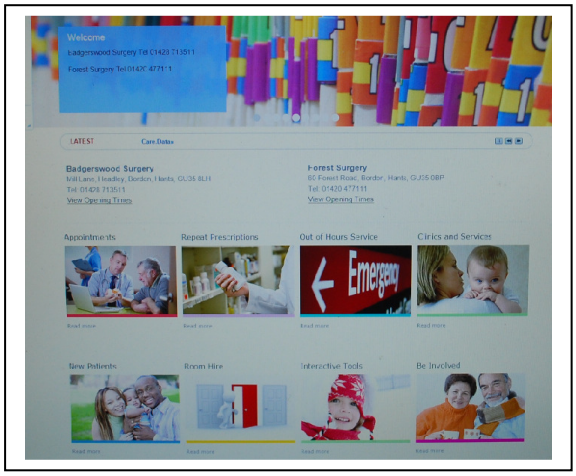
Patient Participation Group

Newsletter

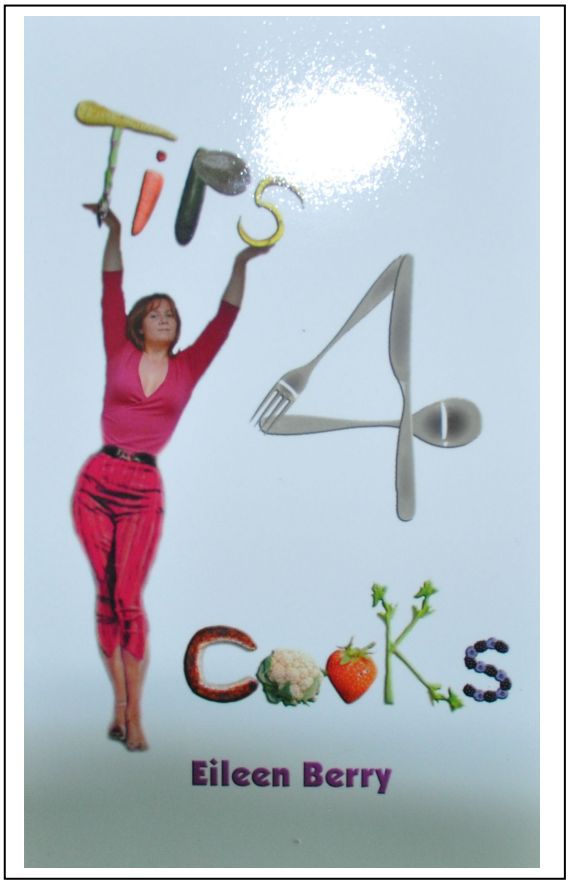


Incorporating the

Friends of the Badgerswood and Forest Surgeries

January 2015 Issue 16

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”.

HEADLEY

VOLUNTARY

CARE

(covers Arford, Headley, Headley Down, Lindford, Standford)

Do you need help to go to

a hospital, doctor or dental appointment?

Call 01428 717389

Also we need more volunteer drivers and co-ordinators.

Petrol costs and expenses reimbursed.

Can you help us? ***Call us on the above number.***

YOU can make a difference to a family in your community

Home Start
Support and friendship for families
Home-Start WeyWater
Alton, Bordon & Liphook

Many parents need help, friendship, advice or support during those early years when children are young. Your experience as a parent can help others. There are a variety of ways you can volunteer for Home-Start WeyWater.

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

Badgerswood Surgery
Headley

Forest Surgery
Bordon

PATIENT PARTICIPATION GROUP

Educational Articles

from the quarterly newsletters

Issues 2 to 11

July 2011 to October 2013

Edited by: David Lee, Chairman,
Badgerswood and Forest Surgeries PPG

Educational Article booklets are available at surgery receptions.
Donations of £2 to cover printing costs would be most welcome.

Applications for PPG membership are on the following page.

Please print out the page, fill out details and hand with Fee to either surgery reception. For those who wish to pay by standing order, the form for this is on the following page.

Badgerswood Surgery
Headley

Forest Surgery
Bordon

PATIENT PARTICIPATION GROUP

Mr Ian Harper
Treasurer

MEMBERSHIP REQUEST

Membership of the Patient Participation Group of the Badgerswood and Forest Surgeries is available to all who wish to join at a cost of £5 annually. This can be paid by cash, cheque or standing order.

Cheques should be made payable to:-
Patient Participation Group of Badgerswood and Forest Surgeries
Alternatively, an annual standing order can be set up using one of the forms available at one of the surgery receptions.

Membership helps to support the aims of the Group and also improves the service provided by the Practice. All members will receive a direct copy of our quarterly newsletter (by Email if you provide your Email address). To ensure our records are up to date, please enter the information requested below and return with your payment or with the standing order form to one of the surgery reception desks.

Title: Mr / Mrs / Ms / Miss / Other ……

Forename: …….. Surname: ……

Address: ……

……

……

Post-code: …… Telephone number: ……

E-mail address: ……

(We guarantee that your Email will not be divulged to anyone else, used for any other purpose than for Patient Participation Group's activities, and be available to only those members of the PPG who require this for PPG activities.)

Badgerswood Surgery
Headley

Forest Surgery
Bordon

PATIENT PARTICIPATION GROUP
STANDING ORDER MANDATE

I / We authorise you to set up the following Standing Order and debit my/our account accordingly for the credit of the :-

Patient Participation Group of the Badgerswood and Forest Surgeries £…… (amount in words ……..) on receipt and every year annually thereafter on the 1st of this month (state month ……) until further notice.

Name of your bank ……

Address of your bank ……

…… Post Code ……..

Account in the name of ……

Current account No…… Sort Code …….

Signature / s ……

Date ……..

Bank instructions. : - Please pay to NatWest Bank , Grayshott.

(Sort Code 60 – 11 – 08) for the credit of the Patient Participation Group of the Badgerswood and Forest Surgeries

Account No. 16543467

Bank please quote the following reference

Chairman and Vice-Chairman Report

As you can see, the newsletters get ever bigger as more articles and information keep flooding in. Fortunately, Sarah Coombes, one of our receptionists has kindly helped with the production of this issue, not only in the editing and compiling of the newsletter, but also in writing some of the articles and I am most grateful to her for this.

Sadly we are losing Dr Boyes at the end of January. He has decided to head north and is joining a practice in a most beautiful part of the UK, the Isle of Skye. His new patients are widely scattered, and he will be looking after the islands of Rhum, Eigg and Muck as well! Quite a change. I hope he doesn't get easily sea-sick. We wish him all happiness in his new post and we will certainly miss him.

As I am sure you have all noticed, the new build at Badgerswood is progressing very rapidly. Dr Leung has written a report for us in this newsletter. Please use our new and extended pharmacy. The more it is used, the better it will be stocked and will become.

With the expansion of the surgery building comes the expansion of the service. Dr Leung has written about the proposed expansion into a new respiratory service which is planned. Really exciting times ahead.

The Educational Article in the October Issue of our newsletter was on "Breast Cancer", what to look out for to be able to detect it early. It was written by Dr Sophie Helme. We've asked Sophie if she would follow up on this by speaking at our AGM. She has agreed to this. So, **our AGM is on Thursday 30th April at 7.30pm at Lindford Village Hall and the speaker is Dr Sophie Helme speaking on Breast Cancer** (probably its treatment and outcomes). We have placed a flier in this Issue.

Our Educational Article in this newsletter is by Mr Bruce Tulloh, an Australian Surgeon now based in this country, writing about "Obesity". We plan to follow this up with an article by a dietician in the next newsletter.

On 9th October we had a members' evening at Lindford Village Hall and ran a course on First Aid and Basic Life Support. This was well attended. Following this we have approached Headley Parish Council and together we hope to fund raise for a defibrillator in Headley High Street. It is important that people know how to use this equipment properly although it does 'talk' to you as you use it and is 'fail safe'. However we plan to run

another First Aid course in the near future for those in the village who are interested including use of defibrillators. We will advertise this locally.

The 'Headley Annual Report', issued by the Parish Council, comes out at the beginning of 2015 and reports have to be handed in by the middle of January. We submitted our report in time last year but unfortunately it was not included then. We published it in our newsletter and it appeared on the village web-site. We have completed our report well in time so it should appear this year. We have published it in this newsletter giving an account of our last year's activities.

Many of you may have noticed our new web-site with its new home page. I hope you find it much easier to use. The PPG App is on the bottom right corner under 'Be involved' and will take you directly to our newsletters. The 'introduction' was transferred from the old web-site and was out-of-date but we have been in touch with the web-master and it will be updated. We hope that we will be able to insert current information into this site on a regular basis rather than simply our quarterly newsletters and we plan to work at this in the coming months.

The Friends of the Chase Hospital held their Annual Fete in Bordon on the 29th November and again we took a table. On this occasion we were more organised and we have reported on this later on.

Our Clinical Commissioning Group has brought together the Chairmen of the PPGs of all the SE Hampshire Practices north of Butser Hill as a group – now called the 'North Butser Locality Patient Group'. We have met twice and are sorting out our Terms of Reference with the CCG at present. Certainly the meetings with the other PPG Chairmen has been most interesting as each PPG seems to have a different approach.

Our article on Great British Doctors has been written by Sarah Coombes and this time is on Lord Lister. I'm sure many of you will have heard of him but it is certainly an interesting read to know exactly what he did for the development of surgery in the mid-1800s.

We keep you abreast of progress with developments at Chase Hospital. Still slow progress. Still no business case accepted. Still no funds. Still no contracts signed.

We have placed a self-measuring BP monitor in Forest Surgery and have the funds for a monitor for Badgerswood Surgery as soon as the waiting room is finished. Please use this. High Blood pressure is a silent killer

and a major cause of strokes and is very treatable. High blood pressure is normally totally asymptomatic until disaster strikes.

We have been very active in helping the practice with various problems. In the past 2 issues of the newsletter, we have documented difficulties arising from the GPs receiving delayed discharge summaries from the major hospitals, causing prescribing and follow-up issues. We have spent much time with the hospitals and have reported on our activities and results. Please read this article.

Also there are issues with our district nurses which are causing major concerns. Please look at our article on this as I'm sure it will cause you concern as well.

Increasingly patients are now attending the Royal Surrey County Hospital in Guildford. We attended a meeting in Haslemere on November 11th and have reported on this for you. Major changes are planned which will affect both this hospital and Haslemere Hospital and will probably have major repercussions on us here is SE Hampshire. Again this is worth reading to keep in touch with developments. Mr Peter Dunt, Chairman of the Royal Surrey, has visited us here in Hampshire to meet the Chairs of the PPGs and also met some Practice managers and Dr Leung at that time. His visit is also reported later in the newsletter.

As you know, over the past 3 years the PPG have been working with the Practice to carry out patient satisfaction surveys. These were set up nationally and we now have the opinions of 500 patients. The BMA, NHS England and our parent body NAPP, wish us now to run 'Friends and Family Tests'. Our practice set this up at the beginning of December. We enclose a report on this test for you later in the newsletter and we would be grateful for your help.

As mentioned by Dr Leung, a small amount of cash is available for Saturday opening for a limited period. Please see Dr Leung's note about this.

Finally, a note came round both from NAPP and from the CCG stating that by April next year it would be a contractual requirement that all practices in England must have a PPG. I have discussed this with NAPP who were not in agreement with my opinion. One cannot contract a practice to have a voluntary organisation. We make comment later.

From everyone at the Practice and the PPG we hope you had a very happy Christmas and we wish you a very healthy 2015.

Issue raised through the PPG

Problem doors at Forest Surgery for wheel-chair users
We have been approached by a wheel-chair user who is a frequent patient at Forest Surgery who tells us that he has problems managing the doors into the reception area at Forest Surgery. In fact on occasion the receptionists have to come round to help him. He wonders if automatic doors can be fitted.

There are several aspects to this query which need consideration:

1. *We have checked and there is enough space for sliding doors to be fitted*
2. *At times the queue for reception is quite large and when this happens, this could lead to the doors been triggered open continually, leading to a through draught into reception. To avoid this happening would need automatic outer doors as well.*
3. *Cost*

The PPG will discuss these items in detail with the receptionists, the doctors and the management, obtain costings and return with a full statement about this item.

New examination couch for Badgerswood Surgery
We wish to thank Headley Voluntary Care for their kind donation towards the cost of a new examination couch for Badgerswood Surgery. The cover on one of the couches had torn and the couch itself was old and beyond repair. The PPG has been able to raise the extra funds necessary to replace this couch and this has just been purchased.

Defibrillator for Headley Village
Following our First Aid and Basic Life Support event (reported later in this newsletter), we feel that it is important that a defibrillator be available in Headley village should the need arise. There are 2 defibrillators already in the village, 1 in the Badgerswood Surgery and the other in the Sports Centre, but neither are immediately available for the village itself should the need arise. We feel acquiring a defibrillator for the village is outside the remit of the PPG, so we have approached the Parish Council to ask if we can liaise with them to fund raise and purchase one to place, probably in the High Street, where it would be immediately accessible. To link with this, we are keen to run another Basic Life Support training course and will announce this in the near future.
We will need funds for these but first we want the approval of the Parish Council who are due to meet in January. If agreed, we shall make announcements through the Parish Magazine, the Headley Village web-site, the Practice web-site and the newsletter, about how we shall progress this. We look forward to your support with this venture.

Badgerswood Surgery
Headley

Forest Surgery
Bordon

THE 4th ANNUAL GENERAL MEETING

of the

PATIENT PARTICIPATION GROUP

of

BADGERSWOOD AND FOREST SURGERIES

to be held on

THURSDAY 30TH APRIL 2015 AT 7.30pm

at

LINDFORD VILLAGE HALL

followed by a talk by

DR SOPHIE HELME

Consultant Breast Surgeon
Portsmouth

who will speak on

BREAST CANCER

Wine and cheese will be provided

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

PPG Annual Report 2014 – as submitted to the 'Headley Report'

The PPG has undergone some changes this year. Maureen Bettles, our fund raiser, retired from our committee but has been replaced by Barbara Symonds and Gerald Hudson. Our patient membership continues to rise and is now nearly 100.

Many changes have occurred in the Practice. Dr Mallick and Dr Carrod had been appointed following Dr Rose's retiral but unfortunately Dr Carrod resigned this year. In October Dr Sherrell was appointed. Dr Boyes is due to retire from Forest Surgery early next year. Badgerswood Surgery is undergoing expansion providing more consulting rooms and a larger pharmacy. Under the control of Dr Mallick the Practice web-site has altered.

In April, we held our 3rd AGM when over 60 people attended. Professor Robert Mason from Guy's and St Thomas' Hospital in London spoke about "40 years at the coal face – a surgeon's journey" and his talk was published in our July newsletter. In October we ran a first aid and life support training exercise and 32 members attended.

This year our fund-raising activities resulted in a new medical examination couch for Badgerswood Surgery, a booking-in touch-screen for Forest Surgery, and self-measuring blood-pressure monitors for each surgery. We are at present fund-raising for a spirometer for the new respiratory clinic which Badgerswood and Forest Surgeries are planning. We have approached the Parish Council and together hope to purchase a defibrillator for Headley village to be placed near the shops on the High Street.

Our newsletter, published quarterly, is distributed to all members, advertisers and contributors. It appears on our Practice, Headley Village and Lindford village web-sites and is available at both reception desks. Over 500 copies are read. We have no shortage of people offering to write articles but our main aim is to keep everyone informed of what is happening in the Practice and about those things which affect the Practice.

Education of the public on medical matters is a high priority and we include Educational Articles with each newsletter, many written by our GPs. A booklet of the Educational Articles from our 1st 10 newsletters is available from the surgery receptions. Newsletters also include other

articles of medical interest and topics of relevant local interest eg regarding the Chase Hospital. We include all comments made to us by patients, constructive or otherwise, the actions taken from these, and the results of our 'Patient Satisfaction Surveys'. Every issue seems to get larger.

The PPGs of the 7 adjacent GP Practices have now joined together to form a group and we have also joined with the Clinical Commissioning Group to form a "Local Activity Group" linking patients with the CCG.

We have many plans for 2015. Our 4th AGM is planned for the 30th of April. Dr Sophie Helme, Consultant Surgeon from the QA Hospital in Portsmouth is coming to speak on Breast Cancer. This is an open meeting for anyone who wishes to attend. Details will be posted in the newsletters and surgery receptions. In our next newsletter, Issue 16 due in January 2015, the "Educational Article" is on "Obesity" written by Mr Bruce Tulloh, Consultant Surgeon. By enlisting the help of the Chief Quality Officer of the CCG and the Clinical Directors of our local hospitals the PPG have taken a lead at improving communications between the hospitals and our Practice and all discharge summaries are now received electronically. We are running a trial on the effectiveness of the self-monitoring BP machines in our practices.

What benefits will you get by becoming a member? For a £5 annual membership fee you will receive our newsletter either in electronic or printed form directly. You will be invited to our members' evening events. You will receive a membership card and we are working with local firms to obtain discounts with this. You get a direct contact to the PPG to make comments which will be handled personally and will appear in the newsletter, by which you can help to improve the standard of the Practice. All funds we receive are used for the benefit of the patients of the Practice in ways we have outlined above. Please join us and help us. Membership request forms are in all copies of newsletters in the GP surgeries, or contact us on ppg@headleydoctors.co.uk or ppg@bordondoctors.co.uk

Changes in the Practice

by Dr Leung

Badgerswood Extension

By the time you read this, the new pharmacy and new waiting room will have opened. Thank you for all your patience throughout the disruption. The builders have worked very hard and delivered this large project over a month ahead of schedule. The surgery has grown a lot over the last seven years and in the pharmacy, many patients have asked for additional items to be stocked. Do keep passing your ideas to the pharmacy staff and we will see what we can do.

This is not the end of the noise and dust though. For the next two months, the builders will turn their attention to completing the new nurses' rooms, then renovating the old pharmacy area and turning that into more consultation rooms. Dr Sherrell has taken charge of the landscape design and has been busy planting. This has been a big investment for us. We hope it will help us meet the growing needs of our patients for years to come.

Saturday Opening

The Southeast Hampshire Commissioning Group are the people who pay for services. They have been given some money for 'Winter Resilience', recognising that the pressures right now are higher than ever. With that money, they have asked practices if they could extend their opening hours on weekends. This is a one-off effort lasting until the end of March 2015 only.

We should like to support this and my challenge now is to find doctors and receptionists to staff these Saturdays. Half the appointments will be bookable in advance and half on the day. The emergency out-of-hours service does not change and will still be accessible when the surgery appointments are full, so this is true welcome addition. I just wish the planning were not so short-term though – must be an election coming up.

A New Respiratory Service
by Dr Leung

We are teaming up with Prof Anoop Chauhan and his team from Portsmouth Hospital to pilot a respiratory service at both the Badgerswood and Forest Surgeries from January 2015. Historically, patients with more severe asthma and other respiratory conditions have had to go to hospital to see specialists there. We are going to see how this might work if we brought this 'closer to home'.

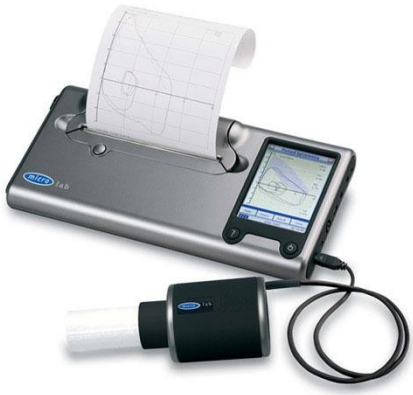
This is a truly collaborative project with the hospital and GP Surgeries devoting their staff time, the Commissioning Group putting in some seed money, Boehringer supplying some equipment and the PPG raising money for another spirometer. We will do a more comprehensive update on this once the service has started.

From the PPG

We regard this as a really exciting development which has the potential to look after our patients with asthma and bronchitis in the Practice rather than their having to travel to hospital out-patient clinics regularly. It also means that patients will probably have a better continuity of care.

We are keen to liaise with Dr Leung and his team to set up a research audit of results of care to see whether this will result in less in the way of respiratory complications in the long term. To help set up this clinic will need some equipment and the PPG are now fund raising for a spirometer which is essential to monitor the respiratory function of patients with breathing problems and their response to treatment.

A new spirometer costs in the region of £1500 with all the soft-wear Any donations please hand in to the receptions of either surgery Contributions to the 'PPG of Badgerswood and Forest Surgeries'



Members' Evening 9th October
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 mnemonic **DR ABC.**
D - Danger - Make sure there is no danger before starting eg the patient has been electrocuted and is still in contact with the electric cable

R - Response - Is the patient unresponsive? Is he/she unconscious? Shake their shoulders gently. See if they wake up.

If they are unconscious, **shout for help**. The sooner you can get assistance eg an ambulance, the better

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 resusciatation**, 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

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.**

Baby and child resuscitation requires judgement of the depth of cardiac compression and amount of air used for mouth to mouth ventilation, but otherwise the techniques are the same. Baby resuscitation is sometimes simpler by holding the child in the forearm with the elbow bent.

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On Thursday 9th October, the PPG together with the Badgerswood and Forest Surgery Practice, held a training session in Lindford Village Hall. 32 people attended a lecture and practical training session. The session was kindly paid for by Mount Alvernia Hospital in Guildford and run by Sirius Business Services Ltd..

Several people indicated their desire to attend but were unable to come on that evening. It is planned therefore, if the numbers are sufficient, to run another training session in the future.

Progress with Discharge Summary problem

For those of you who have been regular readers of our newsletters, you will have been aware that we have been involved in discussions with our 2 major hospitals, the Royal Surrey County Hospital in Guildford, and the North Hampshire Hospital, Basingstoke, because of an excessive delay between the time of discharge of patients and the receipt of notification and summaries by our Practice. Following discussions with the Practice, the PPG decided to engage with both hospitals to see if the situation could be improved.

From the doctors' point of view, the main problems caused by the delay are:

1) Difficulty in knowing what drugs to prescribe for patients immediately after they come home
2) Not knowing what dosages the patients were on in hospital
3) Lack of knowledge about follow-up arrangements

A 2 week survey had shown that the average time delay during that 2 week period was as follows;

Royal Surrey 6.6 days
Basingstoke 10.4 days

The hospitals are contracted to get summaries to the Practices within 24 hours.

We discussed this problem directly with consultant staff at the Royal Surrey and also looked at a system with another hospital group which seemed to be working efficiently (The Chairman knows a Consultant Surgeon and a GP in Coventry where electronic summaries are sent out on the day of patient discharge). We then had a discussion with Julia Barton, Chief Quality Officer of SE Hampshire CCG to inform her of our problem, to indicate what we planned and to enlist her assistance.

On 7th November, we met Helen Collins, Associate Director of Quality, Guildford and Waverley CCG, Phelim Brady, Lay Member for Patient Public Engagement for RSCH and Daniel Lorusso, Information Governments Officer, G & W CCG in Guildford together with Wendy Ball from SE Hampshire CCG. This meeting was very constructive and helpful and produced excellent results.

When the Guildford and Waverley CCG took over the running of the area in April 2013, they were immediately aware of a problem with discharge summaries from the Royal Surrey. Since then they have been working hard to improve on this both in terms of speed

and quality. In the 18 months, they have reduced the delay for GPs to receive their summaries from 10 to 3 days and this is continuing to improve. Drug prescribing at a ward level is done electronically and this is transmitted to the pharmacy for ward dispensing. All GP practices in the area in Surrey around the hospital are all linked electronically to the hospital and when a patient is discharged, the ward prescription data is automatically sent electronically to the GP with the discharge note. In addition, all GPs are informed electronically when any patient is sent for admission electively so every practice knows in advance and all emergency admissions are notified to the practices within 24 hours of admission.

Unfortunately the Royal Surrey and Hampshire use a different IT system but it is possible to link the hospital to any GP Practice so long as the IT personnel in the hospital know which system the practice uses.

After the meeting, we notified our practice's relevant data to Daniel Lorusso, IT Officer, and on 14th December, our practice was linked electronically to the Royal Surrey!! Our doctors now receive all the information at the same speed as the practices in Surrey. We will now run another 2 week survey in January, and Helen Collins is arranging for us to have a conference on 29th January to discuss how this is working.

The Chairman of the Royal Surrey, Mr Peter Dunt, has also become very involved with us and came to visit the Chairs of the PPGs for our area, the practice managers and Dr Leung to discuss proposed changes planned for the hospital in the coming year. These are outlined in another article in the newsletter. At that time we also talked about the problem of the discharge summaries.

On 11th December, Julia Barton and I met at Basingstoke and had a lengthy discussion with the relevant hospital personnel there. The problem was similar and again the approach was very productive. The hospital has an electronic system which we have now linked into. At the same time as with the Royal Surrey, we will carry out a 2 week review.

Not only have we improved the service for our practice but SE Hampshire CCG have taken advantage of our efforts and arranged to link all the practices in SE Hampshire into the Royal Surrey and Basingstoke for all discharges. Well done Badgerswood and Forest PPG!!

We would like to thank Julia Barton of SE Hampshire CCG who has been so helpful in assisting us in this matter and everyone in both Guildford and Basingstoke who went out of their way to be most understanding and constructive in their approach with us.

A Resourcing Problem with our District Nurses

In the past few months, we have become increasingly aware that there has been a problem with our Integrated Care Team as related to the District Nursing service. The whole of the NHS is under severe strain at the moment but there are probably two more factors here

1. There is a shortage of nurses in the service
2. There has been a problem with communication between the hospitals and the nursing service

1. Shortage of Nurses

We quote from an email recently received which summaries this aspect of the problem:

"…… Hence the CCT is left with fewer qualified community nurses specifically serving the Bordon and Liphook area……..Finally there are very significant concerns about the staffing levels of the twilight service. My understanding is that the Twilight team has to cover a geographical area from Hindhead to Hayling Island with only a skeleton staff of one trained and one untrained nurse necessitating great travelling distances. I consider this to be a wholly unacceptable and, quite frankly, potentially dangerous level of staffing."

Dr Leung and Pamela Clarke, practice manager at Pinehill Surgery, met with Richard Samuel, CE of SE Hampshire CCG, Barbara Rushton, Chairman of SE Hampshire CCG and Damian Hind, our MP, at a meeting organised by Yvonne Parker-Smith, our secretary, in her capacity as EHDC Councillor to discuss this situation.

This matter had already been raised independently with the PPG by Julia Barton, Chief Quality Officer of SE Hampshire CCG who had asked for any specific examples of patient problems to be directed straight to her to give her extra 'fire-power' to use to help in any discussions with Southern Health. The Chairman has now discussed this request with our manager, and all five surgeries (Woolmer, Pinehill, Liphook Village, Forest and Badgerswood) are all saying the same thing.

2. Problems with communication

This relates specifically to the Royal Surrey County Hospital in Guildford and was discussed at length when we had our meeting with Guildford & Waverley CCG about the problem of delayed patient discharge summaries. We summarised this nursing problem in our October newsletter and the G & W CCG have been tackling this issue and keeping us informed of progress here since. It would appear that the problem may be related to

one area or even one ward in the hospital only and they are trying to sort this out. Unfortunately the lack of communication led to some patients being discharged without notice and our district nurses being summoned by relatives and/or patients at extremely short notice to deal with urgent situations, sometimes at awkward hours. This may have been one of the tipping factors in the nursing problem we are seeing at the moment.

This is a major problem. Lack of adequate home care will undoubtedly lead to the need for more support from the in-patient care system. Unfortunately this no longer exists in our immediate area with the closure of the Chase Hospital beds 20 months ago. We were assured by Richard Samuel when he defended the closure of the Chase Hospital beds that adequate provision would be in place in the Integrated Care Team to look after patients at home. A discussion with Mr Peter Dunt, Chairman of the Royal Surrey when he visited us, tells us that at least 2 acute wards' worth of patients are at present occupying beds in his hospital because of inability to discharge home because of lack of adequate home care facility. Our situation here is now becoming critical.

It is difficult to see what further action the PPG can do here at present. The actions of Damian Hind, Julia Barton, Richard Samuel and Southern Health are going to be crucial in resolving this situation but the answers may not be quick in coming.

Friends of Chase Hospital annual Christmas Fair 2014

On 29th November, the PPG hosted a table at the Friends of the Chase Hospital Christmas Fair held in the Masonic Hall in Bordon. We all thought our stall looked very professional with our new banner showing the Practice title and surgery photographs. We had books and Christmas cards for sale, PPG information with our current newsletter and the Educational Articles booklets available to hand out, and subscription forms for anyone who wished to join as members. We raffled a bottle of whisky and measured the blood pressure of anyone who wished who was passing our stall.

In total we collected £64 less the £10 for the table making a profit of £54, hard work with items selling for between £2 and 20 pence.

More importantly to the PPG was the fact that we signed up 3 new members on the day with promises from 4 others to send back details +/- standing orders in the follow week. Fifteen people had their blood pressure measured. Eight had high blood pressure and all were sent away to come back later before leaving the fair to have this repeated. Some were known hypertensive but had not had their pressure taken for some time. Others were not known to have high blood pressure. Two were very hypertensive and on re-measuring their blood pressures half an hour later remained very hypertensive. They were recommended to have their pressures re-measured within the next week, either by their Practice nurses or using the self-measuring BP monitor in the Practice reception. It was indicated that they may require re-adjustment of their medication or may require treatment. In one way this may have been the most valuable part of the day.

Our Educational Author this Issue is

Mr Bruce Tulloh

who has written on the problem of

Obesity

Bruce was born and bred in Melbourne, Australia, and graduated from medicine at Melbourne University in 1981. He trained in surgery at St Vincent's hospital, Melbourne, and obtained his Fellowship of the Royal Australasian College of Surgeons in 1990. The next two years were spent doing postgraduate training in general abdominal surgery in Cheltenham, Gloucestershire, UK, before he returned to Australia and set up practice in the rural town of Echuca, northern Victoria, towards the end of 1992.

After ten years in a very broad-ranging practice in Echuca, he moved with his family to Edinburgh and took up a post as consultant General and Upper GI surgeon first at St John's hospital in Livingston, West Lothian, and subsequently at the Royal Infirmary, Edinburgh in 2004. The past ten years have been spent concentrating on upper GI surgery and developing his special interests in both hernia surgery and weight loss surgery there. He is also heavily involved in teaching surgery at all levels and is an honorary senior lecturer at the University of Edinburgh.

Obesity
Prevention and Management

Introduction

Trends in the UK and many other parts of the developed world show a steady increase in obesity over the last 30 years and there are no signs that this is decreasing. Obesity places an enormous health burden on our society because of other medical conditions often associated with it eg type II diabetes, high blood pressure and high cholesterol. These conditions are associated with an increased risk of heart attack and stroke. In general, the higher the weight, the greater the risk. Other associated conditions include fatty-liver disease, sleep apnoea, arthritis of the weight-bearing joints, gastro-oesophageal reflux, depression and infertility and while these are not immediately life-threatening, they certainly affect quality of life.

Obesity is often measured in terms of Body Mass Index (BMI), calculated as body weight in kg/(height in metres)^2. Thus a man of 6 feet (1.8m) weighing 12 stones (76 kg) has a BMI of 76/(1.8)^2 = 23.5. A woman of 5 ft 3 in (1.6m) weighing 19^1/$_2$ st (124kg) has a BMI of 124/(1.6)2 = 48.4. By convention, normal BMI is 22-25; overweight is 25-30, obese is 30-40 and severe obesity is >40. Some use the term super-obesity for BMI>50. The point is that the risks of developing type II diabetes, hypertension, stroke and cardiac death all escalate exponentially as the BMI rises over 40 kg/m^2. Over this level, the risks become so great that they begin to outweigh the risks of surgery and therefore this level is taken as the threshold for eligibility for surgery around the world.

Ways to lose weight

Diet and exercise remain the key to successful weight loss but alone are rarely successful for severe obesity. Even if significant weight loss is achieved, it is generally unsustainable. Modern humans have evolved from nomadic hunter-gatherers and our physiology defaults to energy-storage in periods of food shortage. Dieting switches on a physiological adaptation to starvation, which stimulates appetite, induces the bowel to absorb a greater proportion of food eaten, reduces energy loss by a subtle lowering of body temperature, and promotes fat storage.

Furthermore, it seems we all have a natural set-point for our weight, controlled by complex hormonal mechanisms thought to be orchestrated in the brain. Trying to deviate from this causes the body to work hard to restore us to the set- point. After all, most people can sit at a steady

weight for years without really having to count calories every day. When we diet, we find it difficult to maintain the new weight because our set-point recognises that it is not "normal" for us. It is thought that obese people have their set-point *too high*, and so their physiology is driving them to maintain their obese status… because it thinks it is normal for them.

That's why a commitment to serious weight loss has to become an entire lifestyle change, not just a diet. All the physiological mechanisms contributing to the weight set-point need to be altered simultaneously in order to re-set it. In addition to portion sizes, food choices and avoidance of snacks, lifestyle change has to involve changing routines and breaking habits. This will extend to the whole household, affecting meal times, shopping lists and social planning. Also with exercise there are many simple ways to increase one's daily energy expenditure incorporating a lifestyle change: walking to the shops; taking the stairs more than the lift; throwing away the TV remote, etc. Once these new behaviours become the "normal", the set-point will adjust and the new weight will be easier to maintain.

The higher the BMI when you start, the harder it is to make an effective difference. For many people, losing a stone in weight would elicit comments from friends and family, but if you start at 25 stone and come down to 24 stone, who will notice? For people with BMI in the 40s and more, other treatments are often required.

Several prescription drugs have been tried over years but none has been very successful. Broadly speaking they work either by speeding up metabolism (eg thyroxine), reducing appetite (sibutramine, rimonabant or phentermine) or specifically targeting fat absorption (eg Orlistat). In clinical trials these drugs have, at best, achieved an average 5-10kg weight loss in one year – which is put back on again when the drugs stop! Sibutramine and rimonabant have been withdrawn due to cardiac side-effects. Of course there are also many over-the-counter preparations which are unproven and possibly of questionable safety.

<u>Surgery</u>

"Bariatric" surgery (from the Greek *baros* = weight, *iatrikos* = medical), aimed specifically at weight loss, has been developing since the 1950s but it is only in the last 10 years that it has become popular. Long-term outcome studies have confirmed significant improvement in cardiovascular risk and mortality and techniques have advanced, particularly laparoscopically ("keyhole"). Surgery is now the most

effective treatment for severe obesity.

Different procedures do this in different ways. Traditionally, weight loss operations have been described as either “restrictive”, which physically limit the amount of food that can be eaten, or “malabsorptive”, which reduce the ability of the body to absorb food from the intestines. But these are over-simplifications. In reality they all work by influencing the physiological mechanisms of weight control. Most importantly – and this is a point often forgotten by many people who wonder why they begin to regain weight some years after their operation - patients still need to make healthy lifestyle changes by eating sensibly and being physically active. No operation can make people slim while allowing them to eat and drink whatever they like. Successful weight loss surgery still relies heavily on good eating behaviour and regular exercise.

The commonest weight loss operations around the world at present are the gastric band, the gastric bypass and the sleeve gastrectomy but there are many others and the reason that so many options exist is because no procedure is perfect. Nevertheless, these 3 are extremely successful in producing sustainable weight loss and long-term health gains. There is little evidence to indicate which operation suits which patient and the final choice of operation emerges from a detailed discussion between the patient and their surgeon about the options available and the benefits and risks of each. To be eligible for bariatric surgery in the UK, patients must have a BMI > 40 and have tried all other measures to lose weight first. The BMI threshold can be lowered to 35 if there are also obesity-related co-morbidities such as type II diabetes, hypertension or cholesterol. Referral into the system generally starts with the GP, whether going through the NHS or privately. It is important to note that private insurance companies currently do not cover bariatric surgery.

Summary
The modern developed world’s rising trends in obesity parallel an unprecedented availability of fast, tasty, high-calorie food along with increasingly sedentary lifestyles. It takes knowledge, skill, effort and willpower to even maintain a healthy weight in the face of all these temptations, let alone lose it. Plenty of help is available for advice and assistance to lose weight, but the fundamentals will always remain dietary control and physical activity. Surgery remains the only sustainable method for significant weight loss for people with a BMI > 40.

Following the ‘Obesity’ article, for people who are overweight and wish advice about losing weight, there is a programme available through our Practice as outlined below:

Lipotrim

The Lipotrim Programme is a weight loss programme developed in Britain by qualified nutritionists for people who are overweight or obese, and are serious about losing weight. It is a very low calorie programme which totally replaces food with nutritionally complete formulas comprising drinks – vanilla, chocolate or strawberry flavour (the vanilla and chocolate flavours can also be prepared as a mousse), chicken soup and flapjacks – coconut and peanut flavour. The programme is slightly different for men and women, recognising the difference in nutrient requirements. On the female programme, three liquid meal replacements are consumed per day, and from the second week one of these meal replacements can instead be one flapjack. For the male programme, the liquid meal replacements are larger servings and two are consumed per day, and from the second week one of these can be replaced by two flapjacks. The programme works by maintaining the body in ketosis, a state in which body fat is broken down for energy.

Originally only available from GPs, the Lipotrim Programme is now available from participating pharmacies. Aside from ensuring a suitable weight to start the programme, the participating pharmacy also ensures suitability via a medical screening process, as certain medical conditions can make the Lipotrim Programme unsuitable for some people.

Headley Pharmacy and Chase Pharmacy are participating pharmacies in the Lipotrim Programme.

"From 1 April 2015, it will be a contractual requirement for all practices to have a patient participation group (PPG)"

This is a statement issued by the British Medical Association, supported and endorsed by the parent group of the PPGs, the National Association of Patient Participation groups, NAPP. NAPP was founded in 1978 and has been striving to have a "PPG in every practice" since its foundation.

Previously in hospital practice, patients who wished to suggest change had difficulty in approaching this, so in the 1960s hospitals set up "Patient Liaison Groups". In General Practice however, many GPs who had known their patients for years, felt that they could easily be approached with suggestions, critical or otherwise. They felt groups similar to the hospital liaison groups were not necessary and therefore many practices did not set up PPGs. It became apparent however to those practices which did set up PPGs how useful these were and NAPP has been keen that all practices recognise this.

After many years of striving and being told by the GPs that the number of PPGs would only increase if there was a financial incentive to do so, in 2011 Patient Reference Groups (PRGs) were set up in General Practice in England negotiated with the BMA and NHS Employers. An amount was deducted from the sum which practices received through extended hours and those practices which formed PRGs received additional funding depending on the number of patients recruited into the scheme funded by this deducted sum. The aim was to promote the proactive engagement of patients through the use of effective Patient Reference Groups and to seek views from practice patients through the use of a local patient survey. The aim behind this initiative was to kick start more patient participation in primary care, by providing a financial incentive for GP practices to form patient groups and understand the benefits of consulting patients. The long-term aim was for the PRGs to contribute to the strengthening of the PPGs, not the other way round.

So, the key requirements of the patient participation arrangements were that GP practices:

- Develop a structure gaining awareness of patients' views and obtaining feedback from the patient population
- Agree areas of priority with the patient reference group
- Collate patient views through a patient survey
- Agree an action plan with the patient reference group
- Publicise the results of the survey
- Publicise the actions taken and the results achieved

Patient Reference Group surveys were intended to run over 2 years but have run now for 3 years to 2014. During this time, the number of PPGs which registered with NAPP has almost trebled (including our own).

The aim of the PRGs was to attract a group of patients willing to form a PPG with the aims of providing:

- continuous long term improvement in quality of patient care and patient experience
- long-term friendship and work partnership with the Practice
- Practice negotiations issuing patient perspective, health promotion, surveys, newsletters, service development, support
- representation of all sections of the population
- regular meetings both together and with members of the Practice

In December 2014, the Friends and Family Test was introduced into the practices again working with the PPGs. The PPG Chairmen were notified of this through NAPP. In April 2015, the PRG surveys will end and the payments will revert to be part of the 'global sum' paid to the practice.
So, what is meant by the BMA statement: *"From 1 April 2015, it will be a contractual requirement for all practices to have a patient participation group (PPG)"?* The statement continues later to state *"Having a PPG is already the norm for most practices and is expected for CQC inspection".*

PPGs are obviously voluntary organisations and no practice can be contracted to have volunteers. But as is obvious from the above, it is desirable that every practice should have a PPG, and most are now becoming aware of this. It has taken some financial incentive to make this happen, but now that this has taken place, replacing the funding into the standard contract will not mean any withdrawal of the PPGs. The Practices will have come to realise just how important PPGs really are.

And **the CQC will not penalise a Practice which does not have a PPG. So long as a Practice is safe, effective, caring, responsive to people's needs and well-led, then the CQC will grade the practice accordingly.** However it will make the review easier and more accurate, if the practice has a PPG, with a PPG representative available to talk to a CQC member when they attend, rather than simply meeting 2 or 3 of the patients only who happen to be in the surgery at the time of the visit.

The challenge for the future is to ensure that the PPGs provide a quality of service expected from them. NAPP plans to lay down guidelines for the PPGs to follow. A careful line needs to be laid, flexible for all the PPGs to adapt to, but not too strict and dictatorial.

Friends and Family Test

For those of you who have read our July and October newsletters, you will have followed our articles about NHS Choices and their 'Friends and Family Test'. We have reservations about this test and it was with some concern therefore that we discovered that NHS England has decided that all GP Practices will now have to carry out this test commencing December 2014. We are pleased however to note that there will be no 'Star scoring' system as is used by NHS Choices which was one of our main concerns..

This test was originally developed for use in Obstetrics and A & E Hospital Departments to assess how good they were as seen from the patients' point of view. Patients were asked "Would you recommend this department to a friend or a member of your family if they needed similar care or treatment" and were asked to rate it over 5 levels from 'Extremely likely' to 'Extremely unlikely' with a 6th option of "Don't know"

The test will be used to assess all points of contact between patients and each GP Practice including doctor and nursing surgery consultations, home visits, telephone consultations, telephone reception enquiries, prescriptions, and all others. To try to give all patients the freedom to make as frank a response as they would wish, all responses should be anonymous. Although this will involve the Practices in some considerable effort, work and time to set up and run this system, no financial aid is available to them for this from central source.

No PPG is obliged to be involved in this 'Test', but we wish to assist our Practice in this, firstly to help off-load some of the effort involved, but more importantly, to ensure that a scheme is developed which will result in as open and fair a result as possible. Once more, for a Practice to develop its own Test, run it itself, collect its own results, collate its own data, and then publish its final results, may be seen to produce a biased result, no matter how carefully they may seem to do this.

We have therefore already worked with the South-East Hampshire CCG and our Practice to set up a system which we feel is the ideal to run our 'Friends and family Test' as cheaply and efficiently as possible with minimal disruption to the Practice and to involve the maximum number of patients anonymously. It conforms to the rules laid down by the

Government with its 2 question lay-out, question 1 being a fixed question which we have to provide and cannot be changed. Question 2 has to be a blank text where patients can write an open script. This makes collating comments very difficult and we would rather have had this question zoned into defined areas by which we could more easily have collated problems within the Practice but this is not allowed. This question can remain blank if the patient wishes.

In order that it is seen that the Practice does not bias the process, the PPG will collect and analyse data and present the results.

The Process in our Practice will therefore be:

Questionnaire

Q1 - has been designed centrally and cannot be altered

Q2 - must be open text

- the PPG has designed this question to allow an opt out if a patient does not wish to make a comment

Process

South East Hampshire CCG, the PPG and the Practice have all discussed the different options for running this 'Test'

Based on these discussions, the PPG and our Practice have together decided on the most cost-effective, efficient and least disruptive system to the Practice and to you, the patients

The PPG and the Practice have designed the forms for collection of patient information

The Practice will print the forms 'in-house'

The Practice will hand out and collect the forms anonymously on completion by the patients and will forward these to the PPG.

Data analysis

The Treasurer of the PPG will construct a spread-sheet for data assimilation and analysis.

Results

The results will be published monthly on the Practice web-site and will also appear in the PPG newsletter which is published quarterly.

The higher percentage returns, the more accurate is a Friends and Family Test. It is our experience that a small return tends to reflect a higher percentage of patients who have a grievance with the Practice. Patients who are happy, in general tend not to respond so frequently. We would therefore encourage EVERYONE who makes contact with the

Practice to fill out a form for us on every occasion to give us a more accurate assessment of how the Practice is doing from the patients' point of view.

The design of the form is as below:

We would like you to think about your experience in the surgery
How likely are you to recommend our service to friends and family if they needed similar care or treatment?

1. Extremely likely ☐
2. Likely ☐
3. Neither likely nor unlikely ☐
4. Unlikely ☐
5. Extremely unlikely ☐
6. Don't know ☐

If you wish, please can you tell us the main reason for the answer you have chosen?

Date of visit …… Name of Dr or Nurse ……

What is your sex? ☐ Male ☐ Female ☐ Prefer not to say

What age are you? 16-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65-74 ☐ 75-84 ☐ 85+ ☐

What is your ethnic group? ☐ White ☐ Mixed/Multiple Ethnic Groups ☐ Black/African/Caribbean/Black British*+ ☐ Asian/Asian British ☐ Other Ethnic Group

Thank you for taking the time to complete this survey, we value your opinion.
This survey is being collated by our Patient Participation Group

New Practice Web-site

Our new Practice Web-site came on stream in November and is under the care of Dr Mallick. It is very easy to use and contains a wealth of useful information. To access the Home Page, simply use the same www. address as before either www.headleydoctors.com or www.bordondoctors.com On the home page you will find a top bar of options and 8 Apps.

The top information bar is an access for information about the Practice and lists the following:

- Home
- About us
- How do I..
- Practice policies
- Clinics and Services
- Support and Advice
- Latest News
- Contact us

Simply hit the relevant topic and up will come a series of options under the appropriate heading for you to choose.

The main screen contains 8 windows apps for you to use to make contact with the surgery. These are clearly indicated and are:

- Appointments
- Repeat prescriptions
- Out of hours service
- Clinics and Services
- New patients
- Room hire
- Interactive tools
- Be involved

Hit whichever topic you are looking for and up will come a very user friendly window which will guide you through the process you are after. Even for someone who is not very computer literate, all the steps are clearly described.

There is also a coloured banner across the top of the Home page which highlights in turn the main topics as the banner changes.

In addition to this, where this is necessary, a notice-board will appear in the top left corner of the screen on the home page for important

information. For instance, if the surgery is closed at a specific time for in-house training or a meeting, this will appear on the notice-board and details of what you should do at that time if you need to make an appointment then will be provided.

The web-site carries you into a host of additional information both about the practice and into the health service as a whole. You can, for instance, obtain a wealth of detail from the 'Support and Advice' section on the top bar such as advice about 'Healthy living' or 'Health advice about travelling abroad'. You can also glean quite a lot about NHS reforms that are going on at present from this section.

If you enter the 'Be involved' App, you will find under this, amongst others things, the Patient Participation Group. At present it is headed by our original introduction but we plan to change this soon. It also contains all our newsletters. However we hope to use this site to be very interactive and to be able to put into this, items on a more frequent basis, not just our newsletters.

As you can see, it contains a note about the Patient Representative Group which were the surveys we were also involved with, but these are now finishing this year, being replaced by the 'Friends and Family Test' as outlined in the newsletter.

I'm sure you will agree that the practice web-site is a big improvement on the old site. It is much easier to use, is easier to travel round to obtain the information you wish and to get to the site you desire. It contains a wealth of information. From the PPG point of view, I hope it will be easier for us to place items on a more regular basis which will be available to you sooner and, being more current, will be more relevant. It may take us some time to take advantage of the improved site but we plan to try our best.

Total Fundraising Efforts So Far for Badgerswood and Forest Surgeries

We received our first donation for equipment on the 27th June 2011. Receiving most of our money from appeals resulting in donations, we also sell books and attend fairs, and this is an area we hope to become more active in. We also obtain funds from subscriptions and newsletter adverts. Below outlines the equipment we have collected over the past three years…

2011

ECG machine for Badgerswood Surgery	£1,885
Baby scales for Forest Surgery	£180

2012

Ambulatory blood pressure monitor (24hr bp monitor)	£1,200
Portable heartscan meters	£561

2013

Treatment chair	£1,073
Examination couch for Badgerswood Surgery	£944
Oximeters	£268

2014

Touch screen and software (for self check in at Forest) £1,992

Blood pressure monitor at Forest Surgery £1,560

2015 will see us purchase a blood pressure monitor for the Badgerswood Surgery's waiting room (£1,590) and a new examination couch (£900). We already have the funds for these in our accounts. We are now fundraising for a spirometer for the new respiratory clinic about to be established in the Practice as described elsewhere in the newsletter.

Total amount of money raised so far ~ £12,153

In addition, we wish to work with Headley Parish Council to raise funds for a defibrillator for Headley village and for first aid training.

We thank everyone who has donated to all our fund-raising efforts so far. The PPG uses all donations for the causes given. None of the money is used for administration or any other costs most of which are paid for by the Practice.

Proposed changes at The Royal Surrey County Hospital (RSCH) and Haslemere Hospital

In April 2013 the Primary Care Trusts were abolished and NHS England and Clinical Commissioning Groups (CCGs) were set up. Hampshire was divided into different regions each with its own CCG. Headley and Bordon were included in South East Hampshire extending from here in the north down the A3 corridor to Portsmouth in the south. Basingstoke fell into North Hampshire. SE Hampshire has been further sub-divided into 2 areas related to Butser Hill in the South Downs, North Butser and South Butser. There are no major hospitals in North Butser.

Transport from Headley and Bordon in all directions is difficult. One would never have thought sitting just south of London just off the A3, that this community would have seemed so remote. There is no rail link. Only one bus passes through Headley, the No 18 travelling from Haslemere to Farnham and Aldershot and back again once an hour. Bordon has in addition the No 13 which passes through on its way from Liphook to Alton and Basingstoke. Haslemere is only 5 miles away and has good rail and road links north to Guildford and London and south to the coast. Because of relative ease of road access to Guildford, especially with the opening of the Hindhead Tunnel recently, and with the comparatively more difficult road access to Basingstoke, the Royal Surrey County Hospital (RSCH) in Guildford has become more commonly used as our provider hospital, especially for Headley. Many people depend on the charitable Voluntary Care driver services provided both in Headley and Bordon.

On 11th November a meeting was held at Haslemere Hall to discuss planned changes at RSCH which could have implications for patients in SE Hampshire. For two years now, RSCH has been in a 'Principle Partnership' with Ashford St Peter's Hospitals Trust (ASPH), comprising two hospitals at Chertsey and Ashford Middlesex, and this has produced a number of benefits for patients through collaboration in provision of services to patients. For the last six months, the boards of both RSCH and ASPH have been carefully examining whether there are further benefits for patients to be gained from merging the two Trusts under one management 'umbrella'. Current thinking is that there would be significant benefits in such a merger: it would enable standardisation of care across the three sites, raising standards through best practice; it would enable 7 day working which would improve quality and safety of services in a number of core specialties; it would deliver improvements and enhancements in cardiovascular and cancer services; and it would support the delivery of integrated care and the provision of more care in the community. Reduced overhead expenditure across the three sites,

by having a single management structure rather than two, would create financial stability for the new trust and mean that the limited funding could be directed at patient care. Most importantly, such a merger would not reduce the services currently being delivered on the 3 sites, and patients would not have to travel further than they do today; indeed, the aim would be to provide more care closer to home so many patients should benefit from not having to travel so far. A good example of this was given as the geriatric service where the Royal Surrey and St Peter's each has a geriatric service with 3 consultant physicians, insufficient to run a 24 hour, 7 day a week cover. This means that both hospitals have no consultant geriatric cover at weekends. Should the 2 hospitals join services, there would now be 6 consultant geriatricians available to cover the geriatric service as one unit for both hospitals and a rota could be implemented affording full cover for both hospitals.

For cancer services, the RSCH intends to enlarge its 'catchment' (the population it serves) from the current 1.3 million to 2 million. This will not only lead to an improvement to the already very high quality of care that is provided for cancer patients, but also enable 'outreach' facilities to be provided, for example at Ashford hospital, so that patients don't have to travel so far for their radiotherapy or chemotherapy treatment. Such an outreach facility was opened by RSCH at Redhill earlier this year, and it is already giving significant benefit to patients. If the merged Trust was able to enhance other specialist facilities, then some patients would no longer need to travel up to London for certain types of care.

There are 2 community hospitals to the South and East of the RSCH which, if developed, would be suitable for use by the new merged Trust for their consultants to run out-patient services, seeing patients as new referrals and for follow-up consultations saving patients travelling time and costs. These are Haslemere and Cranleigh Hospitals. The Royal Surrey is examining ways to develop these hospitals with an increased out-patient foot-print, in the case of Haslemere Hospital, with up to 20 new clinic rooms, for their consultants to use.

Mr Peter Dunt, Chairman of the Royal Surrey spoke at the meeting in Haslemere Hall, then came down to speak to the Chairmen of the local PPGs, some practice managers and Dr Leung at Forest Surgery about the proposed changes.

Although the Royal Surrey and Haslemere Hospitals are in different counties from Headley and Bordon, they are both accessible to patients from SE Hampshire and the Chairman of the Royal Surrey indicated that he was very happy to receive patients from this area so long as there

was a freedom of arrangement with the SE Hampshire CCG and capacity.

If some services were to move out totally from the Royal Surrey to one of the other hospitals, this would clearly be a concern, but Mr Dunt gave assurance that this was not an option at present; he did add that it was never possible to predict precisely what changes would need to be made to healthcare in the coming years, but that uncertainty would exist regardless of whether the merger proceeded or not. Indeed, he contended that the merged Trust would be much better placed in the future to withstand financial and other pressures on patient care than the two current hospital Trusts would be able to on their own. Dr Leung pointed out that at least 50% of hospital referrals from Badgerswood Surgery are now made to the Royal Surrey; Mr Dunt welcomed this and said that the RSCH valued these referrals and would like to enhance its services so that GPs had confidence in increasing the number of referrals

Mr Peter Dunt has seen and contributed to this article for us

Report on Chase Hospital

Where are we heading now with the Chase? Although not finalised, it seems very likely that the Elizabeth Dibben Unit and only 1 GP Practice, the Pinehill Surgery, will move into the building. This will leave a void space where the 2nd GP unit was planned. This will result in an ongoing revenue commitment for the CCG who will have to continue to pay rental for this space but the overall scheme has met with the approval of the Governing Body of the CCG and the development of the hospital will therefore proceed. The business case has still to be approved before the £3m+ will be allocated and improvements to the hospital can begin.

The Alzheimer's Society has now moved into the Chase providing a fortnightly service and is complementing the Memory Clinic. GPs will be able to refer patients directly to this group although the channels for this have not yet been clearly set up. With the move of the Elizabeth Dibben Unit into the hospital, there should be a good cohesion of services and it is hoped that the Chase will ultimately prove to become a centre of referral for dementia including Alheimer's

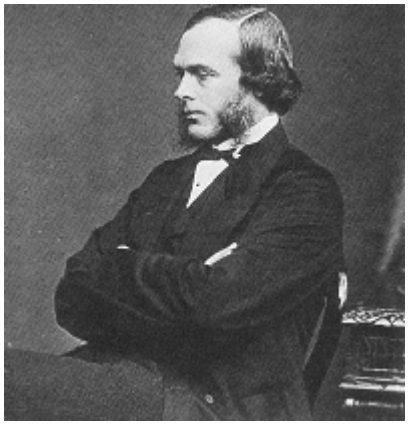
The Chase Times lists the services provided by the Hospital. Importantly the Physiotherapy Department will continue as will the Radiology Department. The CCG is looking at whether ultrasound will be a viable option to bring into the department as a future need. There will be a continued Eye Clinic and a Musculo-skeletal clinic but not orthopaedics.

One really has to look at the Chase in the context of the demands of the population in the future. With the departure of the military in 2015 and the expansion of Bordon by just over 3000 new homes thereafter, there will be an influx of a mainly young to middle aged population. The demand on the hospital from this group will be from a younger age group.

In the surrounding areas outside Bordon, we have quite a large and fairly affluent elderly population. In fact Hampshire has the healthiest elderly population in England and this group will certainly expand and grow older significantly in the next 20 years.

It would seem appropriate that the Chase should be developing with these 2 age groups in mind: For the young, services to treat minor injuries, clinics for sexual and mental health, and addiction. For the elderly, clinics for the management of vascular problems including stroke and cardiac diseases, diabetes including retinopathy, chemotherapy clinics for cancer treatment, all aspects of dementia and mental ill health support. These all seem appropriate to us for consideration.

Great British Doctors
No. 4
Joseph Lister (1827 – 1912)



Joseph Lister was a British surgeon who pioneered 'antispetic surgery' during the 19th century and went on to become known by many as the "greatest surgical benefactor to mankind"

He was born into a prosperous Quaker family on April 5th 1827 at Upton House in West Hampton, Essex. Joseph Jackson Lister, his father was a pioneer in the design of the compound microscope. Most of his early education was at home but as a teenager he attended Grove House School, Tottenham studying mathematics, natural sciences and languages becoming fluent in French and German. Already he was showing an interest in anatomy, and at the age of 14 during his summer holidays, he dissected a sheep's head and drew a human skeleton. At school he also wrote essays on "The Human Skeleton – osteology".

Few Universities at the time accepted Quakers and he attended University College, London, graduating BA in August 1847. But his attendance records for his arts degree were low and much of his time seemed to be spent attending surgical lectures unofficially with a medical student friend. After qualifying, Lister moved on to study pre-clinical anatomy and physiology and in 1850, aged 23, was appointed junior assistant to the University College Hospital senior surgeon. In December 1852, he passed the Fellowship examinations of the Royal College of Surgeons of London qualifying him to practice surgery in England.

It was the following year 1853, that Lister had a significant career move. The Professor of Physiology, William Sharpey, at University College recommended that he should spend some time with his friend Professor James Syme in Edinburgh and gave him a personal letter of introduction. The following January, Lister was appointed Syme's resident doctor and in 1855, was awarded the Fellowship of the Edinburgh Royal College of Surgeons. In 1861,

Lister became Professor of Surgery at Glasgow University and surgeon to the Glasgow Royal Infirmary.

Surgical wards at this time teemed with the foul smell of pus, putrefaction of tissues and gangrene. Many surgical patients died of post-operative infections. Even minor operations were dangerous. The suppurative (pus forming) and putrefactive (rotting) conditions were given the collective name of 'hospitalism' by James Young Simpson, the Edinburgh Professor of Obstetrics (See Great British Doctors No 1). Simpson said that the mortality following amputation inside hospital was greater than if done outside. And "A man on an operating table in one of our hospitals has more chance of dying than at Waterloo". What was causing this problem? Medicine had grown up with ancient theories and the idea of 'germs' and cross-infection was not properly understood. The pioneering work of Ignaz Semmelweiss, who had so clearly shown that transmission of infection was from patient to patient, was so badly ridiculed that it was not accepted anywhere till much later. Surgeons walked from patient to patient without washing their hands and with coats encrusted with blood and filth. In fact it was regarded as a sign of a hard working surgeon, the more blood and gore on his tunic.

The understanding of microbes (germs) came from the work of Louis Pasteur in French vineyards where some wines were going 'off'. Using a microscope, Pasteur saw 'microbes' in the sour wine, not present in untainted wine. He came up with 3 options to destroy these - filtration, exposure to heat, or exposure to chemicals or toxic solutions. He solved his wine problem by working on a heating technique. Boiling solved the microbe problem but destroyed the wine. After much experimentation he found the ideal temperature – 55^0C at which microbes were destroyed but not the wine– a process we now call 'Pasteurisation'.

Lister was intrigued with this work convinced that the pus and putrefaction seen surgically was due to microbes as seen by Pasteur. He obviously could not apply heat like Pasteur to the patient so he worked on finding a chemical solution, something that would destroy the microbes but not human tissue. He heard about the use of carbolic acid to disinfect sewage in Carlisle so decided to try this substance. His most well-known, successful case, still widely quoted, is of an 11 year old boy who came in to Glasgow Royal Infirmary with an open leg fracture where
the bone had burst through the skin. The potential for infection with such an injury is high and in Lister's days had a fierce mortality. He washed the wound with carbolic acid and linseed oil and the leg was splinted.

Over the following weeks fresh applications of carbolic were applied. Six weeks later the fracture had healed and the boy

walked out of hospital, no infection having ensued in the interim. Many successful cases followed and these were written up in the Lancet journal. Lister continued to experiment with his carbolic antiseptic with a high degree of success, developing a carbolic spray gun for use in the operating theatre.

As always in medicine it takes time for ideas to be fully accepted. Others have to experiment and show that they are getting the same good results before it can be said with certainty that a new technique is proven to be better. It took nearly 2 decades for Lister's work to be fully accepted.

He was the pioneer of anti-septic surgery but this led rapidly into the idea that it would be better, rather than combatting microbes in a wound, to avoid having any in a wound at all i.e. use of sterile equipment and instruments, sterilisation of the skin and dressings, and major care to prevent cross-contamination from one patient to another. So Lister really introduced the idea of aseptic surgery which we now have.

While Lister was in Glasgow, he continued to maintain a close, friendly relationship with James Syme, Professor of Surgery in Edinburgh. Syme's daughter assisted Lister with much of his research and they married. When Syme retired, Lister moved to Edinburgh to take up the Regius Chair of Surgery. Some years later he was offered the Chair of Surgery in King's College London and moved back south.

His wife died in 1892 and at that date he retired from practice. In 1902, Edward II developed appendicitis 2 days before his coronation. The risks of appendicectomy at that time were so great that no surgeon could be called to operate on him. Eventually a surgical team was pulled together so long as Lister was present to advise. The King survived without complication and wrote a letter to Lister in which He states "I know that if it had not been for you and your work, I wouldn't be sitting here today."

Lister died on 10th February 1912 at his home in Walmer, Kent. After a ceremony in Westminster Abbey he was buried in West Hampstead Cemetery, London

Despite all the honours bestowed on him - a baronetcy, 2 statues (I in Glasgow and 1 in London), 2 Institutions, a hospital, a mountain (in Antartica), a disease, a drug (Listerine), 2 micro-organisms all named after him, and much more – nothing can state more highly of the man and his work than that sentence quoted above from the King.

Sarah Coombes, December 2014

Practice Details

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G.P.s	Dr Anthony Leung Dr I Gregson Dr H Sherrell	Dr Geoff Boyes Dr Charles Walters Dr L Clark Dr A Chamberlain Dr F Mallick
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	
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