# Park and St Francis Surgery
# Patient Participation Group – General Meeting
### Held at St Francis Church 15th February 2017 at 18:30

# Meeting Notes

## 1. Introduction
Claire Parsonage, Chair of the PPG, welcomed around 60 attendees.

## 2. Practice Update
Dr Mark Rickenback outlined recent events affecting the Practice:

- Three GP trainees would be joining the Practice for 6 months, providing valuable support in the busiest time of year
- The '7 Day Working Week' is not feasible yet, but it might be possible to pool resources between Practices in the area to support Saturday and Sunday working.
- Appointment delays are currently running at around 3 weeks (contrary to what you see in the news), although it may take longer if you wish to see your 'usual doctor'.
- Some research projects are being supported by the Practice. These are useful in that they generate an income and keep the Practice abreast of potential developments. One is called 'REDUCE' and is concerned with reducing dependency on anti-depressants. Another is CANDID (CANcer DIagnosis Decisions) looking at ways of improving predictions of lung and bowel cancer. A third is looking at tiredness. We will be looking for patients affected by these issues to participate in these studies.
- The PPG has been doing useful work in supporting the practice, including the promotion of 'Health Walks'. The walks take about 1 hour and and are a great way to socialise and get some exercise. Everyone is welcome.
  [Find out more at: https://www.walkingforhealth.org.uk/walkfinder/eastleigh-borough-healthwalks-scheme ]
- Internet Pharmacies: Leaflets have been distributed which use the Surgery name, but the Surgery would prefer you to use local Pharmacists wherever possible.
- The British Medical Journal has recently published an article on the importance of 'Continuity of Care'. This concluded that strategies that improve the continuity of care in general practice may reduce secondary care costs, particularly for the heaviest users of healthcare. Promoting continuity might also improve the experience of patients and those working in general practice.
  [This can be read at: http://www.bmj.com/content/356/bmj.j84 ]

## 3. Orthopaedics
Mr Hugh J Fox, Orthopaedic Surgeon, then gave a lively talk, supported by informative graphics, around his specialism – knees. Highlights of this were:

- Arthroscopy: The availability of high grade cameras were improving treatment options and reducing the impact of surgery, thus reducing hospital and patient recovery time.
- ACC (Anterior Cruciate Ligament) Of the four ligaments controlling the knee, this is the slowest to heal, and this has been improved by 'borrowing' pieces of ligament from elsewhere to re-join or re-anchor the ACC.
- Knee Replacements: Various materials and combinations thereof are available and the most hard wearing, while producing less debris may cause the worst biological reaction. It is necessary to look at a range of solutions to optimise the outcome.

- High Tibial Osteotomy: Removal of bone in the joint can correct some problems and defer the necessity of knee replacement.
- Braces: Devices such as the 'Donjoy' brace can give effective support and are used by many athletes.
- Gym: Can be used to strengthen the muscles supporting the knee but programmes need to be suitable to your condition, and low impact, such as spinning or swimming.
- Navigation/Robotics – Various computerised support is available to surgeons but is not at the stage where it justifies its high cost.
- Customised Prosthetics – NHS replacements are not made to measure but selected to suit the recipient – like a pair of well-fitting shoes. This is effective and reduces costs. Gender specific products are available although there doesn't appear to be any evidence of a need for this.

**On a more general note, Mr Fox referred to matters affecting the NHS:**

- Musculoskeletal problems are the largest cause of disability in the UK but is only third in the table of funding.
- In the next 15 years there will be a 40% increase in the population aged over 65, but costs have to be reduced by 18% by 2020.
- Knee replacements: 27 per 100,000 in 2004, 75 in 2009 and 92 in 2014. How can this trend be maintained with reduced funding?
- Body Mass Index: The average UK BMI is increasing: 29 in 2004, 30.6 in 2009, 31.1 in 2014. 35 is deemed to be clinically obese. Our Clinical Commissioning Group is effectively rationing treatment by refusing surgery to those with a BMI of 35 or more.
- Longevity: A study of patients who have had replacements revealed that 17% died within 7 years. The good news is that in their categories they had lived longer than the expectation of the general population.
- Availability of beds: In the UK we have 300 hospital beds available per 100,000 of population. Contrast this with Ireland (500), Belgium (650) and France (700). To address the shortfall in NHS services a further £20 billion per year is required.

**Useful sources of information:**

- Arthritis Research UK: www.arthritisresearchuk.org
- British Osteopathic Association (BOA): www.osteopathy.org
- National Joint Registry (NJR): www.njrcentre.org.uk
- NHS: www.nhs.uk

**And finally … surgery is the last resort. Before that, there are:**

- Physical exercise
- Sticks – yes, they have their role.
- Medicinal injections
- Weight loss.

Mr Fox then took questions form the audience

### 4. Closing comments

Claire Parsonage thanked the speakers and attendees and reminded members that the next meeting will include the PPG AGM. It will take place at the same venue on April 19th, commencing at 6.15 pm.

*PT/CP 22/02/17*