Nurses League Journal

2007

THE UNITED NORWICH HOSPITALS NURSES LEAGUE
EXECUTIVE COMMITTEE AND TRUSTEE MEMBERS

Charity Registration Number 290456

2006-2007

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Notices

The Reunion and AGM on Saturday May 12th 2007

On May 12th 2007 the 77th Reunion of the United Norwich Hospitals Nurses League will be held at the Norfolk and Norwich University Hospital, Colney Lane, Norwich. For those arriving early coffee will be served from 10:00hrs onwards in the rooms adjoining the Benjamin Gooch Hall, East Atrium. This year the Chapel Service will commence at 13:45hrs in the Hospital Chapel, and as usual will be followed by the AGM and afternoon tea. It would be most helpful if you could let Miss Lee know by May 1st if you are planning to join us, as this will assist with catering and seating arrangements.

Editor's Report

Firstly I must apologise to those members who contacted the President to complain about the print in last year's journal. I hope I have rectified the problem this year!
In the absence of any further comments or suggestions from you I have decided to continue with my theme of providing you with what I think are very informative articles about the Norfolk and Norwich University Hospital in addition to contributions from friends and members of the League.
I am extremely grateful for their timely responses to my requests despite the endless demands on their time, to my husband once more for his computer skills and to Betty Lee whose help has been invaluable during my spell as Editor.
This is my third and final edition of the journal. The committee members will put together a journal for 2008 to commorate the 75th Anniversary of the Preliminary Training School, after that the ball is in your court!!

Have a good year.

Lavinia Gordon-Gray

A Message From The President

A belated Happy New Year to you all. I am writing this on the 29th January. It is a glorious winter's day that from inside is more like spring than winter. Wonderful sunshine but quite cold when you go outside. The bulbs are all up and obviously think it is Spring. The grass needs cutting, the roses need pruning but something holds me back from being too drastic in the garden, like the real risk of severe frosts.

If we are confused, what about the plants and animals that usually hibernate. We are feeding baby squirrels that cannot be very old and will surely die if we get severe weather now.

The Annual General Meeting and Reunion in May 2006 was reasonably well attended but numbers were down on previous years. Whilst we recognise that we are all getting older and that some of us find travelling more difficult, we also realise that we are not getting many younger nurses as new members and if the League is to continue, at least in it's present form, we do need to try and recruit members and to persuade those existing members that we need their support and if at all possible, their attendance at our annual or maybe twice annual event.

Likewise, the Carol Service, this was cancelled because it was very poorly attended in 2005 and despite the request in the Journal to let us know whether you wished to continue holding a service and where you wished this to be held, we received only a handful of responses. The Committee therefore took the decision not to hold a Carol Service last year.

The Committee is made up of twelve League members who are all Trustees and who run the League on your behalf. However, because we are a Charity and because Charity law has tightened within the past year, we have to conform to our Trust document and the objects stated within that document in Clause 4. "to assist those nurses who have received their training or held appointments at the United Norwich Hospitals, their spouses, widows, widowers, children and other dependants of such persons who are in condition of need.. The trustees must apply the income of the League, after defraying the Leagues expenses, in furthering these objects." I urge anyone who knows how we can achieve this object to contact a member of the committee.

We have four vacancies on the committee this year, so please consider putting your name forward for election to serve a three year period. If you wish the League to continue we need you to be involved.

We look forward to seeing as many of you as can make it at the Reunion on 12th May. If transport is a problem, please let a member of the Committee know and we will endeavour to try and find someone in your area who might be willing to offer a lift but please give us as much notice as possible.

Sheilah Rengert

Presentation to Miss Beatrice Taylor (Vice President)

Following the AGM and in recognition for her many years of dedicated service as Treasurer to the League a presentation of a bird table and bird bath was made on behalf of the Committee and Members. We are still looking for a suitable garden chair!

Treasurer's Report AGM 13th May 2006

On behalf of Miss Taylor and myself I present the League's Income and Expenditure statements for the year ending March 31st 2006.

Unfortunately Miss Taylor has had a very difficult year with her health and mobility and so decided to hand over her responsibilities slightly earlier than planned after more than 30 years service.

Please note on the statements we have paid for the journal printing and postage for two years in this financial year.

We would of course be happy to answer any questions.

Miss Taylor convinced me that there was nothing to do really as Treasurer but I must say I have been very grateful for the committee members' support and encouragement, especially Betty Lee who has diligently collected and recorded your subscriptions and donations.

Miss Taylor has been dedicated in her work for the League and is a truly inspirational 90+ year old. She has been saddened, I know, not to be able to continue her work independently but my visits over the year, often with tea, have been a real delight. Bea is always interested and always interesting. She has passed on her responsibilities of treasurer for the League to me and I will do my best to follow her dedicated example, but probably not for 30 years.

Mrs Mary Dolding, Treasurer.

United Norwich Hospitals Nurses League Accounts

Year Ended 31st March 2006

Income and Expenditure Statement

Income	**2004/05**		**2005/06**	
Annual Subscriptions	828.00		**1289.00**	
Donations	597.00		**971.95**	
Carol Service Collection	0.00		**87.00**	
AGM Chapel Collection	202.00		**200.00**	
Sale of Membership Lists	7.50		**2.00**	
Income from Investment	499.96		**570.62**	
		2134.46		**3120.57**
Expenditure				
Christmas Benevolent	150.00		**317.51**	
Journal	697.24		**1004.38**	
Postage (journal)	176.53		**328.21**	
Other Postage/ stationary	290.44		**76.59**	
Catering	6.30		**13.02**	
Salvation Army	0.00		**87.00**	
Open Door Appeal	0.00		**200.00**	
Air Ambulance	202.00		**0.00**	
Flowers/ Gifts	241.45		**119.95**	
Memorial Funds	50.00		**30.00**	
		1813.96		**2176.66**
Surplus/(deficit)		320.50		**943.91**
BALANCE SHEET				
Funds Brought forward				
Nat West Capital Reserve	3,476.52		3,521.84	
Barclays BPA	2,069.35		2,089.35	
Barclays Community Account	1,011.98		1,267.16	
Unit trusts & investments	15,000.00		15,000.00	
		21,557.85		**21,878.35**
Surplus (deficit) for the year		320.5		**943.91**
		21,878.35		**22,822.26**
Funds carried forward				
Nat West Capital Reserve		3,521.84		**3,595.80**
Barclays BPA		2,089.35		**2,111.22**
Barclays Community Account		1,267.16		**2,115.24**
Unit trusts & investments		15,000.00		**15,000.00**
		21,878.35		**22,822.26**

Hon. Treasurer…… Date……
Mrs M R Dolding

Hon. Independent Examiner…… Date……
Mr I Murphy

The Path To Director Of Finance At The Norfolk & Norwich University Hospital

When Lavinia contacted me to ask me to write an article for the Nurses League Journal I had no hesitation in accepting the invitation. It's nice to have the opportunity to communicate with you even if it is a bit of a monologue.

I first moved to Norwich as a 'new wife' in 1992 straight from London with my husband who is from old Norfolk stock. In fact it was not really straight from London as we had spent three months travelling round the world with backpacks visiting some weird and wonderful places and having some amazing adventures…. but that is another story for another day!

My job in London was as a chartered accountant in a firm and involved a wide variety of different types of work including a significant amount of travelling within Europe. My clients varied from the Soviet merchant shipping fleet to a famous comedian with just about every type of business in between. One thing defined them all though; they were all primarily concerned with making more money.

What I was searching for when I came to Norwich, perhaps partly informed by our experiences on our travels, was something more meaningful.

However the immediate priority in financial terms with how to pay the rent! The rent was paid by a short stint at Norwich Union which I have to confess I did not enjoy and from there I took on a project role at the Health Authority. With that as my stepping stone into the health service I was successful in getting the job of Deputy Director of Finance and then Director of Resources at the Norfolk and Norwich.

From day one I was smitten. In all the organisations had seen I had never seen anything quite like this before for a whole variety of reasons and I think it is that and the sheer diversity of what we do and the dedication and professionalism of the people who do it that has kept me hooked.

Being a Director of Finance in the NHS can only be described as a Sisyphean task. One thing is certain, as soon as you think you are making progress something else happens to push you back down the hill again!

What keeps me going is the prize at the top of the hill which has to be improving the care we provide to our patients and those of you who know me will know that I am absolutely committed to that. We clearly cannot continue to improve patient care if we are bankrupt, no organisation or individual can consistently spend more than the money it earns and hope to survive intact. My challenge and the challenge that of all of us face is how we can constantly improve efficiency in the way we work and the actions we take, keeping that single focus on our patients.

Anna Dugdale
Director of Finance, Norfolk and Norwich University Hospital

A Visit From Winston, July 1962

Marjorie Mariott (Matron) was away in Australia in July 1962 and I, her deputy, was luxuriating in my hairdressers in Cork Street reading the glossies when Andre the proprietor raised the lid of the hairdryer. "Miss Cooper you are wanted urgently and immediately by Brigadier Hardy-Roberts at the Middlesex Hospital". "Don't bother to take out my rollers, just get me a taxi" I said, and as we sped along Bond Street my mind was full of dread (recently a physiotherapist had had a fatal accident falling out of a window into Cleveland Street). It must be a staff tragedy! (The days of bomb scares of the IRA had not arrived).

The Brigadier sat at his desk looking tense, "Miss Cooper, Sir Winston Churchill has fractured his femur in the South of France, Mr Newman is with him, and he is to be admitted here tomorrow". A wave of relief flooded over me, "Oh is that all, I thought something terrible had happened to one of my nurses!" The Brigadier laughed and relaxed, "you are very good for me, of course he is a distinguished patient, but we are experienced in caring for patients here".

So we set about planning for his immediate long term future:-

1. He was to be nursed on Woolavington Ward B Floor, by Sister H.M.G. Smith, a calm, capable, quiet and experienced Sister and her staff nurse Sally Sinclair and the team. Sir Winston's own male nurse would be joining them. If any additional experienced nursing was required Mr Newman would consult with me.
2. Initially a rest room for the relatives would be provided.
3. Confidentiality: staff of all disciplines must be reminded that the confidentiality given to all patients should apply equally in this case.
4. The Brigadier and I would hold a meeting with representatives of the press prior to Sir Winston's admission.

The special meeting with the press (about two hundred of them) was held in the Courtauld Lecture Theatre and discussion took place and questions were welcomed. I gave the names of the nurses who would be caring for Sir Winston, with the undertaking that under no circumstances should the press attempt to approach individual nurses as they did not wish for this. The Brigadier suggested that they form a rota of five representatives who could use a special press room in the hospital and that a hospital administrator would liaise with them and give them frequent bulletins initially for them to circulate to their colleagues.

Sir Winston was operated on and settled in well and made good progress. Everyone involved has their special recollections and stories of that time and here are mine, for although I was not directly involved in his care I visited him and Lady Churchill daily in Miss Mariott's absence.

1. In the early days Sir Winston did not cooperate with the physiotherapists and said to me "I won't have those physioterrorists!!". However, Miss Marjorie Simpson, Principal Physiotherapist, charmed him into a change of mind!
2. Bishop Cordingley, the Bishop of Thetford, was in a room near to him and on one night whilst Sir Winston made loud speeches in French, the Bishop competed by intoning parts of the marriage service.

3. Sir Winston had an excellent appetite, but when I visited him one evening he said that he wanted his grouse. Lady Churchill intervened by reminding him that he had eaten the brace given to him by Randolph the day before but he was adamant that this was not so. However the conversation changed and as I left about ten minutes later he winked and said "it's a bit much when my son brings me grouse and you eat them".
4. Latterly he enjoyed a film in the evenings and on one occasion told me he had watched "The League of Gentlemen" but that a speech of his had been misquoted, and quoted the correct speech and the misquotation.

After approximately six weeks he was discharged in time to have lunch at his home in Hyde Park Gate. On the day the whole of the area around the hospital was crowded with well-wishers and the police were well organised ready for his departure at 12 noon. Just before that time he told Lady Churchill he was hungry and wanted his lunch and would not be put off by the thought of it awaiting him at home, so Miss Wannop and Mrs Drayson, the dietician, produced a small light lunch of three courses to meet the emergency! Needless to say this delayed his departure considerably.

For all who were involved in his care in any role it was a great moment when he drove off home and one felt that the Middlesex had sent him home healed and restored to face the last lap of his long and eventful life.

Miss P.J. Cooper.

Agenda For Change - Bringing NHS Terms And Conditions Into The 21st Century

Introduction:
The Agenda for Change (AfC) project to change the terms and conditions of work for NHS employees has been huge – for a start there were two or more years of negotiation at national level between representatives of the Department of Health and the NHS staff organisations. From its acceptance in (2004) following a national ballot, it was fondly thought to be a 12 month project to implement for each Trust. However, we started in 2005 and are only now in the final stages of implementation which includes some reviews.

Scope of AfC Project:
It covers all NHS staff except for doctors and dentists and Board Level Directors. At the same time as AfC there have been separate changes to doctor's terms and conditions with the introduction of the new Consultant Contract, GP Contract and from 2007 Modernising Medical Careers.

However, to get back to AfC, around a million staff in England have been moved from a system with almost 650 staff grades governed by 11 Whitley Councils, each with varying terms and conditions onto one system with 12 new pay bands

But AfC does not stop there. It should now become the basis for changing how staff work and how services are delivered. The NHS is under pressure to deliver improved productivity and better quality care within existing resources and Agenda for Change provides tools to help do this[1].

The NHS Knowledge and Skills Framework (KSF): is part of Agenda for Change it defines and describes the knowledge and skills which NHS staff need to apply in their work. It provides a single, consistent competency framework on which to base review and development for staff. The KSF is the key to ensuring we continue to recruit, retain and develop a quality workforce that is fit for purpose. We are working hard with a small (but committed) team of managers and staff representatives to develop KSF outlines for all posts in the Trust. Once that is done the focus will need to shift to the way in which these outlines are used in the appraisal and the personal development review cycle.

KSF is the Key to Pay Progression: Generally, pay progression will take the form of an annual increase from one point within a pay band to the next. At two points in each pay band – known as 'gateways' – decisions are made about pay progression as well as development. Gateways are the method of linking pay progression to the development of staff skills. The two gateways in each pay band are the foundation gateway and the second gateway.

The foundation gateway review takes place no later than 12 months after an individual is appointed to a new pay band, regardless of the pay point to which they are appointed. It is used to ensure that the appointee can meet the basic demands of

[1] Agenda for Change Briefing (Issue 18), NHS Employers

the post. The foundation gateway review is based on a subset of the full NHS KSF outline for a post.

The second gateway is set at a fixed point towards the top of a pay band. It is used to confirm that an individual is applying knowledge and skills consistently to meet the full demands of the post as set out in the full NHS KSF post outline.

Early Benefits of AfC: The NHS has invested £1.1 billion in staff through the implementation of Agenda for Change. Patients now need to see the benefits of this investment. This is the challenge for organisations as the focus of Agenda for Change moves from a transactional process of setting up a new pay system to a set of tools that help in the transformation of services[2].

Improved Partnership Working with Trade Unions: Agenda for Change has been delivered by partnership working between Trade Unions and employers at all levels. The joint approach on issues such as job evaluation has been a huge success and has helped to build trust. The benefits across the NHS from improved partnership working have been tremendous. It has become integral to all our day-to-day business and has changed the culture in many organisations.

Equal Pay for Work of Equal Value: The existing Whitley structures were increasingly open to challenge under equal pay and legislation. Agenda for Change has been designed to significantly reduce the risk through a common job evaluation system and harmonised terms and conditions.

Simplified Administration: To take just one example, pay band five of Agenda for Change encompasses more than 50 Whitley grades. Varying terms and conditions within those grades, including working hours, holiday entitlement, on-call and overtime arrangements, complicated team working, rostering and HR processes had created artificial barriers between staff groups. Under Agenda for Change, such terms and conditions have been harmonised which should assist in service re-design[2].

Efficiency and Productivity: The Trust, along with many other NHS organisations, has been developing new and enhanced roles for many years, but Agenda for Change now supports this process.

It is estimated that 40 per cent of the NHS workforce had no access to training and development opportunities before the introduction of Agenda for Change[2]. The KSF is putting into place a system that ensures all staff will be supported to develop the knowledge and skills they require to be fully competent in their current role and to develop their skills to meet new demands as the service develops.

Whist it has been over the last two years an exciting, frustrating, challenging and at times exhausting process to implement AfC really will deliver huge benefits to the service over the next few years.

Lynne Middlemiss - Deputy Director of Human Resources

[2] Agenda for Change Briefing (Issue 18), NHS Employers

The Big C Cancer Information and Support Centre, Norfolk & Norwich University Hospital

The Big C Centre provides information and support to anyone affected by cancer – either patients or their relatives or friends.

What is available at the centre?

- A peaceful and relaxed setting in which to just sit or to talk things over with a member of staff
- An information library with books, leaflets and videos on various aspects of cancer. These can be looked at in the centre or taken home on loan.
- Information on support groups and local services
- Support and counselling
- Internet access for information on cancer-related topics – centre staff can help with this
- Advice on welfare benefits, housing and employment issues for people with cancer (on a Tuesday)
- Complementary therapies

The centre is situated at the Norfolk and Norwich University Hospital, by the roundabout near the Colney Centre on the east side of the hospital.
Visitors may drop in or contact the centre by telephone, by post or by e-mail for further information.

Opening times:

- Monday – Friday, 9:30am – 4:30pm (closed Bank holidays)
- On the first Wednesday of each month, the Centre is open until 7:00pm

Contact details:

The Big C Centre
Norfolk and Norwich University Hospital
Colney Lane
Norwich
NR4 7UY
Tel 01603 286112 (out-of-hours there is an answerphone: calls are returned the next working day)
e-mail: cancer.information@nnuh.nhs.uk

What It Is Like To Be A Manager In The NHS

An NHS manager falls in the same category as Traffic Wardens and Tax Collectors in terms of being a job that everyone loves to hate.

Since its inception the NHS has always been "managed" to a greater or lesser extent by Consultants, Matrons, Almoners and administrators but it was only in the 1980's that the term "NHS Manager" was widely used and the General Management Structure we know now was introduced.

Today managers are a key part of the NHS, controlling the finance, and providing the equipment, buildings and services required to deliver effective healthcare to nearly 60 million people.

Clearly with upwards of 300 different careers in the NHS, managers are one cog in a very large wheel, but I would argue that good managers can make an enormous difference to the ability of clinical staff to deliver effective services.

Equally, bad managers can have a disproportionate effect on clinical service delivery.

I have always believed that the only justification for my existence, and that of my managerial and administrative colleagues is that we address problems / issues that prevent or adversely affect good patient care.

I do not believe in targets and monitoring unless their purpose is to drive service improvement and I certainly struggle with the huge increases in the numbers of staff employed by the Department of Health and Strategic Health Authorities that have taken place over the last 10 years – many of whom do not appear to have ever set foot in a hospital.

However, I also believe strongly that the NHS does need managing. It is inconceivable that an organisation so large and so complex in the private sector would not have an effective General Management Structure working alongside its professional staff.

I have skills and training that are completely different from those that Senior Doctors, Nurses, Scientists or Therapists have and I think it is foolish and regrettable to assume that because you are a senior and skilled clinician you will automatically make a good manager, indeed I think it is sad that in the absence of a rewarding clinical career structure (particularly for nurses) staff often feel that they have no choice but to go into management.

As a divisional general manager, the key elements of my role in the hospital fall into four main categories.

1. **Staff**
   A large amount of my time is spent "managing" staff. This includes drafting job descriptions and adverts, interviewing staff, managing sickness and other absences, approving annual leave and study leave and helping staff to deal with

issues within and outside work that may be affecting their work, such as family illness or bereavement, childcare or other carers' responsibilities.

I also spend a lot of time communicating with a group of staff on behalf of other groups of staff e.g. doctors and managers, doctors and nurses, nurses and admin staff, and help them to understand how the way in which they work may impact on other people.

2. **Money**

The budget of the division I have responsibility for is approximately £35 million per annum. This is made up of pay and non-pay costs such as drugs, medical equipment and supplies, stationery, travel and study expenses etc.

I have responsibility for approving and monitoring expenditure, working with staff to control and if necessary to reduce expenditure, to help staff prepare business cases for new staff, equipment or ways of working and to meet regularly with staff and the finance department to ensure the correct expenditure and income is attributed to each budget.

3. **Strategy and Policy Development**

It is often my job to analyse how government or Department of Health initiatives will affect the service we provide, and to work with clinicians and other managers to ensure that we respond to these directives appropriately. This could mean reviewing the way we provide services, changing equipment or medication routines, collecting additional or different information to demonstrate what we are doing and writing policies to underpin new or different ways of working.

We also get involved in the review of services following serious incidents elsewhere in the NHS. Recent examples have included:

- Changes to consent for post-mortem and retention of human tissue following the Alderhay Children's Hospital organ retention scandal.
- Changes to the way in which Trust's evaluate concerns expressed by clinicians about another colleague's performance as a result to the Bristol Children's Hospital enquiry.
- The procedure for Radiotherapy planning following the over exposure of patient Lisa Norris during Radiotherapy at the Beatson Oncology Centre.

4. **Targets**

The setting of a range of targets is the way in which the government aims to both improve and monitor performance in the NHS and there are a number of key targets against which the hospital's performance is judged. These include:

- The reduction of maximum elective waiting times to 4 months by March 2007 and to 10 weeks by December 2008.
- The reduction of maximum out-patient waiting times – to 11 weeks by March 2007 and to 4 weeks by December 2008.

- To reduce the maximum routine wait for diagnostics to 13 weeks by March 2007
- To see and treat 98% of patients in A&E within 4 hours
- To diagnose and offer to all patients referred by their GP as a suspected cancer their first treatment within 62 days
- To treat all newly diagnosed patients with cancer within 31 days of the decision to offer them treatment
- To offer all patients the opportunity to book their appointment on a time / date convenient to them
- To achieve financial balance
- To reduce rates of hospital acquired infections

There are strict procedures in place for reporting the Trust's compliance with these targets to the Department of Health and we have had to update many of our IT systems to ensure that we are collecting and transferring the relevant information.

Since I joined the NHS as a national management trainee in 1989 there have been huge numbers of changes to the way in which services are delivered and managed and without a doubt many of these changes have benefited patients enormously. However, there are elements of the "traditional" NHS that have disappeared for ever and only time will tell whether these changes will protect the "free at the point of delivery" service we all joined, for the future.

Melissa Blakeley
Divisional Manager, Norfolk and Norwich University Hospital

Discovering Diabetes – One Story Behind The Statistics

Diabetes has hit the headlines. It's the new buzzword - the latest in a host of twentieth century illnesses linked to our modern day living. About 94% of diabetes in the UK is Type Two, often obesity-linked, with onset later in life. Only 6% is the insulin-dependent (previously 'juvenile onset') Type One diabetes.

Prior to my son's diagnosis, I can safely say that I knew next to nothing about diabetes. I once had a next-door neighbour who was diabetic who I knew would have just one biscuit and never two. I had heard of insulin but, never having been a success in Biology, didn't really know what it did.

We had no history of diabetes in the family. We eat healthily, get lots of exercise, don't smoke, don't drink to excess and do all of those things which you hope will exempt you from major illnesses for as long as possible. To say that we were unprepared for diabetes to steamroller its way into our life would be an understatement.

Dylan was approaching his third birthday, had toilet trained a few months earlier and was doing remarkably well. But then he started to regress, with accidents when we were out and at home. Of course, I had no idea of the symptoms of diabetes. We were in the midst of a heat wave, so it didn't seem extraordinary that he was thirsty and drinking lots – I was too. He was also clingy, tetchy and tired, but what two year-old isn't at times? Again, I put it down to the heat and the fact that he had recently stopped having a nap in the daytime….

Over the course of about a week, a niggling suspicion in the back of my mind that there might be something wrong, had turned to a more persistent concern and so, on Monday morning, I found myself at the doctor's surgery. Having done some research on the internet, I took a urine sample with me, just in case. At this point we suspected that Dylan may be diabetic, but still had no idea at all what this meant.

When the doctor told me that I had a 'very poorly' son; that she was booking an ambulance which would arrive within ten minutes, and that, untreated, he would go into a coma, I started to appreciate the gravity of our situation. She explained that he would be put straight on a drip and would be in hospital for a few days.

At this point I think I switched off emotionally and went onto automatic. I arranged for somebody to collect my daughter from school and give her tea, called my in-laws for backup, and got in touch with my husband, who made arrangements to drop everything at work and rush to the hospital.

I'm one of those people who don't like hospitals. I'm the squeamish sort, who can't look when they have an injection, and who really don't like the sight of blood…. Hospital was not fun; Dylan was attached to several drips, and needed a blood test every half an hour. He cried for food because he was hungry, cried for Daddy because he wasn't there instantly, and cried because he felt rotten and poorly. Tired and tearful, we spent hours just sitting in a ward, not knowing what was happening and feeling desperate.

The suspected diagnosis of diabetes was confirmed and somehow the day passed in a haze of desperation, waiting, crying, and trying to distract Dylan whenever it was time for yet another blood test. It felt unreal and I felt out of control. Nurses came and went, drips were changed, pots brought to wee into.

But it is amazing how quickly you adapt. From finding out on Monday morning to, thankfully, being allowed home on Tuesday evening – (I think they got fed up of hearing Dylan asking for more food) – we had learned how to do a blood test, how to administer an insulin injection and how to calculate insulin dosages. Scary, but we were pleased to be going home and pretending that it was all normal.

I suppose it did slowly become normal. A normal level of panic at how high his blood glucose levels were. Avoiding talking to people about it became normal. Waking up in the night and going in to check on Dylan several times became normal. Emotional detachment became normal, because I couldn't feel the things I was feeling and not cry. Two weeks passed in total bewilderment until we started to ebb into a routine. It's true that you do get used to anything and, finally, we did start to.

Even so, the first few months were an enormous learning curve. We were learning how much was too much, how even a large meal could send Dylan's glucose levels high. His little body was very sensitive to the insulin, so even an extra half a unit would send his sugars plummeting and we would have a hypo to deal with.

The return to school, and nursery meant a new routine, and a loss of control again for a few weeks. Highs and lows, my emotions seemed to follow blood glucose levels… If we could get those magic numbers on target, I was happy, if not I could sink into despair at ever getting it right. Sometimes just one day could be really, really hard.

We're still aiming just to get through this first 6 months, I've been told that's the hardest time. Technology is changing rapidly it seems - we are now already preparing to have an insulin pump fitted. Our latest challenge is to count the carbohydrate content of every meal and every snack that our three year old boy eats. He is very good about having his bread roll weighed and his grapes counted and his parents always watching him and making copious notes on what is passing his lips…

We're also getting used to people's perceptions of diabetes. From the outside, doing a blood test and giving an injection is all you see. That's the easy bit. Getting blood glucose control in the real world is the hard bit, where kids all around are snacking on sweets and chocolate, and drinking squash and fizzy pop. Even where kids are eating healthy snacks, sugar-rich fruits such as raisins and apples, and drinking healthy orange juice, we still have to be careful. We can't stop and snack on a carbohydrate-rich banana without planning it first, and we need to be constantly aware of when Dylan last ate, what he had, and whether we may face a hypo. Being different is not a bad thing, but sometimes all you want is for your child to be able to do the same as everyone else….

But it's not all doom and gloom. We have a healthy, happy son, who is bounding with energy and enthusiasm for life, and has a wicked sense of humour even at the

tender age of three. He swims once a week, attends a gymnastics club, and bounces on our trampoline at every given opportunity. We are very lucky.

That said, we are conscious of the fact that diabetes is with us to stay. We can't ever get rid of it and nor can Dylan. Certainly, technology will improve things for us and for him, but diabetes is likely to present one new challenge after another for the rest of Dylan's life.

Deborah Burbage

A Tale From My Four Arabian Nights

Prologue
During my training at the Norfolk and Norwich Hospital (1945-1948) Sister Doig (sister tutor) said something to my set in a lecture which stuck in my memory and stood me excellent stead during my long career as a nurse, midwife and health visitor, not to mention my private life. It was this: 'Nurses, you never by expression on your face or a flicker of your eyelids let a patient know that you find anything you do for them distasteful'.

Arabian Nights
In 2006 I paid my fourth visit to the Middle East. This trip included my second visit to Jordan which was the most adventurous. This time I decided to go by 'taxi' both to and from Petra through the Siq. The taxi being a horse-drawn buggy, a miniature 'sully with the fringe on top', but very small and a bit grubby. The driver told us, a friend and I, that he was a student studying IT, in his third year and at present on vacation.

Suddenly at the end of the Siq one is confronted with the beautiful carved 'Treasury', a building carved into the mountainside over 2000 years ago by the Napoteans. When the rest of the group arrived we walked for approximately one mile through extremely rough downhill terrain stopping at the various carved facades and being shown where many more excavations were being undertaken. It is thought that about 45% of the city has yet to be uncovered. We were shown one building with scaffolding up its height and were told that a German firm was doing something to the building in order to preserve it. For up to 2000 years the sand had done a good job in preservation. The hotel in which we were staying also ran a restaurant at the bottom of the road at Petra and it was here we were served an excellent lunch of kebabs and lovely salads of all kinds. The walk down had taken about 2hrs including comfort stops, drinks and the usual bargaining with the traders.

As the second oldest member of the party and with groggy knees and an artificial hip joint I decided to precede the party back to the Siq in order not to hold them up, so I manfully strode uphill through the sand and rock, stopping only once at a watering hole and got back to the Siq in 55 minutes. I found myself a seat and awaited the arrival of the others, surrounded by traders again! Their ages ranged from about six years old –Khalid - to men almost my own age, and because it was the end of the day I was offered some 'real bargains madam'. Camel bone necklaces were extremely pretty but somehow I didn't fancy them, although others bought and wore them and I thought they looked very nice. I then had an uncomfortable, rocky uphill journey by buggy through the Siq back to the sumptuous very comfortable hotel.

Next morning we were up very early and driven through most beautiful mountainous country into the desert as far as the coach could take us and here we transferred into open top jeeps. I was allocated to the oldest most rusty thing and had to achieve my transfer by standing sideways on a piece of angle iron about 2 ½" wide and then hoisted myself over the tailgate and onto a seat. We were driven at what seemed like breakneck speed through the desert and through ruts made by earlier expeditions – a most uncomfortable ride – even more so than the buggy ride in Petra. The

countryside was breathtakingly beautiful, the mountains barren and so colourful with strata of different colours of the minerals they contained.

We were driven through Laurence of Arabia country, a man greatly revered in Jordan, a co-saviour from Ottoman rule. A stop was made for photographers to take pictures of the Seven Pillars of Wisdom. Among the party was a professional artist who did a glorious water colour of part of the mountain range. She had her sketch book out at every opportunity. Not really often enough as we were kept moving in order to see as much as possible. That day we took lunch in a Bedouin tent, Bedouin style, with very low tables with couches and cushions. Again a meal of kebabs, salads and some very, very sweet cake and strong Arabian coffee.

Back once more to our hotel, a meal and a good night's rest ready for another early mornings start to visit Jerash Roman remains. As I had visited this town before I decided not to accompany the party on what I knew would be a very long, hot and at times uphill trek so I found myself a seat on a wall in the shade of a eucalyptus tree. There was a small group of about six beautiful teenage Jordanian girls talking and laughing among themselves. Soon they were looking at me, laughing and looking, looking and laughing, and at last one of the more adventurous of their group came over to me and greeted me with a friendly 'hello'. I replied the same with a smile and then the rest of them joined me and they soon established that I was English, 80 years old with one daughter of 45 years, and that no I did not live in London. I was then told their names and had to repeat them. If I managed to get them right at the first attempt I was applauded, if not I had to repeat them until I did get them right, then I was given a clap. They asked if they were disturbing me but I told them no I was pleased to be speaking with them. After a time these young ladies left and I was joined by some much younger children, not quite so proficient with their English but still able to communicate. Their English was better than my Arabic! One of the children gave me a rose she was carrying. Off they went and I was soon joined by several little urchin-like boys and a grown man. The man had a van containing bags of olives and two young boys were given boxes containing bags of olives which they were obviously hawking. The man told me that those two boys were his sons, the youngest two of seven .The youngest one was quite a character and very out going. At one stage in our conversation he took a sweet from his pocket, unwrapped it and before I knew what was happening had shoved it in my mouth!! This was one occasion when Sister Doig's words came into my mind and I sucked with what I hoped looked like pleasure. However the young boy then demanded one Dinar. To which I replied 'no Dinar' and removing the sweet from offered it back to him. He roared with laughter. I had my Sudoku book out and was doing, or trying to do, a puzzle. The children were intrigued and began pointing to the figures and reciting the numbers and we had a lesson in numbers and alphabet. A most extraordinary time but soon for some reason that I could not see the children left me. I then noticed policemen and tourist police on the street beyond the tree and, remembering the young girl's question 'do we disturb you', wondered if they are told not to bother tourists, as the authorities are very keen to promote tourism in the area.

Walking back through the little bazaar to the bus station and our coach, I simply walked over a step and fell a cropper. I was quickly joined by two traders offering to help me, but I said I could manage to get up, and by some miracle made a much better job of it than I do when I get up from washing the floor at home! A trader offered me

his seat to sit on and soon yet another arrived with a tourist policeman to ask if I was OK and did I want to go to the hospital - they would be happy to take me. I said that no I was fine but a little shaken. At which the trader whose seat I had taken asked if I would like coffee or tea and I asked for tea. He left the shop and stall and came back with a steaming cup of hot sweet mint tea for which he refused any payment. I soon felt fit to make my way back to the coach but the trader invited me to look at his wares and I came out with a couple of things I didn't want and didn't barter for. One can't put a price on kindness.

During our talk he told me that he had only been in business six weeks, that trade was not good, but that as the government is anxious to promote tourism he was able to rent the shop at a subsidised rent of 75 Dinars per month - about £60. At least he got half of next month's rent in his pocket. On leaving the shop the trader picked up a walking stick telling me my own wasn't good enough but I declined the offer.

I think our whole party was sorry to leave Jordan- a beautiful country and charming people.

Beula Gray

The Role Of Regulatory Inspectors For The Commission For Social Care Inspection

I suppose I have always had a vested interest in standards of care… this was instilled into me at a very early stage of my nurse training by no other than our Sister Tutor Miss Hale, affectionately known as Aggie.

The Care Standards Act created the National Care Standards Commission, an independent non-governmental public body, which regulates social and health care services previously regulated by local councils and health authorities. In addition, it extended the scope of regulation significantly to other services not previously registered, including domiciliary care agencies, fostering agencies and residential family centres.

In 2002, the Government introduced new **National Minimum Standards** for care homes for older people in England. These Standards set out the quality of care, service and facilities anyone should expect from a care home. They also include advice on what to do if someone is unhappy or concerned about a care home.

The Care Standards Act sets out a broad range of regulation making powers covering, amongst others matters, the management, staff, premises and conduct of social and independent healthcare establishments and agencies.

Under the Care Standards Act the Secretary of State for Health has powers to publish statements of National Minimum Standards.

Compliance with National Minimum Standards is not in itself enforceable, but compliance with regulations is enforceable subject to National Minimum Standards being taken into account.

The Commission for Social Care Inspection (CSCI) inspects all social care services in England, for example, residential care homes, children's homes and local council services. This is done to ensure that they are working properly and meeting the needs and respecting the rights of the people who use them.

What does this mean for us?

It means that The National Minimum Standards for care homes for Older People focus on achievable outcomes for service users (this is the term used for the residents living in the home), that is, the impact on the individual of the facilities and services of the home. The standards are grouped under the following key topics, which highlight aspects of individuals' lives identified during stakeholder consultation as most important to service users.

- Choice of Home
- Health and Personal care.
- Daily Life and Social Activities.

- Complaints and Protection.
- Environment.
- Staffing
- Management and Administration.

Each of these topics is prefaced by a statement of good practice which set out the rationale for the standards that follow.

While the Standards are qualitative, they provide a tool for judging the quality of life of the service users. These Standards are measurable and inspectors look for evidence that the Standards are being met and a good quality of life enjoyed by the service users – through

- discussions with service users, families and friends, staff and managers and home owners.
- observation of daily life in the home.
- scrutiny of written policies, procedures and records.

As an Inspector working for the Commission for Social Care Inspection I am responsible for monitoring the National Minimum Standards. I check the quality of the homes using the National Minimum Standards as my guide lines. There are three hundred and eighty nine care homes in Norfolk and I am responsible for twenty seven of these homes.

Adult inspections can be inspected at any time, but at least once every three years. Most inspections are unannounced; before this happens a full analysis of what we know about the service is carried out.

An Inspector's role is to speak to many people to find out what things are really like, these include the staff working in the homes, the residents and also important others such as relatives. If improvements are needed , the staff and owners are asked to put things right.

When an inspection is completed a report is then written, I write a report about what I found during the inspection process. The report becomes a public document and it is available to read by any one who wishes to, particularly by people who might wish to use a certain service.

I have now been an Inspector for over four years, it is an especially interesting job, diverse and I love every minute of it.

Marilyn Fellingham

A Floating Hospital In West Africa – What Is That All About?

It was in 1998 that I first went aboard the Mercy Ship *Anastasis* in Cotonou, in the little-known country of Benin, West Africa. I remember being very nervous; not knowing what on earth to expect. And my anxieties were not in vain – it really is like going to another planet! I felt totally out of my comfort zone – especially with cabin temperatures of 35 centigrade and 95% humidity, looking after patients with conditions I had never seen before, on a rusty old ship run by a load of Americans!! I survived and have since returned to the ship on a further 9 occasions!

As a Consultant Anaesthetist at the Norfolk & Norwich Hospital, I had volunteered to spend 3 weeks working on this floating hospital ship. The ship is run by a Christian charity dedicated to 'bringing hope & healing' to some of the world's poorest people. The founder realised that two thirds of the planet's population lives within 100 miles of a port city, so why not use ships to bring relief to them?

The *Anastasis* is a grand old lady – she was built in 1953 and is being retired off next year. She was built as a cruise liner plying her trade between Italy and Singapore in her heyday. Apparently she was the very epitome of luxury in those days. She was bought by Mercy Ships in 1977 (as scrap!) and converted into a hospital ship complete with three operating theatres and a 45-bedded ward. She is about the size of a large cross-channel ferry with a crew of 400. As well as surgical facilities there is a host of other projects going on, from dental clinics to water & sanitation projects, construction of AIDS clinics, community health education and so on……

The ship spends most of the year in West Africa, returning to Europe to restock and get maintenance work performed once each year. So what are the countries like that we visit? Can't the locals get surgery done there? Sadly, conditions are very grim in many of these places. The majority of the population lives on less than £1 per day with an average life expectancy of around 40 years of age: if you have 5 children, chances are only 3 will make it to their 5th birthday party. Some countries can offer basic general, orthopaedic and gynaecological surgery, but in shockingly awful conditions and at a price way beyond the reach of most of the population.

What operations can the ship offer? One theatre is generally performing eye operations – lots of cataract extractions and squint corrections. The second does mainly maxillo-facial work. The sights in there never fail to amaze – some enormous benign tumours called ameloblastomas weighing up to 3.5 kg (the weight of an average newborn baby!) appear most weeks. It is just unbelievable that patients can live like this in the 21st century. And couple that with the fact that if you have any sort of facial deformity in that culture, you are likely to be seen as 'cursed' and be mocked or even stoned by passers-by, and you have a pretty miserable life. Surgery really transforms their lives! Cleft lips and palates are fairly common too and seeing 50 year-olds listed for repair is not something we would see in the UK! Again, it does loads to help restore their self esteem.

The 3rd theatre does whatever specialty the visiting surgeon does. This ranges from Orthopaedic (club foot correction etc), Plastics (e.g. burn contracture release, repair of war injuries), General (monster goitre removal!) and Obstetric fistula closure. These

fistulas result from obstructed labour. Typically, it occurs in 16 year-old girls in their first pregnancy who run into trouble in labour and if they cannot afford the cost (often around £75), or there is no availability of a Caesarean section, they are left for nature to take its course. Sometimes both mother and baby will die. Other times, after 5-7 days the stillborn is passed and the women is left with ischaemic damage to pelvic organs, resulting in connections between vagina and bladder and/or rectum. The resulting incontinence often leads to abandonment by their partners. A 2-hour operation will usually close these fistulas and totally transform these girls' lives – you should see the smiles on their faces when the catheters come out and they are dry!! How about that for job satisfaction?!

So why do I go to the back of beyond each year, using some annual leave, paying for flights and board & lodging (£10/day), sharing a cabin with 2 snoring cabin mates, to work in such a strange environment? I suspect you have some idea from the above! It is an amazing experience that helps put our lives in perspective. It is immensely satisfying from the point of view of playing a role in changing lives for the better, the gratitude of the patients, the appreciation of one's skills by the other crew. This is healthcare as it should be – all working together (most of the time!) with a common goal. It is also very challenging from a professional point of view – I see conditions never seen in the UK, and get to see some amazing places and meet some incredible people.

What of the future? Well, as I mentioned, the *Anastasis* is history as of next year. But the good news is that she is being replaced by a bigger, better, newly refurbished vessel called the *Africa Mercy*. She will have 6 theatres and an 85-bedded ward. And very comfortable too apparently! I am looking at longer term involvement somehow in the future – not sure of the detail yet.

If you wish to know more about the work of Mercy Ships, go to www.mercyships.org.uk, or write to Mercy Ships UK, The Lighthouse, 12 Meadway Court, Stevenage, SG1 2EF. Financial support is always appreciated. There are positions for nurses in the ward and theatre/recovery, but there is often a waiting list for these!

Dr Jonathan Payne
Consultant Anaesthetist, Norfolk and Norwich University Hospital
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Post-War Development Of The Orthopaedic Department Norfolk And Norwich Hospital

At the outbreak of World War II there were two orthopaedic consultants, Mr HA (Tommy) Brittain and Mr GK (Ken) McKee. Both at different times served in the RAMC, mainly in the Middle East.

Post war they were joined by Mr RC (Richard) Howard who had served in the RAF's medical division. There was a large patient catchment area. King's Lynn had no Orthopaedic Department until Mr Brittain's registrar Mr Belaon-King was appointed as consultant in 1951. Great Yarmouth had no facilities until much later.

The two orthopaedic wards, Norfolk and Norwich Hospital, Ward 2 (Female) and Orthopaedic Block (OB), seldom had any empty beds. The latter, built as a children's ward in the 1920s, had an operating theatre at the west end comprising of three small rooms, which was totally inadequate for the major surgery carried out there.

Tuberculosis of joints was prevalent and Mr Brittain's reputation for surgical treatment was world-wide especially the ischio-femoral arthrodesis of the hip-joint. Spinal fusions and cross-graft arthrodesis of knees were carried our once the disease had become quiescent. Immobilisation before and after surgery was by installing patients on plaster beds or the application of hip-spica plasters.

Specific and good nursing care were essential. Drugs given were streptomycin, para-amino salicylic acid and isoniazid all of which used in the treatment of tuberculosis. In 1952 a new operating theatre was opened by Princess Margaret at the east end of the block. Sadly Mr Brittain's illness and death in 1953 meant that he did not benefit from his project and brain-child. This and the OB were demolished in the late 1960's to make way for the 'new' Accident and Emergency department opened in 1971.

By the early 1950's Mr McKee was well into his pioneering work on total hip replacement surgery. The consulting team was joined in 1954 by Mr JG (Ian) Taylor who had been working in orthopaedics at Oxford following war service as a Naval Surgeon on the Atlantic and Artic convoys.

Internal fixation of fractures was becoming more common. The Operating Theatre teams led by Sister Shearing (Mrs Latham) in the early 1950s, Sister Bowden (Mrs Fox) in the late 1950's and Sister Scott (Mrs Sherwood) in the 1960's and 70's contributed much to the successful work of the department, as did their permanent staff, particularly Frank Baker theatre orderly, later theatre technician, whose plastering technique was of a very high standard.

In the 1960's the late Mr J (John) Watson-Farrar, having been Mr McKee's registrar, became the fourth consultant so helping to devise the McKee-Farrar Hip Joint.

On a personal note my predecessor Sister Madge Woods (Mrs Allen) was a remarkable person who influenced greatly as to how the department evolved in the early days. As her staff-nurse until 1953 I learnt a great deal from her.

Betty Lee Ward Sister OB 1953-1967

Hospital Radio

History

The origins of hospital radio date back to 1921 when a Mr Thomas Hanstock sought permission from the General Post Office of the time to 'conduct experiments with portable wireless telegraph apparatus'. He went on to demonstrate the potential of broadcasting to the redoubtable matron at York County Hospital and, in 1925/26, 200 sets of headphones and 70 loudspeakers were installed in the hospital. These were fed from a wireless receiving set which was concealed in a small alcove.

Music was not the focus of the initial broadcasting which was more about church services, poetry, plays and football commentary, with the first football commentary service starting in 1935 from White Hart Lane. It is quite possible that there was coverage of the important events of the era, but sadly there is no record of the old radio tapes.

In the 1940's development of hospital radio was curtailed by World War II. However, the 1950's saw a marked expansion from approximately 12 hospital radio stations in 1940 to over 70. Most stations continued to concentrate on football, rugby and cricket commentary, although bowling, ice hockey and even wrestling made an appearance! But bizarrely it was football that promulgated the spread of hospital radio. A director of Portsmouth FC was impressed by the achievements of his local volunteers, who provided match commentaries, and persuaded other clubs to follow suit in broadcasting to hospitals. Thereafter as popular music spread, thanks to the gramophone record, more transmissions were of a musical nature.

This trend continued in the 1960's and was reinforced partly by the fact that lines used by the sports team were not used from one Saturday to the next, and partly by popularisation of music engendered by the 'Swinging Sixties. Toc H, a charitable organisation, took over from the football clubs by supporting hospital broadcasting and encouraging music transmissions, so much so that by the end of the 1960's the 70 hospital radio stations had increased to 100+, over 90% of which provided a music service.

The 1970's saw the consolidation of hospital radio with the launch of the National Association of Hospital Broadcasting Organisations (NAHBO) which dealt with the business, legal and political aspects of the service. In due course as the number of radio stations proliferated NAHBO oversaw rationalisation so that one station broadcast to a number of hospitals.

In the 1980's technology started to replace manual record library systems and the CD superseded vinyl. The standards under which studios operated and the quality of their broadcasting equipment increased dramatically, replicating those of local and even national radio.

As the 20th Century drew to a close, digital technology saw the advent of the mini-disc and hospital radio stations could afford recordable CDs as part of their studio equipment, thus enabling the production of jingles and promotions. NAHBO became a limited company in 1992 and was renamed Hospital Broadcasting Association

(HBA); in 2004 there were 300 members and 11,500 volunteers. Access to lottery funding became a reality and lobbying through HBA has allowed some stations to broadcast on low power AM and even FM.

Hospital Radio Norwich (HRN)
HRN is a registered charity run by unpaid volunteers and totally reliant on sponsorship, donations and fund raising. The latter can be anything from running a stall at an open day or fete, 'shaking the tin' at NCFC or raising money by running a marathon or playing pool.

Studios
The studios are housed in two portakabins on the West Norwich Hospital site and are comprised of a reception area with two phones – one with an external line and one on an internal hospital extension - two broadcasting studios and a record library. Studio 1 is the main broadcast studio and is equipped with the most up to date equipment, (an Alice Air 200 desk for the technically minded reader) and two microphones for either two presenters or a presenter and guest.

Studio 2 has been refurbished and a new mixer and computer, complete with two built-in effects generators, are to be installed which enable multi-track recording in the production of trailers and jingles to be made. Training in the use of the broadcasting equipment also takes place in this studio

The record library houses over 700 CDs, 2,500 LPs and 5,000 singles. These are all logged on computer and can be accessed by composer, composition title or performing artist(s). Once ward visitors (see below) have accumulated a number of requests they can ring the studio from the N&N University Hospital on the internal phone system; a team member takes down information on the request, as well as for whom it is to be played and at what time, which ward the patient is on and any message. The relevant CD or vinyl is then located via the database and taken to the presenter in Studio 1. And yes, when the presenter is on air a red light illuminates in the corridor signifying no admittance!

With the growing use of Mini Disc as a live playing medium, HRN has started to include these in the music log. Each one is tagged with a number and its contents stored on the computer

Broadcasting Teams
HRN has seven teams broadcasting every evening from 7pm to 10pm. Each team, the optimum number for which is six, is headed by a Studio Manager and an Assistant Studio Manager, both of whom have technical abilities. Duties are split into ward visiting (2), answering the phone, searching the record library for requests and broadcasting itself.

Volunteers come from all walks of life: my team has counted among its numbers a dentist, hospital employee, NU manager, former London bus driver, teacher, PA in private business, social services manager and a retired professional.

The format for the three hours is usually two half hour slots, followed by 90 minutes of requests and finishing with a final 30 minutes. For the evening on which I take part the format is Classical Gas, Focus, Requests and Mellow Moods.

Classical Gas, as its name implies, is classical music linked by a bit of chat. Curiously I seem to present this more often than the other members of the team, although no complaints there as it allows me to indulge my fondness for the genre and to share the unforgettable musical moments I have been fortunate enough to experience: the acclaimed version of Porgy and Bess with Willard White at Glyndbourne; Luciano Pavarotti in concert in Birmingham; and Andrea Bocelli at the amphitheatre in Verona reducing me to tears with the purity of his voice.

The 7.30 - 8.00 slot allows the presenter to play to his or her creative talents and interests. It may involve prose or poetry readings, a themed musical broadcast or interviews. One of our team has a particular knack of persuading local celebrities to be interviewed. These include NCFC players and management, business leaders and TV presenters, some of whom attribute their success in their broadcasting careers to their humble beginnings in hospital radio.

The main focus of the evening is playing requests for patients at the N&N University Hospital, mainly tracks chosen by the patients themselves (and sometimes requests for the nursing staff!). Whilst we derive huge pleasure in being able to do this, it is even more gratifying if we can pass on messages and play dedications from patients' friends and relations. Would that more people were aware of this option as I have witnessed the delight with which these dedications are greeted.

The evening winds down with music which is designed to be peaceful without being dreary. Finally, courtesy of modern technology, the studio switches over to the sustaining programme which provides continuous music and an information service.

Occasionally there are daytime broadcasts which are made by a member of HRN who is either retired or has some free time.

Footnote

I am not a sentimental person and would be a fool to claim that hospital radio is of any medical benefit. However, I can attest to its therapeutic side:

- The reassurance given to patients by chatting and, more importantly, listening to them, perhaps even holding the hand of someone frightened, particularly someone hospitalised a long way from home with no visitors;
- The knowledge that explaining the workings of radio in hospital (not just hospital radio) has enabled patients to listen to an entertainment medium to which they did not realise they had access, particularly during long, sleepless nights;
- In the week before Christmas unexpectedly finding a member of the HRN team in the oncology department of the old N&N and being able to take his mind off the fact that he was terminally ill;
- The pleasure that I had allegedly given to a number of patients who asked for their thanks to be conveyed to ‘the lady with the lovely voice.’

My one regret, and this is a personal view, is that HRN does not have a physical presence in the hospital atrium. I feel that visitors would be encouraged to request music and send a message to their nearest and dearest, friends and colleagues, and that is worth more to patients than hearing a request they have asked for themselves.

I trust members of HRN always respect both patients' dignity and their wish for privacy, but also recognise the importance of not interfering with the all important work of consultants, doctors, nurses and ancillary staff. I know we try to do so and always check with nursing staff to see if there are wards or side wards we should not visit.

Finally I simply hope that the N&N University Hospital and HRN can continue to co-exist peaceably and that the latter can help to make patients' stay in hospital a little easier.

Ruth Cranmer

Contact number for Hospital Radio Norwich: 01603 612686

Life As A Professional Jeweller

Throughout the years I have been asked "What is it like being a jeweller?" My answer has always been the same: "Wonderful, but hard work".

Having been in the jewellery trade for the last 25 years, I can honestly say I never have two days the same. The world of jewellery is a fascinating one, and also very close knit. After so many years diamond and jewellery suppliers are friends and this relationship has been built on trust and understanding. Discovering the jewellery trade at the young age of 18 has given me a wealth of experience, knowledge, excitement and along the way, the forging of friendships and celebrating the joy of selling precious gifts which make so many people happy.

A huge part of a jeweller's life is taken up with learning. Like every other trade it takes years of hard work and dedication to achieve the necessary qualifications. There are many examinations and training courses one has to attend and pass to become a professional. Because the items we sell are very precious and often old a good knowledge is essential. We often go on study days dedicated to learning about diamonds or pearls or second-hand antique pieces. This all enriches the job we have to do, thus helping our clients who often wish to know the history of an item of jewellery they are buying. Other courses are geared to display and presentation of stock, others to selling and management. Sometimes there just aren't enough hours in the day! It is not unusual to travel abroad for training or to buy jewellery anywhere in the world.

Jewellery has had a huge influence on society for thousands of years. From early ages we have used beads, shells and bones to form necklaces, head dresses and other pieces of jewellery. Jewellery has been seen as many things, symbols of wealth and status, objects of passion and intrigue. Some pieces are given in memory of a loved one or an achievement, and it was widely believed that certain gems had healing powers or could ward off evil; for example amethyst was thought to keep you sober if placed in wine, whilst ruby was thought to keep you happy and healthy.

Most people will have a piece of jewellery or perhaps a watch given to them and I can guarantee that they will always remember who gave it to them and its purpose. As women, the feeling of receiving your engagement ring or wedding band will be with us forever, and the excitement of getting your first grown up watch from your parents will always remain with you. You see, jewellery and other precious items regardless of value are usually symbols of happy times. They can also hold memories of "what could have been" or "what you have lost". Whatever the memory or purpose jewellery reminds us of a situation within ourselves which we relive and pass on to the next generation.

Throughout history and up until recently jewellery was very much the preserve of the rich and famous. To an extent this is still true today but many people aspire to have beautiful things as well as a nice car and home. Lots of jewellery is affordable so most people will own some jewellery or a wrist watch.

Jewellery reflects the time and mood of society. Distinctive patterns of jewellery we instantly recognise, for example the wonderful world of Art Deco pieces made by Cartier. The use of rock crystal with platinum and diamonds in angular settings is unmistakeable. Flowing natural pieces incorporating beautiful faces of women celebrate life from the Art Nouveau period and sum up the mood of the era.

Diamonds have been and still are the most wanted gem. They range from white diamonds to the ever increasing popularity of pink and yellow diamonds or more fancy colours such as blue, red and green, the latter being extremely rare and valuable. Coloured gems like rubies, sapphires and emeralds all have a large role to play, and are judged on their intensity and evenness of colour and freedom from small inclusions (marks) which were created at the formation stage of the crystal. Watches are also extremely popular. Many people enjoy wearing a superior timepiece on their wrist such as a Rolex or Patek Philippe. Often people become collectors of such watches.

Life as a jeweller is never dull or boring. Our clients see to that!! There are always challenges: a piece of jewellery to be designed, a date to make a dream come true. That's the excitement of being a jeweller. On the other hand there is always the silver to be cleaned, stock taking to be done and the windows to be dressed. Retail hours can be long and tiring but seeing the smile on a client's face and the sparkle in their eyes makes it all worth while.

Maria Pennington
Registered Valuer, Winsor Bishop

Heritage Report, Displays And Help Required

First of all I would like to thank all members who contributed towards last year's display and to Stevie Boyd who kindly displayed them for me in my absence.

Memorabilia have been collected over many years by Janet Hardingham. She passed the collection to Betty Lee who then transferred it to me for storage purposes.

We have now reached an exciting time when it is all beginning to come together. This January Emma Jarvis, Hospital Arts Coordinator, Betty Lee and I met at my home to discuss the collection. We will put this before other committee members at the next committee meeting and will let you know our progress at the Annual General Meeting on May 7th. Emma is very excited about the collection we hold and would like to participate in preserving our history. Since I have been involved with the collection we have moved on with technology in so much that a negative had to be taken off a photograph, now it can be scanned with creases repaired and can produce a good quality picture.

I am aware members' photographs are very precious to them and they would want to pass them on to their families. However, if you have anything which you think could enlarge the collection on the database Emma, Betty and I would be very grateful to receive it. We are all aware of the terrible fire at the former Norwich Library when lots of historical documents were lost. Emma is keen to save everything on the database before the collection is passed on to various places like the Archive Centre, School of Nursing or held for future display purposes within the hospital.

At present we have Nurses League Journals from 1975 to 2006 and would welcome any earlier editions. The Archive Centre has expressed interest in these which we will be discussing at our meeting. We would like to submit a full set of Journals to the centre and would appreciate any further copies to keep for reference at the hospital.

Emma has kindly agreed to be present at the Annual General Meeting and would scan anything which you think could be preserved on a database for future generations. Please look through your photographs which you may have forgotten about which are connected with the United Norwich Hospitals. She will be available from 1.15pm outside the Benjamin Gooch Hall (in the area where we have our refreshments). If you leave your photograph/s with Emma she will scan these whilst the Chapel Service takes place in order that you can collect them before leaving for home. If you are unable to attend the meeting but wish to contribute in anyway, please contact me to see if arrangements can be made to collect and deliver items/photographs. In both cases Emma has requested that you put your name, address and contact number on a large envelope together with any information about the enclosed in order that they are kept together.

This year's display will consist of anything we can find about the West Norwich Hospital. Emma mentioned that she has limited information on this hospital, maybe because it comes under the umbrella of the United Norwich Hospitals. Are there any members who have worked there as a Student, Staff Nurse or Ward Sister, who have photographs or experiences to contribute which will be of interest towards our heritage? Emma is also keen to arrange with anybody who trained in the 1940s and

1950s to be interviewed in a general chat about their experiences. If you feel able to do so, please contact me by post, e-mail or telephone.

There is an Open-Day planned at the hospital on July 7th when Emma plans to put on a display of items which have been stored away. It could be a date to put in your diary. Details about that day will be displayed on the board on May 7th. If you are unable to attend the meeting but would like to know more details please contact me or Emma .

Looking ahead, 2008 is the 75th anniversary of Student Nurse Training at the Norfolk and Norwich Hospital. The Preliminary Training School started in 1933 when probationers were admitted four times a year. The display for next year would be based on this. If you have anything you think will help towards this display e.g. PTS photographs not previously sent in, parts of uniforms, experiences during your training, then Emma and I can start to work towards this project.

My thanks to all members who have helped towards our collection over the years and I look forward to hearing from anybody who feels that they can help in any further way. Emma can check if the information has been recorded.

Margaret Allcock (nee Zipfel)
Address:-Broadlands, 5 The Green, Freethorpe, Norwich, Norfolk NR13 3NY
Telephone number:- 01493700256 E-Mail:- broadlands5@hotmail.co.uk

Help Us Improve The United Norwich Hospitals Nurses League!

In the autumn of 2006 Mary Dolding, UNHNL Treasurer, and Ruth McNamara, UNHNL Secretary, attended a four day course in Norwich for Trustees of a Charity. This was run by EETeC; a Great Yarmouth based training company, who had been given European monies to sponsor the course.

There are courses available nationwide; Level 2 may be attractive to anybody involving themselves in Trustee work. Ours was a very intensive Level 3 course with homework and internet information searching but we would recommend it. All the members of the UNHNL Executive Committee are Trustees of our charity.

After the course we have been able to consider the specific objectives of our charity and make the following points for your consideration:

1. Although the UNHNL is on the right track in meeting the requirements of the Charity Law and Charity Commission in the present world we are no longer a 'club' of nurses but an organisation which has to abide by the new Charities Act 2006.
2. The UNHNL should consider revising our objectives, specifically Clause 4, recorded in the Declaration of Trust Document 2004 which we all received with the 2005 Journal. We must be thinking of ways to improve the survival of the organisation by attracting new members and to broaden the objectives allowing us to spend more of our resources.
3. The UNHNL Journal should continue and develop as a means of communication between the members.

We would both welcome your opinions on our findings and any solutions for their implementation. Any comments should be received by Monday 16th April 2007 so these could be discussed and put forward to those present at the AGM in May.

Ruth McNamara (Secretary)

Changes To Membership (Since publication of 2006 journal.)

NEW MEMBERS.

Mrs H. Howes, nee Bush 1961-1965
Mrs V.M. Meayers-Norkett, nee Cook 1965-1968
Miss J. Milk 1964-1967
Mrs J. Ranjeet, nee Murphy
Mrs M.S. Robinson, nee Harrold
Mrs M.J. Voegeli (Miles) nee Sparkes 1973-1975

DECEASED MEMBERS.

Mrs J. Baker-Jones, nee Gladden 1939-1942 (2005)
Mrs S.F. Butler, nee Morley 1942–1945
Mrs B.P. Claridge, nee Loades 1941-1944
Mrs V. Frankowski, nee Bush 1943-1946
Mrs J.A. Freeman, nee Loveday
Mrs M.E. Gadsby, nee Mobbs 1939-1942 (2005)
Mrs E.M. Green, nee Addey 1944-1947
Mrs B. Howard, nee Royle 1937-1940
Mrs A.K. Jarvis, nee Rose 1946-1949
Mrs L.M. Lingwood, nee Pye 1949-1952
Mrs L.G. Little, nee Elsey 1936-1939 (2004)
Mrs E.M. Roy, nee Howlett 1931-1934
Mrs B. Smith, nee Foulger 1936-1939
Mrs V.F. Thirkill, nee Green 1932-1935
Mrs D.M. Whiteman, nee Hazel 1934-1938 (2004)

CANNOT BE TRACED, NO KNOWN ADDRESS.

Miss M. Chittock (Canada)
Miss J. E. Cowles 1935-1938. (Ipswich).
Mrs A. M. Hill, nee Prior 1932-1935 (Cromer)
Miss M. M. Leach (Felixstowe)
Miss L.M. Rawlings 1927-1930 (Lowestoft).
Mrs K.L. Simmonds, nee Willis 1934-1937 (South Africa).

Please let me know if you have any information regarding the above members, also if and when any changes occur, enabling me to keep the membership list up to date. The revised list will be printed after the AGM, copies will be available on request for £2.00, cheques should be made out to The United Norwich Nurses League.

Thank you,
Betty Lee.

Miss B.L. Lee, Membership Secretary, 119, Cambridge Street, Norwich. NR2 2BD.

Canon Leslie Ward Chaplain 1983 - 2006

Leslie Ward arrived at the Norfolk and Norwich Hospital in 1983, as the first full-time Chaplain. He quickly made his mark and became a much loved and valued member of staff. In the course of time, the West Norwich and Colman Hospitals were added to his area of responsibility. Sadly his wife, Pat, died within a few months of him starting at the hospital; his dignity at this time and subsequently the way he brought up his two sons - Matthew and Simon (who are now both priests) - is a fitting tribute to his ability.

He ran the Chaplaincy as he had run the Parishes in which he had previously served - people came first and he was always willing to give time to anyone in need. How ever busy he was, he had the knack of making people feel he had 'all the time in the world' for them. His gentleness in dealing with patients, relatives and staff was a wonderful gift.

He loved to be part of the family events of staff and was always in demand to baptise their babies; conduct their weddings; and officiate at funerals. On one occasion he was asked to conduct a staff member's wedding and to baptise her baby at the same service - something he undertook just as if it was a normal thing to do.

Leslie was a perfect diplomat. Once he was asked to conduct the funeral of a gentleman who had a wife and a mistress. Somehow he managed to work with them as individuals, so that both felt the service had been compiled by them. It was not an easy task, as the mistress wanted 'Lady in Red' played as the coffin was carried into the crematorium chapel and on the day she turned up dressed completely in red. The fact that this did not distress the wife, was completely due to Leslie's management of the situation.

He had a wonderful sense of humour and loved the banter which went on in the canteen and at the nurses' stations on the wards. He had a vast store of jokes, which he shared at every opportunity; some of you will remember his lovely smile when he was telling a joke, but got the ending slightly wrong!

Administration was not high on Leslie's list of priorities. He would open his post, leave it on his desk and say 'I'll deal with that later ... I've got people to see.' His desk was always piled high with paper and when the inevitable 'avalanche' occurred, it was deposited in a large chest in his office, nevermore to see daylight. The contents of that chest were eventually cleared out and destroyed when the hospital moved to Colney!

Those of us who worked with Leslie are indebted to him for all that he taught us, particularly the importance of 'loving' the people we serve and never appearing to be in a hurry. It was that faithfulness in the God whom he loved and the people he served that will remain an inspiration. There has hardly been a single day since Leslie left the hospital, when someone has not asked after him and expressed their gratitude for his ministry and their good memories of him. He was a wonderful priest and

chaplain and built up the reputation for the Chaplaincy department, the benefits of which continue to this day.

Compiled by Sheila Nunney, in consultation with Pat Atkinson, Michael Reeder and Darren Thornton.

Obituaries

Mrs. S.F. Butler, nee Morley. 1942 -1945.

Following training Sheila returned to Suffolk becoming a District Nurse. Marriage and the birth of a son was sadly followed by the tragic death of her husband. She then moved into health visiting.
A league member for many years Sheila had many interests and her work with the WRVS continued until 2004. Ill health necessitated moving to a residential care home and then to Ipswich Hospital, where she received every comfort and care.

Mrs. P.B. Claridge, nee Loades. 1941-1944.

A long time and loyal league member, Betty did not continue to nurse following her marriage and the birth of her children. However her nursing skills were put to good use when working as a classroom assistant at the Cavell school in Norwich.
Among her many interests were gardening, sailing and the Women's Institute. As a resident at Corton House during recent years Betty still maintained her interest in the League.

Mrs. V. Frankowski, nee Bush. 1943-1946.

Marriage and a family did not prevent Vera from pursuing a nursing career including dental nursing and as a night sister at the West Norwich Hospital.
During her long League membership Vera was for many years a contributing member of the Committee, and maintained her interest until recently. League members were able to join her family and friends for a memorial service.

Mrs. J. A. Freeman, nee Loveday.

Joyce pursued her profession as a community nurse and later as a staff member at the 1968 Maternity Block. Many of her former colleagues attended a Thanksgiving Service at Holy Trinity Church, Norwich, including one lady, a friend since training days, who had travelled a long distance to be there.

Mrs. E.M. Green, nee Addey. 1944-1947.

A league member for many years, Elizabeth attended our re-unions until illness and distance prevented her from doing so. However she looked forward to receiving the Journal often writing to express her appreciation.

Mrs. B. Howard, nee Royle. 1937-1940.

Following her marriage to the late Mr. R. C.(Richard) Howard and the arrival of the family Beryl did not return to nursing. However she was always ready to help whenever there was a need. Beryl was a long time league member. Several of us joined her family and friends for the funeral service.

Mrs. A. K. Jarvis, nee Rose. 1946-1949.

Members will be saddened to hear that Audrey died not long after last year's re-union. Many of us will remember her work as a staff nurse on various wards with appreciation for her competence and cheerfulness. Audrey had been a league member for many years and was a committee member until 2004.
At her funeral ex-colleagues and league members were a large part of the congregation.