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| **PCN Evaluation Template 20/21**Thank you for all your work to improve uptake and coverage in the cervical screening programme. This template will help you to focus in on the data that is needed to understand the feasibility of each of the interventions. Please choose the intervention that you chose to implement in your PCN and add the data submission **PCN area: Chessington and Surbiton****PCN lead:Emily Kelly****Date pilot started: September 2020****Brief summary of pilot and population/demographics:There were 2 arms to this pilot:****1.To offer extended access (weekends initially) to women eligible for cervical screening.** **2. To try and increase the uptake of cervical screening in women with Learning Disabilities by sending out specially writted information prior to a 10 minute consultations dedicated to discussing cervical screening with either a GP known to them or with the nurse who would be carrying out the screening. This could be done alongside or separate to the annual learning disability check.**  |
| **Intervention** | **Data** | **Data Submission** | **Comments** |
| **Baseline statistics – all to complete** | Number of women screened | 2723 | Claremont Medical Centre Data Only |
| Women aged 24 – 49 number and % with a screening result in the past 3.5 years (2019 baseline vs pilot) |  2796, 75% screened |   |
| Women aged 50 – 64 number and % with a screening result in the past 5.5 years (2019 baseline vs pilot) |  803, 78% screened |   |
| **Extended Access (EA)** | Number of EA screening appointments available  |  8 |   |
| Number of these appointments booked and attended  |  8 booked 2 attended |   |
| Any attitudinal/qualitative data available regarding extended access appointments (eg patient questionnaire) | None |  |
| **Online booking**  | Numbers of women screened per month (comparator: same month in 2019 and 3 months prior to intervention start date)  |   |   |
| Number and proportion of screening appointments available to book online per month |   |   |
| Number and proportion of these appointments booked and attended |   |   |
| Any attitudinal/qualitative data available regarding online appointments (eg patient questionnaire)  |   |   |
| **Non-attenders** | Number and % of women who did not attend their cervical screening appointment by practice (DNA booked appointment and/or declined appointment) |   |   |
| Number and % of women contacted about their non-attendance by practice |   |   |
| Summary (number and %) of reasons for non-attendance (suggest you code the data) – may be helpful to present the data using bar charts etc  |    |
| **Learning disability**  | Number of women identified with LD registered with PCN practices aged 25-64 |   |   |
| Number of screening appointments booked and attended |   |   |
| Any attitudinal/qualitative data available regarding LD appointments (eg case studies) |   |   |
| **Text reminders** | **Due a screen:** Denominator: number of women due for a cervical screen (monthly)Number and proportion who were texted a reminder to bookNumber and proportion of those texted/not texted who booked |   |   |
| **Reminder of appointment**: Denominator: number of women with an appointment (monthly)Number and proportion who were texted an appointment reminderNumber and proportion of those texted/not texted who attended |   |   |
| **Mobile Phone number verification**  | Number and proportion of women 24-64 on GP registers with mobile phone number recorded |   |   |
| Number and proportion of mobile phone numbers verified |   |   |
| **Project logistics****How was the project resourced? (new systems, staff, administrative support)**The first arm project (extended access) was run by myself and the PCN manager, Nacima Abdi. In the initial set up we explored possible ways to carry out the extended access using the local Chambers group or nominating one practice to offer extended access to all patients within the PCN. Ultimately it was decided that we would use Chambers to offer Saturday morning clinics therefore we enlisted the manager of Chambers, Penny WIlliams to assist us.The second arm of the project (to improve uptake of screening in women with learning disabilities) was run by myself. I compiled pre-appointment information to be sent to patients beforehand, and guidance for GPs and practice nurses on adjustments to make during the appointments.**What worked well?** The GPs who are clinical leads for patients with Learning Disabilities were responsive to the trial methods.**What part of the implementation was a challenge?**There were several challenges. All are related to the Extended Access clinics. 1) Financial. We could not find a way to cost the pilot to provide any significant amount of cervical screening appointments. Initially we had hoped to use student nurses to bring costs down but before the first clinic but they needed to be supervised by practice nurse who then at the last minute realised there was going to a financial impact in terms of higher taxation, so asked for more money. This eroded goodwill at a very stressful time for all concerned (due to the pandemic) As I have no experience of staffing and payroll I was reliant on the PCN manager for all of this so when I lost her cooperation it became very difficult to progress. I was also unable to invoice for the project myself and as we could not run the clinics without paying the staff involved there was not option but to suspend the pilot in the hope that the invoice would eventually be claimed.2. Timing.  The first EA clinic was scheduled for just before Christmas and after the end of a ‘circuit break’ lockdown so most appointments that were scheduled were not attended. At the same time came the roll out of the vaccination programme which took an enormous effort on the part of the PCN clinical director and the manager. Unfortunately, the vaccination programme had to take priority then for several months. While efforts were put into vaccinating the Manager of Chambers was awarded funding to start an Extended Access clinic specifically for offering cervical screening appointments. There appointments were made available for all practices in the PCN on a much greater scale that the pilot could offer and at this point it was felt that running two similar services alongside each other would cause confusion. Happily, the extended access service does seem to be running well and is popular with patients. 3. Covid 19 I think the unfortunate timing of the pilot, intially due to start just as the first wave of the pandemic hit, then restarted just as both a second wave and an enormous vaccination rollout started, meant that it was incredibly challenging to keep anyone engaged or motivated to persist with this pilot.   |
| **Patient experience and impact****What have you learned about the outcomes of your selected population?**What the doctors who undertook the second arm of the pilot found was that the change in approach to women with learning disabilities did make a difference in womens’ reluctance to have a cervical screen. This was my experience and all women in my practice who have not had cervical screening said that they would be willing to have screening. However all these women had never had any sort of sexual contact with a man or woman and were therefore extremely low risk. All GPs involved in this agreed that it did not feel appropriate to put such patients through a potentially distressing situation.**How will this way of working improve patient experience long term?**I expect that all GPs in the PCN who adopted the improved approach to screening in women with a LD will continue to use these resources long term. |
| **Wider learning****What piece of advice would you give to another practice who wants to implement your chosen intervention?**I would encourage them strongly to adopt the method that was used (pre appointment leaflet, dedicated appointment to discuss cervical screening). This is a low cost low effort method that is easy to incorporate into normal practice and, given the low numbers of this population, requires very little additional resources |