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| BreastScreen Australia. A joint Australian, State and Territory Government Program. |  | **OFFICE USE ONLY** |
| Date of receipt by SCU | Click here to enter a date. |
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| Date of receipt by NQMC | Click here to enter a date. |
| **Quality Improvement Plan** | |

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| Part A Details of Service and/or SCU | | | | |
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| Name of Service and/or SCU |  | | | |
|  |  | |  |  |
| Reporting period | From | Click here to enter a date. | To | Click here to enter a date. |
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| Completed by (name) |  | | | |
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| Document Control | | | | | |
| **Version** |  | **Status** |  | **Date** | Click here to enter a date. |

**Guidance on completing this form (BSA006):**

This Quality Improvement Plan (QIP) form comprises three parts:

**Part A** is a high level Executive Summary designed to inform the Service/SCU management, Survey teams and the NQMC on the broad nature of quality improvement issues being addressed by the Service/SCU. **Part A** is to be provided to the:

* Survey Team prior to an Accreditation Survey;
* NQMC as part of an Accreditation Application; and
* NQMC along with the Service/SCU Annual Data Report.

**Part B** is designed to be used by the SCU/Service at an operational level to detail quality improvement activities.

**Part C** of the Quality Improvement Plan is where the Service/SCU outlines supporting information to its quality improvement issues and activities.

**Note** that **Parts B** and **C** do not have to be provided to the NQMC or Survey teams as part of an Accreditation Application or Annual Data Report. However, the NQMC or Survey teams may request to see **Parts B** and **C** if they need to further detail on a QIP initiative**.**

**Please note** that accountability in **Part A** and **Part B** should reflect clear lines of clinical and management responsibility within the Service and/or SCU.

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| Part A (Cont.) - Executive Summary  Descriptions in the Executive Summary in **Part A** should be kept to a high level and focus on reporting the specific strategies to improve performance against any unmet NAS Measures, or when declining performance trends are identified within the Service and/or SCU. To add more rows, please copy the last row and paste below it. |
| **Area(s) of quality improvement** |

| Standard | NAS Measure | Risk Level | Key issues (problems/causes) | Key improvement strategies | Timeline | Accountability | Status |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 2. Cancer Detection | Example  2.6.1 | 3 | Rate of women aged 50–69 years attending for annual screening has increased to 14.2%. Local policy has changed to offer annual screening to all clients with an elevated personal risk of breast cancer due to unavailability of alternative surveillance options locally. | Structured process implemented through formal Decision Tool for Annual Screening in conjunction with dedicated training on family history and personal risk in relation to eligibility. These strategies have demonstrated marginal reduction in annual screening rate. | 30/6/2017 | J Smith, Clinical Director | In progress |
| 1. Access and Participation | Example  1.1.1 | 2 | Participation rate for women aged 50–69 years has fallen by 2% in the most recent 24-month period. Research indicates this is largely due to the ageing population within catchment. | Wide-range of targeted strategies aimed at increasing participation developed within formal Recruitment and Community Engagement Plan. | 30/6/2017 | S Brown, Program Manager | In progress |
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| Part B – Detailed Plan  This **Part B** of the Quality Improvement Plan is where the Service/SCU outlines its detailed quality improvement issues and activities. The content of this section should be aimed at supporting the operations of the Service/SCU in achieving its quality improvement objectives.  The detailed Quality Improvement Plan should, at a minimum, outline for each quality improvement strategy:   * The relevant NAS Standard(s): * The relevant NAS Measure(s) and their risk levels or the relevant Protocol(s); * The performance levels/issues that need to be rectified or monitored; * The quality improvement activities being undertaken; * How the success of the activities will be measured; * The timelines for the activities; * Who is accountable for undertaking the activities; * The status of the activity, including whether the outcome has been evaluated.   The table below is the **default format** for the Detailed Quality Improvement Plan for the Service/SCU. Alternative formats can be used provided they meet the minimum requirements outlined above.  NB: The examples presented below reflect the minimum requirements for what an Operational level QIP should cover. |

| Standard | NAS Measure/Protocol | Performance (Source/Period) | Risk Level | Activities | Measures of Success | Timeline | Accountability | Status |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NAS Measure noted for improvement from 201x ADR and 201x Accreditation Site Visit/Survey | | | | | | | | |
| ***Example:***  Cancer Detection | 2.6.1(b) ≤ 10% of women aged 50–69 years attend for annual screening. | 201x ADR: 13.5%  201x ADR: 14.2% | 2 | * Formal Decision Tool for Annual Screening implemented. * Dedicated training on family history and personal risk in relation to eligibility. * Refresher training and orientation training for new staff. * Literature review underway to evidence the decrease of family history risk as women age. | <12% in 15/16  <10% in 16/17 | 30/6/17 | Clinical Director | Evaluated December 2015.  Monitor quarterly. |
| ***Example:***  Access and Participation | 1.1.1(b) ≥ 70% of women aged 50–69 years participate in screening in the most recent 24-month period. | 201x ADR: 58.9%  201y ADR: 56.9%. | 2 | * Focus on engagement with GPs; * Increase workplace visits and community events. * Incorporate client feedback learnings into outreach activities. * Identify issues that may impact public perception of Program and respond. * Enhancements to website to facilitate navigation and provide access to a wide range of brochures. * Explore online booking system facility. | >58% in 15/16  >60% in 16/17 | 30/6/17 | Program Manager | Evaluated December 2015.  Monitor monthly. |
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| **NAS Measure noted for monitoring from 201x ADR and 201x Accreditation Site Visit/Survey** | | | | | | | | |
| 3. Assessment | ***Example:***  3.1.1 <5% of all percutaneous needle biopsies of malignant breast lesions are classified as benign or inadequate/insufficient. | 3.9% in 201x (Met);  4.1% in 201x (Met);  4.5% in 201x (Met); | 2 | While NAS measure continues to be Met, an upward trend is apparent. Consideration of:   * whether biopsies are currently overly restricted (i.e. restricting biopsies to those with a high probability of cancer may result in missing some low probability cancers); * if the result reflects a greater proportion of FNAs on lymph nodes; and * sampling error   were undertaken in 201x to address upward trend. | 4.3% in 2013/2014  3.8% in 2014/2015 | 30/6/16 | Clinical Director | Completed |
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| Part C – Supporting Information  *This* ***Part C*** *provides more information, if required, about the issues outlined in* ***Part B,*** *e.g. list of additional documentation, funnel plots.* |

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