Patient Participation Group

Newsletter

Incorporating the

Friends of the Badgerswood and Forest Surgeries

July 2015 Issue 18

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.

volunteer drivers Hampshire

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Spire Clare Park 18x8.indd 1 24/10/2013 09:37

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- Offering chiropractic and osteopathy at Forest and Badgerswood Surgeries both privately and on the NHS with manipulative therapy and other types of evidence based care.
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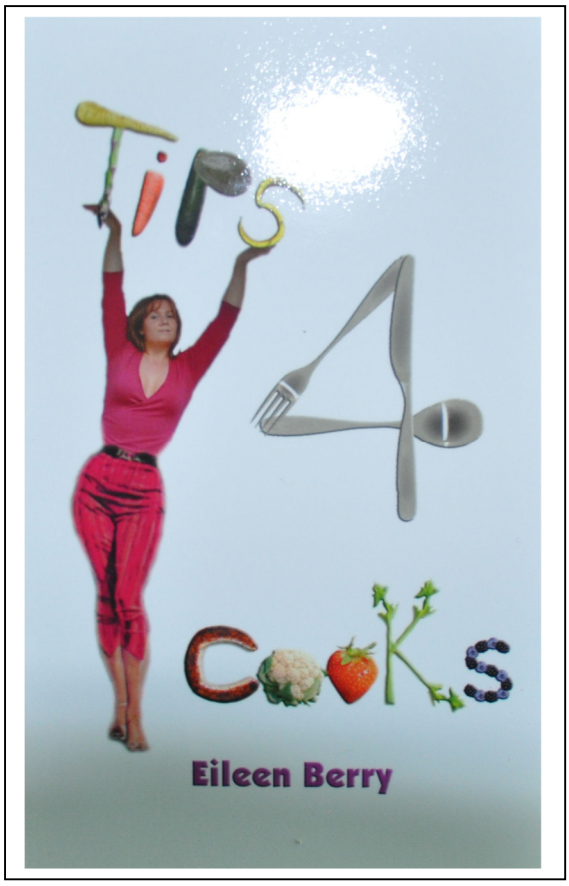
Fundraising – Tips 4 Cooks



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

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

Chairman / Vice-chairman Report

We are delighted to report in our newsletter that we have been awarded 2nd place in the National Association of Patient Participation Corkill Awards. This award is given for the most outstanding piece of work achieved by a PPG in the past year and is open to all PPGs in England and Wales. We received this for our work related to improving the timing and quality of discharge summaries of in-patients from our 2 main local hospitals. For this we receive a plaque as well as a small cheque. This is a high honour of which we are very proud.

In April we held our 4th Annual General Meeting at Lindford Village Hall and there was a good turnout of patients. Dr Sophie Helme spoke on 'Breast Cancer' and her talk was very well received. The minutes of the AGM and a summary of Dr Helme's talk are reported in the newsletter.

Dr Sherrell, one of our GPs from Badgerswood Surgery, is our educational author this time and she has written about 2 skin conditions, eczema and psoriasis. The presentation of these conditions, the variant forms, how to recognise the problems and how to treat are all discussed.

Nick Wilson has recently been appointed as one of the Lay Governors for the South East Hampshire Clinical Commission Group. He gives us an account of his role with the CCG and how he will inter-relate with us, the patients and the PPG , together with his visions for the future.

Following a recent meeting of the Steering group of Chase Hospital together with representation from Southern Health, the CCG and Southern Health produced a paper outlining their commitment to the Chase Hospital entitled "NHS confirms commitment to services in Bordon". This document is worthy of reproduction here in our newsletter.

We give a short summary about NHS England's proposed series of 'Vanguard Projects'. Southern Health and SE Hampshire CCG worked hard to be included as a MCP "Multidisciplinary Community Provider" in this project and have now been accepted.

One of our patients contacted us to say that they were concerned that the osteopathy service 'Back2Health' was about to stop. As explained under 'Changes to the Practice' the funds for this have now been withdrawn. However the Royal Surrey County Hospital physiotherapy department will now be running outreach clinics in our surgeries and Michelle Dawson has written a short article for us outlining the service.

Sarah Coombes, our new committee member, has taken on the role of writing our “Great British Doctors” series and this time tells us about Dr John Snow, the father of modern epidemiology. His methodical study of an outbreak of cholera in London in the 19th century is a classic and is well worth reading. Sarah has also compiled the results of the blood pressure monitor readings from the surgeries and presents these for us.

I have been approached by a long-standing friend from Mumbai (Bombay) in India, who is setting up a state-of-the-art primary care service throughout India – quite a challenge. He is very interested in our Patient Participation Group and wishes a similar model in India. When he visited recently, he discussed his plans with Dr Leung. Professor Gautam Sen and I have written a joint article for your interest.

The Friends and Family test grumbles on very slowly. From the PPG point of view we have received comments which otherwise we probably would not have heard. There seems to be a problem with the telephone system at Badgerswood first thing in the morning, especially on a Monday. We discuss this under our ‘Issues’ column and will discuss this with the Practice. Already we have some ideas about how we may improve this. Of note about this test, **we really need more patients to tick the boxes in some of these forms.** The more forms that are completed, the more accurate feed-back we will get.

Denise Thomas, Dietician and Head of the Dietetic Service at Portsmouth Hospitals, has written an article for us about sensible eating and weight loss. Obesity is becoming a major problem in the UK.

The government is keen to promote weekend opening in all practices throughout the country but we see problems with this. We pen some thoughts and hope to provide more details in the next newsletter.

Our next meeting is a members’ only meeting and is on Tuesday 29th September at Lindford Village Hall. Members and their friends are all welcome. If you are not a member of the PPG, I’m afraid you will have to join for a small annual fee of £5 before you can come. Forms are available at surgery reception desks. At this meeting, the Chairman and the Secretary of NAPP will be coming to present our Corkill Award. Our speaker for the evening is Mr Peter Dunt, Chairman of the Royal Surrey County Hospital in Guildford. Major changes are planned in the hospital services in this area and his talk should be interesting and thought provoking. Please enrol as a member and come and join us.

Corkill Award

There are over 8,000 GP Practices in England and Wales and as reported in previous newsletters, since April of this year, it has been a requirement that each practice should strive to have a PPG, and the Care Quality Commission will expect this.

Our parent body is known as NAPP - the National Association of Patient Participations - and we all enrol with this. Each year NAPP asks every PPG to send in what it regards as its most outstanding achievement and awards a prize for the most outstanding. This is known as the Corkill Award. For those of you who have been following our newsletters, you will have been aware of our efforts to improve the rate and quality of discharge summaries coming from our local hospitals for patients being discharged home after a spell of in-patient care. On occasion, it was taking up to 2 weeks before our doctors were being notified that their patients had even been in hospital and they were frequently having major problems writing follow-up prescriptions and knowing about follow-up arrangements.

We tackled both Basingstoke and the Royal Surrey in Guildford and especially with Basingstoke, have now got most of the discharge summaries coming to our Practice within 24 hours. We submitted this to NAPP as our best achievement in the past year. NAPP contacted us about 2 to 3 weeks ago to say that this year they have apparently been overwhelmed with submissions and ended up with a short-list of 4. Unusually they have produced a winner, a runner-up and 2 highly acclaimed. We have been awarded the position of runner-up.

To come second out of the whole of England and Wales is remarkable and I wish to thank my committee on your behalf for all the hard work they have done in the past year to be able to achieve this. We have received numerous communications of congratulations from many people, including from our Clinical Commissioning Group. Unfortunately, no-one from our committee was able to attend the NAPP Annual conference this year to accept the award, so the Chairman and Secretary of NAPP are arranging to come down to Headley / Bordon to present us with our award, a plaque and a cheque later this year.

Well done Badgerswood and Forest PPG

MINUTES of the 4th ANNUAL GENERAL MEETING of the PATIENTS' PARTICIPATION GROUP of BADGERSWOOD AND FOREST SURGERIES held on 30TH April 2015 at LINDFORD VILLAGE HALL

1. The chairman gave a warm welcome to all present. Copies of the 2014 AGM minutes and the 2014 Annual report were distributed.
2. **Apologies** There were 19 apologies
3. **Committee** The present PPG committee were introduced. Sue Hazeldine, our vice-chairman, was absent due to family illness.
4. **Minutes of the 3rd AGM 23 April 2014** These were agreed
5. **Matters arising** No matters arising
6. **Chairman's report** - David Lee

The Chairman highlighted the main activities throughout the past year. The committee normally meet 6-weekly at alternate surgeries but this has been difficult due to the building works at Badgerswood.

Our newsletter is published quarterly and the pick-up at the surgery receptions has risen dramatically to over 500, to a point where it is now difficult to keep up with printing numbers and costs. All our members receive the newsletters directly, 2/3 by email, and mostly they seem happy to receive the newsletter electronically. Since all the patients who are non-members pick up the newsletters at the surgery reception as printed copies, it has been decided to try to obtain as many email addresses as possible from them. If 2/3 of the patients give us their email addresses, this will significantly reduce printing demands.

In December, NHS England introduced a "Friends and Family Test" into all 8000 GP Practices in England. "Would you be prepared to recommend this Practice to your friends or a member of your family for the treatment you have just received." To make the scoring of this independent of the Practice, the PPG has helped with the design of this test and our Treasurer has taken over the analysis of the results. But numbers of forms returned by you, the patients, has been very low. It is vital that the figures improve to make the statistics meaningful. Please, if you attend the surgery, could you fill out a form

Starting next month, I.e. tomorrow, the 1st May, the PPG wants to run a Stroke Awareness month. A leaflet about the association of stroke with high blood pressure and smoking has already been circulated to

members. This leaflet also gives advice about what to do acutely if someone has a stroke. The aim is to fund raise for a portable 24 hour BP monitor. If anyone wishes to make a donation or would like to help with some fund raising effort eg coffee morning or whatever, we would be most grateful. A donation box will be placed for contributions for every leaflet picked up in each reception.

The committee has been discussing whether our PPG needs to register as a full charity. It is in fact a subsidiary of NAPP. NAPP already is a registered charity and as a subsidiary, it seems unlikely that we will independently have to register.

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

The committee is a very devoted group but has many things it would like to do and really needs extra help. A plea was made for support for the fund-raising committee.

Sarah Coombes, one of the receptionists has helped considerably with compiling the last 3 – 4 newsletters, obtained people to write articles and has herself written articles for the newsletters, especially the series on Great British Doctors. Extra help with the newsletter, such as obtaining advertisers, etc. would be most welcome. There is still space on the main committee for anyone who wishes to join.

A raffle was held with gifts contributed by the committee members.

7. **Treasurer's Report**

Ian Harper, treasurer, presented the PPG's finances over the past year. These had been checked and confirmed as accurate by Mr Bob Wilson, accountant. During the year, the 'Friends' accounts had been closed and these amalgamated into the main PPG account. During the year, a BP monitor had been purchased for Forest Surgery. Over £4,000 were in deposit in the PPG account as at 1st April 2015. However, funds were already committed for a BP monitor for Badgerswood Surgery, the purchase of this having been delayed due to the recent building works, but would now be going ahead. Also a new examination couch was about to be purchased for Dr Leung's room and £671 was in the funds

for a spirometer for the new respiratory clinic. When all these items are purchased, this will leave £1233 in the PPG funds. At the next committee meeting, there will be discussion about the use of these funds as this exceeds the normal level which we wish to have on deposit. Some of this may go into the purchase of the spirometer.

IH then discussed the Friends and Family Test which had been running since December. Although there had been good comments about the Practice from over 90% of patients, the numbers of forms filled had been disappointingly low. A plea was made for more form filling. Mr Peter Vernon commented that the forms were not readily visible on the reception desk.

8. **Election of committee** – All members of the committee were prepared to stand again for another year. The committee was voted in en bloc. The committee is comprised of David Lee, (Chairman) Gerald Harper, Sue Hazeldine (vice chairman), Yvonne Parker Smith (secretary), Heather Barrett, Ian Harper (Treasurer), Barbara Symonds, Nigel Walker.
   Proposed - Peter Vernon Seconded - Marion Davey
   In addition, Sarah Coombes was co-opted onto the Committee.
   Proposed David Lee Seconded Ian Harper
   All present agreed to the appointments.

9. Date of next AGM – possibly last Tuesday in April 2016.

AOB A question was raised by a member of the audience as to who had paid for the extension at Badgerswood – the response was that the partners themselves had paid for this.

After the AGM, a talk, illustrated with slides, was given by Dr Sophie Helme concerning the diagnosis and treatment of breast cancer stressing the role of the oncoplastic surgeon. This talk was most interesting and informative.

A raffle was held, raising £71.

Breast Cancer in the Modern Day
Dr Sophie Helme

At our 4th AGM on 30th April 2015, Dr Sophie Helme presented the above talk. This is a summary of her presentation.

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Dr Helme is a Consultant Oncoplastic Breast Surgeon based at Portsmouth. Her talk was divided into the following parts:

i) Evolution of breast cancer over the past 4 to 5 decades
ii) Dispel certain myths about breast cancer
iii) How each person is assessed for treatment at a breast clinic
iv) Non-surgical therapies
v) Surgical therapy and re-construction (oncoplastic surgery)

1) Evolution of Breast Cancer in the UK

Despite an increasing incidence of breast cancer over recent years there has been an improving survival rate.

The better survival relates to:

Increased public awareness of breast cancer including screening
Improved surgery
Multiple treatment options

2) Myths

Myth I - "Breast Cancer is a death sentence"
No longer - In 1971 the 5 year survival rate was 53%.
In 2015 it is 87%
Myth II - "Surgery must be mutilating" No
Myth III - "Implants are only for Pamela Anderson" No

3) Patient Assessment

<u>Breast Clinic – What to expect</u>

When a patient is referred to a hospital Breast Clinic, the clinic will be set up with all the necessary investigative methods needed to reach a diagnosis during that visit. Patients will go through what is called a "Triple Assessment". The 1st step is to obtain a history of the breast problem and to examine the patient. This is normally carried out by a surgical member of the team. The 2nd step involves a form of breast imaging, possibly a mammogram or an ultrasound scan as appropriate. A radiologist, a doctor experienced in

reading Xrays will be available at the clinic to report on these immediately. The 3rd part of the triple assessment may be a biopsy, usually a needle sample of a breast lump, by which a sample of cells is obtained and microscope slides made.

A pathologist will look at these slides over the following few days if a biopsy is required. If a biopsy is not necessary then the patient can usually be reassured and discharged. If a biopsy is required then the results are given (whether benign or cancerous) a week later. If benign, they are re-assured. If malignant, the patient informed and steps are immediately taken to plan treatment.

Nowadays the treatment for Breast Cancer is complex and involves different medical teams with different expertise. Before a decision is made to start treatment, all the specialists meet to discuss each patient and come to a conclusion about the correct method of treatment, whether a solitary or combination of treatments.
This Multi-disciplinary Team (MDT) consists of

- Surgeon
- Radiologist
- Pathologist
- Oncologist
- Breast Care Nurse

The factors they use in the Assessment of Breast Cancer are:

General	Microscopic
Tumour size	Type of tumour
Single or multiple focus of tumour	Grade of tumour
Size and shape of breasts	Invasive or in-situ tumour
Medical issues	Lymph node involvement
Patient wishes	Hormone status
	HER2 status

The treatment options available are:

Local	Systemic
Surgery	Endocrine therapy
- to breasts	Chemotherapy
- to lymph nodes	Biological therapy
Radiotherapy	

4) Non-surgical therapies

a) Radiotherapy

This can be given to the breast, the chest wall, the axilla and the supraclavicular (neck) area.

b) Chemotherapy

This can be given as adjuvant (after surgery) or neo-adjuvant (prior to surgery).

c) Endocrine (Hormone) therapy

Tamoxifen was the original hormone treatment used for breast cancer and is still commonly used. Aromatase inhibitors are similar in nature and these days are the more commonly used drug.

d) Biological treatment

Herceptin is a biological treatment used in some suitable patients. This is based on tests from the tissue biopsy. It is usually given with chemotherapy. Other biological treatments are likely to evolve into treatments of the future.

5) Surgery for Breast Cancer

Surgery has changed dramatically from the olden days since Halsted introduced Radical Mastectomy where breast, chest muscle and all axillary nodes were removed and no attempt was made to restore any shape. Nowadays breast surgery options consist of

- Breast conservation techniques
- Mastectomy
- Reconstruction

Lymph node surgery options consist of

- Sentinel node biopsy
- Axillary node clearance

Sentinel node biopsy is the technique of injecting a dye or a radioactive substance into the breast behind the nipple and following this to the first draining node (the sentinel node). This node is identified by the dye or its radioactivity and it is then removed and analysed. If there are no tumour cells present, it is highly unlikely cancer will have spread to other nodes in the axilla and no axillary node clearance operation or radiotherapy to the axilla is normally required. If cancer cells are present in the sentinel node then axillary clearance surgery (or radiotherapy) is usually required.

Surgery now has 2 main aims:

1) To eradicate the cancer
2) To conserve or restore the female form as best as possible

Surgeons carrying out this type of surgery are known as 'Oncoplastic surgeons' (Onco= deals with the cancer) (plastic - surgeon)

<u>Breast Conservation Techniques</u>
Wide Local Excision (WLE)
This is removal of the cancerous breast lump known commonly as a 'lumpectomy'. The cancer has to be removed by a wide local margin to be safe that the tumour has all been removed and this is checked microscopically. Occasionally a margin may be too close and a further excision may be necessary for completeness. Studies have confirmed that this treatment must be followed by radiotherapy as there is a percentage of patients with recurrent disease otherwise.
Occasionally the size reduction of the breast leads to an asymmetry and breast reduction of the opposite side is necessary.
Occasionally a large lump may need to be removed using a breast reduction technique.

Simple mastectomy, with or without axillary node surgery as required, is the most straightforward surgical option to deal with breast cancer. Breast reconstruction can be carried out immediately or at a later date to restore the female shape.

Dr Helme went on to describe various techniques of breast reconstruction using implants, tissue expanders, pig tissue, muscle cutaneous grafts based on vascular pedicles eg Latissimus dorsi grafts and other important additions such as nipple reconstructions and contralateral surgery.

Summary
For the majority of people, since surgery and medical treatment now results in long-term survival, cosmesis has become very important. Because of this, conservation and reconstruction are offered as standard in all cases.

Weekend Opening

There seems to be a lot on the news recently about GP weekend opening. Apart from the fact that we wonder where all the new GPs are coming from, we think there is a need for each practice to assess their own requirements eg a surgery in an area where there is a high retired population may have less need for Saturday or Sunday opening.

We in fact have figures for

a) Patient demand from our surveys of over 500 patients where we asked specifically about desire for weekend opening and what patients really wanted. Less than 10% asked for weekend opening

b) Experience of Saturday opening from the A & E initiative over last winter when extra funds were provided to allow us to open on a Saturday. We have the figures to see how many people booked for clinic appointments on a Saturday and how many actually attended.

From this we should be able to produce a sensible approach for the demand for weekend opening for our practice and we plan to produce an article for our next newsletter. When the government comes along demanding Saturday and Sunday opening, we can at least have thought this through sensibly and can put forward our case for opening or not, and for how long, with clarity.

Patient and Public Involvement:
My role as Clinical Commissioning Group (CCG) Lay Member
– by Nick Wilson

I was appointed last December to the South Eastern Hampshire CCG Governing Body as the Lay Member for patient and public involvement. Previously, I was an elected public governor at Southern Health and I was, and still am, on the Chase Hospital steering group. Here I explain what I am doing to make sure patients are at the centre of the CCG's decision making and how you can help.

As part of my role, I chair the Community Engagement Committee for South Eastern Hampshire. This enables different parts of the health and care system (NHS, social care, voluntary organisations, etc) to work together on public engagement and it advises the CCG Governing Body on involving patients in decisions about service developments. Recent things we have advised on include budget priorities, A&E arrangements and support for patients with long term conditions.

The Committee also has an important role in making the CCG aware of major issues or concerns. A recent example, raised by Healthwatch Hampshire, was the possibility of budget cuts to voluntary sector youth services which might put additional pressure on Child and Adolescent Mental Health Services (CAMHS).

We are keen to hear about similar concerns identified by Patient Participation Groups, and also ideas for improving health and care services. There is an existing route to make the CCG aware of individual concerns or to make complaints – by emailing SEHCCG.complaints@nhs.net . But the Community Engagement Committee wants to hear about some of the bigger issues –

particularly things we might not have heard about – and also ideas for service improvements.

I plan to meet Patient Participation Group Chairs on a regular basis and the PPGs are represented on the Community Engagement Committee. So, if you have any big ideas or concerns, please do raise these through the Chair of your PPG.

Our local CCG has recently become one of the first in the country to be given delegated authority for commissioning GP services. We see this as a big opportunity to improve the way all parts of the NHS work together to improve services to patients. So, if you have any good ideas for improving the links between GP practices, community nursing, hospitals etc, please do let your PPG Chair know.

The CCG sees Whitehill and Bordon's development as "Hampshire's Green Town" as presenting great opportunities for a whole range of services to improve people's health and wellbeing. We will be working closely with the local authorities and developers to make sure that health and wellbeing feature strongly in public consultations over the next few months.

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NHS England 'Vanguard' Project Scheme

Last year, Simon Stevens, NHS England's Chief Executive, announced his **NHS Five Year Forward View.** Within this was a series of **"Vanguard Projects"** aimed at creating more integrated services making it easier for hospitals, community services, GPs and care homes to work together. Proposals were put forward by doctors, nurses and other healthcare staff and 29 areas were selected as pilot sites for these projects backed by a £200 million fund.

What are these "vanguards"?

According to NHS England, the vanguards will take the lead on the development of game-changing care models. There will be 3 forms:

1. **Integrated primary Care and Acute Care Systems (PACS)** will join up GP, hospital, community and mental health services
2. **Multispecialty Community Providers (MCPs)** will move specialist care out of hospitals into the community
3. **Care Homes** will offer a model of enhanced health which will provide older people with joined-up health care and rehabilitation services

Twenty-nine project sites were chosen with Southern Health Foundation Trust being included in the list of MCPs. Following the announcement that it had been included in the MCP vanguard list, Southern Health issued the following statement:

"A 'vanguard' partnership between local Clinical Commissioning Groups, GPs, and Southern Health Foundation Trust is set to transform how care is delivered in Hampshire – to improve patients' health, wellbeing and independence.

The MCP in Hampshire will be developed around GP practices and bring nurses, hospital specialists, therapists and other community-based professionals to provide joined up care tailored to the needs of patients and their communities."

The MCP partnership will be located in 3 sites covering a population of approximately 220,000 involving 27 GP practices. These sites have been chosen to cover

1. A rural area with aging demographic – South-west New Forest
2. An urban population with high levels of deprivation and pressure on local GPs - Gosport
3. An aging population in a semi-rural area with difficult transport links - East Hampshire.

The 3rd area covers the region from just south of Butser Hill to Bordon / Headley in the north. There is still debate about where this site should have its hub. Although Petersfield seems central to this area, other parts have significantly different problems which need to be seen and addressed in this pilot project. To us Petersfield alone is not ideal. It may be therefore that there will be several hubs with a central focus where each will come to discuss and present their issues. The CCG is keen that there should be good patient representation in this process.

As you are already aware, our Practice already is in the forefront of this type of development with services such as paediatrics and physiotherapy from the Royal Surrey and respiratory medicine from Portsmouth running outlying clinics in our surgeries.

Our Educational Author this month is

Dr Helen Sherrell

who has written for us on the skin problems of

Eczema and Psoriasis

"As I looked out of my window today and looked at the red poppies growing wildly over the rough ground outside in the sun I felt very glad to be working at Badgerswood Surgery.

My road to medicine was via nursing. I trained at St Bartholomews in 1981 before training in Intensive Care at the Middlesex Hospital, London. I crammed my 'A' Levels and started Medical School at University College and Middlesex in 1987, meeting my husband on the first day in university.

I have been a GP since apart from a skin job and some work in A/E.

I am a keen gardener enjoying both veg and flowers/shrubs and trees. We live in Liss

I share my home with my husband, children, 2 dogs and 10 cats."

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Dermatology, or the study of skin disorders, is a very extensive subject and well beyond the scope of a chapter in this newsletter. This is not the aim of this chapter. In this chapter Dr Sherrell discusses 2 common skin problems, how they present, their different features, when you should seek advice, and what type of treatment is usually effective.

A Brief Look at Eczema and Psoriasis

by Dr Helen Sherrell

Eczema

The terms ‘eczema’ and ‘dermatitis’ are interchangeable. Eczema may be either acute, where a rash has appeared recently and the skin is red, swollen, weepy scaly and tends to blister, or it may go on to become chronic and in this case the skin then becomes dry and thickened. Eczema can be classified into several different types related to the underlying cause.

a) Atopic eczema This is the allergic type of eczema, frequently occurring in children. In this case it tends to occur in the flexures or folds of joints such as the elbows, and at the ankles. It is frequently associated with other allergic conditions such as asthma and hay fever and if all 3 occur together, they are known as the ‘atopic triad’. Blood tests confirm an underlying allergic problem with high immunoglobulin E production. Because the skin is itchy, children tend to scratch a lot and break the skin surface resulting in a tendency to infection. In time the skin becomes thickened.

Management is by moisturisers (emollients), topical agents applied to the skin including steroids, antihistamines, treatment of infection, avoidance of irritants eg washing up liquids and cleaning agents (NB house dust mite can be a problem and frequent hovering and reducing toys in a room can be beneficial), and wet wraps (eg body suits in children).

b) Contact eczema is extremely common and presents with the same features of acute eczema but usually in a very local area. This may lead to the diagnosis and management of the problem which is obviously avoidance of the irritant. Nickel in jewellery, contact with certain plants or flowers, a change in washing up liquid which causes a hand rash, perfumes, soaps, etc.

It is important to note that avoidance of the irritant may not be associated with immediate disappearance of the rash. This may take several weeks, so it must not be assumed that failure of the rash to disappear is not due to the suspected irritant. Again use of topical steroid or non-steroid creams may be helpful in the meantime. Any infection should be treated.

c) Seborrhoeic eczema characterised by red, scaly areas of the scalp, ears, eyebrows and beside the nose , and petal shaped lesions on the trunk and redness of the flexures has been linked to the fungus *malassaezia furfur.* Treatment includes topical anti-fungals and medicated shampoos, possibly complimented with steroids.

d) Varicose eczema occurs on the lower legs resulting from varicose veins and is due to pressure in the venous blood system, producing itchy skin with brown pigment due to extravasation of blood pigment into the tissues due to the high venous blood pressure.

Treatment is directed at the varicose veins and includes support hosiery. If untreated may lead to ulceration.

e) Pomphlyx is a blistering condition of the hands and fingers, usually occurring in people aged about 20. The cause is unknown and it usually settles after about 2 to 3 weeks. Treatment includes avoid irritants, potassium permanganate soaks if wet and weeping, emollients if not wet, potent steroids, infection control, identification and avoidance of allergens (substances that can cause allergy).

f) Discoid eczema occurs usually in adults and is characterised by coin shaped, scaly, red, itchy areas on the limbs and trunk. Management is by emollients, steroids and antibiotics if infected.

g) Infantile seborrhoeic eczema is characterised by yellow scales in the scalp, red and inflamed patches in the nappy area, and dry salmon patches on the face, neck and flexures (knees and elbows). No treatment may be needed if mild and short lived. Otherwise, emollients, antifungal treatment, and occasionally steroids. If on the scalp, scale can be softened with vegetable oil and medicated shampoo can help.

Psoriasis

Psoriasis is not purely a skin disorder but can affect other organs but most commonly it affects the skin. The cause is not known although it commonly runs through families. It is thought that the immune system in the body reacts against the skin resulting in a disorder of skin growth which slows the time taken for cells to travel from the lower layers to the outermost layers where the cells are shed resulting in a thick silvery skin.

It may be made worse with smoking, stress, infection and may be helped with pregnancy and sunlight. It may affect joints and nails where, unlike eczema, it can produce nail pitting. It can both itch and hurt.

Various forms of psoriasis exist –
Plaque psoriasis affects the skin over the elbows, knees, back, legs and scalp. Excessive dandruff may be a huge problem. Management is by emollients, vit d derivative ointment eg calcipotriol, steroids, coal tar or salicyclic acid, dithranol, or UV light or Methotrexate via the hospital.
Flexural psoriasis with sharply outlined red areas in flexures managed by emollients and steroids
Localised pustular psoriasis on soles and palms and characterised by small sterile pustules which burst. This is intensely itchy and again managed by emollients, steroids, vit d analogues, acitretin or methotrexate

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TOP TIPS

1. The only emollient that works is one that is used.
   Find one that you or your child likes and use it frequently to keep the skin moist.
   Generally the drier the skin the greasier the emollient needs to be to be effective.
   Aqueous cream is cheap if you are buying your own and is available at supermarkets.
   Very thick and greasy ones are Epaderm, emulsifying ointment.
2. Avoid soaps and bubble baths . Whisking emollients into the bath cause bubbles which children like but do make the bath floor slippery
3. Antihistamines may reduce itch and are best used at 17:00 as most itches are worse at night.
4. Avoid smoking and alcohol.
5. Avoid repeated skin exposure by chemicals especially to hands.
6. If eczema is painful it may be infected and may need antibiotics to heal quicker.

7. Websites: National Eczema Society
Dermnet (NZ web site for all skin)
Psoriasis Association

Healthy Weight Loss and Maintenance

By Dr Denise Thomas

For our July 2015 newsletter we are fortunate to have an article covering healthy weight loss and maintenance written by Dr Denise Thomas, Dietitian and Head of Dietetic Service at Queen Alexandra Hospital, Portsmouth. Denise Thomas is the manager of the Dietetic Service at Portsmouth hospitals. There are 45 staff in the department and 39 Dietitians many of whom are part time. The Dietitians cover paediatrics, acute adult services and older people, the Wessex Regional Renal Unit, mental health services, adults with learning difficulties. They cover all specialities.

Denise still manages to undertake three clinical sessions a week in conjunction with her managerial responsibility. Her specialism is obesity management including bariatric dietetics. *(Bariatric means 'pertaining to weight' – the main lines of treatment are dietary, exercise, behaviour therapy, drugs, surgery. 'Bariatric dietetics' means weight control by dietary means).* Her Doctorate was in the dietary management of weight loss maintenance.

With so many conflicting messages conveyed to us through the media about which foods we should or should not eat to achieve weight loss, and so many different diet plans from sugar free and 'food combining' to carb free and liquid only, and not to mention the 'wonder weight loss supplements' (many of questionable efficacy and safety), it's no wonder a lot of us end up overwhelmed and confused, and even disheartened to even take our first step towards making positive dietary changes.

Here Dr Denise Thomas gives us her expert advice, encouraging a sensible and healthy approach.

Healthy Weight Loss and Maintenance

I am sure that there are many times when you have seen an advertisement that says 'A new, easy way to lose weight!' and you eagerly scan the text to see the remedy, then at the bottom is the caveat 'Effective only as part of a calorie controlled Diet'. The essence is always that to lose weight the energy equation has to be influenced. If energy taken in is not reduced then weight loss is unlikely to occur.

The greatest impact on weight is a change in energy intake rather than increasing energy expenditure.

Exercise and increasing energy output has the best influence on weight loss maintenance.

By reducing energy (total calories) in your diet by 500 kcals per day over the course of a week this will reduce your intake by 3,500kcals which is the amount of energy stored in 1 lb of adipose tissue (fat). Your energy intake comes from the macro-nutrients: carbohydrate, protein and fat (in that order) and also from the dreaded alcohol, which despite all belief is not a nutrient!

Below is the Eatwell plate which shows the food groups and they are displayed in the portion control we should consume food.

Fruits and vegetables should be taken in large quantity equalling the intake of **carbohydrate** (starchy foods). **Protein foods** are found in the pink section (meat, fish, eggs and beans) and the blue section (milk and milk products). **Fats and sugars** have to be in the diet, but as these are where most energy dense foods are (pastry, biscuits, cakes, sugary drinks, spreading fats etc.) we encourage only a small intake of these items. Further

reduction of energy can be obtained by changing cooking methods such as not adding fat when frying or roasting and draining fat from meat when it's been dry fried.

FRUIT AND VEGETABLE GROUP

- ★ **Aim to eat 5 (or more) portions of fruit, vegetables or salad every day.**
- ★ **Fresh, frozen, dried, canned, cooked or raw varieties are all good for you.**
- ★ **Fruit juice (1 small glass) also counts as part of this group, although whole fruits are better as thev contain fibre.**

BREAD, POTATO AND CEREAL GROUP

- ★ **Have some of these at each meal and avoid adding fat.**
- ★ **Try to have high fibre varieties. These will help fill you up, so don't worry if you appear to be eating more of these**

MEAT, FISH AND ALTERNATIVES GROUP

- ★ **Aim for the low fat varieties of these foods.**
- ★ **Remove all visible fat from meat.**
- ★ **Cook – grill, casserole, roast, poach – and serve without adding fat.**
- ★ **Vegetarian alternatives include pulses, seeds, nuts and soya products**

FATTY AND SUGARY FOODS

Oils, spreads, sugar, confectionary, preserves, pastries, biscuits and cakes have a place in the diet, but take care as these are calorie dense

MILK AND DAIRY GROUP

- ★ **Try skimmed milk or semi-skimmed milk.**
- ★ **Try low fat yoghurt or fromage frais.**
- ★ **Have the lower fat varieties of cheese – Edam, gouda, Cheddar, Camembert, low fat cheese spreads, cottage cheese**

By following our portion guide and the TOP TIPs below you will naturally have a diet under 2000 calories per day.

Top Tips

- Eat at least 5 portions of fruits and vegetables per day
- Have a starchy food (bread, cereals, potatoes, rice and pasta) at each meal
- Watch your fat intake by choosing lean meats and poultry. Include beans and eggs in your diet
- Have fish twice per week, including 1 portion of oily fish
- Eat 3 portions of low fat milk products per day
- Reduce your salt intake by eating less processed or fast foods and do not add salt in cooking and at the table
- Choose olive, sunflower or rapeseed oil instead of butter, lard or ghee to reduce your saturated fat intake
- Drink water! It is recommended that you drink 2 litres/ 4 pints of fluid each day. Tea and coffee count, but plain water is the best (and cheapest!)
- Alcohol contains calories and little in the way of nutrition. Keep within the recommended limits of
    - Women 2-3 units per day
    - Men 3- 4 units per day

Weight Loss Maintenance:

When you have achieved a weight loss of 5 – 10% the key element is to keep it off! The best way is not to 'take your eye off the ball. For instance, If you end up being an ideal weight of 80kg (12st 7lbs) then it is best to set a ceiling weight of 12st 11lb (81.5kg) and a lower limit of 12st 3lbs (78kg). Weigh yourself once a week (no more!) at the same time of day

in the same clothes and on the same scales. If your weight starts to climb and heads towards the top level then ask yourself 'What am I eating / doing that I should change?' It is by adopting such a line of management that generally you can stay in a tight weight range to maintain your weight loss.

For people who are overweight, are serious about losing weight and want help with this, it is possible to join a group such as Weight Watchers or Slimming World both run in conjunction with Hampshire County Council. Both of these programmes encourage healthy eating habits such as those outlined in Dr Denise Thomas's article.

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Our GPs are able to refer patients to Weight Watchers and Slimming World programmes. For referral to be taken into consideration, patients need to match certain eligibility criteria as follows.

Eligibility for Slimming on Referral in Hampshire

- 16 years and above
- BMI >30 **WITH** one or more of the following co-morbidities/situations;
  - **Cardiovascular disease**
  - **High risk of cardiovascular disease**
  - **Diabetes type 1 or 2**
  - **Metabolic Syndrome**
  - **Surgery or medical intervention dependent upon weight loss**
  - **Mental health issues (such as anxiety/depression)**
  - **Parent of a child up to 5 years old**
  - **Pregnancy**
- BMI > 28 South Asian population with one or more of the above co-morbidities
- BMI > 35 without co-morbidities

This service does not accept people who;

- Have eating disorders
- Is a current member/has been a member of Weight Watchers or Slimming World within the last 6 months
- Have special dietary needs, e.g. coeliac disease

To work out your BMI:

- divide your weight in kilograms (kg) by your height in metres (m)
- then divide the answer by your height again to get your BMI

NHS confirms commitment to services in Bordon
(This article was produced by the Clinical Commissioning Group after the Steering Group meeting at Chase Hospital on Friday 22nd May)

NHS partners have confirmed their commitment to services in the Whitehill and Bordon area – including those at Chase Community Hospital.

Southern Health NHS Foundation Trust, which provides physical health, mental health and community services in the Whitehill and Bordon area, is implementing changes within its community teams in order to continue to provide high quality, safe patient care.

With the support of the NHS South Eastern Hampshire Clinical Commissioning Group (CCG), the Trust has been able to take forward the valuable opportunity to bring its community, Older Persons Mental Health (OPMH) and therapy staff together for the first time as Integrated Care Teams to provide more seamless care between these specialisms for the benefit of patients.

Gethin Hughes, Director of Integrated Services (East and North Hampshire), said: “Southern Health is committed to continuing to provide nursing, therapy services and clinics at Chase Community Hospital, and is planning to provide additional specialist clinics on-site.”

The administrative ‘hub’ for Southern Health’s Petersfield and Bordon team will operate from Petersfield Community Hospital, to allow closer team working, but clinical staff are still operating from Chase on a day-to-day basis, in addition to continuing their regular visits to patients and GP surgeries, which will experience no change in service.

The team covers a large and diverse area, and new video conferencing facilities enable staff to join together to discuss complex patients in real time. It means patients will see improved co-ordination of the care they receive and additional support from many other specialists.

Mr Hughes continued: “As part of that commitment to continuing services in the area we are relocating specialist Adult Mental Health, Access to Psychological Therapies (IAPT) and Older Person’s Mental Health (OPMH) clinics from the Elizabeth Dibben Centre in Bordon to Chase, to enhance the provision of services at the hospital and enable our Integrated Care Teams to work more closely together for the benefit of patients.

“This is about ensuring our services are better integrated, best placed to meet the needs of the local population and providing the best value for money for the taxpayer.”

Southern Health’s other services at Chase include health visitors, school nurses, children’s services, physiotherapy and leg clinics. There are no plans for those services to be relocated.

South Eastern Hampshire CCG’s plans to redevelop Chase have been delayed by new processes to obtain funding for building works. But the CCG is working with NHS Property Services (which owns the building) to speed up the release of funding by reducing the cost of the elements of the project which don’t directly affect patient services.

Project Director Sara Tiller, the CCG’s Director of Development, said: “We want to get work started at Chase so we have reduced the costs of elements of the scheme to try to reduce any further delay – without adversely impacting on the quality of what we want to achieve for Chase.

“Our vision has always been to provide people in the Whitehill and Bordon area with modern healthcare facilities in the heart of their community and we have never swayed from that course. The delay to the internal building works has been incredibly frustrating for everyone, we know that.

“But we are working behind the scenes to make things happen as fast as we can – and new services are being introduced at Chase even if people can’t yet see any building work inside the hospital.”

New services introduced at Chase in recent months include a ‘carers’ hub,’ which started last week; an enhanced provision musculo-skeletal (MSK) and persistent pain service, a community ophthalmology service and community midwives now use Chase as a location for their clinics.

New Physiotherapy Service provided by The Royal Surrey County Hospital

An exciting new physiotherapy service is now available at Badgerswood and Forest surgeries provided by the Royal Surrey County Hospital. At Forest, the service is available on Mondays and at Badgerswood, on Tuesdays and Thursdays. The new clinics have been set up so that you can access physiotherapy closer to your own home and have proven very successful at other GP practices.

The physiotherapy team will treat all musculoskeletal problems including common conditions such as low back pain, arthritis, and any pain that affects your joints or muscles including any sports injuries. Patients are offered an initial assessment where you have the opportunity to discuss your problems and what you would like to achieve with a Chartered Physiotherapist.

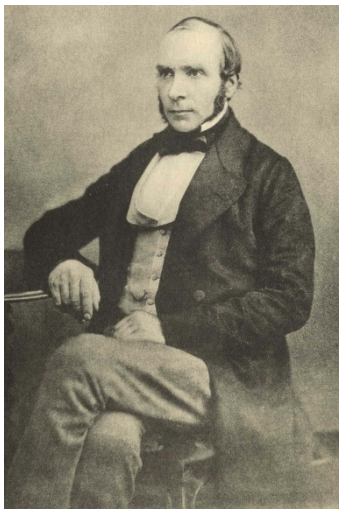
We provide individual treatment plans to all our patients, which may include advice, exercise based rehabilitation, manual therapy techniques and/or soft tissue release. Some of our physiotherapists are trained in acupuncture so this treatment will be offered to you if appropriate. At the Royal Surrey, we run several exercise classes and have a fully equipped gym to aid rehabilitation. Where this may be of benefit to you, you may also access these services at the Royal Surrey County Hospital.

All appointments and bookings/ rescheduling of appointments are managed by the Royal Surrey Physiotherapy department which you can contact directly on 01483 464153.

If you have any further questions regarding the new service, please speak to your GP or contact the Royal Surrey County Hospital and speak to Liz Head or Michelle Dawson. Comments on how we can improve our service are greatly appreciated.

Great British Doctors No 6

John Snow (1813 – 1858)



John Snow was born in York on 15 March 1813, the first of nine children born to William Snow, a labourer, and Frances Snow. At the age of fourteen, Snow finished his early education and was apprenticed to William Hardcastle, a surgeon-apothecary living in Newcastle-upon-Tyne. In 1836 Snow moved to London to start his formal medical education, became a member of the Royal College of Surgeons in 1838, graduated from the University of London in 1844, and in 1850 was admitted to the Royal College of Physicians. Early in his career he became interested in the physiology of respiration.

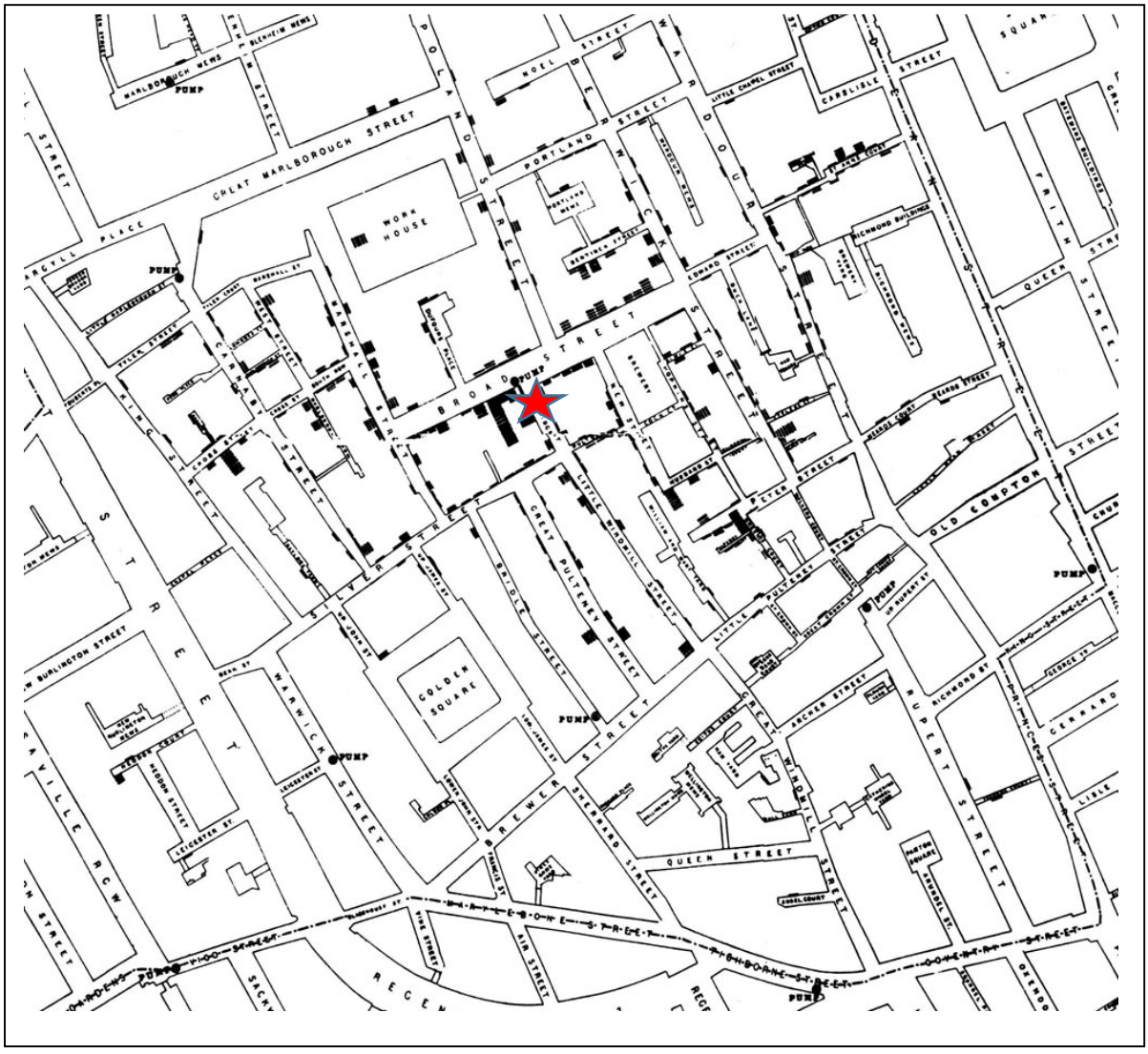
It was during his time apprenticed to Mr Hardcastle that Snow first witnessed cholera. An epidemic of cholera had struck London in the summer of 1831 and spread north to Newcastle in the October. Mr Hardcastle, overburdened by the high number of cholera-stricken patients, sent Snow to the Killingworth Colliery to treat the many coal miners who had fallen sick with the disease. At the time, the germ theory of disease had yet to be developed. The cause of cholera was not known. It was thought that cholera was caused by ‘bad air’ – the miasma theory, in which it was thought that particles, emanating from rotten

material, polluted the air and infected people who inhaled them. Snow, on examining the patients, realised the first symptoms reported in all cases were digestive problems, and reasoned that if polluted air were the cause, then the first symptoms would have appeared in the respiratory tract of patients, rather than the digestive tract.

Snow first took up residence in Soho, London in 1836, and later set up a practice there. A second outbreak of cholera arrived in London in 1848. Snow's previous first-hand experience of the disease during the outbreak of 1831-2 and his studies concerning respiration, led him to question the miasma theory still thought by many to be the cause. Through further investigation, Snow had become convinced that the causative agent of cholera was inadvertently ingested, not inhaled, nor transmitted by touch, and that the likely medium through which the agent was being transmitted was contaminated water. Snow published his ideas in the first edition of his essay 'On the Mode of Communication of Cholera' in 1849. It cost him around £200 to produce, yet his income was only £3.12s. Sadly, the journals dismissed Snow's essay, deeming it 'failure of proof', however deserving of thanks for endeavouring to solve the mystery.

On 30 August 1854, a severe cholera outbreak began in Soho, leading to more than 550 deaths within two weeks. Snow analysed the addresses of the cholera deaths and with the help of Reverend Henry Whitehead, curate of St Luke's Church in Soho, investigated the water drinking habits of the local residents through interviews and questionnaires. It was found that the majority of cholera deaths were clustered around a pump on Broad Street (now Broadwick Street), and from confirming that those who caught cholera were drawing their drinking water from this pump, Snow suspected that the pump was the source of the outbreak. Snow also had the brilliant intuition to particularly focus on the people who did not 'fit in'. For instance, there was a single case of cholera in Hampstead. A woman had moved there from Soho (before the outbreak) and after investigation Snow found that, after having moved there, she missed the lovely water of Soho so much that her son sent her water from the Broad Street pump every day. Other important examples include a workhouse near Soho of 535 inhabitants but almost no cases of cholera, and a brewery on Broad Street where none of the workers contracted the disease. It was found that both establishments had their own well or obtained water from a source other than the pump on Broad Street.

From his investigations, Snow was able to show that cholera was not a problem in Soho, except among the people who were in the habit of drinking water from the Broad Street pump. His studies of the pattern of the disease were convincing enough to persuade officials to remove the handle to the pump on 8 September 1854, although by this time the worst of the epidemic had passed. Snow later created his famous map (pictured), a map of the Soho area with all the streets and pumps marked on it. On this map he also marked, with a black line, each of the individual deaths from cholera, and it illustrates how cases of cholera were clustered around the Broad Street pump.



The cause of the initial outbreak was later determined when it was discovered that a baby from No. 40 Broad Street first contracted cholera from another source. The baby's mother had washed the soiled nappies

in water, which was then thrown into a leaky cesspool just three feet from the pump.

After the 1854 cholera epidemic came to rest, the Broad Street pump handle was replaced, and Snow's theory was rejected. To accept his theory would have meant accepting the faecal-oral transmission method of disease, which was too unpleasant for the public to contemplate.

It was not until after Snow's death that his waterborne theory was proved to be correct by German physician Robert Koch (1843 – 1910), who identified the causative agent of cholera, a bacterium called Vibrio cholerae in drinking water, and in the stools and intestines of infected patients. Notable also, the Italian anatomist Filippo Pacini (1812 – 83) in 1854 observed the microbes that cause cholera in the intestinal contents of victims in Florence – but his valuable work was overlooked.

Snow was also a pioneer in the field of anaesthetics. He made great improvements to the method of administering ether and chloroform, and personally administered chloroform to Queen Victoria on 7 April 1853 during the birth of Prince Leopold, and again on 14 April 1857 at the birth of Princess Beatrice.

John Snow died as a result of a stroke on 16 June 1858, aged 45 years old. He was buried in the Brompton Cemetery. John Snow is considered by many to be the father of modern epidemiology – the study of how often diseases occur in different groups of people and why.

Blood Pressure Readings

Following our April report on the readings from participating patients using the self-measuring blood pressure machines , we have since gathered data from a further 44 patients.

Of the further 44 readings, 23 were normal, 20 were high and 1 low.

Many of the patients were found to be already under review for hypertension by their GP and using the machines to monitor their blood pressure in between appointments, particularly following adjustments to antihypertensive medication or commencement of a new course of this type of drug.

GP appointments prompted by a high reading in a few cases resulted in changes to BP medication or consideration of this.

In the case of the one low reading, the patient was seen by the GP and appropriate action taken.

It has been found that use of the BP machine is helpful to patients who experience 'White Coat Hypertension', where a patient can have a high reading during a doctor's appointment, but outside this setting show a normal reading.

It was also found that 6 of the 44 participating patients were female and taking HRT or the contraceptive pill. In these cases it is important to monitor blood pressure, and the machines are helpful in this instance.

As Dr Leung has mentioned in the 'Changes at the Practice' article, it is advised that you hand your BP reading slip to reception, so that your BP reading can be entered into your medical record.

Primary Healthcare in India – can we help?

Professor Gautam Sen from Mumbai is a recently retired consultant surgeon and has been a long-standing and highly respected colleague of mine for at least 20 years. During that time we worked together developing training and standard setting for surgery in India. When the Medical Council of India (MCI), the equivalent of our GMC, ran into difficulties in 2010 and was dissolved by the president of India, Professor Sen was one of only 6 doctors asked to help and with some reluctance agreed to do so, but only for a short term of 1 year. His aim in retirement from surgery was not to sort the MCI, but to try to resolve the major problem of lack of primary care in India, a major task indeed. After his year with the MCI, he has spent the past 4 years developing good primary medical care (or General Practice) in Mumbai under the title of 'Healthspring'.

Healthspring has 2 Visions :

1. **Clinical Excellence**
2. **Focus on Service** to the patient and their family at the level of point of entry - Primary Care – not focused on profit.

In their constitution they state *"patient convenience, respect for patient's time and privacy, patient's concerns regarding diagnostic and treatment modalities and above all patient's safety, are one of the pillars of Healthspring's core vision. Our entire delivery of care is based on patient engagement and patient convenience, on which we place great importance.*

"*Nowadays in India, the "family's trusted doctor" has "disappeared" and been replaced by "GP's of various standards, of various qualifications". They may be trained or even not trained in alternative medicine. "The whole practice is dominated by crass commercial considerations of kick-backs and commissions". Most patients who can afford, when unwell will visit a hospital specialist who will frequently subject him to a range of unnecessary tests and usually admit them to hospital for several days for further tests, all at high expense, and commonly with no proper aim. Home visits, and certainly night-time home-visits, are a thing of the past,*

Chronic diseases such as diabetes and hypertension which can normally be treated at primary care level are all forced to be seen by a specialist who offers poor care. A single consultation, a battery of tests, a course of treatment and

no follow-up to monitor results of treatment or control progress. Patients are only seen again when complications ensue which should not happen if they were seen properly.

Patient's convenience, respecting patient's time, concerns, queries, and much more, are all ignored, "in pursuit of acquiring technological advancement in diagnostic and treatment procedures, combined with the desire to exploit them with financial gains"

Healthspring is setting up a chain of Community Health Centres taking care of an individual's or family's **routine** and **emergency** medical care needs by **preventative, curative and rehabilitative** medical care. These centres are **protocol driven** using **NICE** and **Harvard Medical School Guidelines**

Each centre will have at least 5 full time physicians of 10 to 15 years' experience and at least 1 physician will have a diploma in paediatrics and one a diploma in obstetrics. Supported by qualified nurses, paramedics, social worker, nutritionists, physiotherapists, each centre will run a chronic disease programme eg diabetes, hypertension with treatment and monitoring of care, have at least 3 consulting rooms , Xray facilities, ultrasound, basic lab facilities, a procedure room including a resusucitation room and an in-house pharmacy. All care will be patient focused and doctors not allowed to see more than 4 patients per hour.

Full records will be maintained on an Electronic Health Record to be obtainable world-wide wherever the patient may be.

The aim is to give health care at an appropriate level at an appropriate time at an appropriate site, including if needed at home as an emergency. Healthspring wants to promote preventative, curative and rehabilitative medical care of international standards.

These will be "One Stop" Health centres. Referral onwards will only be as necessary and only to carefully chosen and accredited specialists and

hospitals. Emergency Medical Event Responses will be 24 hours 365 days a year, at home if necessary.

The ultimate initial aim is 200 centres in 8 main Indian cities. At present there are 15 centres based in Mumbai with immediate plans for 4 more in the adjacent city of Pune this year. Initially Healthspring is targeting the Indian middle-class with plans to expand.

Professor Sen visited our Practice in May and spent some considerable time noting how our PPG works and discussing his plans with Dr Leung. On return to Mumbai, he plans to discuss how he may set up a system similar to the PPG system in place here at Badgerswood and Forest Surgeries and has taken our 'Aims' and 'Constitution' with him. He expressed a keen interest in developing a 'Patient Liaison Group' in Healthspring and is keen that we liaise with him and Healthspring as this develops. We are happy to be involved in this exciting system of primary healthcare as we see great potential here for India. We see this as a big step in India developing a good, honest primary care GP system.

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Practice Donations to the Nepal Disaster

Jagat Mahatara is employed by the Practice as a medical summariser. His family live in Kathmandu and following the recent earthquake disaster, he raised funds through everyone who works in the Practice for Nepal. In total he raised £585 which the practice matched. This was used to purchase rice and roofing materials as well as other smaller items. Here is a photo of the van in Kathmandu with a banner showing the Nepalese appreciation.

Changes at the Practice

We are about to lose the Back 2 Health and Premier Physio services. The CCG has decided to stop funding the AQP (Any Qualified Provider) initiative which was introduced in 2012/13 as a means of commissioning certain NHS services in England. This initiative was used to test implementation of a set of community and mental health services of which musculoskeletal services was one. From March 2014 onwards, the decision to extend this initiative rested entirely with the CCGs nationally and it was decided by SE Hampshire CCG to withdraw the funding for the osteopathy service provided by Back2Health. Our local GPs were not consulted about this change. Many patients have benefitted from their input and feedback has been generally excellent. They will continue to offer their services privately.

Other services continue to be attracted to the Practice, stimulated by our very active medical staff. We are about to see more specialist physio services and Obstetric clinics starting, provided through the Royal Surrey County Hospital. Michelle Dawson has written a preliminary report about the new Physiotherapy service for us and will follow up with a more detail article in our next newsletter.

As you know, Jonathan Winter from Professor A Chauhan's Portsmouth respiratory team has been running a project on Asthma and Jayne Longstaff will soon be starting one on breathlessness – further details to follow.

We should like to welcome Alison Sutton and Claire Rogers who are additional Practice nurses and will work across both surgeries. Many patients will know them already from their work in the community team. We hope that we can have an article from them for our next newsletter once they have had time to settle in.

The building work at Badgerswood Surgery is now virtually complete apart from one or two finishing touches. The blood pressure machine provided by the PPG is now up and running in the information area of the waiting room. If you do use this, please give your slip to reception so your blood pressure can be entered into your medical record. The 'check-in' screen is also now operational, relieving some pressure on the receptionist at busy times. We hope the waiting room screen will become active soon. There is just so much going on, and the PPG will do its best to keep you updated with regular announcements.

Practice Details

	Badgerswood Surgery	**Forest Surgery**
Address	Mill Lane Headley Bordon Hampshire GU35 8LH	60 Forest Road Bordon Hampshire GU35 0BP
Telephone Number	01428 713511	01420 477111
Fax	01428 713812	01420 477749
Web site	www.headleydoctors.com	www.bordondoctors.com
G.P.s	Dr Anthony Leung Dr I Gregson Dr H Sherrell	Dr Charles Walters Dr F Mallick Dr L Clark
	Dr A Chamberlain	
Practice Team	**Practice Manager**	Sue Hazeldine
	Deputy Practice Manager	Tina Hack
	1 nurse practitioner	

3 practice nurses
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
Secretary	Yvonne Parker-Smith
Treasurer	Ian Harper
Committee	Nigel Walker
	Heather Barrett
	Barbara Symonds
	Gerald Hudson
	Sarah Coombes

Contact Details of the PPG ppg@headleydoctors.com
ppg@bordondoctors.com

Also via forms available at the surgery reception desk

www.pinkpersonaltraining.co.uk

I am regularly updating my qualifications and hope to gain my GP referral qualification in May 2015
If any of my services or classes appeal to you
. please feel free to ring me or drop me an e-mail
Thank you.

Looking for a venue for your function or group activity?

Lindford Village Hall

offers:

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

Contact Derek Barr 01420 479486 to discuss bookings.

Bordon and Whitehill Voluntary Car Service

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

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

Our telephone number is

01420 473636

The Gentle nature of the McTimoney method makes it suitable for people of all ages. It's proven to be effective in treating the following conditions: Back, Neck and Shoulder pain.

Pain, discomfort and stiffness in joints, migraine, muscular aches and pains, sports injuries and arthritic pain. To make an appointment or for more information please call 01428 715419.

Headley Pharmacy

Opening hours

Mon – Fri 0900 - 1300
1400 – 1800

Sat 0900 - noon

Tel: 01428 717593

Visit the new expanded pharmacy in Badgerswood Surgery

Chase Pharmacy

Opening hours

Mon – Fri 0900 – 1800

Tel: 01420 477714

The pharmacy at Forest Surgery, adjacent to Chase Hospital

Both pharmacies are open to all customers
for
Prescription Dispensary
Over-the-counter medicines
Chemist shop
Resident pharmacist
Lipotrim weight-management Service

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