at the first network peer review meeting where a specialist nurse from the community learning disability service offered support to the medication reviews for more complex patients.

## 2.4 Implement and embed

The annual health check template for LD had an additional section on medication added to it. The template reminded nurses to send a message to the pharmacist and lead clinician that the health check had been completed. The pharmacist and clinician met on a monthly basis to do a virtual review of medication on everyone who had had

the health check completed. At this meeting it was agreed what, if any, medication needed reducing, stopping or altering. It was also agreed that either the pharmacist, usual GP or the lead clinician would be best placed to achieve this. The patients were then invited to attend the second part of the health check with the clinician. The practice admin team (guided by the pharmacist) ensured regular recall of patients. Changes includes using both locally approved specialist letters and information sheets to ensure a rolling achievement of the health checks and medication reviews.

An additional quarterly search of all patients on the LD register who were prescribed psychotropic medications was reviewed by the pharmacist to identify anyone who had missed out on a medication review or been started on a new medication subsequently. Several complex patients were identified, discussions took place with the local specialist team about the clinical appropriateness of continued prescription.

## **2.5 Sustain and spread**

The practice achieved 100% of virtual reviews and was able to safely stop psychotropic prescribing in four patients over the course of the year. The pharmacist shared the practice's findings at the second peer review where several local practices agreed to adopt the quarterly search for new prescriptions as an additional safety system.

## **2.6 What the practice did next**

The admin team continued to do monthly searches to recall patients on a rolling basis for health checks, and the pharmacist undertook quarterly searches to identify patients in need of a medication review following their health check. The practice highlighted the new process as an example of safe practice at the next CQC inspection visit.

## **2.7 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 and to support individual clinicians in their annual appraisal.

## Case Study 3: Early diagnosis of cancer based on NCDA outcomes

**Practice details:** 12,000 patients, 5.5 WTEs, suburban practice



The team decided to focus on reducing both the primary care interval and the number of consultations prior to referral, in order to improve early cancer diagnosis.

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

**2.8 Culture and context** One of the salaried GPs had attended a regional QI training course, and a health care assistant (HCA) had completed online QI modules. A core team was created to lead the project, made up of the GP, the HCA and an experienced administrator.

A significant event analysis was undertaken at a practice multidisciplinary clinical team meeting following a complaint relating to a delayed referral. Learning from it highlighted that the number of times a patient with vague symptoms attended the practice before referral to the correct specialty was made, varied widely.

### 2.9 Diagnose

The surgery had participated in the National Cancer Diagnosis Audit in the previous year, and the team reviewed the annual feedback analysis report. They recognised that they had a relatively long primary care interval of 8 days (median), i.e. the time taken between the first presentation to a clinician to a referral from primary to

secondary care, compared to local and national figures. Also, their median number of GP consultations prior to referral was 2 compared to the local and national figure of 1.

## 2.10 Plan and test

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

- 1) *Aims:*
  - a) To reduce the primary care interval by 25% over the next 12 months
  - b) To reduce the median number of consultations prior to referral from 2 to 1 over the next 12 months.
- 2) *Measure:* On a monthly basis the administrator searched and created a list of all new cancer diagnoses. The primary care interval was calculated for each new case by electronic notes review – with first presentation and referral date having been documented in the notes. The number of consultations prior to referral was counted by the HCA.
- 3) *Change:* The team participated in an **initial peer review meeting** with their Primary Care Network colleagues and were able to share both data and ideas. Following discussion with their nearby practice colleagues they decided to:
  - a) Discuss the new cancer diagnoses at more regular intervals - in order to make case discussion more commonplace – by creating dedicated new multidisciplinary cancer diagnosis meetings, to occur every month. These were previously happening quarterly. The admin team would also be encouraged to attend.
  - b) Generate quarterly in-house cancer education sessions,
  - c) Agree changes to the rota that allowed all GPs and practice nurses to attend at least one of the wider CCG cancer events throughout the year.

## 2.11 Implement & Embed

The administrator left the practice after 2 months, providing the opportunity to retrain a new colleague in search and list creation. The HCA oversaw the primary care interval calculation. In order to ensure a good mix of clinical colleagues could attend, the team realised they needed to vary the day of the cancer meetings, and also change the frequency to 6-weekly to keep attendance high. They realised that not all of the clinicians were aware of the latest changes to NG12 (*Suspected cancer: Recognition and referral*) guidelines, so this was the focus of the first team educational session. Session changes meant that some GPs were able to attend more educational sessions than in previous years.

## 2.12 Outcome

It was reassuring to find that the median number of consultations prior to referral had reduced from 2 to 1.5 (the new range being 0-5 compared with 0-8 previously) over the course of the project, whereas the primary care interval showed a modest improvement of 15%, to under 7 days. The figures were plotted on run charts in the

waiting room each month so that both the whole practice team and patients could observe progress – and an overall trend improvement.

### **2.13 Sustain and Spread**

By calculating and reviewing the primary care interval themselves on a monthly basis, they felt better able to visualise any changes. They found that an increasing number of the admin team attended the meetings, over the course of the year. The project lead also attended the **2nd peer review meeting**, where she shared the team's work with colleagues from the local primary care network, wider system issues were recognised and ideas for next year's collective efforts were suggested.

### **2.14 What the practice did next**

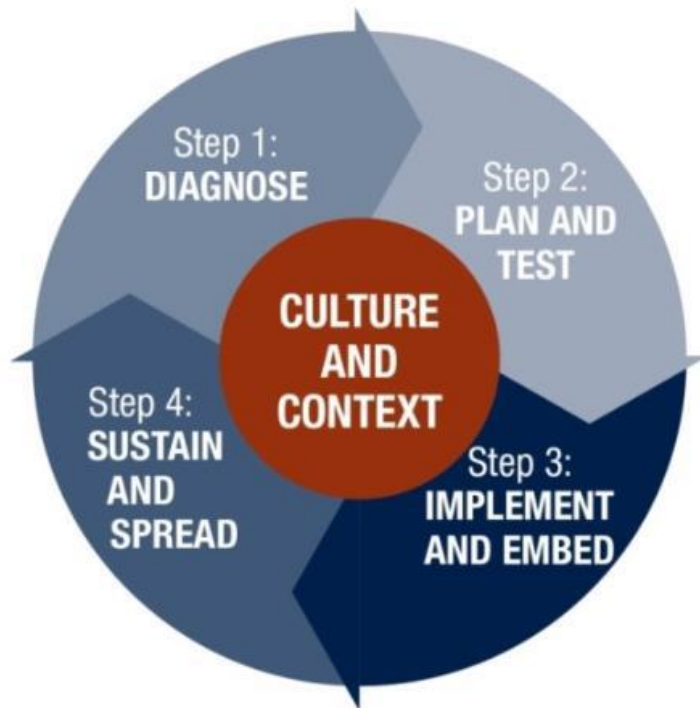
They agreed that they would continue to contribute to the NCDA. Also, that the QI cancer lead would rotate between 2 of the junior GPs who both showed increased interest following the cancer education sessions. They intend to concentrate next year on safety netting 2 Week Wait referrals to ensure patients consistently receive an appointment within 2 weeks and agreed to invite members of the PPG to join in planning discussions for future QI work.

### **2.15 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.

## Case Study 4: Bowel cancer screening

### Practice details:



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

The project team focused on ways to improve the uptake of bowel cancer 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).

### **2.16 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 together a brief SWOT (strengths, weakness, opportunities and threats) analysis in relation to both cancer diagnosis and screening. A low uptake of the national bowel cancer screening programme uptake was recognised as a key area for attention.

### **2.17 Diagnose**

The practice used searches found in Macmillan's quality improvement toolkit, along with Fingertips data and CRUK's "Expected vs actual" tool. They identified the practice as being in the lowest decile nationwide.

## 2.18 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 wants to achieve and by when), a measure (how they will know if anything is changing), and the change itself (what will people do differently):

- 1) *Aim*: The practice team aimed to increase the uptake of patients who default on bowel screening by 10% over the next 12 months
- 2) *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
- 3) *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 to those subjects who had not returned their gFOBt or FIT kit within four months of the BCSP invitation
  - b) Letters were sent, *AND* telephone calls made
  - c) Opportunistic discussion of bowel screening for those patients consulting their GP for other reasons, who have not been screened within the past two years, was undertaken - including coding on the practice operating system (“Advice given about bowel cancer screening programme”).

## 2.19 Implement and embed

The GP had attended a GP Cancer Update Course, and this included a number of proposals for improving the uptake of patients who default or decline bowel screening. The proposals included increasing awareness amongst all clinicians - including 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.

## 2.20 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 had, also using run charts.



## **2.21 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.

## **2.22 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.

## **2.23 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.

## Case Study 5: Cervical Screening

**Practice details:** 4,500 patients, 2.7 WTE GPs, inner-city teaching practice – lower decile deprivation index.



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).

**2.24 Culture and context** In preparation for the QOF QI domains the GP, a practice nurse, a HCA and an administrator undertook the online RCGP QI learning module. We created a QI project team.

At a practice cancer review meeting a case was discussed involving a 32-year-old patient who had recently been diagnosed with cervical cancer. At a routine GP consultation, she presented with vaginal discharge and post-coital bleeding. Her cervix appeared abnormal on examination. She was referred urgently. We realised that she had never attended for a cervical smear. This prompted a review of smear uptake.

### 2.25 Diagnose

Using the PHE Fingertips data, the GP reviewed the cervical screening rates for the practice and compared these to local surgeries and other CCGs nationally. He also used EMIS searches to compare this data to previous years, and to drill down further to identify any inequality within the practice. He also reviewed uptake rates for hard

to reach patients. The data demonstrated that *total* practice cervical screening uptake rates in all eligible patients had decreased over the previous 2 years from 72% to 63%. Rates for women aged 25-34 were notably low, as were rates for female patients without English as a first language.

The data was presented at the next whole team practice meeting and reasons for the decline were suggested.

## **2.26 Plan and test**

It was agreed that the whole busy practice team would consider upping screening rates as a priority, and clinicians, admin and reception worked together to consider how they would approach the challenge, and how they would support each other.

We used the *Model for Improvement* to plan the project. We devised SMART aims (what the project wants to achieve and by when), some practical measures (to understand what had changed) and brainstormed together to consider a range of changes that all would be happy to try out. We used a driver diagram to help focus our list of changes.

*Aim:* Over the next 10 months, we aimed to increase the total *uptake* of cervical screening by 8% to reach the national average, and with a 'stretch target' of 12% - to enter the top quartile.

*Measures:*

- i) Proportion of eligible patients screened adequately within the specified period (25-49y last 3.5y, and 50-64 in last 5.5y), within the last 12m
- ii) Proportion of eligible patients with a) 1<sup>st</sup>, b)2<sup>nd</sup>, and c) 3<sup>rd</sup> reminder letters, in the last 12m
- iii) Average level of confidence across both clinical and non-clinical team members (self-assessed from 1-10) in having conversations with patients about screening.

Measures i) and ii) were taken weekly. Measure iii) taken monthly. All were displayed on *run charts*.

*Changes:* We invited our patient participation group (PPG) to contribute, and from a suggested team list of 22 possible improvement changes, we agreed on the following ideas to implement:

- 1) Relating to education:
  - a) An update to the clinical team on cervical screening and the role of HPV.
    - i) All clinicians agreed to consider opportunistic screening when possible, especially for those women who had been harder to engage.
  - b) Practice learning sessions for the admin team - including basics of screening, clinical importance and how to approach patients to make the most of each contact.
    - i) All receptionists were made aware of how to check the records of women attending the practice for appointments, and to discuss the option of arranging an appointment for screening at a convenient time.

- 2) Relating to access:
  - a) Flexibility was introduced to provide cervical smear testing *immediately* if a patient identified she was ready to have the test (e.g. at baby clinic).
  - b) The rota was revised to allow 2 focused late afternoons and evenings per week
- 3) Relating to invitation:
  - a) Women were actively encouraged to bring a friend along with them to the appointment if they thought that would be helpful – in the invitation letter, at reception, and opportunistically
  - b) Leaflets in different languages were placed in the waiting room for the benefit of the practice's hard to reach cohort

Changes were introduced individually and gradually – in order to notice any change in uptake rates -and reviewed formally at 2 monthly meetings. The question of 'How are things going?', was regularly raised informally.

## **2.27 Implement & Embed**

Several clinicians went on to undertake the NHS cervical screening module programme on [eLfH](#). Comments, collected from women who attended about why they had not done so previously, were used to further promote attendance. The project was advertised on, and some of the feedback attached to, a newly created 'Women's Health' board in the waiting area.

## **2.28 Outcome**

In the first 6 months, the percentage of women attending for cervical screening increased by 3% compared to last year. By 12 months, it had increased by 10%. Improved internal communication – including informal chats, a standing item at practice meetings, and returning the focus frequently to smears, meant that the confidence of receptionists, admin *and* clinicians when discussing smears also increased. Numbers of opportunistic smears also went up. A monthly chart of uptake was shared internally via email, and also posted to the wall for our team and our patients to see.

## **2.29 Sustain and Spread**

We acknowledged, however, that we need to improve our robustness in ensuring all 3 recall reminders are sent appropriately and aim to work on this continuously.

The project team attended the next PCN network meeting and shared the learning with local practices. Tips were also picked up at the PCN meeting from practices taking a different approach. There were wider discussions about poor uptake of bowel and breast screening programmes and plans to work more closely relating to screening in general were proposed. One practice committed to a more frequent (monthly or so) discussion with our QI lead next year as we recognised they were experiencing very similar problems to us. The practice nurse agreed to start work on a plan for next year, taking into account evidence-based suggestions via [Gov.uk Screening](#).

### **2.30 What the practice did next**

Plans to further tweak the content of 'the script', and the manner in which verbal invitations are delivered to women opportunistically are in the pipeline. The GP lead agreed to further modify the letter sent to eligible women and agreed to compare ours to others in the PCN and using resources online. The NHS [Easy guide to cervical screening](#) will also be attached to the letter. Further work to improve the cervical screening offer to women with physical or learning disabilities is planned in the next phase of the project – since this was the next notable group with low attendance rates. We are looking to work closely with the PPG again to understand the main barriers and concerns for women and their carers.

### **2.31 What evidence did the practice provide for QOF payment**

We completed the annual QOF QI domain self-declaration. We 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.