Dr Warner, Chair, Local Medical Committee, 23 November 2001

All GPs employed by community trust (41) have admitting rights to Sultan ward

Gosport-area GPs have always worked together on GWM LMC to develop and agree protocols on admitting to Sultan ward

In LMC's view, Althea Lord and colleagues are excellent: 'we have great confidence in the consultants at GWM'

Nursing staff at GWM tend to be more experience and employed for longer than colleagues at neighbouring acute hospitals

GPs/LMC don't have much to do with Dryad and Daedalus wards except that they will have patients in those wards under consultants' care

Patients in Sultan ward don't need intensive or high dependency care; most of them need physiotherapy or respite care; also occasionally used for patients with MS or even children. Patients also admitted for tests

All three elderly wards at GWM 'have been used to offload patients from Haslar and QA'; not appropriate in Dr W's view to move very ill patients there (ie 'offloads' from Haslar and QA): 'they are not designed to be strip-down beds. Patients should not require too much

medical or nursing care...the beds on the wards have been abused because of district bed crisis. It results in more work than the GWM staff can cope with. 'It's the source of less than perfect care' at GWM

Very critical of 'inappropriate referrals' of patients by SHOs at the QA

When LMC is made aware of such referrals, tend to complain to consultant at QA

There is a clear admitting protocol, at least for GPs; try to admit patients before 12 to allow instructions to be given to nursing staff

Describes communications between GWM and local GPs as 'generally poor'
Eg of patient admitted after 4; impossible for GP to see her so patient sent home

There are problems getting patients in and getting them back out again: eg 6 weeks' delay while patient waiting to have social worker assigned to them

Once patient is there, care is good

'It is definitely our hospital; we are involved in selecting senior staff (head nurses, team leaders
problems at GWM magnified by vidrtual closure of Haslar

feel that trust administrators 'after our beds all the time'. Have a much lower bed occupancy at GWM (82-84%) than other hospitals in trust (Queen Alexandra is 110%). Lower bed occupancy 'means that we're able to get our patients in when we need to'
There's no reason why terminally ill patients can't go in to GWM. I would put elderly patients in there who live on their own if they didn't need intensive care or IV drip, if their only requirement is getting basic medication, some nursing care and diamorphine if they have pain
GWM elderly wards 'not as specialist as true palliative care' centres although 'staff at GWM more than capable of providing that care - I feel more than comfortable about their staff in dealing with that sort of care
I personally feel that patients that I had at GWM were cared for well
Sultan is the busiest of the three wards (nurses there are always very busy); the other two wards have a calmer ambience. (re Dryad and Daedulaus): 'it's a little bit out of sight, out of mind'
Prescribing/administering drugs recorded on standard drug cardexes: GPs write out prescribing instructions which nursing staff follow in administering druges
Nurses will fax GP if test result indicates change in medication necessary; medication changes sometimes agreed over the phone as long as GP attends within 2 working days
Top 3 drugs administered in Sultan are anti-depressants, diuretics and anti-hypertension remedies
Nurses would administer iopiates/other controlled drugs on doctor's prescription
GP would administer first dose of such drugs inter-muscularly or any which might trigger an anacephalectic reaction; Nurses would than be required to note on Cardex; 'I would only allow trusted nurses to administer these drugs'; I have not had any problem with drug administration at GWM-although 'occasional' problems with nurses refusing to follow cardex from another hospital (in Dr W's view, 'patient care is being compromised' in such cases) GWM staff won't give transferred patients the drugs they're used to until we write them up on GWM cardex
Out-of-hours arrangements: patients covered by an on-call GP from patients' own family practice

Can't handle emergencies out-of-hours: admit them straight away to QA A&E
Healthcall doctors don't have accesss to GWM beds out of hours
A lot of hours medicine practised pragmatically and not by the book

Getting access to consultants: procedure is that 1) ask that short letter requesting consultant visit be put in patients' notes and request passed to consultant's secretary; 2) button-hole in corridor; 3) ring them up directly
Consultants department 'always accessible'; they always come back to me quickly not too difficult to get GWM consultants to attend patient when requested; more problematic getting consultants from other hospitals
Holiday leave periods: 'seemless service between Altha Lords and Ian Mears'
In opinion of Gosport GPs 'elderly cmedocomg dept at GWM one of the best'
Consultant geriatricians work with GP surgeries locally; greater cooperation between GPs and geriatricians than any other specialist consultants
Clinical governance: we used to feel that we had more of a dialogue with the trust about incident reporting and risk management; now we don't feel consulted about clin governance
It's less our hospital now; we have nothing to do with Dryad or Daedulas although we do try to work with the staff there
trust directors rarely attend LMC meetings; things would be better between trust and GPs if trust clinical governance lead attended
GPs in Gosport concerned that CHI report may lead to loss of beds for them at GWM
Under current proposals recommended by LMC, one third of GWM beds willl be for GPs and a third for consultants (with GP permission) and remainder consultant -controlled
Expects GP influence to decline after PCT comes into being
Portsmouth is a 'failing' health authority; big trolley wait problem
GWM has suffered because of wider changes in local health economy, especially Haslar closure and bed pressures in acute hospitals
Unless there's change at the top, nothing will change lower down in community hospitals; describes trust as 'understaffed, overworked' with little understnding by management of the problems or desire to bring in expertise from outside; when it's offered, often ignored