8th May 2018

See Distribution

NOTES TAKEN AT A MEETING WITH THE ACUTE TRUST 8th MAY 2018

Present:

From the Gloucestershire Hospitals NHS Trust (GHFT):

Dr Sean Elyan	(Medical Director)
Mrs Felicity Taylor-Drewe	(Director Planned Care)

From the LMC:

Dr Tom Yerburgh	(Chairman)
Dr Phil Fielding	(Treasurer)
Mike Forster	(Secretary)

Apologies:

Ms Deborah Lee	(Chief Executive Officer)
Dr Ros Bounds	(LMC Officer)

1. Actions. All actions complete or requiring no further comment save as under:

   a. Outpatients. There was in place an 'Outpatient Approval Programme', the DNA figures being reviewed monthly. Where the contact information was available on the Spine the Trust also sent reminders of appointments by text. Outpatient appointments were now not issued earlier than 8 weeks from the intended appointment. The LMC were concerned that there had still been examples of the notification arriving after the appointment.

   b. Discharge Summaries. Many practices now delegated to administrative staff the initial reading of discharge summaries and other clinical letters. It was therefore even more important that the format of the discharge summery should be reduced in length and should show in bold lettering at the front of the top sheet that changes in medication etc had been started or were being recommended. .....**GHFT**

   c. Addressing of correspondence. There was a need for both sides to ensure that communications from the hospital went to the right GP. The usual case would be that the reply to an appointment request, test results or discharge summaries should go to the GP who arranged for the appointment, or test, or course of care. Note, however, that if that were a locum GP it would be up to the locum GP to state on the referral etc the name and contact details of the GP to whom a response should be sent.

      i. The LMC agreed to make this an entry in the next newsletter..... **LMC** ✓

      ii. The Trust agreed to publicise this internally.....**GHFT**

   d. NHS Digital's TrakCare recommendations. Action outstanding – Trust to forward them to the LMC .....**GHFT**

   e. Follow-up appointments. The situation was much clearer and by the end of May the Trust should be in a position to know from its patient tracking list whether a patient has been allocated to an appointment, and to be able to review cases administratively and clinically. Consultants would have better visibility and thus should not make promises about follow-up appointments that stood no chance of being allotted in time. The Trust agreed to modify the wording to patients along the lines of, "You should receive a follow-up appointment within 3 to 6 months but if you have heard nothing by 9 months from now please contact us."

   f. Chapel House – lack of two weeks medication. The LMC would check with Dr Hodges whether the system had improved. ..... **LMC**

   g. New 2ww pathway forms. The new forms were to be found on GCare and should be used. The LMC agreed to add this to their newsletter ..... **LMC**

h. No commissioned service for HepB follow-on treatment. The Trust and the LMC agreed to lobby the CCG for a commissioned service .....**GHFT/LMC**

i. Delayed neurology reports. The Department was now fully recruited, but there was a backlog that needed to be cleared.

2. 'Urgent' referrals. The LMC hoped that a length of wait, analogous to the 'two-week-wait (2ww) referral' could be assigned to 'urgent' referrals to distinguish them from 'routine' referrals. After discussion it became clear that this was not feasible; different specialties were under different pressures, the medical need for speed was greater in some specialties (e.g. gastroenterology) and experience taught that taking such a course would result in over-use of the priority. It was also most important to protect the timely reaction to 2ww referrals. GPs could use the Advice & Guidance facility to discuss with the consultant how urgently the patient should be seen. It would also be possible to submit an electronic referral and follow it up with a phone call to the consultant to discuss the urgency of the case. As currently implemented an 'urgent' referral would take the first available slot in priority to any 'routine' referral. This would not change. The LMC agreed to make this a newsletter item ..... **LMC** ✓

3. Downgrading of 2ww referrals. Dr Yerburgh had shared details with Felicity Taylor-Drewe. It was important that the criteria for making a 2ww referral were kept to, and that if a patient needed to be redirected for tests or to another department then the priority needed to be explicitly maintained. The LMC hoped never to hear the words, 'Why didn't the GP use the 2ww system?'

4. Switch-off of Paper GP referrals. A decision would be made on 17th May whether to press ahead with the 4th June switch-off date or delay by some weeks. The figures for April showed a gradual reduction from 140 paper referrals in the first week to only 102 in the fourth, with three practices having made markedly more than others. For some reason there was a significantly higher number of paper referrals to Gynaecology and, to a lesser extent, Orthopaedics. The other measure to consider was the number of ASIs, and the Trust assured the LMC that this was reducing, but no figures were available. They would be provided before the meeting on 17th May.....**GHFT**

5. Any Other Business.

a. Referrals back to GPs from MIUs. The LMC would obtain details ..... **LMC (RB)**

b. Sodium valproate. Since this drug was no longer deemed safe for epileptic women of childbearing age there was a risk of increased referrals to neurologists. The Trust would monitor this.....**GHFT**

c. Advice lines. It had been reported that the Haematology advice line was only available from 15:00 to 17:00 which was inconvenient for busy GPs in afternoon surgeries and impossible for those GPs working half days in the morning. The Trust would consider what could be done to help .....**GHFT**

d. Phlebotomy in the community. Dr Fielding reported that the commissioned service in St Pauls would only take a maximum of 54 patients daily. Any more than that were sent back to their GP who had no choice but to send them to the hospital. The commissioned service was clearly inadequate in the face of the actual demand upon it. Both sides agreed to lobby the CCG about it. .....**GHFT/LMC**

6. Date of Next Meeting. Thu 11 Oct 18 (13:00 to 14:30) in Deborah Lee's office.

M J D FORSTER
Secretary

Annex A: Actions list.

ANNEX A TO
NOTES OF A MEETING
DATED 8 MAY 18

ACTION LIST

Action	On	Progress
Improve the format of discharge summaries – especially putting crucial information on the top of the front sheet, preferably in **bold typeface**	**GHFT**	
Addressing of correspondence to the 'right' GP • Newsletter item • Internal publication	**LMC** **GHFT**	Done, June N/L
Forward NHS Digital's TrakCare recommendations	**GHFT**	
Check with Dr Hodges whether Chapel House was now giving out the correct amount of medication in discharge	**LMC**	Done. No reports that they are not.
Advertise in Newsletter the need to use the new 2ww forms	**LMC**	Done
Lobby CCG to commission a follow-up service for HepB following first immunisation in A&E	**GHFT/LMC**	Negs agenda
Include an article on 'urgent' referrals in the Newsletter	**LMC**	Done, June N/L
Provide all necessary updated figures (e.g. figures and trends in ASI levels and the recent (Apr/May) usage of paper referrals to date) before the 17th May meeting which will discuss whether or not to switch off paper referrals with effect from 4th June	**GHFT**	Done – 15 May
Provide details of the cases referred back to GPs from MIUs	**LMC (RB)**	Done
Monitor increases in referrals to Neurology for women of childbearing age needing an alternative anti-epilepsy drug to Sodium valproate	**GHFT**	
Consider how to make advice lines from Haematology more frequently available at times convenient to GPs.	**GHFT**	
Lobby CCG to increase the provision of phlebotomy services in the community	**GHFT/LMC**	Negs agenda
Enquire into delayed Neurology reports	**GHFT (SE)**	
Follow up a particular DNA case where the Trust had asked for the patient to be re-referred	**GHFT**	