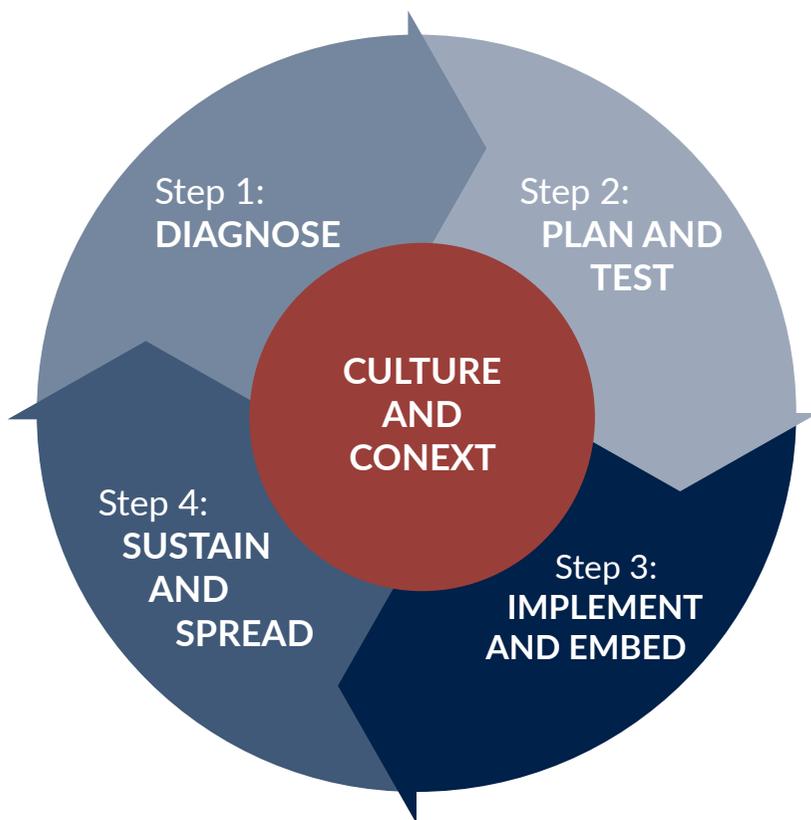




QOF QI Early diagnosis of cancer case study: Cervical Screening

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).

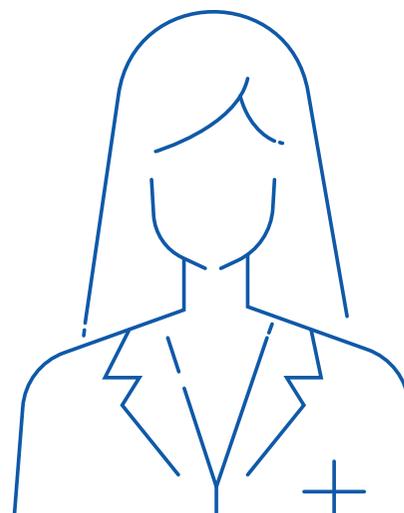


Culture and context:

In preparation for the QOF QI domains a GP, a practice nurse, a HCA and an administrator undertook the online RCGP QI learning module and 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. It was realised that she had never attended for a cervical smear. This prompted a review of smear uptake.

It was noted that there had been a reduction in the number of cervical screens performed following a practice nurse leaving and this was an area for attention.



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 groups who may experience barriers to accessing services. The data demonstrated that total practice cervical screening rates in all eligible patients had decreased over the previous 2 years. Uptake had dropped from a stable 72% to 66% to 63% in 2 years. 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. Reasons for the decline were proposed and included the change in the practice nurse rota – resulting in fewer appointments available after 4pm, along with changes in administration staff. Plus, a general lack of understanding about the process and significance of testing was acknowledged.

✓ Plan and test:

It was agreed that the busy team would consider upping screening rates as a priority and, with clinicians, administrators and reception staff working together, consider how they would approach the challenge, and how they would support each other.

The team used the Model for Improvement to plan their project. They devised SMART aims (what the project wanted to achieve and by when), some practical measures (to understand what had changed) and brainstormed together a range of changes they would be happy to try out. They used a driver diagram to help focus their list of changes.

Aim: Over the next 10 months, the team 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.

Changes were introduced gradually and reviewed formally at two monthly meetings and the question of 'How are things going?' was raised on a weekly basis informally.

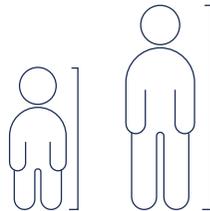
The team attended an initial peer review meeting with their Primary Care Network Colleagues to share both the data they had collected, and ideas of how to improve their performance.

Measures:

- i) Proportion of eligible patients screened adequately within the specified period (25-49 years last 3.5 years, and 50-64 years old in last 5.5 years)
- ii) Proportion of eligible patients with a) 1st, b) 2nd, and c) 3rd reminder letters
- iii) Proportion of eligible patients with text message reminders sent the day before
- iv) Average level of confidence across both clinical and non-clinical team members (self-assessed from 1-10) in having conversations with patients about screening.

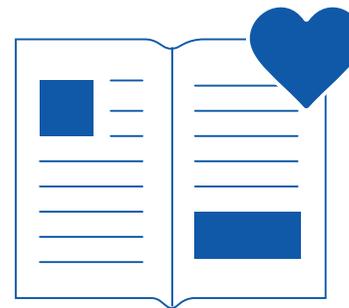
The search was repeated monthly to measure changes.

Change: From a suggested team list of 22 possible improvement changes, the team agreed on the following ideas to work on: 'to ideas to work, which include education, system change and access



Education:

- A teaching update for the clinical team on cervical screening and the role of HPV.
 - All clinicians agreed to consider opportunistic screening when possible, especially for those women who had been harder to engage in the screening programme.
- Practice learning sessions for the administration team including basics of screening, clinical importance and how to approach patients – making the most of each contact.
 - 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 time that was convenient for them.



System change:

- Women were 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
- A text message was sent on the day prior to the appointment to remind the woman to attend.
- Leaflets in different languages were placed in the waiting room for the benefit of the practice's hard to reach cohort

Access:

- 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)
- The rota was revised to allow 2 focused late afternoons and evenings per week

★ Outcome:

In the first 6 months, the proportion of women attending for cervical screening increased by 3% compared to last year. By 12 months, it had increased by 10%. 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. 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, administrators 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 patients to see.

📦 Implement & embed:

A better understanding and empowerment of the team helped contribute to the practice's success. Several clinicians went on to undertake the NHS cervical screening module programme on [eLfH](#). The practice nurse agreed to start work on a plan for next year, taking into account evidence-based suggestions via [Gov.uk Screening](#). Methods to identify those who had failed to attend for screening, via the practice system, were modified as the project progressed, and the reception team felt empowered by recognising their role as part of the solution.

The QI administrator contacted [Jo's cervical cancer](#) trust and arranged for a delivery of free resources to display. The project outcomes and progress were shared in detail with other PCN members at the second meeting.

🔄 Sustain and spread:

They acknowledged, however, that they needed to improve the robustness in ensuring all three recall reminders were sent appropriately. Plans were made to make modifications to the patient record – to better identify those overdue, and to allow an easier offering of appointments. Reception staff resolved to regularly provide a leaflet about the importance of screening to women who were overdue.

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 with other members of the PCN on projects to improve uptake of screening more generally was agreed. One practice committed to a more frequent (monthly or so) discussion with QI leads in the following year as they recognised they were experiencing very similar problems to the practice that had made changes.

➡ What the practice did next:

The content of 'the script', and manner in which verbal invitations were given to women opportunistically were honed – based on feedback actively elicited.

The GP lead agreed to further modify the letter sent to eligible women, and agreed to compare ours to other in the PCN and using resources online. The NHS [Easy guide to cervical screening](#) was also 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. The practice are looking to work closely with the patient participation group to understand the main barriers and concerns for women and their carers.

🔍 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.



CERVICAL SCREENING ATTENDANCE