Patient Participation Group

Newsletter

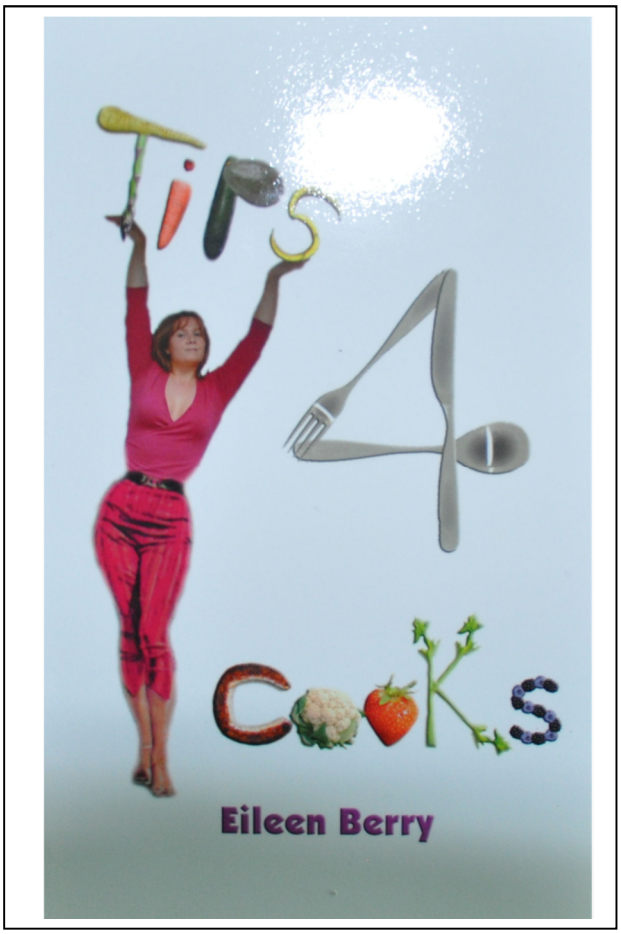
Badgerswood Surgery 'Overflow Car Park'

incorporating the

Friends of the Badgerswood and Forest Surgeries

April 2018 Issue 29

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 and Vice Chairman Report

This year we have a change in venue for our AGM. Our speaker is Rev Wes Sutton and we will be holding our meeting in Acorn in Bordon. The entrance to Acorn is just past Tesco and the Shell garage on the main street. Acorn used to own the ground that the Chase Hospital and Forest Surgery were built on. It is well signed from the main road and there is plenty of parking. Acorn has been working on 'Social Prescribing' in Bordon and is very involved with the Practice with this and has also been helping the PPG with our 1st Aid training. The AGM is on Tuesday 24th April at 7.30pm and Rev Sutton will be talking about the work of Acorn "Preserving Body Mind and Spirit".

We reproduce a copy of the article we submitted to the 'Headley Annual Report' outlining the work we had done over the past year. The Report used to go out in printed form but I think this year will be going out electronically.

Our Education Article this time is by Robert Herron, Dental Practitioner from Liphook, who has written an article for us on 'Dental Care for Patients', explaining how to avoid tooth decay and gum disease. Full of good advice and certainly well worth reading.

For our Great British Doctor series this time we have been assisted by Marcia Hammond who wrote a previous article for us on Trigeminal Neuralgia. The article is about Denis Burkitt who is famous for 2 things. Firstly he identified the tropical lymphoma of childhood which bears his name and secondly he went on to realise the problems associated with the diet of the western world and is responsible for persuading us all to eat more fibre.

We also have an article written by Yvonne Parker-Smith from our committee about the First Aid Nursing Yeomanry (FANYs) of the First World War.

We are very unhappy with the move of the phlebotomy service from our surgeries to the Chase Hospital. We wrote to the Clinical Commissioning Group and received a reply but a meeting with them was cancelled. We enclose the correspondence between us and from a patient for your consideration.

Alan Mowatt, Physiotherapist at Badgerswood Surgery, has written another article for us, this time about muscle pains brought on by cycling

and how to avoid these. If you are having problems with this, this article will explain the problems, how to tackle them and the benefits which can be afforded by good physiotherapy.

At a recent PPG committee meeting, a company 'Lifelight' gave a demonstration of a system they had developed which they wished to trial in our Practice. By shining a single beam of light at a spot on your forehead as you arrive, their machine can instantly read 4 vital signs - your pulse, blood pressure, respiratory rate and oxygen level in your blood. Lifelight have now obtained an NHS grant for this study and chosen our Practice to look into this. Not only will save our GPs time but may alert them to a problem..

Finally we are continuing to run our First Aid courses. In 2017 we trained just over 100 people in Basic Life Support. Already this year we have run 3 courses and have 4 others lined up. If you wish to attend any of our courses, please enrol through either of our surgery reception desks or via our email ppg@bordondoctors.com Courses last about 2 ½ hours and are free. We are now planning to run advanced courses for those with a Basic Life Support certificate and we have also now been in discussion with the local schools about running training courses with school staff and teachers and to set up children's training courses.

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Badgerswood & Forest Friends & Family

December 2014 to December 2017

How likely to recommend services to Friends & Family

	Total	%
Extremely likely	**609**	**78.8**
Likely	**133**	**17.2**
Neither likely nor unlikely	**12**	**1.5**
Unlikely	**9**	**1.2**
Extremely unlikely	**9**	**1.2**
Don't know	**1**	**0.1**
	773	**100**

How is our Practice performing?

In the past year, all GP Practices round the country have been compared for performance. How does our Practice rate?

Our Practice has:

- according to CCG data, the lowest rate for A&E activity of all surgeries in our area (look after your patients well and they don't wind up in A&E)
- according to hospital admissions data, our diabetic admissions are so low they cannot be disclosed because of confidentiality (you would easily identify the individuals)
- a quantified reduction in exacerbations and hospital admissions after the Respiratory Carousel Clinics with Portsmouth QA Hospital
- saved 2 patients from strokes because of the anticoagulation work last year with Basingstoke Hospital (we don't know who they are as they did not have the strokes!)
- the lowest antibiotic prescribing rate among surgeries in the Southeast Hampshire CCG, which is already known to be one of the best areas in the country
- been designated an AHSN (Academic Health Science Network) Demonstrator site (Did you see the piece on BBC South about Atrial Fibrillation?)

Over a hundred GP surgeries have closed in the UK. Ours have grown and are bringing more and more services to patients. They have a lot to be proud of. Well done Badgerswood and Forest Surgeries

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Drive for new innovation in General Practice boosted by £8.7m from SBRI (Small Business Research Initiative) Healthcare

SBRI Healthcare, the NHS England initiative championed by the 15 Academic Health Science Networks (AHSNs), today announced the companies that will benefit from £8.7 million investment to help develop novel technologies aimed at future-proofing primary care and GP services.

GPs and general practices are under serious pressure through increasing workloads not least due to more complex cases and the health challenges of an aging population. The ten funded companies all recognise current technology and pathway limitations and have looked to revolutionise how future general practice will be delivered.

The £8.7 million is the second tranche of investment the successful companies have received having been drawn from a shortlist of 22 companies that received six months feasibility funding in April 2017. The successful companies demonstrated best value and greatest technical feasibility to a panel of experts looking for game-changing technologies with the highest potential value to patients and the health service. With individual awards of between £700,000 and £1 million, the companies will be supported and fully funded to continue with product development and testing.

One of these is LIFELIGHT promoting a technology that allows for automatic vital sign measurement – heart rate, respiratory rate, blood pressure and oxygen saturation – whilst booking in with the receptionist, optimising the patient's visit and maximising time with the GP. Measurements are made by shining a light on a single spot on the patient's forehead for a moment only, to obtain the readings.

Lifelight explained how its instrumentation worked to the PPG committee and will now hope to demonstrate how its technology can not only save on GPs time by recording vital signs before the patient sees the GP but also may alert the doctor to a significant clinical problem at the start of the consultation.. Lifelight have chosen our Practice to look into this

The SBRI Healthcare team works closely with clinicians and frontline NHS staff to identify key challenges from within the service, focusing on specific areas recognised as priority by NHS England and the 15 AHSNs. The programme aims to improve patient care, increase efficiency in the NHS, and support the UK economy by helping smaller companies grow. The programme's network of innovative companies extends throughout the UK. Since launching in 2009, £75 million has been awarded to over 150 companies developing solutions for major NHS challenges such as cancer detection, dementia care, mental health in young people and self-management of long-term conditions. SBRI Healthcare supported companies are already making an impact.

Issues raised via the PPG

Phlebotomy at Chase Hospital

We have had numerous verbal comments made to us about the problems and concerns since the blood letting services was moved from our surgeries to the Chase Hospital in early January. We are very concerned about the service being provided which does not appear well thought through and is not giving a good service from the patients' point of view. We approached the Clinical Commissioning Group to make comment about this and received a reply. Recently we received a very constructive letter from a patient. We reproduce all of these here. We had hoped to attend a meeting with the CCG which included this item on the agenda, but this was cancelled.

Comment to the CCG from the PPG on 2nd February

Can I ask for instance:

1. Has the CCG counted the number of blood tests normally done weekly in this region, how many each day and will they all be covered by the number of stabs they are offering? Or do they have no idea? Does this mean there is a good chance that there will always be patients who will never get their blood tests done ***every week****?*

2. Has the CCG made plans for patients who need ***urgent*** *tests, for those who need their* ***anticoagulants monitored****, perhaps even daily in the first instance, including on a Thursday or at a weekend, as well as diabetic patients. They have obviously made no provision at all for* ***diabetic*** *patients, especially those needing more than one blood sample in a day as in a glucose tolerance test.*

3. Has the CCG calculated into this how this may affect some patients, some quite seriously

- cost of travel, especially if it involves travelling twice if unable to get a blood tests done the first time they attend - will the CCG pay their travel expenses or at least take this into account when working out the costs of this exercise

- have they looked into how patients with no cars will get to the Chase from Headley - all by voluntary care cars? - are the CCG going to pay for all of these cars? - and are they prepared to reimburse drivers who may have to sit for an excessive time in view of the fact there is no appointment system

4. Has the CCG thought about how this may affect those patients who are having to take time off work to get a blood test. It's OK to say there will be no appointments. Does this mean every patient has to take a morning off work to sit waiting hoping to get a blood test - and what will happen if they don't get their blood test on the first day but have to come back the next day - do they ask for another day off work?

5. Has the CCG calculated the DNA rate for blood sampling clinics in this area? If not, how does the CCG justify a no appointment system? They say this is to avoid an unacceptable number of missed appointments due to failure of patients to attend. It is my impression that people rarely fail to attend for blood tests. Before the CCG produce such a statement they should provide for us the actual DNA rate for phlebotomy in this area in order to justify this remark which they plan to tell our patients. We should ask them if they actually have these figures. If they don't have any figures or the rate is almost nil, they should introduce an appointment system and this should be added to their costs. I'm sure we have our own figures for this.

6. Has the CCG truly calculated the total cost savings for this change? I think we should be provided with accurate costings from the CCG for this exercise. How much does it cost to send a nurse up from the south each day - salary and expenses including fuel costs. Is there a rental charge to SHFT? On top of this however, should be included patient expenses with their travel costs, time wasted sitting and costs of lost salary in view of the 'no appointment system'. And how does this compare to the costs of the phlebotomy system when run by the Practice?

7. Has the CCG thought what happens when the nurse is unable to obtain a blood sample due to inability to insert a needle accurately into a patient with difficult veins? Normally in the surgery, expert medical help is available and other techniques can be used to assist venepuncture. Is the patient now simply sent away with no sample obtained? What then happens to the patient? Has the CCG organised what will happen in this situation?

7. Has the CCG really thought about quality of service to our patients. Have they equated which type of service would be better, both socially and clinically, comparing the system we had before to that which they have now introduced. The NHS is here to provide as good a service as possible for our patients. We regard this change produced to the phlebotomy service in our area as a marked reduction in the quality of service we have been receiving till now and we see no justification for this change from a quality of care point of view.

We ask that the CCG provides us with responses to the above points with accurate figures in order that they can show us how they justify the changes they have introduced together with SHFT for phlebotomy in this area. Until such time we ask that they delay issuing their response note which they have forwarded as a draft for comment which we find unacceptable. We regard that this note is biased implying that the sole cause of the changes which have happened is the direct responsibility of the Practice and we disagree with the impression this note gives to any patient who would receive this.

The note states that " Badgerswood Surgery gave the CCG notice to cease providing phlebotomy for their patients some time ago and as a result the CCG immediately engaged with Southern Health NHS Foundation Trust (SHFT), to arrange for them to take over the delivery of phlebotomy services for patients at Badgerswood Surgery." Following discussion with Badgerswood Surgery, we understand this statement is inaccurate. We understand that the problem was that Badgerswood Surgery gave the CCG notice that ***they would have difficulty in continuing to provide phlebotomy services in view of the funding being provided****. This note implies that the surgery was simply pulling out which was not true and should not be stated like this without stating the reason.*

We also feel that the service the CCG and SHFT have introduced has been poorly thought through and will prove to be a significant problem for many of our patients eg urgent cases, those on anticoagulants, diabetic patients, patients having transport problems, patients needing to take time off work, etc. Unless the CCG can respond adequately to show this is an improvement in patient services and not just a cost saving exercise with little thought to patient care, we ask that we return to the service as was previously provided through the Practice and then rediscuss what would be the best way to provide this service for all of our patients with the facilities we have in the most cost-effective way, and not simply looking at a cost-saving exercise. Included in this discussion should be provision of actual costs of running the service including costs to patients. We also don't want this to be seen simply as a way of trying to find a use for the Chase Hospital which is costing the CCG over £400,000 per annum rental at present to NHS Properties Services.

Response from the CCG on 9th February

Dear all,

Once again my apologies for cancelling today's Whitehill and Bordon Stakeholder meeting. Attached is the latest project report to keep you up to date on the work that has taken place since our last meeting.

Also I understand that a number of you wanted to discuss the issue of phlebotomy. The CCG is very aware of the high level of concern about this service having received a number of complaints ourselves, in addition to those which we understand are coming in to the local practices.

In response we held a formal contract meeting with Southern Health this week to pick up on a number of the issues raised, most notably the 'drop-in' nature of the service, the fact that patients are being turned away and also the allocation of certain days to certain practices.

As a result of this meeting we have agreed that the service will be available to all patients on any day of the week – we just need to finalise a date for this arrangement to start. We are also keen to move the service to bookable appointments and are exploring a couple of options. We have a follow up meeting with Southern next week and will be able to update you further after that.

I have also been made aware of a issues regarding phlebotomy for under 17s and INR so we will raise these with Southern Health next week. I hope that helps to allay concerns.

Letter received directly to the PPG from a patient Mrs I B mid-March

Sir,

<u>Re Blood Testing</u>

In response to the request via the Parish Magazine, I would like to pass on my comments re my experiences at Chase Hospital.

On the face of it the opportunity to walk in at any time between 8.30am and 12.30noon for four days a week seemed a good idea. In practice however, it is far from being ideal. My first experience on 29th January proved difficult as I had taken a hospital form (Royal Surrey) and was

told by the nurse it was unacceptable (Despite having been used by the nurses at Badgerswood on previous occasions). Fortunately there was no queue that morning and I was able to return on the same morning with an acceptable form and again there was no waiting time. My second experience on the 26th February was not so fortunate. I arrived just before 10.00am and then had to wait until 11.30am. There appeared to be various problems / reasons for this. It seemed there had been a few failures to get blood from some patients and the other reason, some people had Royal Surrey Hospital forms which were not acceptable. One lady who was in front of me and had the form from Guildford was actually a cancer patient so presumably will require frequent testing.

On that occasion I was 33rd in the queue and was told there could only be another 12 people accepted that morning. Anyone after that would be turned away and presumably expected to try again the following day. I understand that most mornings there are people waiting before the nurse arrives and the quota for the day, once reached, called a halt to the blood testing for that day. This all seems an impossible situation for people with young families, working people, people in wheelchairs (there were 2 that second morning), the elderly and those with poor health. Two people actually gave up and left and, it being a very cold day, sitting in the waiting area and then in the corridor outside the nurse's room was also quite cold. I for one did not 'thaw' out in the 1½ hours I was there waiting to be seen.

I hope you find my comments helpful,

Yours faithfully

Mrs I B.

Comment from the PPG

At the date of preparing this article (19th March) we are unaware that any of the actions outlined by the CCG on 9th February have been implemented.

The Educational Article in this newsletter
is on

Dental Care

and is written by

Mr Robert Herron BDS DPDS
Dental Surgeon
Liphook

Born in Lancashire, I spent from the ages of 6 to 18 in Norfolk, before going to The University of London and graduating in Dental Surgery from Kings College Dental Hospital in 1982.
After initially working in the Community Dental Service in London and general dental practice posts in Cowplain and Frimley, I took over the practice in Liphook in 1990. So, after 28 years I'm beginning to settle in!
In 2003 I gained the Diploma in Postgraduate Dental Studies from Bristol University.
Outside work I can usually be found walking to complete the 'Country Walking Magazine Walk 1000 miles in a year challenge' or trying to beat my allotment into submission and grow something edible.

Dental Care for Patients

The following is general advice and should not replace personalised advice from your own dentist or hygienist. There will always be exceptions to general advice.

Healthy teeth and gums can greatly affect a person's quality of life, from the social effects of being confident in their appearance to being able to chew food effectively and eat comfortably.

To achieve and maintain this status requires some effort and primarily involves the prevention and treatment of tooth decay and gum disease. This requires a combined effort from the patient and dentist, although any dental treatment is more likely to fail if the patient does not or cannot maintain a high standard of tooth cleaning (oral hygiene)

Although mainly involved with the treatment of tooth decay and gum disease your dentist may also be able to help with a range of problems involving the mouth soft tissues, the tempero-mandibular or "jaw" joint, snoring, tooth grinding, headaches, and bad breath (halitosis).

Tooth decay

For tooth decay to occur there needs to be three things present, a tooth, bacterial plaque, and sugar. Remove any one of these things and tooth decay cannot occur. I would usually not recommend having teeth removed to avoid the possibility of tooth decay, so this leaves the removal of plaque and the avoidance of sugar.

Plaque is a mixture of acid producing bacteria, food debris and components of saliva which form a soft film on the surface of teeth. If left on teeth the bacteria in the plaque will act on sugar to form acids which can cause tooth decay.

The importance of the role of sugar in tooth decay cannot be over emphasized. It is important in the quantity, the frequency and to some degree the form of intake. Sugar is contained in many foods and drinks, often not obviously and often not labelled as sugar or sucrose. Some of the more common listing of various forms of sugar which can cause decay are corn syrup, fructose, glucose, dextrose, malt, honey, and numerous others. The more often the teeth are exposed to sugar the more potential there is for decay, so it is frequent intake between meals which present the most risk, whether from food or drink.

And if the risk from sugar in its various forms is not bad enough dentists are increasingly seeing the effects of acidic foods and drinks causing erosion of teeth. This is a particular risk from carbonated drinks but it can also be caused by anything acidic, including fruits, particularly citrus; juices, wine, yoghurt, and some herbal teas.

Some good news! Saliva will help to neutralise the acid produced by plaque which is why some may advocate the use of sugar free chewing gum to stimulate saliva production (especially the gum manufacturers!). Fluoride in toothpaste can help strengthen the hard enamel which is the outer layer of teeth.

So, to prevent tooth decay I would suggest the most important things anyone can do are

1. Make sure teeth are cleaned *effectively*
2. Limit the amount of sugar consumed, especially between meals.

Gum disease

Along with treating tooth decay, the prevention and treatment of gum disease can form a significant portion of a dentist's work.

As with tooth decay, gum disease is caused by the presence of plaque round the teeth at and below gum level, albeit there are different bacteria present to those which cause tooth decay.

Healthy gums should be a light pink colour, firm and should not bleed when teeth are cleaned. Gum disease is first seen as *gingivitis.* Here the build up of plaque where the gum meets the tooth causes inflammation of the gums and they appear red and swollen and they will easily bleed, usually seen when tooth brushing. At this stage effective cleaning can fully reverse the gingivitis.

If gum disease progresses, the next stage is *periodontitis.* This is where the inflammation of the gums causes loss of the underlying bone which supports the teeth. This can lead to the teeth becoming loose and eventually to loss of teeth. The progression of gum disease can vary greatly, some people seem more susceptible than others and conditions such as diabetes can make the disease worse, as can smoking.

So, to prevent gum disease I would suggest the most important things anyone can do are :

1. Make sure teeth are cleaned *effectively.*
2. If you smoke, stop (I realise this is easier said than done!) – and if you don't, don't start! Gums really don't like smoke. And just to make things worse for those trying to give up, the current evidence seems to indicate vaping isn't much of an improvement on smoking as far as gum health is concerned.

Tooth brushing is the most common way to clean plaque off teeth, but it is important that the cleaning is done *effectively.* Plaque is easy to remove but effective cleaning is all about technique rather than scrubbing your teeth as hard as you can. Hard brushing of teeth can lead to gum recession and wear of the tooth, usually where the tooth meets the gum, and this can become temperature sensitive.

It is important that the area between teeth is also cleaned and this may require floss, interdental brushes and/or interspace brushes. All surfaces of the teeth need to be cleaned, not just the biting surface.

I would suggest using a medium or soft brush with a small head, if using an electric brush my preference would be for one with a small round head. An interspace brush has a small tuft of bristles. Inter dental brushes are like small bottle brushes and come in different widths.

When brushing, the bristles of the brush need to be angled at about 45 degrees, so they are worked just under the gum with a small, gentle circular movement. Interspace brushes are gently worked along the gum line and between teeth.

A build up of calculus, which is a hard deposit which can form both above and below the gum can make teeth more difficult to keep clean and harbour plaque. This can be removed by your dentist or hygienist using specialized instruments

Where there is enough spacing between teeth an interdental brush can be used. A selection may be required to match the brush width to the size of the gap between the teeth.

Disclosing tablets which stain plaque, can be useful to identify areas which need to be cleaned more thoroughly.

Your dentist or hygienist is the best person to advise on the most effective way to clean your teeth. Google or You Tube can also give some useful communications (and some not so useful) so your dentist or hygienist is the best source of personalised advice.

I would advise the use of fluoride toothpaste (most are) and after brushing spit out and don't rinse. Don't brush teeth for at least half an hour after eating or drinking acidic foods and drinks. Thorough cleaning is particularly important at night when saliva flow decreases so the protective effect is reduced. Except in specific circumstances there is little good evidence for the use of mouthwashes, but if you choose to use one I would suggest one which is alcohol free.

Your dentist can recommend how often you should have your teeth checked and if necessary, cleaned. An examination may also include the soft tissues of the mouth and can involve more than just teeth and gums. I generally recommend everyone has at least an annual examination.

From a personal perspective in practice I would suggest to patients if they have any concerns about any aspect of their oral health to have it checked by their dentist sooner rather than later.

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NEIGHBOURCARE
HAMPSHIRE
VOLUNTARY CARE GROUPS

Bordon and Whitehill

Voluntary Car Service

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

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

Our telephone number is 01420 473636

Cycling and Avoiding Common Injuries

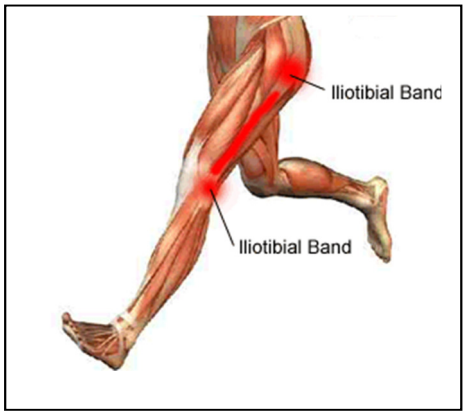
Badgerswood's Private Physiotherapist Writes.

Now that Spring is in the air and, buoyed by recent British cycling successes on the track and road, thoughts turn to outdoor pursuits once more. A perfect time then to address common musculoskeletal problems associated with cycling.

Cycling is an excellent form of exercise but it can also result in simple, avoidable injuries. Here, we discuss two prime examples and ways in which to avoid them.

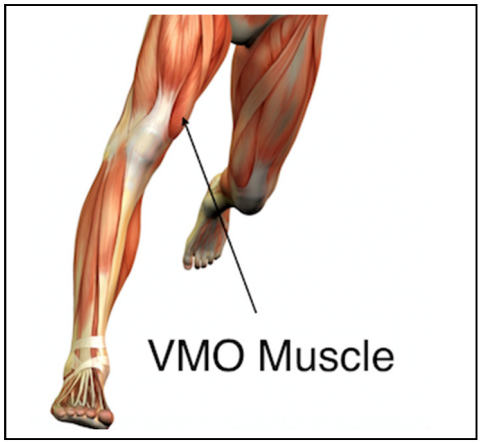
One very common problem is iliotibial band (ITB) tightness leading to hip pain, knee pain or both. The ITB is a connective tissue structure, running between the hip and knee along the outer thigh.

It helps provide lateral stability to the knee and assists with muscle contraction. However, it can also cause a problem known as ITB syndrome. In this syndrome, the tight ITB begins to rub across the structures at the hip or knee. This can start to cause inflammation and eventually damage these structures, resulting in pain and inability to exercise.



To prevent ITB tightness occurring, simple stretching exercises should be added to a

keen cyclist's routine. One method to achieve this is with a foam roller, gently working along the length of the ITB to release the tightness. This may need some guidance from a physiotherapist to tailor the exercise for the individual, but normally resolves the issue very well. Should there be any underlying minor tissue damage, this can again usually be quickly resolved with physiotherapy.



Another similar condition that affects cyclists is a quadriceps muscle imbalance at the kneecap known as VMO insufficiency. The oblique fibres of the vastus medialis muscle (VMO) are important in stabilising the kneecap and, in VMO insufficiency, can lead to pain at the front of the knee itself. In this condition, the muscle on the inside of the knee (the VMO) becomes weaker than the muscles on the outside of the knee. This, in turn, causes the kneecap to pull slightly outwards during exercise and eventually can lead to pain and swelling. Often, this is caused by the cycling position itself and modifications to the saddle height and gearing can make a huge difference.

However, physiotherapy for the VMO muscle should also be focused to improve its strength and function. A simple exercise that can achieve this is to slowly dip up and down on the affected knee, as if slowly descending the stairs. This targets the medial knee muscles and can be very effective. There are many different exercises that can also achieve this and a physiotherapist can guide you as to the best options, as well as treating any underlying problems.

Both of these commonly occurring problems are easily preventable. They are often resolved with simple exercises and addressing the cycling position. However, should you require further assessment and treatment of these or similar symptoms, contact Badgerswood Surgery's private physiotherapist Alan Mowatt on 01428 609975 or email backtogetherphysiotherapy@gmail.com.

Article submitted to the 'Headley Annual Report' 2018

Patient Participation Group of Badgerswood Surgery

On looking back over 2017 the PPG has achieved much. Our membership now stands at over 100.

We are on the 27th edition of the newsletters. Most go out electronically. We encourage as many people as possible to give us their email addresses so we can send out copies directly. All members are guaranteed to receive copies either by email or delivered directly. We now distribute about 500 copies. Please contact us if you wish back copies. In addition to information about the Practice and communications received from patients, the newsletters contain Educational Articles and other relevant health news from the region and topics of interest health-wise.

Every newsletter also contains an article about a Great British Doctor. There is no shortage of British doctors who have made outstanding contributions to medicine. Each article is a brief snap-shot and we now have a sizable collection.

In the last Annual Report we were encouraging the Practice to install a new telephone system. This is now well established and seems to be working well. We also were awaiting the results of a Care Quality Commission report. We were disappointed to be rated only as 'good'. We all think the Practice is 'Outstanding' and still think the CQC got this wrong.

We have now established a very enthusiastic 1st Aid training team. Encouraged by the donation of the use of a set of 6 manikins and kind donations of a digital projector from Dr Clarke and funds from Headley Voluntary Care and Frensham Cycling Club to purchase mock defibrillators, we run Basic Life Support courses to Resuscitation UK standards. We have now trained over 100 people in Headley, Bordon and surrounding areas. In 2018 we plan to continue these courses, to expand into more advanced courses and to run trainer courses. All these courses are free, our aim being to instruct as many people as possible in Basic Life Support and how to use a defibrillator. We have had support from many areas especially Headley Church Centre and ACORN Christian in Bordon who have offered facilities to us for training. Contact us if you wish to attend a course.

We hold 2 formal meetings a year. Our April meeting is our AGM and is open to everyone. This year our speaker was the Interim Chairman of Southern Health, Alan Yates, who spoke about the problems faced by Southern Health, his role as a 'trouble-shooter' and what the future should hold.

The autumn meeting is for members only and this year was based on MISSION ABC, and the research work involving the revolutionary respiratory group developed by Prof Chauhan in Portsmouth with which Badgerswood has been involved.

Earlier this year we had a social event at which Keith Henderson and Steve Hills entertained us in the Church Centre. This was organised by committee members Barbara, Liz, Heather and Gerald and was a sell-out. Another event is being planned this spring. I recommend you be quick if you want tickets for this.

We have now produced a 2018 calendar. Members provided monthly photographs of local scenes for this. The calendar is now printed and copies are still available at time of writing this article. All funds raised are for Practice equipment. We think this is a very professional item.

And for 2018? What do we plan in addition to communicating to our patients through the newsletters and meetings?

We're planning another social evening and advancing our 1st Aid training programme.

We now know the sites of almost all the defibrillators in our surrounding areas. We hope to produce a map of these sites, and their availability. We also plan to approach every company with defibrillators to enquire if their staff are fully trained and if not, we are happy to instruct if desired. And we want to continue to assist our Practice in its research programmes. And another calendar? It depends on how well this present one has sold. And to continue fund raising

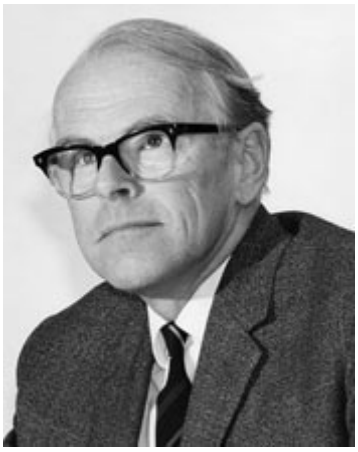
We're always looking for help. Our contact address for any newsletter item, to join the PPG, an article for the newsletter, to attend a meeting or course, or whatever else you want to discuss, is: ppg@bordondoctors.com or via surgery reception

699 words

Great British Doctors No 16

Dr Denis Parsons Burkitt

(28 Feb 1911 – 23 Mar 1993)



Introduction

Imagine how you would feel if someone said this about you*:*
*"At the beginning of our careers, each of us has the dream of someday making a discovery that will change the way our respective disciplines regard something we now regard as fact. Denis Parsons Burkitt was able to change the course of our thinking twice in his career. More remarkably, the two discoveries were, to the casual observer, in widely different fields of study" (*Story and Kritchevsky in their biography of Burkitt).

Burkitt made two outstanding contributions to medicine. He discovered the first human cancer to be caused by a virus and discovered how to treat this successfully. He is also the man who forced the whole world to take dietary fibre seriously. All this is remarkable as he had no training in research or nutrition!

Early life and medical training

Denis Parsons Burkitt was born in Enniskillen, County Fermanagh, Ireland on 28th February 1911, the son of James Parson Burkitt a civil engineer. He was schooled at Portora Royal School in Enniskillen and Dean Close School in England. Aged 18 he followed his father, entering Trinity College, Dublin to study engineering, but while there he had a career change and transferred to medicine. By the time he qualified as a doctor, his chosen career path was in surgery and in 1938 he became a Fellow of the Edinburgh Royal College of Surgeons.

After war broke out, Burkitt joined the Royal Army Medical Corps serving under His Majesty's Colonial Service from 1941 and based initially in England then moving to Kenya and Somaliland. On 28 July 1943 he married Olive Rogers.

An unusual tumour

After the war Burkitt stayed on in Africa and settled in Kampala, the capital city of Uganda. While there in 1957, he noticed a child with a tumour of the lower jaw unlike any he had ever seen in the UK. Soon after, he spotted another child with a similar problem: '*"About two weeks later ... I looked out the window and saw another child with a swollen face ... and began to investigate these jaw tumors."*

A search of the hospital records confirmed that these tumours were common. Burkitt obtained a small grant and wrote to all the surrounding hospitals in Uganda enquiring about their experience with these tumours. It became apparent that they were restricted to the north and northeast of the country. An initial publication of 38 cases attracted little interest but undaunted, Burkitt persisted and in 1961, presented a lecture in London of what he called a 'Lymphoma belt'. By chance, in the audience was a virologist called Epstein who was conducting laboratory work on virus-induced tumours in mice. Epstein approached Burkitt to ask for specimens of the tumours in the African children. Within these specimens, Epstein identified viruses. This proved to be the first virus-induced cancer identified in man, now named Burkitt's Lymphoma.

Realising that surgery and radiotherapy had little effect on the life expectancy of patients with these tumours, Burkitt obtained some early chemotherapy. Amazingly, one dose of cyclophosphamide melted the tumour away. Recurrence however was not uncommon.

Viral origins

The virus, now known as the Epstein-Barr virus (EBV), is one of the commonest human viruses world-wide and is also the cause of Glandular Fever. It is transmitted mainly through saliva and – in those with a competent immune system - often causes no ill-effects other than a mild fever. Once infection occurs, the virus remains in the body and affected people become 'carriers' i.e. have the virus which they can transmit to others but have no ill effects from it themselves. It is thought that about 50% of children in the western world have been infected with EBV by the age of 18 months without experiencing any major viral illness.

Further clinical work has shown that children with the EBV-induced tumours in Africa all live in the malaria belt and almost all suffer from

chronic malaria, which reduces their resistance to infection. As a result, when infected by the virus they experience massive lymph node ('gland') enlargement in the neck and cannot clear the virus from their system, eventually leading to a lymphoma (lymph gland tumour). The tumours are most prevalent in the same geographical areas as chronic malaria.

A new medical interest

By 1964, clinical work had lost its appeal. Burkitt returned to London and continued to work with the Medical Research Council. While there, he read a book published in 1966 by the naval surgeon T L Cleave who blamed many diseases of modern civilisation on consumption of highly-refined foods such as sugar and white flour. Burkitt had been comparing the incidence of certain diseases in the UK and Africa and found that in the latter there was an almost total absence of gall-stones, varicose veins, haemorrhoids ('piles'), carcinoma of the colon and colitis. Rather than being caused by people in the UK eating highly-refined foods, he wondered if the differences were due to lack of fibre – particularly bran – which is removed in the production of highly-refined foods.

To follow this up, Burkitt sent countless letters to hospitals in middle Africa enquiring about local diet, especially the availability of refined foods, and incidence of 'western type' diseases. From the information obtained, he proposed that the high incidence of many western diseases related to the eating of a low-fibre diet. He wrote countless papers and gave innumerable lectures which were always well-attended. Some of his data may have been questionable, but his ideas matched and were accepted by many. Because of Burkitt, enthusiasm for a high-fibre diet – in order to reduce the incidence of 'western style' diseases – caught on, and we are still indebted to Burkitt for his work in this field.

Few men can have achieved so much in their lifetime: the first person to identify a human tumour caused by an identifiable virus as well as the first to postulate the probable relation of a low-fibre diet to major western diseases. However, the effect of dietary changes on the incidence of these diseases in the western world as a result of Burkitt's hypothesis, has been questionable. The incidence of colon cancer in the UK has remained static (it has fallen only slightly in the USA). It is possibly difficult to get people to make the necessary degree of changes in their diet: our idea of a 'high-fibre diet' does not match the levels of dietary fibre eaten in African countries. But conversely, there is no doubt that adoption of a more western style diet in third world countries has resulted in a higher incidence of western diseases, supporting Burkitt's hypothesis.

F.A.N.Y IN WORLD WAR ONE

I had been listening to a talking book from Bordon Library. It was fiction however it was all about a suffragette who had volunteered for the FANY. Apart from this being a mildly amusing acronym, I had never given these corps of women much thought until I listened to this book. I thought you may also be interested

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FANY stood for First Aid Nursing Yeomanry. It was founded in 1907 by Captain Edward Baker. British Society was very much male dominated in 1914, and many in the military and political field held the view that a woman's place was in the home. When WW1 was declared, there was no obvious role for FANY as the military felt that war was the territory of men.

FANY did have some support – from the Royal Army Medical Corps. Grace Ashley Smith and Lilian Franklin ran FANY but no-one at a senior level in the British Army was sympathetic to them. FANY recruits decided to assist in Belgium where they were welcomed. They carried out sterling work in hospitals, they even set up their own hospital in a convent! FANY's drove ambulances and set up soup kitchens and a lot of them were put in touch with the front line and considerable danger. They also brought over to the frontline a mobile bath nicknamed "James" which carried ten collapsible baths.

In 1915, they received more recognition from the British Army. . One officer referred to them as "neither St Johns, nor Red Cross – in fact neither fish, flesh nor fowl but rather damned good herrings". They were given a base in France from which to run as a hospital – the Casino.

There is a story of two British soldiers – one asked the other where the name FANY had originated – the reply was "probably First Anywhere".
After WW1 ended, many FANY's stayed on in France and Belgium and continued to work there. They provided a guard of honour when the body of Edith Cavell was returned to Britain.

The FANY's won seventeen Military Medals, twenty seven Croix de Guerre and one Legion d'Honneur. I think this served to prove wrong those who had held the view that a woman's place was in the home.

Yvonne Parker Smith

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