# PATIENTS GROUP

## Queen Edith Medical Practice

Patients Participation Group (PPG)

Complementing the Work of the Practice

PPG email: ppg@alanwilliams.org.uk

**NEWSLETTER NO 34: June 2023**

**Editor – Alan Williams**

Hello, I am back editing this Newsletter (my first since September 2021). I am grateful for the efforts of David who has worked on the last six editions but is no longer able to continue.

However, this cannot be a permanent solution because I have other duties on the Committee and a range of further activities in the wider field of Patient Participation; there is a lot happening at various levels.

So, I am hoping that someone else will be willing to consider taking over the Editorship and keep the Newsletter going; ever since Roger created the first ever QEMP newsletter in 2014 (and one of the first of any Practice, or of a Patients Group) it has evolved and become a defining product of this Group. As you know, there are four editions per year and I would estimate that the Editorship uses up a relatively small amount of effort (but great care) for each publication month (at the end of March, June, September and in mid-December-- to avoid clashing with Christmas).

The Editor would automatically become a full member of the Committee and would be involved in its decision making. I look forward to hearing from potential enthusiasts to become our Editor.

In this Newsletter, we have some important information on a number of subjects. I hope that some of these will spark interest in several of you. Please let me know what else you would like to know about and we will see what we can do to satisfy your questions.

## Index

## Introduction

The role of the Editor is to gather together a number of different contributions and weld them into a coherent and presentable whole. The other usual contributors have been Claire Surridge (Practice Manager at QEMP) and Howard Sherriff (a former member of the Group) with occasional minor contributions from me. Clare and Howard's latest efforts are included below.

I would like to thank Howard for continuing his contribution. Some of you may know that Howard has had a much wider role in healthcare and worked as a senior member of staff at Addenbrooke's in days gone by. More recently, and very importantly, he focuses on his role as a Governor of Cambridge University Hospital Trust (CUHT) which oversees Addenbrooke's Hospital and the Rosie Maternity Hospital and is presently deeply involved in the plans for the creation of the Cancer Hospital (now underway) and for the forthcoming Children's Hospital. Note that, Royal Papworth, also present on the Biomedical Campus, is closely associated with Addenbrooke's BUT is <u>not</u> part of CUHT; Royal Papworth is a self-governing body.

Structurally, I do not propose to make a large change to the content and approach of this Newsletter. It will continue to have certain known and familiar elements. But there may be the occasional new idea.

As usual, I have contributed a section which is called "Healthcare Snippets" about the development of many aspects of Healthcare as they are coming into being, not just in the UK but also in the main other countries; this also touches upon the industry sources of new medicines, new medical equipment and so on.

The Editor's role is really to create the structure of the NL, to chase all these other people to deliver on time, and make sure it is ready to be circulated (in a coherent form). It is actually sent out by me, as the holder of the confidential membership list; in addition, the Practice also distributes it to a still larger list of patients who have agreed to receive it. Everyone should know that those people are not members of the Group *per se* but they are patients who have registered, as new patients, with QEMP in the last year or so and agreed to receive the Newsletter (they are welcome to become full members of the Group -- by contacting me, but that is their decision).

There is no cost of membership apart from giving me your name and e-mail address (and a phone number – the latter is needed just in case I have to check the e-mail address or the spelling of your name).

I hope everyone finds this (and future Newsletters) as interesting as the last 33 editions produced by three Editors (Roger Crabtree holds the record as the first and most prolific editor having been responsible for 16 of the 34 editions).

## Practice News at June 23 from Claire Surridge, Practice Manager

### STAFF CHANGES

**Nursing Team**

As I reported in the previous newsletter, our Lead Practice, Nurse Laura McClure, has relocated to Bristol with her family and she tells us they are settling well. Our other nurse, Megan Crabtree has stepped into the Lead Practice Nurse Role and I am pleased to say we have been successful in recruiting someone to replace her in the Practice Nurse Role. Laura Hammond joined us this week so I am sure she will soon become a familiar face to you all. Laura comes from a secondary care background so will need some further training over the coming months in some specialist aspects of the Practice Nurse Role but brings with her a host of skills from her previous positions.

**Additional Salaried GP**

I am also pleased to let you know we have been successful in recruiting an additional Salaried GP for the practice. This has been no mean feat with the current shortage of GPs across the country and difficulties in recruitment. Dr Ashish Dave will be starting with us on 10th July and will be working on Monday mornings and all day on Tuesdays and Wednesdays. He previously worked at Priory Fields Surgery in Huntingdon and has a special interest in Cardiology.

I am sure you will give both Dr Dave and Nurse Laura xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

### CHANGES TO THE GP CONTRACT

You may have heard about recent contractual changes imposed by NHS England on general practice without agreement by the British Medical Association (BMA) and practices themselves. Some of these changes involve the way we must offer patients an assessment including appointments, and others are around increasing the options of how our patients can access these.

These contractual changes mean we will need be reviewing our appointment system to meet our new contractual obligations, including allowing our patients to book up to 3 months ahead as well as on the day. On the one hand, we will no longer be allowed to ask you to call back another day for non-urgent problems. On the other, we will be forced to advise many more patients to contact NHS 111 or attend the emergency department than we do currently once we have used up our in-house capacity. We are anticipating that our pre-bookable appointments will fill rapidly and that our "did not attend" rate will also go up significantly – as people forget appointments that they have made some weeks before.

It is worth pointing out, that we did not and do not feel that these mandatory changes are in the best interests of either our patients or the practice in terms of managing demand and workflow safely and appropriately.

Further information on the changes we make will follow in the coming weeks and as always, we will strive to work to provide the best possible care for our patients in an increasingly demanding environment.

We hope that you will bear with us during the transition period and will be mindful that some of the changes we make will not be by choice. **Please be kind to our staff.**

## What About Something New? --- From Alan Williams

I went into hospital on 30th May and had a hip replacement that very day. I was discharged before the weekend and am now in recovery mode. Before going for the operation, I was in touch with several people who had been given the same treatment, quite a few of them had had both hips done (NOT at the same time but with a gap of at least a few months). I was very interested in the similarities in what they said. But not everyone has the contacts to get suggestions from people who have also been down the same path.

I suspect that several other members (male and female) have had this experience already or that others are contemplating it in the fairly near future. I wonder if we should consider forming a little group to share experience (our individual experiences will have differed in detail) and offering positive suggestions to those expecting the experience soon. If you have been treated, or are in line for a new hip in the fairly near future, please let me know about the idea of mutual support. It would be a pleasure for me to contribute to this.

Of course, this provokes a wider idea. There must be several other conditions where sharing advice and support could be of use to others.

**What do you think and what topics could you suggest and/or would really like to hear about?** *I am willing to ask amongst the membership whether anyone would be interested in the ideas I hear about from all of you.*

## The Wider Scene Regarding Patients of QEMP

***A report re CUHT provided by Howard Sherriff (a Governor of CUHT and a founding member of our Group).***

In July the 5-day Junior doctor strike will be the longest in history. The impact will mean cancellation of most outpatient appointments and elective surgery. These appointments need to be re-booked, often several weeks ahead. The NHS has offered 5% backdated, but the BMA is insistent on 35%. The recent increase in interest rates to 5% announced by the Governor of the Bank of England to curb inflation was followed by comments that employers should be careful about wage increases and their effect in inflation.

The public is generally supportive of the juniors. What is not often appreciated is that the taxpayer funds their post-graduate training costing £200,000 for each doctor. As a personal observation I feel that the biggest concern the junior doctors have are their work conditions rather than pay, and long-term fatigue following Covid.

On a more positive side the Health Minister has agreed the OBC (outline business case) for the cancer hospital, and all are waiting for the Treasury to sign this off. The Children's Research Hospital is still waiting for funding approval. Being optimistic the start on the Cambridge South railway station would indicate support for development of the Cambridge Biomedical Campus, which will become the largest in Europe.

A recent presentation to Governors about the Royal Papworth Hospital and new integration is CUH is moving forward. This includes integrated cardiology and respiratory medicine across both sites, and Thoracic Surgery for trauma in CUH. The availability of cardiologists for Women's Services is good., and there is very good integrated radiology services.

Many of these developments have strong senior support but fail because of slippage due to competing challenges at operational team level. Much of this related to fatigue in staff.

One of the real blocks is the Patient Electronic Record (PER). CUH uses Epic. Royal Papworth uses another system, and they cannot link. So work is taking place on this. It also involves getting information to the GP.

***Many thanks to Howard – from the Editor on behalf of Members***

## Healthcare Snippets

***Provided by the Editor from a variety of "News" sources to which he has access (mostly e-mailed from Journals, Governments and a variety of industrial organisations involved in the Pharmaceutical and Medical Device Sectors).***

### 1. Covid and flu

In May, I received a document (written from a USA standpoint) entitled ***The end of the Covid-19 public health emergency: What's next?*** Note the words "end of" and "emergency". This does not imply that Covid is history but rather that it has (probably) reduced to a status similar to flu. So, my interpretation is that Covid has not faded away for ever but that (like flu), as the virus mutates, it may return nastier at some times and be of less concern in other years. The "powers-to-be" (Governments and their agencies) regard it as controllable with the right interventions (new medicines, novel equipment and updated procedures) to deal with it.

Recall that what happened late last year with flu (much the nastiest flu scene for a few years). The message is simple; if you are offered a flu vaccine or a Covid vaccine don't assume that you don't need it – you might!

### 2. Prostate Cancer

This is one of the **Man Only** diseases and a very difficult one to manage. First, all men make some PSA (Prostate Specific Antigen) but a few men produce rather more in late middle age – and this *can* be a sign (or cause) of Prostate Cancer which can be difficult to identify and manage. Apart from elevated PSA, there are no easily recognised symptoms. Also, physical diagnosis is difficult because the prostate is so hidden away in the body; there is no great swelling (the prostate gland is small to start with, like a walnut) and tucked away under the pancreas (which is much bigger), largely hidden by the coils of the large intestine and above the reproductive organs and there is no obvious swelling or pain even when the PSA is up quite a lot. Surgical extraction is difficult and new techniques use robotics to get to it and get it out – apparently more accurate than a human hand. The answer is to have a PSA test when it is advised by your doctor.

### 3. Diabetes and Obesity

The other day I saw a young couple buying rather a lot of food – she was big and he was immense! I also saw a brief article in a Newsletter from Nature (a premier scientific Journal) referring to a study in a different journal (Cell Metabolism), The heading of the article was ***Diabetes and obesity are rising globally***. In many countries (and ours is near the front of the list), Type 2 diabetes, non-alcoholic fatty liver disease and high blood pressure are all increasing rapidly. I can't help reflecting on the fact that the older generation (say born in 1935 to 1955) are rarely represented in that group. When I was younger, there were no supermarkets, food was cooked from fresh (and often seasonal) ingredients

and housewives did a lot of shopping in small neighbourhood shops several days a week because few had fridges at home. Supermarkets, fridges/freezers and manufactured products (with high sugar and fat content) have led to a range of diseases and we tend to see the evidence in the young and middle-aged. Another brief article was headed ***"Rising toll of obese children with diabetes (Type 2)"*** , until the last few years was rarely seen in people under 40. A recent book, called Ravenous, by Henry Dimbleby (son of the famous TV presenter, David) is highly critical of the failure of politicians to act on this issue.

New Drugs (someone has called them *Fat-blasting*) are appearing – they may help some people lose quite a lot of weight but the hype does not seem to meet all expectations. But, their existence suggests that this is a field where progress might be made and better ones may appear. The problem is that the drugs can drive weight loss but that the patient should not relapse into old ways when the initial treatment stops.

**4. RSV**

Don't look away! This is rather serious. RSV is a strange virus which has little impact on most people. But it can be very serious amongst children of less than 12 months and also amongst the elderly; those in the middle are not generally affected.

Three companies, Pfizer, GSK and Moderna (who all produced Covid vaccines) are in the late stages of gaining approval of vaccines for RSV (Respiratory Syncytial Virus). This affects very young children (typically up to 1 year old) and older people . It is worth noting that (about 6,500 older people, over 65 died in the USA from RSV in 2022). If such a vaccine is offered here, I will be in the queue!

This is perhaps the point to observe that vaccines PROTECT people from getting a particular disease; they do not cure it if you already have the disease. Apart from their primary job, they do nothing to almost everyone (one person in the UK has been reported to have died because of the Covid vaccine: how many such vaccine shots do you think were given? I know that I have had five – what about you?). In a population of around 70 million, I think the risk benefit is rather favourable.