St Austell Healthcare (SAHC) PPG

Meeting Minutes – 26/1/2023

Attendees.

Shirley Polmounter (SP)	**Chair**
Pietro Abate (PA)	**Treasurer**
Carol Birchall (CB)	**Mevagissey**
Katrina Rundle (KR)	**St. Austell**
Roger Jones (RJ)	**St. Austell**
Davina Slack (DS	**SAHC – Social Prescribing**
Fliss Kedge (FK)	**Cornwall People First**
Gemma Rodliffe (GR)	**St. Austell**
Paula Volkner (PV)	**ClOS ICB**
Margaret Phillips (MP)	**St. Austell**
Alan Lawler (AL)	**SAHC – Management**

SP welcomed everyone and advised on the apologies as follows – Sandra, Jackie, Norma, and Deborah.
She also advised that Janet had moved out of the practice catchment area.

The minutes of the previous meeting were discussed and accepted.

SP asked Alan for an update on the surgery.

Al advised that the last 2 months had been some of the busiest in the practice history. The urgent workload across Cornwall had grown exponentially as there was a national Strep A outbreak that caused major concern on top of increased numbers of patients with Flu and respiratory issues.
The strikes in nursing and Ambulance services have also had an impact. No staff in SAHC were on strike.

Across Cornwall there is a RAG (Red/Amber/Green) rating for practices reported weekly – currently 2 of the 3 ICA regions are Amber and the 3rd is Red. SAHC is currently Amber as we are using additional workforce to support workload, have high sickness levels and are seeing increased volumes of urgent requests for consultation.

Our urgent caseload increased by up to 50% in December requiring us to get a locum to cover Mondays and Tuesdays and have an additional partner cover also. This has a knock-on effect on the non-urgent appointments and after discussion with the Integrated Care Board (ICB) we moved to an urgent only service earlier than expected. Most GP practices in Cornwall were advised to do the same.

St. Austell is the largest town in Cornwall with some of the most deprived postcodes and unlike Penzance and Cambourne/Redruth has no independent Urgent Treatment centre that can see minor illness. St. Austell has the community hospital that can only deal with injuries. We have raised this as a concern as it impacts SAHC delivering on our Quality and Outcome (QOF) measures which are all planned appointments for the patients deemed most in need of continuous review i.e. Diabetics / Learning difficulties etc.

PA advised that he had to access the urgent service and did so via Klinik and was dealt with quickly on the same day and found the service excellent. AL advised that another patient that has frequently complained about the service also reported a similar outcome having used Klinik. We are still only seeing about 50% of our consultation requests through the online side of Klink with the other 50% calling our phone lines. AL advised that wait time on phones had improved considerable in recent weeks as we have onboarded 5 further reception staff. The more people use the online portal the better as we free up time for reception to book appointments etc.
Al advised that that practice is installing a new phone system in March that has some added capability. It will integrate with our clinical system so we can prioritise specific patients i.e. palliative and they would be answered earlier. It can also open the clinical record for the reception team answering the phone. It will have a Queue busting feature that allows the patient to be called back when its their turn also.

AL updated on recruitment. The GP for women's health unfortunately has decided not to move to Cornwall due to family circumstances. We are recruiting again and have 1 interested candidate so far. We are also recruiting a Diabetes nurse and 2 practice nurses to replace staff leaving. We are holding interviews for 3 urgent care roles this week and have some excellent candidates. We have 3 HCA's joining but have some leaving also so that is a continuous recruitment process. We have 3 nurses leaving since the last meeting. We are seeing staff move closer to home to avoid travel expenses etc. We have 2 social prescribers joining also and 1 will work with younger people supporting DS.

We have received funding from the ICB to hire Community Health Workers (80hours per week) and we had a successful recruitment day Monday. This model looks at the most deprived postcodes in the area and the worker acts as link for the houses to health, social care etc. The idea is to build a relationship of trust and get those households engaged in healthier lifestyles, health care etc. It is based on a model of health care delivery that has been successful in Brasil and was piloted in several UK areas over the last 18 months. There will be key links to Social prescribing and one of the team Debbie Heaslip, will lead this for us.

We have acquired some space in Carlyon house where the vaccination service used to be and this should lead to better multidisciplinary working as social care, district nursing, SAHC home team and social prescribing will be co-located.

AL advised that we have engaged with a national Physiotherapy organisation called Pure Physio to get additional appointments for musculoskeletal issues which we believe accounts for 10% of our consultation requests. We have 1 fulltime physio and hope to add up to 2 more. We start with 20 hours from the 30/1. This is first contact physio that can help to identify what treatment/ medication is needed and refer on to other commissioned services as needed.

With a national shortage of GPs the emphasis is on specialists in areas like physios to become part of the primary care provision through the PCNs (Primary care network) and SAHC are early adaptors. We could not provide the care we do without all these staff, and this was outlined in our last newsletter.

The floor was opened up to questions.

FK asked if the practice tried to identify patients with LD when they answer the phone. AL advised SAHC has a register of all LD patients and gave numbers from a previous QOF report – Below are the latest figures.

St Austell - 295
Mevagissey - 24

Al advised our clinical system identifies those patients on our LD register so when the reception opens up the patient they will see clearly who they are dealing with and can manage the conversation appropriately. We have notes on those with other needs. There may be potential for the new phone to identify this cohort in future but he is confident we already use the notes. There is a quarterly Multi-Disciplinary Team (MDT) meeting that includes community services discussing LD patients.

FK advised that they are available to support and can give feedback from some other practices they are engaged with. AL said he would share her details with the LD team and see how they could be involved as we do not get all LD patients in for their annual reviews – nationally its less than 70% and locally we had delivered over this historically.

SP asked Al how we know the most deprived areas and he explained that the Public Health arm of the council have access to SHAPE and other national tools that can identify the top 10% of deprivation using specific criteria. We have this mapped for the town down to 50 household areas and I will ask if it can be shared.

SP asked if we know why staff are leaving. Al advised we do exit interviews. 2 of the nursing staff have moved to promotions elsewhere and 1 moved closer to home. Pay is mentioned. We try to be competitive but don't have dispensing income so its not a level playing field. We are looking to increase staff salaries from April significantly in reaction to the inflation issues but we are not guaranteed this funding will come from NHS England so it is a risk but the right thing top do.

SP advised that she has been informed by patients that some RCHT staff have been saying derogatory things about SAHC like ' Oh your are with them – that's a pity'. She feels we need to promote all the positive things that we do. Al advised we are not perfect, but we are doing our very best for patients. There are no long waiting like elsewhere in the county where up to 6 weeks for non-urgent is a reality. Waiting time for some hospital appointments are now years not weeks. We all need to work together better.

SP also advised that she had heard that 111 sometimes tell patients to speak to their own GP when it's an emergency issue or get advice on transporting the family member to hospital themselves. AL advised that this is not correct. If its an emergency call 999 and they will advise further. GP are not an emergency service and can not transport patients from their homes or visit them urgently. We do sometimes transport patients from our surgery if there are long ambulance waits but this is done at the risk of the GP who has training in life support if necessary.

DS introduced herself and spoke about the young persons social prescribing service operated in St Austell PCN.

The surgery has both adult and young person's social prescribing support. DS is the support for young people up to 25 and young parents. We have recently recruited another person to support this age group. Referrals usually come from the GP but can be from the council or social care. They deal with a wide range of concerns including mental health, school concerns, autism, ADHA, social isolation, confidence, disability and weight issues to name some.

The role is mainly about signposting to other services that are available both through the NHS and voluntary sector, but we also look for grants to access paid services as not all are free.

We look at some more specialised therapies where we can access funding. One example of this is the Wave project that introduces the young person to surfing. We get 6 1:1 sessions for them for £110 and have had over 30 access this and

the feedback has been amazing. it gets them outside without the fear of a larger group. It is good exercise. It improves resilience as you have to keep trying and you see the results of the effort. Its also something local for them and they can continue to do it after.

We also have animal therapies where we engaged with a local stable for equine therapy. That no longer is on offer, but we are looking for an alternative.

We fund a music practitioner and we off 10 forth minute music sessions to 4- to 19-year-olds per week which has had a very positive reaction. It has proved good for social anxiety and the teachers have additional training in this area.

We have funded residential and day sailing trips which have a wellbeing practitioner and psychologist included as well as our own social prescriber. This is good for team activities but can also be good for 1:1.
We get support from the lions club, church groups. We offer weight management support after hours and over weekends.

This is about building relationships with young people. School is not the right fit for everyone. The programs with individuals are usually 24 weeks but relationships last longer. We can see young people by themselves or with parents.

We have the Help @ Hand app that signposts to local services.

SP mentioned that Cornwall Community Foundation have grants available currently for activities and the PPG could help to source these if needed and others agreed. They would need to have the information on what the funds could be used for etc. DS said that would be fantastic and would link in after.

DS added that young person Cornwall are no longer accepting referrals. Kernow connect have a very long wait time – Oct referrals still not seen.

The group thanked DS and would love to be kept informed. AL advised that a video of the boat trip would be available soon and he would bring it to the group to see.

SP asked how we could publicise all the good work the surgery is doing as it seems only bad press happens. We need to get the positive news out there as News Letters on their own does not work.

SP advised in the treasures report in PA's absence as he had to leave was £ 827.22.

SP raised fund raising and asked the group to see what events we could join, although the coronation events may impact that, Sp happy to organise but need Committee to participate in an event if able.

The meeting was closed @ 12.