Quality Improvement Template

Practice name:	Safari Health Clinic	**Date:**	01/02/2026
QI team:	• GP: Doctor Stripes • PM: Pumba Plains • Nurse: Nala Paws		

Problem:	• Bowel cancer can develop without any signs. It usually starts as small growths called polyps, which can grow and become cancer.
	• Bowel cancer was estimated to be the fourth most commonly diagnosed cancer and the second leading cause of cancer death in Australia in 2023.
	• Approximately 90% of bowel cancer cases are cured if detected early.
	• The National Bowel Cancer Screening Program (NBCSP) aims to reduce bowel cancer illness and deaths.
	• Eligible Australians aged 45 to 74 can get a free bowel cancer screening test every 2 years that they do at home. Population-based screening using immunochemical Faecal Occult Blood Test (iFOBT) is the best early detection method available for reducing deaths from bowel cancer.
	• General practices teams play an important role in helping patients make informed decisions about bowel cancer screening. The Alternative Access Model (AAM) allows healthcare providers to bulk order kits and provide them directly to patients or order them one through the NCSR. Evidence suggests that more patients are likely to complete the test are discussing the process with a trusted healthcare provider.
	• Low participation rates:
	  ○ 41.7% of those invited in 2022–2023 participated in the National Bowel Cancer Screening Program (NBCSP).
	  ○ 23.9% of Safari Health Clinic's patient population has a bowel cancer screening result recorded in our software		

Problem Statement:	Despite a 90% cure rate when detected early, only 23.9% of Safari Health Clinic's patients have a recorded bowel cancer screening result. Increasing participation in the NBCSP is crucial to reduce bowel cancer incidence and mortality.		

This document guides practice staff through the **Model for Improvement** (the Thinking Part) and the **Plan-Do-Study-Act** (PDSA) cycle (the Doing Part), a framework for planning, testing, and reviewing changes.

For guidance and support on conducting quality improvement in your primary healthcare services, please contact your local Primary Health Network (PHN).

Model for Improvement

Step 1: Thinking Part - Three Fundamental Questions
Complete the Model for Improvement (MFI) as a whole team.

AIM	**1. What are we trying to accomplish?**		
*By answering this question, you will develop your **GOAL** for improvement. It important to establish a S.M.A.R.T (Specific, Measurable, Achievable, Relevant, Time bound) and people-crafted aim that clearly states what you are trying to achieve.*			
By 30 May 2026, **Safari Health Clinic** aims to provide 50 eligible patients (aged 45-74) due for bowel screening a kit directly through AAM.			
MEASURE(S)	**2. How will we know that a change is an improvement?**		
*By answering this question, you will develop the **MEASURE(S)** you will use to track your overarching goal. Record and track your baseline measurement to allow for later comparison.* *Tip: Use a Run Chart to plot trends.*			
Kits ordered from the NCSR (baseline) Kits remaining (stocktake count)			
Baseline:	50 kits	**Baseline date:**	01/02/2026
CHANGE IDEAS	**3. What changes can we make that will result in improvement?**		
*By answering this question, you will develop **IDEAS** for change.* *Tip: Engage the whole team in formulating change ideas using tools such as brainstorming, driver diagrams or process mapping. Include any predictions and measure their effect quickly.*			
Idea 1	Increase patient awareness of bowel cancer screening and AAM.		
Idea 2	Opportunistically discuss bowel cancer screening during routine appointments. (CCM, GPMP, 715, Age Health Assessments).		
Idea 3	Provide AAM kits in clinic.		
Idea 4	Manage patients not suitable for the NBCSP		
Next steps:	*Each idea may involve multiple short and small PDSA cycles.*		

PDSA (Plan-Do-Study-Act)

Step 2: Doing Part - Plan-Do-Study-Act
Once you have completed the Model for Improvement (MFI), use the template below to document and track your PDSA cycles (i.e. small rapid tests of change).

Idea	Plan		Do	Study	Act
#	**Plan the test**	**Prediction**	**Do the test on small scale**	**Analyse the results**	**Make a plan for next step**
	How will we run this test? Who will do it and when? What will we measure?	*Prediction or hypothesis on what will happen.*	*Was the plan completed? Yes or No. Collect data. Consider what worked well and why? Document any unexpected observations, events or problems.*	*Analyse results, compare them to predictions, and reflect on what you learned. .*	*Based on your learnings from the test, what will you do next (e.g., adopt, adapt or abandon)? How does this inform the plan for your next PDSA?*
Change idea 2.1	**What:** Add bowel cancer screening prompt to health assessment templates and other templates. **Who:** GP, Nurses **How:** During routine Health Assessments (HA), GPMP or Aboriginal & Torres Strait Islander 715 HA, staff ask about bowel screening status. **When:** Feb–Apr 2026 (trial 15 patients).	Expect 80% of HAs to include bowel screening conversation; predict at least 2–3 patients overdue will be identified.	12 patients seen for HA/GPMP. 10/12 were asked about bowel screening. 3 were overdue and accepted kits, 2 already screened (not recorded, completed through private kit), 5 not yet due.	Most GPs/nurses found it easy to add to HA. One GP noted time pressure in longer consults. NCSR was checked for 4 patients to confirm results.	**Adapt:** Embed bowel screening check into all HA/GPMP templates. Nurse to conduct brief risk assessment to understand patient eligibility and make recommendation to GP to alleviate some time pressure.
Change Idea 3.1	**What:** Provide kits directly to eligible and due patients in clinic. **Who:** GPs **How:** Kits stored in consult rooms and opportunistically given to eligible and due patients. **Using the:**	Anticipate high uptake, with at least 50% of distributed kits returned within 6 weeks.	25 kits issued via NCSR CIS integration; 8 results visible in NCSR within 6 weeks; staff noted patients appreciated convenience.	Uptake was strong; return rate (32%) was lower than predicted but still an improvement on the QR code ordering pathway. Time from distribution to NCSR	**Adapt:** Record distribution in CIS & set reminder in patient file for NCSR follow-up by nurse.

	• **Issuing a kit step-by-step instructions | Best Practice** • **Issuing a kit step-by-step instructions| Medical Director** **When:** Trial for 3 weeks (Feb – March 2026)			result was significantly faster compared with mail-out kits. Staff noted AAM worked best when combined with a demonstration or GP encouragement.	
Summary of Results	From a baseline order of 50 kits (01/02/2026), the team issued 25 kits via the AAM; 8 results (32%) were recorded in the NCSR within six weeks—an improvement on the QR ordering pathway and with faster turnaround. The majority of this improvement came from: • Issuing AAM kits directly in the clinic, which shortened wait times, encouraged opportunistic participation, and gave staff a chance to demonstrate correct use. • Embedding bowel screening prompts into health assessments, which identified overdue patients and increased opportunistic discussions. Staff reported increased confidence in: • Using Primary Sense to identify eligible patients and monitor progress. • Navigating and reconciling records with the NCSR to improve accuracy. • Having clear conversations about bowel cancer screening and applying evidence-based recall intervals in line with national guidelines.				