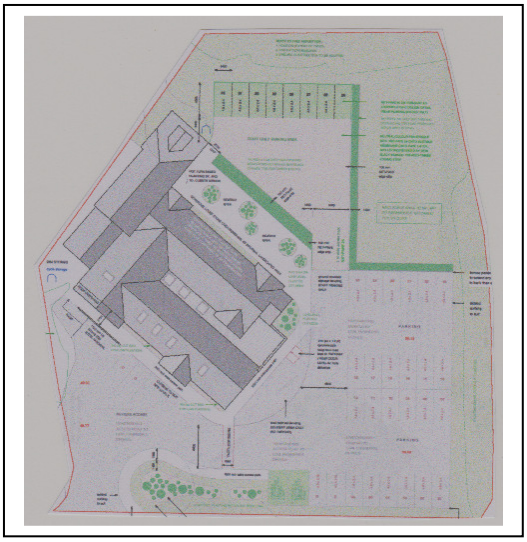
Patient Participation Group

Newsletter



Incorporating the

Friends of the Badgerswood and Forest Surgeries

October 2014 Issue 15

Pain causes *tension...*

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

Change your posture and improve your health & well-being

Alexander Technique

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

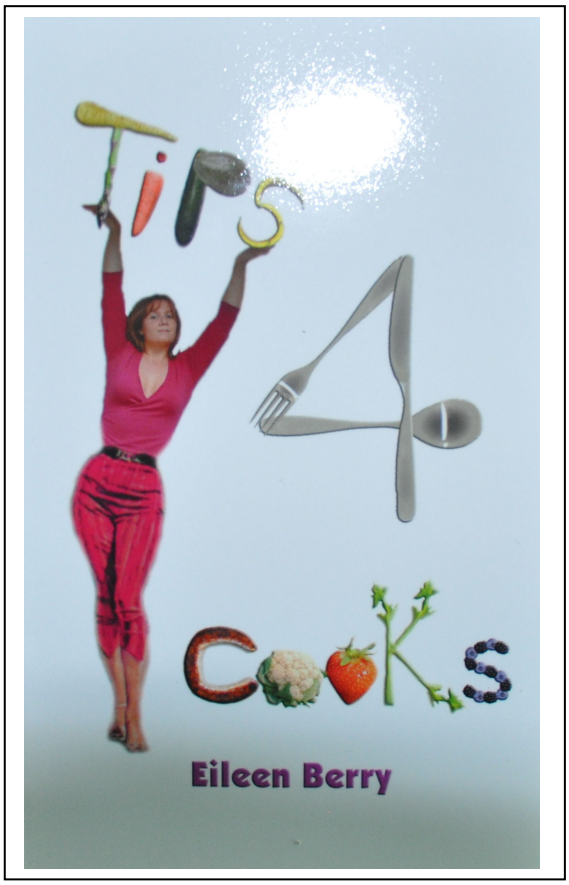
Good posture promotes confidence & energy

Jane Baker MSTAT
greatposture.co.uk

Lindford Hants GU35 0NZ
Tel:01420 488680
Mobile:07775618822

Jane@greatposture.co.uk
www.greatposture.co.uk
www.stat.org.uk

Fundraising – Tips 4 Cooks



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

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

HEADLEY

VOLUNTARY

CARE

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

Do you need help to go to

a hospital, doctor or dental appointment?

Call 01428 717389

Also we need more volunteer drivers and co-ordinators.

Petrol costs and expenses reimbursed.

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

YOU can make a difference to a family in your community

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

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

Home visiting Volunteer – Home-Start provides a unique service for families –recruiting and training volunteers to support parents with young children at home.

Trustee - with your skills and experience you will have an input on how our scheme runs and develops in the future.

'Friend' - you can help us raise our profile in your community and help with our ongoing fundraising.

Home-Start WeyWater, c/o Chase Children's Centre,
Budd's Lane. GU35 0JB

Tel – 01420 473555 E-mail – office@homestart-weywater.org.uk

BADGERSWOOD + FOREST
SURGERIES
BORDON/HEADLEY
Due to retirement and expansion we have vacancies available for:

SECRETARY/ADMINISTRATOR
Excellent keyboard skills (60+wpm) with a secretarial background.
16 hours per week

RECEPTIONISTS
Morning and afternoon/evening hours. Enthusiastic personality with good keyboard skills. Previous receptionist background essential.

Please forward application and CV to:

Sue Hazeldine
Practice Manager
Badgerswood Surgery
Mill Lane
Headley
GU35 8LH
or email:
sue.hazeldine@nhs.net
Closing date Friday
17 October 2014

Chairman / Vice-chairman Report

Much is changing within the Practice – some good and some not so good. Dr Boyes is leaving us at the end of January and we are really sad to see him go. He has been a tremendous support to the PPG since its foundation – someone we can always turn to for advice and help, and know he will always back us whatever we say or do. Forest Surgery will never be the same. His pleasant, calming, supportive, and enthusiastic approach will be sorely missed. He will leave a legacy of an expanded Forest Surgery, carefully planned and developed for the far future. We wish him well. Thank you Dr Boyes. We'll all miss you, not just the PPG but your staff and patients as well.

Badgerswood Surgery is now following in the footsteps of Forest Surgery and expanding its footprint. Dr Leung gives us an account of progress later in the newsletter. Forest Surgery will have to help out with some clinic space during the time of the building.

Our Educational Article this time is on the early diagnosis of Breast Cancer. Sophie Helme, from Queen Alexandra Hospital in Portsmouth, has written a most excellent article. Sophie was one of our medical students in Edinburgh and went on to win the Gold Medal in the Surgical fellowship exams, an outstanding achievement! We hope she will be available to come to speak at our AGM in April next year.

At our AGM in April this year, Professor Mason discussed briefly about surgical training and we followed this up with an article in our last newsletter discussing this in more detail. Dr Mallick has written an article for us in this Issue on GP training. No longer is General Practice a soft option for medical graduates as it was years ago. Trainees now go through a rigorous programme including College examinations as Dr Mallick explains. Our GPs are now well trained and well qualified before they eventually are free to apply for a GP Partnership post.

GP recruitment is still a problem, not only locally but nationally but we are fortunate here at Badgerswood Surgery, and are happy to say that Dr Helen Sherrell will be joining the Practice at the beginning of October. There will be a bit of a movement within the Practice and Dr Mallick will now be spending time between Badgerswood and Forest Surgeries.

Our treasurer, Ian Harper, was recently in hospital, and has written an account of his experience, highlighting the essentials and preparations you should think about before you go into hospital - simple things which

you would probably not consider until you come home and suddenly realise you have a problem and wish you had thought about it beforehand. Interesting reading and an essential to keep for the future.

We now have the funds for our BP reception monitors which we will place in the surgery receptions for every patient to self-check their own BP. The Forest Surgery machine is now in place and there is a photo of one of our receptionists taking her own blood pressure. The Badgerswood machine may need to wait a bit until the building is done. We need to monitor how frequently these are used and how many hypertensive patients are detected. Please use and keep a record for us.

We are now looking for funds for 2 other items. We need a new Spirometer to record a patient's method of breathing eg in asthma or bronchitis. The Practice machine has just broken and is irreparable. Also we need a replacement couch in Badgerswood Surgery where the cover has torn and the couch is too old to repair.

In our last issue we discussed our concerns about the 'NHS Choices' web-site. I'm not sure if you have visited this site since we highlighted this to you. We have had quite a bit of discussion since and are still unhappy. We include further thoughts and some of the correspondence.

We are still in process of trying to improve communication from hospitals to our GPs at the time our patients are discharged home. It is with interest that this item appeared as a feature in the Daily Telegraph at the beginning of September having been highlighted by NHS England as a major problem. Together with the Integrated Care Team (the new name for District Nurses) and the CCG we are now in a position to approach the hospital Chief Executives to hopefully improve the situation.

The problems with Chase Hospital still slowly rumble on. It is now doubtful that we will see the hospital develop into the unit that we were hoping. Details of the present situation are reported. We had hoped to get a report on how the CCG visualise the provision of GP services in this area in 5 years' time especially with the difficulty of recruiting GPs and the expansion of Bordon by approximately 4000 houses, but this is not forthcoming yet.

Our 'Great British Doctor' this issue is Francis Crick. Although not a medical doctor, it was agreed that he has done so much for the advance of medicine that the committee chose him as our 'Great British Doctor' this time.

Badgerswood Surgery Extension

2nd article for PPG

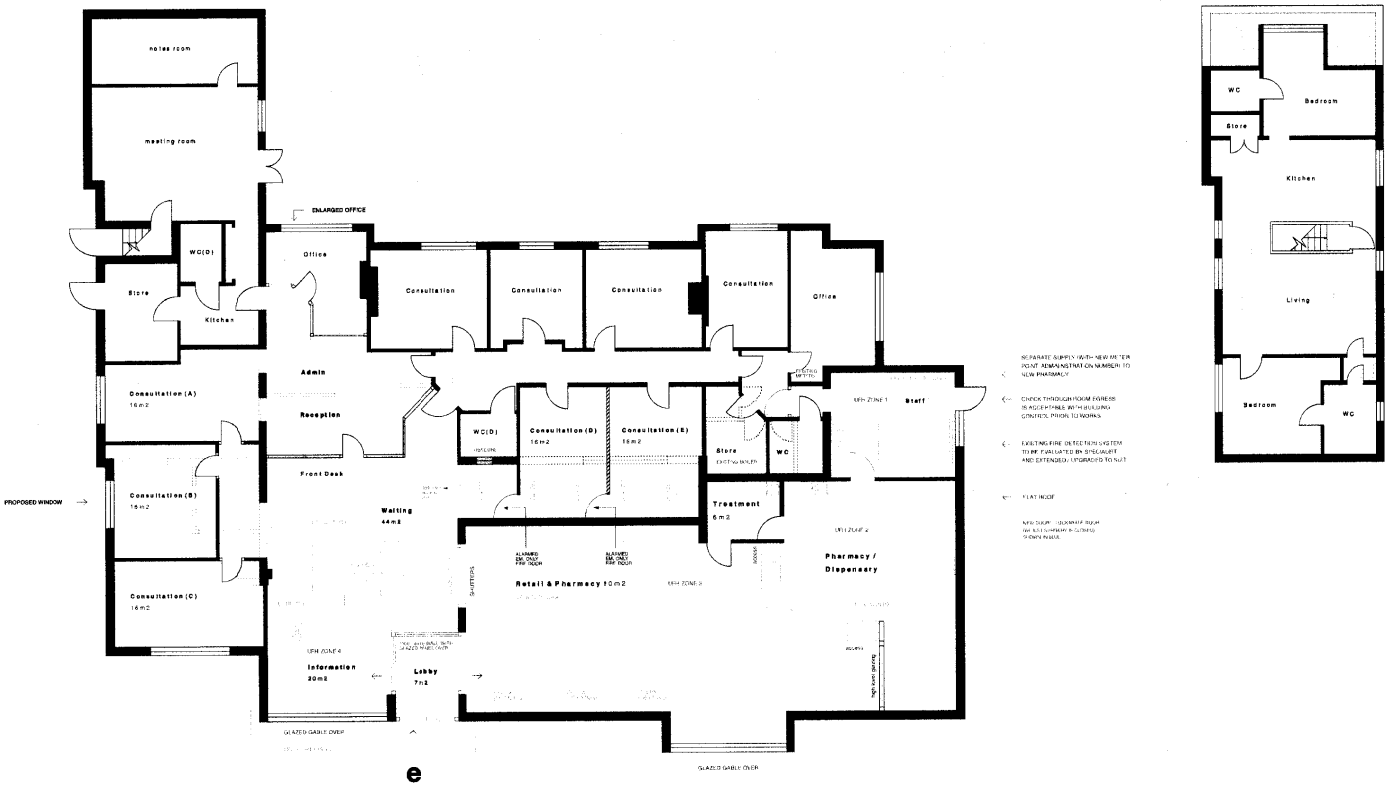
In the two months since our last article, construction of the new Badgerswood extension has started. The staff car park has been completed at the back of the surgery, releasing ten spaces for patients to use in the original car park; the new road layout is now in place, save the top coat of the tarmac to be laid at the end of construction; and the concrete for the foundations has been poured. As you walk past the gaps in the metal boarding, you might next see the floor beams being set in place and then the walls going up. This is all very exciting but unfortunately also very disruptive.

To keep the surgery and pharmacy running during all the work, we plan on:

- leaving the whole front entrance unchanged for as long as possible
- creating a new door to the front of the pharmacy so patients can still use the pharmacy when the surgery is closed
- using a room at the rear as a temporary waiting room while the new one is being refurbished

The surgery is busiest on Mondays and Fridays and that is when we have more doctors and nurses on duty so everything from the car park to phones and the pharmacy experience heavier traffic, especially in the mornings. To ease this, we may in the interim have to move some routine appointments to the middle of the week as well as some clinics to the Forest Surgery.

We have now been through several extensions at the Badgerswood and Forest Surgeries to know that timescales do not always go to plan but the intention is for the pharmacy to move into the new extension in early 2015. We will then start the next phase and convert the existing pharmacy area into more consultation rooms.



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

Unchanged First Floor Plan at 1:100 scale

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

0m 1m 2m 3m

SCALE BAR @ 1:100

CLIENT	Badgerswood Surgery	DRAWING	Phase Two - Proposed Floor Plans	NOTES Drawings are not to be scaled except for planning purposes. Room dimensions are approximate. All dimensions to be checked on site. All dimensions in mm's. Drawings are subject to local authority approval. Drawings are subject to engineers design specification/ approval.	CORINTHIAN ARCHITECTURAL DESIGN 8 Davys Court, Funtington, Chichester, West Sussex. PO18 9LG 01243 576 076 > contact@corinthianad.co.uk > www.corinthianad.co.uk
SITE	Badgerswood Surgery, Mill Lane, Headley, Hampshire	REVISION	STATUS PL		
PROJECT	Proposed Extensions & Alterations	DATE 28.02.14	SCALE 1:100 @ A2		

Construction update as at the 1st October

By the time you read this, the temporary entrance via the front of the pharmacy will be in place. Please do bear with us during the construction disruption. You should see the walls of the extension going up soon, followed closely by the roof. We want to get as much done as quickly as possible to avoid the winter weather.

When the builders come to joining the new roof to the existing one over the entrance, we will have to vacate the waiting room for a few days. This is for safety reasons. During that time we will use our meeting room at the rear as the waiting area. We will also hold some clinics at the Forest surgery to minimise the traffic at Badgerswood. Once the roof has been completed, we can move the waiting area back to the front. You should then see the scaffolding come down, the barriers removed and we will be ready to start on the inside!

- - - - - - - - - - - - - -

IMPORTANT

Flu Vaccination

We have not had a major flu epidemic in this area for some years. This means that many people have not been exposed to the flu virus for years and therefore we must be at risk of having a major outbreak some time soon. It is important therefore that anyone who is at risk of having major problems or side effects from influenza, should have their 'flu jab'. The surgeries are now starting their annual flu injection programme so if you are on the list of people who should have an annual flu injection, please phone in and make an appointment now for your injection

Chase Hospital

I'd like to say I'm about to tell you how things are progressing with the developments at Chase Hospital but as you may have been aware from the past couple of newsletters, things seemed to stall. One thing is certain. The in-patient beds have closed and re-opening these is not an option. The Wenham Holt nursing home in Liss is still in use and the CCG is still in discussion to try to ensure that a nursing home is included in the planning applications for the new build in Bordon. The CCG however, have no power to insist on this.

Delays in the developments at the Chase have been caused by 2 main things – by issues 1) associated with the new NHS England capital approvals process which took the cost of the redevelopment programme over £3m meaning a more complex process for obtaining the capital investment and 2) surrounding all tenants signing up to new contracts i.e. Southern Health NHS Foundation Trust and the 2 local GP Practices who had expressed an interest in moving their surgeries into the Chase and are still in negotiation.

Given the uncertainty around some of the key decisions, a discussion paper was prepared highlighting the financial risks to the CCG which seemed to be appearing with the potential void space in the hospital, and this was taken back to the SE Hampshire's CCG Governing Body for their decision on the best way forward. Five options were discussed:

1) Do nothing
2) Proceed with the existing plans
3) Change the scope of the project to deliver the mental health clinical space, office accommodation and refurbished outpatient area only
4) Deliver the existing project in 2 phases, the first phase as in 3) above. Phase 2 to deliver the redeveloped ward area for GP accommodation
5) Change the scope of the project to deliver Option 3) and space for one GP Practice only.

The CCG Governing Body decided that the CCG should explore Options 4 and 5 and whichever would seem appropriate should be brought back to the Governing Body for endorsement. It now seems very likely that 1 of the Practices will agree to move into the Chase and by the time this newsletter is published, agreement may have been reached on this matter. Written in to any GP contract will be the running of a Minor Injuries Service.

There had also been concern about whether Southern Health will come on board but this has now also been resolved. It was clearly stated at the Stakeholder meeting on Friday 12th September that the Elizabeth Dibben Unit at the Forest Centre will now move across to the Chase Hospital ensuring that Southern Health will sign a contract to maintain mental health services in this region. Southern Health will now continue to maintain a presence in the Chase. It is likely that the site of the present Elizabeth Dibben Centre will be sold.

So there is progress slowly happening. Is it what we all wanted? We all thought not but time will tell. A nursing home in Bordon providing care beds would be very welcome. We hope to get a report from the Integrated Care Team and from our GPs about how they see things working. Are we managing more patients at home? Are more patients being sent outside the area for in-patient care than would otherwise have happened had we had Chase beds? Articles in the next newsletter may enlighten us.

So what is currently available at the Chase? Leaflets are available at all surgery receptions in the region. Please just walk in and pick one up. At the last Stakeholder meeting we discussed the potential of an expanded diagnostic service and the CCG are going to look into this further. At least our hospital is still open. At the end of the day the CCG hope we will come to see a service which will surpass that which we had before.

Problems with continuity of care following hospital discharge

Following the article in our last newsletter in which we highlighted the problems facing our doctors when patients were discharged from hospital without notice or documentation for the Practice, we have now been in contact with the Integrated Care Team (ICT) (District Nurses) as we are aware that they too are having a problem. If we are to tackle the GP problem, it would be sensible to tackle the nursing problem at the same time.

Some of you may have been aware of the article in some of the newspapers at the beginning of September highlighting "Bad paperwork 'endangering lives of patients leaving hospital'." These articles followed a Patient Safety Alert from NHS England which went out in the 1st instance as a warning. In 1 year there were around 10,000 reports of safety incidents related to discharge in England 33% of which related to communication at handover time. Problems were lack of adequate or timely information going out, or lack of action on information sent.

Since the building of the Hindhead Tunnel most of our patients are now seen and admitted to the Royal Surrey County Hospital (RSCH) in Guildford. Crucial to this is the fact that care is being transferred to a different county. Frimley Hospital is also in Surrey, Basingstoke is in Hampshire but not in our area. We come under SE Hampshire CCG, Basingstoke is under West Hampshire CCG. Our main provider hospitals are Portsmouth and Southampton, too inconvenient for travel.

The East Hampshire ICT comes under Southern Health. The District Nurses from Surrey come under Virgin Health Care which took over about 18 months ago. The computer system used by the 2 counties for monitoring and tracking patients is different and not interchangeable information-wise.

The ICT are having problems in 3 major areas. 1) Failure to be notified when 1 of their long-term patients is admitted to hospital 2) Lack of good communication from the hospital, building up to the time of patient discharge back into the community. This is essential especially for patients who will require immediate care on the day of return home. Attempts to develop a liaison tend to fail repeatedly, the wards failing to provide information claiming this infringes 'confidentiality'. 3) Lack of contact by the hospital when patients return home, even when patients will be requiring daily nursing care and medication administration. Only very serious cases seem to be being notified.

The ICT have repeatedly complained and sent in incident forms each time to the RSCH, but this has had no effect at all.

Up till 18 months ago, the situation had been running much more smoothly, with a Discharge Liaison Officer at the hospital who was a point of contact and who assisted in providing information throughout the patient's stay and warned of pending discharge and what would be required. It would appear that with the change in the provider to Virgin Care Trust, this liaison has disappeared and the system has changed.

We wonder whether Virgin Care Trust in Surrey are now providing their own Liaison Officer, rather than the hospital, and since we are not from Surrey, we are not 'in the loop' so to speak.

I think the time has now come to discuss this with the hospital Chief Executive who may not be aware of the problem. SE Hampshire CCG are aware of what is happening and we have been in touch with the Chief Quality Officer to keep her fully informed with progress here. We are awaiting exact details of what the GPs would like to receive on the day of patient discharge, and also what the ICT would like to see put in place before approaching the hospital so that we can go constructively to try to improve the situation.

Structure of GP training

by

Dr Farhan Mallick

Before entering GP training

Immediately after qualification at medical school, all doctors now must complete two years of training which are described as Foundation Years" (Fy1 and Fy2). This involves 6 4-month attachments to different departments during which they must demonstrate and gain 'foundation competences'. During this time they are fully qualified doctors and will achieve full GMC registration at the end of the Fy1 year (in the same way as House officers did in the previous version of training). On satisfactory completion of their foundation training, they are then able to move onto speciality training programmes. Application for these programmes usually occurs whilst they are undertaking their Fy2 year.

Entry into GP Training

To become an independent GP in the UK you must undergo three years of GP specialty training (GPST) which must include 18 months in an approved GP training practice and 18 months in approved hospital training posts. Over the past several years The Royal College of General Practitioners has been trying to increase the length of training required to become a GP to at least four years but this has been resisted by government departments. However some deaneries have introduced some limited four year training schemes.

Entry onto a General practice training scheme is via a competitive recruitment scheme. This involves going through three rounds of assessment.

Round 1 is just an assessment of eligibility – ensuring candidates have GMC registration and have their Foundation competencies.

Round 2: is exam based and requires completion of two papers – one on professional dilemmas and one on clinical knowledge. Depending on the candidates ranking in the exam will allow them go onto stage 3 and also allow candidates to be allocated to certain deaneries. The popularity of deaneries varies considerably.

Round 3: These are run by each deanery and the 'interview' consists of simulation exercises with a patient, relative and non-clinical colleague and there is also a written exercise.

The outcomes of round 2 and round 3 will give each candidate an overall ranking and this will determine the deanery and programme they can go on. The process is competitive and other specialities are moving to exam based systems to determine entry to their specialties.

Below is a table summarizing competition ratios for various specialities in 2013:

(http://specialtytraining.hee.nhs.uk/wp-content/uploads/sites/475/2013/03/Specialty-Training-2013.pdf)

2013 – CT1/ST1 Competition Ratios

Specialty	Applications	Posts	Competition Ratio	Fill Rate
ACCS - Emergency Medicine	534	203	2.6	100%
Anaesthetics	1189	478	2.5	100%
Broad Based Training (Pilot)	429	52	8.3	82%
Cardiothoracic Surgery (Pilot)	68	6	11.3	100%
Clinical Radiology	751	185	4.1	100%
Core Medical Training	3088	1209	2.6	100%
Core Psychiatric Training	650	437	1.5	89%
Core Surgical Training	1296	676	1.9	99%
General Practice	6447	2787	2.3	99%
Histopathology	154	120	1.3	61%
Medical Microbiology & Virology	108	21	5.1	90%
Neurosurgery	183	37	4.9	89%
Obstetrics and Gynaecology	591	204	2.9	100%
Ophthalmology	323	71	4.5	100%
Paediatrics and Child Health	793	360	2.2	100%
Public Health	602	70	8.6	97%
Total	**17206**	**6916**		

GP Training Scheme

Currently the core structure of training is one of 18 months in hospital training posts. These will usually include time in all or some of the following areas: General/Geriatric Medicine; Psychiatry; Obstetrics & Gynaecology; Paediatrics and A&E. Different deaneries will set schemes such that trainees spend four months in a larger number of posts or have a smaller number of six month rotations.

During the hospital posts trainees will be expected to spend time in outpatient clinics and looking after inpatients. They will also be attending weekly teaching from the GP training scheme. During each post trainees will be expected to reach a number of competencies which have to be signed off on an electronic logbook (the e-portfolio). These include clinical topics, procedures and clinical examination techniques – often described as workplace based assessments (WPBA).

At least 18 months will be spent in approved General Practice settings, usually an initial 6 month post followed by a 12 month GP registrar year. As in hospital posts an e-portfolio with WPBA's must be completed for each post demonstrating competencies have been assessed and achieved. During the GP training posts trainees will spend time getting used to consulting in ten minutes as well as learning how to manage risk and uncertainty which underpins dealing with undifferentiated illness in primary care.

To complete GP training the MRCGP examination must be passed as well. This has two components: an Applied Knowledge Test (The AKT) which examines clinical knowledge and the Clinical Skills Assessment (CSA). The CSA consists of several stations which assess clinical consultations skills, examination ability and communication skills – all in ten minute blocks!

Once the AKT, CSA and WPBA's are complete and the GP registrar year is completed the MRCGP can be awarded and the trainee is then allowed to practice as an independent General Practitioner. Completion of GP training is noted by the GMC and this information is accessible to anybody via the GMC website.

On the Future

Before the structure of medical training underwent revolutionary changes in 2005 it was commonplace for GP's to have spent several years in various hospital specialties before entering General Practice. However the system is now set up to encourage young doctors to stay in one area and not to change their interests. This has meant the Royal College of General Practitioners is trying hard to increase the length of training time for trainees entering General Practice. So far they have only had partial success.

Medical training has undergone several changes over the last decade. The outcomes of these changes have yet to be evaluated and it'll always be interesting in the ever changing world of medical training!

The Care Quality Commission

"We want to make sure we look at the things that matter to people"

The Care Quality Commission (CQC) has announced that from this month (October 2014) they will be working with NHS England to introduce a 'Special Measures' framework. All GP Practices in England and Wales will be rated on the basis of whether they are:

Outstanding, Good, Require improvement, or Inadequate.

To rate the Practices, 5 key questions will be asked. Are they:

Safe, Effective, Caring, Responsive, and Well-led

Each Practice will be inspected against 6 population groups:

Elderly
Long-term conditions
Mothers babies and children
Working age
People living in vulnerable circumstances inc people with learning disability
People with poor mental health inc dementia.

Any Practice rated as 'Inadequate' for 1 or more of the 5 key questions or 6 population groups, will be given a specified period of time before re-inspection which will be no more than 6 months. If still inadequate, the Practice will be placed under 'special measures' in consultation with NHS England and will then have to improve to avoid having its registration cancelled by NHS England. Where a Practice has serious problems, it may be put under 'special measures' immediately, and if not corrected within a short space of time, may have its registration cancelled quickly.

The CQC feel that the 5 key questions cover the things that matter to people who use the services and cover aspects of the quality and safety of the GP Practice.

1. Safety Whether the Practice and Surgeries are clean and safe and medicines are managed properly. Whether people are supported by practice staff, particularly those who need safeguarding, and whether the practice learns from safety incidents including prescribing errors or missed diagnoses

2. Effective Are patients given the right diagnosis and treatment? Are patients with long-term conditions managed well? Are patients referred properly to specialist services? Are patients and those involved in caring for them involved in decision making?
3. Caring Are patients treated with compassion, dignity and respect?
4. Responsive Does the Practice assess and respond to the needs of the local population, including in relation to access to appointments? How does the practice respond to feedback from the patients eg through having an effective PPG? The storage of medical records and sharing with the patient and other services are also important.
5. Well-led How does a Practice support its staff, providing training and supervision, making sure they are good at their job? Does the Practice work well with other health and adult social care services in the area?

The CQC will also be looking to see how a GP practice works to prevent poor health and promote healthy living. At the moment the CQC admits it has a "lack of clarity about what good care looks like in general practice". In time, by working with all the practices, with the GPs and practice staff, with the public and patients, and with other bodies such as NHS Education England, they hope to eventually build up a picture of what good care should look like in general practice. Finally, "Our definitions will drive our ratings, which will be the authoritative judgement of the quality of care provided".

So how do we, the PPG, feel our practice is placed when judged by the CQC in its 'Special Measures' framework. We have looked at the Practice from the same side as the CQC will be inspecting, i.e. from the patients' point of view. But the approach is different here. The CQC will now have a broader vision. Take for instance maternity care. It will be looking at all providers in the region and noting how our practice integrates into this service, working with midwives in the community, consultants in hospitals etc. It will be looking at the vulnerable elderly over 70s with complex medical needs and noting the efforts made for this group to stay healthy and to support home-care to stay out of hospital. These may be difficult for us to provide information for and only the Practice can provide this. But other areas we already have information about. Appointment system for the working patient – how well does this work? Long-term conditions such as diabetes – how well is this managed in the Practice?

Out-of-hours service is something the CQC is very interested in and perhaps something we should try to seek your opinions about in the next few months. Any information we can collect to help the CQC to show how active our practice is must help them in assessing our practice.

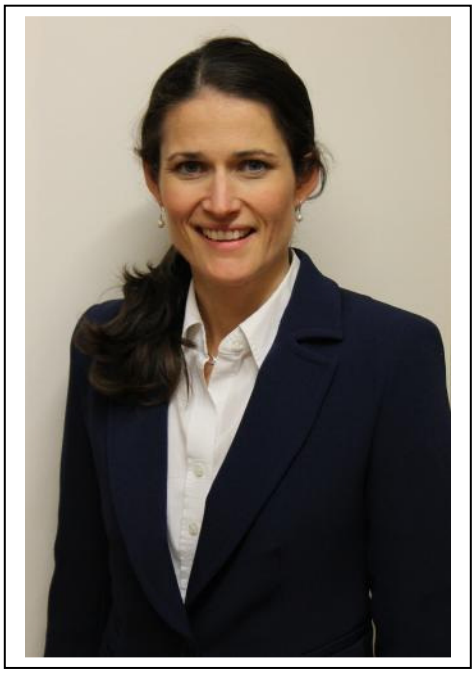
We think our practice is 'safe, effective, caring, responsive to those matters we have brought to their attention, and is well-led". Our surveys of about 500 patients have shown this. However, our surveys have not all been structured in the way that the CQC will now be looking at the practices and we look forward to trying to develop a more integrated approach to the Practice assessments.

We are very fortunate in this issue to have as our Educational Author

Dr Sophie Helme MB ChB MSc FRCS

who has written on the early detection of

Breast Cancer



Sophie was brought up in Surrey and went to St Ives School in Haslemere. She then went to Downe House followed by Wellington College. She qualified as a doctor from Edinburgh University and most of her subsequent training posts have been in London and Kent. She is currently employed by Queen Alexandra Hospital, Portsmouth and has recently been appointed there as a consultant surgeon with a special interest in oncoplastic and reconstructive breast surgery. The breast unit is very busy and performs over 600 breast cancer operations per year.

Her qualifications include MBChB from Edinburgh University, an MSc in Surgical Technology from Imperial College and FRCS (Gen Surgery) for which she was awarded the top Gold Medal prize. She was nationally appointed for training posts in both oncoplastic reconstructive breast cancer surgery and cosmetic breast surgery.

She currently lives in Haslemere with her husband and two small and very cheeky children. When she has time, her hobbies include playing golf, riding, skiing, socialising and cooking.

Breast Cancer- what to look out for

by

Dr Sophie Helme

Breast cancer…. The dreaded words…. Us ladies know we should keep a close eye on our breasts so we can report any changes early to our doctor, but what is it exactly that we should be looking for? And how do we go about doing it?

Breast cancer is a common disease, affecting approximately 1 in 8 women in the UK during their lifetime. 99% of the time it affects women, but occasionally men can get it too.

Unfortunately it is becoming commoner, and so more of us know somebody who has been treated for it. However, it is not all bad news as there are excellent ways that it can be treated, and survival has improved dramatically in recent years. The most recent figures from Breast Cancer UK show that over 85% of women diagnosed with breast cancer survive their cancer for 5 years and more than three-quarters survive 10 years or more.

<u>So how do I know if I might have breast cancer?</u>

The chances of having breast cancer increase with age with the majority developing it after the age of 45-50. There are two main ways that it can be detected- via changes to the breast that the woman has noticed herself, or through the NHS Breast Screening Programme. This programme offers x-ray tests of the breasts (mammograms) every three years to women aged between 50 and 70 (soon to be extended nationally from 47 to 73). The idea is that the mammograms can detect changes to the breasts which may be associated with cancer, and allow doctors to investigate at an earlier stage than might otherwise have been possible.

Self examination is the other recommended tactic for detecting changes to the breasts early. This involves looking at and feeling the breasts on a regular basis, so that any changes can be reported to your doctor. I wouldn't recommend self examination more frequently than once a month, as due to cyclical hormonal changes, the breasts will change naturally day to day and week to week. For those still having periods, the best time may be a few days after your period, when the breasts are less swollen and tender. If you are no longer having periods then choose an easy day of the month to remember. The important thing is to be familiar with how your breasts normally look and feel, so that you can detect if something changes. No two women's breasts are the same in look or feel, so what may feel abnormal for you may be normal for someone else.

Self examination

1. Look at your breasts in a mirror, both with your arms down and your hands on your hips. Then raise your arms above your head. Look especially for skin dimpling at this time.

2. Examine the nipples for any new indrawing, skin change/eczema or nipple discharge (fluid seepage), including blood discharge.

3. Lie down so you are flat, or slightly propped up on a pillow, and raise one arm above your head. With the other hand examine the whole of the breast with the flat of your fingers, feeling the breast tissue as it lies on the chest wall. It doesn't matter how you do it as long as you feel all around the breast, including the central area and up into the armpit. Some people feel in a circular spiral, while others feel each section from out to in as if feeling all the numbers of a clock face. Feeling with the tips of the fingers is not such an accurate way of detecting breast cancer.

Changes to look out for include:

1. A new lump in the breast or armpit. This is probably the most important change. Any new breast lump should be investigated.
2. New indrawing (inversion) of the nipple. Some women naturally have inverted nipples, but any new inversion should be looked into.
3. Skin changes to the nipple- weeping, crusting, or eczematous change.
4. Skin change to the breast- bulging, dimpling, redness, swelling.
5. Change to the contour of the breast or a new size discrepancy between the breasts.

This is only a brief description, and much more detailed information and diagrams are available online or at your GP surgery. Your doctor or practice nurse can show you how to examine yourself if you are not sure how to.

Remember, most changes to the breasts are benign and not related to cancer. In fact 9 out of 10 patients seen in a hospital breast clinic are reassured and discharged. However if there is a persistent change that you have noticed then you should have it looked at by your GP. They can then refer you to the local hospital breast clinic if necessary.

Family History

Many people worry that they might have a faulty gene that will cause them to have breast cancer. This worry usually starts because there is a family member who has suffered with breast cancer. However less than 10% of breast cancers are due to an inherited faulty gene. If you have concerns

about your family history, your risk can be assessed by your GP. Usually this involves detailing exactly who in your family had breast cancer, what type of cancer they had, and their age of diagnosis.

Pointers of particular interest when identifying families in whom there might be a higher risk of breast cancer are:

Bilateral breast cancers (breast cancer affecting both breasts),
Ovarian cancer,
Male breast cancer,
Jewish ancestry,
Young age at diagnosis (<40),
Multiple first degree (mother, sister, daughter) or second degree (aunt, grandmother, niece) relatives who had breast cancer.
It should be noted that both your father's and mother's family history are potentially relevant.

If you have a single family member who was diagnosed with breast cancer over the age of 50, then you are unlikely to be at increased risk compared to the general population.

Breast pain

Breast pain (mastalgia) is a very common problem that affects most women at some stage in their life. While it can be a pain (literally) for many women, it is not usually a sign of cancer but if you are concerned at all, you should see your GP or Practice nurse. It can either be due to hormonal changes affecting the breast tissue, or due to pain in the underlying muscles or cartilages of the chest wall. Simple measures may help :

a) Ensure that your bra fits properly and gives good support. Badly fitting under-wiring can push in on the breast and cause pain, so a trial of a non-under-wired bra may help. A visit to your local bra fitting service will ensure your bras fit properly.
b) Wearing your bra at night if this is when you have pain.
c) Taking simple pain killers when required.
d) Taking exercise, including upper body exercise, to ensure your underlying muscles are in good condition.
e) Reducing caffeine and alcohol. Also trying a diet of less fat, and more fibre, fruit and vegetables.
f) Evening primrose or Starflower Oil. This contains GLA and some women find that taking high doses of this (240-320mg GLA per day) for 2-3 months can help. But these are unproven in clinical trials. These tablets should be available at your local health food shop or chemist.

NHS Choices

Many of you may recall that in our last newsletter, we expressed concern about the NHS Choices web-site regarding its rating of GP Practices. Since then we have been able to discuss this with NAPP (our National PPG body), our CCG, our GPs and with our committee. We have discussed with NHS Choices and they have been very receptive to our comments although I am unsure what changes will result.

With regard to the GP Practices, the NHS Choices web-site was set up about 7 years ago to allow patients to comment, good or bad, about any experience they had when they visited their surgery. This was regarded as a 'Family and Friends Test' – would they recommend this Practice, or not, to a member of their family or to a friend?.. The patient also rated the surgery from 1 to 5, bad to good. Comment made was forwarded to the Practice manager who replied and this was then posted on the internet site. In principle this may seem a good system to introduce. However in practice, it is our opinion that it is not working well.

NHS Choices made several decisions at the start:

1) NHS Choices would not advertise that this service was available to everyone. It was only available by word of mouth.
2) Patients could choose if they wished to remain anonymous both on the internet and also to the Practice
3) The Star rating given by each patient would be summated and used to give each surgery a total Star rating which would be used to compare each surgery locally and nationally
4) The comments made by the patient would be forwarded to the Practice manager before being posted on the internet site for comments to be made but only for a very short period of time and if no reply came quickly, the comment would still be posted.

It is apparent to us that there are problems with this site

1) The majority of people who have been making comments on this site about our surgeries have had a grievance and it is rare for patients who are very happy to write in to NHS Choices
2) Totalling the Star ratings of all these patients has put a total low Star rating which does not equate to the satisfaction levels of our surveys and those of NHS England carried out on our surgeries.
3) Some of the comments are anecdotal, one off incidents which attract a 1 Star rating

4) The nature of the web-site always appears to indicate that every comment is the fault of the surgery when sometimes there is a concern that the patient may have a problem. When the patient remains anonymous, their problem cannot be tackled.
5) We feel it would be better that any problem which appears to be patient related is fully discussed with the patient, and resolved first before appearing as a completed exercise on the web-site.
6) NHS Choices makes no effort to stop one patient sending in more than 1 comment using different Email addresses anonymously. Such a patient can then put in several 1 Star ratings
7) Other NHS bodies may use the Star ratings of NHS Choices to compare the standard of Practices which is unfair
8) Some patients, new to an area, may look at the NHS Choices web-site to decide which Practice to join and may be misled by the Star ratings on NHS Choices.
9) Where it is obvious that a surgery has a low rating, it is possible to raise the total rating without changing the standard within the surgery by asking several patients who feel it is justified, simply to write in and give 5 Star ratings eg we increased the Star rating of Badgerswood from 2 to over 4 in a month. Nothing changed in the surgery.

Can I give you a reply I received from NHS Choices? He agreed to this appearing in our newsletter and we have asked him to check this article before printing. We thank him very much for his assistance. The comments we have made have gone to the User Research Group for consultation and we hope may help to improve the web-site. We think in principle it is worthwhile, but has problems in the way it is functioning.

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"As you recognise, there are a lot of challenges that come with an ambitious project like this but let me assure you that we do everything with patients' and service users' best interest at heart.
User commenting has been going on for years now and more than half a million comments have been posted in this period and we are continuing to grow (with almost 200,000 that will be added this year alone), which means that some of the issues you raise will work themselves out over time - namely, some practices having none or just one comment or rating. Also, even with our current volumes, we see that positive comments and ratings significantly outnumber the negative ones, which, bearing in mind human propensity to be more vocal in criticism than in than praise, is not bad. Also, this is something that will improve further as the volume of comments and ratings grows.

Regarding the listing of practices when user searches by location, the order is decided purely by distance from the centre of the postcode/location entered and not rating and it's pure coincidence that a singlehanded practice with a comment from two years ago is displayed above yours.

Also, it is worth noting that overall rating is based on the median of ratings given in the previous 24 month (rolling) and that once the comment in question becomes older than 2 years the overall rating for the practice will go down to "no ratings". This feature has been designed so that any improvements or deterioration in service can be spotted over time. However, with a bit of luck more, new, comments will added before then.

Regarding your suggestion of selecting a group of patients at random and allowing only them to comment would meant that we would, in effect, take away the right to comment from 4,900 patients per practice site on average. This is something that goes against the core purpose of NHS Choices, which is to give a voice to all patients. Additionally, with more than 10,000 practice sites in England alone, administering such a scheme would be hugely complicated and expensive if we are to ensure that it remains completely impartial. In any case, as previously mentioned, any potential bias will be soon resolved with the greater numbers of patients leaving reviews on NHS Choices. In any case, I can assure you, next time we look at our ratings and commenting functionality, as we do on a regular basis, we will bear your comments in mind and include them in our user testing.

With regard to patient names and sharing them with practices, we are obligated to create an atmosphere where users can feel free to comment on and rate a service without fear that it may affect their future treatment in any way and that is why we allow them to post anonymously. Having said that, if we are ever contacted by a practice asking for a patient to get in touch with them to discuss their comment so they can investigate it properly, we are more than happy to reach out to the patient and ask them to get in touch with the practice if they wish to discuss their comment further. As I mentioned before, I will run your suggestion past our user research group to test if it would have any negative effect on commenting if put into practice.

As far as publicising NHS Choices goes, we are in complete agreement but we have never been allowed to advertise, locally or nationally, and have always had to rely on word of mouth. Despite this NHS Choices has grown for a small website, seven years ago, receiving about 8 million visits every year to one of the largest health information websites in the world with more than 600 million visits per year. In addition to this we are the largest health service rating site in Europe and possibly in the world."

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If you have visited either of our surgeries recently and wish to make a comment and Star rate your visit, this may help to give a fairer rating.

Hip Hop

By
Ian Harper
our Treasurer

Those of you that know me, could be forgiven seeing the title of this article that I am about to write a piece on music, but they would then realise Hip Hop / Rap Music is not my style. Anyway what would a music article be doing in a PPG newsletter?

What the title refers to is my recent experience of receiving a new hip. I thought it would be interesting to set out the process from start to finish. I hope some of you find it interesting and some of you may even find it useful.

I first noticed pain over 5 years ago and tried physio and ultra sound with little effect. I had the hip x-rayed and was told it was in the early stages of arthritic decay. I was in my late fifties and was told the longer you can put off an operation the better.

I was able to do this with changes to my life. The first was early retirement which stopped me sitting at PC's for long periods and reduced long haul flights. The second was a change in life style. I had gone to a gym for 10 years but with, "A relaxed attitude " I joined a local gym with my wife, going 4 times a week, followed by 20 lengths in the pool. At my doctors advice I also took up Pilates. This all resulted in a weight reduction of 2 stone and greatly increased flexibility and body strength. . This all helped enormously and I am sure delayed the next step by 4 years. But by autumn 2013 I knew something would soon need to be done. Dr Leung arranged for X-Rays, which I had at The Chase in mid November 13. I remember what they said. :-

There are severe degenerative changes in the left hip with almost complete obliteration of the joint space superiorly.

Did not sound too good but with Christmas and a holiday coming up I delayed the next move until mid February when I asked Dr. Leung to refer me to "The System ". Asked which hospital I would prefer I said "Royal Surrey". I received a letter a month later giving me an appointment on the 18th March with Mr. Rosson of Trauma & Orthopaedics. My wife and I arrived half an hour early and were sent straight away to X-Ray. Back to Mr. Rosson who confirmed I needed a new hip and told me to go down to the Pre-Op department. There a couple of forms were filled in, blood pressure, heart rate, etc taken. A few swabs to ensure you are not carrying anything nasty and that was it. I would hear in a few weeks when the Operation would be. I asked the obvious question, How many weeks? Patients are meant to be treated in the NHS within 18 weeks of a referral but I was told for my procedure at this hospital at this time it could be 10,

A mild panic came over me that England's first World Cup was 12 weeks away, a thought I expect never crossed my wife's mind.

The next thing was a phone call on the 27th May offering me an operation on the 5th June. They said I would be phoned the evening before giving me a time. That happened and was told I would be the first operation in the morning so report at 7-15. By 8-30 I was talking to the anaesthetist who was giving me a spinal block and the next I knew was awaking up looking at a clock in post-op that said 11-15. Five minutes later I was having a cup of coffee and a packet of biscuits. The best thing, for the first time in nearly 5 years I was in no pain. About an hour later I was taken to the ward and was lucky enough to have a private room. That's what I call service. The next day I was visited by the occupational therapist who discussed the correct way to dress, post-operative precautions, using appropriate aids and how I would manage daily activities once home.

I was also visited by the Physiotherapist, first in the morning to show me the bed exercises you must do. She also got me out of bed and using a Zimmer frame walked me a few yards and got me to sit in a chair and out again and back into bed. Time for lunch what a morning! In the afternoon my surgeon came by to say how things had gone and soon after the Physio was back to repeat the morning's work and using the Zimmer frame a little walk down the ward. The next morning the Physio was back, this time with a pair of crutches. By the end of the day I was using the crutches to walk up and down the ward on my own. The next morning was Sunday, 3 days after my operation. The Physio took me to their gym and showed me how to walk up and down stairs. Ten minutes later we were back in the ward and he said he was signing me off as good to go. The nurse said with luck the doctor would do the same and I could go home later that day. And so at 5 in the evening I was sitting in my wife's car being driven home. In all I was only in the hospital three and a half days.

And now for the interesting part, you are on your own, no hospital to help.

Getting up stairs that night was the first big test. With my wife there for reassurance I made it. I went to the loo using a raised toilet seat for the first time. Got into bed and with a cushion between my legs to stop me turning onto my side, I slept on my back for 8 hours.

The next few days were spent, learning, adjusting, laughing, crying, cursing and resting. I was very lucky as the weather was excellent which enabled me to practise walking outside. How many times do you want to walk up and down your hall or living room? I started walking with two crutches and soon learnt an important lesson, exercise little and often. It is very easy to overdo it. Listen to your body. Rest on your bed for two

hours every afternoon. Don't be surprised how quick muscle loss happens.

At this point I would like to give a few words of advice to anyone about to have this type of operation. Be prepared. After a couple of days my leg and foot swelled. This is common, they had told me. It was by chance I had some footwear that fitted. The area around the wound is heavily protected so a pair of tight jeans will not do. Make sure you have loose fitting clothes to hand. Before you go in you receive information about furniture. Height of bed, height of toilet seat, height of chair. Make sure you have this ready before you come home. Think of where you have things in cupboards. You will not be able at first to get things from lower shelves for example.

By the end of the second week I was down to one crutch. I also went up to our practice and had the stitches removed by one of our very caring nurses.

Once you have a routine it gets easier. By the end of four weeks I stopped using crutches. Then bad mistake. Remember I said earlier," little and often. It is very easy to overdo it. Listen to your body". I went on a walk much longer then I had before and did not listen to my body. Back onto one crutch, back onto painkillers. It put me back a week. It is at this point I will mention my only disappointment of the process. I think if I had been offered some physiotherapy during my recovery this may not have happened. But you do feel on leaving the hospital it is a bit "Get on with it".

But now it is seven weeks since my operation and I have just returned from Royal Surrey where my Surgeon has signed me off. I can drive again, exercise again, swim again, even cut the grass.

My left foot is still slightly swollen, the area around the hip a little tight but he said this is all quite normal. So taking it very carefully I'll be back in the gym and pool helping my body to fully recover. I still have a month or two until I am back to normal but I know that to have no pain was well worth it.

I have so much to thank my wife for because without her help this process would have been almost impossible. How someone living on their own copes I cannot imagine. I must also thank Mr. Rosson and his Orthopaedic team at Royal Surrey, all the staff of Bramshott Ward, Badgerswood Surgery and my friends. I think I still owe a few pints.

So back to where I started. Do I put James Weldon Johnson's song Dem Bones, Dem Bones onto the turntable so I can check if " The thigh bone connected to the hip bone, the hip bone connected to the back bone " is correct or do I get Etta James " Blues to The Bone " LP out and relax in no pain. Hello Etta.

Great British Doctors
No. 3
Francis Crick (1916 – 2004)

Francis Crick was not a doctor of medicine but held a PhD, and in 1962, together with James Watson and Maurice Wilkins, he was awarded the Nobel Prize "for their discoveries concerning the molecular structure of nucleic acids and its significance for information transfer in living material". Basically Crick was a molecular biologist who discovered the basic structure of DNA (Deoxyribonucleic Acid) and RNA (Ribonucleic Acid) and their importance in the transfer of genetic information from cell to cell. His discovery is changing the whole face of clinical medicine in the 21st century.

Francis Harry Compton Crick was born on 8th June 1916 near Abington Park and Weston Favell, near Northampton, where his father owned a shoe factory. His grandfather was an amateur naturalist and knew Charles Darwin. Crick attended Northampton Grammar School till the age of 14 then obtained a scholarship to Mill Hill School in London where he studied Physics, Chemistry and Maths. He went on to University College London studying physics and graduated in 1937. An initial attempt to gain entry to a PhD course at Cambridge was unsuccessful because he failed the Latin test and also because war interrupted his progress! During the war he worked for the Admiralty as a scientist on magnetic and acoustic mines designing a mine that was effective against German minesweepers. He left the forces in 1947.

After the war, supported by a Medical Research Council grant and with family financial help, Crick changed subjects and started to study biology at Cambridge. He had no knowledge of the subject and his early years were spent studying organic chemistry and crystallography. Crick was interested from the start with 2 fundamental problems of biology – how non-living chemicals are involved in the formation of living organisms and how the brain makes a conscious mind. As his studies progressed, he became more convinced that it would finally be possible to create life from chemicals and molecules in a test-tube.

When you look at a tissue under the microscope it is made up of cells, and each cell contains a central part called a nucleus. For many years there have been known to be strands within this nucleus called chromosomes and the number of these and their shapes vary from creature to creature. Humans have

46 chromosomes, and these can be matched together in identical pairs apart from 2. We therefore have 22 paired chromosomes called 'autosomes'. The remaining 2 chromosomes are called sex chromosomes. In a man 1 looks like an 'X' shape under the microscope and the other looks 'Y' shaped, while in a woman, both look 'X' shaped. We receive half the pair of autosomes and one of the sex chromosomes from one parent, and the other half from the other. Unlike what King Henry VIII thought, your father determines whether you will be female or male by donating either your 2nd X or your Y chromosome!

Crick's research, and that of his colleagues, concentrated on these chromosomes. It is known that tissues in the body grow by cell division. The first move is the chromosomes splitting in half, and each half forming an identical original by picking up pairing chemicals. Having formed paired new identical chromosomes then causes the nucleus to split in 2 followed by the cell. Using crystallography, Xray diffraction work, and knowing the chemicals present in the chromosomes and how they pair up, Crick with colleagues Watson and Wilkins were able to deduce the double helical or spiral structure of DNA which forms the chromosome and how it separated and re-formed the paired new chromosomes. Basically Crick had discovered the chemicals and how they formed the basis of our cell structure – of our very body!

One item of controversy surrounded Crick's work in that a researcher, Rosalind Franklin and her student, Raymond Gosling, did all the X-ray diffraction work. They left the department just before Crick and Watson published the work which gave them the Nobel Prize. Much of this contained the work of Franklin and Gosling who, when they left, were forced to leave the results of their work in the department. They therefore received no credit for their contribution to Crick's discovery although it was in fact immense.

Although the Nobel Prize came primarily because of the theory, Crick spent several years afterwards proving that DNA was in fact the genetic code of the nucleus and transmitted information to the cell via a transmitter molecule called RNA, which then instructed the cell to form specific proteins and perform specific actions needed by the body.

In 1974, Crick moved to the US and became Professor of Biological Studies at Salk University in California. He died on 28th July 2004 from Colon Cancer. Throughout his life he remained totally anti-religion, convinced that life was composed of chemical structures

which controlled and formed the body and he publicly called for humanism to replace religion as a guiding force for humanity.

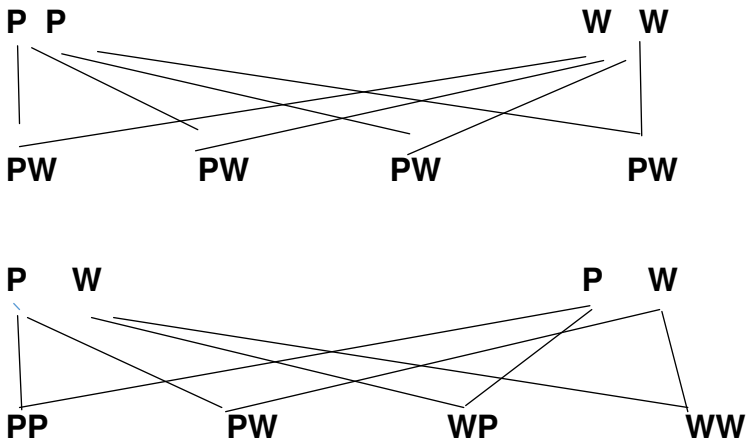
On 19th March 1953, Crick wrote to his son about his discovery, the letter starting "*My dear Michael, Jim Watson and I have probably made the most important discovery …"* The letter was auctioned at Christie's New York in April 2013 and sold for over $6 million.

Crick's work is now being developed and its potential is yet to be recognised. Just this month, our government has given a large grant to map the whole 'normal' human genome or pattern of chemicals in all the human chromosomes, in order to define and match to abnormalities that can be found in human diseases. The work is immense and once mapped, the work to try to alter the defects will then begin. Crick's work is about to change the whole pattern of medicine for the 21st century.

Good examples of the application of the knowledge of DNA

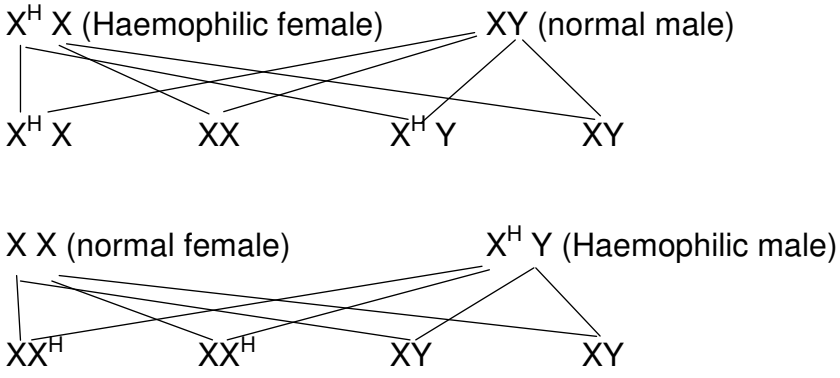
Haemophilia and MEN II Syndrome

To understand the basics of genetics we need to go back to the Austrian monk Gregor Mendel and his famous work on flowering peas in the 1860s. Mendel is called the Founding Father of Genetics. Mendel experimented with 2 pure coloured hybrids of peas, purple and white. When he pollinated the purple flowers with pollen from purple flowers, he obtained seeds which produced purple peas, and likewise white flowers pollinated with white pollen produced white peas. However, when he pollinated purple flowers with pollen from white flowers, he always obtained all purple flowers! But if he then pollinated this second generation of purple flowers with pollen from the second generation of purple flowers, he obtained a mixture of purple and white flowers in a ratio of 3 purple to 1 white pea plants. To explain this Mendel produced a graph with each parent plant donating a single colour gene to the offspring which would pair together. The first generation plants would therefore each have a purple / white linked gene. Mendel postulated that purple was a dominant gene, so all the plants would be purple. In the second generation, the plants would pick up one gene from each parent, and statistically the chances of having 2 purple genes were 1 in 4, 2 white genes 1 in 4, and 1 white and 1 purple gene 1 in 2, as shown in the graph below. Since purple is dominant, 3 plants in 4 will be purple and 1 will be white. This work forms the basis of genetics.



We know of many inherited human diseases. Some we call dominant and others recessive. Over the past decades workers have linked these to specific chromosomes.

For example, Haemophilia, the bleeding disorder common in the Royal families of Europe is linked to the Sex Chromosome and is recessive. It is carried on the X-chromosome and does not express itself clinically in the female because of the other X-chromosome which is normal and is dominant. However since the male has only 1 X-chromosome the disease expresses itself. So haemophilia is carried by women who are clinically well but expresses itself in the male of the family. Daughters of female carriers have a 50/50 chance of being carriers and sons a 50/50 chance of having the disease. Daughters of haemophiliac men will always be carriers. Sons of haemophiliac men will never have the disease and their offspring will never carry or transmit the disease.



MEN, or Multiple Endocrine Neoplasia, is an uncommon disease which has interested the medical profession for years. Neoplasia is the medical term for cancer. Endocrine refers to anything related to hormones. MEN is a disease which runs through families which affects their hormone glands – their thyroid, parathyroids, adrenals, pituitary, pancreas, and others. It is divided into 2 types MEN I and MEN II depending on which cluster of glands is affected and is autosomal dominant.

MEN II has caused particular interest because the disorder caused in the thyroid is a rare type of cancer called Medullary Cancer and this is frequently the presenting feature into the whole family. When someone presents with this cancer, the patient needs to be investigated for problems with all their other glands, and their whole family also needs to be checked as well. Over the last 3 or 4 decades, in the UK, US, and other countries with highly developed health services, it seems likely that all the families with this genetic disorder have been identified. Rarely an occasional new patient appears.

About 20 years ago, Professor Sam Wells, from St Louis in the US presented a paper which amazed the medical world. He had been studying all the families in the States with MEN II having noted especially that there was a large cluster of apparently unrelated families in the

Boston area. He felt that several generations back, they must be related to each other and he had spent some time with them exploring their family trees, eventually proving that they were in fact all related to each other through their past relatives. In addition to this, there was a family which had been picked up in San Francisco who were apparently also unrelated, and he went on to prove they were also part of this same family group and had crossed the States with the wagon trains in the 1870s. A family in Tasmania also ultimately proved to be related to the family in San Francisco having crossed the Pacific in a Con Tiki raft. Professor Wells now had all the families known in the States related to each other and he worked backwards to what seemed to be point 1, thinking they must all have come from 1 individual. When he did this, he came back to a date corresponding closely to that at which the Pilgrim Fathers crossed to the States. He therefore thought that someone from the UK must have brought the MEN II gene at that time. He then worked with workers in the UK and they worked backwards from their known families until they came to where they thought the MEN II gene must have started. They now think that all the MEN II families in the world are descended from 1 person who was born in the Black Isle north of Inverness before the time of the Pilgrim Fathers.

MEN II particularly affects the parathyroid glands, the adrenal glands (producing tumours causing very high blood pressure), and the thyroid gland causing a vicious cancer which affects the very young and is rapidly fatal. The interesting thing about the thyroid tumour is that it can be prevented if the thyroid is removed before the cancer arises. Obviously one would only want to do this if the child has inherited the disease, and even if he/she has inherited the gene, it is not always certain they will develop the thyroid cancer.

This is where Crick's work has come to the fore. We now know which chromosome is abnormal and even the chemical abnormality. Since we know all the families who are affected, if any child is born to that family, we can obtain some cells from a cheek swab and check the chromosome at birth and tell the parents right away whether the child has inherited the gene. If not, there is no problem. If 'yes', we can test to see whether they will develop the thyroid malignancy. The youngest child ever to develop such a tumour is age 3. If everything points to tumour development, the child should have a total thyroid removal before the age of 3.

One day, perhaps soon, we may be able to perform genetic engineering to modify the gene back to normal. MEN II may be one of the first diseases to try this when the time comes.

Changes within the Practice

Major changes are occurring within the Practice, many of which have already been mentioned. Dr Boyes is leaving us, Badgerswood is being extended, a new GP, Dr Helen Sherrell, is joining us at Badgerswood, and Dr Malllick is moving some of his sessions down to Forest to help there. We are hoping that we may get another GP to join us with some sessions in November but this has yet to be confirmed.

The building of Badgerswood is progressing well and we hope to get the extension watertight before the wet weather arrives. Of course, this is not helped when a palette and a half of bricks are stolen from the site!

The papers and the news keep making worrying noises about General Practice and threats from the CQC seem unsupportive. However, we think our Practice is well placed and by striving forward, enlarging, and aiming to provide services totally in house such as diabetes and chest services, and to aim to be a teaching and research unit in the future, these can only make our Practice ever more secure.

Discussions are underway at present to try to develop a chest service in the Practice. Equipment for this will be necessary, and in the first instance, we need a new Spirometer to measure respiratory function. The old spirometer is broken beyond repair The PPG will again be looking for funds to help the Practice purchase this machine.

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

New BP Monitor in Forest Surgery

We have now installed a blood pressure monitor in the Forest Surgery for all patients to use as they arrive. The monitor will give 2 readings and if your level is above 140 / 90, either of these readings, sit and relax for 2 or 3 minutes, then take a reading again. If it is still above this level, show your readings to your doctor or nurse as you attend for your consultation.

One of our receptionists is demonstrating the monitor in use. It's easy to use and is painless.

.**We need some information on how useful this machine has been. We don't want your readings. We only need to know the number of people who use the machine and the number who have a high level. Please tell us if you use it and if your level is normal or high.**

Thank you

WE NEED YOUR HELP AGAIN!

BADGERSWOOD SURGERY NEEDS A NEW MEDICAL EXAMINATION COUCH

A new couch cost about £850 + VAT

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

Can you help us with a donation however small?

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

Practice Details

	Badgerswood Surgery	Forest Surgery
Address	Mill Lane Bordon Hampshire GU35 8LH	60 Forest Road Hampshire GU35 0BP
Telephone Number	01428 713511	01420 477111
Fax	01428 713812	01420 477749
Web site	www.headleydoctors.com	www.bordondoctors.com
G.P.s	Dr Anthony Leung Dr I Gregson Dr H Sherrell	Dr Geoff Boyes Dr Charles Walters Dr L Clark Dr A Chamberlain
		Dr F Mallick
Practice Team	**Practice Manager** Sue Hazeldine **Deputy Practice Manager** Tina Hack **1 nurse practitioner** **1 practice nurse** **2 phlebotomists**	
Opening hours	Mon 8.30 – 7.30 Tues/Wed/Thurs 8.30 – 6.30 Fri 7.30 – 6.30	
Out-of-hours cover	**Call 111**	

Committee of the of the PPG

Chairman	David Lee
Vice-chairman	Sue Hazeldine
Secretary	Yvonne Parker-Smith
Treasurer	Ian Harper
Committee	Nigel Walker
	Heather Barrett
	Barbara Symonds

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

Also via forms available at the surgery reception desk

Badgerswood Surgery
Headley

Forest Surgery
Bordon

PATIENT PARTICIPATION GROUP

Educational Articles

from the quarterly newsletters

Issues 2 to 11

July 2011 to October 2013

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

Available for purchase at Practice reception desks

Bordon and Whitehill Voluntary Car Service

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

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

Our telephone number is

01420 473636

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

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

Voucher

Headley and Chase Pharmacies

can now offer

Lipotrim

which is a weight reduction programme

Interested ?

Please ask for

Teresa @ Chase Pharmacy

Emma @ Headley Pharmacy