Patient Participation Group

Newsletter

Incorporating the

Friends of the Badgerswood and Forest Surgeries

July 2014 Issue 14

Pain causes *tension...*

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

Change your posture and improve your health & well-being

Alexander Technique

- Relieve muscular tension and stiffness
- Help back, neck and shoulder pain
- Learn to manage the symptoms of stress
- Become more attuned to your body and aware of bad postures and movement habits
- Develop better balance and co-ordination
- Improve performance and prevent injury in sport and music

Good posture promotes confidence & energy

Jane Baker MSTAT
greatposture.co.uk

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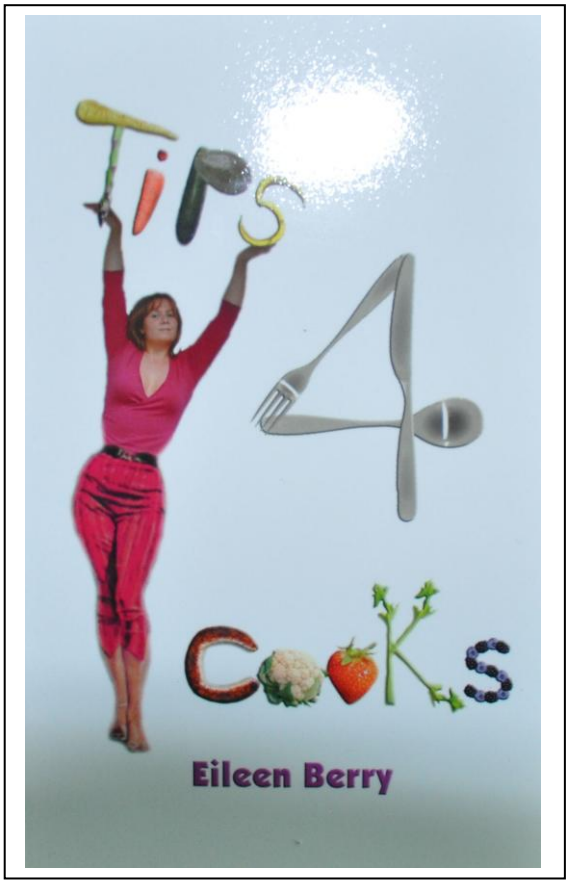
www.stat.org.uk

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”.

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

Available for purchase at Practice reception desks

Chairman / Vice-Chairman Report

We are all agreed that our AGM was a great success and our committee think that Professor Mason is going to be a hard act to follow. If you missed the AGM, we have included in this newsletter a summary of Prof Mason's talk together with the minutes of the AGM.

In our discussions with him while he was here, we talked about our aims and what we were trying to achieve. Prof Mason specialises in oesophageal or gullet cancer and is very keen that people are aware of the early symptoms of this disease as early detection makes this disease more treatable and more likely to be controlled in the longer term. He has therefore written our Educational Article for us entitled 'Dysphagia' or 'Difficulty in Swallowing'. Please read it. It is well presented. 'Thank you, Prof Mason'

We are sad to say that Dr Carrod has resigned from the Practice after just under a year with us. She was well liked and will be sorely missed. We have included some data from the Wessex Local Medical Committees showing the problems that exist in recruiting into General Practice in the Wessex region. We shall keep you informed of developments here.

Also we are sad to say that one of our long standing committee members, Maureen Bettles, has resigned. We talk about Maureen later in our newsletter.

Prof Mason's talk discussed some of the problems we are seeing in changes occurring from the hospital side of medical practice. I have included articles on how the patient may perceive these changes on admission to hospital and may have wondered why these are happening and also the effects on training.

As many of you may be aware, we have been actively collecting data about problems associated with poor communications to our Practice from hospitals at the time of discharge of patients. I now have data from patients, some of our members who have recently been in hospital, from a consultant who works in one of our local hospitals, from a consultant from another hospital outside our region, and from a short survey conducted by the Practice manager collecting figures on how many days it takes for information to come to the Practice after patients are discharged. I now plan to contact the Clinical Commissioning Group to discuss how to progress this further. I include a short article with details of what we have so far.

Following the recent development and expansion of Forest Surgery, we now see that Badgerswood Surgery is bulging with steadily increasing patient numbers and demand for more clinic space. Plans have now been drawn up and approved and most of you will have seen the ground works already started in front of the surgery. Dr Leung has written an article for us outlining the plans for a new Badgerswood Surgery and Headley Pharmacy to be built over the next 18 months. A floor plan of the new Surgery is attached.

We have become aware of a web-site run by NHS England known as NHS Choices. We have some reservations about this site and have discussed this in an article. We have been in touch with the administrator of this web-site to express our concerns and will inform you of the results of our discussions.

We continue our articles on medical terminology and this newsletter discusses the term '-plasty'. We also continue our articles on famous British doctors and we have an article on one of the most outstanding doctors of the past, Edward Jenner. I'm sure many of you may have heard his name.

The plans for Chase Hospital continue to rumble on. It is interesting to note that the new head of NHS England has a new approach to small district hospitals and I suspect that had he been in charge when we were trying to keep our beds open, we would still have our Chase beds. I think we have now probably committed too far to go backwards. What a pity!

For our members, please put the 9th October in your diaries. We are arranging a members' evening for that date. The venue has been booked at Lindford Village Hall. We have not yet finalised the topic but have a few interesting ideas. Also we are now issuing membership cards and hope that we may be able to arrange discount offers with some local retailers for our members through these in the future but will be in direct contact to our members regarding this.

We need a new examination couch for Badgerswood Surgery. One of the old couches needs to be replaced so we are starting to fund raise for this. Contributions would be most welcome.

Finally could I point out the advert for our Pharmacies on the back page of the newsletter with 15% off all perfumes and after-shaves for the next 3 months? Simply tear the back page of this newsletter and take it to one of the Pharmacies to obtain your discount. A real bargain!

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Issues raised through the PPG

We are keen to know of any problems within the Practice where we can assist and improve and we have been approached with several issues over the past 3 months. However, some of these have been in the form of formal complaints which do not fall into the remit of the PPG. We would ask that if anyone has a formal medical complaint, that this be directed to the Practice in the first instance. We are keen to act as a liaison between the patients and the Practice looking for constructive ways by which the Practice can be improved. We appreciate that there is occasionally a fine line between complaining and constructively criticising but where you wish to make us aware of a problem, we ask that you also suggest to us how you visualise we can assist the Practice in improving the situation. Simply writing repeatedly to voice a criticism over a single event is not helpful.

1. Difficulty in making routine appointments

A patient contacted us to say he had to take time off work to phone in to make a routine appointment as the surgery is only open during working hours.
Appointments can be made:

a) at the reception desks
b) by phone during clinic hours
   (see times later in newsletter)
c) on-line at any time (contact reception to obtain
   instructions and a password)

Please note that most patients phoning at 8.30am are contacting for an emergency consultation that day, so if you simply wish a routine appointment, please make clear what you wish.

2. Can we please have a Prescription Drop Box at Forest Surgery? One already exists at Badgerswood. Apparently one used to exist at Forest Surgery but was withdrawn. This seems a good idea as this will further help to reduce the queues at the reception desk. It may need to be in the form of a letter flap in the desk. We shall discuss this with Forest Surgery.

3. **The new booking-in screen at Forest Surgery indicates the delay, if any, to be seen with my appointment but is not always accurate.** The time delay on the screen is that which exists when you arrive. This can change with every patient going through. The commonest reason for a delay in being seen occurs when a patient in front has more than 1 problem and therefore doubles their time with the GP. If the screen says there is a 10 minute delay when you arrive, there is no point in going back to reception after 10 minutes to ask why you are not being called. It simply means the patient in front has taken longer than their allocated appointment time. When your turn comes, you may take longer than your allocated time. The GP will always spend as long as is necessary to sort your problem.

4. **A patient contacted to say that they found the home-page on the Practice web-site very complicated.** A new web-site is under construction at the present time and we hope this should soon replace the present site in the next 6 to 8 weeks. We have made comment about this in the 'Changes to the Practice' section of the newsletter.

MINUTES OF ANNUAL GENERAL MEETING OF PATIENT PARTICIPATION GROUP BADGERSWOOD AND FOREST SURGERIES HELD ON 30 APRIL 2014 AT CHASE HOSPITAL WHITEHILL/BORDON

1. The chairman gave a warm welcome to all present.
2. 11 apologies were received for absence.
3. The committee were introduced.
4. Minutes of previous AGM 23 April 2013 were agreed.
5. There were no matters arising.
6. The Chairman gave his report

"Our PPG continues to be very active, the committee meeting approximately every 6 weeks depending on everyone's availability and we try to alternate meetings between the 2 surgeries. GPs are in attendance for specific items on the Agendas. The newsletter continues to be published quarterly with constructive comments, changes happening or about to happen in the Practice, other informative medical information, what is happening at the Chase Hospital, and with the centre spread Educational Article. These articles are written in a format which we hope is easily readable and very educational. After a series of 10 newsletters had been published, we felt it appropriate to condense the educational articles into 1 collection in order not to lose these and these booklets are available for a modest £2 to cover printing costs.

One of the main roles of the PPG has been to monitor Practice standards, and we have now conducted 3 patient satisfaction surveys over 3 years in conjunction with the Practice. These have drawn on the opinions of approximately 500 patients at random from the Practice in total, and they all show how satisfied you all are in general with your doctors, nurses and support staff. There have been one or 2 areas of discontent which have been highlighted and these have been addressed. Your Practice is very open to constructive criticism and change for improvement as seen from your point of view.

We are also very active outwith the Practice. I sit on 4 committees of the Clinical Commissioning Group and have been vocal about the changes associated with the Chase Hospital. What good this has done is debatable. I also sit on a joint PPG chairman's committee encompassing 7 PPGs from locally adjoining areas and we are beginning to draw from each others' experience to see what we can develop. We are a member of the National Body of PPGs and Ian Harper our Treasurer attended the Annual meeting in Bristol last year which we reported in our newsletter and he came back with lots of good

ideas which we also reported. My present bug-bear is about poor immediate communications from hospital to GPs at the time of discharge from hospital. The CCG have asked me to look into this for Hampshire and Surrey and report back on this and many of you have helped me by replying to my Email which I circulated recently. Thank you for this. I shall be reporting back to you of events here in the next newsletter.

We are still running with small charity status but I think the time is fast approaching when we may have to think of signing up formally to the Charity Commission. I'm not sure that our finances yet meet the requirements to do this but this will need to be on our next committee agenda.

We have been active in fund-raising and membership recruitment but I shall leave comments about fund-raising, membership numbers and membership to Ian when he gives his financial report.

1. Financial Report – The Treasurer gave his report for the year ended 31st March 2014.The total receipts for the year came to £5138, £4472 being donations and £410 from membership fees, the remainder from advertising and sale of books. Over the year the PPG had purchased a nurse's treatment chair, a doctor's examination couch, and 6 pulse oximeters. At the time of the meeting, the PPG had £4885 in bank accounts but £1800 had been already earmarked for a booking-in screen at Forest Surgery and £2296 towards BP monitors for the reception areas at both Surgeries. There are now 88 PPG members.
2. Election of committee – the committee was voted in en bloc. Maureen Bettles has resigned due to pressure of work. The committee is comprised of David Lee, (Chairman) Sue Hazeldine (vice chairman), Yvonne Parker Smith (secretary), Ian Harper (treasurer), Heather Barrett, Barbara Symonds, Nigel Walker.
3. Date of next AGM – possibly last Tuesday in April 2015.

After the AGM, Prof. Robert Mason, Guy's and St Thomas' Hospital, London, gave his talk entitled "40 years at the coal face – a surgeon's journey".

A raffle was held raising over £60.00.

Recruitment Crisis in General Practice
Summary of Report from Wessex Local Medical Committees

Wessex Local Medical Committees (LMCs) represents 3000 GPs in 480 Practices covering Bath and North-East Somerset, Dorset, Hampshire and the Isle of Wight, and Wiltshire. On 19th May 2014 they reported on a survey they had carried out of individual GPs in their catchment area, asking them to comment on GP, nursing and manger recruitment and retention. This article is a summary of their report and is relevant to our Practice as we are about to start on a GP recruitment search again.

Some facts about general practice throughout the UK

There are about 40,000 GPs in the UK and an average GP looks after 1700 patients. In 2004, there were 240,000,000 GP consultations. By 2013, this figure had risen to 340,000,000 consultations which means 1,000,000 patients consult their GP every day. This means a GP on average sees 40 – 45 patients per day.

General Practice receives 8% of the NHS budget but accounts for 90% of all patient contacts. Practices receive £60 - £80 per patient per year, or less than £2 per person per week.

In the Wessex area

- 66% of Practices had a GP vacancy in the past 12 months and 28% had failed to recruit.
- 54% had a Practice Nurse vacancy in the past 12 months and 20% had failed to recruit.
- Over 30% of Practices at the time of the survey reported they were short of GPs and 27% said they were short of Practice nurses.
- In the past 12 months, 6% of Practice Managers indicated that they intend to retire, 9% intend to reduce their working hours and 8% intend to leave the profession altogether.

Quote from the Chair of the BMA's GP committee, Dr Nagpaul

"GP practices in Wessex, like many across the country, are under relentless pressure from rising patient demand from an ageing population, falling resources and workload being moved from hospitals, into the community.
This survey provides further evidence that GP practices are struggling to recruit vital staff they need to deliver care to patients in this difficult climate. Without an adequate workforce of GPs, nurses and healthcare professionals it will not be possible for GP practices to provide enough appointments and services to meet the sheer volume of patients coming through the surgery's doors."

Badgerswood and Forest Surgeries

Exactly 1 year ago, Badgerswood and Forest Surgeries were looking for 2 new partners and in July appointed a new partner to Badgerswood (Dr Mallick) and a new partner to Forest (Dr Carrod). It had not been long since we had appointed and lost Dr Paterson from the Practice.

We are sad to say that Dr Carrod is leaving us and we are now plunged back into the cycle again of recruiting another new partner. As you can see from the article above, the process is not easy despite the large numbers of medical students who are qualifying each year. One would think that a post in Hampshire, 1 hour's journey from the centre of London would be highly sought after, but it seems to be difficult to find colleagues who wish to settle permanently in this area. We shall keep you informed of progress here.

'Put Patients First – Back General Practice'
We are looking at the serious possibility of closure of up to 100 GP units around the country in the foreseeable future. This is related to funding and recruitment problems. The RCGP is running a petition amongst patients to gain support to try to prevent this happening. You may be asked to help if you visit the surgery in the next few weeks by answering a few questions and providing a signature if you agree.

A problem of continuity of care at the time of hospital discharge

In the past few months we have become aware of problems, some serious, which may have arisen from a lack of immediate communication from hospital to GP at the time of patient discharge. An initial enquiry to our GPs confirmed this and we have therefore made preliminary investigations to see if we can constructively assist in improving the situation.

We felt this problem could be approached at 1 of 3 levels:

i) Clinician -> GP level
ii) Hospital management level / CCG level
iii) Senior administrator level eg CQC level

In the first instance we approached at Level i) to obtain data from both sides to see how extensive the problem was and where the issues lay.

GP enquiry

It is not uncommon for the GP to be faced with patients who are discharged from hospital who make an appointment and the GP has no immediate information at all from the hospital. The main problem is continuity of drug prescribing, especially of drug dosage. GPs frequently have to telephone the hospitals to try to speak to the clinician in charge of the patient or to find someone who can find the case notes to obtain information. On occasion, they have to prescribe on the knowledge provided by the patient themselves. The main difficulty is that most of the local hospitals only provide a very limited supply of take home medicines and the GP has to continue these almost immediately. Patients also frequently come home without information about follow-up and are uncertain whether the GP is making the follow-up or whether they will be seen back at the hospital again. GPs also are sometimes uncertain whether they will be following up the patient or whether the hospital will be back in touch to see the patient again at this time.

Practice nurse enquiry

Patients frequently arrive directly from hospital requiring dressings without notification. Sometimes they arrive for their first post-operative dressing. Frequently no instructions come with the patient and no dressings, even where the dressings are of a specialised nature. The costs of all of these dressings have to be borne by the Practice. Again hospital follow-up is uncertain in many cases.

PPG members

An enquiry from members who have recently been in hospital and returned home resulted in 4 members confirming that on a return home,

1 was uncertain whether he would be sent a hospital appointment for follow up, or whether he should see his GP after discharge. 3 confirmed that they needed follow-up medication. 2 were aware that the GP was uncertain what drugs to prescribe as he had had no information from the hospital, and 1 had to provide all the information with drug names and dosage by showing the drugs she had been given on discharge.

2 week Practice survey showing the delay between date of discharge of patient and date of receipt of first communication at Surgery

Over a 2 week period, a consecutive study was performed of all discharge notes received on all patients who had been in hospital. The dates of discharge of the patients and the dates of receipt of the 1st communication about the patient were recorded and the number of days delay were noted. The results are as below:

Hospital	Time for summaries to arrive	Average Time (days)
Royal Surrey	2 to 11 days (1 patient 5 months!)	6.6
Basingstoke	1 day to 3 weeks	10.4
Frimley	2 to 7 days	4.5
Guy's London	1 patient - same day fax	

Communication with a consultant at a local hospital

An initial communication from him indicated that he thought there was no problem with summaries of patients going out immediately as the patient was being discharged. A subsequent communication to him indicating that this was not the case for all departments in the hospital and asking if we could approach the Chief Executive to ask why all the departments could not follow the pattern of his department produced a brisk reaction saying that all departments followed the same pattern. Further communication then indicated a problem with junior staff providing the summaries and that the hospital was looking into the problem and would be installing a new computer system later this year which would provide electronic summaries to all Practices.

Communication with a consultant in Coventry and a local GP

Consultant - All summaries are sent out electronically on the day of patient discharge.

GP - All summaries are received on the day of patient discharge

It may be that the hospitals are unaware of the problem caused by lack of immediate information being available to our GPs when patients are discharged. We shall discuss at our next committee meeting how to tackle this. Perhaps discussion with the hospital Chief Executives is the next path to follow to see how this can be resolved.

Perhaps the problem is already being tackled with electronic summaries.

Badgerswood is Growing

The Badgerswood Surgery and Headley Pharmacy are expanding. A new extension will be built on the front of the surgery. The Pharmacy will move into the extension and the vacated pharmacy will be turned into consultation rooms. (See the ground plan on the opposite page)

Nationally, the number of consultations with GPs has grown from 240,000,000 a year in 2004 to 340,000,000 in 2013. That is about a million consultations a day. On average, a GP sees 40 to 45 patients a day. The pressure at Badgerswood is even greater as the number of patients registered has been growing by half a percent per month for at least five years. We have also increased the clinics and range of services we offer, all of which have placed increasing demand on rooms. Mondays are our busiest day but the car park can get quite full most days.

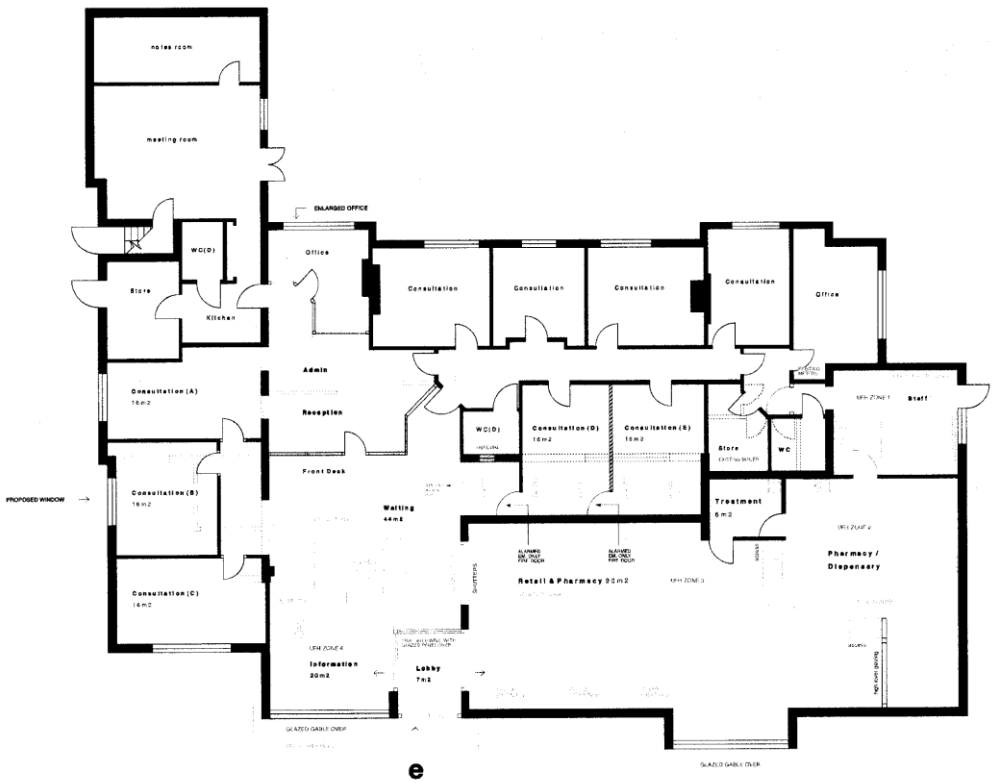
It is also a survival strategy for the surgery. It seems the current political strategy to centralise hospitals into bigger units is being extended to GP surgeries. A lot of smaller surgeries will be forced to close. We will have to borrow 100% of the money from the bank so it is a risk, but we want to still be here in 10 years time.

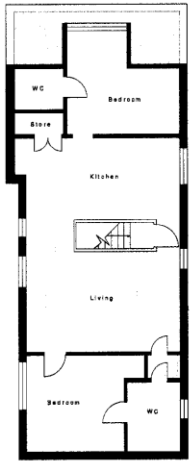
We did think about building a separate pharmacy but that would have meant patients had to cross to another building for their medicines – fine in good weather but not so easy in the wet or snow, especially for patients who are wheelchair bound or have walking difficulties. It will also mean the pharmacist and doctor can continue to have their direct line of communication – we see each other every day and sort out problems for patients e.g. when there is a shortage of a particular drug for the UK, the pharmacist will ask the doctor directly for an alternative.

We have spent the last year planning the extension. We obtained every sort of survey you can imagine, from tree to environment, drains, highways and more. Permission was granted in April 2014 and we are now negotiating with builders to have the work done. The first steps will be to fence off the area and make sure pedestrian access is maintained. As the extension goes round the entrance, there may be a few months when we have to use a different door but we will try to keep this to as short a time as possible.

Look out for an update in the next PPG newsletter.

Dr Anthony Leung





Proposed Ground Floor Plan at 1:100 scale (PHASE TWO)

Unchanged First Floor Plan at 1:100 scale

NOTE SOME INFO PROVIDED BY THIRD PARTY, INTERIOR NOT FULLY SURVEYED, ALL DIMENSIONS TO BE CHECKED ON SITE. THESE ARE NOT SURVEY DRAWINGS. DRAWINGS ARE ONLY TO BE SCALED FOR PLANNING PURPOSES.

0m 1m 2m 3m

SCALE BAR @ 1:100

CLIENT	Badgerswood Surgery	DRAWING	Phase Two - Proposed Floor Plans	NOTES Drawings are not to be scaled except for planning purposes. Room dimensions are approximate. All dimensions to be checked on site. All dimensions in mm's. Drawings are subject to local authority approval. Drawings are subject to engineers design / specification approval.	CORINTHIAN ARCHITECTURAL DESIGN 8 Davys Court, Funtington, Chichester, West Sussex. PO18 9LG 01243 576 078 > contact@corinthianad.co.uk > www.corinthianad.co.uk
SITE	Badgerswood Surgery, Mill Lane, Headley, Hampshire	REVISION		STATUS PL	
PROJECT	Proposed Extensions & Alterations	DATE	28 02 14	SCALE 1:100 @ A2	

WE NEED YOUR HELP AGAIN!

BADGERSWOOD SURGERY NEEDS A NEW MEDICAL EXAMINATION COUCH

A new couch cost about £850 + VAT

The cover on one of the couches has been torn
The couch is now reaching the end of its life and needs to be replaced soon anyway.

Can you help us with a donation however small?

All donations to be handed to reception please
Cheques to be made out to 'PPG of Badgerswood and Forest Surgeries'
Please leave your name and details so we can record your donation.
Thank you

Professor Robert Mason
BSc(Hons) MD ChM FRCSEd FCSHK

"Dysphagia"

We are very fortunate this issue to have an article written by
Professor Robert Mason
Professor of Surgery
Guy's and St Thomas's Hospitals

Qualified in Manchester with Honours – 3rd generation to do so
BSc 1st class hons in anatomy

Went to Prof Unit Edinburgh as an MRC training fellow doing research into Breast Cancer. Obtained MD and FRCSEd before moving to Guys Hospital as Lecturer / SR and then Senior Lecturer and Consultant where stayed since and moving to St Thomas with merger of the Trusts.

Leads the Upper GI Unit which has an International reputation in treatment of oesophageal cancer and salvage of complications of oesophageal surgery. He obtained a ChM and Huntarian Professorship for work in oesophagogastric cancer as well as being appointed to a Personal Chair at Guys and St Thomas. He has always had a major commitment to education being convener of exams for the RCSEd for 3 years.

Dysphagia

Professor Robert Mason BSc ChM MD FRCSEd FCSHK
Professor of GI Surgery, Guys and St Thomas' Hospitals

Dysphagia means difficulty in swallowing and is a symptom which should never be ignored regardless of age. In the majority of cases, it is caused by a blockage at the bottom end of the gullet or oesophagus, although the patient often feels that the blockage is at the root of the neck. This is due to poor representation of the oesophagus in the brain. Dysphagia can be associated with heartburn and indigestion.

There are 2 main causes of dysphagia, either narrowing / compression of the oesophagus or an inco-ordination of the muscles of the oesophagus, a condition known as achalasia. Dysphagia due to narrowing usually starts with solids such as white bread and red meat and progresses on to soft diet and eventually liquids. This narrowing may be benign but if associated with weight loss, this is a serious combination of symptoms, usually indicating cancer. Where the problem is achalasia, the problem usually starts with difficulty swallowing liquids and weight loss is unusual. Most patients with achalasia can be managed without surgery but some do need operation and this can be done by keyhole surgery.

What should you do if you have dysphagia?

If you have any symptoms of dysphagia regardless of age, see your GP. They will refer you urgently for investigation which will usually be an endoscopy. This is a painless, procedure which involves spraying the back of the throat with a local anaesthetic and swallowing a fine (5mm) flexible telescope. It normally slides over very easily and with the local spray, most patients are not even aware of it. If you are very anxious, an injection of a sedative relaxes you completely. The doctor can now visualise the whole oesophagus and stomach and take biopsies of anything which causes concern. If you are really too anxious and refuse the endoscopy, an alternative is a barium swallow Xray but this does not allow a biopsy to be performed and may miss very early disease.

Gastro-oesophageal reflux and the oesophagus

The commonest causes of blockage of the oesophagus are cancer and benign scarring resulting from long-term reflux of gastric acid damaging the lining of the oesophagus associated with a hiatus hernia. This acid reflux burns off the lining of the oesophagus which then heals by scar tissue which contracts as it heals causing the gullet to tighten and narrow.

BUT, acid reflux is also the main cause of cancer by causing the cells in the oesophagus to change from their normal type to the types of cells which resemble those lining the stomach. This condition is known as Barretts oesophagus and is a precursor to cancer. The incidence of this type of cancer has increased more rapidly than any other cancer in the Western World in the last 30 years.

This association between gastro-oesophageal reflux and cancer also means that symptoms of heartburn should not be neglected especially if they persist and don't respond to simple measures such as antacids and Gaviscon. This must be kept in perspective as we must not forget that heartburn affects up to $^{1}/_{3}$ of the population on a regular basis especially after a heavy meal at night. If heartburn occurs de novo especially after 50 years of age it should be not ignored and advice from your GP sought. This also goes for patients who develop weight loss or whose symptoms do not respond to usual over the counter medications.

If Barretts oesophagus is found on endoscopy and there is no evidence of cancer or premalignant change in the biopsy, patients are offered screening on a regular basis. If the early changes which lead to cancer are found then these can be treated through an endoscope and cancer prevented and surgery avoided. The risk of patients with Barretts oesophagus developing cancer is around 1%.

If a cancer is found on endoscopy then the patient will be referred to a specialist team who will do further tests to confirm and stage the disease (carry out tests to see how far it has spread). A multidisciplinary team involving surgeons, oncologists, radiotherapists and other support staff will then decide on treatment which will usually involve a combination of surgery and chemotherapy $^{+}/_{-}$ radiotherapy. This combined approach treating the whole patient has improved the long term survival with treatable disease from 25% to 50% in 15 years. The earlier the disease at presentation, the better the outcome.

It must not be forgotten that the majority of patients with dysphagia will **NOT** have cancer as the cause. They usually have gastro-oesophageal reflux and possibly some scarring producing a stricture which is perfectly benign. Such cases respond well to treatment with tablets to reduce acid and on occasions a dilatation of any narrowing which can be performed through the endoscope. This combined with dieting and sensible eating can control symptoms in the vast majority of cases. Surgery for gastro-oesophageal reflux should only be the exception.

So, take home message

1. Dysphagia or difficulty swallowing especially if of short duration and progressive should not be neglected and you should seek the advice of your GP as a matter of urgency

2. Heartburn due to gastro-oesophageal reflux is very common but if associated with dysphagia or arising denovo and not responding to simple over the counter medications also requires consultation with your GP

3. The vast majority of cases of dysphagia are due to benign causes but early detection of cancer improves outcome so don't neglect your symptoms – **see your GP**! A simple endoscopy will rule out cancer and may detect Barretts oesophagus which can be kept under surveillance.

40 YEARS AT THE COAL FACE – A SURGEON'S JOURNEY[1]

Professor Robert Mason BSc, ChM, MD, FRCSEd, FCSHK
Professor of GI Surgery
Guy's and St Thomas Hospitals
London

At our 3rd AGM on 30th April 2014, Professor Mason presented the above talk. This is a summary of his presentation.

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In London, unlike many other cities around the world, the population which comes through the hospital door is very multi-ethnic. At least $^{1}/_{3}$ speak no English and many arrive unprepared with no translator. At a clinic, you can be faced with 1 of 148 different languages and this can cause major problems not only with clinical history taking and diagnosis, but with items such as consent for surgery where one has to be certain that correct information is being relayed in the correct format to the patient. Religious beliefs have to be taken into consideration and many races from many foreign countries come with many unusual diseases rare to this country and one has to remain vigilant to these, especially TB which can present in many ways.

Nowadays the relations of the medical and nursing teams on the wards have changed considerably from previous years when the consultant was God and the Nursing Sister wore a starched uniform and hat and was in total control of her ward. Ward rounds are now conducted as integrated teams with everyone wearing short sleeved shirts and where everyone equally contributes to the care and management of each patient.

Junior doctor training in hospitals is now proving a major issue. The European Working Time Directive has dramatically reduced the number of hours doctors work, affecting the hours of each shift and total hours of work. Previously a junior surgeon would have performed about 25,000 hours of work before taking on the role of consultant. Nowadays this may be only $^{1}/_{10}$th of this time available to a junior during his training life-time. Shift-work has also affected continuity of care, with juniors no longer seeing patients from the time of admission through their total management. For accreditation purposes, much time has to be spent attending courses and the cost of these is not inconsiderable.

Examination fees are expensive with the final Fellowship fee now standing at £1700. Job security is difficult. For instance if one equates the number of oesophageal surgeons in the UK at the present time and relates this to retirals per year, only 3 surgeons will require to be trained in oesophageal surgery every year. Training in a highly specialised field affords no ability to move sideways into another field and an attempt to do so, will lead to loss of past training experience from that period and difficulty in competing with applicants coming in from subsequent years. Job security can therefore be very difficult and stressful.

From the patient point of view, not unreasonably, certain things are expected. For instance the management of a waiting list may dictate that for a certain condition patients must wait only a certain time for a specific condition from the time of referral. By the time the patient is seen at out-patients, any tests ordered and performed, then re-assessed again and a decision made for treatment, the time left in which to perform the care may be very short and the penalties to the hospital cost wise are very high if the time is breeched. Treatment of minor conditions may seem to take priority over major conditions in some situations because of this. Also it may mean that another surgeon may have to perform the treatment to meet the deadline. You may see one consultant who decides surgery is the correct treatment eg for heartburn, and are called to another surgeon's list for your surgery. However the 2nd surgeon may disagree with the 1st surgeon's opinion. It can be difficult to have a conversation about your management $^1/_2$ an hour before your operation if the 2nd surgeon disagrees and wants to cancel. Increasingly, because of junior inexperience, the whole service is becoming consultant delivered, not consultant led, and because of time constraints, is resulting in less junior training. Because of GP contracts, more out-of-hours work is being downloaded onto the hospital casualty departments, especially in the city areas. Although there is still a need for a general surgeon, because of more specialised training, the generalist is disappearing which is causing a problem especially in the emergency and rural scenes. Cost constraints are resulting in Trusts having to make decisions on rationing care and decisions on, for instance, the dispensing of expensive chemotherapy drugs.

But all is not doom and gloom. For instance, the results of oesophageal surgery at St Thomas have improved over the past 25 years

Oesophageal Cancer		
1980s-	Mortality 20+%	5ys <10%
1995-	Mortality 3.5%	5ys 28%
2010	Mortality 0.8%	5ys 48%

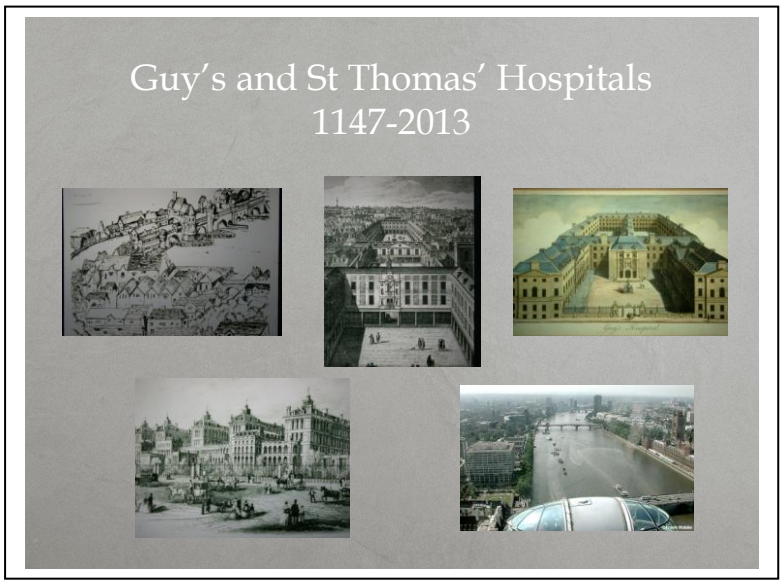
This has been due to a better approach to overall patient management:

- Accurate staging of the disease
- Assessing fitness for surgery
- Better surgery
- ITU care
- Multimodality therapy with better planned use of better chemotherapy and radiotherapy
- Multidisciplinary management

St Thomas now has the largest and most advanced ITU in the UK which can take over the function of all essential body functions for a patient. Patient with tumours which are smaller and have spread less survive better after treatment. Pre-operative therapy now plans to down-stage a tumour to a smaller size and with a view to destroying the visible spread on a scan, resulting in survival figures similar to those of smaller tumours.

For the future of the NHS, one will have to look at costs and inflation, making reasoned choices about what can be afforded and what should and cannot be treated, about rationalisation of the service and its staffing, about providing a 24 hour service where care is of equal standard at all times of day and night, and of recognising that quality comes at a cost.

Finally Professor Mason illustrated the old St Thomas and Guy's Hospitals on a slide, St Thomas have moved several times to its present site on the Thames.



Who will look after me when I go into hospital?

30 years ago, the wards were eagerly awaiting the arrival of the consultant for his ward round. The nurses ensured all the patients were at their beds and ready to be inspected. The junior medical staff were getting the case notes in order ensuring that they knew every patients' history and clinical findings, the results of all their investigations, and any changes in their clinical conditions since the consultant had last been in the ward. The ward note book was ready and a check was made to ensure that what had been asked for at the last ward round had been ordered or done and all the results were back.

The consultant would arrive and would welcome the staff, compliment the nursing staff on the ward, thank physio etc for joining on the round and head off round the ward. The consultant would expect the juniors to present the patients, their progress, their results and following discussion would then advise on how the patient should be managed next. The consultant would not forget what had been discussed previously. The resident's dread "I asked for this test. What is the result?" and the resident had forgotten to write it in his book. But most frequently the decisions about the further care of the patients had been made by the juniors and the nurses, and were simply agreed by the consultant.

But times have changed. Junior doctors worked too hard. Their hours were too long. They were exhausted and because of this were making mistakes. Patients were suffering as a consequence and the press reported on several high profile cases. This should stop. The junior doctors now fall under the European Working Time Directive and the Junior Doctors Hours are now down to 48 hours per week. Any hospital which now allows a junior doctor to work more than this time and allows a patient to suffer a complication as a result of this will face serious consequences and therefore this is not allowed. All junior doctors are forced to leave the hospital when their shift finishes.

So junior doctors are no longer responsible for their patients throughout their stay. No longer do they admit patients and follow through their care. One junior doctor may admit a patient and arrange tests. His shift then finishes and he goes home. A second junior doctor comes on duty and receives the results, but knows nothing of the patient other than what he reads in the notes. He can make no co-ordinated decision on treatment. When a decision on management is made, a 3rd junior may be involved as the 2nd junior may now have gone off duty.

The only doctor who is not committed under the European Working Time Directive is the consultant. Only the consultant nowadays can co-ordinate all the stages of the patient's care. He / she is around on all the ward rounds, when all the results come back and when there are problems. So ward rounds are now very different. Consultants are now telling the juniors what is happening to the patients and it is not unusual for a consultant to say on a ward round to a junior registrar "Do you remember Mrs Smith? We operated on her together for a perforated ulcer when you were on duty last time. She's been pretty sick since you last saw her. Been in Intensive Care with pneumonia, had a nasty wound infection and we've had her on antibiotics, but she's getting better now. Do you remember her?" "Yes sir". What a shame. The junior has missed out a crucial part of the care of a patient he was involved with at the start because of the restrictions in junior hours.

This leads to problems in continuity of care – with training where the juniors lose out in following cases through but also to a difficulty in continuity of clinical care. It is also leading to other problems.

1) we are now having the older section of the medical staff spending the longer time in hospital. As a consultant about 4 months before I retired, I spent 116 hours in 1 week working in hospital, this not counting travelling time. Was this good either for me or the patients?

2) we are seeing a different breed of consultant emerging and quite rightly. These are surgeons who have become used to having time off. They grew up through the Junior Doctors Hours and now expect to have time off and don't expect to have to work the excessive hours that most of the older surgeons do at present. They are used to working a rota system and we are now seeing consultant rotas where they are spending time looking after each other's patients – again a loss of total continuity of care, now at consultant level.

3) there is a problem of continuity of care from hospital to primary care. Juniors don't know the full details about all the patients and it takes time for them to collate these to be able to forward these to the patient's GP. This gives a problem particularly when the GP needs to know details of their patient immediately at the time of discharge.

Times are changing and gone are the times that a patient can expect to be cared for by a single senior clinician day and night from the time of their admission till they are discharged. The patient is under a named consultant but he / she is not around 24 hours a day. The team he / she is involved with is around all the time. As with juniors, errors would inevitably happen with a single consultant practice and a compromise must be reached where integrated care can be given by a team of clinicians working closely together producing a specific standard of care.

Have we improved our surgical training?

The pattern of surgical training has changed considerably in the past 3 decades. The changes have been forced on the profession because of alterations in the work pattern of junior staff. Has this led to better training? Can we be so confident when we are seen by a hospital consultant nowadays that he/she is as competent as their predecessor 3 decades ago?

Surgery is not just about operating. A surgeon has to be trained in the knowledge of surgical diseases, the symptoms and signs of these conditions, how to detect them and what investigations will help in the making of decisions about management, what complications may arise from the diseases and their treatment and how to look after these. Also the management of the patient and their concerns are an important part of the surgeon's training.

So, what has changed over the years and is the training better or worse and where are the problems nowadays?

Years ago, surgeons were trained 'on the job'. Their training was by apprenticeship. To be able to progress in surgical training, junior doctors had to pass 2 examinations held by the Royal Colleges - a basic sciences section which had to be passed before a doctor could apply for a registrar post, and a fellowship examination consisting of a clinical section diagnosing patients' disorders followed by a set of oral examinations. These were unstructured and tended to be of a variable standard depending on the examiner. The examinations were not integrated into clinical training and bore no relation to surgical standards, in particular, operating ability. They were simply a test of knowledge. In reality, the trainees were only able to progress in their training by promotion and were only promoted by being good at their role as a surgeon. Only good surgical trainees tended to become senior surgeons. At that time surgeons ended up with a wide breadth of experience and expertise and developed a specialty expertise late in training, usually related to their topic of research interest. Normally the time taken to reach consultant level was at least 12 years from the time of qualification as a doctor, frequently more.

Nowadays, basic and specialty training is more structured. Junior doctors have to decide very early, not only if they wish to become a surgeon, but also what specialty they wish to pursue. After a residency period which may not be related to their final aim, they enter a programme of specialised training, normally for 5 years,

which guarantees to take them to consultant level. The number of trainees in each slot is supposed to equate to the number of posts which will be available for every trainee at the end of his/her training period. The training is very restricted to the area of specialisation eg orthopaedic or bowel surgery.

They now attend laboratory surgical skills courses where they may be taught how to suture and join bowel, blood vessels, tendon together or how to do key hole surgery, all this before they ever place a suture on a patient. They have to pass structured exams which are carefully crafted to ensure that all areas of knowledge at the correct depth of knowledge are covered. No longer is there the 'luck' of meeting an examiner who is a 'hawk' or a 'dove'. At the end of their 5 year period of structured training, they should be skilled in their specialty.

There is a good thing and there is a problem with this style of training over the previous system. If you require admission to a specialty unit for your surgery, eg for bowel cancer, it is highly likely nowadays that you will meet a surgeon who has gone through a training in a highly specialised unit and received very good specialty training. He will be good at this branch of his trade.

However there is a major problem. The problem is the emergency situation and about 40% of a general surgeon's operating time is spent on the emergency case. It is more of a problem in the rural or peripheral hospital which has a small number of surgeons tied into a rota. In previous years, surgeons had a breadth of training in most areas and therefore were able to handle most problems which they faced unexpectedly as an emergency. Nowadays, it is not uncommon for a consultant surgeon to be faced with a problem which is in a field they have had no opportunity to deal with during their training at all. In a large centre, it is possible to call on a colleague to help. In a rural or smaller hospital, this may prove to be a problem. The situation may be further compounded by the fact that surgery has advanced so much in the past few years that some surgeons are so trained in one style of surgery that it may be difficult to handle some situations as an emergency eg a surgeon highly skilled in keyhole surgery may find that dealing with a problem by open surgery is now outwith his / her skills. Many large symposia or meetings have been held to discuss this problem but still there seems to be no easy answer forthcoming. The directing of all major emergencies to major hospitals in a region seems to be the favoured solution even if this means a long distance or time.

NHS Choices

As you know, at the PPG we monitor the standard of our Practice by carrying out surveys on an annual basis. We look at other surveys, especially the NHS England survey which comes out annually and compares all aspects of all 8000+ surgeries throughout England. In both, our Practice performs very well.

It was with some surprise therefore that I received an Email from a patient last month which stated that following some 'diabolically poor service at Forest Surgery' he had researched the internet and it appears 'noticeable that you appear to ignore the extremely poor Customer Satisfaction reviews that the Practice receives'. After a search, I discovered that the patient was looking at a government web-site called 'NHS Choices'.

NHS Choices is an inter-active web-site which allows you to send in your opinion, good or bad, of the NHS or, for instance, of your GP Practice. On looking at this web-site, it seems to attract mostly critical comment. The web-site then encourages the writer to rate the Practice by giving a Star Rating from 1 to 5 (1 being diabolical and 5 being good). At the time I looked at this web-site for Forest Surgery, there were 7 letters, all critical and all giving 1 or 2 out of 5 stars. Forest Surgery therefore rated just over 1 out of 5 in total. The patient who had written to me had written 2 of the letters so he had contributed 2 of the 1 stars!

The site is supposed to allow the Practice, or the person who is being commented on, the opportunity to see these remarks before they appear on the internet. I spoke to the Practice manager and this either is not happening or is happening but the comments are appearing before the replies can be posted back. The patient who had contacted me initially sent on some other comments which I tried to respond to, but obviously not to his satisfaction because he then went on to send a note to NHS Choices about me stating that my response was to dismiss his comments as inappropriate and that I was going to ignore his complaints. I was given no chance by NHS Choices to respond to these remarks. When I contacted the patient about this he apologised and is now about to write to NHS Choices to put a note to say that I did in fact action his requests.

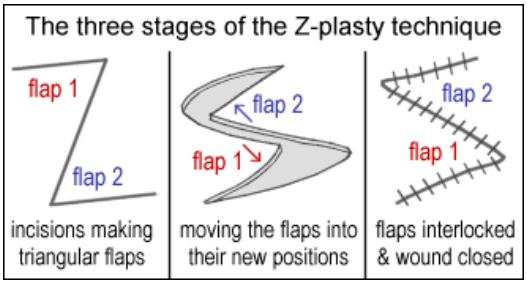
I dislike this web-site, especially the Star Rating system. To rate a Practice on the strength of 7 letters written by 6 patients (less than 0.01% of the total number of patients in the Practice) is unacceptable and bears no relation to the results of other surveys which rate this Practice highly. I have no objection to a forum for people to write in their criticisms or praises and would encourage as many people as possible to do so to balance the ratings.

MEDICAL TERMINOLOGY

-PLASTY

The medical term we wish to explain in this issue is the suffix **–plasty.** This term is used to describe the refashioning, repair, restoration or replacement of part of the body. It may or may not involve the use of an artificial material or 'prosthesis'
The term is frequently used in Plastic Surgery where it is qualified by a description of the procedure being carried out :

i) a 'Z-plasty' is the name of a type of skin flap. The scar is excised and from the ends of the incision, cuts are made at an angle, one on either side making the shape of a 'Z'. The flaps are then transposed bringing the points one over the other and moving the scar into a different position. This moves the tension of the wound, gives length to the tissue and can relieve a tight scar eg over a contracted joint



ii) aabdomino-plasty is the term used in obesity surgery where the excess fat and issue in the abdomen is removed. Simple removal of the fat from the abdomen is not enough as the skin and tissues will have stretched and a plastic procedure is required to redesign the tissues to get these to lie flat. This is known as an abdomino-plasty.

iii) The –plasty suffix is not just reserved for plastic surgery procedures. The definition is as above and is used throughout medicine. In hardening of the arteries, where the blood vessel walls have become thickened by a layer of fat or atheroma on the inner lining, this can lead to obstruction of the blood vessel. Under Xray guidance, a fine tube called a catheter can be steered into the affected blood vessel and a balloon fed down this. The balloon is then inflated and the blood vessel stretched open. The term we use for blood vessels is known as 'angio-' so the procedure of stretching arteries open this way is known as an 'angioplasty'. If the blood vessel is one of the arteries to the heart, a coronary artery, this procedure is a 'coronary angioplasty'. Usually if left, the vessel will close again very quickly so this procedure is usually accompanied by the insertion of a wire mesh tube known as a 'stent' which holds the vessel permanently open.

Great British Doctors
No. 2
Edward Jenner (1749 – 1823)

It is said of Edward Jenner that his work has "saved more lives than the work of any other human". He pioneered vaccination and is called the "founding father of immunology".

Jenner was the 8th of 9 children of the Vicar of Berkeley and was educated at Wotton-under-Edge and Cirencester. At the age of 14, he was apprenticed to Mr Daniel Ludlow, surgeon at Chipping Sudlow, Gloucestershire where he was based for 7 years and following this moved to St George's Hospital in London to work under the great John Hunter. At the age of 24 he returned home to Berkeley taking on the role of local family doctor and surgeon.

Jenner wrote widely on many medical matters, his particular interests being angina, cardiac valvular disease and smallpox. Records from that time suggest that over 60% of the population of the UK were infected with smallpox. Variolation, the technique of injecting a dose of the smallpox liquid from a weak strain of the disease into people to try to prevent them catching the disease severely, was practised widely but was poorly effective. The first record of the use of a disease inoculation used to prevent another disease was by Pewster in 1765 who published a paper on the use of "Cowpox and its ability to prevent smallpox", but he failed to follow this up. In the next decade, anecdotal papers appeared claiming similar results. In 1774 there is a record of a Dorset farmer called Jesty successfully inoculating his wife and 2 children with cowpox during a smallpox epidemic.

It was not until 20 years later however that Jenner, spurred to investigate the care of patients with smallpox and noting the resistance of milkmaids to smallpox, set up the first trial of the use of cowpox vaccination against smallpox. He perhaps read of Jesty's report. His trial methods would not stand scrutiny today but his results were so dramatic, there was no question of the efficacy of his treatment and the proof of his theory. On the 14th May 1796, he injected 8 year old James Phipps, his gardener's son, with fluid from a cowpox pustule from the hands of the milkmaid Sarah Nelson. She had caught cowpox from Blossom, whose hide still hangs on St George's Medical School walls.

Jenner followed this some days later with the standard variolation technique as used for smallpox. James had no reaction at all. Jenner then followed this with various pox materials and James showed no sign of infection. This work was confirmed on 23 other subjects. Jenner had shown that resistance to smallpox could be achieved not only by the use of injection of a material from a disease similar to smallpox but not smallpox and with none of the dire effects of smallpox i.e.cowpox, but also that this material could be obtained by transfer from human to human.

As always in medicine, it takes time for a new theory and technique to be accepted, but after many years and studies from other centres confirming Jenner's work, the 'Vaccination Act' was eventually passed in 1840, banning variolation and issuing cowpox free for the whole public to be vaccinated.

In the early 1800s, Jenner's work on vaccination was attracting so much of his time, he returned to London where he set up an Institute aimed at eradicating smallpox from the UK. In 1805 he became a Member of the Royal Society of Medicine, sponsored by John Hunter and Physician Extraordinaire to the King.

Jenner had many outside interests. He and his nephew redefined the life pattern of the native cuckoo. Previously it had been thought that the adult cuckoo scooped all the eggs and fledgling birds out of the nest before laying her egg, but Jenner confirmed that it was the baby cuckoo which did this and had a special depression on its back for 12 days from birth for this purpose. His work resulted in his being elected as a Fellow of the Royal Society in 1788. He also was interested in balloons. One day his balloon landed in Kingscote Park, owned by Anthony Kingscote. Following this misadventure Jenner met one of Mr Kingscote's daughters, Catherine, whom he later married.

In January 1823, he had a stroke and died the following day.

Jenner's Contribution to Medicine

Jenner could never have imagined how far his work would have extended. In the latter half of the 20th century, the WHO entered on a campaign to eradicate smallpox completely from the world. In 1979, they declared this had been achieved. The main part of this campaign used the vaccination work pioneered by Jenner.

Many other diseases for which we have no treatment, we now can only control to a large degree by vaccination techniques, either by use of organisms which cause similar but less toxic diseases as with cowpox/smallpox, or with disease organisms which have been killed or rendered non-toxic but still able to produce an antibody reaction in the person in whom it is injected, diseases such as tetanus, diphtheria, polio, tuberculosis, typhoid and many others. Much work is done to produce influenza vaccines each year. Great efforts are being put into trying to produce anti-malarial vaccines.

We are even now aware that cervical cancer is associated with papilloma virus and there is a vaccination programme against this virus to try to control this malignancy.

This has all stemmed from the work of Jenner. It truly can be said that his work "has saved more lives than the work of any other human" and this still seems to be expanding. The potential of his work almost seems to be limitless.

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Changes within the Practice

We are sad to have lost Dr Carrod, especially so soon after she arrived. You may recall that she kindly helped us with an Educational Article on Hypertension and encouraged us when we were considering fund raising for the purchase of BP monitors for patients to use in the reception areas of the 2 Surgeries. At present we are unsure what action is being taken to replace her position but we have seen Dr Rose around a few times helping out with locum work. We gather she found the pressure of full time GP Practice and family life too onerous – an exceedingly common problem.

We hope soon to have BP monitors installed in the reception areas of both surgeries available for all patients to use on arrival to check if their Blood Pressure is normal and make sure this is not too high. We thank everyone for their donations, especially one patient who kindly completed our fund raising efforts for the monitor in Forest Surgery but wishes to remain anonymous. The works at Badgerswood may however delay the installation of the monitor at this surgery.

The new booking in screen has now been installed at Forest Surgery and we hear that this is working well. We understand that the receptionists do not always have the same close contact with all the patients as they come through the door as they always did and as they would wish, but if this eases the queues at busy times, this must be good.

We are sad to have lost Maureen Bettles who has resigned from our committee. We really will miss her. I cannot imagine the committee without her. She seems to have been with us forever. However the pressure of being a Matron at a very busy Nursing Home in Alton eventually proved too much with being on our committee as well. Thank you Maureen for all the help you have given us and the Practice.

We are looking forward to a new Practice web-site which should be going live in the next 6 to 8 weeks with a new home-page This should make it easier to access on-line repeat prescriptions and appointments. We also hope to have our own PPG site where we can input our own data including our newsletter.

Practice Details

	Badgerswood Surgery	Forest Surgery
Address	Mill Lane Bordon Hampshire GU35 8LH	60 Forest Road 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 Anthony Leung Dr I Gregson Dr F Mallick	Dr Geoff Boyes Dr Charles Walters Dr L Clark
	Dr A Chamberlain	
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	**Call 111**	

Committee of the of the PPG

Chairman	David Lee
Vice-chairman	Sue Hazeldine
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Contact Details of the PPG ppg@headleydoctors.com
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Also via forms available at the surgery reception desk

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