Patient Participation Group

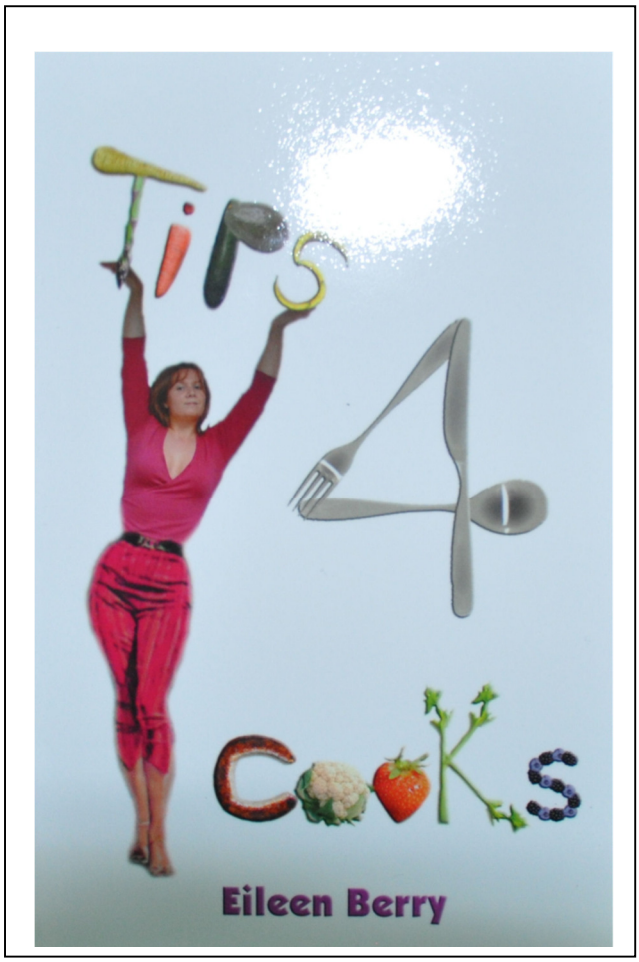
Newsletter

Incorporating the

Friends of the Badgerswood and Forest Surgeries

April 2017 Issue 25

Fundraising – Tips 4 Cooks



Brian Donnachie is a patient of Badgerswood. He has very kindly given the PPG copies of this book “Tips 4 Cooks” to sell to raise money for our latest projects. It was written by his wife Eileen who sadly passed away recently

We would recommend a minimum donation of £2. Copies are available in the receptions of Badgerswood and Forest surgeries. Please support us and give a thank you to Brian by buying a copy of “Tips 4 Cooks”.

Chairman / Vice-chairman Report

The Educational Article this time is on First Aid. The PPG has recently set up a 1st Aid training team and plans to run training sessions throughout Headley, Lindford, Whitehill, Bordon and surrounding districts. Following kind donations from one of our patients, from Headley Voluntary Care and from Dr Laura Clarke, we now have all the equipment we need to run these courses. After a discussion with Headley Parish Council last year, the Council installed a defibrillator in the High Street in the old telephone box. It is important that the people in our district know about how to care for the unconscious patient and how to use a defibrillator. Initially we plan to train people who live and work near the defibrillators, the drivers of Headley and Bordon Voluntary Care who take patients to and from hospital, and our PPG members. After this we plan to offer training to all who wish, especially carers.

Southern Health Foundation Trust has come in for much criticism last year, especially in relation to its mental health care. With the appointment of a new interim Chairman, Mr Alan Yates, and a new Chief Executive, Julie Dawes, marked changes have occurred. Now as a Public Governor of Southern Health since the end of last year, I have become involved in discussions in these changes. I have taken over the role of Chairman of the Patient Experience and Engagement Group. The Trust has been liaising with Northumberland Tyne and Wear Health Board Trust and with Deloitte LLB to introduce a new style of mental health services in the near future. (Northumberland T & W has been rated outstanding by the CQC with regard to its mental health provision). In April Mr Alan Yates is coming to talk at our AGM. Please come to hear what he has to say.

This time we have had no complaints raised by patients directed through the PPG or NHS Choices but we have been sent a note praising an aspect of the services of Forest Surgery. Our Friends and Family Test is scoring well.

Our Great British Doctors series by Sarah Coombes continues with John Charnley. For those of you who have had a successful hip replacement which has transformed your life, you owe a great deal to Professor Charnley. This article is a must to read. A surgeon destined to be one of the Greatest British Doctors.

With the development of the Bordon Healthy New Town, emphasis is being placed on footpaths and cycleways with less roads and cars. However, with the possible move of the GP Practices into the new town centre, it is important to know how many patients will need to come by car transport and how much parking space will be required. Too little road access and parking in the first

instance may cause problems and may necessitate expansion very quickly. The PPG has therefore been running a survey looking at numbers of patients coming by car / van etc and numbers who will be able to walk and come by cycle, in order to give accurate figures to calculate what facilities should be provided.

Dr Lalonde has written an article for us about how the Practice together with other local practices will be becoming involved in research in General Practice. Our Practice is now involved in numerous research projects.

The PPG is also involved in research and development independent of the Practice. We received an award 2 years ago from NAPP, the National Body of PPGs, for work done in improving hospital and primary communication at the time of patient discharge. I gather this work has now been expanded to other hospitals in Hampshire. This year, our PPG is again submitting to NAPP for consideration for an award. We'll keep you informed about how we get on.

We continue to collect local photographs for our 2018 calendar and we attach the photos for December, January, February and March. (October and November photos were printed in the January newsletter). Please keep sending us more photos in the coming months.

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Issues raised through the PPG

This past quarter, neither the PPG nor NHS Choices have received any adverse comments about our Practice. But, we print all comments that come to us and this arrived by email recently. Well done Forest Surgery.

"Good evening - recently I went for a pre-op assessment at Basingstoke. However, during the process I became aware of a compliment made by the Staff Nurse reviewing my 'copious file' about the staff at the Forest Surgery!
She was referring to the file seeking some information that the hospital had requested from the Forest Surgery and made the following comment [- related as best I can]: "Ah here it is - all the info needed - your surgery has sent it in - the Forest Surgery in Bordon is one of the best surgeries for providing the information we need - they always respond with good info - sometimes we don't get anything from some surgeries."
I do not know what the 'info' was - it looked like a two-page [front and back] letter.
I telephoned Tina (our Forest Surgery practice manager) and advised her of this and I advise you in a similar way as a compliment is due somehow 'to whoever' - but I don't know how we can impart it?"

Badgerswood & Forest Friends & Family
December 2014 to February 2017

How likely to recommend services to Friends & Family

	Dec 2014 to Dec 2017	Jan 17	Feb 17	Total	%
Extremely likely	**372**	**6**	**43**	**421**	**79.1%**
Likely	**76**	**1**	**11**	**88**	**16.5%**
Neither likely nor unlikely	**9**		**1**	**10**	**1.9%**
Unlikely	**9**			**9**	**1.7%**
Extremely unlikely	**4**			**4**	**0.8%**
Don't know	**0**				
				532	**100%**

Extremely likely and likely **95.6%**
(as at 12.3.2017)

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Southern Health Foundation Trust (SHFT)

I'm sure most of you will be aware of the problems which the Trust faced last year especially in relation to the provision of its mental health services. These were certainly well publicised on the television. Since the end of last year and into this year, SHFT has rarely appeared on the news. A change has occurred within the Trust. A new Chief Executive and a new Interim Chairman have taken charge and this has resulted in a different approach. The Care Quality Commission (CQC) had expressed concern about the Trust and although they are still keeping the Trust under review, all 7 'Special Measures' have now been withdrawn.

The Trust has been working with Northumberland Tyne and Wear Health Trust who have had an 'excellent' rating from the CQC and with Deloitte LLP to improve their services in mental health and are about to announce their "Clinical Services Strategy". It is hoped from here on, the Trust will produce a service which will excel way beyond that previously given, far into the future. This strategy will then float out into their other services, not just mental health.

Major changes are about to happen at a senior level within the Trust to drive this forward. We are fortunate that Mr Alan Yates, Interim Chairman of the Trust is coming to speak at our AGM on Tuesday 25th April at Lindford Village Hall. His talk should be fascinating and tell us all about what the plans are for our future health service in Hampshire. Please come to listen.

Stroke Article

As mentioned in our previous newsletter, on the 8th January this year the acute stroke unit in the Royal Surrey County Hospital, Guildford, closed and services moved sideways to Frimley Hospital. The Waverley and Guildford Clinical Commissioning Group had agreed to go out to public consultation about this and on 15th March, a public meeting was held in the Millenium Hall, Liphook. In the audience at this meeting was representation from SE Hampshire CCG, other local PPGs and various members of the public.

An initial presentation from W&G CCG outlined the scope of the problem they had been facing with acute stroke services in Surrey. Unfortunately, initial studies and decisions were made before it was realised that the majority of patients from our area also used the services of the Royal Surrey County Hospital. However, as soon as this was drawn to their attention, this was factored into the programme and it was thought that the original decisions were also appropriate for people from this area.

We pointed out that it seemed inappropriate that the services were relocated and then a public consultation came afterwards. However the stroke services in Guildford were acutely affected when one of the consultants resigned his post to move to a London hospital and his post could not be filled, precipitating closure of the unit in Guildford before full consultations could take place. W & G CCG had not intended that this happen this way round.

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After a lengthy discussion, there were 6 points I concluded from this meeting

1. The situation of relocation was reversible, especially if new applicants for posts could be found. However it was still felt that the new structure was preferable to the original and would probably remain.

2. All patients with acute stroke from our area will be transferred to Frimley Hospital and not the Royal Surrey **now**. The hospital has now set up an arrangement with the ambulance service of pre-warning of cases arriving, meaning the patients will by-pass A & E and go straight to the Stroke Unit where they will have priority on the CT scanner and an urgent decision made on care. Previously in Guildford, the unit was not staffed by specialist physicians from Friday evening to Monday morning. Now Frimley has a 24 hour 7 day a week cover. Patients will therefore be put through the hospital assessment side more rapidly than before reducing the time before treatment commences.

3. The ambulance services have a time issue and this needs to be resolved, this being a problem more from Liphoook and Liss than Headley and Bordon. From Headley / Bordon ambulances merely need to travel to Farnham. Travel-time to Frimley or Guildford then is about equal. From Liphook and Liss, there is a problem with a cross country run now to Frimley, especially if there is heavy traffic.

4. Following the initial therapy and immediate recovery, patients will be transferred within a few days to a step-down rehabilitation hospital unit in one of the peripheral Surrey Hospitals – Farnham and Milford will be used in our case. These units are specially equipped and staffed to liaise with the stroke unit in Frimley and will do the 2nd phase of care with a stroke patient which is vital for the future. The members of the SE Hampshire CCG present indicated that they had been in discussion with Surrey regarding the setting up of a rehabilitation unit in Hampshire nearer to home, equipped and liaising in a similar way with Frimley.

5. Despite the lack of contact between the W & G CCG and the SE Hampshire CCG when this move was planned, we were re-assured that good liaison is now taking place. W & G CCG apologised for their oversight but it was now felt to have resulted in no serious consequences.

6. Transport arrangements for visitors from this area to Frimley, especially from Liss and Liphook, may now prove a major problem. SE Hampshire CCG indicated they would review this matter and try to find a suitable solution.

Physician Associate at Badgerswood

What is a Physician Associate (PA)?

This title refers to a new type of clinician trained to work as part of a medical team but without a formal medical degree. To train as a Physician Associate, most programmes require that an individual should have a prior University degree usually to an honours 2:1 level, preferably in a health science, and that they should have some health or social care experience. Most courses are an intensive 2 year programme followed by a national examination.

What do Physician Associates do?

Physician Associates work with doctors providing an important part of health care. In this role they are supervised but can work independently into specific areas delegated by their supervisor.

They have a defined scope within which they work which includes

- taking medical histories from patients
- carrying out physical examinations
- seeing patients with undifferentiated diagnoses
- seeing patients with long-term chronic conditions
- making differential diagnoses and management plans
- performing certain diagnostic and therapeutic procedures
- developing appropriate treatment and management plans
- requesting and interpreting diagnostic studies
- providing health promotion and disease prevention advice.

At present, their role does not allow writing of prescriptions or ordering certain tests, especially those which include Xrays.

How are Physician Associates who have no medical degree, able to practice medicine in the UK?

Remember that nurses and pharmacists are able to see, advise and perform treatments for patients. Permission for Physician Associates to practice medicine falls under this statement from the GMC to the supervising doctors:

"***Delegation involves asking a colleague to provide treatment or care on your behalf. Although you will not be accountable for the decisions and actions of those to whom you delegate, you will still be responsible for the overall management of the patient, and accountable for your decision to delegate. When you delegate care or treatment you must be satisfied that the person to whom you delegate has the qualifications, experience, knowledge and skills to provide the care or treatment involved. You must always pass on enough information about the patient and the treatment they need."***

Badgerswood Surgery now has a Physician Associate working since the end of last year, Sharmin Ullah. Many of you may now have seen her. This appointment has undoubtedly assisted the Practice and taken some pressure off our doctors from the rising requests for appointments.

Be reassured, Physician Associates are well trained and as noted in the GMC statement above have "*the qualifications, experience, knowledge and skills to provide the care or treatment involved".* The extent of their duties and the immediate presence of the doctors to assist and supervise should re-assure how safe and reliable these Physicians are.

Bordon and Whitehill
Voluntary Car Service

We take people in the Bordon and Whitehill community who do not have their own transport to Hospitals, local Surgeries, Dentists, etc. If you need help please call us.

Also, we are desperately in need of co-ordinators to help us take telephone calls from patients and arrange drivers. They do this at their own home. Can you help us?

Our telephone number is 01420 473636

Looking for a venue for your function or group activity?
Lindford Village Hall offers:

- a large, light Main Hall with semi-sprung wood-block floor;
- a Committee Room ideal for small meetings: and
- a fully equipped kitchen.

Contact Derek Barr 01420 479486 to discuss bookings

Parking Survey

With the development of the Bordon Healthy New Town, there is an eagerness to encourage walking and cycle tracks in the centre of town. Plans to move the GP surgeries into the centre of the town should take account of the fact that many patients may need car transport and parking facilities adjacent to the new surgery. Accordingly the PPG have conducted a survey of how patients have been attending the surgeries by what means of transport and how many will need to continue to have car parking facilities provided in the new surgery.

In a week 2311 patients attend our Bordon surgery for doctor and nurse appointments. The following is a survey of the transport needs of these patients.

In our survey, 42.3% were male and 57.7 were female. 24.4% had a long term medical condition requiring regular attention and 7.5% were registered disabled.

76.2% of patients travelled to the surgery by car or van and 23.8% travelled to the surgery on foot. 7.1% of patients occasionally came by other modes of transport, usually by bicycle. 97.1% of patients who came by motorised transport parked at the surgery.

54.2% of patients travelled less than 1 mile to the surgery, 28% coming less than ½ a mile and 11.3% coming less than ¼ a mile. 45.8% of patients travelled more than 1 mile, 16.7% of patients coming more than 2 miles. 65% of patients indicated that at least part of their journey involved a significant uphill section.

52.8% of patients confirmed that it was important that when they came to the surgery by car it was important that they had parking facilities available to them, whereas 13.3% felt this was not important at all.

60.6% of patients confirmed that they could have travelled to the surgery by foot and 3% regularly by bicycle.

It is hoped that this survey will help the town planners budget for the need for access and parking for our patients to the new surgery in Bordon Healthy New Town.

FIRST AID TRAINING

On Saturday 18th March, the PPG, together with Bill Pasquier, Senior Resuscitation Officer at the Royal Surrey County Hospital in Guildford, ran a Basic Life Support and defibrillator demonstration course at Headley Village Hall. The course was run through the Headley Parish Council who arranged availability of the Hall and thanks must be given to Mr Terry Eamey and Katie Knowles, for their assistance.

This course was intended to match with, and teach the use of, the defibrillator which has been installed on the High Street. The importance of continued resuscitation throughout the process of care of the unconscious patient before and after arrival of a defibrillator on the scene, was stressed and is summarised in the Educational Article in our newsletter.

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Donations of resuscitation mannequins from a patient, funding from Headley Voluntary Care for the purchase of equipment and the kind donation a digital projector from Dr Laura Clark, mean we now have all the basic equipment needed for us to run these courses.

In the first instance we plan to run courses for specific groups most likely to be called on to need this expertise:

1. The shop keepers and house owners near the defibrillators in the High Street and shops at Lindford
2. The drivers of Headley and Bordon Voluntary Care groups
3. Members of our PPG
4. Home carers and carers in nursing homes

plus for anyone else in Headley who wishes to acquire this expertise.

It is our ambition to try to make Headley. Lindford and Bordon, centres where the standards of Basic Life Support care are as good as any that can be achieved in any area in the UK.

Our Educational Article this month is a brief summary of

BASIC LIFE SUPPORT

Basic Life Support

What does the term "**Basic Life Support"** mean? This is the phrase used when a person's heart stops beating and they stop breathing and someone applies **external cardiac massage** and **mouth to mouth** ventilation.

How successful is this? In ideal circumstances, over 65% of people will survive.

What is ideal? This means that someone who is knowledgeable in resuscitation is available within 2 minutes and there is a defibrillator available within 4 minutes.

When can this happen? This is almost only in a hospital, Rarely elsewhere.

How successful is Basic Life Support when someone has a cardiac arrest and is not in hospital, say at home or in the High Street?
The figures in the UK are poor. Only 5 – 10% survive to get to hospital and then get home. The best figures in the world are in Seattle in the USA. Here the figures are up to 35%. In some other States of the USA, the figures are worse than the UK.

Why are the figures in Seattle so good? Every child in Seattle is taught Basic Life Support at school until they are good at it. This means almost everyone on the street can do Basic Life Support properly. Also there is a defibrillator on almost every corner.

How can we improve the figures in the UK? Basic Life Support is easy. Everyone should be taught how to do this, not just children at school. Defibrillators are not expensive and they are easy to use. They should be more readily available.

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If someone who is skilled in Basic Life support reaches you in 2 minutes and a defibrillator reaches you in 4 minutes, you have the same chances as in Seattle!!
Learning Basic Life Support is not difficult. Nor does it require you to be very strong.

Start by remembering the sequence

B - C A – B – C - D

First :

B - BEWARE for any dangers.

C - CONFIRM the patient is unconscious
- **CALL** for help.
- **CALL** for an ambulance
- **CALL** for a defibrillator

Basic Life Support :

A - AIRWAY - Check their airway is not obstructed - vomit etc. The commonest cause is the tongue has fallen back against their airway. To lift this forward, simply tilt their head backwards and bring their chin up as high as possible.

B - BREATHING - Are they now breathing? Use your cheek to feel for breath. Watch their chest rise and fall for 10 seconds. If so, rotate them towards you onto their side into the **recovery position** with their face slightly inclined downwards. Ensure they are still breathing

C - CARDIAC RESUSCITATION If their airway is clear but they are NOT breathing, carry out **cardiac resuscitation**, 30 cardiac compressions at a rate of **100 – 120 compressions** / **minute** to a depth of **5cm.** Ideally combined with **2 breaths of mouth to mouth ventilation**.
Continue this sequence until:
a) expert help arrives
b) the patient starts to breathe spontaneously
or c) the patient starts to waken up
Start this immediately. Do not wait for a defibrillator to arrive.

D - DEFIBRILLATOR Modern Defibrillators are now available at sites around the country and give clear verbal instructions on how and when they are to be used. They are fail safe in their use other than **the patient must not be touched by anyone when the machine is fired.**

Research in the Practice – Dr Lalonde

Badgerswood and Forest Surgery are to become a research active practice. This means that the practice will be working with the local Clinical Research Network – CRN Wessex - to deliver research studies supported by the National Institute of Health Research (NIHR). These organisations are responsible for research to develop medicines and treatments to benefit the NHS going forward. In addition the practice may become involved in some commercial research developed by other organisations.

Within the surgery Helen Sherrell is the lead GP responsible for research and will be able to provide any information if things are unclear. Each study will have information leaflets regarding what is involved and there is usually information to take home and read. As a patient, you may be approached about a study at the time when you come to the surgery or sent a letter if you have a particular condition which makes you eligible for a study. There is absolutely no obligation to participate in any trials and it does not affect your medical care in any way if you do not wish to participate. You are also able to change your mind at any point during a study.

The studies on offer can vary considerably. A study may run out of another centre such as a local hospital or at the surgery itself. Studies can take many different forms - they can be simple such as one telephone interview or more involved with additional visits to see your health care professional and medicines as well.

Any studies performed in the United Kingdom are subjected to rigorous checks before they are allowed to be carried out. This ensures that the study is felt to be in the interests of development of treatments going forward and any risks are thought to be outweighed by potential benefits. The information leaflets will always tell you the potential benefits and any possible risks of being involved in research, such as the time to complete a questionnaire or unforeseen side effects of a drug being tested although this is rare.

Patient Confidentiality is of great importance and therefore the practice is the one to approach patients rather than the study team. It is only if someone agrees to being involved that the study team is allowed to contact the patient. Any information gathered is stored securely and anonymised to protect confidentiality.

Research may be of benefit directly to those involved such as a new drug or treatment that is currently not available. Alternatively research may be of no benefit to those involved but can help to develop treatments in the future. Without research there would be no new treatments available in the future so please consider taking part.

Great British Doctor No 12
Professor Sir John Charnley
(1911 – 1982)

Osteoarthritis (OA) is defined as a degeneration of a joint due to wear and tear of the joint surfaces. Mostly it is a disease of age but it can arise from specific joint problems such as a previous fracture through a joint line or where generalised disorders such as obesity put extra stress on the joint. Osteoarthritis leads to pain and restriction in joint movement. There is no medical treatment which can cure this condition so patients tend to take pain-killers and try to keep the joint mobile for as long as possible by continued exercise, good physiotherapy or Pilates.

Most of the weight of the body is transmitted through the hip and knee joints and these in general tend to be the joints most frequently affected. Following the pioneering work of John Charnley after the 2nd World War, hip joint replacement for arthritis has become the procedure of choice for severely disabled patients world-wide and thousands owe a great debt of gratitude to him for an improvement in their 'Quality of Life'. The only procedures which have been shown to improve Quality of Life more than total hip replacement are coronary artery bypass surgery and stenting.

For hip joint replacement to be successful, certain criteria must be met.
1) The operation must relieve the patient of their symptoms of pain and restricted movement.
2) The complication rate of the surgery must be low since this is not a life-saving procedure. Immediate and/or persisting long-term complications can make this procedure a disaster for an individual, causing greater problems than existed before surgery.
3) The replacement must work well in the long-term. Rapid failure of the replaced joint may result in greater pain and restriction of movement. This

may necessitate re-replacement which may be difficult to perform and result in even less success and greater complication risk.
4) The success of this operation should not be based on achieving good pain relief and good joint movement alone. The patient expects to return to a “normal” way of life and this procedure may be deemed a failure if this does not happen. Before this operation was ever accepted, studies on Quality of Life after surgery had to be performed, assessing patients before surgery, immediately after surgery and in the long-term, before this was recognised as an acceptable form of care.
5) Patient selection for surgery is therefore crucial. Age, severity of symptoms, clinical signs, Xray assessment, and most importantly, patient expectations, are all important before the decision is made for joint replacement (arthroplasty). However, the final decision to operate must always rest with the patient aided by careful assessment and with knowledgeable guidance from the surgeon.

Enter Sir John Charnley. John Charnley was born in Bury Lancashire in 1911, graduated from Manchester University Medical School in 1935 and received the Fellowship of the Royal College of Surgeons in 1937. He was knighted in 1977.

Initial training in Manchester, King’s College Hospital in London then back to Manchester, was interrupted with the outbreak of war. Postings to the Middle East and Dunkirk ended up with an appointment to the Orthopaedic Hospital in Cairo.

After the war, he returned to Manchester eventually taking up an appointment as Consultant Orthopaedic Surgery in Manchester Royal Infirmary. His appointment included a part time session at Wrightington Hospital in Wigan. It was here that he conducted his research centred on friction and lubrication of joints, both animal and artificial. The hip joint is a type of joint called a ‘Ball and Socket Joint’ with the head of the femur or thigh bone inserted into a natural cup in the pelvis bone. Charnley spent much time working out the dynamics of this joint and also what materials could be used to make and line an artificial joint.

Early attempts at joint replacement proved spectacularly problematic. The artificial head of the femur was cast in a resin but in initial cases disintegrated early. Promising attempts at different lining materials in the artificial joints also failed. The initial lining was ‘Teflon’. Disappointingly this wore down within about 3 years.

Nowadays the replacement head and cup is made of non-reactive metal. A good lining for this was eventually found with a chemical related to Teflon but with the hydrogen atoms replaced by fluorine (UHMWP). This has better impact wearing resistance, better wearing properties and is still the main lining material in use today. Stable fixation of the metal inserts to bone was by the use of dental cement.

In November 1962, Charnley inserted his first modified and much researched total hip replacement. His publication on hip fixation and its importance, published in 1960, proved crucial to its success.

Infection is a disaster when it occurs with an operation involving insertion of a foreign material. Normally the only way to control such an infection when it occurs, is by removal of the implant. In the case of a total hip replacement, this would leave the patient with no hip joint with marked instability on standing and trying to walk. Charnley's work came soon after the war which was at a time of introduction of antibiotics into medicine, so he tried various methods including mixing gentamicin with bone cement. He eventually devised a special cabinet device with the patient inside, with only the wound exposed, with the surgeon and assistant operating through special windows with their arms inserted into surgical gown sleeves inside the cabinet. A laminar flow air system of 'purified' air meant the patient was in as sterile a situation as possible and with this, sepsis rates fell to well under 1%, a remarkable level.

Continued work over many years since Charnley has resulted in improved techniques and better, longer lasting joints. At present, comparison between hip joint replacement and joint relining are still undecided.

Quality of Life studies reveal a poor result in the first month after surgery but from there on, with studies now up to 10 years, these confirm better life experience for patients overall than in patients not offered surgery. Patients no longer have to suffer to the point of 'having to earn their operation'. Surgeons now offer treatment for earlier and lesser symptoms with more confidence. With the knowledge of the duration of survival of present hip replacement joints, surgery is now being offered to younger patients realising that re-operation because of replacement wear out is becoming less of an occurrence.

All of this is as a result of Charnley's pioneering work and there is no doubt his name will survive in orthopaedic history as one of the 'Greatest British Doctors'.

Noticeboard

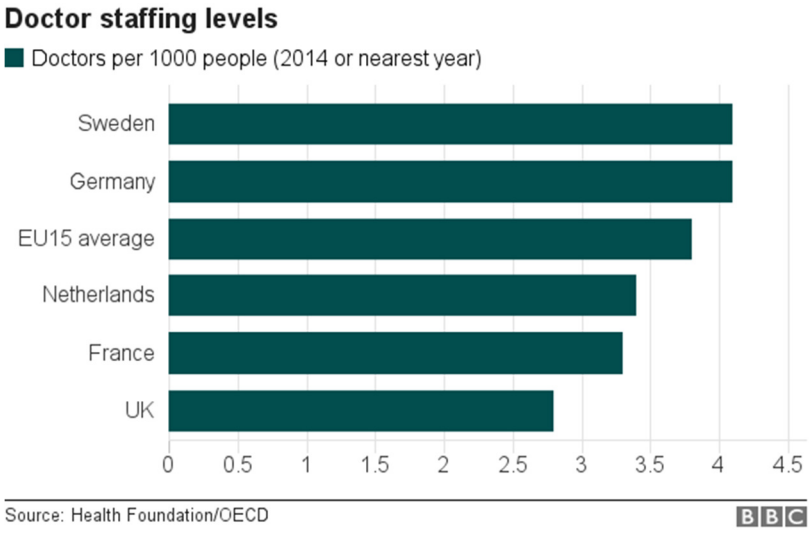
Why the NHS is performing miracles
(from an article by **BBC News – January 18th)**

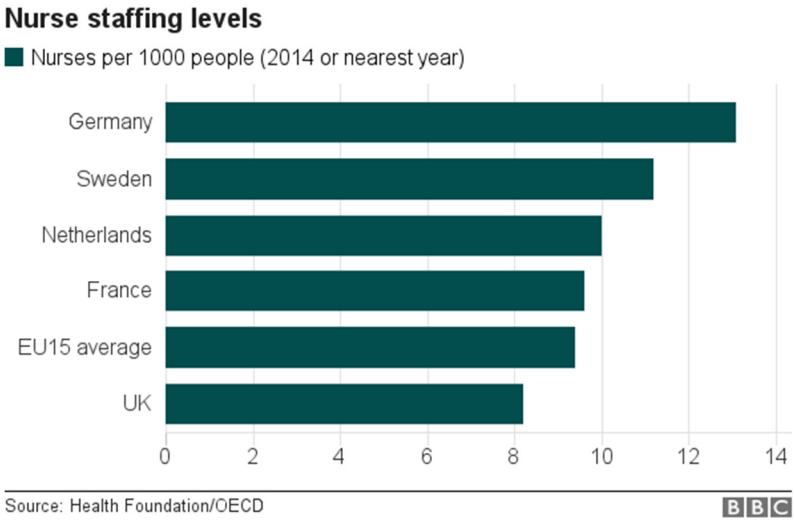
It has been a remarkable few weeks for the health service hasn't it? The worst waiting times in A&E for over a decade. Patients left for hours on trolleys. Vital cancer operations being cancelled. Hospitals across the country declaring major alerts. A humanitarian crisis in the making, says the Red Cross.

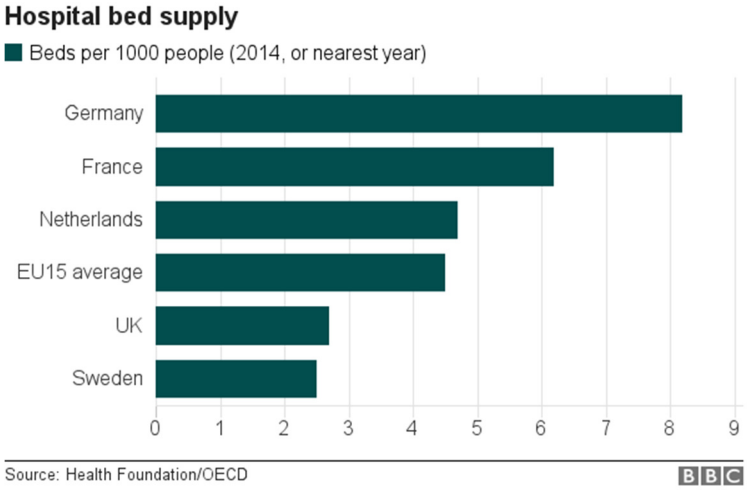
But amid all this what we haven't heard is just how well the health service is coping. Given what it is facing, the NHS and, in particular, hospitals are performing miracles. How? Let me explain.

The NHS is in the middle of the most sustained squeeze on its funding in its history. Until 2010, the budget increased by an average of about 4% a year once inflation is taken into account to help it cope with rising pressures. Since then, the average annual rise has been around 1% - and that will continue until 2020. The only period that comes close is the early 1950s when there was a cut in the NHS budget, prompting charging to be brought in for dentistry, prescriptions and spectacles. And that was pretty quickly followed by large cash injections to get the NHS back on track.

There's nothing like that this time. Instead, the health service is being asked to carry on as normal with fewer doctors, nurses and hospital beds than many other developed countries - as the graphs below illustrate.







Now international comparisons can be difficult. You could argue, for example, that Germany only has so many more beds because it counts long-stay beds reserved for elderly people in its health figures whereas in the NHS they come under the nursing home sector, which is separate.
Nonetheless they pose an interesting question: are we simply expecting too much of the NHS?

Anita Charlesworth, a health economist at the Health Foundation think tank and former Treasury official, thinks so. She says the NHS is being asked to provide "world class access" without the corresponding levels of funding and staff. Looked at like that, it puts the recent performance in a slightly different light.

Faced with rising numbers coming in the front door (A&E) and increasing difficulty getting patients out the back (because of cuts to social care services), hospitals in England have found themselves full-to-bursting.

In recent weeks, bed occupancy rates have hit 95%. Now that may not sound like the definition of being full, but it is well above the 85% recommended threshold for a hospital to work effectively. Above this level hospitals start to unravel, patients end up in the wrong places, infection rates start to rise and a backlog of patients builds up in corridors, in A&E and outside in ambulances dropping patients off. Yes, some of this has started happening, but in many respects you would have expected performance to deteriorate even more than it has.

During the first week of the year - the most difficult so far this winter - more than three-quarters of patients arriving in A&E were still seen in four hours. Yes the rate of so-called "trolley waits" - where patients admitted as an emergency are left waiting more than four hours for a bed - doubled to one in five patients. But the number of "dire" 12-hour waits only amounted to 0.5%. A week later bed occupancy rates had risen slightly - and guess what happened? Performance actually improved on many measures. Ask anybody working in the health service and they will say this is down to the dedication and hard work of hospital staff.

Lord Kerslake, chairman of King's College Hospital in London and a former senior civil servant, has described the efforts of staff at his hospital as "extraordinary", while the BBC coverage over the past week or so has been full of doctors, nurses and managers recounting how everyone is pulling together. But there is more to it than that. The NHS has become very adept at managing pressure points. Daily reports are sent from hospitals to NHS Improvement, a newly-created regulator, about everything from the number of ambulances queuing outside A&Es to how many patients are stuck on trolleys inside. It means when there is a problem resources are immediately deployed by bosses at the centre. Extra managers are deployed, GPs and council care staff geed up and beds at local nursing homes used to move patients out of hospital.

The result has been that the NHS has been able to - by and large - prevent the situation spiralling completely out of control and into a full-blown national crisis. Those involved in the process speak in admiration of the way the regulator has managed the situation. But make no mistake, this is fire-fighting and, as such, it can only last so long. An outbreak of flu or a sustained cold snap could alter the picture completely.

And if it does not happen this winter, what about next? Or the one after that?

Practice Details

	Badgerswood Surgery	Forest Surgery
Address	Mill Lane Headley Bordon GU35 8LH	60 Forest Road Bordon Hampshire GU35 0BP
Telephone Number	01428 713511	01420 477111
Fax	01428 713812	01420 477749
Web site	www.bordondoctors.com	
G.P.s	Dr Anthony Leung Dr I Gregson Dr H Sherrell	Dr Charles Walters Dr F Mallick Dr L Clark
	Dr Laura Hems	

Practice Team

Practice Manager Sue Hazeldine
Deputy Practice Manager Tina Hack
1 nurse practitioner
3 practice nurses
2 health care assistants (HCAs)
1 physician associate

Opening hours	**Badgerswood**	**Forest**
Mon	8 – 7.30	8.30 – 7.30
Tues/Wed/Thurs	8 – 6.30	8.30 – 6.30
Fri	7.30 – 6.30	7.30 – 6.30

Out-of-hours cover **Call 111**

Committee of the of the PPG

Chairman	David Lee
Vice-chairman	Sue Hazeldine
Secretary	Yvonne Parker-Smith
Treasurer	Ian Harper
Committee	Nigel Walker
	Heather Barrett
	Barbara Symonds
	Gerald Hudson
	Sarah Coombes
	Liz Goes

Contact Details of the PPG ppg@headleydoctors.com
ppg@bordondoctors.com
Also via forms available at the surgery reception desk

Are you in need of help?

Trips to the Hospital, Doctors & Dentists difficult for you?

Headley Voluntary Care are here to help

Perhaps you would like to join us for a coffee and meet up with other local people, we meet at 10.30 every Thursday at the Church Centre, pop in and see us.

Telephone: 01428 717389

We cover Arford, Headley, Headley Down, Lindford & Standford

Can you help?

Volunteer Drivers needed

Your petrol costs will be re-imbursed

Telephone now while you think about it.

01428 717389

Headley Pharmacy

Opening hours
Mon – Fri 0900 - 1800
Sat 0900 - noon

Tel: 01428 717593

Visit the new expanded pharmacy in Badgerswood Surgery

Chase Pharmacy

Opening hours
Mon – Fri 0900 – 1800

Tel: 01420 477714

The pharmacy at Forest Surgery, adjacent to Chase Hospital

Both pharmacies are open to all customers

for

Prescription Dispensary
Over-the-counter medicines
Chemist shop
Resident pharmacist
Lipotrim weight-management Service

You don't need to be a patient of
Badgerswood or Forest Surgery to use either pharmacy