**Wimborne & Ferndown PCN - Who are we?**

Wimborne and Ferndown Primary Care Network is a group of five GP practices in the areas of Wimborne and Ferndown. We work closely with each GP practice. The PCN is made up of the below practices:

* Walford Mill Medical Centre
* The Old Dispensary
* The Quarter Jack Surgery
* Orchid House Surgery
* Pennys Hill Practice

We aim to focus the services available around local communities to support the healthcare teams with workload support for each practice at the same time.

**Our team:**

**Physician Associates :**

**Chloe Wiener**

**Emily Davies**

- Works alongside the medical team to see and examine
 patients, order and interpret investigations and treat/manage medical conditions.

**Pharmacy Team :**

**Jackie Knott**

**Ceris Walker**

**Tracey Moore**

**Catherine Walker**

**Julie Dijkstra**

**Dee Loughman**

* The PCN Pharmacy team works closely with the GPs providing primary support for prescription and medication queries. The PCN Pharmacy team conduct a number of reviews including Hypertension, HRT and Polypharmacy whilst also actioning clinic letters and assisting with medication queries. The Pharmacy team work closely with Community Pharmacies locally to manage medication shortages and sourcing alternatives. You might be invited for an appointment with one of the Pharmacists or Pharmacy Technicians, who cover the 5 practices within Wimborne and Ferndown. Alternatively, please contact your Surgery if you feel you may benefit from the team’s help.

**Mental Health Practitioner:**

**Mimi DeWinters**

**Social Prescriber:**

**Chris Shuter**

* Sees patients from the age of 13 years upwards that are registered at the PCN surgeries.
* Provided holistic patient assessments through motivational interviewing and guided conversations around their emphasis on "What Matters to Me". Co-designing a social prescription with the patient to improve the health and well-being outcomes for individuals with a longer-term outcome of reducing the number of clinical/ medical interventions and to promote lifestyle change to prevent ill-health using patient- led behavioural change techniques.
* Undertakes holistic assessments and co-designing Health and Wellbeing Plans with individual patients, identifying support needs to ensure maximum engagement in improving their health and wellbeing.
* Works with patients, using behaviour techniques such as motivational interviewing and guided conversations to support them to identify, set and meet achievable goals to improve their physical and emotional wellbeing.
* Provides patients with continuity and a coordinated experience of care and remaining the point of contact throughout the individual’s social prescription.
* Works with patients in GP surgeries to signpost them to local services / organisations which the patient themselves feel would be of benefit to reach their goals. These services may include, befriending, weight management, mental health support, smoking cessation, local social groups, leisure centres and volunteering etc. to name but a few.
* Follows up with patients and support them on an ongoing basis to enable them to reach their SMART goals.
* Maintains contact with local health and wellbeing service providers building a network and knowledge of referral routes to and from service providers.
* Signposting and linking of individuals with services.

**Paramedics:**

**Emma Woods**

**David Beardwood**

* The PCN Paramedics work closely with the GPs to respond to acute medical requests from patients who are housebound. They will visit patients in their own homes or residential and nursing homes.
* They are experienced in in-depth history taking and can see, treat and refer patients independently, or liaise back with the GP to formulate a treatment plan. Our Paramedics work towards managing patients safely, in their own homes and avoid them going to hospital unnecessarily. If they feel that a patient needs hospital treatment, they can liaise directly with specialty teams within the hospital to arrange a direct admission. They can also refer to community services, including Social Prescribers or District Nurses.

**Certified Health and Wellbeing Coach**

**Kelly Haysom**

* Coaches patients over the age of 18 years with long term health conditions and those at risk of developing them.  During up to 6 x 45 minute, free and confidential sessions, we will discuss what matters to you, what motivates you, possible positive lifestyle changes (good nutrition and sleep hygiene, physical and relaxation activities) and establish personalised, smarter goals to help you feel more confident about managing your health and wellbeing. Essentially putting the patient back in the driving seat.

**Musculoskeletal (MSK) First Contact Practitioners (FCPs)**

**Adrian Barnes**

**Declan O’Hara**

* If you are concerned about a bone, joint or muscle problem, and feel you need a consultation at the surgery, you can see a specialist physiotherapist instead of a GP.  This gives you faster access to expert diagnosis and you’ll leave with the advice and guidance you need to start tackling the problem. The FCP can arrange tests, prescriptions or refer to other hospital services if necessary. Simply speak to the care coordinators at the surgery to arrange an appointment. Alternatively, for further information on a variety of conditions and for self-referral directly to the Physiotherapy service please use our Dorset MSK website <https://www.mskdorset.nhs.uk/>

**Digital Transformation Lead**

**Jenny Smith**

* Worked at The Quarter Jack Surgery since 1997 and joined the PCN in June 2023 to take on the new role of Digital Transformation Lead.
* Works closely with staff from the PCN and the 5 practices, the role concentrates on understanding and improving the use of digital technology to help clinicians and patients get the best from the PCN collaboration.

**Ageing Well Team**

**Sarah Walbrin – Frailty Nurse**

**Tina Male – Ageing Well Care Coordinator**

* Working across all 5 practices in our PCN, our aim is to contact our more severely frail patients and offer an advanced health review and assessment and implement advanced care planning.  This will include a patient focused Dorset Care Plan, where we discuss individually the patient’s wishes and expectations.  These care plans are sent to the patients in own homes, Nursing and Rest homes to assist healthcare professionals that would visit our patients to aid and support continuity of care for our known frailer patients.
* Accept referrals for non-urgent issues relating to frailty from the GPs or outside agencies and aim to visit within 1-2 weeks of the referral.
* Both the Frailty Nurse and Coordinator have many years’ experience and clinical skills to ensure that the severely frail are well cared for and all their needs met. They are supported by the whole MDT ensuring the patients’ needs are being met and cared for in the patient’s home environment. Working together with the MDT ensures better continuity for our patients. Referrals are made to MDT members ie physiotherapy, OTs, CMHT or Social services.
* Offering this support it enables the patient, their family and carers to avoid admission to hospital and allow them to stay and be cared for in their own home. This service is offered to all patients in Nursing and Residential homes as well as patients in own home. We both support the care homes with their care plans and referring the resident to the correct service required as well as completing annual health reviews. We are both very keen and enjoy supporting the care home staff to help meet all their patient’s needs.