

# **GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE**

## **MINUTES OF THE MEETING ON THURSDAY 13<sup>th</sup> MARCH 2008**

The regular meeting of Gloucestershire Local Medical Committee was held at Witcombe & Bentham Village Hall on Thursday 13<sup>th</sup> March 2008 at which the following members were present:  
Dr. A Seymour, Chair, Dr. P Fielding, Vice Chair, Dr. S Steinhardt, Treasurer  
Drs. Alvis, Bayley, Booker, Bye, Coker, Fellows, Gale, Good, Hayes, Hollands, Morton, Patterson, Rigby, Salter, Simpson, Siva, Ulahannan and Yerburgh.

### **Also present:**

Representing the PCT:

Mrs Jackie Huck, Deputy Director Community Services & PBC

Dr. Tony Walsh, PEC Chair

Ms Nikki Holmes (nee Tew), Acting Assistant Director Primary Care

LMC:

Mr Mike Forster, LMC Lay Secretary

Mrs Sue O'Sullivan, Administration

### **26/2008 APOLOGIES FOR ABSENCE**

Dr. C Haseler, Dr. P Fielding (Vice Chair) absent for part of the meeting.

### **27/2008 RESULT 2008 ELECTION – Chair & Treasurer**

The Returning Officer announced the result of the nominations to Chair and Treasurer. Dr. Andrew Seymour had been duly re-elected unopposed as LMC Chair. Dr. Steve Steinhardt was re-elected unopposed to act as Treasurer to the Committee.

Nomination papers to fill the roles of Vice Chair, Fourth Executive Member and Conference representatives had been tabled. Members were requested to either complete the nomination papers and hand them in at the close of the meeting or post to the office by 25<sup>th</sup> March so that if necessary, a postal ballot could be put in place, to be completed by 8<sup>th</sup> April 2008.

**Action: Members**

### **28/2008 CHAIRMAN**

The Chair welcomed from Gloucestershire PCT, Jackie Huck and Nikki Holmes, Acting Assistant Director Primary Care. Nikki was in post whilst Sue Adams was on maternity leave. Jackie Huck announced that Sue had given birth 2 weeks before to a healthy baby girl, weighing in at 6lb 13 oz. The Committee asked that Jackie pass on their congratulations to Sue. Dr. Tony Walsh would be joining the meeting later in the afternoon. Dr. Seymour reported Barbara Piranty, Gloucestershire Village Agents had been delayed and would be joining the meeting a little later to brief the Committee on this trial scheme to support the over 50's living in outlying areas, enabling them to make informed decisions about change and develop their own communities. Dr. Peter Scanlon and Dr. Graham Wilson were to inform the Committee on changes to Diabetes-related eye testing.

Dr. Seymour also welcomed Dr. Michelle Hayes.

Tea Rota – Drs. Morton & Simpson

### **29/2008 MINUTES OF THE LAST MEETING**

The Minutes were agreed and signed as a true record.

### **30/2008 REGISTER OF INTERESTS**

There were no declared conflicts of interest to be added to the members list.

### **31/2008 ACUTE TRUST ISSUES**

#### **• Pre-Op antibiotics leading to cancellation**

Dr. Siva had raised with the office that one of his elderly patients had been due to have hip surgery in Cheltenham Hospital. But having had a mild chest infection and been prescribed antibiotics about 10 days before, the patient was told at the Pre op assessment clinic 5 days before the operation date, that she could not have the operation because she was on antibiotics and would have to

### 31/2008 cont.

wait for 6 weeks before being booked in again to have the operation. The patient was advised to go and see her GP to say that she was fine to go back on the list. This was completely new to the practice. Normally if a patient was going for any surgery, if there was any doubtful infection they were usually treated to prevent an unnecessary cancellation of the operation. In this situation the operation had been cancelled and postponed for 6 weeks just because the patient had been prescribed antibiotics, even though they had recovered fully from this.

If the Acute Trust had changed their policy GPs should be made aware of this to prevent unnecessary cancellation of operations like this.

The Chairman asked if anyone had had any similar experience to Siva; members had no knowledge of anything exactly like that and Dr. Ulahannan agreed to take back to the Trust and have a look at it. Dr. Good said he had had an occasion where an operation had been refused because there had been a fear of an infection getting into a joint but there was sound medical logic behind the decision.

#### **Action: Dr. Ulahannan**

Dr. Yerburgh quoted an instance where a patient of his had declined an operation because of a holiday booking and on return was made to wait 12 weeks before the operation could go ahead.

Dr. Rigby was concerned about who was responsible for dealing with a case when the hospital had initiated a test and found an abnormality. Dr. Ulahannan replied that responsibility lay with the person who ordered the test.

Dr. Fellows raised a problem he had experienced commissioning a direct referral of a patient to Dr. Dutta for a CT scan following a suspected TIA. It had not been possible to do a direct referral; Dr. Fielding was pleased to be able to report that following this there was now a direct referral in place for patients having suffered a TIA. This was seen as a QoF issue. An evidence based contract needed to be put in place.

Dr. Ulahannan enquired if, as reported in the last minutes, Dr. Walsh had made contact with Mike Webb, Acute Trust, regarding the problem with consultant paediatric bookings. As Dr. Walsh was not present at this point, the question could not be answered.

As there were no other issues to be aired concerning the Acute Trust, Dr. Ulahannan left the meeting.

### 32/2008 **GLOUCESTERSHIRE VILLAGE AGENTS – Barbara Piranty**

Ms Piranty in her presentation to the Committee said Village Agents were in place to bridge the gap between communities and organisations that were able to offer help or support. It was an independent charity set up 2006.

They were based in the rural parts of Gloucestershire and supported the over 50s.

Among the aims were:

- To provide high quality information
- To put people in direct contact with the agencies that were able to provide the service they needed
- To carry out a series of practical checks
- To help build communities

The Village Agent project was part of LinkAge Plus and was funded by the Department for Work & Pensions. It was jointly managed by the County Council and GRCC - Gloucestershire Rural Community Council. Ms Piranty was pleased to announce that continuation funding had been secured. Of the 258 parishes in Gloucestershire; 160 were covered by Village Agents. The Agents were reimbursed in a small way but were in the main volunteers. Ms Piranty felt that as the existence of the scheme grew, perhaps GPs in the future might refer some of their patients to them to access the kind of help they could offer. It was agreed to make this a Newsletter item.

#### **Action: Newsletter**

Dr. Seymour thanked Ms Piranty for an interesting presentation.

### **33/2008 EYE TESTS – DIABETES – DR. P SCANLON AND DR. G WILSON**

Dr. Scanlon and Dr. Wilson informed the Committee of the changes to eye tests for patients with diabetes. This was a proposal for a quality-assured screening programme for diabetic retinopathy. The programme would screen people with diabetes registered with practices in Gloucestershire. The specific issue to be considered by members was the transfer of data between general practice and the screening service and before going out to general practice the screening service needed to validate their list of patients suffering from diabetes. To reduce practice workload the service had requested and it had been sanctioned, to directly transfer data of patients with diabetes. The data transfer system was currently Apollo but they were planning to extend the project to EMIS. There would be a small amount of work for practice managers switching on the system. Dr. Scanlon said one of the problems experienced by the screening service was that they didn't have knowledge of patients' risk factors, i.e. high blood pressure, haemoglobin A1C etc. They would like patient permission to access this information.

Dr. Fellows stated that as a diabetic, he had nothing but praise for the screening service but was worried about data transfer; he reported that the BMA also had concerns. He was also concerned about practice manager extra workload; Dr. Scanlon felt that once the system was up and running the workload would be less.

The Committee wondered whether at the annual diabetic screening of patients they could be asked if they agreed to the information download. One of the main aims of the project was to catch patients who didn't turn up for appointments. Historically these patients were among the worst cases. Dr. Wilson said it was a small investment in time to eventually lead to less input and ultimately would make statistics and accuracy more useful. There would be an opt-in and opt-out facility; Dr. Salter felt it had to be an opt-in but Dr. Rigby considered it had to be an opt-out as technology would get in the way.

Dr. Good asked that the legislation be checked i.e. terms of wording in the Act. Dr. Scanlon stressed that the screening service had strict control over the database and no one else except eye screening could access or use the information. They had a contract with EMIS which had been drawn up by a barrister that stated that the information could not be used by anyone else. Dr. Rigby thought the project had a sound medical basis and he did not have Dr. Fellows' fears on confidentiality of data. His difficulty was how general practice actually got there and practice workload. Dr. Rigby would like to see the system piloted and, when found to be seamless, run out to practices. Dr. Wilson said that the flow of data was comparatively easy; Dr. Scanlon pointed out that any software updating required for practices would be paid for by the screening service and to that end they needed to negotiate a good price.

Dr. Bye wondered whether information gathered by PCAAG could be used but all the data information gathered by PCAAG was anonymised so could not be used by the screening service.

It had to be assumed that those patients who did not respond to the invitation to attend eye screening/direct transfer of data did not want to get involved in eye screening. Dr. Scanlon was asked where they were with annual diabetic eye screening. In Gloucestershire the number of people being diagnosed with diabetes was rising by 1600 a year. It was an increasing disease and a moving target for the PCT to fund. Currently there was 14-month screening but it was hoped to get this down to yearly. Dr. Simpson said that some patients were seeing their own opticians and GPs were falling foul of QoF on this. Screening by other methods was not good for QoF or patients. Dr. Scanlon felt that the PCT changes had made it very difficult.

Dr. Seymour felt that some discussion needed to take place outside of the meeting but he asked if Dr. Wilson would be willing to put together an article for the LMC Newsletter. Members agreed that it was prudent to defer making a decision at the meeting. Dr. Graham Wilson, Dr. Phil Fielding and Jackie Huck would meet and have a discussion about retinal screening. The Chairman thanked Drs. Scanlon and Wilson for attending.

### **33/2008 cont.**

During the discussion Dr. Fellows had raised the question of the levels of stress being felt by Practice Managers and in particular his own concerning QoF and practice protocols not being found acceptable by the PCT. Jackie Huck stated that she needed to speak to a lot to Practice Managers and intended to go to Practice Manager meetings.

### **34/2008 Co-option of new Members for the March meeting.**

The Chairman invited Drs. Alvis and Hayes to leave the room. The Committee unanimously agreed to co-opt them both on to the Committee for the remainder of the meeting. Both will take up their new roles as full members of the Committee in April 08.

### **35/2008 MATTERS ARISING**

- **LNC (Local Negotiating Committee)** LMC representation

It had been Ms Colleen Rothwell-Murray's intention to attend the meeting but commitments had not made it possible. However, discussions followed about the question of LMC representation to the Local Negotiating Committee. The Lay Secretary had written/spoken to Mr Paul Wilson, Medical Lead, Care Services, who had agreed to go back to see if funding for attendance could be identified. The Chair had also spoken to Mr Wilson along the same lines but to date nothing had been forthcoming. It was agreed to bring back when there was more information.

**Action: Bring back at a later date**

- **Controlled Drugs Liaison**

The issue raised at the February meeting regarding the destruction of controlled drugs had been discussed with Teresa Middleton who would be happy for one of their Pharmacists to attend a practice to witness the destruction of drugs. It was agreed to make this a Newsletter item.

**Action: Newsletter**

The Committee enquired if there was any action to deal with an emergency such as the flooding of a controlled drugs cabinet, as had happened to one practice. Teresa Middleton would be happy to be contacted in such an event.

### **36/2008 FOR DISCUSSION**

- **Motions to Conference**

Members had been asked at the February meeting to forward to the office any suggestions for Motions to the 2008 Annual Conference. A few had been received and tabled at the meeting. Members were requested to study the suggestions and tell the office by 25 Mar which 10 of them they would like to see taken to the LMC Conference. The Executive would polish the wording and bring them to the April meeting.

**Action: Members to study Motions and forward to the office by 25 Mar.**

- **Clinical Pathway Group for children**

This was a very lengthy document which Mike Forster had summarised. As part of the Darzi NHS Review, Yorkshire and Humber had been tasked with setting up a committee (of whom only one was a GP) to examine how current health services met the needs of a child and its family as it travelled through NHS children's care services, and how future health services should meet their needs to provide 'world-class outcomes'. They had been tasked because that region was among the worst in England (and England fared less well than most EU countries) for infant and child mortality rates, teenage conception rates, breast-feeding initiation and obesity rates. One in 10 of their children needed professional help with their emotional or behavioural problems.

The review committee came up with some far-reaching recommendations, which they admitted should be the basis for further discussion. Their main finding was the proposal of Children's GPs: These Children's GPs might work out of Urgent Care Centres near A&E units, to which children would have access '8 till late'. These specialists would care for between 1500 and 2000 children each and would lead multi-professional primary care teams for children. In addition:

Gloucestershire LMC concerns / queries included:

- This was a direct threat to the general knowledge and capability, perhaps ultimately the existence, of current GPs.
- The average practice 'weighs in' at many fewer than the 20,000 mentioned in the paper. Was this another shot in the war to close down small practices?
- How would CGPs (Children's GPs) be contracted? Would they be part of the normal practice, or an additional PCT employee?
- As to Out of Hours (OOH), the relationship between CGPs and the out of hours service was completely unaddressed.
- How would CGPs be selected, trained, accredited, and appraised?
- The CGP would need to spend time on his/her wider role (coordinating services, liaising with social and mental health services, working closely with secondary care colleagues). The cost would not be small. Would it not be better to train the normal GPs using that money?

It was not clear how their proposals would be taken forward within the Darzi study.

- **Darzi Review**

The result of the Darzi Review into the effectiveness of PCTs in England found that Gloucestershire was ranked 20<sup>th</sup> from the top out of 152 PCTs. Over the NHS South West, 8 of its 14 PCTs were in the top 20 and none in the bottom 40. The worst PCT was Manchester at 1.70 points below the national average. The best PCT was North Yorkshire & York at 1.8 points above the national average. Gloucestershire PCT was reported as being 0.61 points above average overall and only below average in four of the categories assessed.

From these results it appeared that the need for a Darzi centre in Gloucestershire was low but every PCT was meant to be opening a Darzi polyclinic in 2008 – or at least allowing the contract for one. Members wondered how many PCTs had actually been surveyed and why should good PCTs have to plan for a Polyclinic. On the question of the number of PCTs surveyed, Jackie Huck was unable to answer; probably a mix of sources had been used in the survey. The National Operating Framework instructed PCTs what they must do and areas where there would be additional funds for deprived/under doctored areas. The nearest to Gloucestershire was Bristol and Weston Super Mare. Gloucestershire PCT were required to establish a Health Centre under an open tender process and a contract had to be in place by December 08. It would be a GP-led service open from 8 a.m. until 8 p.m. 365 days a year and delivered under an APMS contract. Gloucestershire PCT had put forward a proposal to the SHA but to date no response had been received. Jackie Huck said that Gloucester had been identified as the area for a wrap-around service. 50,000 people came into Gloucester city to work each day. The centre would offer: health promotion; a sports injury service, diverting people away from A&E; support to Carers; and Benefit advice – all complementary to services already in place. Dr. Bye wondered how the needs assessment had been arrived at; he would have preferred more investment in things like infant mortality. Jackie Huck highlighted the asylum seeker/translation service issue as an illustration, to build in and target resources as best they could without destabilising existing services.

Dr. Fellows said he had no respect for Lord Darzi. Dr. Sharma had been to see him and raised extended hours and how Lord Darzi was going to staff emergency services etc. Lord Darzi admitted that he hadn't thought about that! Polyclinics would be staffed along the lines of 3 untrained doctors to 1 trained doctor; leaving GP practices to manage patients with chronic diseases. Dr. Hayes was concerned about 'convenience health' a service for people who work and who may feel that work was more important than health. Jackie Huck stated the PCT would take care that they didn't take patients away from a GP practice and by that affect their ongoing care. The question of a patient being registered with a Polyclinic was raised. Jackie was trying to avoid registration but was waiting for a decision from the SHA. Dr. Walsh thought that a wrap-around service could be beneficial to a patient with, say, diabetes travelling to the city and suffering an episode, since any treatment could be fed back to their GP.

## 36/2008 cont.

Dr. Booker asked if there was a shortage of GPs i.e. patients having difficulties getting access. The only area where there was an issue about access was Gloucester City but this was more about premises.

The Review would be discussed further at the Negotiators meeting on 17<sup>th</sup> March 08.

## 37/2008 ACTIVE TOPICS

- **PBC**

There was nothing to report except one key issue, the development of community hospitals in Cheltenham and Gloucester.

- Savings and the question of how to invest next year.
- Clusters were looking at C&B.

Jackie was looking for as much patient care as possible being done in primary care with secondary care being used less. The probity issue, i.e. getting the balance right, was proving difficult.

- **IM&T**

Nothing to report. There was an IM&T Group meeting that afternoon. Dr. Rigby had decided that his representation at the LMC was more appropriate!

- **Choose & Book**

The PCT now had staff employed in the booking office. The 18-week target could have been an issue with GRH but the hatchet had been buried. The target had only to be hit very briefly to achieve it for a month. The LES would be 500-700k across the county = £5/£8 per referral. The PCT would be asking practices if they wished to sign up from the 1<sup>st</sup> of April 08. Practices would be paid provided by they hit a target of 90% on a quarterly basis. There would be a 15% error rate, plus or minus. Dr. Bye raised the issue of payment for referrals, which had somewhat surprised members. Dr. Fellows didn't feel that payment of £5 per referral would encourage GPs to refer more. Dr. Fielding asked if GPs should engage on a Cluster level. Dr. Rigby felt that the money should not go anywhere else – he agreed that £5 wasn't an incentive for GPs to over-refer. Dr. Bye suspected that GP referrals would grow with an ageing population and growing obesity problems. Jackie Huck said that the PCT had examined the referral statistics over a 3-year period which had risen, unplanned, to 4.5%. Dr. Alvis wondered if the falling waiting list time for appointments in the NHS had attracted patients who had previously gone down the private insurance route. Dr. Good felt that a demoralised workforce would refer more, not wishing to take any risks. Dr. Simpson said that practices that had historically referred more than practices that had efficiently managed their referrals would get more money under this system. Dr. Bayley felt it would be a disincentive to practices that thought they wouldn't hit the 90% target. The DES ran out at the end of March and a LES needed to be in place by April 1<sup>st</sup>. From the 1<sup>st</sup> of April GP services would count for C&B.

The question of paper referrals ending at the end of September was raised; Dr. Fellows didn't feel that this could be enforced, there were medico/legal issues and wasn't in a GPs terms of service. He thought it was a feather in Gloucestershire's cap that GPs were still actively engaged in C&B.

- **Access**

Papers tabled:

- o **GP Contract 2008-09 – What the poll outcome means – March 08**
- o **GP Contract 2008-09 – Summary results of the GPC poll – March 08**
- o **GP contract 2008-09 – Full results of poll**
- o **GP Contract 2008-09 – Press Release**

Faced with two unsatisfactory options for extended hours, the UK's GPs selected the proposal which they believed posed the lesser risk to patient care. Over nine in ten (92%) selected Option A over Option B -the only two alternatives the government had allowed.

The vast majority (96%), although opposed to both options, selected A because they believed it was the less worse of the two.

### 37/2008 cont.

Over 27,000 GPs responded to the BMA poll, which came after the government refused to accept a BMA proposal on extended hours in December 2007. The government then gave the BMA's GP Committee (GPC) the choice of two non-negotiated options and the BMA decided to poll the profession.

The poll results showed the level of anger among GPs at the way the government imposed changes to their contract for the year 2008/09, with 98 out of every 100 GPs saying they believed the government's method of negotiation was unacceptable.

PCT thoughts on extended hours – A DES would come out soon and they would be going out to practices to see who wanted to do extended hours. Saturday mornings had been cited by patients as an area of dissatisfaction, so they would be looking at that. The PCT was aware of what hours practices were currently open. Dr. Fellows again said that the GPC advice was not to give the PCT full details of GPs working. The DES hadn't yet been worked out, the negotiators were still working on it but apparently there had been some softening in the approach. PCTs were coming up with a LES; the advice was don't jump into the DES until the LES is known.

Dr. Salter asked if patients wanted to see a GP up to 7 p.m. could a practice open 5-days a week. Jackie responded that they would be looking at that. She also said that elderly patients were frightened about access to their GP during normal working hours and she was looking for a flexible way through to deal with this and was work in progress. Dr. Morton had major concerns regarding OOHs – Saturday mornings and Community Hospital work which would de-stabilise his practice. Dr. Hayes felt that lots of patients misinterpreted the questionnaire. Dr. Fielding stated there was a lot to sort but not to panic ourselves; it was matter of dilution not flexibility! Dr. Simpson was worried how the PCT was going to engage with practices when the DES was an unknown factor. Dr. Bye felt that a Working Party dedicated to this issue should be set up. Jackie Huck would be happy to meet with a working group and discuss further. It was agreed that the Working Group should have an internal meeting first and the following members were nominated:

Dr. Ian Simpson  
Dr. John Salter  
Dr. Nigel Booker  
Dr. Peter Fellows  
Dr. Andrew Seymour

It was agreed to meet before April to discuss strategy.

### 38/2008 **TREASURER**

#### **Treasurer's Report:**

- **Gloucestershire Medical Benevolent Trust Financial Statement**

The Financial statement was examined by the full Committee and:

Proposed: Dr. Rigby

Seconded: Dr. Good

Unanimously accepted.

Dr. Steinhardt said that a Deposit Account was being sought to maximise interest on the funds but that would also be easily accessed in the case of a call on the money. It was agreed to have a Newsletter item drawing constituents' attention to the existence of the fund.

**Action: Newsletter**

- **Gloucestershire Local Medical Committee Receipt & Payments Account**

The LMC Accounts were examined by the full Committee and:

Proposed: Dr. Fielding

Seconded: Dr. Fellows

Unanimously accepted.

- **Forecast 2008**

The Treasurer expanded on the financial plans for the coming year detailed in the 2008 Forecast. The full-time Secretary's remuneration and GPC funding would increase spending in 2008. The rest of the forecast was fairly straightforward. A surplus of £46k had been identified. Dr. Morton questioned

### 37/2008 cont.

the £10k office expenditure. Dr. Steinhardt explained that this was due to PAYE expenses now that some members were paid through the payroll. He felt that the statutory levy would need to be set at 37p per registered patient for 2008-09.

Proposed: Dr. Salter  
Seconded: Dr. Fellows  
Unanimously accepted.

The Committee thanked Shelina and Dr. Steinhardt for the work they had done on the budget.

### 39/2008 REPORTS

- **Meeting of the Mental Health Shared Care Monitoring Group 30.01.08**  
As tabled. Of interest was an item available on the web 'Living your Life to the Full'; apparently it could be Google'd. The Committee still had misgivings about the revolving door and lack of access to a Consultant. Dr. Salter said that the Partnership Trust would be contacting all practices with the name of their PCAP worker. Also noted was the change of title for the Partnership Trust which was now to be known as '2Gether'.
- **LMC Negotiators meeting 18<sup>th</sup> Feb 08**  
As tabled. The question of harmonisation of phlebotomy services across the county had been raised. The PCT had gone away to produce figures (which had been received today) and would be discussed at Monday's Negotiators meeting. This would take some time to sort out and Dr. Morton felt that it looked very much in the too difficult tray for him!  
Repeat Prescriptions (INR Warfarin). The yellow book had to be seen and could be a legal problem if GPs weren't doing this. Dr. Yerburgh agreed to take this back to the Medicine Management Group.  
**Action: Dr. Yerburgh**
- **Meeting with MPs**  
Dr. Fellows felt his MP had been very supportive.  
Dr. Salter reported that the meeting with David Drew had turned up the heat. Mr Drew sits on a cross party Medical Committee which could be useful.  
Dr. Morton didn't feel that going through the Opposition had any benefits.
- **GPC Roadshow - Taunton 28<sup>th</sup> February 08**  
As tabled.
- **Substance Misuse Treatment Shared Care Monitoring Grp (SMSCMG) 15<sup>th</sup> Feb 08**  
As tabled. GpswSI re-accreditation to be managed by the PCT but standards were already implicit within the NES.
- **GPC Meeting 20<sup>th</sup> March 2008**  
The meeting was being held later in the month than usual. The GPC meeting held on 7<sup>th</sup> February had been reported at the February LMC.
- **Office Report**  
Noted.

### 40/2008 ANY OTHER BUSINESS

- **Temporary Operating Theatre in Stroud**  
Dr. Salter drew the Committee's attention to the plan to install a 'mobile' temporary operating theatre at the Health Centre in Stroud from 1<sup>st</sup> May 2008, whilst the Stroud hospital's theatre facilities were being updated/improved. The temporary operating theatre was huge and would take up at least 30 car parking spaces out of 110 spaces available and needed to be parked in a flat area; Stroud being very hilly this would prove a planning challenge, apart from the effect it would have on patients attending the Health Centre. There had been other sites considered i.e. the 'Focus' car park and the former Standish Hospital site. Dr. Salter was very concerned about the scheme as it would directly affect 25,000 primary care appointments while it was open. He asked the Committee for its support to challenge the PCT's decision. The Committee agreed to write to the PCT in support of Dr. Salter.

**Action: Letter to PCT**

#### 40/2008 cont.

- **GP Hotline**

Gloucestershire PCT was setting up a helpline, managed by PCT bed managers, designed to support GPs in ensuring that patients receive the right care in the right place by the right team. It was anticipated that this would help some patients avoid hospital admission. This was a pilot and the PCT would be gathering views towards the end of the project.

**Who was it aimed at?**

Primarily for GPs to use when normal routes of access to Health and Social Care services have failed.

**What was it?**

It would be a helpline service, manned by PCT staff that would support resolution of any GP issues. They would raise the issue with the appropriate manager and work with them to identify a short or long-term solution.

**How would it work?**

It would be a single telephone number (*telephone no. 08454 222222, the GP would ask for GP Hotline*) through to a PCT bed manager who would take details of the issue and then resolve it wherever possible. The GP would be informed of the outcome within a 4-hour response time.

This was the first that anyone present had heard about it. Jackie Huck said again communication had been poor and they needed to investigate.

**Action: Newsletter**

- **GP/Consultant Event 12<sup>th</sup> March 08 – Care pathways**

Dr. Alvis had attended the event. Of concern were emergency admissions at GRH. They needed to employ a lot more A&E Consultants. A diagram of problem areas had been tabled - single point of entry, diagnostics sorted out, rapid liaison with appropriate services. Dr. Alvis noted that the pharmacy was not on the diagram. Jackie Huck felt that GRH were doing an internal review on how they deal with patients in the Acute sector. Dr. Bayley said this formed part of the PEC work and would be happy to hear of any ideas to take to the meeting.

**Action: All to consider and inform Dr. Bayley**

#### 41/2008 FORTHCOMING MEETINGS/EVENTS

- o **17<sup>th</sup> March LMC/PCT Negotiators**
- o **27<sup>th</sup> March Executive Meeting**
- o **10th April LMC Meeting** (Newly elected Committee)

**There being no further business the meeting closed at 4.55 p.m.**

## OFFICE REPORT MARCH 2008

### Amendments to the Gloucestershire Medical List

Noted the change of role of Dr. Eleanor Anne Aston from Locum GP to Salaried/Locum GP with Dr. J R Murphy and Partners, Hadwen Medical Practice Gloucester  
Effective date 1st December 2006.

Noted that Dr. Katherine Joanna Whybrew received approval to change her role from Locum GP to Salaried/Locum GP with Dr. T G Healy & Partners, Stow Surgery, Stow on the Wold.  
Effective date 1st August 2007.

Noted the change of role from Locum GP to GP Retainer of Dr. Alyson Jane Wheeler.  
Partnership: Dr. A J Campbell & Partners, St. George's Surgery, St. Pauls Medical Centre, 121 Swindon Road, Cheltenham Glos. Effective date 1st January 2008.