Transforming Planned Care Workshop – Wednesday 28th June
Diabetes, Digestive Diseases, Urology

The notes below are a summary of ideas that came out of the transforming planned care workshop on Wednesday 28th June. These will now be discussed further within specialty working groups.

Diabetes		
Rainbow Tier		Description
A	**Social prescribing, increasing activation & self-care/ management**	▪ Differentiate between type 1 and type 2. ▪ Newly diagnosed to attend education. ▪ Ensure referrals are made for structured education. ▪ Resolve patchy uptake of education – what are the barriers to patient uptake of education? ▪ Peer support groups. ▪ Make information Croydon-specific. ▪ Psychological support. If the threshold for IAPT is not met use community provision. ▪ Community exercise – Thornton Heath network example.
B	**Digital connectivity**	▪ Issues with Vision need to be looked into. ▪ Access to records is a two stage process. ▪ What's App group in diabetes? ▪ Opportunity for Skype (timescale = 6 months). ▪ Share meter readings. ▪ Advice & Guidance roll-out
C	**Health coaching & group consultations**	▪ Consultation in groups of 10-15 patients. ▪ The concept is based around learning from one another. ▪ Recent pilot (mostly based on diabetes) was successful (led to good outcomes on diabetes indicators). ▪ Group consultations should always optional for patients.
D	**Primary care core services**	▪ What are the 5 key things to do for a diabetes patient? ▪ Address variation in primary care. ▪ Delays for annual diabetes check. ▪ Professionals need to be clear about what is required. ▪ HCA education required. ▪ Poor engagement from some practices – understand what the challenges are. ▪ Workforce issues in primary care (shortage of GPs, Nurses and Pharmacists). ▪ Shared decision making – reliant on relationship-building continuity of care
E	**New enhanced primary care team**	
F	**Specialised secondary care**	▪ Type 1, Diabetic Foot, Renal, Transitional, Gestational. ▪ Need to increase levels of integration. ▪ Improve communication between Acute and Community. ▪ Role for youth worker working with adolescents.

Digestive Diseases		
Rainbow Tier		Description
A	**Social prescribing, increasing activation & self-care/ management**	▪ Improve patient Activation in IBD patients ▪ Health Help Now App ▪ Self-care and health and well-being should be promoted in schools across all age groups, including diet and alcohol use ▪ Diet and healthy lifestyle ▪ Educate patients on red-flag symptoms ▪ Consistent messages to patients and public ▪ Work with community/ religious leaders to facilitate more discussions around health and well-being and act as a signposting function for community activities and groups. ▪ Community and religious leaders to allow consultants to present to their members and attendees ▪ Pharmacists should be able to do social prescribing and signposting, as well as giving advice on self-care and self-management ▪ Communication strategies need to address and manage patient expectations ▪ Businesses should promote employee health and well-being ▪ Shared decision-making to allow patients to understand the risks involved with procedures
B	**Digital connectivity**	▪ Web-based tool for patients to look up test results ▪ GP advice from consultants ▪ Podcasts to promote patient education ▪ Virtual IBD follow-ups ▪ All first attendances for Upper GI to be carried out virtually as there is no physical examination done ▪ Telephone clinics ▪ SMS messages to patients
C	**Health coaching & group consultations**	▪ GP behaviour change to see multiple patients at once ▪ Health coaching can be delivered by community/ third sector rather than by GPs ▪ Expert patients/ patient champions ▪ Group consultations should be offered with flexible times so people are more likely to attend
D	**Primary care core services**	▪ Dietary advice services in primary care ▪ Specialist nurses should run clinics in the North and South of the Borough ▪ Specialist nurses should run GP education sessions ▪ Nurse-led triage services ▪ Address variation – why is elective prevalence higher in Purley? Do GPs require more education or are referral thresholds low? Or just high prevalence? ▪ GPs should refer patients back to Tier A of the rainbow
E	**New enhanced primary care team**	▪ GPs should be able to order faecal calprotectin diagnostic tests ▪ Consultants based in clinics in networks
F	**Specialised secondary care**	▪ Appropriate access for red-flag symptoms ▪ Consultants should vet all referrals to assess appropriateness ▪ Sigmoidoscopy vs. colonoscopy

Urology		
Rainbow Tier		Description
A	Social prescribing, increasing activation & self-care/ management	▪ Reduce the number of patients requiring GP appointments by enabling local pharmacies to provide UTI tests and prescribe antibiotics. Use signposting tools/mobile phone apps to increase patients' awareness of services/pharmacies they can use before accessing primary care services. ▪ Chlamydia model could be used for UTI tests. ▪ Signpost patient to online symptom checkers such as NHS choices. ▪ Increase the general public's awareness of prostate cancer, what men should be looking out for, what are the red flags. It was agreed that a prostate cancer campaign should take place in Croydon, the campaign should take place in areas where men will see it i.e. gyms, pubs, shopping centres. The campaign should also target women as this will also increase awareness. ▪ BAUS and Prostate UK – great information source for campaign. Need patients to see this before coming to primary care. ▪ LUTS – campaign – educate men on how to self-manage their LUTS https://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/Male_LUTS14.pdf
B	Digital connectivity	▪ CUH Urology service should ensure they are enabled on advice and guidance service when it is launched. GPs will then be able to seek consultant advice before sending a referral leading to a potential reduction in inappropriate referrals. Training and comms strategies need to be planned/ implemented ▪ All follow-ups to take place in a virtual clinic. ▪ The entire healthcare system needs to manage patient expectations better; a patient should be informed that their care is being transferred rather than being discharged. This will show the patient that providers are working together. ▪ Referrals should be exceptional rather than routine.
C	Health coaching & group consultations	▪ Patients should be fully informed about a PSA test by their GP before they are referred. Improved communication/campaigns required to educate men and women on a raised PSA, a PSA test and what the red flags are. ▪ Use information that has already been produced by Prostate UK and the British Association of Urological Surgeons. ▪ Ensure that patients have access to signposting apps/ information such as Health Help Now – review information on the App to ensure that it is accurate and up to date. CHS should support the review. ▪ Support groups should be offered to patients that have had life changing operations; patients are able to share non clinical recovery methods. Support groups also allow patients to discuss their experience and how their life has changed post-surgery, which reduces low mood and isolation.
D	Primary care core services	▪ Up-skill primary care nurse specialists/ practice nurses to enable them to manage LUTS patients in primary care. CUH suggested nurse specialists/ practice nurses spend some time at the LUTS clinic and are trained by urology consultants. Nurses can then train other practice staff and reduce the number of patients requiring secondary care treatment by managing them in primary care. ▪ If a patient has blood in their urine they could be tested for infection at their GP practice. GP would prescribe antibiotics for an infection and non-infection cases would be referred to secondary care for further investigations.
E	New enhanced primary care team	▪ A urology primary care hit team based in the community is required to support elderly patients with incontinence or catheter problems and live in care homes. A primary care hit team would be able to identify the problem and suggest appropriate treatment reducing the number of patients requiring non-elective care. ▪ It was agreed that the current community/ out of hospital pathway should be reviewed. ▪ 25% of biopsies could be avoided by investing in more uro-radiologists. Invest to save – agree a risk share with CHS.
F	Specialised secondary care	