North Arden Primary Care Network Newsletter

NORTH ARDEN
PRIMARY CARE NETWORK

Issue 07

May 2025

Issue Contents

Please scan the QR code below to visit our homepage

Welcome to the North Arden PCN Newsletter!

Hello and welcome to the latest edition of our Primary Care Network (PCN) Newsletter.

Each quarter we at the North Arden PCN will be releasing a newsletter with updates, news and more about what's happening in our PCN. Our goal is to keep you up to date with the progress of our PCN and provide you with news and information from the surgeries in your area. It has been written with our patients in mind, focusing on the information they want to hear.

What is a Primary Care Network (PCN)?

Primary Care Networks were introduced in July 2019 by NHS England to create groups of GP practices in local areas who would work closely together along with other healthcare staff and organisations in providing integrated services to the local community to better help meet the needs of patients and provide a wider range of services.

Our Network comprised of The Atherstone Surgery, Springhill Medical Centre and Station Street Surgery covers approximately 31,000 patients. It is our aim to support patients to make informed decisions about their health care and to connect them to most appropriate health or social care provider to ensure care that is timely safe and all encompassing.

Mission Statement

The North Arden PCN is committed to improving and supporting patient's health journeys by working with partner organisations and providing a person-centred care approach – promoting health and wellbeing and ensuring equality of access for all.

The PCN's vision is to look at improving health outcomes for our local population by developing services based on their needs which will then be delivered locally. Ensuring that we reduce duplication and address any gaps in the services already available to our patients.

Our Board Members

Executive Members:

Dr. Rachael Davies

Clinical Director

Atherstone Surgery

Dr. Tom Hywel-Edwards

Executive Member

Atherstone Surgery

Dr. Chintan Shah

Executive Member

Springhill Medical Centre

Dr. Obaid Ullah

Executive Member

Station Street Surgery

Karen Clarke

Practice Manager

Atherstone Surgery

Avis Lynch

Practice Manager

Springhill Medical Centre

Lisa Bird

Practice Manager

Station Street Surgery

ARRS Role Spotlight: Luke Sadler

This quarter, we would like to shine a spotlight on our Health & Wellbeing Coach Luke Sadler and the terrific work he's been doing by sharing one of his recent case studies.

Patient Case Study: Overcoming Bulimia After 20 Years

This presentation explores a remarkable case of overcoming bulimia nervosa. Our patient faced daily purging, chronic fatigue and compulsive weighing (six times per day). They had struggled with disordered eating since age 30, leading to extreme dietary restrictions and binge-purge cycles. Through personalised support and small, manageable steps, they embarked on a transformative journey towards recovery.

Key Challenges

- **Metabolism & Fatigue:** Patient expressed deep fear of weight gain, leading to prolonged undereating, a significantly slowed metabolism, and malnutrition. This has led to fatigue and reduced physical activity.
- **Compulsive Weighing:** This can lead to feelings of guilt, often accompanied by a strong desire to purge, which can be incredibly difficult to navigate.
- **Skeletal Muscle:** Lack of proper nutrition and physical activity leading to deterioration muscles and overall health.

Support Strategy

Instead of forcing immediate behavioural changes, Luke focused on validating the patients emotions, explaining the physiological effects of undereating, and emphasising the importance of metabolic recovery.

- **Metabolism & Fatigue:** Luke explained that undereating signals the body to conserve energy, causing fatigue. He asked the patient to identify safe foods, noting she could have oats in the morning but would fast until evening, leading to extreme hunger and purging. To help, Luke suggested adding another pot of oats in the afternoon to manage hunger and reduce anxiety around eating.
- **Compulsive Weighing:** Instead of telling the patient to stop, Luke allowed them to continue while making gradual adjustments. He managed their expectations by explaining that a minor initial weight gain might happen, but reassured them it would stabilize quickly due to insufficient caloric intake.
- **Skeletal Muscle:** Luke highlighted the importance of resistance training and nutrition for muscle retention and quality of life, suggesting a whey protein shake to boost muscle protein synthesis and metabolic function.

Outcome

By the end of the first session, the patient felt heard, validated, and optimistic about the small, manageable steps they had committed to. Moving forward, they successfully incorporated oats and a protein shake into their daily routine. The patient continued to weigh themselves but approached it with a healthier mindset, no longer fearing small fluctuations. Without any external prompting, they reduced her weigh-ins from six times a day to three. To the patient's surprise, avoiding purging did not lead to weight gain, which reinforced their trust in the process. They also shared her first meal out with her partner without purging—a significant milestone for them.

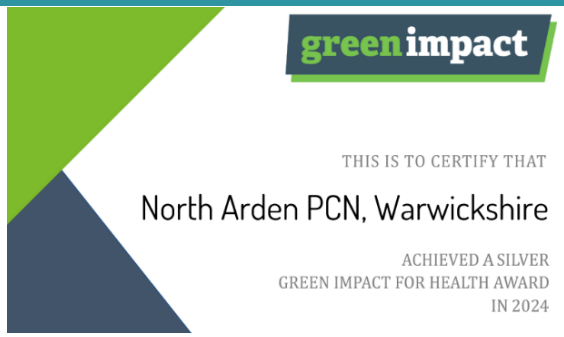
Patient Progress

- **Purge-Free Streak –** Achieved a significant milestone of being purge-free for 15 weeks to-date, by far their longest streak in 20 years. Leading to enjoyment of family holidays and 3lb weight gain over Christmas without panic.
- **Increased energy –** Reported higher energy levels and returning hunger signals, indicating metabolic recovery.
- **Resistance training –** Started noticing positive body changes and became interested in resistance training, enjoying physical and mental benefits.
- **Return to work & public sharing –** Patient returned to work after being on sick leave to focus on their recovery. They stood up in front of 30 staff members, shared their journey, and moved them to tears with their courage and honesty. The patient also revealed their struggle with bulimia to their son, describing the experience as "freeing."

Conclusion: This patient's journey highlights the power of validation, small achievable steps, and a personalised approach to recovery. By avoiding pressure and allowing the patient to feel heard, they was able to make profound, sustainable changes. Their transformation from daily purging and fear of food to embracing balanced nutrition and resistance training is a testament to the importance of compassionate, individualised support.

In the patient's own words, they "could not have done it without feeling heard and not pressured into big changes too soon." Their resilience and commitment to recovery remain an inspiration, and Luke will continue to support them as them progresses on this journey.

Green Impact Silver Award



Sustainability is a serious issue, and as such, we wish to do our part as a PCN to protect the environment. We are proud to announce that we have earned the Green Impact Silver Award for 2024.

This past year we changed to sensor taps, lights and energy efficient bulbs, encouraged methods to reduce wasted paper and resources, brought in recycling bins across our practices, changed the suppliers of our ink toners and drums so that they can be recycled and have supported the use of green prescriptions (eg, referrals to Fitter Futures and supporting ARRS roles).

We also promoted the use of reusable period products and raised awareness of period poverty by putting posters in our visitors toilets and advertising via a new period poverty page on our website.

To help our efforts progress and earn the Gold award in the future we are encouraging our clinicians to undertake some or all of the methods below:

- Review inhaler prescribing - Clinicians are being encouraged to review their inhaler prescribing for patients, where it is appropriate to do so.
- Encourage patients to recycle their inhalers and blister packs – instructions and recommendations on how to do this can be found in the sustainability section of our website.
- Patients are also being encouraged to utilise the insulin, weight management and hormone injection pen recycling schemes offered by Sanofi and Novo Nordisk.
- Reduce the number of unnecessary letters sent out of practice – this can be done by utilising services such as AccuRx to contact patients. We also encourage clinicians to have patients come into the surgery to collect blood forms rather than wasting the extra paper in envelopes to post them out.
- Ensure that all windows and doors are closed (if possible) when heating is on.
- Ensure double sided printing and copying where appropriate.
- Reduce the number of unnecessary prescriptions through the facilitation of Structured Medication Reviews for some patients.
- Encourage staff to use Ecosia (https://www.ecosia.org/) as their web browser rather than google or other similar browsers. Every four times we use Ecosia they have pledged to plant a tree, helping our environment.

For more information on our most recent award, how we earned it and our plans for the future please click on the link below.

Our Green Impact Award - North Arden Primary Care Network

Help us protect the environment and earn the gold award.

Our Board Members

Non-Executive Members:

Jordine Crooks

Nurse Clinical Leader

Spring Hill Medical Centre

Claire Brown

PCN Coordinator

Christine (Tina) Billington

Development Consultant and Health Inequality Lead

Marcia Sherriff

PCN Finance Administrator

Juliet Reeves-Eastwood

Website and Communications Co-ordinator

Atherstone Leisure Centre

Wendie Fraser one of our Health and well-being coaches at North Arden PCN, has successfully arranged a 20% discount for three months at Atherstone Leisure Centre for our patients and staff. Recognizing the importance of physical activity for overall health, she initiated discussions with North Warwickshire Borough Council and the Leisure Centre to explore a partnership that would encourage more people to engage in exercise.

Through negotiation, she highlighted the mutual benefits-improving community wellbeing while increasing leisure centre memberships. Wendie then coordinated with surgery staff to promote the offer ensuring patients and colleagues could easily access discounted gym sessions, swimming and fitness classes.

This initiative has helped improve accessibility to exercise, supporting both patient health outcomes and staff well-being.

How to access the offer:

Visit your local surgery

- **The Atherstone surgery Ratcliffe road, Atherstone CV9 1EU**
- **Station Street surgery Atherstone CV91DE**
- **Springhill Medical Centre Arley CV7 8FD**

Book appointment with Health and well-being coach for referral.

Veterans in our PCN

Veterans Health Checks

We at North Arden PCN understand the importance of our military veterans and are endeavouring to help them all that we can.

We have been working closely over the last few months with Warwickshire County Council and the Veterans Contact Point on a project which offers free health checks to veterans living in North Warwickshire. These health checks will be delivered by nurses from GEH out in the community.

These checks are designed to give veterans peace of mind, make sure they are pointed in the right direction for any medical needs and catch potential health problems early, allowing veterans to live healthier, more active lives.

The first checks were offered as part of the 'Brew and Banter' events at the Veterans Contact Point Nuneaton Hub from Wednesday 22nd of January, with further sessions in different community locations to be released throughout the year.

For a list of currently arranged dates and locations for upcoming events please see below:

May

- 8th – VCP Hub, Atherstone, Thursday 10:00 – 14:00
- 10th – Breakfast Club, Middlemarch Pub Nuneaton, Saturday 09:30 – 12.00
- 14th – VCP Hub Nuneaton, Wednesday 10:00 – 14:00
- 19th – Breakfast Club, Middlemarch Pub Nuneaton, Monday 09:30 – 12.00
- 22nd – VCP Hub, Atherstone, Thursday 10:00 – 14:00
- 25th – Breakfast Club, Middlemarch Pub Nuneaton, Sunday 09:30 – 12.00
- 28th – Kingsbury Water Park, 50th anniversary event, Wednesday (Time TBC)

Veterans looking to find out more, keep updated on the latest events or to book a health check can call 02476 343 793 or visit www.geh.nhs.uk/veteranshealth

The nation regards its veterans highly and they are recognised by NHS England as a 'special group' within the general population. NHS England seeks to ensure that veterans are always considered when commissioning services. Whilst many aspects of the health needs of veterans are the same as for the general public, there are sometimes significant differences, particularly in relation to conditions attributable to service life and the associated impact for individuals and their families.

Luke Sadler our health and wellbeing coach and veteran lead has been spearheading a campaign to better identify and guide our veterans to the help and care that they are entitled to. To facilitate this, he has been sending out Accurx messages to determine the veteran status of our patients.

A veteran is anyone who has served a day or more in the UK Armed Forces, whether as a regular or reservist and can be of any age, gender, sexuality, ethnicity and nationality.

As a PCN we have pledged to support our ex-military as best we can, and we would like to urge our surgeries to encourage their staff members to ask patients their veteran status.

If you would like to find out more about veterans and the services, they are entitled to please scan the QR code below to take a look at the veteran's section on our PCN website.

PCN Facebook Page

We are always seeking new ways to reach out to our patients and provide support. With this in mind, we have recently launched our new PCN Facebook page.

We aim to share important health information, provide updates on our services, and announce community events through our page. This will make it easier for residents to stay informed and engaged. We are excited about the opportunity to connect with our patients in a new way and look forward to finding innovative solutions to meet their healthcare needs. Please use the link below to explore our exciting new initiative.

https://www.facebook.com/NorthArdenPrimaryCareNetwork

Springhill Medical Centre, one of our valued healthcare facilities, also became an active participant in the online Facebook community in January of this year. Since then, they have successfully engaged with and reached out to their local community, fostering stronger connections and better communication. To explore the valuable resources and information they provide, please visit their Facebook page using the link below.

https://www.facebook.com/people/Spring-Hill-Medical-Centre/61572449408428/

Think - is your patient frail?

The North Arden PCN are undertaking a project to identify and support their patients living with moderate and severe frailty.

What is frailty?

- “Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. " This may be due to a range of factors such as illness, disability or aspects of the ageing process meaning that frailty is sometimes complicated, is individual, and is varied and changeable.
- A long-term condition, associated with aging but it’s important to remember that it is not an inevitable part of aging.
- Around 10% of people aged 65-69 years and 40% of people aged 85-90 live with frailty.
- The average life expectancy at 65 years is now 21 years for women and 19 years for men and this is increasing.

Things to consider

Almost 50% of patients over 85 years admitted to hospital die within one year of admission and 50% of patients aged over 85 will lose the ability to complete one or more activities of daily living if admitted to hospital. When having a conversation with someone who you consider to be frail be positive about building on what they are doing to stay well, and not about making assumptions based on age. Give them their privacy don’t make the conversation about labelling or interfering in their life. Speak Plainly, avoid being over technical.

The word frailty is not important – it’s about what is helpful for the person. "You do not feel frail, and we want to help keep it that way."

- You need a bit more help to do the things you usually did
- You take a bit longer to ‘bounce back’ from something simple
- You tire more easily or feel less string than you used to
- You may feel more apprehensive and less confident

Don’t forget a person’s frailty should be judged on their condition two weeks before admission – this level of wellbeing should be the target at discharge.

Services for the frail

- Start in house; think Social Prescriber and Health and Wellbeing Coaches
- Fire Service, Age UK, Occupational Therapy

It is important to consider a person's frailty during all interactions and Care navigators / patient administrators can support clinicians with identifying frailty (does someone always attend appointments with this patient? Does someone always phone on their behalf? Who orders this patient’s medications?).

If you think a patient may be frail, in line with the below criteria, please inform a clinician so that their frailty status can be reviewed, and if agreed, appropriately coded – this will allow the patient to access support.

Clinical Frailty Scale

1. **Very Fit –** People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.
2. **Well –** People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.
3. **Managing Well –** People whose medical problems are well controlled, but are not regularly active beyond routine walking.
4. **Vulnerable –** While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up”, and/or being tired during the day.
5. **Mildly Frail –** These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.
6. **Moderately Frail –** People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.
7. **Severely Frail –** Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).
8. **Very Severely Frail –** Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.
9. **Terminally Ill -** Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Once coded, patients can be easily identified for services, e.g. Structured Medication Reviews. Proactive care can be started, with services focused around helping the patient to live well, and continue to live well, at home. By Identifying our frail patients, we can better help them by improving care and health outcomes and reducing unplanned hospital admissions.

Identification of patients with frailty is everyone’s responsibility and identification of our frail patients will help us to help them to live well, and to live independently for as long as possible.

Friends & Family Tests

We as a PCN always strive to improve our services. We are dedicated to constantly enhancing the quality and efficiency of the healthcare services our surgeries provide. The key to doing this is to gain feedback from our patients.

By reaching out to the community, we not only improve access to healthcare but also foster a sense of collective responsibility towards health and well-being. Our goal is to make every patient feel heard, respected, and well-cared-for, fostering long-term relationships based on mutual respect and trust.

All our clinicians are provided with friends and family feedback forms that we actively encourage be handed out to patients. This will help us gather invaluable insights to guide our improvement endeavours.

The results of these test can be found by scanning the QR codes or visiting the web pages below.

Springhill

https://www.springhillmedicalcentre.co.uk/pages/Friends-and-Family?Highlight=Friends+and+Family

Station Street

https://www.stationstreetsurgery.co.uk/practice-information/friends-family-test/

The Atherstone Surgery

https://www.atherstonesurgery.co.uk/practice-information/friends-family-test/friends-and-family-results/

Check Out Our New Women's Health Section

As a PCN we aim to support our patients in all matters of health and general wellbeing by providing all the information and support they need to stay happy, healthy and safe.

With this in mind we are proud to announce the addition of our new Women's Health section which offers a wealth of information to our female patients. Please see below for some of the subjects that are included.

- Period Health
- Healthy living
- Menopause
- Maternity
- Contraception & Sexual Health
- Pelvic Floor Dysfunction
- Endometriosis
- Breast screening and how to examine breasts
- Cervical cytology screening
- Domestic Abuse and Sexual Assault

To check out our new section for yourself, please follow the link below.

https://practice365.co.uk/u54565/womens-health/

Did you know that you can book appointments afterhours and on weekends?

Thanks to our PCN's extended access appointments patients can now book appointments outside of their surgery's normal working hours.

Telephone slots with GP's are available every evening Monday-Friday and Face to Face appointments can be booked every Saturday with our extended access team comprising of Nurses, Doctors and Advanced Nurse Practitioners. All weekend appointments are based at The Atherstone Surgery.

Our Doctors and ANP's can prescribe, refer and do everything that a regular GP can do. Our extended access nurses can also provide a variety of services including:

- Cervical Screening
- Wound Care
- Contraceptive Support
- Depo (contraceptive)
- Depot (mental Health)
- B12 injections
- Childhood Immunisations
- Blood Pressure Monitoring
- Clip/Suture removal

Patients wishing to use our extended access appointments should contact their GP surgery to inquire about available slots.

In recent months, our utilization of these appointments has significantly improved, as we've implemented new strategies and outreach efforts. This positive trend reflects our dedication to maximizing efficiency and ensuring that more individuals benefit from the services we offer. We've seen an increase in attendance and engagement, demonstrating that our initiatives are making a real impact in meeting our community's needs.

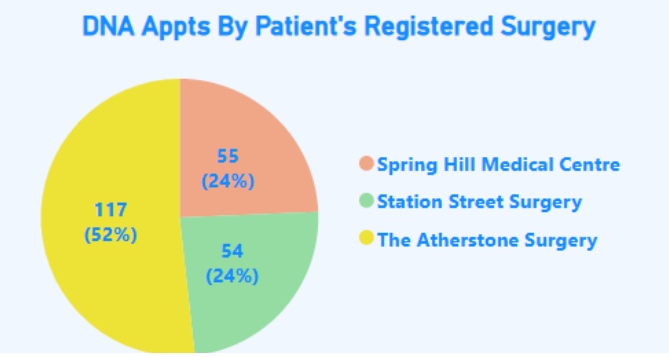
Unfortunately, despite our efforts, we still have patients who do not attend their booked appointments. For more information regarding this and on the appointments available, please see below.

Dates: November 2024 to January 2025 (3 months)

Type of Appointment	Number of appointments available	DNA's
GP	948	63
ANP	352	42
Nurse	323	41

Dates: August 2024 to January 2025 (6 months)

Type of Appointment	Number of appointments available	DNA's
GP	1894	116
ANP	552	47
Nurse	693	64



Pets As Therapy Is Joined By Open Hands

Luke and Wendie, our Health and Wellbeing Coaches have been working with the Pets as Therapy organisation allowing patients the opportunity to pet and play with a range of therapy animals.

Pets As Therapy (PAT) is a national charity that enhances the health and wellbeing of thousands of people in communities across the UK via guided interactions with a trained animal and its handler.

They strive to ensure that everyone, no matter their circumstances, has access to the companionship of an animal and the emotional and psychological benefits that can be gained from this interaction.

Their volunteers and their temperament- pets bring smiles to many faces. People of all ages get the chance to chat to someone — and stroke a friendly dog or cat.

This service is held on the 1st Wednesday of every month beginning at the Mancetter Memorial Hall from 2:00pm-4:00pm.

Whether the patient suffers from Anxiety, Depression, Dementia or even just feels as if they would benefit from love and attention from a selection of therapy pets, these meetings are available to everyone including carers with no booking required.

This service has now been joined in their sessions by the Open Hands CIC team who are an organization dedicated to serving the community in various ways, including assisting with form filling, making referrals to outside organizations, and helping individuals read and understand letters. They have been operating for seven months and have already supported approximately 187 service users who rely on their services.

Their mission is to engage with the community and foster an inclusive and supportive environment for everyone in Atherstone Town Centre and its surrounding villages. They provide unwavering support, creating a welcoming space where every voice is heard and valued. By offering practical information and advice, they support residents across Warwickshire. They strive to be a cornerstone for local connections, promoting a sense of belonging and unity among all who come through their doors. They are hoping to better access those who may need their help by attending our sessions.

For any additional queries patients can contact our Health & Wellbeing Coaches:

Wendie Fraser: 07932 234024

Luke Sadler: 07957 565913

For more information about Open Hands please take a look at their website below.

https://www.openhandscommunity-

Living Well For Longer (Pain Management)

LIVING WELL FOR LONGER
NORTH ARDEN PRIMARY CARE NETWORK

Our Primary Care Network (PCN) has been actively engaged in the development and launch of a new initiative called "Living Well for Longer." This program aims to promote healthier lifestyles and improve overall well-being among our community members. By focusing on preventive care, education, and support services, we hope to empower individuals to take charge of their health and enhance their quality of life as they age. We are excited to share more details as we move forward with this important initiative.

The main modules of this new venture will be:

1. **The Proactive Care Programme:** This involves arranging structured med reviews for housebound patients.
2. **Support for the recently bereaved:** Losing a loved one is one of the most challenging experiences we can face. During this difficult time, our priority is to provide compassionate support and care to our patients as they navigate their grief and begin to heal. You are not alone in this journey; we are here for you every step of the way.
3. **10 Steps Support for patients with Fibromyalgia:** Fibromyalgia is a long-term condition that causes widespread pain, fatigue, and other symptoms. This can make daily life difficult for those who have it. By offering clear and simple support that addresses the needs of people with fibromyalgia, we can help improve their quality of life.
4. **Reaching out to those who don't reach us:** We're looking to reach out to patients who don't attend their surgery and to understand the reasons behind their absence. Are they facing difficulties getting to the surgery, hesitant to contact their doctor, or is there another reason? Our goal is to identify these challenges and provide support to help patients attend their appointments and have their needs addressed.

Clinicians are reminded that patients should be referred to the HWBC via task and not directly booked into their appointment slots unless discussed with the HWBC's first.

Welcome New PCN Members

We at the PCN are delighted to welcome new team members. We are pleased to announce the addition of Judy Shaw our new Social Prescriber and Marie Jordan our new Occupational Therapist. Please see below to learn a little more about our new members.

Judy Shaw – Social Prescriber

Judy joined our PCN on the 10th of March 2025 as our new Social Prescribing Link Worker and will be accepting appointments sometime in April after her 1 month induction.

At 15, Judy volunteered at a local hospital and a Prince's Trust respite holiday camp, sparking her passion for helping others. She began her career in a care home, where she learned the importance of kindness and compassion. Progressing to a senior carer, she managed staff rotas, medication, and personal care.

Judy spent over 10 years in secondary care, including orthopaedic trauma, intensive care, and accident and emergency, gaining a solid clinical foundation. She earned health and social care diplomas and a foundation degree from Coventry University. As a member of the first cohort of the Nursing Associate programme in general practice, she supported the training of new nursing associates while ensuring adherence to NMC guidelines.

Judy's training includes contraception, menopause management, learning disability care, and smoking cessation, and she is a qualified mental health first aider. She was part of the nursing team awarded the Pride of Coventry for outstanding service.

Now, as she embarks on her journey in social prescribing, Judy aims to comprehend her new role thoroughly and aspires to be a team leader, committed to enhancing team dynamics and well-being for those around her.

What does a Social Prescriber Do?
Social Prescribing is a non-medical approach to enhance overall health and well-being. Social Prescribers help individuals access tailored services, such as community groups, local council or charity programs, and advisory services. They can help in a variety of ways with all the following issues.

- Loneliness & Isolation
- Health & Lifestyle management
- Carers support
- Bereavement
- Housing issues
- Money worries
- Employment support
- Living Independent Support
- Access to Local Community
- Substance misuse

They connect people to community groups for practical and emotional support. For example, signposting people who have been diagnosed with dementia to local dementia support groups.

Marie Jordan – Occupational Therapist

Marie began her career as an Occupational Therapy Assistant at UHCW in 2004, where she worked alongside occupational therapists, gaining experience in medicine, surgery, and oncology.

She enjoyed this role so much that she decided to pursue further training at Coventry University in 2007, earning a BSc Honours degree in Occupational Therapy. While completing her studies, she enrolled with a healthcare agency and gained experience as a carer in people's homes.

Marie completed her qualifications in 2010; however, due to a shortage of job vacancies, she temporarily worked as a carer in the Community Emergency Response Team. She then transitioned to a role in the hub, where she triaged referrals and directed them to the appropriate teams in South Warwickshire.

In 2012, she began her first Band 5 position with Birmingham Community Healthcare, where she gained experience running groups for Parkinson's patients and falls prevention. She later rotated into Urgent Care, focusing on admission prevention and facilitating safe hospital discharges. Marie was also involved in developing and facilitating a virtual bed service for elderly people living with complex conditions in their homes, collaborating with an interdisciplinary team.

In March 2016, Marie advanced to a Band 6 role in the Community, where she assisted in developing a new service within the Integrated Neighbourhood Team. In this position, she managed a caseload of patients with complex conditions, concentrating on preventing hospital readmissions.

Her next role was in the Out of Hospital (OOH) therapy services, where she worked on planned reablement therapy and urgent care, aiming to prevent hospital admissions and ensure safe, seamless hospital discharges.

Most recently, prior to joining us at the PCN, Marie worked as part of a large Community Neuro Rehabilitation interdisciplinary team, helping patients aged 18 and over with complex needs, such as those who had suffered a stroke or brain injury. She visited patients at home, working towards meaningful goals tailored to each individual.

This new role within the primary care setting presents a fresh experience for Marie. She will be focusing on embedding and developing the occupational therapy role across three GP practices and collaborating closely with the PCN. Marie is passionate about her work and is eager to introduce new services that will promote patients' health and well-being by partnering with the PCN on innovative projects.