Health Forum Minutes - Wednesday 26th June 2024 10am-12pm

1) Welcome and Introductions

There were 49 people in attendance.

2) Minutes and matters arising – Physician Associate

The minutes were agreed as accurate. The physician associate discussion has been postponed. Healthwatch has conducted a survey and will provide a report for the September meeting.

3) Practice and PCN Updates

Portslade – Tracy

- Premises project complete 5 new clinical rooms, 2 being utilised by PPN
- Staffing stable
- Part of General Practice Improvement Plan. Increasing e-consult capacity - work in progress

Hove Medical Centre - Rick

- 2 new GPs started – both are pregnant so changes being covered by locums
- Recruited an Advanced Nurse Practitioner starting 1st September
- Issues last week with sickness (7 receptionists at same time)
- A new receptionist has started
- Ring back now sorted – well received by patients
- Monthly friends and family audit re appointments 250 completed – 242 stated service good/very good

Q Patient issues were raised about the lack of continuity with GPs, no time to look at history/notes. Could older patients/those with complex issues be allocated a permanent Dr?
A There are currently 9300 patients, with senior Drs managing 2,600. It would mean deciding who is most needy. which is not appropriate. Must state if have a particular need and will try to accommodate. Also, only a few core partners in the practice, so it's hard to achieve continuity. Continuity is compounded by access – not mutually exclusive.

Sharon reported the Community Health Panel has also identified access as an issue. An ongoing part of the conversation is both access and continuity of care. No quick solution because of constraints and resources.

Q Why are there some GPs not employed?
GP surgeries operate like independent businesses, for the past 5 years GP funding has declined and some funding was restricted to employing pharmacists, paramedics, social prescribers not Drs – so this has mainly affected GPs who want to work as locums. Have had to use different resources, streamline work, so GPs can see more patients, therefore less work for locums. Capacity issues, ageing population, lots more medical treatment/referrals across all conditions, resulting in a more complex job.

WellBN (Benfield/Burwash/Brunswick) - Louise

- Lindsay, non-clinical partner is retiring in March. Development around management structure taking place
- Burwash is fully staffed
- Thank you to HKP for help with improving the garden
- Call back facility installed. Patient feedback very positive
- Phones system upgraded going well
- Employed reception team leaders

- Upskilled some of the admin team to take bloods
- New GP and Paramedic starting next couple of months
- Flu season discussions started.

Jo wanted to pass on thanks to Lindsay, as a founder member of the HF and instrumental in many developments over the years.
Jo also commented that the positive feedback from patients about call back has resulted in the roll out of the phone system across the PCN.

Wish Park/Links Surgery – Pat Weller from Patient Participation group (PPG)

- Emma (Practice Manager) and Martin (chair of PPG) sent apologies
- Meeting on Thursday with Sussex Primary Care and Health Watch to discuss digital inclusion – they have been consulting on digital inclusion strategy w PPG and Murray has met w JM from HKP to discuss their experience in delivering this work
- Fulltime GP at Links Road (Dawn has reported they are wonderful)

Acting Together on Cancer update (Claire Hines)

- City wide cervical screening awareness last week. Increasing awareness and training opportunities
- Spoke to young women's group at HKP on importance of screening. Cervical cancer awareness session yesterday.
- Takepart event at Hangleton park 6th July in partnership with healthy lifestyles team. Lots of opportunities to engage in activities. Act on Cancer will be there.

PCN update - Dr Rowan
As part of the preventative work taking place, patients might get invited for a health check based at Portslade Health Centre. Blood pressure, cholesterol checks etc. and healthy living advice – asked that people respond to this as a really useful preventative intervention.

4) Feedback from Community Health Panel and ICT update 10 mins

- Community Health Panel in June - 19 representatives came together
- Analysed a fictious ICB case study of a patient with multiple needs, range of interventions, highlighted the importance of integrated arrangements and holistic approaches
- Caroline Boulding from Adult Social Care team gave a presentation; support available, role of access point and reinforced case study conversations. Significance of social prescribing in the future - information gathering, needs analysis and priority identification
- Experience of hospitals; access to acute care, discharge arrangements, health panel want to explore further and are pursuing
- Access to equipment issues. Clinical needs different route. Recognition able to access equipment various ways, too often patients and carers reach crisis point.
- Example of one WellBN patient with access to equipment issues - lack of communication about what was needed and difficult to get right thing. Learning opportunity for the community and primary care regarding access points.

Chas Walker – leads delivery of the Integrated Care Strategy in BH- aim to improve joined up services. Supports partners to deliver on this ambition. He reiterated that for people to remain independent at home, they need the right equipment. Health Forums raise issues and need to ensure learning is brought to community oversight board.

Action: Katie Chipping, Ageing Well, will follow up on the equipment issues for the WellBN patient.

The Health and Well-being Board is the statutory governance for all healthcare in Brighton & Hove (detailed in the Health and Well-being Strategy). The Board meetings look at the Integrated Care Strategy. HKP's Health Forum has influenced a lot of work and is an exemplary role model. Health Forums are seen as an integral part of Integrated Community Teams and are incorporated into the Shared Delivery Plan – to support other Health Forums in the city. The Community Health Inequality Programme (CHIP) – looked at issues and concerns and identified a set of priorities. Community development response is learning from CHIP outcomes. Looking at how to find local solutions and provide local funding support.

5) Social prescribing

Amelia Lewis - Age UK AARS funded primary care Social Prescribing

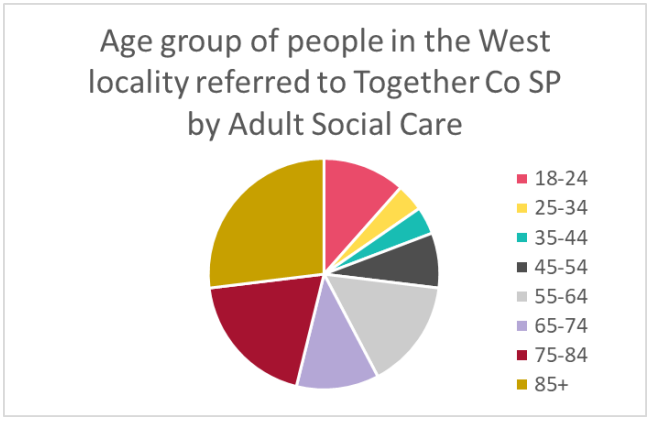
- Responsible for providing Social Prescribing services based in GP practices for adults from 18+
- 4 new Social Prescribers in post in West Hove
- Range of issues supported e.g. social isolation is quite a big concern, housing, financial worries
- Provide health and wellbeing support for the individual and link to other charities and services for support
- Offer 6 supported sessions between a 3 – 6 month period to achieve goals. Holistic approach
- Referrals all come through primary care route – any member of staff in GP practice can refer

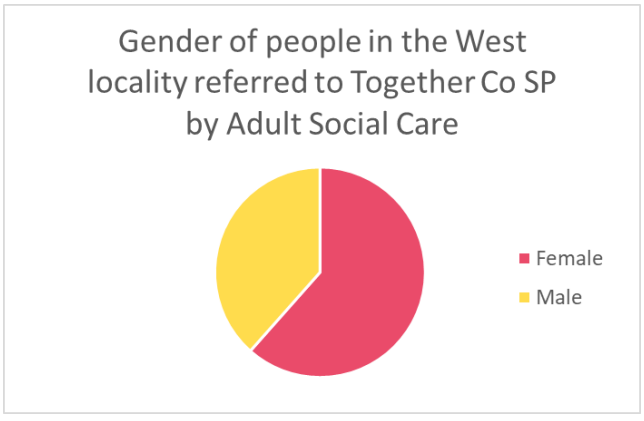
Sneh reported she had found the service extremely beneficial, and the Age UK staff were wonderful.

Rachel Friggens - Together Co Social Prescribing update – information regarding referrals to social prescribing from Adult Social Care

- Together Co deliver a community social prescribing service ('Citywide' SP service); this social prescribing provision sits outside of Primary Care and receives both self-referrals and referrals from a range of professionals and organisation
- One of the established referral routes into this service is from the council's Adult Social Care (ASC) teams.121 referrals were made by Adult Social Care into Together Co's Social Prescribing service in the 12 months April 2023 to March 2024
- 26 of these referrals were for people living in the West locality area. Further information about these referrals is provided below.

<u>People supported</u>





'SP' = Social Prescribing

Reasons for referral

People were referred to social prescribing (SP) for a wide range of reasons (chart below). NB: people often have more than one reason for referral / more than one need.

Onwards referral destinations

Onward referrals were then made by Link Workers to over **43 organisations/service/groups**:

Impact Initiatives - The Hop 50+	BHCC - Healthy Lifestyles Team
Speak Out – Advocacy	LifeLines
Ageing Well - Information & Advice	UOK Brighton & Hove - Central Access Point
Stay Up Late - Gig Buddies	Brighton Housing Trust (BHT)
Good Life Sorted	Community Transport
Together Co - Befriending	East Sussex Vision Support (ESVS)
East Brighton Food Co-operative - Free Meal Delivery	Campaign Against Living Miserably (CALM) - CALM helpline
ESTEEM – Mentoring	Parkinsons UK
DWP (Department For Work & Pensions) - Home visiting service	Figment Arts - Figment Arts Studio
Hangleton & Knoll Project - 50+ Group	Off The Fence - Gateway Women's Centre
Grace Eyre – Activities	MindOut – Advocacy
Hangleton & Knoll Project - Coffee Morning	Standing Tall
Impact Initiatives - Advocacy	B&H LGBT Switchboard - Older LGBT Project
St Luke's Advice Service	AMAZE
The Silver Line	Spiral Sussex
Brighton & Hove City Council (BHCC) - Access Point (Adult Social Care)	Grace Eyre - Supported Living
Time to Talk Befriending - Befriending	Hangleton & Knoll Project - Lunch Club
BHCC - Seniors housing	Portslade Library
Together Co - Connector volunteer service	Ralli Hall - Lunch & Social Club

Synergy Creative Community	Rocket Artists
Ageing Well - Food & Nutrition	Seniors Helping Seniors - Home Care Services
BHCC - Healthwalks	**Total onward referrals made = 62**

Link Worker insight to accompany and enhance data

- Majority of referrals were for **older adults, with isolation a key issue.** Onward referrals include Hop 50+ activities, Ageing well - for advice or information including benefits, Hangleton & Knoll Project 50+ activities.
- For people who are **housebound** referrals included Department of Work & Pensions (DWP) home visit service & befriending services.
- Several people referred have a **learning disability and/or autism** – usually living independently. Referrals made to Learning Disability organisations including befriending, activities, advocacy.
- Fewer referrals for **younger people.** Referrals made to Esteem mentoring and for support with mental health.
- Several referrals are for **carers** who often have their own health / support needs.
- Several of the referrals included **housing issues.**
- Many people referred have **multiple needs** – for example mobility issues, learning disability, neurodiversity, memory loss, mental health, sensory loss, housing concerns, isolation.
- Some people require **longer-term support** but are not always eligible for statutory services. Referrals to advocacy are made where appropriate.

Barriers & facilitators (for people being able to connect to or access support)

- **Digital inclusion:** where people are not online (and may not wish to be) this can make accessing support and activities more difficult, including form filling processes.
- **Transport:** limitation of public transport options and the cost can be prohibitive. Where people are housebound they can't always use public transport.
- Lack of services able to visit/offer **support in people's homes** where they are unable to leave/travel.
- **Financial**
- Facilitators within the community could include help with **form filling**, including in people's homes, in particular for Homemove and Blue badge applications.

Collaboration & integrated working

Some of the people referred to social prescribing feel that they need more long-term support. Therefore, it is sometimes necessary to refer people back to Adult Social Care (ASC) and/or to work jointly to support individuals. Having established pathways between services and staff facilitates this.

Most of the individuals who were referred from ASC did not necessarily have needs which required input from ASC, which indicates there is some more work do as a system around improving information, advice and guidance to help guide people to get to the right support.

Closer working between the services is being explored & developed through Multidisciplinary Team (MDT) models and more regular connections of professionals to share information, knowledge & expertise. The opportunities for MDT working being explored by ASC includes looking at how housing colleagues can also be connected to this.

Contact and referral details for Together Co Social Prescribing (Citywide/community service)

Information about Social Prescribing at Together Co can be found on our website:
Social Prescribing Brighton & Hove, Sussex - Together Co

People can self-refer (or be referred by someone else with consent) via our website
Make a referral - Together Co / Loneliness Charity Contact - Together Co

Or contact via phone **01273 775888**

Jo thanked Rachel for producing the report. The Community Health Panel also identified a need to help with form filling. **Action:** HKP will pick this up in the autumn.
Steve Horne mentioned that foodbanks are looking to expand their offers - money advice plus drop ins, also can help with form filling. Currently reevaluating activities, looking at how to offer more services.

Jo Martindale HKP Community Connectors and partnership with Hove Park School

Community connectors (health champions) are informal networks of volunteers (e.g. MCWG, ACT volunteers, CHP members etc.) that support and share experiences, form groups and provide information that helps identify local health and well-being needs/issues. Everybody involved in Health Forum is an informal health champion. Also, it is possible to get involved with the Community Health Panel. By working with a demographic, the number of people amplifies the offer and spreads the word.

HKP are involved with a pilot project with Hove Park School starting in September for years 9 and 10

- Pupils with less than 50% of attendance (some never returned after COVID) and that are experiencing anxiety/depression and/or self-harm which is affecting how they live their life
- The school will provide a couple of hours of learning and HKP will provide a wraparound coaching offer with activities, support networks for young people, set goals, support and encourage positive behaviour
- Aim is to try and make a difference to wellbeing and get young people back into education.

6) New Healthy Weight Service Teheillah from Gloji

- Gloji is new to B&H started on 2/1 and supports people to lose weight. Partnered with Slimming World and MAN v FAT
- 5 pillars of lifestyle: mind, movement, alcohol, nutrition and sleep to identify ways to develop a healthier lifestyle
- Advocate for preventative care, support changing habits before becomes a long term health problem
- Offering is widely accessible to everyone, recognition weight loss is not easy, groups and one to one support
- Four main pathways (12 week programmes)
    - Digital/web based App
    - Group – adult weight management weekly meetings
    - Exercise – beginning with swimming led by a coach (backed up with digital programme too)
    - Children and families – activities coach for children (45 mins) adults have knowledge based sessions – habits and routines. Final 15 minutes joint session – missions for week, activity together
- Extra pathways for people with learning difficulties or that are pregnant
- Priority support for certain groups – learning disabilities group and one to one how to have healthy lifestyle (12 weeks)

- Referring pathway – can self-refer or by a professional e.g. BHCC Healthy Lifestyles team
- Eligibility - any adult with a Body Mass Index (BMI) 25+ or 23+ if from an ethnic minority group – can calculated by Gloji or using a calculator:
    - https://www.nhs.uk/health-assessment-tools/calculate-your-body-mass-index/
- Can self-refer to the service

Q - Moving away from BMI now more emphasis on waist measurement so using BMI might be off putting and misleading for people.
A - BMI provides a general indicator. Also look at lifestyle, diet, exercise habits etc. and support areas that need improvement. Can look at waist measurements too. Priority groups have lower thresholds also bound by government (NICE) guidelines

Q - What is lead time assessment to joining?
A - Quarterly groups not a long wait list. Depending on intervention required, generally spaces on next available group.

Abi from the BHCC Healthy Lifestyles team also explained that they offer a range of free or low cost activities, services and advice to improve health and wellbeing. This includes increasing physical activity, eating well, stopping smoking, drinking less alcohol, improve general well-being and losing weight. More information can be found here:

Health and wellbeing (brighton-hove.gov.uk)

The team also offer both telephone and in person appointments to discuss the support available. Contact:

HealthyLifestyles@Brighton-Hove.gov.uk or **01273 294589**

There was feedback that the one to one support from BHCC to help stop smoking had been fantastic. Reports that certain stop smoking medications (Zyban) have been out of stock for a long time. There have been some supply issues. Cytisine is a new medication but isn't included on the current list for NHS Sussex. Discussion taking place with the ICB.

7) Sarah Rodgers Community Equipment reuse service

NRS Healthcare is the Community Equipment Provider for BHCC and NHS Sussex, available to those living in and registered with a Brighton and Hove GP surgery. To access the service the individual or professional should contact Adult Social Care - **Access Point 01273 295555** and explain they need an assessment for equipment (or other social care services). A professional (Occupational Therapist, Social Worker, Physiotherapist etc.) will call or visit the home and discuss needs, asking questions around what the person can do independently and what they feel they need support in. Should the professional identify equipment is needed, they will order this through NRS. NRS will then contact the individual to arrange delivery. The equipment is on loan to the individual for as long as they need it. During this time NRS will inspect and repair where required and when no longer needed, collect the equipment. NRS also has recycling points at the local Recycling Centres in Brighton and Hove, should anyone wish to return equipment they can take to either centre, and ask where the container for NRS equipment is located. These are collected on a regular basis.

The equipment, where suitable to do so, is recycled for reuse within the community. This depends on the equipment type. Where equipment cannot be reused, it is either recycled by donating to charities who can utilise within the UK or overseas. If not suitable for reuse, the equipment is broken down into recyclable components to reduce landfill waste.

Q A concern was raised over equipment that was returned not being checked and put straight into a skip
A Sarah will take the concern back accordingly

Steve Horne reported that there are four foodbanks serving Hangleton with lots of families caring for dependents and not getting what they need around benefits.
Jo reported the highest density of carers in the city are on the Knoll. JM happy to support Steve in contacting the Carers service or in putting on a special training if theres a group that could benefit

8) Any other business

Vanessa also updated that for anyone suffering with long COVID the Nuffield Hospital in Woodingdean offer free 12 week courses.

https://www.nuffieldhealth.com/about-us/our-impact/healthy-life/covid-19-rehabilitation-programme

NHS PCASS (Post- COVID Assessment and Support Service) service is also still running. Patients are advised to talk to any healthcare professional at their GP surgery who will be able to refer them to PCASS, but they might have to have some tests done first to rule anything else out.

This is a link which can be shared:

Long COVID Support Service - Sussex Health & Care (ics.nhs.uk)

Q - A question was raised if triage teams in surgeries comprise of Drs and Nurses.
A – All triage teams work closely with a clinical lead, GP, Advanced Clinical Practitioner or Advanced Nurse Practitioner. Always have contact with a clinician when discussing cases.

Meetings 2024: 25th September, 27th November
Meetings 2025: 5th February