Minutes for Joint PPG/PCN meeting
Tuesday 6th September 2.30pm
Northway Surgery

Present:

C. Thomas, A. Costigan, L. Rattu, L. Mason, R. Clarke, J. Baine, A. Whittam, E. Thompson, M. Taylor, T. Jevons, K. Tomlinson, B. Tomlinson, R. Humphries, D. Gill, C. Bate, C. Chapple, P. Hawthorne, R. Fossey, R. Gardner, Barbara Bryan, K. Watson (on line)

Apologies:
K. Evans, A. Wakefield, I. Campbell, Y. Gittins, H. Woolf, P. Norton, D. Norton, H.Codd

Introduction: Dr. Steve Pritchard gave a short introduction welcoming so many practices – Ridgeway, Bath St, Bull St, Northway, Coseley had sent apologies.
Missing are Greens (on line) and Castle Meadows.
We are in front of the curve in holding joint meetings which is gratifying. Dr. Girish Narasimhan from Ridgeway is taking over as Chair of PCN. Flu vaccinations are due for most PCN practices on 19th September and Covid vaccinations are due weekly from mid-September, however supplies are limited at present. Care homes and house bound are required to be vaccinated first starting in September, the relevant public from October starting with the over 75s. Ridgeway are starting on 1st October with their first flu clinic, they have intermittent clinics in the days after that and another flu clinic on 29th October, it should be noted that healthy 50-64 year olds cannot have their vaccination from GP or pharmacy etc until 15th October onwards. Dr. Pritchard thanked people for responding to the extended access questionnaire. NHS want practices open for longer and with 'hub' practices offering Saturday clinics – probably the Brierley Hill Health & Social Care facility. We need to find out what people want to hear about and showcase what we do through these meetings.

Mark Taylor -One Health Care – Shared Care Records:
Mark gave a very detailed run down on what these are and how they will work for the benefit of patients and clinicians. All the facilities will still hold their individual records, but they will be aligned and some parts shared - so patients don't have to keep answering the same questions at different appointments – and a clinician can access all the notes on a patient in front of them.
This is not replacing the NHS summary care records. The ambulance service will have access. The concept is to disseminate information to all relevant parties to make treatment easier and quicker. It supports the already rich patient record. For multi disciplinary and end of life care it should make sure that key checks are not missed. It is intended to cover all the West Midlands and Shropshire. Some of this is already available to patients who can see their own records through EMIS. It is Read Only so cannot be altered.
Questions were asked about security and sensitivity. Mark felt that it is as safe as any of the other NHS platforms and there are many safeguards in place to secure sensitive data. What do patients need to do? Nothing as yet – all patients will be contacted with the option of opting out of the system – but if someone opts out these records cannot then be accessed at a later date in an emergency!

The analytical purpose is possibly the most important aspect – while the G.P. might not see a great deal of benefit, the continuity across the piece for the patient is important.
From an admin point of view – does a surgery have to regularly review peoples' decisions?
Marks showed a comprehensive list of slides which will be **attached.**

CVS presentation
ShCR Nov 21 - MT -

Care Co-ordinator Team – PCN:
Rachel Clarke and Lucy Rattu gave an overview of their work in the PCN. They are a team of 5 and they work to increase uptake in cancer screening, cardio-vascular and long term condition management. They see the frail and elderly and visit the housebound. They, too attempt to co-ordinate appointments and visits into one plan – a centralised and simplified process for patients. They visit care homes and deal with mental health cases.
The objective is to make people feel more comfortable and more confident in dealing with their health problems. They have time to sit down with the patients and discuss their problems so it is personalised care. They can raise issues within the multi-disciplinary team meetings. They seek to raise the awareness of the importance of screening. They can lend machines for monitoring – eg. blood pressure kits. They take information back to the g.P.s for a phone consultation with the patient if necessary. People with learning disabilities also qualify for home visits, and those with mental health difficulties get the same careful approach through home visits where appropriate.
Frailty in the elderly is also covered. They go in to care homes and can administer vaccines, build care plans and offer carer support and discuss patient welfare with the family. All practices have access to the information gathered.
Comprehensive slides were shown – **also attached**

Care Coordinator
Powerpoint - Read

Anne-Marie Cooper – Health & Wellbeing Coach:
Anne also provided slides which will be **attached.** She worked for Action Heart for many years, is a psychotherapist and has seen the benefit of a healthy approach to wellbeing. She has established clinics through the PCN.
She offers a step-by-step focus to change for those people wanting to change something about their lives.
Establish step by step goals
Help to acquire knowledge and skills
The person must be persistent
Seek support - one day at a time
Reward success
The key is – 'what matters to you' not 'what is the matter with you'.
There are 6-8 week sessions of 45 minutes each but it can be offered for up to 10 weeks, to explore why a person wants to change; to provide confidence building, self realisation, feeling more successful.

There are leaflets for the surgeries and people can ask for referrals through their G.P. but appointments can be arranged quickly. The service is always based on patient choice.

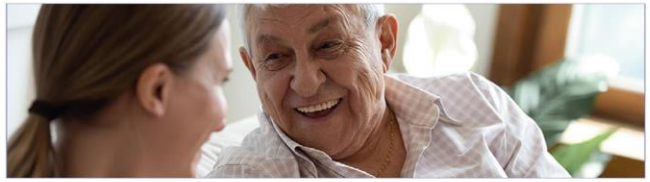
Participants were asked for views and comments on what they would like from the meetings in future – who they would like to hear – any ideas – to their practice manager or to Ella Thompson at Ridgeway.

HWBC PPG.pptx

WHAT IS CARE COORDINATION?

NHS Dudley Integrated Health and Care NHS Trust

Having many health conditions can mean that you see a variety of health and social care professionals; it can impact on different aspects of your life. A care coordinator wants to make sure you have the fastest and best-quality service with continuity of care.



A health professional may have talked to you about a referral to a care coordinator to help support you to manage your health condition or to support someone you are caring for.
Your care coordinator will review your health and care needs and ensure that you are accessing the right care and support. They will coordinate your support across health and social care services and develop a personalised care and support plan which brings all your care and support needs together into one plan.

CARE COORDINATION WILL:

- **Ensure you only have to tell your story once**
- **Help improve your choice and control over how your care and support needs are met**
- **Enable you to have a single support plan which identifies all your needs**
- **Enable better understanding between you and your family and health professionals to support you to better manage your condition**
- **Help the different people and services that support you to work together in a better way**
- **Give you a single point of contact for your health and wellbeing needs**
- **Support shared decision-making between professionals and patients**

For an appointment or more information
Contact: SCG Care Coordinator Team on
Tel: 01902 240 791 / Email: dihc.ccscg@nhs.net

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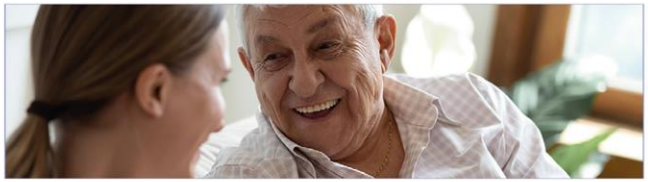

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