The Oaks Medical Centre
Drs: Mansford, Jacklin, Laurance, Harris, Johns, Burns & Swain.
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Patient Participation Group
Minutes of the Meeting 6.30pm Tuesday 28th February 2017

PPG Members	**Practice representatives**
Graham Mansfield (GM), Chair	Laura Scott-Lead Secretary (LS)
Edward Jolley (EJ)	Dr Claire Harris (CH)
Barbara Worrall (BW)	
Michael Worrall (MW)	**Apologies**
Sharron Bilbey (SB)	Ellie Duncan
Thomas Turner (TT)	John Sellers

Ref	Discussion
1	**Welcome, introductions & apologies** Graham Mansfield, Chair, welcomed everyone to the meeting. Introductions were made and apologies noted.
2	**Minutes of the last meeting / matters arising** Everyone was in agreement that the minutes were accurate. No questions arose from the minutes of the last minute. However EJ mentioned the fact that we had spoken about the hospitals wanting to remove 200 beds at the last meeting and wondered where we were with that. GM explained that it wouldn't happen overnight and the "200" was just a figure to keep the press at bay. TT also added that that was the figure they were aiming for but they wouldn't be taken out of service until they had become surplus and it would be realistically 100 at City and 100 at QMC but it would be a long time before it happened. Also mentioned was that they were looking to take 7 services out of hospital and put them in the community however neurology and renal would stay within the hospital location.
3	**EPS Launch-1st/2nd/3rd** CH gave an overview of how EPS would work and mentioned that we were slow to take it up as worried about the system and how it would work with prescribing costs and admin time but now it has been going a few years and it is ironed out now and works very well meaning a green prescription will become a thing of the past. GM asked if control would still be with the patient in terms of ordering medication to which the PPG was informed it would. MW also asked about current patient online access and still be able to order medication online to which he was informed yes. CH also mentioned that the only problem with it at present is that controlled drugs such as Tramadol can't be sent via EPS. TT mentioned that he was actually on a medication that was only available from the hospital and not via EPS and every few months he had to go to QMC to get them. EJ asked about NAMS and how they would fit in with EPS to which CH informed that that patients are able to have a separate nomination for usual pharmacy and an appliance dispenser nomination however we don't prescribe any appliance products now so it wouldn't be an issue. BW asked about the repeat side of the prescription and how patients would go about ordering medication and was informed that the pharmacy should still be giving the patients the

	repeat side for repeat ordering. MW asked with regards to when away on holiday at the coast and forgetting to take medication with them would they be able to have a prescription sent to a local pharmacy to which they were informed that that was possible. However CH did inform them that if they were in a situation where they had forgot/ran out of medications when away any pharmacy should have the ability to supply an emergency 7 days' worth of medication as long as they can show a repeat side.
4	**Feedback from PRG-Tom Turner** TT gave feedback from the PRG. The main discussions included: • Buddy System- NWCCG have taken this up where we partner up with another surgery in our CCG and sit in on each other's meetings to see what is going on. • Community Respiratory & Diabetic Service-seem to be aware of the services but they aren't not be used efficiently so looking into how they can be made better use of. • Cardiac catheterisation-112 elective cases that are currently over the 18 week period of being seen so they have become more serious. Referrals for treatment are at 91% but should be at 92% so they are looking to improve that and get more people seen/treated. • Personal health budgets- choice and control over own health care is still on going. • CQC published strategic plan for 2016-2021 • Trillium will cease to be the provider to NUH from 1st April only keeping the car parks. • OTC medications effective from 1st March 2017-consutlations in NNE, NNW and Rushcliffe proved that 87% of patients said they wouldn't be affected if they had to buy the medications over the counter. GM mentioned that people who pay for scripts anyway would benefit as much cheaper to buy paracetamol etc OTC as a lot cheaper and it doesn't affect patients with chronic illness. CH mentioned that patients taking 8 a day will need it on prescription due to the quantity but GPs are now to encourage buying it OTC. TT mentioned that stopping paracetamol prescriptions could save £200,000 a year. CH mentioned that it appears to be inner city practices that have more of an issue and won't affect us too much as we don't give it out very often. GM commented that it was an example of government starving the NHS of money and eroding at it. EJ asked if the money saved would be spent on other services but GM thought it would be more about recovering debt from underfunding and that the press never mention the good prompt healthcare that the NHS give.
5	**AOB** GM mentioned that he had noticed the posters indicating that all patients have a 'Named GP' and asked what is meant. CH explained that it basically meant you were on someone's 'list' and used to be more valid when each GP had an individual list which meant a patient was triaged/seen by that GP only. Nowadays it is more of a formality on the admin side that everyone has a GP who's 'list' they are on but can be seen by anyone the patient wishes but we just have to make patients aware of who their 'Named GP' is. EJ asked if that was related to the fact that he had been referred to OT but without him knowing but CH explained that it wasn't necessarily the case, it would have been the GP who had possibly most recently seen and thought that patient could benefit from that service-it was the individuals decision. CH also explained that any clinic letters will go back to the GP who has been seeing the patient with regards to the

	problemsor who knows the patient best for that GP to action despite the name on the top of the letter. CH gave an example that she had seen a patient only once as the GP the patient had been seeing wasn't available and it was CH that ended up referring as the previous GP had done all the work up ready for the referral. In essence CH was indicating that the GP's don't bounce around any work because their name isn't on the top of it and it has never been an issue here. End 19:20
	Date of next meeting and close Graham Mansfield, Chair, thanked everyone for attending. The next meeting will be on **Tuesday 9th May 6:30pm**