REPORT TO:	**Health and Social Care Scrutiny Sub Committee** **17 January 2017**
AGENDA ITEM:	**10**
SUBJECT:	**CCG Progress Report on The Primary Care Variation Reduction Strategy**
LEAD OFFICER:	**Paula Swann, Chief Officer, Croydon CCG**
CABINET MEMBER:	**N/A**
PERSON LEADING AT SCRUTINY COMMITTEE MEETING:	**Paula Swann, Chief Officer, Croydon CCG** **Stephen Warren, Director of Commissioning Croydon CCG**

ORIGIN OF ITEM:	**This item has been suggested by the Committee as an update on work programme for 2016/17, to monitor the progress of GP performance and variation.**
BRIEF FOR THE COMMITTEE:	The Primary Care Variation Reduction Strategy aims to optimise the delivery and quality of primary care in Croydon. This is central to supporting the delivery of a number of the CCG's strategic goals We would want to share with the committee: ▪ The progress made to date against this strategy
CORPORATE PRIORITY/POLICY CONTEXT: This strategy supports: • Maintaining and improving safety and quality of care. • Transforming the way care is delivered for the future. • Achieving financial sustainability.	
FINANCIAL IMPACT N/A	
FORWARD PLAN KEY DECISION REFERENCE NO: This is not a key decision	

1. Introduction

The Primary Care Variation Reduction Strategy aims to optimise the delivery and quality of primary care in Croydon. It is central to supporting the delivery of a number of the CCG's strategic goals and is a key enabler in achieving transformational change within primary care, contributing to Quality, Innovation, Prevention and Productivity agenda QIPP projects, reducing inequalities and improving the health

and overall experience of healthcare for the people of Croydon. It is inextricably linked to the clinical engagement work stream with networks and practices.

This paper reports progress on implementation of the strategy a year on. In summary the work of the variation team agenda has supported the delivery of a number of the CCG's strategic goals including achievement of quality premiums and continues to be a key enabler in achieving transformational change within primary care, contributing to QIPP projects, reducing inequalities and improving the health and overall experience of healthcare for the people of Croydon.

The team have been involved in a wide range of projects both initiated by the team itself and also supporting CCG wide projects and initiatives.

In order to maximise impact the variation team have been working on building relationships with the practice teams they are responsible for, covering all 58 practices in the borough.

The team have utilised a wide range of data and information sources including public health practice profiles, national GP patient survey data, local patient feedback, Healthwatch information, NHS Choices reviews, Right Care data and a range of relevant dashboards to inform their work.

The key vehicles for implementation of the strategy have been:

- Engagement with primary care through three levels of practice visits
- Installation of PRIMIS software in all GP practices to support reducing variation in prevalence and management of common long term conditions e.g. diabetes, COPD and asthma.
- GP Practice Development and Delivery Scheme
- GP Practice Local Incentive Schemes
- Support for implementation of clinical pathways

More detail on achievements in these areas is provided below.

2. Background

The strategy was presented to the CCG SMT, Clinical Leadership Group and Governing Body in September 2014 and was approved as one of a number of work streams contributing to improving the outcomes for all patients as part of the CCG strategic goal to deliver longer, healthier lives for the residents of Croydon and support out of hospital care.

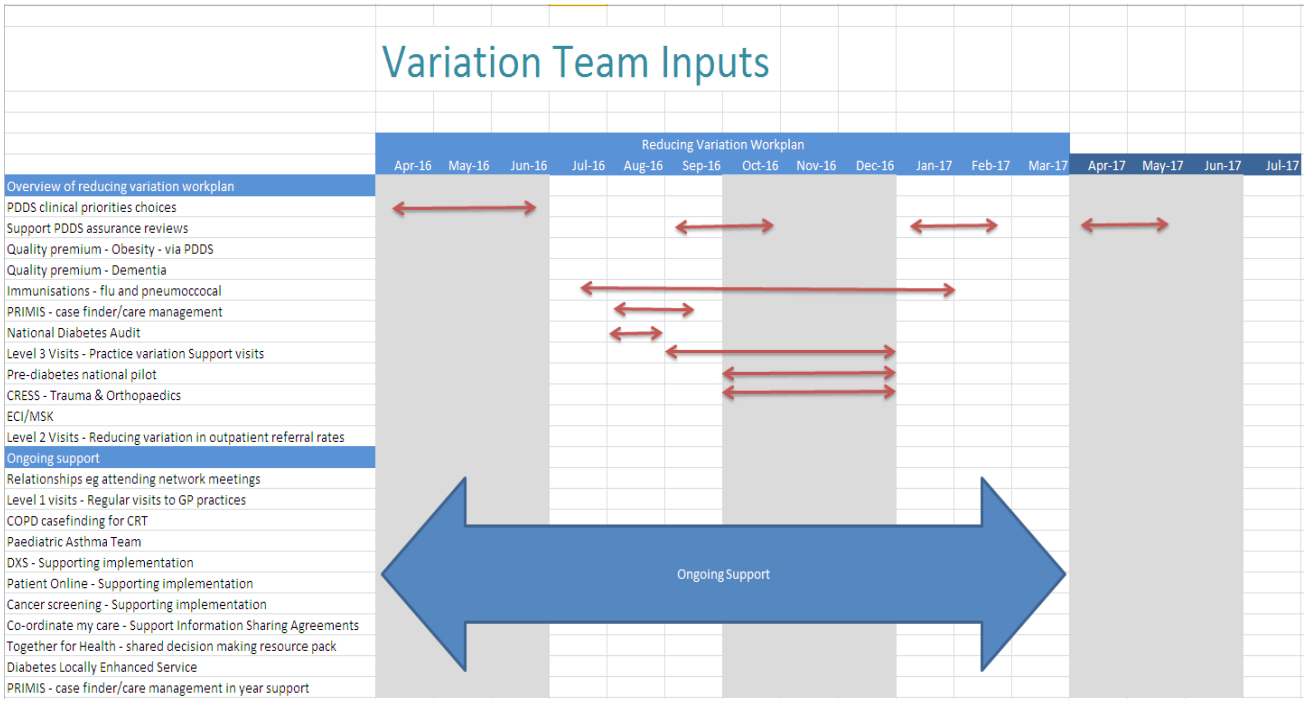
In December 2015 the Overview and Scrutiny Committee received a report on progress with the Primary Care Variation Reduction Strategy 2014. It set out the CCG's Primary Care Variation Reduction programme for 2015-16 with the aim of optimising the delivery and quality of primary care in Croydon

- It is inextricably linked to the clinical engagement work stream with networks and practices
- The Variation Team were appointed in late 2015 under the Chief Pharmacist in the Medicines Optimisation team.
- The Variation Steering Group was set up in early 2016 to drive forward this important, cross cutting agenda
- An update was provided to the Committee in June 2016 on the strategy

3. Engagement with primary care

A core work plan for the variation team is in place based on the strategy. This includes a wide range of topics and projects in line with CCG priorities see Fig 1. below. The work plan is flexible allowing for focus to be shifted as appropriate in accordance with the CCG priorities.

Fig 1. Summary of variation team work plan and inputs



Impact

In the last year over 750 activities / interactions between practices and the variation team have occurred, working with individual practices raising priority topics such as cancer screening; coordinate my care , influenza and pneumococcal immunisations, PRIMIS asthma, COPD and diabetes.

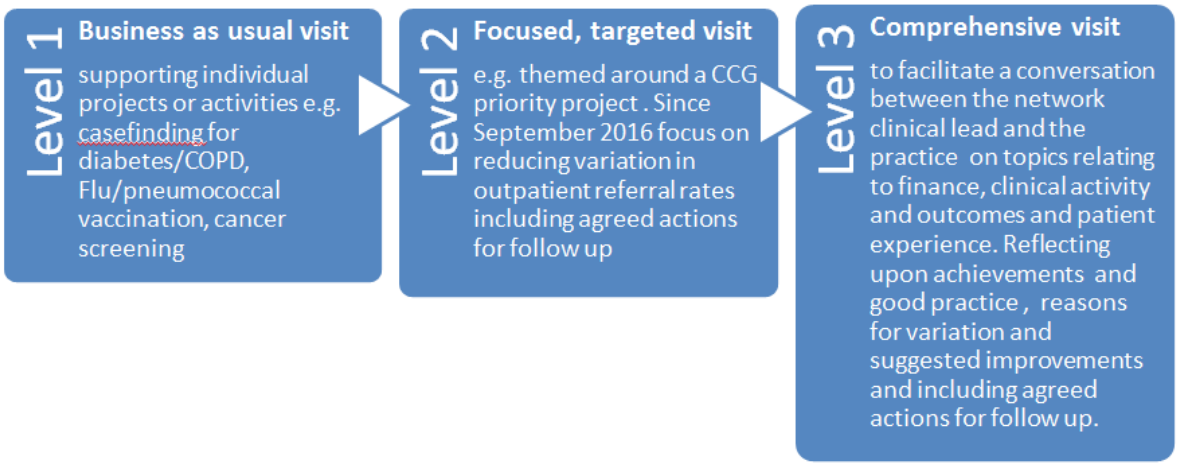
4. Collaboration and partnership working

Success of the variation team work plan has and will continue to depend upon effective partnership working. This includes with the following teams and organisations:

- Primary Care - GP practice teams and clinical leaders in particular
- Secondary health care e.g. Facilitating Croydon Respiratory Team working with practices to improve diagnosis and management of patients with COPD
- Third sector e.g. Cancer Research UK to promote cancer screening in GP practices
- Local authority e.g. with public health on primary care data profiles

The variation team workplan is structured around three levels of support for GP practices as described in Fig 2. below:

Fig 2.Engagement with practices



Level 1 support is ongoing on a wide range of topics depending on the practices activities and informed by a wide range of data including patient feedback.

Level 2 activities since August 2016 have focussed mainly on addressing the marked variation in outpatient referral rates between Croydon GP practices. A programme of visits led by the network clinical leads and supported by the variation team have been undertaken to the highest referring practices. The following has been achieved thus far:

- 20 of the 27 (74%) highest referring practices were visited by end of November. This is 34% of all Croydon Practices.
- By mid-December 2016 100% of the 27 practices will have been visited. This will equate to 57% of all Croydon practices having received a comprehensive visit or focussed visit
- Action plans completed for all practices & date for progress update agreed
- Each visit has focussed on a number of related topics including:

- Practice peer review processes
- Shared decision making discussions with patients
- Regular audit of referrals to specialities with highest or increasing referrals
- Regular monitoring of all referrals made

- Alternative routes of condition management as appropriate including patient education, use of Apps, group consultations, internal second opinions, using in house expertise and knowledge

Level 3 support continues with 15 comprehensive practice visits completed by the end of November 2016 a further three diarised for December 2016. Action plans are completed for all practices & date for progress update agreed and followed up.

5. Programmes of work supported by the variation team

5.1 Reducing variation in prevalence and management of common long term conditions

During October 2015 – February 2016 the variation team achieved installation and implementation of PRIMIS software in all Croydon practices. This software was then used as a platform for a number of projects in relation to diagnosis and management of long term conditions including:

- Using the casefinder functionality in this software, to identify almost 6,000 patients with possible missing diagnosis of COPD, asthma or diabetes. The aim of this exercise was to support practices in preventing or reducing the likelihood of patients presenting at A&E with these long term conditions who had not previously been diagnosed.
- Supporting the Practice Development and Delivery Scheme (PDDS).
- Monitoring a local incentive schemes for diabetes and prevention of diabetes.
- Supporting practices on the prevention agenda for conditions such as diabetes.

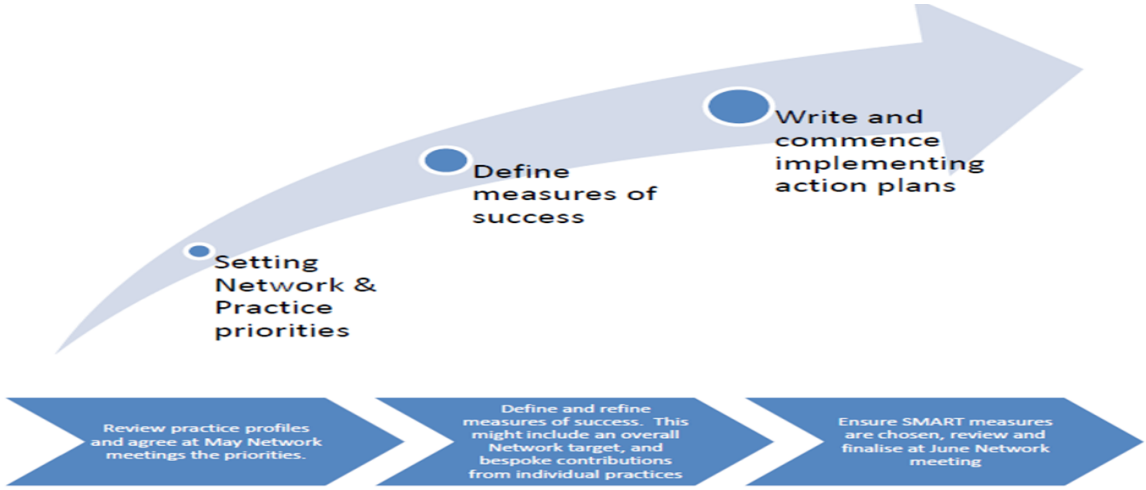
5.2 GP Practice Development and Delivery Scheme

The CCG Primary Care and Clinical Engagement team have offered this since 2014 which is designed to offer member practices an integrated scheme that supports their ongoing engagement with the CCG while supporting their development to meet the challenges within the Croydon healthcare economy. The scheme includes elements relating to financial balance, acute monitoring targets such as rates of A&E attendance and admissions, care management and coordination and clinical priorities. This year's scheme built on the positive progress made by practices in the previous years. See Fig 3

The variation team led the clinical priority element of the PDDS for 2016-17 initially with well attended workshop for practices. They then worked closely with practices and networks to develop a menu of possible priorities for practices to select from based on

national and local priorities and robust and challenging measures of success. Practices and networks chose four main priority areas overall: Tackling obesity; diabetes; dementia

Fig 3 PDDS scheme



Impact

- *Practices clinical priority choices now fully supporting CCG and national priorities*
- *Promoting increased impact as practices focusing on 4 main quality improvement areas – reduced from 23 different areas in 2015-16*
- *SMART measures for priorities designed and agreed in partnership with GP practices*
- *Positive feedback from practices on support received by the variation team*

All six GP network chose obesity as one of their PDDS clinical priorities. The variation team have supported practices in identifying patients eligible for offer of weight management service. As a result this service has demonstrated a significant increase in uptake.

Impact

- *Significant increase in referrals to weight management services since April 2016 (Approx 700 April-October 2016 compared to 1300 in total since April 2014)*
- *Since April 2016, 65% of participants have completed the 12 week weight management programme with 5% body weight lost and 83% of participants completed the programme achieving a 3% reduction of body weight.*

5.3 Flu and pneumococcal vaccination

Croydon CCG has implemented a system-wide plan to improve vaccination uptake amongst all eligible cohorts involving District Nursing Teams to deliver flu and

pneumococcal vaccinations in eligible housebound patients and their carers that are on the District Nurses caseload. A number of community pharmacies have also been commissioned to support GP practices with the vaccination of their housebound patients not on the district nurse caseload.

The variation team continue to support the broadened flu and pneumococcal agenda by delivering key messages to practices through peer review discussions at network meetings and during Variation practice visits to work with the practices to develop action plans.

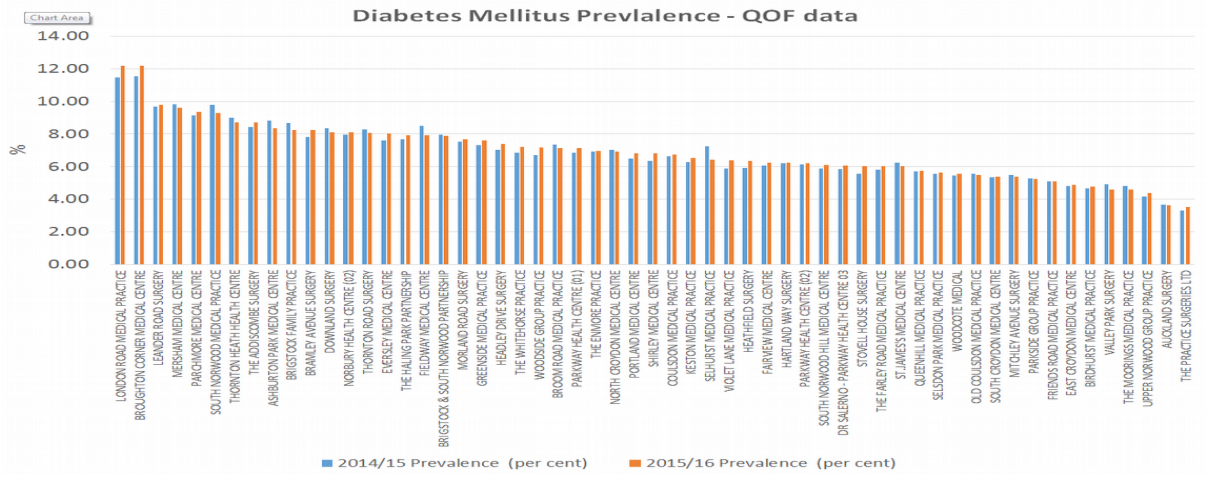
5.4 Cancer screening

The variation team continue to work with Cancer Research UK (CRUK) and Macmillan Early Diagnosis Programme engagement team to facilitate discussions with the lowest performing practices to improve early diagnosis of cancer.

5.5 Diabetes prevalence, care and prevention of diabetes

The variation team have acted as an enabler for a number of initiatives and projects relating to diabetes. These have included:

- Using PRIMIS casefinding tools in all practices, to identify patients with a possible missing diagnosis of diabetes. Identifying these patients allows earlier routine follow up and care management to take place which in turn improves care and patient outcomes.
- Using PRIMIS care management reports for monitoring of a local incentive scheme for improving care of patients with diabetes
- Supporting practices participating in a pilot local incentive scheme to identify patients eligible for the national diabetes prevention programme.
- Encouraging practices to participate in the National Diabetes Audit.
- Providing a primary care perspective on the Croydon Diabetes Steering Group.



Impact

- *80% of Croydon GP Practices participated in the National Diabetes Audit for 2015-16 up from 40% the previous year.*

5.6 COPD prevalence

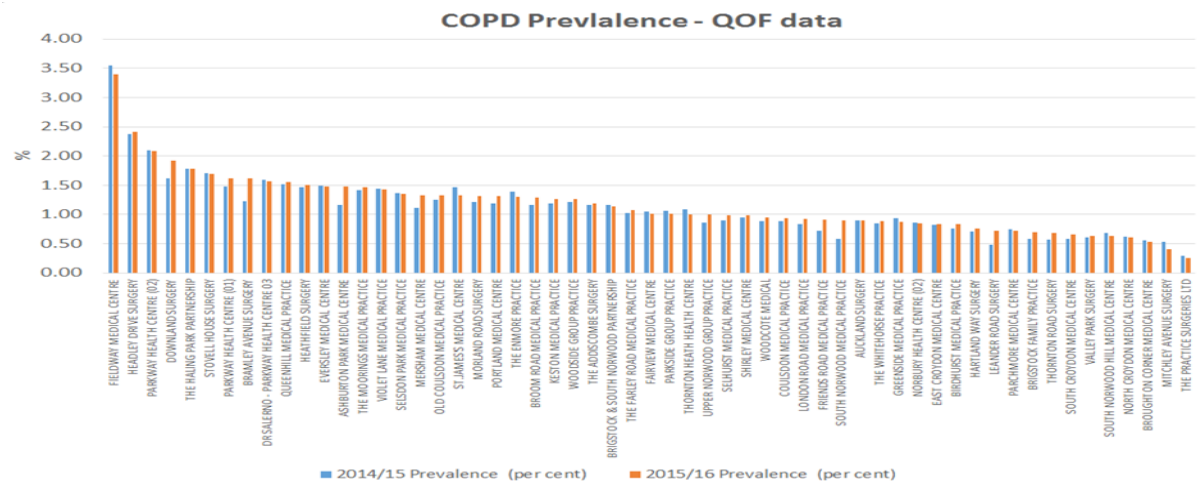
The variation team has been supporting Croydon CCG COPD improvement programme which is aimed at identifying and diagnosing patients with COPD in Croydon. The team works closely with Croydon Respiratory Team (CRT) on improving the diagnosis and management of COPD. Initially facilitating the installation of PRIMIS software in all GP practices the variation team then supported the practices in reducing variation in prevalence of COPD by identifying patients with potential missing COPD diagnosis.

The team worked as an enabler to ensure that the CRT had access to GP practices and provision of 6-12 clinical sessions over a consecutive 12-16 week period depending on practice size. By the variation team highlighting the patients with a high likelihood of COPD the CRT made more efficient use of their clinical sessions

The sessions provided by CRT include: patient review clinics, assessment of spirometry provision, identification of training needs and spirometry training if required, provision of advice regarding COPD patient management and signposting to Pulmonary Rehabilitation, smoking cessation and oxygen assessment services as appropriate.

With the support from the variation team the CRT visited 26 Croydon practices.

From the identified lists of patients potentially missing COPD diagnosis 378 patients were spirometry tested and as a result 69 were identified with COPD and added to the COPD register increasing COPD prevalence allowing earlier access to treatment..



Impact

- *With support from variation team the CRT visited 26 GP practices which contributed to provision of Croydon CCG COPD improvement programme*
- *As a result:*
  - *378 patients were spirometry tested*

6. Patient experience

During the level 3 comprehensive visits patient's experience of the practice is explored using GP patient survey data, local patient feedback, NHS Choices reviews and any Healthwatch information. Access to services is explored in terms of patient experience and also impact on other services for example accident and emergency attendances if access to primary care services is limited.

As part of the level 1 support the variation team have supported the implemention of Patient Online by encouraging practices to increase the number of patients registered and using this service.

Good practice is shared where between practices where appropriate including how patient participation groups are recruited and used by practices and actions taken in response to patient feedback.

6.1 Shared decision making

Shared decision making is a key aspect of the CCG's Together for Health programme, is promoted as best practice by the Royal College of General Practitioners and is a key aspect of General Medical Council duties of a doctor.

Shared decision making offers one method of having conversations with patients about their treatment options in an open and productive way. There is good evidence that not only do patients want to be fully engaged in decisions about their care, but that when they understand the options and pros and cons involved they will often opt for less interventional approaches and better outcomes are achieved.

The variation team have contributed to moving this agenda forward by promoting this with GP practices including the use of a GP resource pack for shared decision making. See Appendix 1.

Impact

- *Promoted shared decision making on all level 2 and 3 practice visits including*
    - *Distribution of the shared decision making resource for general practice*
    - *Encourage sharing of good examples of where shared decision making has been used and the outcomes*

6.2 Co-ordinate My Care

Co-ordinate My Care (CMC) is a clinical information sharing system between GPs and other healthcare providers for example London Ambulance Service. GPs use CMC to record the wishes of patients, how they would like to be cared for and clinical information such as medicines. In addition the service allows access to end of life information such as do not resuscitate and preferred place of death.

The Variation Team have facilitated the completion of practice information sharing agreements and training.

7. Next steps

- Continue with workplan
  The team will continue to apply the workplan across practices in Croydon, with new topics agreed via the variation steering group
- Programme of practice visits to continue building on establishes relationships action plans monitored to encourage implementation of changes.
- Work with primary care engagement, planned care, IT and business intelligence to develop regular data feeds for practices to inform new areas or practices to prioritise and the impact the variation team is having.

Appendix 1 Shared decision making resource for general practice

Shared Decision Making A resource for General Practice

Croydon CCG - Dr Emily Symington
August 2016

"There's nothing really wrong with you but I think a little surgery would make us both feel better."

What is shared decision making?

Shared decision making has been much talked about recently. It is embedded in the NHS Five Year Forward View, it is enshrined in GMC Duties of a Doctor and the NMC Code, and for the 2016/17 year it forms part of Croydon CCG's PDDS scheme. But what really is shared decision making and how to we make it a reality in the busy and often chaotic world of general practice?

Shared decision making is defined as;

> "A process in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient's in-formed preferences. It involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for recording and implementing patients' informed preference."1

At its core shared decision making recognises the equal value that clinician and patient bring to any choice regarding care and is recommended in the majority of clinical circumstances (however big or small the decision). A recent BJGP article discussed how shared decision making represents a middle ground between the extremes of paternalistic medicine and unrestricted patient autonomy, with the skill being in supporting patients to explore their values and discuss how these fit with the clinical options available.[2]

There is good evidence that patients want to be involved in decisions about their care and that where they are actively involved in decision making better outcomes are achieved.[1] Shared decision making improves compliance with medications and self-care advice. It also often results in patients choosing less interventional treatment options once they truly understand the options, reducing morbidity and financial cost.[3] Improved satisfaction with care and confidence around self-care also leads to more appropriate use of health services and reduction in repeat attendances.

NHS inpatient data from 2002 to 2009 demonstrates that almost 50% of patients would like to be more involved in treatment decisions, with this figure sadly

remaining static for the 7 years surveyed. [4] Many reasons are given as to why clinicians do not use shared decision making consistently when interacting with patients. One suggestion is that sharing of uncertainty can be uncomfortable for both clinicians and patients. Moving to shared decision making certainly requires a willingness on the part of the patient to accept an active role in the management of their condition which is a challenge for some.

The MAGIC programme run by The Health Foundation between 2010 and 2013 looked to demonstrate how shared decision making could become part of routine clinical practice. Working in primary and secondary care settings they came across several barriers to implementation of shared decision making, most consistently the challenge of engaging with senior clinicians and the perception that shared decision making was too time consuming.[6] However following training for staff, the use of decision aids and campaigns like 'Ask 3 questions' to raise patient awareness they were able demonstrate change in clinical practice.

For Croydon shared decision making forms a key part of the CCG's Together for Health strategy and underpins other aspects of this vision such as self-management. This resource package contains a collection of references, training tools and ideas to help you learn more about shared decision making and how to make it a routine part of your clinical practice. There is also an extensive list of resources which are freely available online to use with patients.

This resource will help support you to meet the shared decision making requirement of the PDDS. It can be used in conjunction with other Together for Health initiatives and in discussion with the variation team. I hope you find it useful.

1 Couler, A & Collins, A. 2011. Making shared decision-making a reality: no decision about me, without me. The Kings Fund; http://www.kingsfund.org.uk/sites/files/kf/Making-shared-decision-making-a-reality-paper-Angela-Coulter-Alf-Collins-July-2011_0.pdf
2 Staveley, I & Sullivan, P. 2015. We need more guidance on shared decision making. BJGP 65(641) 663-664
3 Elwyn, G. Laitner, S. Coulter, A. Walker, E. Watson, P. Thompson, R. (2010) Implementing shared decision making in the NHS. BMJ 2010; 341:c5146
4 NHS Surveys [online] Available at: http://www.nhssurveys.org/ [Accessed 2nd August, 2016]
5 Elwyn, G. Edwards, A. Gwyn, R. Grol, R. (1999) Towards a feasible model for shared decision making: focus group study with general practice registrars. BMJ 1999; 319:753

6 Ewan, K. Taylor, J. Williams, R. Vanson, T. (2013) The MAGIC programme: evaluation. An independent evaluation of the MAGIC (Making good decisions in collaboration) improvement programme. The Health Foundation [Online] Available at: http://www.health.org.uk/sites/health/files/TheMagicProgrammeEvaluation.pdf

I already use shared decision making

There are few clinicians who don't agree, at least in principle, that patients should be involved in decision making around their care. Consultation tools such as ICE (ideas, concerns, expectations) are well established prompts to ensure you are directly asking patients about their priorities and values. GPs who have recently done the CSA part of MRCGP will remember that shared decision making is a key part of the assessment criteria. However despite good intentions the evidence suggests that shared decision making is not a routine part of most patient's experience of health care.

My patients are not ready for shared decision making

It is certainly the case that shared decision making requires the active involvement of both clinician and patient (or carer). Some patients, possibly based on past experience, cultural background or lack of understanding may not expect to be involved in making decisions about their care but the guidance is clear that this does not absolve the clinician of responsibility for offering that involvement. A response of 'whatever you think best doctor' (or similar) may be the active decision on the part of that patient to take the advice of the medical practitioner, but this should not be presumed.

As we know well in general practice, the relationship between clinician and patient is not the making of a single 10 minute consultation. While the patient may be taken aback by the offer of shared decision making initially, if this becomes the expected style of communication they are likely to become increasingly open to their role in the process.

Shared decision making takes too long

Any new skill takes time to master so including shared decision making in your consultations for the first time is likely to take a little while to get used to. However the experience of the MAGIC programme was that once established shared decision making does not take longer than more traditional consulting styles, and patients and clinicians came to expect it.
Also importantly, shared decision making is associated with improved outcomes and better patient confidence. While the initial consultation may take longer there is a considerable saving if that patient is how better able to manage their condition and understands the options, reducing unnecessary repeat consultations and patient worry.

Shared decision making involves changing a consultation style I have developed over many years

For those who do not currently practice shared decision making routinely, incorporating this into their consultation style will require a change. This resource contains several links to on-line learning packages to support clinicians to understand shared decision making in more detail and embed it into their clinical practice. The MPS also runs a workshop on shared decision making which is free to members (more details later).

Shared decision making is only necessary for 'big' clinical decisions

While shared decision making may be particularly crucial for significant clinical decisions, practicing it at all times not only embeds it as routine communication but ensures that when those 'big decisions' need to be made both patient and clinician are ready. For ex-ample a discussion about the pros and cons of referral for knee replacement is going to be much easier with a patient who has had a shared decision making conversations about their knee pain in the past and therefore feels comfortable with the options available.

Shared decision making isn't possible in the clinical pathways available

Shared decision making is not about stepping outside of clinical guidelines and pathways. As described in the earlier definition shared decision making involves the clinician's use of evidence based practice (of which clinical pathways forms part) to inform a discussion with the patient about what of the available options is best for them as an individual in their personal circumstances.

What if the patient choses an option which is not available on the NHS?
As explained above, shared decision making is not about patients being able to demand treatment options which are not available or appropriate in a given clinical situation. It is about patients having the evidence based information so they can make an informed choice.

Many GPs are comfortable with for example mentioning therapies such as acupuncture or supplements such as glucosamine and chondroitin where appropriate to patients, making clear that these are available for patients to purchase themselves but cannot be prescribed on the NHS. In a shared decision that advice would be no different.

What if my patient makes an unwise decision?

As we are all very familiar with from the Mental Capacity Act 2005 any competent adult is entitled to make an unwise decision.

Ideas for initiating shared decision making in your practice

For many shared decision making is a lovely ideal, but it can feel like a daunting task to begin to implement in your practice. A few ideas to begin;

1. Have a practice meeting or learning session to discuss shared decision making as a clinical team. Maybe all agree to complete one of the free online learning modules before the session so you can bring an informed view to the discussion.

2. Changing practice is hard and it can be difficult to remember during a busy surgery. Agree as a practice that you will use shared decision making in one clinical setting, for example knee pain or PSA test requests. This way you can set up reminders and get into the habit. This could be an excellent practice improvement project for a trainee.

3. Start read coding shared decision making and conduct an audit. Read codes are as follows;

Version 2 READ Codes (used by all GP clinical systems except TPP SystmOne and HealthySoft Crosscare)

8Cl.	Shared decision making
8Cl0.	Shared decision making with patient decision aid
8Cl1.	Shared decision making without patient decision aid
8Cl2.	Shared decision making with decision support
8Cl3.	Shared decision making without decision support

CTV3 Codes (used by TPP SystmOne and HealthySoft Crosscare)

XaYjg	Shared decision making
XaYjh	Shared decision making with patient decision aid
XaYji	Shared decision making without patient decision aid
XaYjj	Shared decision making with decision support
XaYjm	Shared decision making without decision support

4. The NHS England website contains further advice and information about using shared de-cision making in clinical practice for those who are interested;
https://www.england.nhs.uk/ourwork/pe/sdm/

Shared decision making CPD ideas

On-line learning modules

http://www.e-lfh.org.uk/programmes/shared-decision-making/

Two brief on-line learning modules introducing shared decision making and discussing how to embed shared decision making into your clinical practice. A great overview of shared decision making for all GPs and practice nurses. Very relevant for appraisals.

http://elearning.rcgp.org.uk/course/info.php?popup=0&id=80

An on-line learning module developed by the Self Care Forum and RCGP. The module contains learning to help you develop a consultation style which promotes confidence around self-care, and includes ideas for the whole practice in ensuring patients have the information and support they need to self-care for minor self-limiting illness. Again very relevant for appraisals.

MPS course - Mastering Shared Decision Making

The MPS run a 3 hour workshop about shared decision making. This is free for members. As with all MPS courses the emphasis is on avoiding litigation through improved consulting skills. The information presented in the course is good and the opportunity to reflect on shared decision making in your own practice is worthwhile.

Being Mortal – Atul Gawande

A very accessible book written by an American surgeon. The book examines the realities of ageing, life-limiting disease and palliative care through the mixed lens of a clinician, relative and friend. A very thought provoking reflection on the limitations of modern medicine and the role clinicians have to play in supporting a good end to life.

Later chapters reflect on the conversations clinicians have with their patients and the value of understanding your patient's priorities to facilitate shared decision making.
I would strongly recommend this as a read for all GPs, whether still in training or significantly more senior.

Transactional analysis
http://www.bradfordvts.co.uk/wp-content/onlineresources/0200consultation/transactionalanalysis/transactional%20analysis%20by%20bill%20bevington.doc
http://www.lynneforrest.com/articles/2008/06/the-faces-of-victim/

Transactional analysis is an interesting frame to use to reflect on the interactions between clinicians and patients, or even the practice as a whole and its patient group. This model provides insight into the attitudes we are all too familiar with from some patients and the traps we can fall into in response.

A great starting point for a practice meeting discussion or trainee tutorial.

Health coaching

A technique based on motivation interviewing which looks to support people to develop the knowledge and skills to manage their own health. Health coaching can be delivered by a clinician or trained coach.

Several different courses in health coaching and motivation interviewing exist at varying levels.

Resources for use with patients

Shared decision making prompt - http://personcentredcare.health.org.uk/resources/ask-3-questions-materials

This link provides access to the Ask 3 Questions campaign materials

Health Help Now - http://www.healthhelpnow-nhs.net

This website and smart phone app is intended to support patients to manage their health needs and find the right support when they need it. All the health information is directly from NHS Choices and location specific information will direct patients to their nearest pharmacy, OOH service etc as appropriate.

This resource will shortly be available with Croydon specific information. In the meantime have a look online and download the app so you are ready to start encouraging your patients to use it when it becomes available. (Updates to come from the CCG.)

MSK Help - http://www.nhsinform.co.uk/msk/

This NHS Scotland developed website and app provides information about management of all musculoskeletal conditions. There is self-management advice and exercises to be used at home and guidance on when to see further medical attention.

The app is significantly easier to navigate than the website. A great resource to recommend to any patient presenting with a musculoskeletal problem and shaves on printing out exercise sheets which probably get lost.

Information prescriptions

Diabetes UK has produced an excellent range of information prescriptions for use with patients. These cover blood pressure, HbA1c and cholesterol for diabetic patients and healthy diet and being active for patients who are not diabetic. They contain easy to understand in-formation for the patient and a small amount of space for the clinician to fill in some specific details.

All these information prescriptions contain an action plan section at the bottom.

While you might feel filling this in with the patient is too time consuming during a consultation, getting

them to complete it themselves before a follow up appointment is a good way to reinforce the message.

All the information prescriptions are available to download for free here;

https://www.diabetes.org.uk/Professionals/Resources/Resources-to-improve-your-clinical-practice/Information-Prescriptions-QA/

Decision aids - http://patient.info/decision-aids

There are many decision aids available, some of which are more accessible than others. This link provides access to all decision aids recommended for use in the NHS. They are listed alphabetically by condition.

You will see they contain details of where they were developed in brackets after. Here is my personal take on their relative usefulness;

- Option grids; usual single side of paper, brief summary. Very good for reviewing with a patient during a consultation.

- Magic; developed as part of the Magic project. Often several sheets of paper but well writ-ten and comprehensive. Some are clearly more secondary care focused.

- Patient; developed by patient.co.uk. Similar to the Magic ones.

- NHS; go through to a weblink which provides a very comprehensive shared decision making approach. This would need to be completed by a patient themselves at home and is not suitable for use during a consultation. A gold standard approach to shared decision making but only really suitable for a very computer literate and engaged patient.

- NICE; based on NICE guidelines. Not very patient friendly

Self Care Forum - http://www.selfcareforum.org/

The Self Care Forum is a charitable organisation which aims to promote the value of self-care to clinicians and the general public. Their excellent website provides tips on promoting self-care in your practice, including posters which you can download and print. There is also the e-learning module mentioned previously.

The fact sheet section (http://www.selfcareforum.org/fact-sheets/) includes several

very useful information sheets which can be printed off for patients consulting for a range of rou-tine general practice conditions.

Patient accessible videos

- Jo's cervical cancer trust; excellent videos explaining the importance of cervical screening and what to expect. Videos are in English and a full range of different languages.
https://www.jostrust.org.uk/video-page

- DocMikeEvans; a Canadian doctor who has produced a series of illustrated explanations of common conditions. These are very accessible, comprehensive and entertaining. They are freely available to patients via YouTube. While intended for a Canadian market they are just as relevant for UK patients. The PSA testing and back pain ones are particularly good.
https://www.youtube.com/user/DocMikeEvans/videos

Explaining risk to patients

ClinRisk which developed the well known QRISK has a series of other risk calculators. When accessed online these generate a result with a Cates plot to help you explain risk to patients more clearly. The calculators available are;

- Type II diabetes; http://www.qdiabetes.org
- Renal failure; http://www.qkidney.org
- Hip and other osteoporotic fracture; http://www.qfracture.org
- Undiagnosed cancer; http://www.qcancer.org
- Risk/benefit of taking a statin; http://qintervention.org

Shared decision making - the links

Print out this page to have quickly access all shared decision making links.

Shared decision making prompt - http://personcentredcare.health.org.uk/resources/ask-3-questions-materials

Health Help Now – smart phone app & http://www.healthhelpnow-nhs.net

MSK Help – smart phone app & http://www.nhsinform.co.uk/msk/

Information prescriptions - https://www.diabetes.org.uk/Professionals/Resources/Resources-to-improve-your-clinical-practice/Information-Prescriptions-QA/

Decision aids - http://patient.info/decision-aids

Self Care Forum - http://www.selfcareforum.org/fact-sheets/

Patient accessible videos

- Jo's cervical cancer trust; https://www.jostrust.org.uk/video-page

- DocMikeEvans; https://www.youtube.com/user/DocMikeEvans/videos

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