Transforming Planned Care Workshop – Wednesday 19th July
Cancer, Cardiology, Neurology and Respiratory

The notes below are a summary of ideas that came out of the transforming planned care workshop on Wednesday 19th July. These will now be discussed further within specialty working groups.

Cancer		
Rainbow Tier		**Description**
A	**Social prescribing, increasing activation & self-care/ management**	▪ Increase role of 111 service to provide cancer specific advice to public ▪ Phone line for public and professionals to give advice and signposting (all tumour sites) ▪ Mobile van to spread cancer awareness messages (all tumour sites) ▪ Public Health Changing Behaviour Interventions ▪ Role of Public Health in Prevention ▪ Increase involvement with the Tesco Help Centre regarding Cancer to promote cancer awareness ▪ Usage of social media (Facebook/ Instagram) to promote cancer awareness to the public ▪ Enlist Crystal Palace Football Club to promote cancer awareness ▪ Implement support in the community to encourage the public to present earlier to Primary Care with potential cancer symptoms ▪ Increasing the use of the Health Help Now (HHN) tool to the public ▪ Improving and increasing education for the public on the signs of cancer and lifestyles that increase the risk of cancer, changes that could be made to prevent cancer (NB: there needs to be the right balance of providing the necessary information and not causing undue anxiety) ▪ Implement Community Champions to reach members of the public with specific beliefs ▪ Health Care Professionals presenting to members of the public in places of worship ▪ Promoting cancer awareness and signposting in cinema car parks and foyers, on the streets, gyms - particularly targeting young people (e.g. New Addington) ▪ Mile a Day Challenge ▪ Use existing Mental Health Community Development Officers to promote cancer awareness, screening etc. ▪ Use Community Pharmacies to sustain the message of cancer awareness to patients and provide encouragement to recognise the signs
B	**Digital connectivity**	▪ Look at Advice and Guidance currently available for each tumour site and fill the gaps ▪ The ERS A&G function of the ERS system allows GPs to contact Consultants in Secondary Care for specific advice regarding potential referrals. This function will enable GPs to be better supported to make the right decisions regarding 2ww cancer referrals. ▪ NB: GPs should expect responses from Consultants within 48 hours through the system (response times will depend on the manpower available and this could be different for each tumour site). ▪ Suggestion: Running specific telemedicine support at peak times for specific tumour sites e.g. skin in summer ▪ Patient notes will follow them around the system and between providers of care/treatment. This will reduce the duplication of tests etc. and MDT notes will be added to the system in real time. ▪ Further improve the links between Croydon University Hospital, St George's Hospital and other specialist cancer services
C	**Health coaching & group consultations**	
D	**Primary care core services**	▪ Empower patients to be more forceful about expressing their worries about cancer to Health Care Professionals ▪ Enable GPs to have more in-depth conversations/discussions with patients about cancer ▪ Increase the number of diagnostic tests that could be done in Primary Care ▪ Getting more people to the test/diagnostics stage of cancer ▪ Making Difficult Cancer Conversations Training mandatory for all GPs ▪ Enforcing the requirement for GPs to inform all patients they are referring to Secondary Care on a 2ww suspected cancer pathway that they are doing so and why and providing them with the relevant Pan-London Patient Information Leaflet ▪ CUH Cancer Management Team (CMT) to conduct an audit of GP referrals to establish which practices are high referring. This information should then be used to target these practices for additional advice and guidance on and support with referral decision making ▪ Develop a GP Practice Score Sheet informing the GP of the number of 2ww referrals made and for which tumour sites, the number of referred patients that were informed they were on a 2ww pathway and had received a leaflet and information on the quality of referrals (e.g. adequate clinical information etc.) ▪ Making it business as usual for all GPs to ask all female patients if they have examined their

		breasts recently and checking that they are doing it correctly ▪ Up skilling Practice Nurses to do more in terms of promoting awareness and diagnostic testing ▪ Encourage GPs to target specific hard to reach patients in their practice to take up screening and increase awareness ▪ Implement Peer Reviews in GP practices for all 2ww cancer referrals to Secondary Care. Up skilling GPs to look for other routes of treatment if a 2ww cancer referral is not appropriate ▪ Re-frame the 2ww referral pathway to communicate a different attitude about the pathway being to 'rule out' cancer
E	**New enhanced primary care team**	▪ Develop community based 'hub and spoke' model for spirometry supported by robust quality assurance/accreditation
F	**Specialised secondary care**	▪ Resolve internal CUH Walk-In X-Ray issue ▪ Investigate how Croydon compares to other areas in terms of cancer referrals which are converted into a diagnosis of cancer (conversion rates)

Cardiology/ Respiratory		
Rainbow Tier		**Description**
A	**Social prescribing, increasing activation & self-care/ management**	▪ Local classes and community activities to reduce social isolation and get people engaged ▪ Trainers with healthcare knowledge/ experience for patients and public ▪ Change public mind-set to understand that the NHS is not free ▪ Patient and public education needs to be more widespread and driven by Public Health ▪ Advertising and public education/ information needs to be advertised in places such as bookmakers, pubs and social clubs and corner shops ▪ Focus on getting the basics right – ensure the correct cohort of the public is being reached and that communications to the public is clear and easy to digest ▪ Asset map for Croydon ▪ Take a positive approach to encouraging patients on what they are already doing right instead of deterring them from looking after their health by lecturing them on what they are doing wrong
B	**Digital connectivity**	▪ Health care practitioners need to be educated on what is available to the public in terms of social prescribing and information/ sources of information. ▪ Explore how PPGs can support primary care to deliver care to patients ▪ Mobile units ▪ Nurse-led triage service
C	**Health coaching & group consultations**	▪ Heart failure support group – led by expert patients and facilitated by clinicians ▪ Cardiac physiotherapy based in community, along with support on diet and lifestyle ▪ Group consultations for COPD/ pulmonary rehab/ asthma
D	**Primary care core services**	▪ Telehealth for heart failure ▪ Blood pressure monitors with functionality for GPs/ nurses to monitor remotely ▪ Specialist advice from secondary care clinicians to primary care clinicians and patients ▪ Video conferencing with consultants ▪ Telehealth example from Cornwall
E	**New enhanced primary care team**	▪ The right messages need to be shared to help patients understand why receptionists are asking what the nature of their appointment is - to support GPs by streaming patients ▪ Echo cardiograms should be made available in GP practices ▪ 24 hour heart monitoring to be carried out in GP practices or in the community ▪ Cardiac Nurses could feed into Primary Care MDT meetings (along with other specialist clinicians) ▪ Pharmacists should be linked in with Primary Care, asking patients questions about their well-being regardless of what they are purchasing ▪ Better access to diagnostics in Primary Care ▪ Up-skill GPwSIs and COPD nurses to deliver same care locally and replace OP FUs ▪ Cardiologists in the community for rapid access chest pain ▪ Ensure that all appropriate patients with long term conditions have an advanced care plan
F	**Specialised secondary care**	▪ Train junior doctors to understand the nuances of chest pain ▪ Enable cardiac MRI capability at CHS ▪ Move Chest clearance clinic from King's to CHS

Neurology		
Rainbow Tier		**Description**
A	**Social prescribing, increasing activation & self-care/ management**	▪ Health Help Now App to be promoted as a first stop rather than going straight to Primary Care ▪ Support groups facilitated by a clinician to promote the benefits
B	**Digital connectivity**	▪ GP Education ▪ Peer review and for headache pathways ▪ Better access to tests for GPs
C	**Health coaching & group consultations**	▪ PPGs to promote support groups and group consultations
D	**Primary care core services**	▪ Advice and Guidance between primary and secondary care ▪ Virtual follow ups ▪ Epilepsy society App? ▪ Ensure that if Apps are introduced, that patients are shown how to use them in an optimal manner – either by clinicians or at patient support groups ▪ Apps could be used to remind patients to take their medication at the right time
E	**New enhanced primary care team**	▪ Stable patients to be monitored in primary care ▪ Community nurses for MS and Parkinson's working closely with consultants ▪ Specialist nurse team and palliative care nurse team ▪ District nurses to meet with GPs and take part in MDT meetings
F	**Specialised secondary care**	▪ Specialised care delivered more locally