ISSUE NO 66 **SPRING 2015**

PARTNERSHIP FOR HEALTH

Davenport House Patient Group

Quarterly Newsletter

KEEPING YOU ADVISED OF CHANGES AT DAVENPORT HOUSE

The one constant in life is change which is also true for the National Health Service and for the Davenport House Surgery.

So our theme in 2015 for the 4 editions of the Newsletter is "Keeping you advised of Changes".

PERSONNEL CHANGES

- Dr Sneha Wadhwani and Dr Kirsten Lamb have left the Practice, Dr Wadhwani to Australia and Dr Lamb to well earned retirement.
- Accordingly we have two new doctors, Dr Emma Chakravarty and Dr Hannah Carter, both of whom are featured on page 4.

CHANGES TO THE APPOINTMENT SYSTEM

- We have moved to a full triage arrangement so that any requests for an appointment will be the subject of a call back from your doctor, or in some cases the duty doctor, to establish the best course. In some cases the matter may be resolved over the telephone, in others an appointment will be arranged. I have written a full explanation on page 3.

OTHER CHANGES

Springfield Pharmacy is under new ownership and has introduced a free prescription delivery service.

Change is an inevitable part of life which provides the opportunity to move forward positively with new ideas and solutions to growing demand.

FEATURED IN THIS EDITION

CHAIRMAN'S COMMENTARY—CHANGE

By Roger Gedye

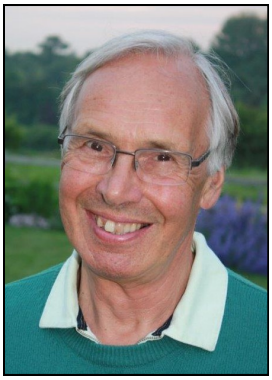
The theme for this year's series of Newsletters is Change without which progress can never be achieved. I should like to offer a patient's eye view of a few changes in our health care system, for better or for worse, which seem significant to me.

Let me begin with a couple of changes for the better, good news stories which reflect the way in which parts of our NHS are responding constructively to the increasing demands to which it is subjected year on year. I wrote in my Commentary to the Autumn Newsletter 2014 of my experience of the L and D Hospital at Home scheme: a short stay in a hospital ward and then a fortnight of follow up home visits by a team of qualified hospital nurses – morale boosting to the patient and a real answer to the problem of bed blocking.

In this issue Dr Charli Barber-Lomax writes on the opposite page about the brave initiative by Davenport House to counter the problem of patient demand through GP Access: doctors responding promptly by telephone to every patient who calls in for an appointment. The available evidence suggests that patients will receive a better service and, importantly, will have a much better chance of speaking to, and where necessary receiving a timely appointment with, the doctor of their choice.

Both of these initiatives are constructive solutions to real problems which deserve to be more widely practised and publicised. It seems to me that triage, the initial classification of patient need by an experienced practitioner, could be a way of resolving the overwhelming demand on hospital Accident and Emergency departments, treating patients with life threatening conditions ahead of those with less demanding ailments: common sense rather than targets?

In January, the Harpenden Society hosted a presentation at which representatives from NHS Hertfordshire presented their plans for future health care in West Hertfordshire as part of the NHS Five Years Forward View, 2015-20. The central theme was 'Integration of health care in the community' and included a future role for a re-developed Harpenden Memorial Hospital. It was encouraging to learn that the plans to develop the Memorial Hospital site for the provision of a modern health and well-being facility for Harpenden and nursing care for convalescing patients, are moving forward. But, progress is incredibly slow – the earliest date for resolution was quoted as 2018 – and these are facilities that are needed now.



The Red House Forum, set up by the Harpenden Society to bring pressure to bear on the county authorities, deserves our full support.

For the past 25 years successive governments have promoted Care in the Community and the integration of health and social care services as the best way to improve patient care and reduce costs, which sounds splendid until you examine the staffing implications. Change requires careful planning.

On Sunday1 February 2015 BBC Radio 4 broadcast an episode of File on 4 which examined the nursing shortage in the NHS, **"Where have all the nurses gone?"** Since 2003 the number of highly trained district nurses, the core of health care in the community, has fallen from 12,000 to 5,500. In 2014 a survey by Professor Jane Bell showed that 80% of district nurses were working, on average, 80 minutes of overtime to complete their daily shift. England's chief nurse, Jane Cummins, said the country needs senior, experienced nurses to lead the 5 year forward view – we have a grand plan but we have not got the nurses to deliver it.

Change can be incredibly difficult to realise and the barriers at times can seem insurmountable, but can the NHS survive without it? Personally, I do not think so.

THE APPOINTMENT SYSTEM HAS CHANGED

By Dr Charli Barber-Lomax

BACKGROUND

From the last week in February 2015, Davenport House Surgery has changed the way we make appointments for patients.

Last year we found ourselves inundated with appointment requests and unable to meet perfectly reasonable enquiries from patients who needed attention on that day. To deal with this, we introduced a 'duty doctor triage system' whereby the doctor would ring those patients whom we couldn't accommodate, but who still needed to see someone that day.

Not only did this prove very popular, we also discovered that many queries could be sorted out on the telephone without the need for a face-to-face consultation, and those that had to be seen were found appointments in the duty doctor's emergency Surgery....***and from this little acorn grew a New Way of Working!***

In fact we have employed a company called GPAccess who have developed a scheme for on-the-day-working. We are about the eightieth Practice they have helped and their system has proved very popular.

THE NEW SYSTEM

In the future our day will start with perhaps four pre-booked appointments. All the remaining slots will be vacant - patients ringing to see the doctor will be asked a brief question to allow the doctor to do any necessary preparation before he or she returns their call. We will aim to return the call within the hour (hopefully much sooner than that) and if necessary, patients will be able to book a phone-back time for later in the day.

Our experience this past year is that perhaps half the phone calls will be sorted out over the phone, whilst those that need to be seen face-to-face, such as a feverish child, or someone in pain, will be provided with an appointment at a time that is hopefully more convenient for the patient. Apart from a midday ninety minutes, when we will be out visiting the housebound, we will be telephoning or seeing patients every hour of the day - the idea of 'morning Surgery' and 'evening Surgery' will disappear.

Our Earlybird Surgeries from 0700 to 0800 on Tuesdays through to Fridays will continue and we will book some face-to-face consultations therein. Also, as now, patients will be able to book a slot on the internet, but now this will be for a telephone conversation.

ONGOING REVIEW OF THE SYSTEM

GPAccess will monitor the statistics and feedback from patients, staff and clinicians and doubtless our templates for telephone slots and consultations will be tweaked, but with over 40 phone slots and 24 face-to-face consultations in a day per GP we hope that we will be able to satisfy everybody. And if when patients phone to speak to their GP, they discover he or she is away, they will be offered the choice of talking to another GP or knowing when their GP will be back.

None of the GPs are present all the time, **but our timetable is published on the Surgery website and in the Practice** so patients can see at a glance when their GP is consulting.

THREE SIMPLE STEPS TO THE NEW SYSTEM

1. You phone the Surgery

All our doctors are qualified to help, but if you want a particular one please call on the day they are working.

2. The doctor calls you back

When? Usually within the hour. You can ask them to call at a time to suit you.

3. You are always seen if needed

When? There is no need to book in advance. Nine out of 10 patients choose a convenient time of the day.

These simple changes make it easier to get through on the phone, shorter waits to see the doctor and no wasted journeys to the Surgery when you don't need to come in.

CHANGE—TWO NEW GPs FOR THE PRACTICE

By Anthea Doran, Practice Manager

Dr Hannah Carter

qualified from the University of Sheffield in 2008 and completed her GP training in Camden, attached to the University College London Hospital training scheme.

Her qualifications are MBChB, MRCGP, DRCOG and DFSRH and she has an interest in women's health.

She grew up in Bedfordshire, attending school in Dunstable. Both her parents continue to work at the Luton and Dunstable Hospital.

She is married to a Danish architect working in Farringdon with hopes one day to live in a house he's designed.

Her interests include travel (usually to and from Denmark at present, although previously further afield), appreciating good architecture, running, craft projects and music. She is also a very keen baker and has applied for the Great British Bake Off twice! "Unfortunately unsuccessful as yet, but with intentions to keep developing my repertoire….."

Dr Emma Chakravarty

Dr Emma Chakravarty qualified from Nottingham medical school in 2007 and continued her foundation and GP training at the Luton and Dunstable hospital.

She studied her general practice component at Davenport House Surgery, completing her MRCGP. She has spent a year developing her skills in Leighton Buzzard, and is returning to take post in Harpenden.

When not in she is clinic, usually found swimming or creating works of music or poetry.

SURGERY SNIPPETS

By Anthea Doran

CHANGE OF PRACTICE DOCTORS

Following the move to Australia of the Wadhwani family in February 2015 and the retirement of Dr Kirsten Lamb at the end of March 2015 we are delighted to announce that the two new GPs featured above will be joining us.

Dr Lamb's patients will be ably served by Dr Emma Chakravarty who many may remember was a training GP with us. Dr Wadhwani's patients will be allocated to Dr Hannah Carter. Patients do not need to take any action as their care will automatically be transferred to their new GP.

FRIENDS AND FAMILY TEST

Patients who have visited hospital in the last few years may be aware of the Friends and Family Test. This test asks patients if they would recommend the service to friends or family and why. The Government has now extended this scheme to Surgeries and we would urge patients to complete a card at Reception or on line via our website. All responses are anonymous but they will enable the Surgery to improve on what we do well and try to improve things that fall short of patients' expectations.

GP ACCESS

Monday 23 February saw the start of the new telephone consultation system and, on the whole, the system was well received by patients.

During the day we returned 264 telephone calls of which 37% (98 patients) were booked for an appointment. Not all telephone slots were used and we had a total capacity on the day of 279 telephone slots.

Under the old system, the nine doctors who were available would have offered 235 appointments thus the new system allowed another 44 patients to make contact with us had they required our services.

While it is very early days, we are pleased that the change has been accepted so positively by patients and we will endeavour to take on board any feedback so we can adapt the system as appropriate.

PERIPHERAL ARTERIAL DISEASE (PAD)

By Dr Mark Sandler

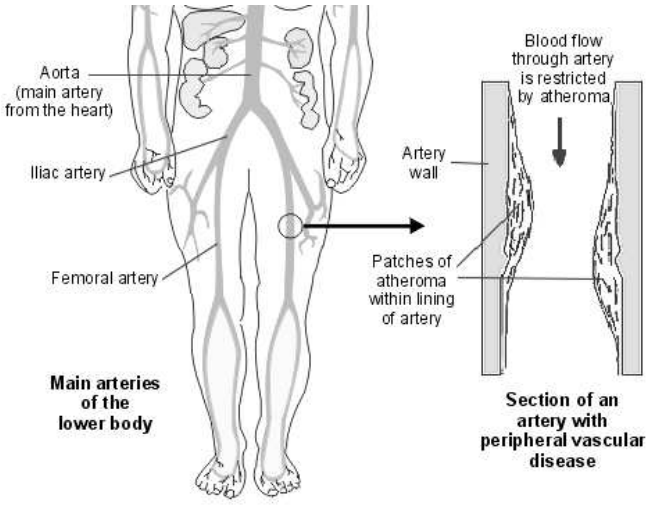
Introduction

Peripheral arterial disease (PAD), also called peripheral vascular disease (PVD), is a narrowing of the arteries. It mainly occurs in arteries that supply blood to the legs. The main symptom is pain in one or both legs when you walk. Treatment usually includes: stopping smoking (if you smoke), regular exercise, medication to lower your cholesterol level, a daily aspirin and lowering your blood pressure if it is high. Medicines to open up the arteries may help. Surgery may be needed in severe cases. It is also sometimes called hardening of the arteries of the legs.

In the UK, around 1 in 5 men and 1 in 8 women aged 50-75 years have PAD. It becomes more common with increasing age.

What causes peripheral arterial disease?

The narrowing of the arteries is caused by atheroma which is like fatty patches (plaques) that develop within the inside lining of arteries. A patch of atheroma starts quite small, and causes no problems at first. Over the years, a patch of atheroma can become thicker. (It is a bit like scale that forms on the inside of water pipes.)



A thick patch of atheroma makes the artery narrower. This reduces the flow of blood through the affected section of artery. Tissues downstream have a reduced blood supply, which can lead to symptoms and problems. Atheroma can develop in any artery, but the common arteries affected are:

- Arteries taking blood to the heart - this is called ischaemic heart disease and may lead to problems such as angina and heart attacks.
- Arteries taking blood to the brain - which may eventually lead to a stroke.
- Arteries taking blood to the legs - which may lead to PAD.

What causes atheroma?

Everybody has some risk of developing atheroma. However, certain factors increase the risk:

Lifestyle risk factors that can be prevented or changed:

- Smoking
- A sedentary lifestyle
- Obesity
- An unhealthy diet
- Excess alcohol

Treatable or partly treatable risk factors:

- High blood pressure
- High cholesterol blood level
- Diabetes

Fixed risk factors - ones you cannot alter:

- A strong family history. This means if you have a father or brother who developed heart disease or a stroke before they were aged 55 years, or in a mother or sister before they were aged 65 years.
- Being male.
- An early menopause in women.
- Age. The older you become, the more likely you are to develop atheroma.
- Ethnic group - for example, people who live in the UK, with ancestry from India, Pakistan, Bangladesh or Sri Lanka, have an increased risk.

What are the symptoms of peripheral arterial disease?

The typical symptom is pain which develops in one or both calves when you walk or exercise and is relieved when you rest for a few minutes. This pain varies between cases and you may feel aching, cramping or tiredness in your legs. This is called intermittent claudication.

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It is due to narrowing of one (or more) of the arteries in your leg, the most commonly affected being the femoral artery. (See chart on page 5)

When you walk your calf muscles need an extra blood and oxygen supply. The narrowed artery cannot deliver the extra blood and so pain occurs from the oxygen-starved muscles. The pain comes on more rapidly when you walk up a hill or stairs than when on the flat.

If an artery higher upstream is narrowed, such as the iliac artery or aorta, then you may develop pain in your thighs or buttocks when you walk. (See illustration on Page 5)

Severe cases

If the blood supply is very much reduced, you may develop pain even at rest, particularly at night when the legs are raised in bed. Typically, rest pain first develops in the toes and feet rather than in the calves. Ulcers (sores) may develop on the skin of your feet or lower leg if the blood supply to the skin is poor. In a small number of cases, gangrene (death of tissue) of a foot may result. However, this is usually preventable (see later in this article).

How is peripheral arterial disease diagnosed?

The diagnosis is usually made by the typical symptoms. A simple test that your doctor or nurse may do is to check the blood pressure in your ankle and compare this to the blood pressure in your arm. If the blood pressure in your ankle is much different from that in your arm this usually means that one or more arteries going to your leg, or in your leg, are narrowed. Although this test can help your doctor find out if PAD is affecting your legs, it will not identify which blood vessels are blocked.
More sophisticated tests are not needed in most cases. They may be done if the diagnosis is in doubt, or if surgery is being considered (which is only in the minority of cases).

What is the outlook (prognosis) for peripheral arterial disease?

Studies that have followed up people with PAD have shown that:

- Symptoms remain stable or improve in about 15 out of 20 cases.
- Symptoms gradually become worse in about 4 out of 20 cases.
- Symptoms become severe in about 1 out of 20 cases.

So, in most cases, the outlook for the legs is quite good. However, if you have PAD, it means that you have an increased risk of developing atheroma in other arteries. You have a higher-than-average risk of developing heart disease (such as angina or a heart attack) or of having a stroke.

Note: your chance of developing severe PAD (and heart disease or a stroke) is **much** reduced by the self-help measures and treatments described below.

What self-help measures can I do?

Stop smoking

If you smoke then stopping is the single most effective treatment. Stopping smoking increases walking distance by two or threefold in over 8 out of 10 people with PAD. (Stopping smoking also greatly reduces your risk of having a heart attack or stroke.)

You should see your Practice nurse for help if you find it difficult to stop smoking. Nicotine gum or patches to help you stop may be an option. There are also other medicines that are sometimes prescribed to help people stop smoking.

Exercise regularly

Regular exercise encourages other smaller arteries in the legs to enlarge and improve the blood supply. If you exercise regularly, there is a good chance that symptoms will improve, and the distance that you can walk before pain develops will increase.

Walking is the best exercise if you have PAD. Regular exercise means a walk every day, or on most days. Walk until the pain develops, then rest for a few minutes. Carry on walking when the pain has eased. Keep this up for at least 30 minutes each day, and preferably for an hour a day. You should try to do at least two hours of exercise per week. The pain is not damaging to the muscles.

Other exercises, such as cycling and swimming, will also help you to become fit and are good for the heart. However, these should be done in addition to walking, as walking has been shown to be the best exercise to improve symptoms.

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Lose weight if you are overweight
You should eat a healthy diet

This is the same as advised to prevent heart disease. This reduces the chance of atheroma forming. A Practice nurse may advise you on how to eat a healthy diet.

Briefly, a healthy diet means:

- Five portions, and ideally 7-9 portions, of a variety of fruit and vegetables per day.
- You should not eat much fatty food such as fatty meats, cheeses, full-cream milk, fried food, butter, etc. Ideally, you should use low-fat, mono-unsaturated or polyunsaturated spreads.
- Try to include 2-3 portions of fish per week, at least one of which should be 'oily' (such as herring, mackerel, sardines, kippers, salmon, or fresh tuna).
- If you eat meat, it is best to eat lean red meat or poultry such as chicken.
- If you do fry, choose a vegetable oil such as sunflower, rapeseed or olive.
- Try not to add salt to food, and limit foods which are salty.

Alcohol

Some research suggests that drinking a small amount of alcohol helps to reduce the risk of developing cardiovascular diseases such as PAD. The exact amount is not clear, but it is a small amount. Men should drink no more than 21 units of alcohol per week, no more than four units in any one day, and have at least two alcohol-free days a week. Women should drink no more than 14 units of alcohol per week, no more than three units in any one day, and have at least two alcohol-free days a week. Pregnant women should not drink at all. One unit is about half a pint of normal-strength beer, or two thirds of a small glass of wine, or one small pub measure of spirits.

Take care of your feet

Try not to injure your feet. Injury may lead to an ulcer or infection developing more easily if the blood supply to your feet is reduced. Do not wear tight shoes or socks which may reduce blood supply. Tell your doctor if you have any foot injury, pain in a foot when you are resting, or any marked change in skin colour or temperature in either of your feet.

These self-help measures are the most important part of treatment. In addition, medication is often advised. Surgery is only needed in a small number of cases.

Medicine

Asprin is usually advised. A daily low dose (75 mg) is usual. This does not help with symptoms of PAD, but helps to prevent blood clots (thromboses) forming in arteries. It does this by reducing the stickiness of platelets in the bloodstream. (Aspirin is an antiplatelet medicine.) A blood clot is an uncommon complication of PAD. However, as mentioned, people with PAD have a higher-than-average risk of developing a heart attack or stroke, which are usually caused by blood clots. If you cannot take aspirin then alternative antiplatelet medicines such as clopidogrel and dipyridamole may be advised.

A statin is usually advised to lower your cholesterol level. This helps to prevent a build-up of atheroma.

If you have diabetes then good control of your blood glucose level will help to prevent PAD from worsening.

If you have high blood pressure then you will normally be advised to take medication to lower it.

Surgery

Most people with PAD **do not need surgery**. Your GP may refer you to a surgeon if symptoms of PAD become severe, particularly if you have pain when you are resting. Surgery is considered a last resort. There are two main types of operation for PAD:

- **Angioplasty** is where a tiny balloon is inserted into the artery and blown up at the section that is narrowed. This widens the affected segment of artery. This is only suitable if a short segment of artery is narrowed.

- **Bypass surgery** is where a graft (like a flexible pipe) is connected to the artery above and below a narrowed section. The blood is then diverted around the narrowed section.

So self-help is by far the best way of avoiding/treating peripheral arterial disease.

TRAINING THE NEXT GENERATION OF DOCTORS

Rob McKenzie describes his first term at medical school

Following two stressful years of interviews, aptitude tests and A-Levels, it feels odd to be writing this piece, looking back on it all as a first year medical student at Leicester University.

Hopefully I will be able to communicate at least a little of my experience of applying to medical school, and my first term there.

I grew up in Harpenden and went to The Grove Infant and Junior School, then on to Roundwood Park School. Competition for medical school places is fairly intense, with a quick google showing somewhere in the region of 84,395 applications being made in 2013, with 7,151 being accepted. Because of this, applying to medical school starts a few years in advance. I first decided I definitely wanted to study medicine towards the end of my GCSE year. As well as needing good grades at A-Level and GCSE, a key part of a strong application is work experience in healthcare and volunteering.

Around this time I was very lucky in having a chance meeting with my GP, Dr Kirsten Lamb, strangely in the waiting room of a dentist's Surgery! Dr Lamb was extremely helpful, both with interview preparation and putting me in touch with the Davenport House Patients Group, with whom I worked on the Children's Health Fair. This was great experience (and I like to think I helped a little bit). As well as this, I spent time in a Luton GP Surgery, a local pharmacy, a care home and helping to run the 3rd Harpenden Scouts.

Finally, in September last year, I actually started my medical education. At Leicester we are taught five units per semester, with five pre-clinical semesters for a total of 25 units. At the start, basic sciences are taught. My first semester has concentrated on genetics, metabolism, histology, anatomy and epidemiology. This is taught via lectures as well as group work sessions.

Leicester is one of the few schools that offer full cadaveric dissection, which is an incredibly odd experience to start off with but something I find extremely valuable-removing a cadaver's lung in the third week will always leave an impression. From the next semester until halfway through my third year, the focus shifts to teaching by body system and includes more about disease processes and managements. Clinical placements start properly after this, and continue until graduation at the end of the fifth year.

Alongside all the scientific teaching, we are also taught clinical and communication skills. Consultations and histories are first practised on simulated patients- actors who brilliantly play the part of a patient. Also a local GP allocates an actual patient who has a long-term condition such as heart disease or osteoporosis. Focusing on their families and the psychosocial impacts of their condition rather than its medical aspects, we visit our patients in their homes regularly then write a dissertation about them and their condition. This is my favourite part of the course by far, though I feel far too young to have the privilege of such a personal insight into a stranger's life. In fact my allocated patient spends a lot of time feeding me during my visits.

University is a huge jump from living at home. Sadly, sleep has rapidly slipped down my list of priorities. Medics have a lot of work to do, but also feel the need to enjoy the social side of university as well, so life has become extremely busy. Overall, these past few months have been overwhelming, tiring and stressful but also incredibly rewarding and a lot of fun. At the moment, I struggle to see myself doing anything else.

EDITOR'S COMMENTS

Rob was an extremely valuable member of the Patient Group Health Fair Committee giving us an insight into how teenagers were already well informed about smoking, alcohol and drugs, together with many other aspects of health.

In reading his account of his first term it was very interesting to learn of the early emphasis on communications skills and how students are already allocated a patient with a chronic condition to learn of the effects on the whole family.

Here is another example of positive change in the training of the next generation of doctors where we wish Rob well with his studies and practical experience at medical school.

REPORT OF DOCTORS TALKS AT THE PATIENT GROUP AGM

By Sheila Uppington

Can the Expectations of Patients and Politicians be successfully managed at Davenport House?

Presentation by Dr Charli Barber-Lomax

Over the years the politicians have thrust many changes on doctors, mostly to save cash. As GPs are given control over much of their own budgets the shift of blame for failure ends up with them. Increasingly, primary care is having to fund more investigations prior to patients being referred without the extra cash to pay for it. Our group of Practices locally is the cheapest in Hertfordshire and Hertfordshire the cheapest in the South East but still cost-cutting is required.

Simon Stevens has been appointed as Chief Executive for the NHS to look at solutions, and with the age profile of patients and the costs of medication going up he has published a five year plan. He wants to break down barriers between GPs, hospitals and other health care workers by creating 'multi-speciality providers' providing an out-of-hospital care system. Sounds great, but there are many difficulties, not least of which is the extra doctors needed. Numbers in training are decreasing; vacancies for GPs have doubled in two years and the workload is not helping morale; paramedics have a shortage as they leave for less stressful jobs, district nurses are critically endangered with no recruits; a shortage of midwives exists. To fund Simon's plan £30 billion a year would be needed up to 2020. But will the Government provide this level of additional funding?

So far action is said to be needed on 3 fronts:

- Demand must be reduced by patients losing weight, drinking less and exercising more
- Efficiency must be increased with more than the current 1.8% savings made per year
- Funding has been altered – our Practice is only funded for 10.5 thousand patients despite having 12.5 thousand on the books, being in an affluent area.

As a part response to these pressures and to help us have better access to them, the doctors have introduced the new GP access scheme, which is described elsewhere in this Newsletter. But to completely answer the question posed by this talk - ONLY if more funding is released.

Difficult decisions in General Practice

Presentation by Dr Alka Cashyap

With a background just outlined we heard of the dilemmas confronting a GP in a 10 minute appointment. Diagnosis must be made by taking history and examination, investigations may need to be ordered, prescribing done, and possible referral. Then the patient says….'while I'm here'. Ought the second problem to be addressed now, is the computer saying check blood pressure anyway, advise on smoking/weight/diet, remind the patient to see another professional (eg asthma nurse). No wonder 74% of GPs are saying they can't deal with the workload. There are also difficult decisions to be made by the Practice as a whole:

- GPs to be paid £55 for each newly diagnosed dementia patient. Is this the wrong incentive? Davenport House is trying to identify patients who have suffered memory loss over some years and go on from there.

- Local incentive schemes are in place to reduce referrals. Individual GPs and the Practice are compared with others in the area. We are the highest referrer in Harpenden, but not in the wider locality.

- Audits are done by choosing 10% of the referrals and seeing if any could be avoided.

- Multi-speciality providers (see opposite) is happening elsewhere to counterbalance doctor shortage. Should this happen here? We are fortunate to have recruited our 2 new doctors.

There was much Practice discussion about the introduction of the GP access scheme, but it is hoped it will increase patient satisfaction, use the doctor time more constructively and reduce A&E attendances.

So treasure our NHS, use it sensibly and be prepared for changes, for its future survival is at risk.

Our sincere thanks to our doctors for trying to address all these issues with our well-being at heart.

AT YOUR SERVICE - THE SILVER LINE

By Gillian Thornton, journalist and Patient Group Committee member

For most of us, domestic circumstances will change regularly throughout our lives. We move out from our parents, maybe get married and have children, then downsize again as the younger generation leaves home. But inevitably, half of every couple will one day face living alone – an unwelcome change especially as we get older.

In Britain, more than half of people over 75 live on their own and even people with family can feel lonely when loved ones live far away or are out at work. Many older people cannot easily get out to make friends or simply feel too proud to ask for help.

But although many organisations in Britain tackle loneliness amongst the elderly. The Silver Line, launched in November 2014 by broadcaster Dame Esther Rantzen, is Britain's only free confidential helpline that is open 24/7 for the over-60s.

In August 2011, Esther wrote an article about feeling lonely after losing her husband, but she never expected the deluge of letters that followed. So within three months, she came up with the idea for a helpline to support vulnerable older people, direct them to projects and services that could help them, and break through the stigma of isolation. An initial grant of £50,000 was pledged by the Department of Health and, following a successful pilot scheme, The Silver Line was awarded a £5 million grant from the Big Lottery Fund in September 2013.

'That grant was intended to cover our first two years of operation, based on what we thought we needed,' explains Sarah Caplin, Director of Development and Communications. 'So now we are trying to build up enough resources to deal with the increasing volume of calls and to train more volunteers to offer a weekly befriending phone call.'

The statistics make sobering reading. The Silver Line anticipated around 100,000 calls in its first year but received nearly three times that number and expects to be taking a million calls within five years. The biggest single problem is loneliness with nearly 90% of callers living alone. More than half say they have no-one else to speak to and many callers ring the helpline on a regular basis, just to help them get through the day. Manned around the clock by 160 trained staff, The Silver Line helpline is, quite literally, their lifeline.

So far, 850 volunteers have been trained as Silver Line Friends and between them they make regular befriending calls to more than 1100 older people.

'We know how important this is to our callers,' says Sarah. 'Not just because it is someone to ask how their week has gone but also because it makes them feel part of the wider world again. They don't ever meet their Silver Line Friend face-to-face, but real friendships can develop over the phone.'

Then there are Silver Circles – conference calls for like-minded people who want to chat in a group – and Silver Letters for people who like to write and receive hand-written letters, perhaps because they are hearing impaired. But the demand for befriending still exceeds the supply of volunteers and Silver Line staff make an additional 1,000 calls a week to callers still waiting to be matched with a Friend.

'When you can't sleep at 2 o'clock in the morning, you can't ring up a friend, but you can ring Silver Line,' says one elderly lady. 'Suddenly you aren't alone any longer. There's somebody out there who worries about you.'

Call The Silver Line

Dial 0800 4 70 80 90 from a landline or 0300 4 70 80 90 from a mobile.
Volunteers are urgently needed to become Silver Line Friends, working from home and donating an hour a week to befriend an older person by telephone. For information, visit **www.thesilverline.org.uk**

The Silver Line
helpline for older people
0800 4 70 80 90

KEEPING IN TOUCH

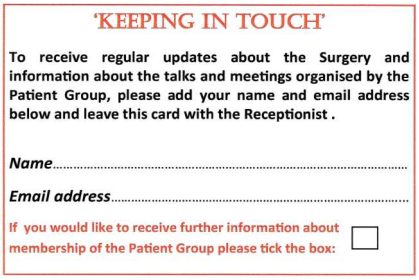
By Roger Gedye, Patient Group Chairman

INTRODUCTION

Patient Group members may be aware that our membership is declining gradually year on year as people's circumstances change, and that recruiting new members is a constant challenge. One way that we hope to reverse this trend is through a new Patient Group initiative 'Keeping in Touch' which will bring potential members onto our database, as well as providing them with a valuable extra service.

HOW "KEEPING IN TOUCH" WORKS

The printed business card illustrated invites Davenport House patients to register their name and email address with the Patient Group. Patients who join the 'Keeping in Touch' database will receive a quarterly Bulletin by email that includes Surgery Snippets, details of forthcoming events, and encouragement to upgrade their status to full membership of the Patient Group. Existing PG members will continue to receive four full-colour Newsletters delivered to their home and free access to our programme of health talks.



RESULTS OF TRIAL

Members of the committee carried out a recent trial, visiting the Surgery waiting rooms with a small pack of the new 'Keeping in Touch' cards. We were well received by the waiting patients, almost all of whom were happy to sign up with their email address. Most also ticked the box requesting more information on the Patient Group. The trial suggested that 12-14 patients could be recruited in a one-hour visit to the Surgery and we already have an encouraging number of patients on the database.

VOLUNTEERS REQUESTED

We now need volunteers for an informal rota of Patient Group members who would be willing to visit the Surgery for one hour from time to time – at times to suit themselves – and to distribute 'Keeping in Touch' cards and collect names and email addresses.

Would you consider joining the rota? If so please contact me, Roger Gedye via

- **the Patient Group Box in the Surgery**
- **email to roger.gedye@btinternet.vom or**
- **telephone on 01582 832374**

with details of your, name, address and telephone number. I will then be delighted to visit you to explain what is involved.

THE STROKE ASSOCIATION

Contact Details

In the article on the Stroke Association in the Winter Newsletter reference was made to a local Stroke Club, but no details were given as to how to contact the Club.

If you are interested in becoming a member, ring **Joyce Gooding on 01727 856962** or if you might be interested in becoming a volunteer, ring **Carol Short on 01582 872112**.

The St Albans and Harpenden Stroke Club meets on Tuesday morning form 10.30 to 12.30 at Christ Church Hall, High Oaks, on the north side of St Albans. Approach via Green Lane on the right before the Ancient Briton crossroads.

Enjoy quizzes, talks, games, entertainment, outings and companionship. For a 'taster' come to our Open Morning on Tuesday 5 May - you will be very welcome.

WANTED - VOLUTEER NEWSLETTER DELIVERERS

For the Batford and Southdown areas to deliver around 15 Newsletters to each area 4 times per year. If you can help please contact Helen Hartley - **01582 767462**

DAVENPORT PATIENT GROUP

HEALTH MATTERS!

PAIN RELIEF

Dr Martyn Fox

A consultant anaesthetist with a special interest in Pain Control. He uses a holistic evidence based approach to chronic pain.

An open meeting at Fowden Hall, Rothamsted Research on

Monday 11 May 2015
starting at 8.00pm

Plenty of parking next to the Hall

If you would like us to arrange transport to and from the meeting, please fill in and return the tear-off slip below by Friday 1 May 2015

To: Mr Mike Thomas, Davenport House PPG, c/o Davenport House Surgery, Bowers Way, Harpenden, Herts AL5 4HX

I/we would like transport to be arranged if possible for……..persons.

Name (Mr/Mrs/Miss)_____

Address_____

Postcode_____Telephone_____