A – Social prescribing, Improving Activation, Self-care & Self-management

Examples of groups that could be available on social prescription:

- Talking Groups
- Self-help groups
- Exercise sign-posting
- Singing/ yoga/ Pilates/ gardening groups

MSK:

- Repository of information – perhaps based at the Healthy Living Hub, on DXS, sign-posting gateway
- Advertise social groups on Social Media and in local newspapers and magazines
- GPs should signpost patients to social groups to promote healthy lifestyles. These could include Weight Watchers, gardening groups, singing groups, yoga and exercise groups
- This needs to be driven by the CCG and there needs to be a dedicated programme manager to coordinate and maintain the repository mentioned above and signpost people to the correct solutions for them
- Better visibility of community groups – many groups already exist but social prescribing is a new phenomenon among clinicians and patients
- Good advertising strategies are required for these groups, such as:
  - social media
  - local newspapers and magazines (Selsdon Gazette, Sanderstead Gazette etc.)
  - residents associations
  - PPGs and at GP practices
  - patient champions
  - schools, 6th Forms and colleges
  - churches and other religious communities
- Patient support groups at practices should be encouraged for long-term conditions.
- Options for social prescribing should be added to DXS

Ophthalmology:

- Improving patient basic knowledge
- Upskilling the patient
- Empowering the patient to manage their own conditions
- Signposting for patients so they know where to go depending on the condition
- Utilise health help now app
- Information must also be updated on DXS so that GPs can signpost patients
- Ensure educational courses (dafne/desmond) are providing substantial self-care information so that high-risk patients are aware of the risks.
- Provide primary care with information on the 12 minor eye units managed by COS, where they are located and how they can be accessed. Upload onto DXS, clear information pack.
- Update Health Help Now app with COS information

Gynaecology

- Education for patients in leaflet form in GP surgeries (to advertise social groups etc.)
- Possibly a Croydon advertiser could be advertising basic health information. Possibly a publication could publish specific self-help information for people on a regular basis
- There is a recognised need for information to be provided to patients about health and lifestyle choices that directly affect certain conditions e.g. for gynae this would be obesity
- Use of Pharmacy
- printed leaflets / pharmacies / libraries
- Information for people who may have had a procedure and may need simple advice and reassurance
- When discharged from secondary care, having advice on how to alleviate certain conditions, what constitutes something that might be worrying etc. providing self-care information on discharge on long-term management

- Recognising that self-help is needed at the beginning as well at the end of the pathway, so support re-referrals etc.
- Squeezy app for pelvic floor exercises
- need to sign post patients to recommended health websites such as NHS Choices

Dermatology:

- We should assess whether there are any local patient support groups available for skin conditions and look at linking in to promote self-management. If not, perhaps the CCG could look into getting one going.
- What might be the contributing factors around common skin conditions such as eczema or psoriasis that can be looked at from a prevention perspective? For example, stress can often exacerbate such conditions. Is there a way that patients that experience dermatological issues triggered by stress can be signposted to lifestyle support? How do we link disease and health conditions to environmental/ stress triggers in a clear and simple way?
- There is a lot of emphasis on emollients and creams that patients often struggle to comply with. Can we provide more information (i.e. simple leaflets on DXS) that give a bit of information on these medications?
- What local communities/ centres could we engage with to give information around common skin issues?
- Consider how coding in GP practices could help paint a picture of where self-care and shared decision making is being advocated and carried out? If there is income attached to the coding, this will provide incentive.
- Noted that coding is a huge admin burden – however the content on DXS is fully coded. The CCG can ask DXS to apply only certain codes to the content and this would be written back to the patient record. Can we create support tools that can be saved back to patient records?

ENT:

- People should access advice and signposting using the HealthHelpNow app. Some discussion was held on whether the app needed to be made more accessible by availability in local public places/assets (e.g. libraries), although there was some feeling that the advice and guidance needs to be immediately available, hence why an app on a mobile phone is effective
- HHN app should be better promoted in local assets (libraries, secondary audiology, local charities)
- The CCG could investigate whether HHN app can be preloaded onto new mobile phones
- Training practice staff to ask patients whether downloaded the Health help now app when they ring to make an appointment
- Signposting – patients could choose whether they need virtual or non-virtual support
- Potential conditions suitable for this approach include:
  - Upper respiratory tract infections
  - Viral illness
  - Nose bleed for a child (but not adult)
  - Other types of prevention (e.g. someone who keeps getting glue ear)
  - Blocked ears (old people) or blocked noses (young people)
  - Sore throat, although if recurrent need a tailored system to ensure they seek GP advice if particular signs/length of condition occurs
  - Rhinitis – Generally suitable for GP support
- ENT Medications which are over the counter but at a cost which means that those who receive free prescriptions need to their GP should be identified and offered free without a GP visit
- Self-referral to a nurse led service where patients confirm that they have undertaken certain self-care actions (blocked ears)
- CCG should publish ECI/IFR pre-approval criteria on HHN app.

B – Primary Care Core Services

MSK:

- More GP education
- Upskill GPs to provide different services – however, GPs are already at capacity and need to be supported
- Could longer appointments be offered for MSK conditions?
- Improve links with and access to other clinicians to support GPs
- GPs should be educated on different ways to manage pain
- IAPT offers a pain management support service – there should be better uptake of this as an holistic approach to support patients with pain
- IAPT should become a core GP service and patients should be able to self-refer
- Meditation, yoga and CBT should be offered as a way to improve well-being

Ophthalmology:

- Upskill primary care's basic knowledge on ophthalmology
- Primary Care needs access to a directory of medication that can be used.
- COS need access to Croydon's approved prescribing list – be aware of what can/can't be referred
- 1 single point of access for all ophthalmology referrals
- COS could leave appointment slots open for emergency patients, patients would visit COS rather than Moorfields A&E (depending on inclusion/exclusions).
- COS open a live triage service via telephone for primary care/patients to access the emergency slots

Gynaecology:

- Support for GPs in terms of clarification of patient pathways. Within these would be embedded advice on clinical work-ups and triaging
- Make the pathways available for patients to manage their expectations about how their treatment will progress etc. This should also support shared decision making
- make ECI criteria available on the HHN app
- Advice line for consultants- operationally would be best for gynae consultants to have an established slot in their work plan at say the end of a clinic to return calls and provide advice for GP's (reportedly the cardiology approach seems to work well so there is an opportunity to share information and models across specialities)
- GP education is needed through study days (attendance not good)
- Issue of GP's using old forms and therefore not using the most effective approach to making referrals (thus a greater number of inappropriate referrals to secondary care)
- Ensure there is a reduction in use of diagnostics in the PW (AX forms and advice on work-ups is helpful for GPs)
- Possible to launch a campaign like that used in Stoke-on-Trent, asking patients to ask their GP 3 questions (to promote self-care) i.e. what is my problem, what do I need to do, and why is it important that I do it.

Dermatology:

- There is a lot of variation across networks and practices, how can the networks support this? All agreed that the networks should do more to support each other – i.e. pool resources for a population within a network to meet dermatology needs.
- Is there a minimum core service that patients should expect – i.e. access to dermatology GPwSI or dermatology nurse? Could the GP alliance provide a way of increasing access to dermatology care that is appropriate for primary care delivery?
- Often skin conditions flare up quickly and require quick resolution – how can this be delivered for patients in a primary care setting to prevent them needing access to intermediate or secondary care services?
- We should try and pull together a registers of skills in primary care so that we can map out where GPs with a dermatology interest already are. What are practices already doing with dermatology?
- There is an opportunity for practice staff to skill up to a point, but what would make a difference?

- Need to identify referrals by practice
- What prescribing data is available? Which conditions illicit the highest spend on drugs?
- Could there be a “video doctor” in surgery?
- GPs need to be given all the tools to a) sign post patients appropriate and/ or b) provide them with appropriate information to enable and promote self-care/ self-management.

ENT:

- There could be one hub in each network, the pathway operating potentially in the following way:
- Person with blocked ear uses HealthHelpNow app, which identifies that due to their current symptoms, they should seek advice from a pharmacy
- Patient seeks advice from a pharmacist, who advises they need to seek clinical support from an MDT service
- The patient is able to self-refer to the MDT service at a hub. Ideally they would be able to book through an app. They would then receive an ear investigation at the MDT

C – Health Coaching & Group Consultations

MSK:

- Group consultations for MSK would work well.
- Group consultations enable patients to support each other and share learning and experiences, encourages self-care and self-management, provides peer support, allows more time for discussions with clinical input and for broader discussions
- PPG groups could work at network level to organise group consultations for different conditions
- Joint pain advisors – would these sit in enhanced primary care?
- Use connectivity of various services to get patients to a level where they can self-manage their condition
- 1:1 Health coaching within the community at GP level
- Provide assistance in the community to support patients through exercise and lifestyle changes
- Create expert patient networks

Gynaecology:

- In gynae there is an opportunity to improve services for incontinence patients by offering group incontinence services. It is recognised that the lead Physio would require extended skills as otherwise, this would only create duplication in the pathway if Physio treatment was ineffective
- Potential for gynae to in-reach into schools (or school nursing?) to provide advice and support for girls on gynae conditions

Dermatology:

- It might be good to start a pilot group session in one or two networks. Need to see whether there would be proper uptake of this. Patients shouldn't be left with a group session as their only option.

ENT:

- Recurrent dizziness and tinnitus
  - Dizziness may be difficult as a group exercise due to the potential different causes and symptoms. Could be more applicable for health coaching on a 1:1 basis
- Time-limited group consultation for tinnitus could work, and be delivered in primary care settings. A peer support model may also be applicable
- GP based peer support groups for tinnitus once patient has received assessment or treatment by clinician as appropriate

D – Digital Connectivity

MSK:

- Virtual consultations between GPs, clinicians, physios etc.
- Advice and guidance
- Skype to contact other healthcare providers for advice
- Apps to self-manage conditions. Croydon Physio offers a 6 week exercise programme for patients who have suffered whiplash; could this be replicated for other conditions?

Ophthalmology:

- COS need to be available on e-referral which will enable COS to onward refer for practices
- COS are keen to utilise e-referral advice and guidance function.

Gynaecology:

- Use of this medium to promote self-care and activation (in 10 most common languages in the borough)
- Update content for Health help now app (via a group of both clinicians and patients)
- Messaging in terms of health advice/self-help must be consistent and from a reputable source e.g. link to NHS choices etc.

Dermatology:

- Telederm should be available in primary care
- Could there be something similar to the 12 Lead ECG Service? The photograph is taken in primary care, sent to the diagnostics service for interpretation and report returned to primary care to enable primary care management? This could be done on a SWL wide basis.
- Could we make use of FaceTime/ skype type software to enable virtual consultations for some conditions?
- How could we use Advice and Guidance with Telederm? (If we are going to use advice and guidance).

ENT:

- Could a consultant deliver support in a general practice setting? This would depend on whether it is the best use of their time
- Digital scoping of ears
- Digital scoping of nose and throat, risks are greater, issues with training, skill, consultants needing to trust the quality of the images, only pilot was recommended if at all. Could lead to double scoping of patients.
- Telephone advice for GPs

E – New Enhanced Primary Care Team

MSK:

- Introduce domiciliary physios to carry out home visits – could be at network level
- Would self-referral to community based physios work? This could take pressure off GPs
- Practice or network based physios would allow GPs to get timely advice and also patients presenting with MSK conditions could be immediately triaged away from GPs allowing patients to see an expert earlier in the process and therefore reducing the number of GP visits for these patients

Ophthalmology:

- GPwSI – GPs need to have a clinical passion in ophthalmology
- COS to see paediatrics (aged 0-5)
- Could cataract procedures take place in a primary care setting?
- Post-op cataracts should be treated by COS in the community – Croydon CCG to update and amend service spec
- Diabetic screening is commissioned by NHS England; could local guidelines and processes be incorporated within the service i.e. technicians forward ophthalmology referrals to COS triage service rather than direct to Moorfields
- Review current pathways

Gynaecology:

- Procedures could be done in primary care e.g. smears, pessaries, menorrhagia
- (Intermediate service reports that removal of coils is a common procedure and may be an opportunity for primary care, as currently many emergency coil removals go to A&E)

Dermatology:

- Consultant in the community?
- Enhanced care team in a targeted geographical location?

ENT:

- Community clinics could be developed that provide an enhanced service delivering more diagnostic tests that focus on nose and throat. These areas requiring specialist equipment are currently delivered in the acute setting that is slightly above general practice level, but could be within scope of community delivery.
- Ear investigations are more suitable for GP delivery
- Ideally the consultant should only see patients who require services in a theatre, or other types of interventions.
- Community support could be delivered in either GP or 'community settings', dependent on facilities available
- Telephone/virtual support for general practise – Email support does not work, as the response must be immediate and not a request for a call-back at a later time. The bets type of support would be a telephone 'hotline', where consultant/clinical expertise are available on a rota basis to support GPs. The route must be formalised, not just on a basis of a GP and consultant knowing one another
- Audiology hearing reviews could be provided by an enhanced GP service
- Chronic ear service
- Nurse practitioner to carry out prescribing for the chronic ear service

F – Specialised/ Secondary Care

Ophthalmology:

- Are patients aware of COS 12 minor eye units across Croydon – promote service
- No COS information on Health Help Now app – update app
- All messages must be aligned/linked
- GP Practice websites should signpost practices to COS website

Gynaecology:

- Possible to utilise pre-assessment clinics to
- Concern that if you create GP hubs, other GP's may choose not to maintain their training in the procedures and create a shortage, thus there may be benefit in ensuring all GP's maintain some core skills in gynae (e.g. smears, coils etc.)
- For information, the intermediate service currently provides:
  Outpatient hysteroscopy
  Removal of coils
  Note that the service has a very high DNA rate (e.g. when people present with irregular periods, but then these resolve by the time the person has their appointment and thus do not attend).
  Note the group identified the importance of shared decision making to reduce DNA's
- Note current CUH initiatives:
  EPA unit
  Enhanced recovery, i.e. reducing the need for an inpatient stay

Dermatology:

- Patients should only be referred when level of risk has been determined.

ENT:

- Urgent care would be best placed to see an adult patient with a sudden nose bleed, as they are potentially very serious situation. However, for a child this would not be the case.
- Foreign bodies – micro-suction could potentially be completed in a community setting within the ear
- Removal of foreign bodies from nasal is less likely to be suitable for community support, as a nasal blockage could cause a respiratory emergency
- Bell's palsy – One of the conditions on the St Georges Urgent ENT service referral form History is a key part of forming the diagnosis, with a large number of 'rule-out' tests required. However, potentially there are tests within that diagnostic process that could be suitable for community support, for example hearing tests. Treatment of Bell's palsy seems to be inconsistent.
- There may be activity referred to St George's that could be repatriated to local Croydon services. However, in the majority of cases the CHS consultant felt most care was already provided by CHS that could be. Potentially though a system could be developed where waiting times at different providers are flagged to GPs and patients, as the care provided outside Croydon is not necessarily of a higher quality (it is often delivered by the same consultants) but generally have longer waiting times
- Increase intermediate care to reduce pressure on secondary care

Part 2

Ophthalmology:

- Educational sessions for Primary Care on Ophthalmology referral pathway – network meetings.
- Review Ophthalmology content on DXS
- Upskill primary care to manage common eye conditions
- Advice local pharmacies of COS pathway – make pharmacies aware of 12 minor eye units and where they are located in the borough, so that pharmacies can direct patients straight to COS. Skip out primary care.
- COS to create paediatric (0-5) patient pathway

Gynaecology:

- Group prompted to discuss the potential impact on secondary care is we made the changes
- Possibly a central place for day cases to decrease the inpatient demand (propose looking at the day case rates). Current IP rates are about 1-2 inpatient cases per month, all the rest are day cases
- Consultant advised that the design of the pathway should take account of the potential impact on the attraction and retention of O&G trainees who need exposure to emergency gynae work which would not be available if services moved out of the hospital setting
- Note that the OOA activity is high at out of areas hospitals (i.e. one third) compared with CUH (two thirds)
- Stoke-on-Trent model of 3 questions for patients:
    - What's my problem?
    - What do I need to do?
    - Why is it important I do this?

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