Patient Participation Group

Newsletter

Incorporating the

Friends of the Badgerswood and Forest Surgeries

April 2013 Issue 9

Pain causes *tension...*

Learn how to -
Release tension to improve posture
and reduce pain

Change your posture and improve your health & well-being

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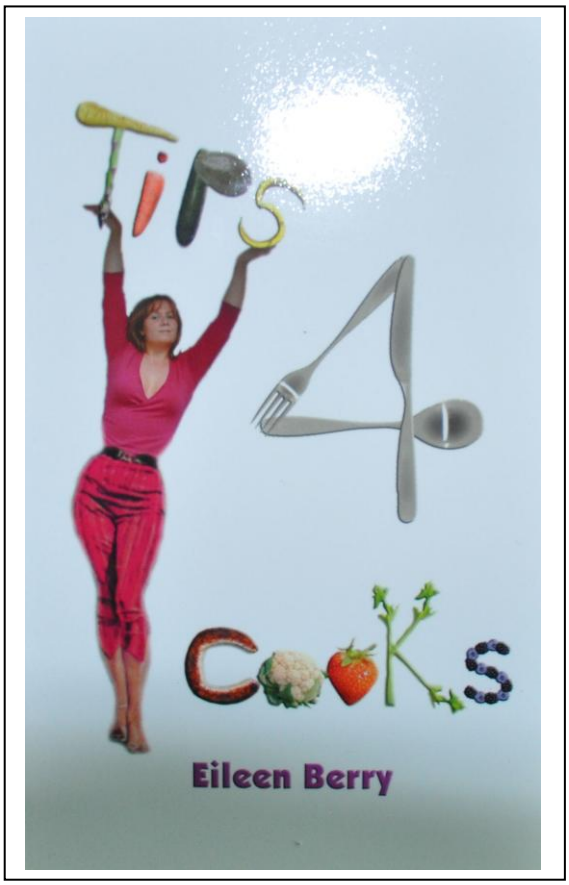
Jane Baker MSTAT
greatposture.co.uk

Lindford Hants GU35 0NZ
Tel:01420 488680
Mobile:07775618822

Jane@greatposture.co.uk
www.greatposture.co.uk
www.stat.org.uk

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”.

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Alton, Bordon & Liphook

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Home visiting Volunteer – Home-Start provides a unique service for families –recruiting and training volunteers to support parents with young children at home.

Trustee - with your skills and experience you will have an input on how our scheme runs and develops in the future.

'Friend' - you can help us raise our profile in your community and help with our ongoing fundraising.

Home-Start WeyWater, c/o Chase Children's Centre,
Budd's Lane. GU35 0JB

Tel – 01420 473555 E-mail – office@homestart-weywater.org.uk

Chairman / Vice-chairman Report

Our newsletters are going from strength to strength. Whereas before we sometimes struggled to find people to write for us, we now have a wealth of articles at our disposal, as can be seen from this current edition.

Our 2nd AGM is planned for the 23rd April in our newly extended and renovated Forest Surgery. It is over a year since our last AGM but we have delayed this until now to bring this into line with our annual accounts, our financial year running to the end of March. We are very fortunate to have Col Alan Mistlin speak to us about Headley Court, the Military Medical Rehabilitation Unit. We hope to see as many members, patients and Practice staff as possible at this meeting.

The decisions regarding the beds at Chase Hospital have now been made. The PPG became involved, not only in discussions which took place at which we expressed our opinions voicing what we felt was best for the local community, but we are now involved in helping to develop the best possible services for the future. Dr Boyes from Forest Surgery has written an article in which he expresses his concerns for the future and Dr Barbara Rushton, Chairman of the Clinical Commissioning Group, has outlined the Group's reasons for change.

Despite the weather, holiday time is approaching and it is timely to have an article on DVT and its prevention, especially during long-haul flights. This is also a problem post-surgery so is relevant to patients about to go into hospital.

We have repeated our patient questionnaire this year, having made some minor adjustments to the Practice following last year's survey. We have also added some further questions targeting other areas – carers, out-of-hours service and patients with long term ill-health - and we plan to follow these up in the coming year.

We thank Dr Ian Gregson for writing our Educational Article this issue on "Meningitis". Also, we congratulate Dr Gregson, together with Dr Mark Paterson, who have both recently taken up appointments as partners in the Practice.

Julie Osborne, of the Dementia Advisory Service, which is one of the services offered by the Alzheimer Society based in Petersfield, has kindly written an article for us based on Dementia. Her article helps to identify when and how to get in touch and briefly outlines what this new service provides.

Up till now the Government Care Quality Commission (CQC) has been looking into standards of hospitals, nursing homes, etc., but at the beginning of April is starting to look at all GP Practices throughout the country. Immediately they have indicated an interest in the work of the PPGs. We have written an article about this later in the newsletter.

We are grateful to Anna Couldridge for writing another article for our series about local services provided, this time about the Bordon Community Care Team or district nurses.

Dr Rose has a wealth of experience over many years of ultrasound scanning in General Practice, which is a most unusual service for a GP to provide. He has kindly written a most enlightening article for us about his experience.

Highview Surgery in Bordon closed at the end of January. Patients could choose which Practice they would like to re-register with, but come the closing date, over 600 patients had still not changed. They were automatically taken over by our Practice, mostly registering with Forest Surgery, but some coming to Badgerswood depending on their home location.

NAPP, the National Association of Patient Participation Groups, is holding its annual meeting on 6th June in Bristol, its main theme being “Primary Care in the Digital Age”. Ian Harper, our Treasurer, plans to attend and will provide us with a report of this meeting.

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ANNUAL GENERAL MEETING
of the
PATIENT PARTICIPATION GROUP
of
BADGERSWOOD AND FOREST SURGERIES
to be held on
TUESDAY 23rd APRIL 2013 at 7.30pm
at
the newly expanded and renovated FOREST SURGERY
(adjacent to Chase Hospital)

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followed by a talk by

COL ALAN MISTLIN
HEADLEY COURT, DEFENCE MEDICAL REHABILITATION CENTRE

ALL PATIENTS OF BOTH SURGERIES WELCOME

If anyone wishes to stand for membership of the PPG committee, either please leave a note at a surgery reception or Email www.headleydoctors.com or www.bordondoctors.com at least 24 hours prior to the meeting

A Personal View of the Closure of Chase Hospital Beds
Dr Geoffrey Boyes

The closure of the Chase Hospital beds in August this year is going to be a huge loss for the provision of medical care for our local area. Despite continued objections from the local population, council and local GP's, the decision to close the beds, primarily for financial reasons, has been forced upon us. My fear is that the promises of additional services will be just that, just promises, and like so many promises that we have had in the past will remain unfulfilled. In the new NHS where PCT's are scrapped and the new GP led CCG's are being introduced to ensure that patients receive the best possible treatment, I feel that this first decision made by the local CCG to support the closing of the Chase Hospital is misguided.

The major loss that results from this closure of the in-patient beds is the loss of continuity of care that our primary care teams can offer. At present we can transfer an ill patient from their home into a safe monitored environment and provide first class nursing, physiotherapy and occupational therapy care to improve their health before they return home. The proposed use of Virtual Wards to replace some of these beds results in the patient staying in their own home and often alone for over 20 hours of the day. This does not to my mind compare to a hospital bed. The use of the Chase in our care for those patients who are sadly terminally ill, has been vital when the family has decided that care at home is not ideal. The alternative solutions that are being offered are wholly inadequate and unsuitable.

The planned new £2.9 million refurbishment of the Chase promises extra facilities and greatly increased patient numbers. There are plans to move local GP practices and the Adult Mental Health team into the Chase. From my viewpoint moving GP practices and the mental health team 200yards from their present locations does not significantly increase local health care provision. The fact is that the relocation of adult mental health has already occurred out of the Elizabeth Dibben Clinic in preparation for the closure of the ward, to Havant and Petersfield. This has caused major disruption to service provision in Bordon and when I contacted the clinical lead of the Psychiatric Services in East Hampshire to complain he was unaware that his service was meant to relocate to Chase

Hospital after refurbishment. He admitted that he had never even been to Bordon.

Rather than seeing an improvement in local services I am only aware of a recent decline in local service provision.

- Sexual health service provision has recently changed and I know of a patient being offered an appointment in Andover and treatment in Bournemouth, involving travel of over 170 miles - hardly a local service.
- The drug and alcohol unit has now withdrawn initial assessments from Bordon, only offering them in Havant. Yet another deterioration in local service provision.
- In Bordon not all women are offered local antenatal classes, which is the norm in every other part of the county. All young mums to be are expected to travel to the main units often over 20 miles away for antenatal classes. I see this as wholly unacceptable.
- The Out of Hours provision has recently changed, offering shorter hours of cover in the Chase Hospital and often closing due to lack of staff. The Dr's car is no longer based in Bordon but in Portsmouth where patients have been offered appointments if the Bordon base is closed, whilst I know of one patient being offered an appointment to see a GP in Southampton for their sick child.

The provision of a new Nursing home to support the closure has yet to even apply for planning permission, wherever it is located, and so must be several years from opening, yet we are loosing the Chase hospital beds now. I do not feel seeing my patients in a nursing Home in Liss over 6 miles away will be a service that I will be able to provide. In addition the addition of a new minor injury service may not be provided in a way that most everyone expect. As I understand the new service will be a contract offered to local GP's, who will be expected to squeeze the minor injures on top of existing work load, and as we all know GP's tend to be rather short of spare time.

I truly hope that in time I will have to apologise to Dr Rushton, Chair of our local CCG, for my pessimistic outlook, and that my fears were all unfounded. However I feel I am a realist and can only express my grave concerns based on my own recent experiences.

Chase:
Your hospital is "safe in our hands"

by

Dr Barbara Rushton, Chair, South Eastern Hampshire CCG

I'm really excited about the future for Chase Community Hospital. After years of talking and careful consideration, the decision has now finally been taken to redesign services at the site, and introduce a new model of care. In a year or two, people will see a very different Chase.

It won't look much different from the outside – but there will be many changes inside, all part of a £2.9m package of improvements to the fabric of the building to prepare for the extensive range of new and improved services available for you there. Our prime aim all along has been to ensure that Chase has a vibrant, long-term and financially stable future and provides local NHS services that local residents want and need. For too long now, it has been under-used. We're making changes to ensure its survival and some tough decisions about the future have not been taken lightly.

We recognise that there are real concerns about closing the ward and the new 'model of care.' We know there remain anxieties about end-of-life care, the lack of public transport and a local nursing home. But I want to re-assure you that we are working hard to address all these key issues.

The way the NHS cares for people now is very different from the 1990s, when the Chase opened. Most of the patients admitted to Chase – and that was only 136 in the year to June 2012 – could have been appropriately cared for in other settings.

Let's look at what you will get under our plans. And when I say 'our' plans, they are proposals that we have developed in partnership with you for more than two years. A steering group, comprising various stakeholders including local politicians, has been meeting monthly to shape our thinking and there has been a great deal of other community engagement and consultation along the way.

We were united that to close Chase, or to take no action, were not options at all - and that we would instead focus efforts on redesigning clinical and cost-effective services through full use of

the hospital's accommodation. You've continually told us that you wanted to expand outpatient and diagnostic services. So we are looking to dramatically expand the range of outpatient appointments provided locally from 8,900 to 18,000 – that's more than 9,000 cases where patients will be able to access services on their doorstep rather than having to travel outside the area.

In improving patient choice, we will extend contraception, sexual health and substance misuse services and expand current services by introducing new services that you asked for - including dermatology, renal, mental health, older people's mental health clinics, on-site GP services, community clinics, voluntary services, healthy lifestyle initiatives, diabetes education, blood services, local screening and one of your top priorities - a minor injuries service. The ward closure will give us the space we need to introduce these new services.

Over and above the 18,000 outpatient visits mentioned earlier, we believe a further 5,286 patients a year will use the on-site GP services and 136 patients will receive care and support either at home or in a nursing home

We are also investing money and resources to increase the community nursing and therapy teams so that more patients can be looked after in their own home or in a nursing home. The new model of care will involve a team of health and social care professionals working together to support patients in their own homes and prevent admissions to acute hospitals. This integrated approach will include:

- community matrons and community nurses with input from therapists, specialist nurses and mental health nurses
- support from consultant geriatricians and in-reach nurses
- social workers, domiciliary care and the community independence team.

If required to do so, they will visit a patients' home between 7am-11.30pm and provide night nursing from 10pm to 7am. They will also provide direct access and referral to the GP out-of-hours service if the patient should deteriorate and need to be admitted to an acute hospital; and facilitate earlier discharges for any patient admitted to an acute hospital to ensure that there is an opportunity to regain and maximise independence.

In the new model, each patient has a designated care co-ordinator responsible for synchronising every aspect of his or her care. Extra NHS staff have already been trained to prepare for this new model.

We are highly encouraged by our ongoing discussions with parties interested in building a nursing home in Whitehill and Bordon. Several possible sites have been identified. As an interim measure, we've worked with local GPs to identify two existing nursing home providers in Liss, 6.3 miles away, from which the NHS would 'purchase' beds for local people who would still need access to step up, step down and end-of-life care. This new model can be put in place as soon as required - and we are arranging for transport to be provided to and from Liss for patients and their relatives.

I hope this re-assures you about our plans for your hospital. Some of you have told us that you feel that Whitehill, Bordon, Lindford and Headley is a poor relation for local services.

But, in healthcare at least, I firmly believe that our plans are great news for you as patients – and that they will greatly extend the reach of the NHS throughout your community.

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Is available for hire for
receptions, activities, parties
Kitchen facilities, ample free parking
Accommodation up to 70 people
Very reasonable hourly rates

For further information, please contact

Keith Henderson 01428 713044

Patient Questionnaire 2013

The PPG ran a patient satisfaction questionnaire again this year with the Practice. Last year we had 118 patients helping us and again this year we aimed for similar numbers with many of our PPG members filling in the questionnaire on-line. We had 120 completed questionnaires for comparison this time. Our aim has been to see on this first questionnaire whether there have been any areas of patient dissatisfaction which we could improve on, and having dealt with these, to run another questionnaire down the line, to see whether these improvements caused better patient satisfaction with the Practice. You may recall we reported the results of the first questionnaire in the July 2012 Issue of our newsletter.

In fact the results of the first questionnaire were so good it proved difficult to find areas for improvement. When over 90% of the patients are happy with the service in most areas, any alterations may result in increasing patient dissatisfaction.

Can we highlight some examples? 10% of the patients would prefer that the surgeries opened at a different time. Of these last year, most (about half which is 5% of the patients) would have liked to see the surgeries open in an evening. In fact this was already happening. Only a small minority would have preferred to see weekend opening although the number has risen slightly this year from 1.5% to 3% but not significant to make the changes worthwhile. Any of these changes would mean closing the surgery at some other time, probably to the dissatisfaction of a higher percentage of patients!

An area which caused real concern last year was telephone response times and difficulty in speaking to a doctor or nurse on the phone. A closer look at this problem has identified that the main difficulty with telephone response times lies at Forest Surgery and much less at Badgerswood Surgery. In view of this a new telephone system is about to be installed in Forest Surgery which should significantly help to improve the situation here. Also, many patients were obviously unaware of the fact they could book telephone appointments to speak to a doctor or a nurse and this has been better highlighted in the past year.

Yet again 13% of patients confess to having forgotten to attend

appointments this past year!! Black marks again. About 2/3 of patients are seen within 20 minutes of their appointment time which is the same as last year and about 20% of you think this is poor. Remember however, if a clinic is running late, it probably means a doctor is spending extra time with some patient getting things right for him/her rather than cutting their consultation short in order to keep to time. When your turn comes, if needs be, he/she will probably do the same for you.

The receptionists starred again although at Badgerswood there have been some complaints about confidentiality of handing over results at the reception desk. This relates more to the layout of the building rather than a fault of the reception staff but changes have been made since this has been brought to our attention. Also the timing and method of reporting of results has been changed at both surgeries following your communications to us.

Your opinion of clinical care as before has been that this is excellent. Our doctors and nurses could hardly get higher praise from you.

Out-of-hours service is a new question since last year and obviously is a problem to many of those who used this service. At least 25% had a problem and over 1/3 of those who required medication had problems too. The service is about to change so we will be keeping a close eye on this.

We are pleased to see that more of you are reading our newsletter and finding our Educational Articles valuable (over 76%).

We introduced 2 new areas into the questionnaire which the PPG is interested to pursue, that of carers and that of patients with long-term illness. Those patients who replied stating that they had carers' duties and were happy to be contacted regarding this, were sent a further questionnaire asking for more detail. The PPG is keen to set up a self-help sub-group and has already had contact with the incoming Clinical Commissioning Group to look at this issue for the whole region.

Regarding the issue of long-term ill-health, we plan to tackle in the first instance specific problems highlighted by Practice, such issues as, for instance, wheel-chair users, to see what help is provided and how this can be improved if necessary.

DVT and Pulmonary Embolism

Most people will have heard of a 'Deep Vein Thrombosis' (DVT) and possibly of a 'Pulmonary Embolism' (PE) and will associate these with long-haul air flights. However, what exactly is a DVT, what causes it, how serious is it, and can it be prevented? DVT is not restricted to air travel eg it has been a known serious consequence of major surgery for many years, and it can also occur spontaneously.

Blood and clotting

Blood has amazing properties. It is normally fluid but if you cut yourself, it turns solid and seals the cut within minutes. Imagine how serious it would be if clotting occurred in blood vessels throughout the body without any injury. This could block blood vessels and the circulation. Such clotting is known as a '**thrombosis'**. Blood has the inherent ability not only to clot when and where needed, but also to **not** clot where it is **not** needed and to dissolve any unwanted clot if this occurs.

What makes blood clot? Three things cause clotting - the rough end of a cut vessel, anything which causes blood to stop moving, and anything which disturbs its smooth flow. A diseased blood vessel with atheroma or 'hardening of the wall' can cause the blood to swirl and may stop flow causing the blood to clot and block the vessel eg in coronary arteries causing a coronary thrombosis.

But if blood simply stands still in a vessel without moving it will have a tendency to start to clot, even if the vessel is normal. This is the situation with a DVT.

What is a DVT?

All the blood in our body is pumped round the body by our heart in blood vessels called arteries, and returns in veins. It is easy to visualise how blood returns in the veins from the head and arms, but have you ever wondered how blood returns from your toes when you are upright? It's a long way up. The blood in our legs returns through the major veins deep in the leg muscles, especially of the calf. These are known as '**Deep Veins'** to differentiate them from the veins in the skin. These veins have valves which allow blood flow in one direction only - upwards. Contracting your calf muscles compresses these veins and acts like a pump pushing the blood up to the heart.

In addition, when you breathe in, you create a significant negative pressure in your chest to suck air into your lungs. This negative pressure also sucks blood to the chest and into the heart from all over the body including the legs.

If you sit with your feet down for a long time, not contracting your muscles, the flow of blood in the deep veins will tend to stop. Also if you fall asleep breathing lightly, you will not suck much blood back into your chest. These 2 factors result in venous stasis with a tendency for clotting to occur – a **deep vein thrombosis (DVT)**.

What are the risks of a DVT?

The most serious risk is a Pulmonary Embolism (PE). When a DVT starts, it may block the flow through a vein completely, circulation stops, and then the whole vein clots. Unfortunately this clot is usually only tethered to the vein where the DVT started. If the non-attached bit of the clot, which may be the major part, breaks off and floats off into the circulation, this is known as an **embolus.** It will float up to the heart through wide vessels and be pumped from there to the lungs where the vessels narrow again as they divide, and at this point will jam. This is called a **pulmonary embolism.** If it is big, it will affect lung circulation, or if it is huge, it can block both lungs and stop the circulation completely causing sudden death.

How to prevent?

So, what to do during a long-haul flight or after major surgery:

1. Exercise your calf muscles - any movement helps but specifically, **pressing your toes to the floor and tightening your calf muscles is best**. This compresses the deep veins and pumps the blood out of them and up to the heart.
2. **Deep breaths to suck blood back into the chest** These 2 exercises need to be performed together. Take a deep breath in at the same time as you press your toes to the floor and tighten your calf muscles. Breathe out and relax your legs. Do this about 6 times, and repeat it as frequently as you can.
3. **Do not take sleeping tablets before a long-haul flight!**
4. **Anti-DVT stockings** act by forcing the blood flow into the deep veins enhancing the flow through these. They are particularly recommended for people with varicose veins but the upper cuff of the stockings must not be too tight or it may hold-up venous flow from the calf muscles. Ill-fitting stockings can be dangerous so you should be properly measured and fitted.

Dr Ian Gregson

We are delighted that Dr Gregson agreed to write our Educational Article
for us this month.

As noted in this newsletter, Dr Gregson has recently been appointed to a position as full-time partner in the Practice.

The Educational Article for this Issue is on

Meningitis

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Dr Gregson studied medicine at Newcastle University and qualified in 2003. After graduating he trained initially in the North-East of England before entering the GP training scheme in North Cumbria where he gained specialty experience in paediatrics, obstetrics and gynaecology, and psychiatry.

In 2011 he moved south to Hampshire to be nearer to family and worked for Thamesdoc and Harmoni before joining the Badgerswood and Forest Practice in January 2012.

Meningitis

by **Dr Ian Gregson**

Meningitis is inflammation of the meninges, the protective membranes that surround the brain and spinal cord. It is usually due to an infection from bacteria and viruses and can sometimes be associated with septicaemia, or blood poisoning. Some of the common bugs that cause meningitis are covered by the childhood immunisation program and this reinforces the importance of ensuring that all children receive full vaccinations.

Symptoms

Meningitis can be very serious and can cause death or permanent brain damage. Although the disease can develop very quickly, even in a few hours, the early symptoms may suggest a more minor illness, frequently mimicking a mild viral illness such as flu. Progression to the more typical symptoms of meningitis of high temperature, headache, confusion and a stiff neck with intolerance to bright lights or loud noises should alert that there is something more serious. Not everyone gets all of these symptoms however.

Children with meningitis may begin by simply having a fever or being more tired than usual. At an early stage they commonly develop leg pains, cold hands and feet and their skin may look pale, dusky or blue-tinged.

Babies in particular will often have non-specific symptoms. They may cry excessively or in a high-pitched way, different to their usual cry. They may have a fever, breathe rapidly, not take feeds, be irritable especially when picked up, or become very drowsy or sleepy and difficult to wake.

Rashes

Rash is often talked about as a key sign in meningitis. A typical rash does develop in certain types of meningitis. At first it looks like small red spots that do not disappear when pressed on, such as when you roll a glass over the skin. As the rash develops the spots get bigger and darker and can start to join together.

However, absence of a rash does not mean that the person or child does not have meningitis. It is often a late sign and the patient is frequently seriously ill by the time the rash appears. As it is a condition that is best treated early, it is risky to wait until a rash appears.

So what is important?

1. Meningitis can occur at any age.
2. It can be difficult to diagnose in the early stages especially in babies or young children.
3. Not everyone with meningitis develops a rash.
4. The typical rash of meningitis is commonly a late sign.
5. Treatment must be implemented as soon as possible.
6. Meningitis can progress rapidly from onset to serious illness, even only if a few hours.
7. The sooner treatment is started, the less likely will be brain damage or death.
8. Do not wait for a rash to appear before seeking advice

So what should you do?

1. Any concerns about an infection which seems excessively severe and especially if there are symptoms as described above, you MUST call the surgery urgently.
2. Do not assume if there is no rash that the illness is not meningitis. Do not wait for a rash to appear
3. Since meningitis can start with non-specific symptoms in the early stages and be difficult to diagnose, your doctor may find it difficult to be sure of the diagnosis initially. Do not assume always that a certain diagnosis has been made. Since meningitis can worsen quickly, WE WOULD ALWAYS WANT TO SEE SOMEONE AGAIN IF THEY WERE TO BECOME MORE UNWELL AFTER BEING SEEN.

Remember:

At the surgery, we are always happy to see anyone urgently who is concerned about possible meningitis.

For more information please check the website shown below.

http://www.meningitis.org/

NOTICEBOARD

Cyclists

Although research from many centres around the world has failed to provide any evidence for the value of helmets for pedal cyclists, their use is still to be recommended. Most fatalities occur from collision with cars and lorries and appear to result from failure to notice or be seen but are rarely due to fatal head injuries.

The problem is 2-way. Cyclists should make themselves as obvious as possible to other road users – eg luminescent vests or strips, flashing lights, etc. However, failure to hear other vehicles by the use of digital players and ear-phones is asking for trouble. So a plea - cyclists please avoid their use, especially in busy traffic.

Antibiotic Resistance

There has been much publicity about “antibiotic resistance” on the news lately and the worries of taking surgery back to the dark ages if we are not careful. Undoubtedly care about antibiotic usage and the dangers of increasing bacterial resistance are things we must be aware of as a medical profession, but we have been aware of this for decades.

The body can clear many infections itself by the development of antibodies without the need for antibiotics, especially viral infections. The lax prescribing of antibiotics is not the sole reason for increasing bacterial resistance. Widespread veterinary use, the ability simply to buy antibiotics over the counter in many overseas countries, and the fact that many bacteria have an innate resistant population anyway, are all reasons for increasing resistance.

Note that surgery does not routinely depend on antibiotics for prevention of infection. All our equipment is sterilised and the use of good antiseptics mean we can operate on a virtually aseptic field resulting in very low infection rates without antibiotics. Only in an infected or contaminated case would be want to use antibiotics and in such a situation, increasing antibiotic resistance is very important to us.

This may be a good topic for a future newsletter.

What is dementia?

by **Julie Osborne**

The term 'dementia' describes a set of symptoms which include loss of memory, mood changes, and problems with communication and reasoning resulting from brain damage due to certain diseases.

Dementia is progressive, which means the symptoms will gradually get worse, but how fast will depend on the individual person and what type of dementia they have. Frequently the person's family and friends are more concerned about the symptoms than the person themselves.

What causes dementia?

There are several conditions that result in dementia.

Alzheimer's disease − The most common cause of dementia affecting the chemistry and structure of the brain leading to death of brain cells. Problems of short-term memory are usually the first noticeable sign.

Vascular dementia − A problem of oxygen supply to the brain due to vascular disease may result in brain cell death and this can cause the symptoms of vascular dementia. These symptoms can occur suddenly, following a stroke, or over time through a series of small strokes.

Dementia with Lewy bodies − Tiny abnormal structures develop inside nerve cells leading to degeneration of brain tissue. Symptoms include disorientation and hallucinations, with problems with planning, reasoning and problem solving. Memory loss is less of a problem. This form of dementia shares some characteristics with Parkinson's disease.

Fronto-temporal dementia (including Pick's disease) − Damage to the front part of the brain results most obviously as personality and behaviour changes

Who gets dementia?

There are about 800,000 people in the UK with dementia. Dementia mainly affects people over the age of 65 and the likelihood increases with age. However, it can affect younger people: there are over 17,000 people in the UK under the age of 65 who have dementia. Dementia can affect men and women. Scientists are investigating the genetic background to dementia. It does appear that in a few rare cases the diseases that cause dementia can be inherited.

Symptoms of dementia may include the following:
Loss of memory − this particularly affects short-term memory eg forgetting what happened earlier in the day, not being able to recall conversations, being repetitive or forgetting the way home from the shops. Long-term memory is usually still quite good.
Mood changes − people with dementia may be withdrawn, sad, frightened or angry about what is happening to them.
Communication problems − including problems finding the right words for things, for example describing the function of an item instead of naming it.

When should you seek help?
If you feel that you, or a relative, are starting to develop some of the above symptoms, it is best to seek advice early, especially if these symptoms are starting to affect your day-to-day life. It is also a good idea for both the patient and possibly a close relative to keep a diary of events.

Diagnosing dementia
It is very important to get a proper diagnosis. A doctor will rule out any illnesses that might have similar symptoms to dementia, including depression. Having a diagnosis may also mean it is possible to be prescribed drugs for Alzheimer's disease. Whether you are someone with dementia or a carer, a diagnosis can help with preparing and planning for the future.

The diagnosis may be made by a GP or a specialist eg a geriatrician (a doctor specialising in the care of older people), a neurologist (someone who concentrates on diseases of the nervous system) or a psychiatrist (a mental health specialist). The doctor may carry out a number of tests to check basic thinking processes and the ability to perform daily tasks and may request further tests, such as a brain scan or a more in-depth assessment of memory, concentration and thinking skills.

Getting advice and support
A diagnosis of dementia often comes as a shock even if expected. It will be a worrying and upsetting time and be hard for patient, family and friends. Early contact with ‘specialists’ (medical and non-medical) at all levels can give much reassurance and support and, with careful planning, make life easier and more enjoyable - both now and in the future.

Independence is important for as long as possible. Although the amount of support needed will increase as the dementia progresses, it is important to make sure that the person with the diagnosis is consulted on all matters that concern them. This gives the opportunity for the person to continue making their own choices for as long as possible and in turn helps retain confidence, dignity and self esteem.

Dementia Advice Service
This new service, run by Alzheimer's Society, is open to anyone with a suspected or confirmed diagnosis of dementia, their families and carers. The service provides information and support on dementia and on available support services in the local area. These are tailored to each individual's needs and circumstances, and focus on well being rather than illness. The Dementia Advisor can offer support on the phone, via e mail or through face to face meetings at a mutually convenient location and works closely with GPs and those services which provide support for specific needs.

The Alzheimers Society Dementia Advisor Service can be contacted as follows;

Alzheimers Society
John Pound Centre Tel 02392 892034
23 Queens Street
Portsea Email
Portsmouth@alzheimers.org.uk
Portsmouth
PO1 3HN

The Portsmouth Office will then put you in contact with the Dementia Advisor for your local area.

The Care Quality Commission

The Care Quality Commission (CQC) is "the independent regulator of health care and adult social care services in England". Up till now it has been inspecting all hospitals (both NHS and private), care homes, home-care agencies, dental practices, ambulance services and community-based healthcare services to make sure they are meeting national standards of quality and safety but from April this year it will also take on responsibility for regulating and inspecting all GP practices across England.

A pilot study was carried out in November 2012 to help set up how the programme of inspections would be carried out and the role of the PPGs as a valuable source of people's views and experiences of care was immediately highlighted. Unfortunately only 50% of the 42 practices involved in the pilot study had a PPG. The CQC pilot also worked with other local stakeholders, local medical committees, and primary care Trusts. The aim was to see whether the current methods needed refinement and also to train the Inspectors for the primary care sector.

Where a practice had an independently chaired PPG the CQC inspector contacted either the chair or another representative from the group and the information gathered was useful and was helpful in reaching a decision about whether the practice was meeting the essential standards of quality and safety.

Inspections

When the inspectors come to assess the Practice, they will spend most of their time talking to patients and staff. Wherever possible they will observe the interaction of staff and patients (for example in the reception area) and there will also be discussion with GPs, practice nurses and practice managers. Information from other sources, such as our Group, from whistleblowers and other regulators will be noted.

There will be three types of inspections

1. Scheduled – carried out regularly, and with 48 hours notice.
2. Responsive – carried out if concerns are raised over essential standards or for follow-up of non-compliance from a previous inspection possibly without notice.
3. Themed – looking at particular health or social care issues

The pilot study concluded that:

- primary medical services should be given a 48-hour notice period for scheduled inspections and no notice for responsive inspections.
- an inspection should look at a minimum of 5 of the 16 outcomes across the essential standard areas.
- an inspection every two years is the best approach for primary medical services.

It may be that as the Inspectors become more accustomed to working in the GP sector, they will be able to cover more of the essential areas in a single visit.

It is possible that at some time you may be asked to assist the Inspectors in their role of assessing the Practice. Your GP will have been asked to ensure that you are fit enough to participate and will have agreed to your being asked. Any help you can give to the Inspectors would be appreciated

Further information is available on the CQC website at www.cqc.org.uk

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Why are surgeons 'Mr's' and not 'Dr's'?

All surgeons are medically qualified doctors so why do we call them 'Mr' and not 'Dr'. They have spent 5 to 6 years at University learning to become doctors and were called Dr so-and-so when they qualified. Those doctors who wished to become surgeons then went on to train for a minimum of a further 5 years and to sit a set of difficult, stressful and specialised examinations of one of the Royal Colleges of Surgeons, and after passing these successfully, became qualified surgeons. At this time they now reverted to Mr so-and-so or Miss so-and-so. It hardly seems a worthwhile title after all that work, especially as they have just given up the title of 'Dr'.

Only in Britain and some Commonwealth countries, are surgeons called 'Mr'. In most countries such as the US and Canada they call themselves 'Dr'. In many countries they are even called 'Professor' though many are not actually University Professors. So why in Britain are surgeons simply Mr or Miss?

Let me explain because the story is interesting and goes back over 500 years – to Edinburgh.

In the UK, there are 4 Royal Colleges of Surgeons, in London, Edinburgh, Glasgow, and Dublin. (Yes, Ireland still has a Royal College with our Queen as its patron). Edinburgh is the oldest and the largest of these. It was founded in 1505, celebrated its 500th birthday in 2005, and now has over 20,000 Members and Fellows world-wide.

The Edinburgh College started life in the early 1500s as one of the Guilds of the City of Edinburgh – the Guild of Barber-Surgeons - and together, these Guilds formed the City Council. The surgical part of their trade was primitive – lancing of abscesses, perhaps even extending to amputations. The barbers had the tools for the trade. They apparently had little medical teaching but learned their surgical skills by apprenticeship.

The doctors, or physicians, at the time were known as apothecaries and were called by the title 'Dr'. They had some sort of training programme but did not recognise the barbers as having any medical knowledge or skills at all. They were simply 'Barbers'!

However, all changed on 4th July 1505 when King James IV of Scotland, a very enlightened king, being so impressed with the Guild, decided to join the Barber-Surgeons and he took up the specialty of dentistry. One year later he presented the Guild with a Royal Charter and they became the Royal Guild of Barber-Surgeons. Unfortunately the apothecaries did not have a Royal Charter but now that the Barber-Surgeons had been so royally recognised, they contacted the Guild and said that they could now call themselves 'Dr's', to which they received the obvious reply - and surgeons in Britain have been 'Mr' (and Miss) ever since.

September this year is the 500 anniversary of the Battle of Flodden Field. In 1513, James IV marched out from Edinburgh against Henry VIII insisting that all his Guilds support him at Flodden as he invaded England. The King and hardly any of the Barber-Surgeons survived the massive slaughter of the Scottish by the English and that day nearly ended the future of the Royal College of Surgeons of Edinburgh forever. It is said it took at least 50 years for the Guild of Barber-Surgeons to recover.

Looking for a venue for your function or group activity?

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- a fully equipped kitchen.

Contact Derek Barr 01420 479486 to discuss bookings.

The Bordon Community Care Team

by **Anna Couldridge, Community Matron**

Known to many as the District Nurses we have not only changed in name but also in what we do.

The team is made up of

1 Community Matron
2 Community Nursing Sisters
6 Community Staff Nurses
2 Associate Practitioners
3 Health Care Support workers
1 Virtual Ward administrator

We have a "Virtual Ward" and this is for patients with complex health needs who require extra support to prevent unnecessary acute hospital admission or to enable earlier discharge from hospital. To do this we work closely with the Occupational therapists, the Physiotherapists, Social services and GPs carers and family.
A senior nurse or matron will help patients understand and manage their chronic condition, recognise early signs and symptoms of worsening of their condition. A plan is put in place for this event following close discussion with GP, family, carers Physiotherapists etc.
A major role is educating and supporting carers who are managing to care for people with more complex conditions at home.

We also look after housebound patients; this generally means that they can only leave the house by ambulance. We do however take on care for non housebound patients if our service is more appropriate, such as in complex wound care, end of life care, Intravenous medication. We also run clinics at the Chase for continence and wound care.
We work together with the Macmillan Team, the Rosemary Foundation to provide care to those who wish to die in their own homes

How To Access Our Service.
Patients or carer's can discuss any concerns with a member of the team or with their GP or Practice nurse.
Team Contact Number for new referrals via Magna call centre on 01305 213895

Ultrasound scanning in General Practice

by **Dr Rose**

Medical diagnostic ultrasound uses sound waves beyond human hearing to peer into the body's tissues. The principle is akin to that used in echo-location by ships looking for submarines. Some animals, particularly marine ones, also use it for communication and echo-location - ultrasound travels with less distortion in water than in air. The brilliance of physicists has allowed the development of systems to transform sound into pictures that we can recognise. They have been able to develop probes which emit ultrasound waves and then capture the re-bounding sound signals and, the brilliant bit, convert them into pictures on a screen. Nearly everybody will have seen pictures of developing babies, either their own, or on television as obstetric ultrasound reveals what is otherwise hidden from us. Diagnostic ultrasound has some great advantages over X-rays. It can visualise soft tissues such as liver, fluids (and so is very good at looking at cysts in accessible organs) thyroid, breasts, kidneys, the womb and its contents (looking to see if a pregnancy is viable or miscarriage has occurred is a stressful and difficult but common request), tendons and ligaments, arteries and veins and the blood or clot within them. So it is extraordinarily versatile and has the huge advantage of not using ionising radiation – so it doesn't increase cancer risk, as high doses of X-ray irradiation can do. A drawback of ultrasound is that it cannot see through gas or bone. So it is not usually at all helpful in diagnostics concerning the bowel, unless one is looking at a solid mass. However, in a new born baby, ultrasound can be very useful for looking inside the skull where there remain openings in it (the 'fontanelles') to diagnose bleeds or look at brain and ventricular structure.

The restrictions caused by the poor or uninterpretable views through gases, has led researchers to find ways of bypassing gas obstructions. So now ultrasound scanning has extended from external hand-held body probes to probes on the end of wands or even on the ends of long tubes which look inside the gut (endoscopes). This has extended the areas that can be looked at to include ovaries (by transvaginal scanning), the

prostate (rectal scanning), the heart – from both outside the body in trans-thoracic echocardiograms and now a tube down the gullet (oesophagus) to look at the heart from behind in trans-oesophageal ultrasound, and ultrasound of the internal lining of the stomach in endoscopic ultrasound, and even the heart during angiography. Things don't stop there. It is now common for ultrasound to be used during operations when the body is opened up to try to answer questions without opening up the organ under investigation.

The paragraph above has been solely on how the organ 'reach' has been extended over the years. But there is much much more that has happened. Physicists found that shorter wave ultrasound sees near objects more clearly than distant ones and vice versa. So each probe has a different wave-length or wave length band depending on how close the object you want to look at is. A short wave-length ultrasound probe would be used to look at superficial structures, longer waves for deeper ones, like the aorta. Then colour-doppler, which gives a visual interpretation of motion in fluids has been developed. Doppler looks at how movement affects the rebound of echo and, again, the brilliance of physicists has enabled the simple doctor to capitalise on calibrated Doppler machines that tell the velocity of flow. This can be very useful in looking at the flow of blood in the umbilical cord of babies (babies are sometimes delivered early if flow is poor – for example in pre-eclampsia, on the basis of this information). At the other end of the spectrum, it is Doppler that looks at narrowings in the arteries to the brain of adults (the carotid arteries in the neck) and can calculate the flow within them. In the foetus, babies, children and adults, ultrasound can look at the heart valve and provide information on the direction of flow, and speed of flow, highlighting, for example, problematic restrictions. In thrombosis diagnosis in the legs (or occasionally the arms), again it is Doppler that is used to see if veins are compressible and whether there is flow in them, to look for evidence of thrombosis. The kidney arteries can be checked for flow restrictions (renal artery stenosis) and in the 'balls' (testes), ultrasound is the best non-invasive way of checking the flow in the artery to the testis in suspected twisting or torsion – a medical emergency. Extraordinary technology.

it doesn't stop there. Ultrasound is now being used in guiding treatment and tissue sampling. Ultrasound guided injections are performed every day in our district general hospitals at Basingstoke, Frimley and Guildford. These can help ensure accurate injections into structures or joints such as the shoulder, hip, foot (for neuromas). In tissue sampling, ultrasound guided biopsy can try to ensure that the right (usually abnormal) bit is sampled through a sampling needle – so-called ultrasound guided biopsy.

There has been an ultrasound machine at Badgerswood Surgery (and Lindford Surgery before that) since 1992. I purchased this equipment to look first for aortic aneurysms, after going up to Charing Cross Hospital in my holidays and days off to learn scanning techniques, and scanned well over a thousand of our patients in the at risk age groups (over 60s) then. The British Medical Journal published an article on this work and many patients had surgery which probably saved early deaths. Anonymous data from this work contributed to the pivotal studies which defined the rationale for ultrasound screening for aneurysms across the world. There is now a UK aneurysm screening programme offered to men over 65 years of age (aneurysms are commoner in men and benefits from screening – finding the aneurysm and then operating on them - has not been proven in women). I then went to my alma mater to train in obstetric ultrasound – unborn baby scanning, before going to other hospitals (Kings again, and Basingstoke) to learn more about abdominal ultrasound. The equipment at the surgery is now time-expired and not up to modern machine standards, but, as I approach retirement, I don't see that at present the capital costs of a new machine can be justified. The machine costs though are secondary to a more important one – that of operator training and knowing ones scanning limitations. I wish I knew how to do more – the range of capabilities outlined in paragraphs above is way beyond me. I would dearly love the 'tradition' of scanning at Badgerswood to continue into the future. May I suggest that an interested reader qualifies in medicine, trains and certificates in diagnostic ultrasound, and joins the team? It has been done locally- in Alton. Now there's a challenge!

Recent Changes to the Practice

We are delighted to announce that Dr Ian Gregson and Dr Mark Paterson have been appointed as full-time partners to the Practice. Dr Gregson will take up duties mainly at Badgerswood Surgery and Dr Paterson, mainly at Forest Surgery. Dr Laura Clark will be taking up sessions at both Badgerswood and Forest Surgeries.

At last we are nearing the completion of the extension to Forest Surgery. Those of you who have recently been into Forest Surgery will have seen the new extension to the waiting area and perhaps the extended area to the back of the building where the new consulting rooms, note filing and meeting rooms will be situated. The PPG are funding a cold water dispenser behind the waiting area. This is being installed by, and partly funded by advertising from, Eau Coolers from Bordon.

From our recent 'Patient Representative Group' (PRG) survey, it was apparent that there were delays on the telephone system at Forest Surgery. A new telephone system is being installed. Also to ease 'booking-in' at the reception desk where there is frequently a queue, a 'Touch-screen' check-in system is being installed.

Patient numbers are still rising, and have shot up this quarter with the closure of Highview Surgery. Patient numbers are now over 12,600 between the 2 surgeries.

Fund Raising

The PPG unfortunately did not receive any donations this year from Headley Open Gardens, the funding going to other more worthy causes. We had hoped to raise funds for a new nursing chair in Badgerswood but in fact an anonymous donation means we now have funds to purchase this. However the Surgery there is in need of 2 new examination couches and we are aware that the defibrillator may need replacement soon, so we will be starting fund-raising for these in the near future.

Forest Surgery is running a 'Teddy-bear Raffle' £1 a ticket starting at the time of our AGM. Funds will go to help our children's corner in our new waiting-room extension there.

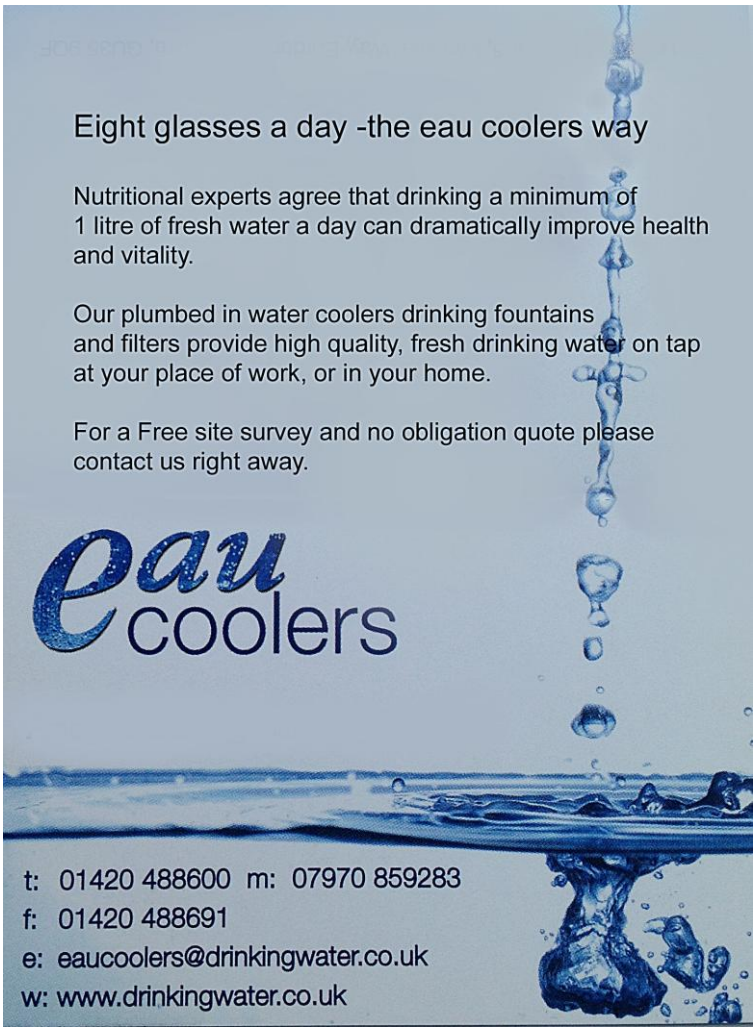
Practice Details

	Badgerswood Surgery	Forest Surgery
Address	Mill Lane Headley Bordon Hampshire GU35 8LH	60 Forest Road Bordon Hampshire GU35 0BP
Telephone Number	01428 713511	01420 477111
Fax	01428 713812	01420 477749
Web site	www.headleydoctors.com	www.bordondoctors.com
G.P.s	Dr John Rose Dr Anthony Leung Dr I Gregson Dr L Clark	Dr Geoff Boyes Dr Charles Walters Dr Mark Paterson Dr L Clark
	Both Surgeries Dr Stephen Carr-Bains	
Practice Team	**Practice Manager** Sue Hazeldine **Deputy Practice Manager** Tina Hack **1 nurse practitioner** **1 practice nurse** **2 phlebotomists**	
Opening hours	Mon 8.30 – 7.30 Tues/Wed/Thurs 8.30 – 6.30 Fri 7.30 – 6.30	
Out-of-hours cover	**Hampshire Doctors on call** 01962 718697	

Committee of the of the PPG

Chairman	David Lee
Vice-chairman	Sue Hazeldine
Secretary	Yvonne Parker-Smith
Treasurer	Ian Harper
Committee	Maureen Bettles
	Nigel Walker
	Heather Barrett

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



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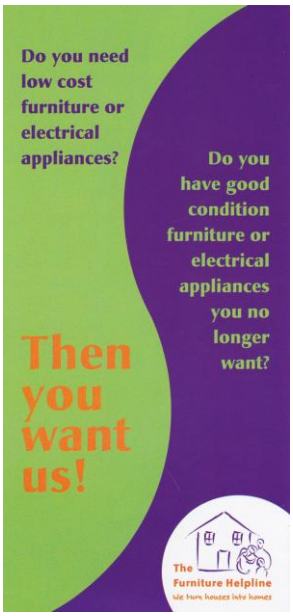

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