Summary of discussions from Transforming Planned Care Workshop

Gynaecology

- 2ww –Could they be seen within a community setting rather than in secondary care?
- Set up virtual clinics/follow ups
- GPs should be coached on how to reassure patients without making referral – need to manage patient expectations and have alternatives to clinical referral (Together for Health principles).
- High number of poor quality referrals in the system –referral forms/templates should have mandatory fields that will not allow the referral form to be sent unless it is complete. It will act as a prompt to remind the GP of the criteria that should be completed before a referral form is sent
- NICE guidelines advise GPs to refer when it may not always be necessary – develop local guidelines for GPs to follow and explicit criteria that must be completed before a referral is made. Work closely with Intermediate Services and Secondary Care services to develop this. Audit referrals to gain understanding on why the referral was inappropriate and what should have happened to the patient
- Kinesis/ Advice & Guidance – Consultants would be able to respond to the GP query within 2 hours
- TVUS should be used as a referral management tool – show the patient that their scan is all clear and therefore they do not need a referral. TVS training/equipment should be made available to GPs to help reduce referrals
- Behaviour change within consultants – consultants advise patients to ask their GPs to make further referrals, the patient then expects a referral and it makes it very difficult for the GP to refuse. The whole healthcare system should work together in reducing the number of gynaecology referrals
- Uro-gynaecology patients can be seen by specialised nurses in the community/primary care rather than a consultant. However CCG would have to invest in the specialised nurse, but invest to save. Would reduce secondary care activity and would be a better experience for the patient.
- More focus on preventative measures should be used such as pelvic floor exercises,
- Better patient education – Health help now, professional leaflets, with support from the voluntary sector and pharmacies.
- Practices should triage gynaecology appointments then information should be sent to the patient informing them of the steps they should take before they ask for a referral and the criteria they must fulfil. The patient may then find that a GP appointment is not necessary.
- Greater focus on GP education to reduce variation across Croydon practices. GP training for gynaecology should be made available to all practices to help improve GP skillset in order to shift work from community/secondary care back into primary care.
- Coils (Mirena) could be fitted in primary care for medical reasons, in addition to contraceptive reasons, if GPs receive appropriate training
- Genital swabs do not need to be provided by intermediate service as GUM clinic already provides the service
- Referrals from other practices to GPwSI practices and advice lines with for GPs managed by GPwSIs. Therefore only complex patients should be referred onto intermediate care/secondary care.
- CHS to recruit another uro-gynaecologist
- Health websites and apps must be regularly updated and appear professional so patients have confidence in the information they are provided with

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- Voluntary, GP and consultant led education sessions held in schools

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Dermatology

- GPwSIs to provide educational support for GPs on a monthly basis and run educational workshops
- Implement consistent referral protocols across Croydon so that referrals for dermatology are properly vetted. Implement strict criteria where a referral can only be made once A, B, C and D has been done
- GPwSI could do sessions in GP practices in their network. That way they would have access to patient history via practice clinical system. Or even a community dermatology nurse?
- There is a huge variation in GP dermatology skills. A system whereby GPs are upskilled should be considered
- Communitas could work with the variation team to support practices where dermatology referrals are high and/ or found to be inappropriate
- Teledermoscopy could be used. The software is quite expensive; however it can be done cheaply via ERS. With good guidelines, the risk of using this in primary care could be reduced. Communitas is currently rolling out at Surrey Downs CCG. Croydon should push for a telederm pilot
- Can we tell the trust to reject any referrals that are bypassing triage?
- An advice line could be developed for dermatology? Perhaps use something like Kinesis? Communitas are set up to give advice and guidance via ERS in other places. Kinesis could support giving feedback on rejected referrals so that there is some learning in place in these situations. GPs need to be encouraged to check their work list on ERS. Effective feedback could reduce excessive follow ups
- Could consultants run clinics in primary care or the community for a reduced tariff?
- Are there any conditions that should stop being treated immediately?
- General practice could be doing cryotherapy. Depending on volume, this could be done on a network basis with referrals made between practices within the network
- Keloid scar reduction should be considered as a “Choosing Wisely” policy
- Suspected cancer referrals should be audited so that inappropriate referrals that are not meeting suspected cancer guidelines could be looked into
- A debate was had around whether the setting for the 2ww dermatology pathway needed to be in secondary care. It was agreed to assess the guidelines
- 2ww rx could be filtered within 24 hours to tease out the inappropriate referrals
- Develop an exit strategy for patients that enter the intermediate services
- There is a role for pharmacists in giving advice to improve patient compliance with their treatment
- A lot of follow up appointments are normally duplication and not needed. These should be discouraged unless necessary
- The CCG should encourage the hospital to align with primary care prescribing guidelines for when management shifts to GP, as often the GP is being pushed to prescribe more cost-effective medication, but as the patient has an expectation that they will be prescribed what the consultant has recommended, they will often not comply with GP recommendation

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MSK/T&O

- More time needs to be given for effect of exercise management or lifestyle advice to take effect – this should be closely monitored by primary care to prevent repeat attendances within a given period of time.
- Non-medical element to the model should be a strong focus – greater emphasis on coaching and support on lifestyle management, weight management, dietary advice, referral to community exercise classes, mindfulness
- Self-help, self-management, patient education, patient champions and expert patient-led classes
- More focus on patient education and managing patient expectations
- Integrated multi-disciplinary hub or hub and spoke model – combining expertise from physios, exercise therapists and weight management, dietetics, psychological therapies, rheumatology and pain management
- Integrated hub could provide multi-disciplinary support for GPs via virtual means, as well as virtual consultations
- Improve communications and sign-posting by putting information in gyms, leisure centres and pharmacies
- More emphasis on maximising GPwSIs skills within Primary Care
- Better provision of GP education (PLT in June is focusing on MSK education for GPs) from a range of sources – from T&O consultants to rheumatologists
- Physios deliver programmes in leisure centres – this is being done in Lewisham already
- All practices should use EMIS everywhere in order to improve channels of communication and allow access to GPwSI advice
- Practice-based physios could see patients, relieving the burden of MSK appointments on GPs, as well as providing GPs with support, advice and education as part of their PDP, for example, techniques for carrying out minor examinations
- Repatriation of patients from other trusts to CHS should be considered as MFF is lower.

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ENT

- Hearing loss without ENT symptoms to be signposted to hearing screening (Croydon Hearing Resource Centre) via Health Help Now and GPs
- Under-60s hearing test no longer required to have ENT outpatient 1st attendance
- One-stop-shop Micro-suction and Hearing Aid assessment at two sites
- Virtual 1st outpatient and follow-up appointments using digital photo-enabled scopes
- Shift of Otology day-case procedures to Outpatients.
- Tinnitus patients don't need to be seen by the ENT doctor but audiologists
- Could micro-suctioning be undertaken in primary care with investment on a network hub model
- More emphasis on screening before hearing test – free boots test, Croydon Hearing Resource Centre – need to establish a screening criteria
- Rhinitis discussion; should allergy tests be requested by primary care? Could the patient information be improved?
- ENT theatre not being used therefore capacity to increase activity if work repatriated from other trusts, St Georges has a higher MFF therefore more expensive to undertake activity there
- Segmentation of patients – Stockport model
- Most day-case otology surgery can be undertaken in Outpatients
- Purley war memorial hospital has unused audiology booths.

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