Patient Meeting, Wednesday 17th June, 7.15pm, Townsend Hall, Shipston

Meeting contributors included the Shipston Medical Centre Partners, the Frailty Team and PPG. Also representatives from the District Nursing Team, Shipston Home Nursing and the Stour Health and Wellbeing Partnership.

Carole Nossiter, PPG Chair welcomed all attendees to the meeting, introducing the two main agenda topics, namely, 'Updates from the Practice', and 'Working Together to Support Healthy Ageing'.

Updates from the Practice

Dr Richard Levison covered the following topics:

- Staffing
- Medical Centre refurbishment
- Appointment triage

Staff who have left

SMC Shipston Medical Centre

- From Dispensary, Donna Fisher.
- GP trainees Deborah Eapen, James Mackintosh, Tom Stroud, Vignesh Shankar Babu and Owen Yang.
- Carolyn Barcoe GP.
- From Reception, Rachel Hayward, Kate Gardner, Rebecca Taylor and Claire Morgan.
- From the back office staff, Becki Freeman and Sarah Heath.

Staff who have joined

SMC Shipston Medical Centre

- Alex Logan and Wendy Hillyerd GP assistants.
- Jo Markham, Gemma Coe, Lisa Jewett and Lauren Davis have joined the reception team.
- Ibrahim Jeries GP trainee.

With regard to the medical centre refurbishment, Dr Levison explained that the building was first constructed in 1969 and that the current work would modernise the infrastructure and improve energy efficiency to meet current standards. Further improvements will follow when resources allow. Photos capturing the progress of the refurbishment were shared with the meeting attendees, including the following 'before' and 'work in progress ' photos of the waiting room.

Medical Centre refurbishment





Finally, Dr Levison outlined the fact that changes to the GP contract means that all appointments must be triaged and a response provided to patients on the same day. The AccurX on-line triage process which was implemented by SMC in February 2024 meets these requirements and has been well received by the majority of patients who have used it.

Dr Levison explained that AccurX on-line forms can be completed via the website or NHS App. For those who contact the surgery by phone or by attending in person, receptionists will fill in the form although experience shows that forms completed by the patient themselves tend to provide more comprehensive information for the duty team to review.

The meeting continued with a presentation by Dr Tim Marshall focussing on plans to introduce 'Abtrace – a smarter way to manage patient recalls and monitoring'. Dr Marshall explained that the Practice has around 12,000 registered patients which means that the team are handling thousands of monitoring events annually, leading to hundreds of thousands of results to be reviewed each year. Monitoring activities include medication monitoring, long term condition reviews and preventive care and screening.

The new system identifies the monitoring requirements for all relevant patients, triggers recalls when due, generates appointment invitations, communicating with patients by text and email. It operates continuously in the background, always operating to practice protocols. The benefits of implementing this new system for patients and the Practice are summarised below:

Abtrace benefits for patients:
- Fewer recalls
- Fewer appointments
- Better communication
- Better visibility
- Improved safety

Abtrace benefits for the Practice:
- More proactive care
- Better use of clinical skills
- Reduced administration
- More time focused on patients

Carole invited questions from the audience at this point:

1) A question was raised about the wording of the asthma questionnaire. It was explained that the questionnaire is a nationally validated tool designed to accurately assess asthma control. Patients who feel it does not reflect their circumstances are encouraged to book an appointment with the asthma nurse.

2) A query was raised as to whether the Abtrace system was fully operational as yet. Dr Marshall confirmed that the system is only partially operational at this stage while the practice ensures that it is operating safely and appropriately. Although the software has many features available, each element has first to be tested to ensure it delivers the correct outcome for patients before being fully activated.

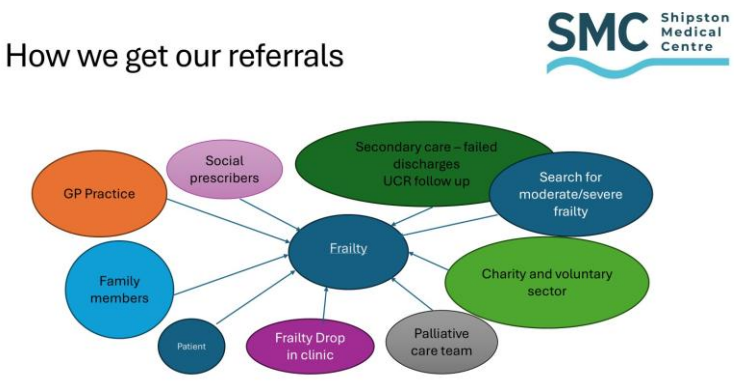
3) An audience member queried whether the Abtrace system can be accessed via the NHS App when fully implemented. It was explained that Abtrace and the NHS App are separate systems, although they have a similar appearance. Patients were encouraged however to continue using the NHS App for triage requests and communication with the practice.

At this point, Carole introduced the second topic for the evening, **'Working Together to Support Healthy Ageing',** handing over to Jan Flynn, Frailty Advanced Nurse Practitioner to explain who the Frailty Team are, (ie including Nikki Futers, Frailty Nurse), how they work together, and how they collaborate with the wider health and social care network to support older and vulnerable patients.

Jan explained that the team focuses on **proactive, holistic care**, identifying early signs of frailty or declining health before they lead to loss of independence. Rather than viewing frailty simply as old age, the service aims to help people remain healthy, active, and independent for as long as possible.

The presentation outlined:

- **Referral pathways** into the service.



- The **comprehensive assessment process**, including physical health, mental wellbeing, medication reviews, falls prevention, social support, carer needs, and advance care planning.

- Where patients are seen, with an emphasis on **home visits** to better understand their circumstances, alongside clinic appointments and community outreach.

- How the team provides **continuity of care**, supporting patients as their needs change, including any transition into a care home.

It also highlighted the team's close collaboration with a range of wider services, including:

- GP practice specialists
- Physiotherapy and occupational therapy
- Adult social care
- District nursing
- Social prescribing
- Palliative care
- Hospital frailty teams, memory services, virtual wards, Hospital at Home, Home First/Community Emergency Response Teams, the Ellen Badger Medical Unit.
- Voluntary and community organisations

Two case studies demonstrated how the service addresses, as required, some of the **clinical and social challenges** faced by patients. Representatives from the following organisations described how they contribute:

Jane Parsons, District Nurse, outlined the team's role in providing support such as wound care, catheter care and palliative care, highlighting the strong partnership working with Shipston Medical Centre and the excellent integration of local health services.

Anna Briggs, Head of Nursing at Shipston Home Nursing, described their hospice-at-home service, which provides nursing, emotional and wellbeing support, and end-of-life care in patients' homes. She emphasised the value of providing person centred support by working closely with patients, families, the Practice and wider teams.

Kirsty Holder, CEO, presented the work of **the Stour Health and Wellbeing Partnership**, including falls prevention classes, physical activity sessions, community wellbeing hubs and around 800 community activities each year. She also highlighted collaborative initiatives such as the recent Death Matters event, promoting conversations about end-of-life care and advance care planning.

Chris Hemsley, PPG committee, confirmed that trained members of the PPG are now proactively making calls to patients who have highlighted to the Practice that they have caring responsibilities. They are able to signpost to local services such as the Carers Champions at SMC, to the Frailty Team and to the social prescribing team as appropriate. Also to the Warwickshire Carers Trust which offers carer assessments and a range of resources for carers including access to equipment, benefits and emergency planning. Chris encouraged patients to inform the practice if they are an unpaid carer so that appropriate support can be offered.

Jan concluded the presentations on this topic by emphasising that the Frailty Team has become an integral part of the wider neighbourhood multidisciplinary team, delivering coordinated, person-centred care which reassures and supports patients and their families. This in turn helps

reduce unnecessary GP and hospital involvement while maintaining continuity of care.

At this point, Carole invited any further questions from the audience – there was just one:

A *patient shared concerns about seeing an unfamiliar GP during their partner's end-of-life care. Dr Marshall apologised for their experience and acknowledged the importance of continuity of care. He explained that while continuity cannot always be guaranteed due to staffing and GP availability, the effort to continually improve practice efficiency aims to increase opportunities for patients to see familiar clinicians. Dr Marshall concluded by reaffirming the practice's commitment to continually improving services, enhancing patient safety and providing compassionate, high-quality care for the local community.*

Closing Remarks

Reflecting on the presentations, Carole commented on behalf of the PPG and patients that we were privileged to already receive an excellent service from SMC and from the wider team. She went on to say that the presentations clearly demonstrated the constant effort to look for ways to improve – whether that be through renovation of premises or new ways of working, leading to more efficient but also safer services and better patient experience too.

She thanked all presenters, not only for their presentations but also for the service they provide to our community – this was met with applause from the audience.

Attendees were directed to seek more information as required from the PPG, SHN and SHWP stands, or via the latter's websites, to include SMC. It was confirmed that patients can always communicate with the PPG (as a means of communicating with the Practice), via shipstonppg@gmail.com

Attendees were also asked to complete a meeting feedback form to assist with planning future Patient Meetings.

Meeting ended at 8.45pm.