Patient Participation Group

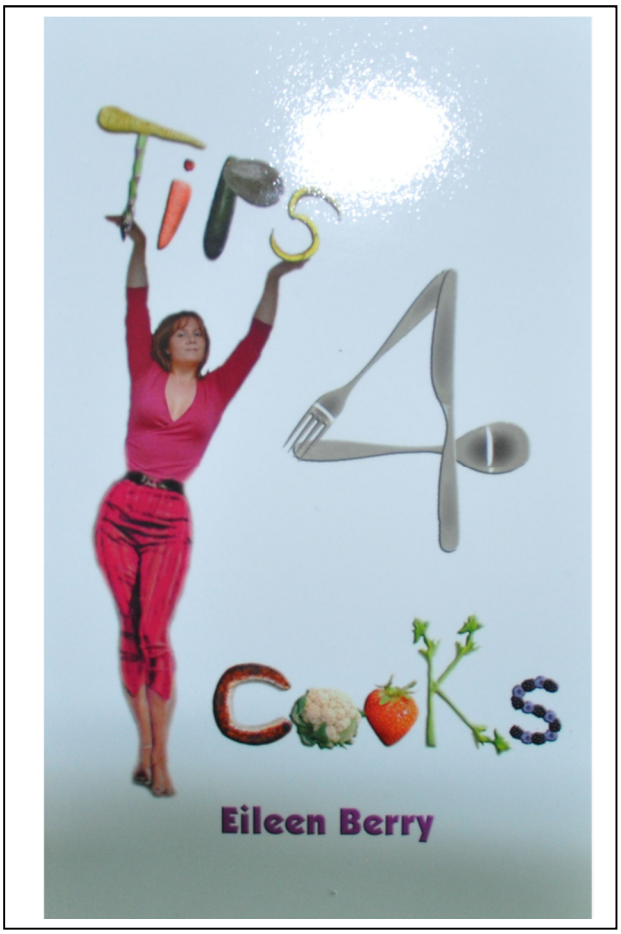
Newsletter

incorporating the

Friends of the Badgerswood and Forest Surgeries

July 2018 Issue 30

Fundraising – Tips 4 Cooks



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

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

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Chairman / Vice-chairman report

We are delighted to say that we now have help in the production and editing of our newsletters. Marcia Hammond has previously written an educational article for us on Trigeminal Neuralgia. In this issue, she has written our educational article and also our 18th Great British Doctor article, as well as helping to edit this newsletter.

This newsletter contains articles on the following:

1. An Educational Article on the increasing problem of short-sightedness in children. If ever you needed a reason to persuade your children to get outside more to play, this is it. I urge you to read this article
2. Are you a blood donor? Our 18th Great British Doctor article is about the obstetrician, Dr James Blundell, who is credited with having given the world's first successful blood transfusion.
3. The phlebotomy (blood-letting) clinic which was moved from the surgeries to Chase Hospital looks as though it may be moving back thanks to patient, doctor and PPG persistence.
4. Basingstoke Hospital is responsible for 5 clinics and the X-ray services at Chase Hospital. It plans to close these down in the near future and move these services to Alton.
5. Southern Health Foundation Trust, after a rough period of poor performance 2 years ago, has now been steadily making major improvements as recorded by the Care Quality Commission (CQC). Penalties levied recently as a result of the past problems have come back to plague present and future plans.
6. 1st Aid Training by the PPG continues but now is pursuing a different pathway. We are heading down a route which we hope will achieve a safer environment for the 'Golden Hour' forever in the future.
7. Did you attend the AGM in April? The minutes are reproduced here.
8. Are you a regular athlete? Are stretching exercises before and after of value? Read on to see what a professional physio has to say.
9. Read a personal note from an A & E professional when faced with an impersonal communication from an administrator.

Issues raised through the PPG

The following comments have been directed via NHS Choices. We have had no comments directly to the PPG

Forest Surgery now has 3.5 stars

Impossible to join this practice
Twice I have tried to join this practice and on both occasions I have been denied. They say it's because I already have a GP elsewhere already. I have tried to explain to them that I am not happy with my current GP and I wish to register here with a new doctor.
Their excuses were that they are only taking on patients who don't have a current GP, and that I would have to put in a letter as to why I want to join this practice. This is total rubbish, as it states clearly on the NHS website that you do not have to put anything in writing about why you want to leave your current GP if you are not happy with them.

Again I have been fobbed off by the miserable looking and very unsympathetic receptionist.

I've paid into the NHS for all of my working life (31 years) and am a UK citizen.
I am in poor health at the moment and would appreciate some form of communication regarding this matter.

If this email is read by somebody in authority, please give me details of where or who I can make a formal complaint.

Reply from Deputy Practice Manager

Thank you for your comments. There is currently a very high demand from people wanting to register at the practice. Due to this we are trying to register people in a safe and controlled way.
If you would like to discuss this further please contact the practice.

To say thank you
The staff are very helpful and the Doctors are very professional. We are happy to go to see the Doctors as they are calm and not hurried and will listen to you.

Good surgery
All the staff from receptionist, nurses and doctors have always been professional and helpful. They don't make you feel rushed. They have always been on hand to offer advice when needed and the services that the surgery offers are good and varied.

Badgerswood Surgery now has 4 stars

Quality of all aspects of care
Although my Wife & I have only been attached to this practice for about 2.5 years we already knew some of the current Doctors from other practices. We now consider ourselves very lucky to be looked after by this group of professional people & their staff. We are very aware that some members of the public like to be seen exactly on time but I would ask those people to bear this in mind when they have a difficult problem themselves and take up much more than the allotted time.

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Badgerswood & Forest Friends & Family – 2015 - 2018

How likely to recommend services to Friends & Family

	Total	%
Extremely likely	**711**	**78.1**
Likely	**159**	**17.5**
Neither likely nor unlikely	**15**	**1.6**
Unlikely	**10**	**1.1**
Extremely unlikely	**14**	**1.5**
Don't know	**1**	**0.1**
	910	**100**

as at June 2018

95.6% extremely likely or likely to recommend our Practice

Phlebotomy

As many of you will be aware, both as a result of requiring to use the service and from previous articles in our newsletters, the Clinical Commissioning Group of SE Hampshire withdrew funding for our phlebotomy (blood-letting) services from our Practice and asked the Southern Health Foundation Trust (SHFT) to provide this service at Chase Hospital from 19th January.

The move was done without agreement of the Practice and was badly thought through both by the CCG and the Trust. As a result, many patients have been inconvenienced by this change. The CCG has received numerous complaints from patients, from the Practice and from the PPG.

We, at the PPG, wrote a lengthy note to the CCG outlining the problems which had arisen because of this change and have attended several meetings where we have raised this issue for discussion. We have also complained several times to the SHFT, both by note and by direct conversation with the Chairman. All complaints we received from patents who contacted us directly, were redirected to the CCG. We are not alone in how vocal and constructive we have been with this matter.

As a first move, the CCG agreed to introduce a system of booking appointments starting on 19th June.

However, at a meeting with the CCG on Friday 8th June, the CCG have agreed that this clinic is not working well and will now make moves to return this service back to the surgeries. No date has been set for this but certain conditions will need to be agreed before this happens, not least the question of adequate funding from the CCG to the Practice.

In this regard the CCG may have a problem. They provide funding for phlebotomy services for all Practices throughout Hampshire. Many are run in different ways and costing of these thus varies from area to area. The CCG may have a difficulty to resolve the change in this clinic if the request to return the service to the Practice results in a request for funding which exceeds that of many other practices. Funding for phlebotomy really has to be seen to be equally shared throughout SE Hampshire.

Services provided by Hampshire Hospitals NHS Foundation Trust at Chase Community Hospital:

Clinics and X-ray facilities at Chase Hospital are provided by several providers. One of these, Hampshire Hospitals NHS Foundation Trust / Basingstoke Hospital, wishes to withdraw and move all the services it provides to Alton. At a local meeting Basingstoke explained that consultant time and costs were proving too much, clinic numbers appeared to be dropping and they regard our area as being too peripheral for them to reasonably continue to service.

Basingstoke runs the following services at Chase Hospital:

- X-ray department
- Ear nose and throat
- Audiology
- Maxillo-facial
- Paediatrics
- Midwifery

According to their presentation, numbers of people attending these clinics are small and reducing. Taking into account consultant travel time to Chase Hospital, it is becoming more difficult for the Trust to justify spending consultant time and finance on servicing these clinics and the X-ray department. All these services are already in place at Alton and the Trust wishes to close the clinics in Chase and hopes that patients will now attend Alton. Transport difficulties were discussed. The increase in numbers of population over the next 10 years with the probability that clinics would expand during this time, were discussed. But apparently these factors have all been taken into account in the decision to close these services.

The Clinical Commissioning Group had been unaware that this change was about to occur but have now been in discussion with Haslemere Hospital and Royal Surrey County Hospital in Guildford to see what services they can provide for our region to replace these if Basingstoke does close these services as it indicates.

It should be noted that there are no plans to alter any of the services delivered at the Chase Hospital by any of the other providers.

How would you penalise the Trust? The Chairman's opinion

Southern Health Foundation Trust (SHFT) went through a difficult time two years ago following the deaths and mishaps with several patients under their care. The cases hit the news and every new problem hitting the Trust seemed to be reported on the BBC national news for weeks. The Care Quality Commission (CQC) visited the Trust and placed it in 'Special Measures' with at least seven major problems needing urgent attention.

Times have changed for the Trust. The chairman, chief executive, all the non-executive directors (NEDs) and most of the governors have now changed. A temporary chairman was appointed as a 'trouble shooter'; Mr Alan Yates, and he came to speak to us at our AGM in 2016. Within six months of the change of chairman and CE, the Trust was re-inspected by the CQC, and all but one of the special measures were withdrawn, the other concerns having been either dealt with or being handled in such a way that the CQC were comfortable with the progress being made.

The Trust now has a new chairman, Mrs Linda Hunt, and a new CE. The job descriptions of the NEDs were changed and new appointments were made of people carefully chosen to fulfil the requirements of the new posts. Assistance was sought from Tyne and Wear Trust, which had been given an outstanding rating by the CQC, and was willingly given.

The Trust still has a way to go but is now clearly handling all the deficiencies and problems which were present in its previous existence. The CGC is due to revisit soon but all the Special Measures have been withdrawn and good progress is being made. The whole atmosphere of the Trust has changed with more open-ness and freedom of discussion between all levels of staff and of patients, and a willingness to take note of all comments, constructive or otherwise. There is an aim to try to make this Trust now one to be admired, respected nationally and a Trust to be proud to work in.

However, the problems of the Trust from two years ago were still under discussion at a higher level, relatives of two of the patients who had died bringing these cases to court. The Trust accepted the faults which had led to these deaths and did not contest that they had been at fault at the time. The situations which resulted in these deaths have now been fully handled and will not happen again.

How would you deal with this from the court's point of view? The cases came to court earlier this year and the Trust was fined £2 million. This has come straight out of the Trust funds being used for patient services.

We therefore have a situation where a Trust, which was struggling and is making huge efforts to resolve its problems and is now just starting to get its head above water, which has to fund on-going services this year and has had plans to use what little excess funding it has to develop new methods and ideas, suddenly loses about 4% of its annual budget this year. The Trust is now struggling to fund all its essential services for the rest of this year and will certainly have little funding to plan significant changes for the future as had been hoped and planned.

Was this the right way to penalise the Trust at this moment in time? Could some system not have been put in place whereby, if the Trust was seen to be driving forward to resolve its deficiencies and trying to develop new and improved strategies to make patient care better, the penalty would relate to the Trust's activities and not now penalise it financially but try to encourage and support it to get better. The courts have almost brought the Trust to its knees.

By doing what it has just done, the courts are now making things even more difficult for our Trust. Of course the Trust will manage to continue to provide essential services but this fine will undoubtedly have an effect on the services the Trust can now provide for several years into the future. Surely the courts must have been aware of the effect this fine would have on the functioning of the Trust. It certainly has been an unhelpful, and I think unthoughtful, move by them. We need to think of our Trust and how we can support it, as the Chairman, CE, Trustees, NEDs, and governors, try to bring this ship back into line.

NHS frontline staff watch children die, but managers tell us to keep it to ourselves

I find it naive a data manager can tell me that, having kept a stiff upper lip at work during an awful shift, I cannot tell the person closest to me a bit about my day

It was fitting that I received my information governance questionnaire on the same day that a little girl died. It was distributed by management at work, so I dutifully worked through the multiple choice questions that checked whether I knew to not share my computer passwords or look at my workmate's blood results.

The last question stopped me in my tracks, and paints a comedic picture of the distance between NHS and middle management. "You've had a very difficult shift with a very unwell patient and your partner asks how your day was. What do you tell them?" Clearly the correct answer would have been "nothing".

These questionnaires are compiled by the NHS Trust that I work for. They accompany the guidelines we're issued, which outline a number of elements, including the need for retaining confidentiality of our patients, which is of course crucial. However, on this occasion it suggested that even discussing our day in the vaguest of terms could constitute a problem. This is not the first time I've been faced with NHS guidance that makes me question the management priorities at play.

I doubt any of the data governance managers were in the resuscitation room when the four-year-old girl arrived. A number of my intensive care and emergency colleagues were, however.

She had fallen from a great height in a tragic accident. An air ambulance doctor and paramedics tried desperately to treat her injuries at her home, but it was clear that little could be done when she arrived lifeless to our hospital. Further desperate attempts were made to save her life until finally, an hour and a half after the accident that would change many people's lives forever, the team took the decision to stop.

I'm glad I wasn't there. During seven years spent predominantly in intensive care and emergency departments, I've seen awful things happen to adults that I can rationalise and desensitise myself from, but I have yet to master the art of hiding behind the uniform when it comes to children.

Seeing a child or baby die suddenly is horrendous. You can try your hardest to regard them as just another patient, but seeing them lying there in their toddler clothes, or a mum and dad coming to say goodbye and restarting CPR in their desperation, threatens to tear you apart there and then.

Afterwards, in thick silence, the team slowly evaporates, and you disappear to a quiet corner with a cup of tea to pull yourself together before seeing the next patient as if nothing has happened.

So I find it slightly naive that a data manager tells me that, having kept a stiff upper lip at work for the remainder of an awful shift, I cannot tell the person closest to me a bit about my day. Of course, I would never allude to a patient's name, occupation, or anything whatsoever that threatens to reveal their identity – this is deeply ingrained into my being since my first day in a medical school lecture theatre.

I hope that my colleagues who dealt with that awful incident did go home and if they wanted to, felt able to tell their partners or families they had an awful day because they failed to save the life of a little girl who was involved in a terrible accident.

Working in today's NHS is becoming more and more intense, and there is less and less time to decompress and reflect with our colleagues. Screwing down the release valve of our support networks outside work is absurd, and has nothing to do with confidentiality. It threatens our own mental health and our personal relationships. Had I wanted to be involved with remarkable work, see awful things and maintain an impermeable code of silence with those close to me, I would have joined MI6, not become a doctor.

In my incredulity, I read the information sheet which came with my governance questionnaire to see the official line on finding support. It recommended that clinical staff arrange a meeting with their line manager to discuss difficult issues stemming from work.

There certainly is a role for discussion and reflection with colleagues following traumatic events, but even these sessions are not protected from the onslaught of work. My intensive care colleagues involved in the death of this little girl participated immediately afterwards in a "hot debriefing", the current protocol for a paediatric death.

However, they had to leave halfway through due to another cardiac arrest call on an adult ward. The irony was lost on nobody, and I know from my own experience of kids dying that debriefing sessions are arranged with the best of intentions, but we are often too snowed under with clinical commitments to even attend.

While I present a florid example, such prescriptive and short-sighted guidance is released almost daily from on high. While it is, ostensibly, well-meaning, it can be difficult for those who have never laid their hands on patients to criticise in a way that is sympathetically understood. Likewise, we trudge knee-deep through paperwork and safety questionnaires; a battle-worn army of frontline clinical staff who have become overburdened by administrative departments which are increasingly a means to their own end.

My colleagues continued their day with admirable professionalism, both the consultants with their own young children, and the juniors who were inexperienced in such tragedy. I know it will have dug away at them all day however, even though, like me, they would have felt a ridiculous embarrassment in admitting it.

In hospital medicine the show just goes on, and putting tragedy to one side until you get home is part of the required professionalism. Bottling up such terrible events is not, and this clueless guidance tells you everything you need to know about the growing disconnect between frontline NHS staff and the politicised managers cast above us.

If only confidentiality would allow it, I would ask them to join me to see life and death playing out daily on our intensive care unit. I wonder, then, if they could manage to live behind their own wall of silence.

The Educational Article in this newsletter
is on

Myopia (short-sightedness) in children

and is written by

Marcia Hammond

assisted by

Mrs Zaman, optician,
Grayshott

This is the second article Marcia has kindly written for us. She previously wrote for us on

Trigeminal Neuralgia

In addition she has written our ‘Great British Doctors’ article for this newsletter

Children may see better if they go outside more often

A ‘hot topic’ in the ophthalmic professional press in recent years has been the discovery of factors which may be associated with short-sightedness. One of these includes the importance of exposure of children’s developing eyes to the outdoors.

Short-sightedness

Short-sightedness (myopia) is difficulty in seeing into the distance and – depending on its severity – it can lead to difficulty in reading a car number plate at a distance or seeing what’s written on a whiteboard or screen from the back of a classroom. Short-sightedness often begins in childhood, becoming progressively worse with age until growth stops and possibly requiring spectacles at some stage. It often results from the eyeball growing too much and becoming too long in its horizontal axis. This means that light rays are focussed by the eye’s lens to a point that is in front of, rather than being on, the retina. This results in the images of distant objects being blurry and indistinct.

A high degree of short-sightedness is associated with a risk of developing other eye conditions including glaucoma (raised pressure inside the eye), cataracts and detached retina. The earlier short-sightedness starts to develop in children, the worse it tends to be, so anything that prevents it or slows its progression is advantageous.

Short-sightedness is increasing

In some parts of the world such as urban areas of East and Southeast Asia, short-sightedness is reaching epidemic proportions. In these areas, 80-90% of high school graduates have the condition, with 20% having a high degree (defined as up to minus 6 dioptres) of short-sightedness. Although not increasing as rapidly as in Asia, the proportion of people with short-sightedness has also been growing in Europe (including the UK) and the Middle East. Globally, the increase in the number of cases of short-sightedness is of concern.

What causes short-sightedness?

For a long time, it was thought that short-sightedness was a genetic defect and passed on through the generations. But in recent years, researchers have put forward a number of other factors which may be related to the development, or progression, of short-sightedness. In some cases it is difficult to ‘tease’ these factors apart. For example, it has long been thought that short-sightedness is associated with better education i.e. the more hours spent studying books, the more likely the chance of being short-sighted. The image of the ‘swot’ wearing glasses is common throughout children’s literature! But this might mean that the ‘familial’ connection is not just genetic but is an environmental factor –

the children of well-read parents possibly being more likely to be studious themselves. Also, other environmental factors such as lack of sporting/physical activity and time spent outdoors have been linked to short-sightedness. So maybe Billy Bunter wears specs. because he doesn't do sports, rather than because he spends so much time in the school library?

Can short-sightedness be prevented?

Unlike genetics, some of the factors mentioned above are modifiable, suggesting the possibility that short-sightedness might be preventable, or at least its progression reduced. One of these factors is exposure to the outdoors, something which many modern children do not experience as much as their predecessors. A survey in 2016 found that nearly three-quarters of the UK children studied, spent less than one hour a day outdoors. That's less than recommended for prison inmates by United Nations guidelines. The poll found that on an average day, a fifth (20%) of children do not play outside at all.

Has time spent outdoors been proven to prevent short-sightedness?

A number of clinical trials examining the effect of time spent outdoors in protecting children's eyes have been undertaken. Most of these trials have been undertaken in Asia, particularly China and Taiwan because of the huge increase in short-sightedness in these parts of the world, but the results may still be relevant in other countries.

The studies took large groups of schoolchildren with, and without, short-sightedness and compared the eyesight of those who spent longer outdoors with those who didn't. All the published studies have reported a difference, although the results vary from study to study. Two studies which only increased the time the children spent outdoors by 40 minutes per day, found that progression of short-sightedness was reduced by 11% and 18%. Another study, which increased outdoor time by 80 minutes per day found that progression was reduced by 23%. It also found that over a year, the number of new cases of short-sightedness was halved. A further three-year study of six-year old children in China, found a 9.1% reduction in new cases, as a result of an extra 40 minutes per day of time spent outdoors. Overall studies seem to indicate a 'dose response' effect, in other words, the benefits increased the more time that was spent outdoors.

How does time outdoors protect eyesight?

Initially it was thought that physical activity might be the crucial factor, but results seem to be similar whether the children exercise vigorously or lounge about in the sun. So now it's thought that the constituents of daylight might be the important factor. Many of these components are filtered out by modern glass windows in the schoolroom or home and are

not present in artificial light sources. In particular, natural light is known to stimulate the production of a chemical messenger called dopamine, from the light-sensitive cells in the layer at the back of the eye (the retina). Release of dopamine slows growth of the eye and this has been proven by blocking dopamine, which led to increased growth of the eyeball. Thus, the hypothesis is that when insufficient time is spent outdoors, growth of the eyeball in not kept under control by dopamine and the eyeball grows too long, leading to short-sightedness. This would explain why time spent outdoors affects both children with, and without, short-sightedness: excessive eyeball growth is curbed by natural light, so both prevents development of the condition, and also slows its progression in children who already have it.

Does it need to be sunlight?

No, because it's thought that the factors needed are in ordinary daylight and it doesn't even have to be that bright – light shade under trees does not appear to diminish the effect. This means that protecting developing eyesight doesn't necessarily mean risking excessive sun exposure.

Is time spent outdoors the only factor in causing short-sight?

No, because genetics probably do influence the chances of a child having short-sight and the risk of it becoming severe. But it's possible that exposure to daylight may moderate inherited risks. It's also thought that excessive time spent on close work, such as reading books or screens, may also adversely affect developing eyesight. The increase in short-sightedness in Asia is blamed on greater pressure on children in academic achievement i.e. studying. But is it a direct effect of studying, or is it that excessive schoolwork limits their time outdoors, or both? A study comparing children in Sydney, Australia, with those of similar ethnicity (and therefore genetic risk) in Singapore, found that those in Sydney spent much longer outdoors (14 hours a week compared with three hours in Singapore) and had much lower prevalence of short-sightedness (3.3% compared with 29.1% in Singapore) despite doing considerably more schoolwork. So it looks as though time spent outdoors is possibly more influential on developing eyesight than schoolwork.

How can this knowledge be put into practice?

The parts of the world with the most alarming increases in short-sightedness, such as Singapore, have introduced campaigns to encourage children to go outside, and are also educating parents about why this is important for developing eyesight. Encouraging children to play outside cannot be anything but beneficial and some suggest that spending time outdoors should be as important a part of the educational system as studying.

Singapore screensaver

© Health Promotion Board, Singapo

MINUTES OF THE 8th PPG ANNUAL GENERAL MEETING

TUESDAY 24 APRIL 2018

Held at Acorn Bordon

1. In the absence of David Lee (Chairman), Ian Harper welcomed all present. He thanked Nigel Walker, Sue Hazeldine and Rev Wes Sutton on facilitating the evening and the practice for supplying the refreshments. Ian informed the group of fire exits and toilets for the building and again thanked Rev Wes Sutton and the staff at Acorn who had helped to arrange things for the evening. Ian also promoted the raffle, tickets purchased from Barbara who would then draw at the end of the evening.
   GDPR – Ian briefly explained the new data protection laws that were being introduced 25//05/18 and the obligation to inform members of the PPG on the personal details held and the use of these details. He confirmed that no bank details for those with standing orders were kept on file and that personal details were not given to any third party. He also confirmed that members would be contacted regarding opt in to the data base in the near future.
2. **Apologies for absence** were received from David Lee, Liz Goes and Gerald Hudson.
3. **Introduction of Committee:-**
   - David Lee (Chairman)
   - Sue Hazeldine (Vice-Chairman)
   - Ian Harper (Treasurer)
   - Yvonne Parker-Smith (Secretary)
   - Barbara Symonds/Liz Goes/Gerald Hudson (Fund-Raising team)
   - Nigel Walker (Meetings Organiser)
4. **Minutes of the previous AGM** on 25 April 2017 were agreed, proposed and seconded by Yvonne Parker-Smith.
5. **Matters Arising:** None
6. **Presentation of Chairman's Report:** delivered by Ian Harper on behalf of David Lee. Our PPG has a membership of just over 100. We rely upon our members for support especially for input of ideas, comments and when running surveys. We are always looking for new members to join and Ian signposted any interested to complete a form which was available in the room. The benefit to joining was the receipt of the newsletter either electronically or as a printed copy if wished.

The newsletter is published quarterly with about 200x copies printed and about 300x copies going out electronically. We encourage people to receive the newsletter by email to save time and money. Ian ran through the format of the newsletter content.

NAPP – the PPG are considering whether to continue the subscription to the national body NAPP. The PPG is unsure whether this group is really providing any benefit to us and we note that many other PPGs in the area have already withdrawn from this body.

Fund Raising – we continue fund raising both for items for the practice but also for the villages. You may have seen the defibrillator inside the phone box at the Holly Bush. We recently bought a Hyfrecator which controls bleeding during minor surgery allowing our GPs to carry out more cases locally. We are at present fund raising for a FeNO monitor, a machine recommended by NICE for the accurate detection of asthma in all patient in primary care.

First Aid Training – We are regularly carrying out First Aid training throughout the area and all the training sessions are free. We have now trained almost 150 people to Resuscitation Council UK standards and everyone who attends receives a First Aid Certificate recording their training. We are presently liaising with some local schools and are developing training programmes which we hope soon to start with children. Dr Leung and David Lee have been helping to facilitate these sessions.

Phlebotomy – the CCG have moved funding for phlebotomy from the surgeries to Chase Hospital and changed the style of the clinics i.e. no bookable appointments and a cap on number of patients seen each day. This has caused major problems and we have now been involved in major discussions both with the CCG and Southern Health Foundation Trust. Our aim is to try to get the clinic returned to the surgery but in the interim, a clinic run by an appointment system at the Chase. (At this point there was a general discussion and comments from Dr Leung, Dr Sherrell, Dr Zaman, Yvonne Parker-Smith and Sue Hazeldine with regard to the current situation. Dr Leung pointed out that no provision had been made with regards to certain blood tests that could not

be carried out without an appointment system and no provision for under 17 year olds. He felt that lessons should have been considered by the CCG when they trialled the service for Pinehill patients and within 6 months had a thick folder of complaints. Dr Sherrell felt that CCG/NHSE were looking at all services being carried out at scale and this clearly had a detrimental impact upon these services as then potentially not locally based. She praised Dr Leung for his efforts in securing Badgerswood as a spoke for GP extended access which would otherwise have been centred purely at Petersfield hub. Dr Zaman, Yvonne Parker-Smith and Sue Hazeldine also added their comments to the discussion and pointed out that patient power was more likely to be acknowledged by the Commissioners. Ted Wood, a Forest patient asked if David Lee's original email to the CCG regarding phlebotomy had been acknowledged and if not, was he following this through. Ian Harper responded by saying that David Lee was persuing this as was the practice and an outcome would be forthcoming in the near future).

General – The new year had got off to a good start with the fund raisers already busy. Barbara and Liz had organised a second musical evening about two weeks ago in the Headley Church Centre which was a sell out. It was a very enjoyable evening with lots of dancing and great music performed by Keith and Steve. A quiz night is planned for later in the year.

7. **Financial Report:**
   Ian Harper presented the financial report for the year - £4k had been received in income and £4k had been spent resulting in a balance of approximately £2k. Ian confirmed that he liked to keep £300 as a float. In total £20,532 had been raised over the 7 years the PPG had been in operation.

8. **Election of Committee for 2018/19:**
   The previous committee were re-elected en bloc, proposed by Helen Sherrell and seconded by Keith Henderson.

9. **Any Other Business:**
   Ted Wood wished to express his gratitude and acknowledge the exceptional service received from the staff at Badgerswood and Forest Surgeries over the years, but also Headley and in particular, Chase Pharmacies. He declared that in his life time he had not experienced this level of service in any other surgery or pharmacy.

10. **Date of Next Meeting:**
    April 2019.

11. **Rev. Wes Sutton "Preserving Body, Mind and Spirit"**
    Rev. Wes Sutton introduced himself and Acorn and gave a brief history on the formation of the foundation. He then went on to deliver a fascinating talk regarding the synergy between mental well being, faith and conservative medicine. The talk was interactive with the audience which resulted in the following comments:
    Ted Wood asked if there was an opportunity for the GP surgeries to look at working with Acorn in relation to patients who may be EOL etc. as he currently had personal experience. Dr Leung responded and said that he had already entered into conversations with Acorn and MacMillan Service as he felt there was an opportunity to work closer together for the benefit of patients. Dr Leung then expanded on some other projects in the pipeline such as social prescribing in conjunction with Radian (project housing).
    Ian Harper concluded the evening with thanks to Rev Wes Sutton for his talk and the raffle was drawn accordingly.

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Great British Doctors No 17

Dr James Blundell

(27 Dec 1790 – 15th Jan 1878)

2018 marks a major milestone in the history of blood transfusion: the 200th anniversary of the first recorded transfusion of human blood. It was carried out by an obstetrician, James Blundell, at Guy's and St Thomas' hospital in London, to treat a haemorrhaging patient.

James Blundell was born in London in 1790 to non-medical parents, but was undoubtedly inspired by his uncle, the physiologist John Haighton. The latter was a skilled surgeon and anatomist, with a particular interest in obstetrics. Some instruments still used in delivering babies are named after him. James Blundell's initial training was with his uncle before entering Guy's Hospital in London to study medicine. He finished his training and qualifyed MD in 1813 at the University of Edinburgh Medical School. Taking an interest in midwifery and physiology, he succeeded his uncle as lecturer in these topics at Guy's by 1818.

In his obstetric work, James Blundell had witnessed women dying during childbirth from blood loss and was determined to devise a way to treat this haemorrhage. In 1818 he proposed that giving blood from one person to another would be feasible and that so long as the blood was transferred quickly (to avoid clotting) it could be carried out by syringe. As proof of his theory, in 1818 he successfully gave blood via a syringe from a husband to his wife following childbirth. Over the next five years he carried out 10 more transfusions, only half of which were successful – for reasons that wouldn't be understood until many years later.

Since Harvey's discovery of blood circulation in 1616, transfusion of blood from animals and humans had often been attempted. But it was nearly another 300 years before the reasons that it wasn't always successful, were understood. An Austrian scientist, Karl Landsteiner, realised that not everyone's blood is the same. When blood is spun at high speed (centrifuged), the red cells separate from the liquid component, which is known as serum. Landsteiner separated his own blood and that of six other workers in his lab. and mixed up the red cells and serum. He found that some serum would make the red cells clump together (agglutinate) while others didn't. It was found that there were proteins (antigens) on the red cell surface and that antibodies present in some serum reacted to them, causing the red cells to clump together. At this time, the only known antibody reactions were to bacteria, so initially it was thought that the reactions between the blood cells and serum were due to infections. But Landsteiner was able to show that these reactions occurred with healthy blood.

Landsteiner deduced that the reactions between blood cells and serum were due to the presence of just two types of antigen on red cells (A and B) and the antibodies to them in the serum (anti-A and anti-B). Because attachment of the corresponding antibody to antigen causes clumping of blood cells together, the presence of an antigen on the blood cells naturally means that the antibody to it will be absent from the serum. For example, someone with only antigen A on their blood cells (blood group A) will not have anti-A antibodies in their serum but will have anti-B antibodies. From this understanding, Landsteiner proposed in 1901 that there are just three main types of blood group: A, B, and O. It was a year later that Decastello and Sturli described a fourth (and the rarest) blood group: AB.

People with blood group A have red cells with antigen A and their serum has anti-B antibodies only. Those of blood group B have B antigen and anti-A antibodies. Therefore, if blood is given from someone who is group B to someone with blood group A, their anti-B will react with the B antigens in the red cells of the transfused blood and cause these cells to clump together. This is life-threatening as it will lead to destruction of the red cells (which are vital for carriage of oxygen around the body) and the clumps can block blood vessels. This interaction between blood of different groups was the reason why many of the earliest attempted blood transfusions failed. But clearly some would succeed if blood of the same group was transfused. Also, successful transfusion doesn't have to be of the same blood group.

Universal donors and recipients

Blood group	Red cells		Serum		Recipient of…	Donor to…
	Antigen A	Antigen B	Anti-A	Anti-B		
A	✓	×	×	✓	A, O	A, AB
B	×	✓	✓	×	B, O	B, AB
AB	✓	✓	×	×	A, B, AB, O	AB
O	×	×	✓	✓	O	A, B, AB, O

For the purposes of blood transfusion, the presence or absence of antigens on the red cells of the recipient patient is the critical factor. So, groups A and B can only receive blood from groups without antigen B or A respectively. But group AB can receive blood from any group because it already has antigens to A and B and no anti-A or –B antibodies so will not react to any blood, either A, B, AB or O. Hence group AB is known as the Universal Recipient. Similarly, because the red cells of blood group O do not have antigen A or B, they can be given to any of the other groups. Whether the patient has any A or B antibodies makes no difference as O blood contains no A or B antigens. Hence group O is known as the Universal Donor.

Following the identification of the main four blood groups, many other red cell antigens and their antibodies have been discovered, the most important being the Rhesus factor, first identified in Rhesus monkeys.

The discoveries of Landsteiner and those after him, paved the way for successful blood transfusions. To save lives by transfusing blood, you need donors and the means of collecting and storing blood. Calcium in blood is an essential factor for blood clotting. The addition of sodium citrate to the donated blood binds calcium and thus prevents clotting. Also keeping blood at 4^{o}C prolongs survival of red cells allowing blood to be stored for up to 4 weeks. Measures to control disease transmission through transfusion eg HIV, hepatitis, is a crucial role of the Blood Transfusion Service (BTS).

Over the past decades, advances in surgical procedures and increased skills training have reduced the overall blood loss at routine surgery and the consequent demand for donated blood. But there is still a huge requirement for blood for emergency surgery, obstetrics and trauma cases. As mentioned banked blood, and some components, only have a short shelf-life so there is always a constant need for donations.

Being a blood donor

Are you a blood donor? The BTS runs donor sessions around England and Wales, mostly in community buildings, village halls, entertainment venues, etc and also at regional centres. If you go to the website https://www.blood.co.uk/ you can find your nearest venue and book an appointment now. Donation involves insertion of a canula (large needle) into a vein in the inside of your elbow. This feels no worse than having a blood sample taken – the proverbial 'sharp scratch'! But after that you can lie back (think seaside deckchair position) and marvel at the thought of the life you might save, or even read the latest page-turner. Before you've got to 'who dunnit', you'll be up and at the tea table, helping yourself to a well-earned cup of tea or soft drink.

If we are unfortunate enough to require blood ourselves, we all assume that it will be available. But this wouldn't be the case without blood donors. Most individuals only donate every three to four months and if you book your donation appointment you should be out and back at work or home in about an hour. Donation of 1 unit of blood rarely affects the way you feel. It's not much to ask for the guarantee that there'll be a pint or two for you when you need it, is it?

Save a life, give blood

We need over 6,000 blood donations every day to treat patients across England which is why there's always **a need for people to give blood**.

Each year we need approximately 200,000 new donors, as some donors can no longer give blood.

Most people between the ages of 17 and 65 are able to give blood.

We need more donors from all blood groups and types. We particularly need more people from black, Asian and minority ethnic communities to give blood so that we have a supply of certain blood types.

To find out if you can give blood and for details of the next donor sessions, go to www.blood.co.uk or call 0300 123 23 23.

Should I be stretching?

How do I warm up?

There is so much written about stretching and warming up, it is confusing for everyone. Should you stretch before or after exercise? What are the different types of stretching and are they in fact helpful or harmful?

There are different types of stretching-

- **Static stretching** involves putting a muscle in a lengthened position, taking it to the end of its range and holding it there for a sustained period of time.
- **Dynamic stretching** is when a muscle is taken through its range one way then the other repeatedly in a slow and controlled movement.
- **Ballistic stretching** involves bouncing at the end of range (not recommended unless prescribed by and under supervision of a physiotherapist)
- **Contract / relax (PNF) stretching** are forms of stretches and movement used by physiotherapists for treating problems.

What stretch should you be doing?

This depends on the reason for stretching, your desired outcome and psychologically how you feel about stretching.

Traditionally static stretching was used pre and post exercise. It is now felt that static stretching before sport or exercise could reduce your performance. For a perfectly healthy injury free individual warming up pre sport, dynamic stretching is thought to be better. However, for increasing range of movement, muscle length and maintaining flexibility static stretching is best.

The evidence?

Research has found that static stretching can reduce power and performance however the conclusion was based on a static stretch as the sole activity during warm up and did not consider the benefits of a combined warm up routine. (Simic et al 2012). It found the effects were small (5.4 – 1.9% reduction in strength, power and explosive performance) and that they were short lived with the effects wearing off after 5-10 minutes. The effects were negligible if the stretch was kept to less than 45 seconds. It also found that short static stretching is recommended for sports requiring greater range of movements such as gymnastics.

Behm et al (2011) in their system review found that dynamic stretching either had no effect or may augment performance. So dynamic stretching may or may not help performance! They then concluded that a combination of sport specific static and dynamic stretches along with dynamic activities would be the best type of warm up. The emphasis is sport specific.

So what should my warm up routine consist of?

This will depend on the activity you are warming up for and for how long you plan on doing the activity.

Generally speaking, the longer the duration of the activity the longer the warm up. Dynamic stretching and dynamic motions that reflect the movements made during your sport or activity should be mimicked during the warm up. Starting with small movements and increasing the range, taking the muscle and joint through its full range in a smooth and fluid

motion. If your sport requires full range of motion eg dance or martial arts you will need to include some static stretches to increase range at the end of movement. Any injuries may require specific stretches or exercises.

Belief systems

If you have always stretched and warmed up in a certain way and it works for you then do continue. If static stretches pre-run have helped you feel more relaxed and confident, this is excellent preparation. As with everything – there is no 'one size fits all'.

How about cooling down?

Again there is mixed evidence on the effects of stretching post-exercise.

A study published in the British Journal of Sports Medicine found that post exercise static stretching reduced the post exercise soreness and also reduced the risk of injury to muscles, ligaments and tendons.

Personally I advocate a gentle cool down after exercise, combining dynamic stretches along with static stretches, to increase range of motion and reduce soreness and stiffness. A further episode of dynamic and static stretches a couple of hours after exercise can also be helpful. If you are suffering from muscle tightness, or have an injury or persistent reduction in range of motion then regular mini sessions of combined dynamic and static stretching can really help between exercising.

Physiotherapists use static stretches as part of treatments and home exercise programs to increase soft tissue length and flexibility, especially for injured tissue. There is a very large amount of evidence to support this, so don't stop any stretches you've been recommended to do.

Of course, everyone is different. If you are concerned about your stretching routines, please feel free to contact Alan Mowatt at backtogetherphysiotherapy@gmail.com or telephone 01428 609975 for a consultation.

Practice Details

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G.P.s	Dr Anthony Leung Dr I Gregson Dr H Sherrell	Dr Charles Walters Dr F Mallick Dr L Clark
	Dr Laura Hems	

Practice Team

Practice Manager Sue Hazeldine
Deputy Practice Manager Tina Bell
1 nurse practitioner
3 practice nurses
2 health care assistants (HCAs)
1 physician associate

Opening hours	**Badgerswood**	**Forest**
Mon	8 – 7.30	8.30 – 7.30
Tues/Wed/Thurs	8 – 6.30	8.30 – 6.30
Fri	7.30 – 6.30	7.30 – 6.30

Out-of-hours cover **Call 111**

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

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Keith Henderson 01428 713044

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Tel: 01420 477714

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