HIGH FIELD SURGERY – PATIENT REFERENCE GROUP

Minutes of the Patient Reference Group held on Tuesday 26 November 2019 commencing at 6.00pm

Present: Chair - (GB).
(DM), (KB), (DP), (LB), (LW), (DD)

Practice Manager - Mike Holmes (MH)

Guests (TT – Ireland Wood Surgery PPG)
(V – New Croft Surgery PPG)
(OC – Primary Care Network Project Support Officer)
(TL - - Primary Care Network Case Manager)
(AK – Linking Leeds Wellbeing Co-ordinator)

1. Apologies and Introduction

Apologies: (BA), (CA), (GP), (VT), (MK)

2. Chair

GB opened the meeting, welcomed the guests and outlined the agenda for the evening. Particularly welcome to representatives of local PPGs met at the Headingley event, with which we may develop further formal relations in view of the PCN (Primary Care Network)

3. Review Last Minutes

MH reviewed the last minutes and actions. Nothing carried forward, several items also on todays agenda.

4. Update on Leeds PPG Meeting

GB summarised the CCG (Clinical Commissioning Group) PPG event held last month at Headingley Stadium with DM, LW and KB.

Key Points:

- Well put together and worthwhile event
- Presentation from a gold standard practice (Leigh View Medical)
- Lots of ideas from other practices to use as best practice
- Overview on PCNs
- Met representatives from other surgeries in our PCN (Ireland Wood & Horsforth, Fieldhead) hence their attendance today

MH then provided a copy of some PCN based stats for Holt Park Locality, these were discussed by the group as areas for further discussion on a PCN basis as well as for High Field surgery.

MH then outlined how these stats looked different for High Field in isolation:

Top 3 Health Issues

1. Diabetes – we have as many patients diagnosed as pre-diabetic as on the diabetic register
2. Common Mental Health Issues
3. Asthma

Top 3 areas of improvement from GP patient survey

1. Length of time to wait for a routine GP appointment (we are only 2 weeks at present which is much better than local surgeries)
2. Continuity of Care – booking with the same GP for the same problem
3. Opening hours – education of patients that the Hub at Ireland Wood is an extension of our service

5. Social prescribing

AK provided a very informative presentation about the role of social prescribing as provided by Linking Leeds. See appendix 1. There was then a helpful Q&A so attendees could get more background on the service. The group enquired about some patient representation at PCN level regarding recruitment.

TL then provided information about how the PCNs are in the process of employing 4 extra Wellbeing co-ordinators to work in conjunction with linking Leeds and expand the offering locally. She explained how we envisage this working and why, because of funding reasons, the 2 services will be separate.

Action: MH will send out a Job Description for the Well Being Co-ordinator role.

6. Patient Survey 2019

MH gave a summary of the survey results from a surgery perspective; all participants had reviewed the results prior to the meeting.

The group agreed to review the results in view of the surgery priorities away from the main meeting

The group will discuss strategies for contacting potential new PPG members gleaned from the survey.

7. Surgery Update

Adel Surgery Closure – no further news, public consultation is on hold until after the General Election

Surgery Improvements – the programme continues, new GP desks fitted, update computers to Windows 10, Surgical Microsuction Microscope,

8. AOB

LW enquired about Mental Health services. The surgery refers to a different NHS service, formarly called IAPT (Improving Access to Psychological Therapies). This service has been recommissioned as Leeds Mental Wellbeing Service, more information is available here:
https://www.leedscommunityhealthcare.nhs.uk/our-services-a-z/leeds-mental-wellbeing-service/home/

9. Meetings

The next PPG meetings were agreed for:

- 14 January 2020
- 31 March 2020

Interim meetings for PPG only were agreed for:

- 11 December 2919
- 04 March 2020

To be held at Holt Park Active Café (Leisure Centre) from 3.30pm - 4.30 pm. Please contact Graham Bell direct on blgrh@aol.com if you are unable to attend.

GB thanked everyone for attending

The meeting closed at 7.30pm

Appendix 1

Linking Leeds

What is this? -

- Linking Leeds is a city-wide social prescribing service formed by merging Connect for Health, PEP and Connect Well.

- Community Links is leading a consortium of 7 local partners to deliver the new service. They are; Community Links, Leeds Mind, Better Leeds Communities, Barca-Leeds, Feel Good Factor, Leeds Irish health and Homes and Age Uk.

What does it offer? –

- Social prescribing is a way of linking individuals with a range of local community services to improve social, emotional and mental wellbeing. We work with clients for up to 3 months and deliver between 10-12 interventions. The service provides a person-centred approach, each client can be offered a 1.5 hours assessment allowing the client to identify what they may want to change or need help with.

How does it work?

- At the first meeting with the client we complete an assessment, a wellbeing wheel, questions around loneliness and coproduce an action plan which identifies the areas that the client needs help with.
- We can offer referrals to appropriate services, provide clients with a range of information about other organisations and encourage and motivate clients to engage with support.
- Common services that we refer people to are; Engage Leeds Housing Support, Peer Support-Mental Health, Debt Advice, support groups, neighbourhood network groups, but there are also hundreds of different services, activities, groups that we can discuss with the patient.
- We then follow up with clients via email, phone, and face to face. It may be necessary to see the client for follow ups to complete work or to accompany the client once to an activity or group. Once the links have been made, we offer a review to see if there are any further links needed, or any additional information required. At this stage, we evaluate the service with the client. If there are no further links needed, we then close a client's case.
- Clients can be re referred later if needed.

Case Studies-

1. Assessment Visit:

Client booked into a surgery slot at the GP surgery. The client has psoriatic arthritis which affects all her joints and makes mobility difficult/ painful along with another condition causing painful knees. She has had a stroke like episode 7 weeks ago which has left her with speech difficulties and weakness on her left side and spasms in her body. Following investigations, she was told that this was not a stroke, however she was left with speech difficulties, mobility difficulties and this was impacting on her mental health. She experiences depression, anxiety, panic attacks, and was socially isolated. Whilst in the assessment, she disclosed historical child abuse and domestic violence and was tearful at the assessment. Her partner is her main carer and she has debts.

Follow up Conversations:

Discussion about her debts and she agreed a referral to BLC Debt advice service.
Discussion about her physical health and she agreed a referral to adult social care for a bathing assessment.
We agreed to send her details about mental health support options, / domestic violence support, historical child abuse support and organisations that support people with physical health difficulties.
We discussed her finances in terms of what she received, and we encouraged her to make a new claim for Pip. She was given a booklet on PIP along with a crisis card which was explained to her.
After the assessment visit, the client looked at the information provided, got in touch with the different strokes group and tried this. She found out that her friend also attended, and they now travel together to the group which she says is very friendly.
Her partner has also attended, and they have been on a trip with the group and enjoyed this. Discussion with her partner about carers Leeds and a leaflet given.

Review:

The client was seen by BLC debt advice service at the GP surgery and she is now engaging with them to manage her debts.
The client did refer herself to IAPT and they have advised a referral to Northpoint counselling which she is going to do.
At her review, she said that adult social care were going to visit to fit grab rails after an assessment of her needs.
The client is feeling a little better now and looks forward to getting help with her bathroom and her mental health.
She continues to attend the different strokes group and work with the debt advice service.

Assessment Visit:

Client booked into a surgery slot presenting with severe anxiety, depression and panic attacks. At the assessment the client was very tearful and scrunched up tissues into balls constantly throughout the assessment.
The client is a student at Leeds university and is struggling to manage her course and final thesis that she has a deadline to complete. She has stopped attending a local Zumba class and is experiencing insomnia, social isolation, depression and feels isolated from friends. The client's family does not live in the UK and although she speaks to them often, she has no local support and they are not aware of her mental health difficulties. She lives alone and does not discuss her difficulties with anyone at the university or with anyone else. At the assessment we completed the assessment, a wellbeing wheel and then completed a stress bucket exercise to help her to understand the pressures that she has and how this may have become overwhelming. We sent a long time looking at what measures she could take to relieve the pressure, including going back to exercise, seeking mental health support. She was given a crisis card which was explained to her.
We discussed talking to someone about the stress she is feeling as a first step and the possibility of the university giving her an extension. She agreed at the assessment to ask for help on that day.

Follow up:

We agreed to email her some information about mental health support options and she was given information about IAPT. We booked her onto another GP surgery clinic 2 weeks later as it may be difficult to follow up over the phone due to language difficulties and her mental health. The client did email the university the same day as the assessment and then went to see them. They offered an extension period of 6 months on condition that she get a letter from her GP to explain why she needed the extension and to give some details about her health. We left a message for her GP to say that we had assessed her as having severe anxiety and that we had encouraged her to ask about an extension to allow her extra time to recover and complete her work. We asked if the GP would consider writing a letter to present to the university detailing her mental health difficulties.

Review:

At a follow up visit 2 weeks later, she presented as a smiling and cheerful person and was not tearful. She had contacted her GP and collected a letter at her visit to the surgery and would be emailing this today. Also, she had registered with IAPT, had signed up to a controlling stress course for 6 weeks at the university and started a yoga class at her local leisure centre. She was very thankful for our help and said that although her sleep pattern had not changed, she felt positive and was less angry. She stated that she has started to talk to colleagues about her stress and anxiety.