Health Forum Minutes
Wednesday 27th March 2024
10am-12pm

1) Welcome and Introductions

There were 51 people in attendance.

2) Minutes of the last meeting

The minutes were agreed as accurate. Dawn reported that her son's burns issue is all sorted and he is well again and thanked WellBN surgery for their help with this following the meeting.

3) Surgery Updates

WELLBN – Benfield Valley healthcare hub including Burwash Surgery - Louise Bridle

- Have had a lot of staff turnover - recruited receptionists, another paramedic, mental health worker, hormone nurse and new practise nurse. Will be able to fully staff Burwash all week by circulating staff to accommodate this.
- Upgrading phone system – which will include a call back facility.
- Lousie has just finished GP improvement programme - highly recommend attending – lots of ideas/changes to processes. Smoking cessation campaign, PCN staff completing drop-in sessions to navigate the NHS app – will be offered in Benfield and Burwash soon.

Portslade - Dr Rowan

- Tracy's currently attending NHS Improvement programme. Dr Rowan is the Clinical Director for West Hove PCN and a partner GP at Portslade.
- Improvement to premises is currently being undertaken. PCN will have permanent rooms and will enable capacity to increase.
- Staffing stable and with some resilience in system. Very busy surgery trying to accommodate as many patients as possible.

Wish Park Medical Centre - Emma Bourlet

- Fully staffed and steady - recently employed female GP and trainee GP
- Lots of training at practice. No issues.

Links Road Emma Bourlet

- Recently recruited two GP's – starting May and July. Also, a full time paramedic called Victoria. One GP is due to go on mat leave – full time locum covering. Advertising for admin help. Advance care practitioner.

4) Social Prescribing update Tory/Age UK

Delivered by together co currently. From 1.4.24 changing to new provider Age UK, who deliver elsewhere in Brighton and West Sussex. We are the first area to pilot social prescribing. Experienced and well connected team. Jo Clarke and Rowan Pellier from Age UK updated that they have recruited two internal candidates and two new staff, will be fully staffed from May. Social Prescribing offer is initially 6 sessions, referral by any member of staff from GP surgery. 18 + service offering help with social isolation, providing a holistic overview – housing, debt, finances, any practical thing barriers stopping people engaging with the community. Staff all experienced in delivering social prescribing and supported by team leader – Stephanie, who assists with triage of patients, linking to right service e.g. mental health coordinator etc.

There is a citywide offer run by Together co - patients can self-refer.

Q Issue raised that BHCC offer healthy life services but must be referred by GP, should be self-referral options.
Q will the service be working with voluntary organisations?

A: The ICT work with community health panels has started to uncover the need for referral pathways to be straightforward and self referral an option as we move to ICT working. There is a clear need for more informal Social Prescribing e.g. community connectors who can link people in with opportunities without the need for case work or visits
A: Need to come together as a community to link up. Stephanie will create partnerships with charities as part of her role and already explored links w the Hangleton and Knoll project to access all the older peoples and community offers.

5) Feedback from ICT work

- Community Health Panel – process and priorities – Sharon Lyons – CHP Chair

Anyone interested in being part of the panel talk to Sharon or email Joanna.martindale@hkproject.org.uk to get invites.

Integrated work – working in connected ways. Patient group panel have met twice since Jan. Reps from across PCN, surgeries, MCWG. Looked at data from public health and ICB colleagues. Snapshot of what happening in B&H and needs across the west. Headline information explored – sense checking if it resonated. Identified three priorities:

1) Mental health and wellbeing issues affecting young people
2) Older people – isolation, access to services around digital barriers and English not as a first language
3) Hospital discharge – concerning anecdotes and the profound impact of readmission to hospital.

Planning more focused work around hospital arrangements

Social Prescribing will be a fantastic means for information gathering and identifying community needs. Important to target services not just deal with crisis care. Next meeting is in June for anyone wishing to join.

Age UK have a Crisis Care contract to help with hospital discharges, which offers short-term support e.g. support after a fall returning to independence or help getting long term care package in place.

The value of sharing information via HF meeting was highlighted through an example of self-referral to MSK, with very positive outcomes.

Katie shared the Sussex NHS ICS Team – social prescribing works plan here:

https://www.sussex.ics.nhs.uk/wp-content/uploads/sites/9/2024/03/Social-Prescribing-Works-2024_SHC.pdf

- Stakeholders group – process and initial thoughts - Dr Rowan/Tory/Jo

ICT West Area Group, comprises of reps from the Community Health Panel and brings together all the services that will be needed as part of Integrated services team. Rapid and exciting process building on last few years work. 22 services represented at inaugural meeting. Identified service ideas/concerns. Need time

to digest all information and will continue to refer to it. There is a commitment to meet again. Will continue to report back to the HF.

Dr Rowan described it as the beginning of a journey, ICT means different things to different people. Wider element bringing in community partners e.g. housing. Local connections are evolving. West Area highlighted as a forerunner partly because of the HF. Hope to improve communication and connections with services as it evolves. Ambition is a more connected, seamless system. West needs are different to other parts of Brighton and Sussex etc.

Jo updated that HKP has just agreed pilot project with Hove Park School and funded by ICB for children and young people's mental health and wellbeing and Social Prescribing. HKP works with 500-600 children in the West and wellbeing issues are an issue. Next term pupils with health and wellbeing needs and low attendance at school will be identified. HKP will provide a wrap-around coaching and activity offer on top of education provision. Aim is to get young people timely help and starts beginning of April.

- Next steps ICTs – Chas/Jo

Chas' role supports the Integrated Care Strategy. Key system partner update – local authority new Chief Exec Jess Gibbons started last week. New political administration with a new corporate plan that is exciting and ambitious. Period of change in the council. Aiming to break down silos that prevent working in a connected way integrated way.

NHS is currently organised to work to managing budget situations, which are declining and will have an impact on services. Need to look at different ways of doing things and use our resources more effectively. Integrated Community Teams join things up from a local level. Health Forum model is an example of how to achieve a locally led strategy. This is now emerging in the East, North and Centre. Integrated team – pilot. Need to recognise and build on our assets. Community Health Partnership, Family Hubs etc. are good examples of how to develop integrated community teams.

Q – Will Physicians Associate (PA's) be used as they are in hospital pilot schemes?
Jo suggested PA's and their roles are added to the next HF agenda as too wide a discussion for today and will explore who might speak to this next time.

6) Dominic Leslie – Southdown Mental Health Manager – what is the Mental Health Coordinator role? Who do they see? What are the gaps?

West Hove PCN has three Mental Health Co-ordinators (MHC) c30 people caseloads. Drs can refer to the team. MHC works at tackling issue e.g. money issues, COL and working with other services to help mental health. Looking at social issues and support in conjunction with mental health. Initially 6 sessions every other week, if the need is more clinical need they are referred to a mental health practitioner. Once discharged can be re-referred. Short waiting list currently. Can work remotely or in surgery. 30-45 minutes sessions to enable more time to uncover issues. Better ways of looking after mental health, refer to other services – courses, voluntary work, applications etc.

Q How can we encourage men over 50 to talk about their mental health as engaging with them is difficult.
A Need to look at other ways to approach discussions e.g. volunteering roles, community involvement activities, walk and talk can work well.
It can be very GP centric. Need a system for all services to be accessible, at ICT level need to identify areas which might tap into men. Need to look at informal connector roles to build on HKP community model.
A good example of engagement was a men's breathing workshop, which was successful and well attended, mental health needs to be marketed in right way for the demographic.

Oasis Foodbank regularly has a group of men that come to have coffee and chat. No point contacting GP as they wouldn't go. CAB provide advice sessions within the foodbank.
Q Is there a massive wait when referring them on to other services?
A Current waiting list 6 people, generally seen within 2 weeks of referral. Wouldn't be discharged before accepted by next service.

7) Mark Cannon – what is the Fed? What might Feds role in developing a new way of working in localities?

Mark gave a short presentation – details and slides included in separate reports.

For more information https://www.brightonandhovefed.co.uk

8) Childhood Immunisation

Tina from the Public Health Team gave an update in Anne's absence. Have worked closely with HKP and TDC/other community groups. It provides a great way of working, to share information with communities and colleagues, and adjust system to address health inequalities. Expanding work on childhood immunisations this year. Anne visits community groups, talks about vaccinations, and provides information to enable people to make an informed choice. Working hard to provide easy read measles, mumps, rubella (MMR) information in as many languages as possible. There is a lack of knowledge about what vaccinations may contain (e.g. gelatine). Schools and GPs service can be confusing for parents. Developing resources and feeding back to partners. Brighton & Hove MMR rate is just under 90%, messaging needs changing a bit.

9) Health Counts survey

Catherine from the University of Brighton updated that a city-wide health and lifestyle survey was recently launched to identify a range of health behaviours around physical and mental health. GP text messages have been sent. Survey results will inform understanding about the city's health. Commissioned by BHCC. Attending some community activities e.g. MCWG to help complete survey. Healthy response so far from West. Can help to identify where health inequalities are growing as it runs every decade. Summary level responses will be fed back via council website and at PCN in summer. Can provide text for newsletter, social media etc. runs until late April.

www.brighton.ac.uk/healthcounts

10) Covid Vax – feedback for Spring vaccine

From 15th April Covid Vaccine will be offered in care homes, programme completed by 30th June. ICB have been working with pharmacies to link with a particular care home. Pharmacies are coming on board - Mile oak, Neville Road, Kamson and Osborne in Portland Road. Team at HKP have been discussing where people would like the vaccine if extended to community groups. Eligibility will be over 75, immune compromised and housebound.

11) Health Inequalities Partnerships update

Jo highlighted just a few of the successful communities health inequalities achieved within the last year – she will circulate evaluation report when finished

- Digital 160 people now have NHS app

- Blood Pressures 176 taken w referrals for high BP, diabetes and weight management and 321 one to one health conversations/referrals
- Courses delivered with Benfield (breathing 2xworkshops) with Mile Oak 3xdiabetes group consults delivered
- Quarterly peer support for diabetes and menopause
- Cancer screening uptake projects with Portslade and WellBN
- Events and outreach with health information reaching 17,000 people online and w leaflets, over 1000 attending events, 912 signposted to community support

AOB

Tim has just finished a breathing course with B&H Albion Foundation. Now looking at using same programme elsewhere as it is robust and helps people to breathe with greater consistency and control. Liaise with Jo and Claire Hines in terms of promotion.

Claire Hines updated that Burwash surgery are looking for volunteers. Leslie holland is the contact (poster attached).

Meetings 2024: 10-12 26th June, 25th September, 27th November