Patient Participation Group

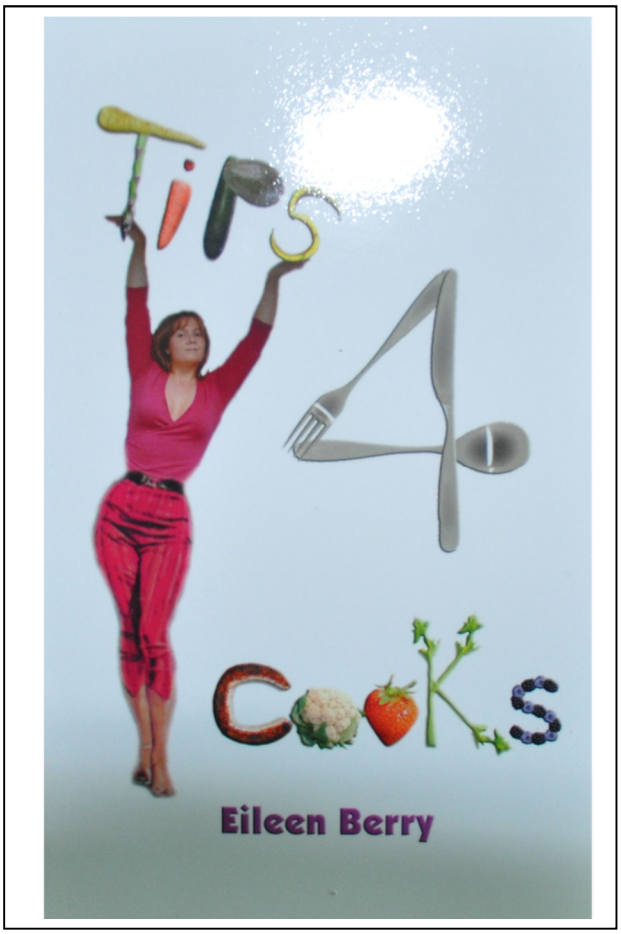
Newsletter

incorporating the

Friends of the Badgerswood and Forest Surgeries

October 2018 Issue 31

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”.

Flu Jab

For everyone who is due their flu jab

Remember

Don't forget to contact the Practice and book into one of the clinics

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Chairman and Vice-chairman report

We have much to report from the PPG this time.

1. Our Educational Article this issue is on the common problem of "Acute Appendicitis", regarded by many as a minor affliction but still responsible for the occasional death every year.
2. Our Great British Doctor is about Prof Richard Doll and written by Marcia Hammond, our co-editor. He is the man who confirmed the association between smoking and lung cancer.
3. We reported previously that the phlebotomy (blood sampling) clinic would be moving back to the surgeries from Chase Hospital on the 1st of October. There has been an unforeseen problem which is going to cause a delay. We explain in the newsletter.
4. Our plans for 1st Aid Training are being adjusted. We are having difficulty providing the dates many people want. We explain what we plan to do.
5. We also plan to hand over the printing of the newsletter to a printing firm. This will be for a trial period initially next year.
6. As Pinehill and Forest Surgeries seem to be slowly drifting closer together, we share some thoughts we have been having with the Pinehill PPG.
7. A recent Quiz night at the Church Centre in Headley was great fun and also raised further funds for PPG and the Practice
8. As noted, fund raising is still high on our list of activities. We have now purchased a FeNO machine for the practice and thank everyone who contributed.
9. We have recently made contact with the Whitehill and Bordon Town Partnership, assisting with the servicing of their defibrillators and also running a 1st Aid Training course for them. We hope to have an article from them some time telling us about their activities.
10. We seem to have had no complaints about the practice activities this quarter, either to us at the PPG or via NHS Choices. However NHS Choices has had 4 complimentary emails which we publish. We also produce our Friends and Family Test results so far again.
11. As mentioned in our previous newsletter, Basingstoke is planning to withdraw its clinics and X-ray facilities from the Chase Hospital. This is not likely to be soon as they are trying to find alternative providers to run these services before they leave, so it is likely these clinics and X-ray will continue well into next year. No firm decision has been made yet however about their leaving if no other provider can be found.

Issues raised through the PPG and NHS Choices

NHS Choices now rate

Badgerswood Surgery 4.5 Stars out of 5

Forest Surgery 4 Stars out of 5

Four comments were received at NHS Choices in the past 3 months.

Saturday morning Extended Hours - (rated 5 stars)
My 89 year old, deaf father needed to see a nurse on a Saturday morning for a leg wound. It was booked by his own Surgery (Pinehill) as part of the extended hours service. We had never been to Badgerswood but what a lovely place it is. We received a warm welcome from the receptionist and the nurse called us at our exact appointment time. She was kind, patient, reassuring and efficient. Thank you.
(Posted in August 2018 regarding Badgerswood)

Excellent care - (rated 5 stars)
Rang this morning for an appointment for my son. Got one for 9:20am. While there he needed specialised treatment for an ear infection. The GP phoned the hospital and he soon was seen in the morning clinic in Basingstoke. Within 3.5hrs we had seen the GP and the ENT consultant - fantastic service from our NHS. Thank you to all.
(Posted in August 2018 regarding Badgerswood)

Excellent GP - (rated 5 stars)
Went to see the doctor today and as usual the staff in the surgery were happy and helpful. The doctor was wonderful, caring and made me feel like I was the only person in the world that mattered to her at that point. I cannot praise this GP enough. She is so down to earth caring and just how a family dr should be. Nothing is ever too much trouble and she gives her time so freely.
(Posted in July 2018 regarding Badgerswood)

Great help with online system problem – (rated 5 stars)
Following changes to the patient online system had trouble logging on. A member of staff in the practice over the phone helped to get it working. A number of people are having the same problem which is an outside system so not the surgeries fault. Very understanding. Thanks very much
Posted in July 2018 regarding Forest

Badgerswood and Forest Surgeries Friends and Family Test

December 2014 to end of July 2018

How likely to recommend services to friends and family

	Total	%
Extremely likely	744	78.6%
Likely	161	17.0%
Neither likely nor unlikely	16	1.7%
Unlikely	10	1.1%
Extremely unlikely	14	1.5%
Don't know	1	0.1%
	946	100.0%

Extremely likely + likely = 95.7%

As at 6.8.18
Please continue to complete this survey each visit

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Printing of newsletter

At our committee, we have been discussing handing over the printing of our newsletter to a professional printer. We have now had several quotes for this and all seem about the same, at about £74 for 100 copies. Up till now we have been printing the newsletter in house, partly funded by the Practice. In future we hope to fund the printing from adverts in the newsletter. To begin with we have laid aside a small amount of our PPG funds for a trial run of printing to see how this will work.

As you may be aware, most of our newsletters are sent out electronically and this will continue, being sent out directly from the PPG. We hope to increase our numbers going out electronically as this is much easier and cheaper for us.

We now have a distribution of just over 400 newsletters going out quarterly, about 250 going out electronically. We plan therefore to request the printing of 200 newsletters with 150 being distributed and a small number being available for distribution at the Practice reception desks.

Asthma and FeNO

In the UK records confirm that there are 5.4 million asthmatics (9% of the population). The UK has the highest incidence of asthma in Europe and the highest recorded incidence of asthma in children world-wide. Figures from 2014 showed that on average 185 asthmatics were admitted to hospital every day and 3 asthmatics died every day. Over half of those who died did so before the emergency services could reach them. Over 75% of those who died were on the wrong medication, had not seen a doctor for over a year and a significant proportion had never even been properly diagnosed or studied.

A study of all the asthmatic patients at Badgerswood Surgery by Prof Chauhan, Prof of Respiratory Medicine from the QA, using more sophisticated studies confirmed that a small percentage of asthmatic patients were not on what his team would regard as ideal treatment and had to have this changed. Since that time, his study has been swung out to the whole of SE Hampshire and no asthmatic patients he has studied have had to be referred to hospital for an acute attack and there has been no mortality.

In GP practice, many patients are diagnosed as asthmatic or bronchitic, but a significant proportion of patients with respiratory problems have no firm diagnosis made and are labelled as 'breathless'. Many end up on inhalers despite no actual diagnosis of asthma being definitely made. Studies have confirmed that up to 30% of these breathless patients are probably truly asthmatic.

The standard method of diagnosis of asthma in general practice is by a careful history from the patient and examination of the chest and by spirometry testing for airway obstruction as the patient breathes out. During an asthmatic attack, these tests will be positive and if treatment is given with an inhaler to relax the airways at that time and shows that the patient has responded, the diagnosis is usually made. However between attacks, when a patient may present to the GP clinic, examination and spirometry may be normal and therefore it can be difficult to make the diagnosis, hence the label of 'breathless'.

Asthma however is an inflammatory condition of the lung with immune inflammatory markers and if the GP was able to test for these, even between attacks, a firm diagnosis could be made. In a true asthmatic, nitric oxide will be present in significant proportion in the breath, even between attacks and if detected can confirm the diagnosis for certain. A

simple breath into a FeNO machine (measuring Forced Expiratory Nitric Oxide) may be diagnostic. If the test is positive, the patient will be correctly labelled and treated as an asthmatic, if the test is negative, other causes for the symptoms should be looked for.

NICE (the National Institute of Clinical and Health Excellence) is a non-departmental body of the Department of Health and produces an evidence based service for health, public health and social care professionals, producing guidelines for all aspects of medical care. NICE have made an exhaustive study of the care of asthma from all available reported medical studies and come to some firm conclusions about FeNO testing.

NICE recommends the use of a FeNO machine in all adults over the age of 17 in the diagnosis of asthma and to assist in the monitoring of the effect of treatment. In children between the ages of 6 and 17, FeNO testing can be essential where there is doubt from examination and spirometry. Ideally FeNO testing should be a first line investigation carried out in general practice. Referral to a specialist clinic is expensive and a waste of useful resources when this can all be done with ease at primary care level.

FeNO machine

In Prof Chauhan's study at Badgerswood in the past year using a FeNO machine, this was used over 100 times by the Practice as recommended by the NICE Guidelines. His study is now complete and the FeNO machine has been returned to his Unit. Unfortunately these machines are not funded for GP surgeries through the NHS.

With donations from East Hampshire District Council, Headley Voluntary Care, very generous donations from patients, and from PPG funds which include patient and PPG fund raising activities, we are now in a position to purchase a FeNO machine for Badgerswood Surgery and for Forest Surgery.

The Practice and the PPG would like to thank everyone who so generously donated to such expensive equipment for the Practice which NICE deem essential as a first line investigation.

1st Aid Training

We have decided to change the way we plan to run our 1st Aid Training programme. Up till now we have been offering training asking people to tell us when would suit to have training eg during the day, which day of the week, in an evening or at a weekend. It has proven almost impossible to develop courses to suit everyone and for many people we have not always been able to find groups big enough to run courses to suit all.

We therefore plan to book halls in advance and advertise courses with dates and times and see whether we can fill these more easily. This would mean that we will have to pay for the halls in advance which in some cases we may have to cancel if very few people apply. We plan to alternate initially between Headley and Bordon but will be open for people from either town to attend courses in the other. We will also book halls at different days and times month by month. Our hope is to train as many people as possible in the skills of the resuscitation of the life-threatening conditions of unconsciousness, choking, major haemorrhage and anaphylaxis or major allergic reaction. Our courses will still run for free but any donations to help pay for hall hire and disposable equipment will always be welcome.

We have trained approximately 150 people in Basic Life Support and we are now keen to train people in the care of conditions which require 1st Aid care but are not life threatening, such as management of fractures, seizures, nose bleeds, heart attacks, acute asthma attacks etc. We plan to contact many of those patients we have previously instructed in Basic Life Support to ask if they would like to attend a refresher course combined with a course on non-life threatening conditions.

It is our main ambition however to train as many children as possible in Basic Life Support. If we capture young children at the age of about 8 to 11 years in the basics of resuscitation, it is possible to train all the future members of a population and they should remember how to resuscitate anyone who suffers any of those conditions which are life threatening, for the rest of their lives. We have been working with Bordon Junior School and have now trained just under 140 children and plan to pick up more now that the school term has restarted.

The government have now recognised the importance of training young children in 1st Aid and want to introduce this to schools. We are well ahead of their recommendations in our area. It is of note that our 1st Aid

Training courses follow the recommendations of the Resuscitation Council UK (of which I am a member) but there are no recommendations on what should be taught to children either from the Council or the Red Cross. Training to children therefore has to be given by adaption from that which is advised to be taught to adults and from expert experience which only someone who has a wealth of knowledge in this field can give. As a surgeon who spent about 40% of his time dealing with trauma and taught 1st Aid over many years and who also spent time in training on paediatric units, I feel very competent to be able to adapt to what should be taught and how this should be delivered to children.

This must surely be one of the most important developments in making Bordon a 'Healthy New Town' for the future. We are very keen that as many people as possible become familiar with life support techniques. Our courses are free. Please come along and let us show you how easy it is to save a life if someone suddenly needs your help. We will also show you how to use a defibrillator and let you practice with one of our defibrillators on our courses.

Please contact us for details of our courses via either Badgerswood or Forest surgery reception or better via ppg@bordondoctors.com

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Message from the Resuscitation Council UK

CPR Education Campaign: CPR to be added to the school curriculum

Department for Education

In July the government announced draft guidance which proposes to make health education (part of Personal Social Health and Economic Education (PSHE)) a statutory requirement in English schools. This includes proposals to include basic first aid in the curriculum at both primary and secondary level and how to do CPR and the purpose of a defibrillator at secondary school.

The RC (UK) very much supports and welcomes these proposals after spending significant time campaigning on the issue.

How has this happened?

In February, we responded to the Government's call for evidence on whether or not to make PSHE compulsory, arguing for the inclusion of first aid and CPR training on the curriculum. We also contributed to a

joint response with our partners in the Every Child a Lifesaver coalition. This highlighted our support for first aid and CPR training on the curriculum and how the RC (UK)'s award winning CPR training app, Lifesaver and Lifesaver VR, and our World Restart a Heart campaign can support CPR education in schools.

That's why we're so pleased to hear that in response to our evidence, the Government have now proposed to make health education compulsory and get CPR on the curriculum in all secondary schools from September 2020!

Thank you to everyone who supported our submission to the call for evidence, but there is still more you can do to help us ensure that CPR goes onto the school curriculum.

What can I do?

We want to ensure that the positive proposals on first aid and CPR included in the draft guidance for schools make their way into final guidance, so it's important that as many people as possible make their voice heard on this important issue. You can share your views on CPR education in schools by responding to the Department for Education's consultation. The consultation closes on 7 November 2018.

The consultation seeks views on many other areas, including relationships and sex education, so if you're short on time, the most relevant questions to complete are:

- **Questions 1-9** (introductory questions)
- **Questions 16-19** on the draft statutory guidance on physical health and wellbeing
- **Question 24** about views on the draft statutory guidance (see pp. 8 and 24-30 for the proposals about compulsory health education, especially p. 30 for CPR training).

You may also wish to respond to:

- **Question 21** on delivery/teaching strategies
- **Questions 26-27** on school support
- **Questions 28-29** on the draft regulations
- **Questions 30-31** on the regulatory impact assessment (cost burdens of the proposals).

Key facts

To help you with your consultation response, it is worth noting and including some of the key statistics and figures we have on CPR:

- CPR is attempted in nearly 30, 000 people who suffer an out-of-hospital cardiac arrest (OHCA) in England each year.[1]
- Fewer than 1 in 10 people survive an OHCA in the UK.[2]
- Currently only 30-40% of victims receive bystander CPR.[3]
- As this intervention can treble survival, it is a key intervention in improving overall survival.[4]
- There is strong evidence to show that teaching young people essential life-saving skills leads to more lives saved in all settings and over many years. In Denmark, where CPR training in schools has been mandatory since 2005, the chances of recovery from an out-of-hospital cardiac arrest are triple those in the UK. In Norway, where CPR is also a mandatory part of the curriculum, survival rates from bystander CPR are an astounding 70%, compared to less than 10% in the UK.[5]

CPR training in schools could improve the low chance of survival after OHCA in the UK. Training on crucial lifesaving skills and knowing what to do in an emergency can also empower students, increasing their confidence in emergency situations. One such example is Oliver Davidson, who saved his dad Neil's life through the quick provision of CPR, a skill he learned at school 10 years before.

What happens next? Next steps:

The consultation closes on 7 November 2018. The results of the consultation and the department's response will be published within 12 weeks of the consultation closing, in early 2019. MPs will debate the Government's response shortly after it is published.

We will keep our website updated with news about our CPR education campaign, so follow us on Twitter or Facebook to stay up to date.

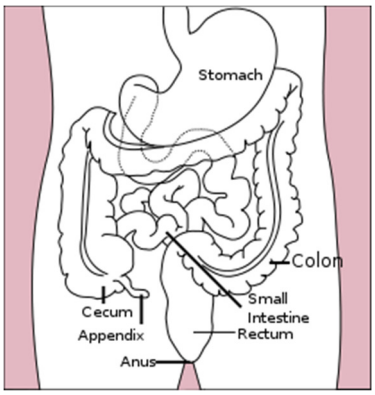
To hear more about our policy and campaigns work, email us at publicaffairs@resus.org.uk.

Let's get CPR education on the curriculum. Make sure you submit your views to the consultation.

Acute appendicitis

Different tissues and organs in the body are classified according to how essential they are for life. 'Vital' organs are those which are necessary and cannot be removed without transplantation eg heart or liver. Oher organs may function and serve a useful purpose but if removed their work can be undertaken by some other structures eg the spleen filters the blood and removes dead and dying cells but if it has to be removed, eg after injury, this work can be taken over by the liver. Many organs in the body serve no useful function but comparison with other animals shows that these structures are important for them eg the appendix has no important role to play in the human but in many herbivorous animals it is important in cellulose digestion. These are 'vestigial' organs and can be removed without any effect on bodily function if causing a problem. Acute infection in the appendix can therefore be dealt with by simply removing the appendix and this will have no effect on the body afterwards.

Anatomy



The bowel is divided into 2 main parts which we call the 'small intestine' and the 'large intestine' or 'colon'. The upper part, the small intestine, is very long and lies coiled up in the centre of the abdomen. It eventually runs down to the lower right side of the abdomen where it joins the colon. From here the colon runs round the periphery of the abdomen to end up at the rectum. Medically we divide the colon into parts and the first part in the lower right side is called the caecum. Attached to the lower part of the caecum is the appendix, a narrow, blind-ending tube of bowel.

The appendix is of variable length and most commonly lies upwards tucked behind the caecum. In about 10% of people, the appendix dangles down into the pelvis. It rarely lies in other positions such as across the front of the small intestine just before where the intestine and the caecum join. Depending on the position, the symptoms and signs of acute inflammation of the appendix vary.

Disorders of the appendix

The appendix rarely causes any problem and most people live their

whole life with their appendix. The commonest problem by far is acute appendicitis where the appendix becomes acutely inflamed. Rarely a tumour can arise in the appendix, the commonest being a very rare tumour called a carcinoid Although this has the potential to be malignant, this tumour usually presents so early in the appendix, it has rarely spread by the time of treatment and is normally cured by removing the appendix.

What causes acute appendicitis? Acute appendicitis can occur at any age and the author has seen a new-born child of 48 hours who presented with an obvious abdominal problem and at surgery had a perforated appendix. He has also operated on a lady of 94 years who presented with all the classical features of acute appendicitis.

Despite the commonness of the condition, the cause of acute appendicitis has never been determined. Acute appendicitis can be divided into 2 types, inflammatory and obstructive. It is impossible to differentiate these clinically. The type of appendicitis can only be noted at surgery. Inflammatory acute appendicitis probably results from infection in the wall of the appendix, bacterial or viral although no specific infecting agent has ever been incriminated. Obstructive appendicitis results from blockage of the lumen of the appendix causing bacterial infection inside the appendix with abscess formation. Obstructive appendicitis progresses more rapidly and is more likely to rupture resulting in generalised intra-abdominal infection called peritonitis.

Why either form should happen has never been discovered. No dietary factor has ever been associated with the occurrence of appendicitis. There is a slight rise each year in incidence during the summer months and this seems to be related to people developing the problem within 24 hours of returning from abroad after a long-haul flight. Whether an abrupt change in diet or a change in the timing of meals related to moving time zones is responsible, is unclear. Therefore there is nothing you can do to prevent acute appendicitis happening. A rise in incidence in 3rd world countries as they adopt a western type diet suggests that a low fibre diet may contribute to the cause but this is not certain.

Symptoms and signs

There is a clear sequence of symptoms which tends to occur with appendicitis but not all patients follow this pattern and sometimes the diagnosis can be really difficult. In a clear cut case with a typical history and obvious signs, the diagnosis can be easy

In an adult, the patient has usually felt unwell for at least 24 – 48 hours before they present to a doctor. Typically they develop vague abdominal symptoms with central abdominal discomfort, not wishing to eat, and with increasing constipation. In the first instance, most patients feel like they are about to have a stomach upset with vomiting and diarrhoea but this doesn't happen. After 24 to 48 hours, the pain starts to localise into the lower right abdomen and this gradually becomes more severe. Eventually the pain here can become very severe if untreated.

In the small percentage of patients with a pelvic appendix, the right abdominal pain may be minimal, but because the appendix lies close to the rectum in this case, it can cause rectal irritation resulting in diarrhoea.

In children, the time scale is much shorter. A young child may have only 6 hours of abdominal pain before developing right lower abdominal pain.

If the appendix ruptures resulting in peritonitis, this is usually an abrupt episode and causes severe generalised abdominal pain with discomfort on moving, breathing and especially trying to cough.

Examination of the patient is crucial in making the diagnosis as there is no test which specifically identifies acute appendicitis. Because appendicitis is an inflammation, the patient may show signs of sepsis with elevated temperature, rapid pulse rate and, because this is affecting the bowel, will have a sour smell to their breath called 'foetor'.

Abdominal examination may show a distended abdomen which is not moving easily as the patient breathes. Getting the patient to try to cough and their inability to do this properly, is normally a clear sign of intraperitoneal irritation. Gentle palpation starting away from the site of maximum pain and working towards the right lower abdomen should show that the patient is 'guarding' in this area, holding the muscles rigid over the site of pain and unable to relax here. Rebound tenderness, which involves pressing then quickly releasing to see if this causes increased pain, can be very sore for the patient and normally is not attempted unless there is real doubt about the diagnosis and guarding seems to be minimal.

Patients with pelvic appendicitis may have minimal abdominal signs but a rectal examination may reveal exquisite tenderness to the right side as the appendix is touched.

A blood test to reveal an elevated white cell count and elevated

inflammatory markers may aid in the confirmation of the diagnosis but normal values do not exclude acute appendicitis.

Treatment

Where the diagnosis is certain, treatment is by surgical removal of the appendix – appendicectomy. This is curative and since the appendix is not essential to body function, the patient should recover quickly. The major complication to surgery is wound sepsis resulting from the bacteria which caused the appendicitis. Normally patients are therefore given a single injection of antibiotics at the time of surgery. Where the appendix has perforated and generalised peritonitis has occurred, the patient may be very septic and a prolonged course of antibiotics may be essential. Perforated appendicitis can be very serious and is occasionally fatal, especially in patients with low immune resistance to infection.

Nowadays the techniques of laparoscopy (key-hole surgery) are so well known and practised by most surgeons that a straight-forward appendicectomy can usually be carried out by this technique. In an uncomplicated case with a very fit person, discharge home on the same day or the following morning is commonly possible. Occasionally open surgery is necessary.

Where the diagnosis is uncertain, a period of observation may be adopted monitoring the patient's temperature and reviewing later to see if the signs have worsened. Sometimes doubt about the diagnosis persists and eventually a policy of 'look and see' becomes necessary rather than run the risk of leaving the patient to suddenly perforate. This is normally done laparoscopically. In this situation, even if the appendix is normal and provided that no other problems can be found, the appendix should be removed.

At one time some surgeons and gynaecologists had a policy of removing a normal appendix during pelvic surgery while operating for some other condition. However, the increased risk of wound sepsis associated with this and the low chance of ever developing acute appendicitis during one's lifetime, has rendered this practice unadvisable.

So anyone with vague abdominal discomfort with increased pain localising to the right lower abdomen after about 24 hours should seek medical advice, or sooner in the case of a young child. And there's nothing you can do to prevent acute appendicitis happening.

Phlebotomy Clinic – delay in move back to the surgeries

When the phlebotomy (blood-sampling) clinic moved from Practice to the Chase Hospital in January of this year, it was contracted by the CCG to the Southern Health Trust and has been run by the Trust since it moved. The Trust at the time contracted 2 nurse phlebotomists to run this clinic.

We were informed, and we told you, that the clinic would be returning to the surgeries on the 1st October but now there is a hold-up. It has appeared that the contract with these nurses which is between the nurses and the Trust goes beyond the October date and this has caused a problem with the planned move of the clinic back to the surgeries. This was unexpected. Many other areas covered by SE Hampshire CCG who have made a similar change, do not wish to move their phlebotomy services back to the surgeries. In fact we may be in rather a minority in this desire.

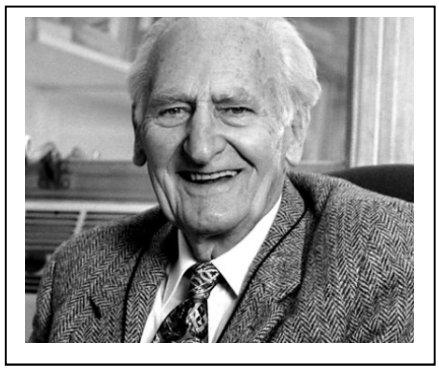
I met with the Chairman of the Trust and the Trust Director of Operations last week and discussed this with them. Neither had been aware that this problem had arisen but are at this moment looking into relocating these nurses into a different role within the Trust.

We all are in agreement that we do not wish to break the contract with these nurses and make them redundant. Neither do we want to leave the clinic at the Chase. However it may take a bit of time to find an alternative acceptable role for these nurses. Our Practice Manager is at present in touch with the Trust Director of Operations to clarify the situation and help to resolve this.

The Trust is sympathetic to our wishes and I am sure will sort this as quickly as possible. There is nothing further we can do at the present time but hopefully this glich can soon be resolved and the clinic return to the surgeries as we all wish.

Great British Doctors No. 18

Sir Richard Doll
28 October 1912 – 24 July 2005



©BBC Desert Island Discs
https://www.bbc.co.uk/programmes/p009494q

Sir Richard Doll was a physician and epidemiologist to whom many important discoveries in medicine are attributed. But the one for which he is best remembered is for establishing the link between smoking and lung cancer. It is difficult now to imagine a time when this wasn't 'obvious', but it took the meticulous research of this great British doctor to prove it.

Mathematics' loss was medicine's gain
Born in Hampton, Middlesex in 1912, Doll was the son of a doctor whose career was prematurely ended by multiple sclerosis. Although expected to follow his father into medicine, Doll decided instead to apply for a mathematics scholarship to Trinity College Cambridge. However, the fateful enjoyment of three pints of the College-brewed 8% beer the night before the entrance examination, led to his failure to achieve that ambition. This was to be the first of many 'cause and effect' phenomena that he discovered…...Plan B was to study medicine at St Thomas' Hospital Medical School in London, from which he graduated in 1937.

A strong social conscience
While studying and practising medicine in the 1930s (during 'The Depression'), Doll was troubled by the effects of high unemployment and accompanying deprivation on the health and well-being of his patients. He attended to the medical needs of the Jarrow Marchers in 1936, who marched from Jarrow in Tyneside to London to present the government

with a petition to reinstate employment in the town after closure of the shipyard, a major employer. He is described as a socialist and had a significant role in the Socialist Medical Association. This organisation's campaigns are credited with leading to the formation of the National Health Service in 1948.

Ongoing medical career

After the outbreak of the second World War in 1939 Doll joined the Royal College of Physicians and served as a medical specialist on a hospital ship for most of the war.

Afterwards Doll returned to St Thomas' to study asthma but then moved on to a research unit at the Central Middlesex Hospital in London that was part of the statistical unit of the Medical Research Council (MRC). He was initially involved in researching the effect of occupational factors on development of stomach ulcers (peptic ulcer disease). But by the 1950s, the increase in the incidence of lung cancer prompted a change to researching its causes. In total, Doll enjoyed at a 21-year career at the unit, for part of which he served as its Director.

Smoking and lung cancer

Doll said that at the beginning of the twentieth century, lung cancer was a relatively rare disease. But by the 1920s the incidence had increased considerably and by the end of the second World War Britain had the highest incidence of lung cancer in the world. Nobody knew the reason for this and Doll became interested in discovering the cause. Although smoking was considered a possible culprit, air pollution from open coal fires in homes and from cars, and the new material tarmac (for coating roads) were the prime 'suspects' at the time. Patients with chronic bronchitis (often related to cigarette-smoking) would claim to need a cigarette to 'clear my chest' and although doctors recognised 'smoker's cough', smoking was not thought to be particularly harmful. Indeed, some doctors (mostly psychiatrists, Doll noted) would offer cigarettes to patients during a consultation, to 'put them at their ease'.

It was only when Doll analysed the results of an observational study of hospital patients with suspected lung cancer that he started to see a connection. The study recorded many factors including whether the patients were smokers or non-smokers. When Doll checked on the final diagnoses of the patients, he found that in the non-smokers, the putative diagnosis of lung cancer was nearly always wrong i.e. they had another condition. Whereas it generally turned out to be correct in the smokers. A number of pieces of research established an association between smoking and lung cancer, but at the time (early 1950s) some of the medical profession did not see this as a causal link, but more of a coincidental finding.

Smoking and lung cancer in doctors

Doll and his colleague, Austen Bradford Hill, realised that the only way to investigate the possibility of a causal link between smoking and lung cancer was to carry out a prospective study: one that looked forward in time, rather than being retrospective. The study, started in 1951, was of 40,000 doctors who each answered a questionnaire about their smoking habits. The cause of death of all the study participants who died during the study was obtained from the UK Registrar's office. Not only was a direct link between smoking and lung cancer proven, but the study also found a link between smoking and coronary vessel disease (coronary thrombosis).

'Heavy' smokers are most at risk

After the earlier lung cancer patient study Doll had remarked: 'The risk of developing the disease increases in proportion to the amount smoked. It may be 50 times as great among those who smoke 25 or more cigarettes a day as among non-smokers'. And according to Doll and Bradford Hill, the subsequent doctor study confirmed that relationship. Doll also felt that ex-smokers were at lower risk of lung cancer than those who continued to smoke. He gave up cigarettes (after 18 years of smoking) as soon as he saw the link with lung cancer but had greater difficulty in getting his wife to drop the habit. Health warnings were ineffective, so he took to bribery, offering her money for every cigarette-free week. He also suggested that she spend the money saved on some luxury. He successfully weaned her off cigarettes but didn't cure her of the habit of spending £20 a week on luxuries! (The sums involved show how long ago this took place…..).

Further cancer research

In 1955 Doll established a link between asbestos and lung cancer and over a ten-year period helped to established causation of lung cancer in nickel and coal tar workers. He also helped to establish radiation as a cause of the blood cancer, leukaemia, and calculated the quantity of radiation able to cause the disease.

The birth of rigorous trials and epidemiology

While prospective studies of the type that Doll and Bradford Hill conducted in the 1950s are commonplace now, at the time it was a new approach to studying cause and effect. As such these trials were pioneering and laid the solid foundations for current research practices. Doll was one of the first to use controls in trials, to mitigate the effect of confounding factors, and he used carefully-controlled trials to investigate treatments for stomach ulcers.

Doll put his enthusiasm for mathematics to good use by using statistical tests in his research. He helped develop the science of epidemiology to which he was ideally suited with his numeracy, medical knowledge and social conscience. For Doll, epidemiology gave him the chance to try to address major public health problems around the world. Research avenues included HIV/AIDS, oral contraception and water fluoridation.

A further career in Oxford

Doll became the Regius Professor of Medicine at Oxford in 1969, making Oxford a centre for epidemiology. The 25 years after his retirement were still productive and he worked daily at the Cancer Epidemiology Unit up until a few weeks before his death.

A recognised and celebrated talent

Doll's abilities were recognised by multiple awards including the United Nations prize for outstanding research into cancer; the Bisset Hawkins medal from the Royal College of Physicians for preventative medicine and the Edward Jenner Medal of the Royal Society of Medicine in 1981, the same year in which he became a founding member of the World Cultural Council. He became a fellow of the Royal Society (FRS) in 1966 and knighted in 1971.

Sources

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- World Health Organisation (WHO). WHO Bulletin. http://www.who.int/bulletin/volumes/88/7/09-075325/en/
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- Doll R, Bradford Hill A. The mortality of doctors in relation to their smoking habits. British Medical Journal 1954; 4877:1451-55

Liaison with Pinehill Surgery PPG

In Whitehill and Bordon, we now have only 2 GP surgeries remaining: Forest Surgery and Pinehill Surgery. Recently the PPGs from these 2 surgeries have been working more closely together and on 18th September, I met with Bruce, Chairman of the Pinehill PPG.

NHS Choices list the practice size of Forest Surgery as 13238 but this includes the number of patients registered at Badgerswood Surgery in Headley. Approximately half of these will be at Forest Surgery, approximately 6,500 patients. Pinehill Surgery is listed as having 3671 patients. These numbers are likely to rapidly rise with the major expansion of the Bordon Healthy New Town.

Pinehill Surgery has already helped our PPG recently. Whitehill and Bordon Town Partnership installed 5 defibrillators in the town about 3 years ago and we became involved with this group trying to arrange a system for regular servicing of these machines. Forest Surgery had just had all their machines serviced so we asked Pinehill, who were just about to have all their equipment serviced, to help, and they have taken on the role of handling the regular servicing of the Partnership's defibrillators for us.

Also we have now received enough funding for a FeNO machine for Forest Surgery which we plan to share with Pinehill Surgery. This means that this machine will be available for all the people of Whitehill and Bordon.

Bruce and I discussed about how we could work together in the future. We hold twice yearly meetings and I hope the Pinehill PPG members will be able to attend these with us. Also I have invited Bruce, as Chair of the Pinehill PPG, to attend our committee meetings which are held 6 weekly. I hope to receive contact details of their members to be able to circulate our newsletter to all of them.

We are aware that the Practices are tending to gel together, especially with discussions about a central medical hub in Whitehill and Bordon, and it is therefore essential that the PPGs should start to think about working more closely together now, especially if the practices eventually do unite.

From now on we would welcome a regular contribution to our quarterly newsletter.

Quiz night

On 14th September, over 60 people gathered for a Quiz night in the Church Centre in Headley. Liz Goes and her husband Gerry, hosted the evening which proved a spectacular success and was thoroughly enjoyed by all. Unfortunately Barbara Symonds and her husband John, and Gerald Hudson, who had been very involved in the organisation of the evening, were all unable to be present.

Gerry acted quiz master and the selection of questions was pitched to a perfect level with a range of easy to challenging. Eight tables competed and scoring remained close throughout to the end. The noise level confirmed how enjoyable the evening was and how excited everyone became and it reached a pitch with the 'heads and tails' challenge. A raffle of gifts donated by the committee helped to boost the funds obtained by the event.

Midway through a dinner was served of quiche and salad which, at our table, was well washed down by the bottles of wine everyone had brought to lubricate the evening. The organisation of Liz and her friends in the serving of this was so efficient.

At the end the event raised over £400 for the PPG funds and this will be used to help with the purchase of a FeNO machine used in the diagnosis and monitoring of patients with asthma in Badgerswood and Forest Surgeries.

From the PPG, the Practice, and from everyone present who had such a great time, we would like to thank everyone who was involved in the organisation and running of this evening. This was so good, pressure will now be on to host a similar event in the future.

Southern Health Foundation Trust
- Members' Meeting 11th September 2018

Since its spell where Southern Health seemed to appear every second week on the National news and was given a severe warning by the Care Quality Commission (CQC), the Chairman, the Chief Executive, all the Trustees, directors and most of the Governors have changed. The CQC have now removed the Trust from Special Measures (It was given 7 Special Measures!!). Many may remember Alan Yates who came as the Interim Chairman and was put in as a trouble shooter for the Trust and undoubtedly turned the Trust round.

On 11th September, the Trust held its Annual Members' Meeting in Winchester which I attended (I am now a Governor of the Southern Health Trust). The presentations are all available on the Trust website and you can now hear this at

https://www.southernhealth.nhs.uk/get-involved/membership/meetings-and-minutes/annual-members-meeting/

In the left column, hit Members meetings

At the bottom of this screen, hit "Medicine for members"
A voice will start but ignore this
On the left is a large white arrow inside a multi-colour circle
hit this arrow
hit topic "annual members meeting 11.9.18"
hit the white arrow with red ball beside this
You should now hear the voice of the Chairman, Lynne Hunt, at the start of the Annual meeting

I think you can hear how everyone now has a desire to make this Trust one of the best possible in the country.

Practice Details

	Badgerswood Surgery	Forest Surgery
Address	Mill Lane Headley Bordon GU35 8LH	60 Forest Road Bordon Hampshire GU35 0BP
Telephone Number	01428 713511	01420 477111
Fax	01428 713812	01420 477749
Web site	www.bordondoctors.com	
G.P.s	Dr Anthony Leung Dr I Gregson Dr H Sherrell	Dr Charles Walters Dr F Mallick Dr L Clark
	Dr Laura Hems	

Practice Team

Practice Manager Sue Hazeldine
Deputy Practice Manager Tina Bell
1 nurse practitioner
4 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**

Committee of the of the PPG

Chairman	David Lee
Vice-chairman	Sue Hazeldine
Secretary	Yvonne Parker-Smith
Treasurer	Ian Harper
Committee	Nigel Walker
	Barbara Symonds
	Gerald Hudson
	Sarah Coombes
	Liz Goes

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

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Private Physiotherapy at Badgerswood

Back Pain..?

Neck Pain..?

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NEIGHBOURCARE HAMPSHIRE VOLUNTARY CARE GROUPS

Bordon and Whitehill

Voluntary Car Service

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

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

Our telephone number is 01420 4736

Headley Voluntary Care
looking after people

Are you in need of help?

Trips to the Hospital, Doctors & Dentists difficult for you?

Headley Voluntary Care are here to help
Perhaps you would like to join us for a coffee and meet up with other local people, we meet at 10.30 every Thursday at the Church Centre, pop in and see us.
Telephone: 01428 717389
We cover Arford, Headley, Headley Down, Lindford & Standford

Can you help?
Volunteer Drivers needed
Your petrol costs will be re-imbursed
Telephone now while you think about it.
01428 717389
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Headley Pharmacy

Opening hours
Mon – Fri 0900 - 1800
Sat 0900 - noon

Tel: 01428 717593

Chase Pharmacy

Opening hours
Mon – Fri 0900 – 1800

Tel: 01420 477714

The pharmacy at Forest Surgery, adjacent to Chase Hospital

Both pharmacies are open to all customers

for

Prescription Dispensary
Over-the-counter medicines
Chemist shop
Resident pharmacist
Lipotrim weight-management Service

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