Ivel Medical Centre

Patient Participation Group

Minutes of Meeting Held on 23rd June 2026

Present: Chris Day, Georgina Howson, Gwyneth Lawton, John Hampshire, Julia Ainsworth, Peter Davies, David Wheeler (Chair), Rita Andrews (Secretary), Kelly Houghton PCN

Practice Members: Dr Kirti Singh, Paul Lindars

Apologies: Alan Porter, Christine Taylor, Gillian Gordon-Macintosh, Harold Ross, May Ross, Helen Bell-Day, Jean Gunton, John Palmer, Joyce Bilcock, Keith Coxon, Sandra Richardson, Stepehen Williams, Trudy Emery

Kelly Houghton, Sandhills PCN (Primary Care Network) Manager attended our PPG meeting to explain to us what can be provided for the practice. The PCN is made up of the following local practices: Ivel Medical Centre, Saffron Road Health Centre, Sandy Health Centre, and Greensands Medical Centre. Services such as physiotherapy, social prescribers, paramedics, Learning Disability health checks, Cancer services – smears, bowel and breast screening. Out of hours appointments are also provided by the PCN. Some work of the PCN has been paused due to the expansion of the ICB announce earlier this year.

PCN PPG membership consists of two members from each practice. They meet every 6 weeks via Teams. We thanked Kelly for attending the meeting.

David announced that Britta Holland, a longstanding PPG member passed away in April.

1. **Total Triage Appointment System Update** – the Practice is undergoing an HR process - to change the role of receptionist to Care Navigator. All receptionists had to apply for the new roles which are very different and involve higher skill levels. As part of this, a training programme for the new Care Navigators has been set up over the coming weeks/months. Pharmacy First, Social Prescriber and other services are not being accessed as much as they should be, and it is important that the new roles understand patients needs and where to sign post them.
A patient spoke about being asked to make an appointment and about the difficulties they had – it was resolved but hard to navigate the system. Headings on the forms can be misleading. The practice is drafting a patient leaflet explaining what each box means.
ACTION: PL to send a copy of the patient leaflet re TT System Headings to RA.

All Practices must use the online system for accessing appointments. IMC has some regularly patients filling in forms (70 in 60days) and others abusing the system.
The Practice is able to monitor all calls and can review them if necessary.

Problems with ordering repeat medicines was discussed. Unsure of that the issue was – repeat medications can only be requested every 22 days. One lady now uses paper and pen to request her medications - Paul advised her to speak to the dispensary team.

2. Staff Training – clinical huddles are continuing. Care Navigator training as mentioned above.

3. Staffing Updates

- Paramedic (Abbie) is leaving but may be able to help out in the future. The Practice may have found a replacement.
- New dispensary team member post did not work out. Looking to advertise.
- 2 Care Navigator roles are out to advert.
- 1 x Physician Associate is to help with clinical triage and support care navigator staff.
- Pharmacist – still looking for new pharmacist / Pharmacy Technician.
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4. **Plans for next 3-6 Months -** to continue with Care Navigator training. Continue with QOF work (Quality Outcomes Framework).

5. **Any Other Business** –

   Medical reviews are now working better.

   NHS AAA Screening Reminder (Abdominal Aortic Aneurysm) – All men over sixty-five are offered appointments for a quick scan test. Twenty percent of men do not accept the offer. Screening service can be done at IMC. (see next page)

   NHS to offer Multibeam Precision Radiotherapy for prostate cancer (SABR) this will reduce the number of radiotherapy sessions from 20 to 5. (see last page)

   Biggleswade Pharmacy – patient had issue with them recently.

6. **Date of Next Meeting** – September 2026 – date to be confirmed.

By WILL STODDART

Why are men refusing the free ten-minute heart check that could spot a silent killer?

John missed his screening for aortic aneurysm – and almost bled to death



JOHN SIMPSON doesn't recall seeing the NHS invitation for a ten-minute ultrasound designed to detect a silent but potentially fatal swelling in the aorta, the body's main artery.

But given what he has been through over the past few months, he wishes he had.

The ultrasound, which every man is invited to attend when he turns 65, aims to detect an aneurysm (or swelling) when it is small enough to be fixed with surgery. Left untreated, the aneurysm can weaken the artery and burst – the person could bleed to death in minutes.

John concedes that even if he had seen the invitation, 'I wouldn't have known what it was, so I wouldn't have gone'.

It was in September 2024 – 12 years after missing his first screening appointment – that John woke at 11pm while staying at his sister's house in Newholm, Yorkshire, in the worst pain of his life.

'It was indescribable,' says John, 78, a retired electrician from York. 'I had backache and stomach ache that I wouldn't wish on anyone.' It was so excruciating, it made him violently sick.

His sister, Paula, called an ambulance – but paramedics told John to take paracetamol to ease 'muscle fatigue'.

The pain eased, but it returned the following evening. As he was writhing in agony, an ambulance rushed him to York Hospital, where an emergency scan revealed that John's aorta, normally 2cm wide, had ballooned to 13cm – and burst.

John had suffered a rupture of an abdominal aortic aneurysm (known as a 'triple A' or AAA).

This develops silently when the wall of the aorta weakens and bulges, like a worn section of inner tube on an old bicycle tyre.

'Someone can have this ticking along in the background, not knowing a thing about it,' says Rachael Forsythe, a consultant vascular surgeon in Edinburgh and chairman of the Circulation Foundation.

They can burst out of the blue, causing severe abdominal or back pain – together with low blood pressure. Around 80 per cent of people whose aneurysm ruptures outside hospital do not survive.



Urging caution: John Simpson

Picture: ALAMY

THAT'S why the NHS introduced a UK-wide screening programme in 2009, which has helped roughly halve deaths from ruptured AAAs in men over 65, according to a 2025 review by the UK National Screening Committee.

Screening is aimed at men as they are three to six times more likely to develop an AAA than women – because the female hormone oestrogen protects the aorta wall, while testosterone hastens its breakdown. (Women with a family history, a history of smoking, or chronic lung disease, can ask their GP for a scan.)

Yet around one in five men invited for the AAA scan don't attend. Of the 337,752 men NHS England invited for screening during 2024 to 2025, nearly 60,000 didn't go.

Screening is aimed at the over-65s as around one in 20 men will develop an AAA at this point – the stretchy fibres that help the artery expand and spring back with each heartbeat weaken with age, leaving the aorta wall thinner and less able to withstand the pressure of blood being pumped through it. Accordingly, under the age of 55, they are considered rare.

Smoking also increases the risk as cigarette smoke causes inflammation in the aorta wall and increases the destructive action of enzymes that weaken it more. Other risk factors include family history – around one in five people with a parent or sibling who has had an AAA will get one themselves, too.

Yet in the most deprived parts of the country – such as Blackpool, Middlesbrough and Liverpool – where AAAs are roughly twice as common as the national average (partly because smoking and high blood pressure, which also damages the blood vessel walls, are prevalent) – only 65 per cent of men turn up for their scan, compared with around 84 per cent in the least deprived areas.

'We don't fully know why men don't attend,' says Professor Matt Bown, chairman of vascular surgery at the University of Leicester. 'We think it is probably a combination of a lack of awareness around what an AAA is, appointments clashing with work or family commitments, or fear of being diagnosed.'

Most AAAs found through screening are small – between 3cm and 4.5cm. At this point the risks of surgery are bigger than leaving the aneurysm in place, so patients would be monitored with scans every 12 months.

'AAAs broadly grow around 2mm per year,' says Ms Forsythe.

Once they reach 4.5cm, scans increase to every six months – and after that every three months, until it reaches 5.5cm.

'That's the point where the risk of the aneurysm rupturing becomes higher than the risk of the operation to fix it,' says Ms Forsythe – and so surgery is usually offered at this point.

The least invasive surgical option is endovascular aneurysm repair (EVAR), where a stent (a metal mesh tube covered in fabric such as polyester), is threaded through an artery in the groin and guided by X-ray up into the weakened section of aorta to line it. The metal frame expands to anchor itself inside the aorta without stitches. Patients can go home the next day and the risk of death is less than 0.5 per cent, says Professor Bown. But not every AAA case is suitable for a stent procedure: It needs a length of healthy artery just above the bulge to anchor it in place – and some aneurysms sit too close to other vessels for that to work.

'The keyhole procedure also needs monitoring over time and sometimes needs to be revised because it can leak blood into the old aneurysm sac – which means the aneurysm can keep growing,' says Professor Bown.

The alternative is open surgery – a surgeon makes a large incision through the abdomen, cuts out the aneurysm in the aorta and manually sews a synthetic tube (made from polytetrafluoroethylene or Dacron, a type of polyester) in place to replace the damaged section of the artery. This requires a ten-day hospital stay and has a 3 per cent risk of death.

'Once this is done, no further monitoring is required,' says Professor Bown.

Timing of treatment for an AAA is crucial for patients' survival.

The aorta sits in front of the spine surrounded by tissue at the back of the abdomen. If the AAA bursts backwards into that space, the tissue can briefly act as a seal – buying time to get to hospital. That is what saved John. In his case, the initial tear was small (hence the first night of pain) and the tissues sealed it briefly – before the tear extended and the bleeding started again, causing a second bout of severe pain the next day.

If the rupture had been forwards, into the open space of the abdominal cavity, he could have died within minutes. John's surgeon said at 13cm his AAA was the largest he'd ever repaired.

'I was very fortunate,' says John. 'If this had happened in Rhodes, where I'd been on holiday just a few days earlier, I don't think I'd be here now.'

John underwent an open repair and spent four days in intensive care, several weeks on a ward – and then a fortnight in a rehabilitation unit, learning to walk again because weeks in bed had wasted away his muscles.

Seven months on, John says: 'Life is as normal as it can be. I'm still very tender. My surgeon's said it'll take a good year for my tummy to heal properly.'

There is currently no proven drug treatment to stop an aneurysm growing, but research is ongoing to find one.

SCIENTISTS have tested several possible drug treatments, including blood pressure drugs such as propranolol and amlodipine; antibiotics such as doxycycline; anti-platelet drugs such as aspirin; and cholesterol-lowering statins – but none has shown convincing benefit in stopping AAA growth.

However, studies have found that people with diabetes are around 40 per cent less likely to develop an AAA and scientists believe the diabetes drug, metformin, may be why. The drug appears to dampen the inflammation that weakens the artery wall and leads to an aneurysm.

Now the Metformin Aneurysm Trial, a 1,000-patient study running across the UK, Australia and New Zealand, is investigating whether the drug can slow aneurysm growth in people with small AAAs being monitored on the screening programme.

Professor Bown, who is leading the UK arm of the research, says metformin 'could be the treatment for AAA we've long been looking for'.

Meanwhile, John says: 'If I had gone for the scan, I could have avoided an awful lot of pain and suffering – I would urge other men to keep a lookout for their invitation.'

■ *circulationfoundation.org.uk*

FIBRE MATHS

UK adults eat only an average of 18g of fibre a day. Here's how to get the recommended 30g, to cut colon cancer risk



40g bowl of All-Bran (10g fibre) + *One pear (3.9g fibre)* + *Tesco vegetable tikka masala with pilau rice ready meal (7.3g fibre)* + *80g curly kale (2.5g fibre)* + *Kind dark chocolate nuts and sea salt bar (5.9g fibre)* = **29.6g fibre**

NHS to offer ‘multi-beam’ precision radiotherapy to thousands with prostate cancer

10 June 2026

- Cancer

Thousands of men with prostate cancer are to be offered high-powered ‘precision’ radiotherapy on the NHS to target the disease more effectively, helping reduce side-effects and spare them 15 courses of treatment.

NHS England has today announced that, for the first time, eligible men with early prostate cancer will be offered pioneering therapy known as SABR on the NHS, which delivers a higher dose to the tumour with pinpoint accuracy to avoid harming healthy cells.

The highly targeted SABR (stereotactic ablative radiotherapy) delivers radiotherapy to the tumour from many different directions to help reduce the risk of cancer spreading or returning, and has been proven to be effective at far fewer doses than conventional radiotherapy.

The cutting-edge technique will be made available within days and will significantly reduce the number of hospital visits required for treatment, enabling thousands of men to spend more time at work or at home with their loved ones.

SABR is typically delivered in 5 doses within a fortnight, compared to at least 20 doses with standard (external beam) radiotherapy, which can be a major burden for patients and loved ones, due to the substantial treatment and travel time.