GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

Neath Port Talbot Community Network News

Planning and Delivering Core out of Hospital Services

Issue 3 July 2012

Since the last newsletter, Neath Port Talbot hospital has been in the news quite a bit so I am using the first part of this newsletter to highlight what has been happening.

It is important that I begin by saying the priority of the Health Board is and always will be the provision of safe high quality healthcare services for ABMU residents.

Intense discussions have been going on regarding the changes to CT2 doctors (senior junior doctors) rotas which involves them moving from Neath Port Talbot Hospital to other hospital sites in ABMU Health Board and the effect this will have on acute medical admissions at NPT Hospital as a consequence.

Following advice from senior doctors, the Health Board agreed at its meeting in July to an urgent change to the delivery of acute medicine at Neath Port Talbot Hospital from September.

I would like to allay any fears that Neath Port Talbot Hospital is facing closure. Nothing is further from the truth and this is evidenced by the fact that we continue to invest in the hospital with initiatives such as the installation of state of the art MRI and CT scanners, the relocation of ABMU's neuro-rehabilitation service and laser clinic to NPT Hospital and the development of the new Women's Health Unit to name but a few. Future plans for the hospital include the introduction of a new IVF facility in 2013; a purpose built investigation, treatment and diagnostic unit for urology patients; and the consolidation of Elderly Mentally Ill Assessment Services.

However, staffing of the acute medical care provision with the correct number of suitably qualified and experienced doctors to provide a safe service has presented a huge challenge for us. From August, the CT2 doctors (senior junior doctors) will be relocated to other hospitals to meet with Deanery requirements for them to be supported by more senior doctors on site such as specialist registrars and to have a wider breadth of experience than can be offered at NPT Hospital. This will have a major impact on the acute medical services we can offer. Without these doctors we will not have enough experienced acute care doctors available at the hospital to provide safe medical care for our patients whilst they are acutely ill.

We have made concerted but ultimately unsuccessful efforts to recruit appropriate doctors locally and abroad in order to continue to run safe and effective acute medical services at the hospital. This means we now have to plan and run our acute medical service in a different way to ensure all our patients receive the appropriate medical care they need, and this service will not be available at NPT Hospital in the future.

Hilary Dover
Locality Director
Neath Port Talbot

We recognise that this will be unsettling for both staff and local residents. However, no staff will lose their jobs as a result of these changes and we intend to further develop local services for specific healthcare issues such as chronic conditions and frail older people.

The Locality is currently working very closely with our neighbouring localities, particularly Swansea and Bridgend, to develop and implement our plans to ensure that acutely ill patients are treated in the most appropriate place. We also need to continue with our development of integrated care services, in partnership with the Local Authority and the third sector so that we can, where possible prevent patients being admitted to hospital unnecessarily and discharge those who have gone into hospital in a timely and safe way. Alongside this, changes for our staff are also being worked through. Both services and workforce plans will be completed by the end of July.

Local GPs have already been working closely with us through our community network projects, such as the GP based consultant-led community diabetes clinics, and the specialist heart failure nurse-led clinics, and I would like to thank our GP network leads for their hard work in leading these developments. Communication between hospital based services and primary care is key to the provision of safe services and these projects are helping to ensure there is a continuous pathway of care.

Please read on and I hope you find the following articles interesting.

In this issue:

Consultant Diabetes Clinics out in the Community

Dr Geraint Jeremiah, Consultant Diabetologist is carrying out a programme of visits to GP practices in NPT locality that are aimed at:

- Increasing access to consultant services in the community for diabetes patients requiring increasingly complex care;
- Increasing the flexibility of the diabetes service offered by the hospital;
- Assisting and strengthening diabetes health care through closer cooperation and joint consultations;
- Developing opportunities for increased interaction between GPs and specialists;
- Providing a forum for mutual education;
- Reducing unnecessary investigation and hospital admission.

All twenty three practices have been engaged in the project and since its November 2011 inception across the three networks more than 250 patients have been seen in the familiar surroundings of their local GP surgery rather than most likely being referred to secondary care.

Dr Jeremiah with Practice Nurse Dorothy Greenway at Kings Surgery

A formal evaluation of the joint consultant/GP service is currently underway but initial feedback would suggest that at least 50% of the patients seen and treated in the community would have become secondary care referrals.

The evaluation, which is being carried out through semi-structured interviews with the GPs and Practice Nurses directly involved in Dr Jeremiah's clinics, is designed to determine:

- How useful the clinics are
- What impact they have on patients' self-management of their condition
- Whether the clinics have enabled patients' care to be continued in primary care and reduced the need to refer them to secondary care
- Evidence of improvement in diabetic control and/or general condition.

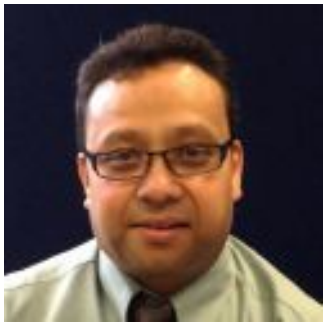
The evaluation will also inform the future shaping of diabetes services across NPT.

By Krysia Groves, Planning Lead - Afan Network

Improving Communication with Secondary Care – Respiratory pilot

Effective communication is the key to success and improving collaboration between GPs and Consultants. This is a crucial element in the provision of high standard, safe and cost effective care in the community. This will strengthen the relationship and reduce unnecessary referrals and acute hospital admissions. Keeping this in mind we are working out the best possible ways to improve communication.

Being a GP myself, I value direct telephone or email access to secondary care colleagues, but this is not always possible with all specialities for various reasons. An alternative way to improve communication and reduce the gap is by involving the specialist nurses to work more closely with the practices. The specialist nurses are extremely skilful clinicians and take the lead in making sure patients get the best possible care.



Chiranjib Ghosh Network Clinical Lead

We hope to start a pilot in the Upper Valleys Community Network soon with the help and cooperation of our respiratory specialist nurse and hope this will open the gate for nurses from other specialities to work hand in hand with GP practices in the near future.

By Dr Chiranjib Ghosh, GP Lead - Upper Valleys Network

Neath Port Talbot Joins the Fight Against Heart Disease

Heart charity awards £100,000 to fight one of the area's biggest killers-

People living in Neath Port Talbot are more likely to have cardiovascular disease (CVD) than people in most other counties in Wales. Therefore, the prevention of cardiovascular disease has become a priority for Abertawe Bro Morgannwg University Health Board.

Neath Port Talbot Council for Voluntary Service, leading a partnership bid to the British Heart Foundation (BHF) on behalf of Neath Port Talbot Local Service Board, and involving Public Health Wales, and Neath Port Locality of ABMU Health Board has been awarded £100,000 to improve the heart health of some of the County Borough's most disadvantaged areas. The investment is part of the BHF's UK-wide Hearty Lives programme to reduce geographical inequalities in heart disease.

The Hearty Lives Neath Port Talbot project will work in the Borough's most disadvantaged areas and train volunteers as 'health champions' to promote healthy lifestyle messages in their community. The health champions will be given information and resources which they can pass on to their friends and neighbours with the aim of improving the health of the whole community. It is hoped that cascading information in this way will mean that the project has lasting effects in some of the most disadvantaged communities where people have higher chances of suffering from CVD.

BHF Hearty Lives Programme Lead Shirley Hall said:

"We are delighted to be working with Neath Port Talbot Council for Voluntary Service on the Hearty Lives Neath Port Talbot project. We believe that the best way to tackle heart health inequalities is to empower communities to make sustainable change for themselves. We hope that people in Neath Port Talbot see significant health improvements as a result of this investment."

Dr Anne Delahunty, Consultant in Public Health Medicine ABMU Health Board said *"We are really pleased to have this opportunity to work with British Heart Foundation and local partners to make a real difference to the health of people in our most disadvantaged communities."*

Gaynor Richards, Director of NPTCVS said *"We are very excited about developing this new project in conjunction with BHF and our local partners in health and the local authority to achieve sustainable change by empowering people to take control of their own health."*

The award to Neath Port Talbot is part of the BHF's £11 million nationwide Hearty Lives programme, which is the first time the heart charity has worked in partnership with local NHS services and local authorities to tackle geographical inequalities in heart disease. There are now 31 Hearty Lives projects around the UK and more are planned for later this year.

By Lorraine Miles—Deputy Director - Neath Port Talbot Council for Voluntary Service

Did you know...?

"Life expectancy in Neath Port Talbot, as in Wales in general, is increasing. However, this improvement is not experienced equally across all areas. There are in many cases substantial national and local inequality gaps between the most and least deprived areas in both life expectancy and deaths from different causes. There are also inequalities in the quality of life in terms of healthy life expectancy and disability-free life expectancy". To find out more go to http://www.wales.nhs.uk/sitesplus/922/page/58379

Reflections of Network Practice Manager Leads

Farida Patel – Practice Manager Lead, Afan Network

By Farida Patel, Afan Network Practice Manager Lead.

Being involved with the Afan Community Network as a Lead Practice Manager, has been a steep learning curve, and in the beginning I was quite apprehensive about taking on this role. For me especially, Networks were an unknown concept developed as a result of the Welsh Assembly Government's " Setting the Direction" Framework and would entail a new way of working amongst the local GPs and therefore gaining everyone's confidence within the Primary Care setting was a huge task.

The Networks were set up in the first instance, to reflect joined up working between local GP practices and for Primary Care to become the driving force to help promote equity of services within the NHS for the patient population irrespective of where they lived.

My role is to assist the Network Lead GP in coordinating the GP Network and disseminating information which includes minutes of meetings. The minutes are of particular importance when the meetings for the Quality and Productivity indicators are held.

As time has passed the Networks are slowly beginning to gain momentum. There is still a long way to go, however the GPs are gradually working more cohesively within their Networks. This type of working together also helps provide GPs with an opportunity to work in partnership with their secondary care colleagues and other healthcare professionals thus enabling everyone to work towards a seamless service for the local patient population.

As a Lead Practice Manager my role is to continue being supportive and to assist the Network Lead GP in achieving the present and future Network goals.

By Steffan Gimblett, Neath Network Practice Manager Lead.

Steffan Gimblett Practice, Manager Lead Neath Network

When I first put myself forward as a Practice Manager Network Lead, I was apprehensive to say the least as when I thought of the term's 'Community Networks' & 'Setting the Direction' all I could think was 'what exactly does that mean,' and 'what do they want us to do?' Even when the very first network meetings began, there were many perplexed faces surrounding me as none of us really knew what to do.

However, during that first meeting, it became apparent that all of the GP leads attending seemed to be discussing the same problems, be it communication with secondary care or appropriate staffing levels in the community. I very quickly realised that all the surgeries in our network seemed to be affected by the same problems.

Community Networks were partly set up to reflect joined working between local GP practices. Even with the uncertainty surrounding community networks, from the offset, we could all see that by working together as a network, problems could be shared and the voice of many could make a bigger difference than the voice of one.

My role within the network was to facilitate any agreements or tasks the network had agreed on. Fortunately, our network was led strongly and capably by our clinical lead, who later became a real driving force for change. Although the facilitation role sometimes meant quite a lot of administrative work, the role was made easy by the very nature of the goals we had set ourselves, which if achieved, would make a real difference to our patients and to the practices within the network.

Reflections of Network Practice Manager Leads ...continued

By Lorraine Flowers, Upper Valleys Network Practice Manager Lead.

Lorraine Flowers Practice Manager Lead, Upper Valleys Network

When I was asked to be the PM lead for the Upper Valley Network I was very apprehensive, especially as the role was new and there was no job description to refer to. I also felt very strongly that the role should not be a "secretarial one" i.e. taking minutes of the meeting etc. We have enough minutes to take already.

The Practice Manager lead role has now developed and I feel that my opinions and ideas are being valued and this has given me the motivation to continue.

Time will always be an issue and taking time out of the practice is difficult but hopefully the benefits will outweigh negatives.

Well Done to Community Networks Nurses

The community network nurses in Neath Port Talbot continue to take their professional development very seriously. Some of the nurses have recently completed courses which have enhanced their nursing skills, thereby improving the quality and safety of care delivered to patients. The knowledge gained has also resulted in improved efficiency and effectiveness as the nurses are now able to issue prescriptions at the point of care, reducing delays in patients receiving the products they require.

From left to right Andrea Davies (Afan network), Nina Owen (Upper Valley Network), Rhian May (Out of Hours Team) and Sharlene Evans (Upper Valley Network).

Congratulations to Janette Morgan, on recently achieving a Distinction as a Specialist Practitioner in District Nursing from the College of Human and Health Sciences, Swansea University. Janette has been working as a Community Staff Nurse in Neath Network.

Also to be congratulated are Andrea Davies (Afan network), Nina Owen (Upper Valley Network), Rhian May (Out of Hours Team) and Sharlene Evans (Upper Valley Network) who have all received the Community Practitioner Nurse Prescribing V150 qualification, also from Swansea University.

Fiona Reynolds, Head of Nursing & Community Services said, *"The volume of district nursing work undertaken makes it a significant contributor to health services, especially given a growing older population and increasing prevalence of long-term conditions. The development of nursing roles, notably but not only prescribing, has opened up new areas of practice. District nurses are expert practitioners who have a specific set of knowledge and skills which will always be required to nurse people outside of clinical settings. The locality is committed to developing staff and equipping them with the skills to maintain people at home where they want to be."*

Nina Owen (Upper Valleys Network) said, *"I applied for the V150 course as I am always looking for ways to improve the care I deliver to patients. I thought it was an exciting opportunity to be part of the first cohort and one of the first staff nurses qualified to prescribe in Wales. I thoroughly enjoyed the course and it has inspired me to apply for the BSc in Community Health Studies starting in September."*

Neath Community Network Work plan 2012/13

Dr. Andrew Muir Neath Network GP Lead

In May, Neath Community Network met to discuss and agree a workplan that takes us up to March 2013. This was a well attended meeting with good engagement and debate from all areas of the Network. The following provides a short overview of each priority area. Since May, leads have been assigned and work is already underway on each of the priority areas. We shall provide further updates in future Newsletters.

Virtual Ward and PRiSM

PRISM is an electronic tool that enables GP practices to identify which of their patients are most at risk of requiring unplanned hospital admissions within the following 12 months. Swansea University and ABMU Health Board are undertaking an academic study of its application and implementation. All of the 8 practices in Neath Community Network have signed up to PRISM and we are aiming to implement a 'Virtual Ward Team' to support these patients to improve their health and well being and enable them to remain at home. This team will focus very much on a proactive and preventative approach to healthcare as the PRISM tool will enable us to work with people before crises occur.

Heart Failure

Katherine Roberts, Specialist heart failure nurse is in the process of visiting practices in the network together with Bethan Jenkins, pharmacy advisor from the Health Board. Their aim is to improve the accuracy of the heart failure registers and to aid practice nurses in implementing NICE guidelines for the treatment of heart failure. GPs have identified that it takes a long time between referral for an echocardiogram and receiving a report. We have identified bottlenecks and places in the pathways where delays occur. The cardiology department has undertaken to rectify these problems and we will be monitoring whether the situation improves.

Carehome Coordination

We have recognised that people living in the Residential and Nursing Homes in Neath are amongst our most frail patients. We also recognise that a lot of input is given to the Care Homes by various elements of the Primary, Community and Secondary Care Services. However, there is no 'model of agreed practice' and these valuable services are at times delivered in isolation of each other rather that in a coordinated manner. We aim to review this position to ensure that all of the work provided by District Nurses, GPs, Nurse Assessors, Palliative Care Team, Pharmacy Team, Intermediate Care Services etc. is drawn together so that the interventions received can be 'greater than the sum of the parts' and that the Neath Community Network can agree a model of practice for all of those living in the Care Homes.

Wound Management

A large proportion of wounds seen in clinical practice are chronic in nature. Studies indicate that 1% of the population has a chronic wound at any one point in time. Chronic wounds affect the individual's quality of life and reduce their ability to optimise their contribution to society. The management of wounds is also very costly to the health service with the largest portion of that cost being nursing time. The protracted course of treatment and potential for infection, supports the need for pathways to promote evidence based practice. The Network has identified Wound Management as part of its work programme for the forthcoming year and our aim is to map current service provision, assessment models, management plans and training needs to facilitate practice which is evidence based, minimises avoidable harm; and to develop knowledge and skills required for optimal management in the provision of wound management.

Resource Mapping

Understanding the population profile, including the makeup of the GP registered and the resident population of the network, prevalence of chronic and other health conditions, levels of deprivation; as well as the strengths and skills of our workforces across all our partners agencies, will enable better integration and joined up working to meet the aims of the network and implement efficient change.

The network has therefore decided to map the human and other resources, assets and services currently within the network to support the planning and development of initiatives.

Neath Community Network Work plan 2012/13 continued...

Pilot Network for the Information Portal

Neath Network has been nominated as one of three ABMU networks to work with the Management Information Project Board to develop a web based portal to enable the sharing of management information. The project will also enable the provision of costing information to inform the networks of where resources are being consumed, with a view to facilitating discussions on resource management and patient pathways. The role of the network will be to review and feedback on content and structure as well as advise on whether the management information needs of the Pilot Community Networks are being met.

For further information contact Neath Network Planning Lead, Andy Griffiths

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The Community Resource Service (CRS)

Preventing unnecessary hospital admission

In our last edition we reported on the development of the NPT Community Resource Service (CRS), and that it will contain a number of community-based health and Local Authority services. The CRS offers both nursing and reablement support and is constantly adapting to local needs and the pressures of unscheduled care. Service collaborations have resulted in developments that bridge the gaps between primary and secondary care. This month we focus on one element of the CRS — the CIIS nursing team.

The nursing team has become increasingly proactive in preventing hospital admissions by improving the interface with the Medical Admissions Unit (MAU) and Local Accident Centre (LAC) at NPT Hospital. A nurse from the team now joins the post take ward rounds on MAU and helps identify patients who would otherwise have been admitted but are suitable for discharge with support; for example patients with newly diagnosed atrial fibrillation (AF), on IV antibiotics, frail elderly with worsening health (falls, infections etc) and those with social issues. Similar patients are identified in LAC.

The team plays an important role in the DVT Pathway, working with District Nurses to prevent admissions. A recent development has seen nurses accepting patients with suspected DVT to assess, take bloods and, depending on the WELLS score (to assess risk of DVT), liaise with the LAC staff regarding Doppler ultrasound. The opportunity is also taken to provide a comprehensive health and social assessment of the patient if appropriate. The whole process is streamlined via direct referral to the service eliminating previous lengthy discussion with various colleagues.

The nurses now also administer intravenous antibiotics to appropriate patients at home. Nurse practitioners prescribe antibiotics, monitor the patient, review bloods and liaise with hospital consultants and/or microbiologists for advice. In this way, there is reduced potential for hospital acquired infections. Significant savings to the Health Board result from reduced unnecessary admissions.

The nursing team works closely with the Elderly Day Unit (EDU) at NPTH and has rapid access to the Intermediate Care Consultant for patients at risk of admission. The Rapid Access Clinic provides a comprehensive geriatric assessment and access to immediate investigations and tests. Typical examples of patients referred by nurses include those with worsening mobility, newly diagnosed AF, shortness of breath (not acute), weight loss, worsening confusion, and falls. The nurses work closely with the Haematology day service at EDU to streamline the pathway for blood transfusions and for the assessment and management of patients with anaemia. GPs are now able to refer patients who need blood transfusions directly to the team, avoiding admissions.

Finally, the nursing team works with Nursing Homes in Neath Port Talbot to provide urgent assessment to prevent rapid deterioration. The nurses initiate intravenous antibiotics and subcutaneous fluids to residents where necessary. The Intermediate Care Consultant provides domiciliary support and works with the GPs and families to avoid an acute hospital admission, where it is not in the patient's best interest.

By Annette Davies, CRS Clinical Lead and

Dr. Firdaus Adenwalla, Consultant Physician, Intermediate Care Services

Profile - Head of Primary Care and Planning, NPT Locality

Lindsay Davies joined Neath Port Talbot locality as Head of Primary Care and Planning in April. Read on to find out a little bit about Lindsay…

Lindsay Davies
Head of Primary Care and Planning

Tell us a little bit about your background:

I am originally from Scotland and came to Wales in 1975 as a 6th former when my engineer father joined the former West Glamorgan Health Authority as Head of Estates.

When did you join the NHS?

I joined the NHS in 1983 as one of the first cohort of Welsh Management Trainees.

What have you done since you joined the NHS?

I have held a wide variety of general management and policy posts across South Wales Health organisations and at a Wales level. My most recent role was a national one supporting NHS Wales' Directors of Primary Community Care and Mental Health as '*Setting the Direction'* Programme Manager in which capacity I also supported the recent Out of Hours review. Most of my general management posts have had a focus on managing change and service improvement in an acute hospital environment, backed up by experience in Planning and HR strategy at a Health Board and Wales level.

What has been the most interesting aspect of your career?

Mmm... It's very hard to say. I suppose the variety and, on a personal level, the opportunity to operate at national and local level (often one immediately followed by the other) keeps one grounded as well as better informed.

What would you say most motivates you to do what you do?

I am a very strong believer in public services and the role of the NHS in improving health and wellbeing on a more equitable basis for all. This drives me to give my best at whatever I put my hand to.

What do you bring to the job of Head of Primary Care and Planning?

I would say that I bring a desire to support health professionals in improving health care, over twenty years of senior NHS management experience, as well as a wealth of useful contacts – if I don't know the answer to a question, I'll probably know someone who does.

How do you feel about the changes happening in the Health Board?

Change is inevitable and in many cases desirable, although the current need for change is often somewhat undermined in terms of Public Relations by also being required at the same time as a substantial reduction in expenditure is necessary. In implementing change the focus on securing services for local people, as opposed to meeting the demand for all-comers to hospitals, should not be lost, particularly within the much larger structure of the new Health Boards.

What do you feel about community networks?

Implementing community network working is a lot easier said than done and requires a huge amount of clinical and general management leadership and energy from within the NHS and from its partners. I do, however, believe that a bottom-up approach to identifying and tackling need has to be the way forward in ensuring that, particularly in these straitened times, we don't duplicate service assessment or provision with our partners and have a firm grasp of what's in place and what's needed.

And Finally…

It is an honour to join the NPT locality team. I have already met with several of our primary care contractors and am working very closely with the Community and nursing team to ensure that all the necessary links are made; plugging gaps and supporting the contracted professions and Health Board staff in progressing a range of initiatives that will help improve local health services on an integrated network basis.

ABMU Implements Welsh Government Measures

Improving Mental Health Services

The Mental Health (Wales) Measure 2010 is a piece of law made by the National Assembly for Wales and it has similar legal status to an Act of Parliament. The Measure introduces a number of important changes to the current legislative arrangements in respect of the assessment and treatment of people with mental health problems and is being implemented in stages throughout this year. The legislative requirements come in 4 parts.

Part 4 was the first to come into force in April and consisted of the extension of Independent Mental Health Advocacy to ensure that advocacy is available to all patients receiving inpatient care for mental health problems.

Parts 2 and 3 came into operation on 6th June. Part 2 of the Measure places statutory duties on LHBs and Local Authorities in Wales to provide care and treatment plans for service users of all ages who have been assessed as needing secondary mental health services. Part 3 of the Measure enables individuals who have been discharged from secondary mental health services to refer themselves directly back to these services, without needing to first go to their GP, if they believe that their mental health is deteriorating.

The Measure's final provision is for the development of Local Primary Mental Health Support Services (Part 1), which will be operational from 1st October 2012.

Alison Davies, ABMU's Part 1 Implementation Lead has attended Community Network meetings in Neath Port Talbot to brief members on progress within ABMU. The requirement of a scheme for the implementation of Part 1 has been developed and agreed with Partner agencies in health and social care. The next stage is to set out the resources that are being committed and the partnership arrangements in place to monitor the service.

Further information on the Measure can be found at

http://www.wales.nhs.uk/sitesplus/863/page/60790

By Alison Davies - Part 1 Implementation Lead, ABMU Health Board.

Meeting the Information needs of Carers

ABM Health Board and staff are to lead the way in empowering carers. It is estimated there are over 340,000 carers in Wales with over 11,000 of these being children.

A carer is someone who provides a considerable amount of unpaid care on a regular basis to a family member, friend, neighbour or partner because of age, ill health or disability.

Carers play a very important role in supporting health services by caring for individuals who would otherwise need to be cared for by local health and social services.

In 2010 the Welsh Government passed the Carers Strategies (Wales) Measure 2010. This measure acknowledges the important role of carers and their right to information and to be consulted.

The strategy will include how the health board and staff will ensure carers:

- are identified;
- have access to relevant and up to date information;
- are informed of their rights;
- are signposted to appropriate services;
- young and old are identified as distinct groups.

For more information visit http://www.wales.nhs.uk/sitesplus/863/page/52091

Marie Amanoritsewor—Planning Support Manager

Closing the Gap

Beyond The Lung is a two-day Royal College of Nursing (RCN) accredited course for nurses involved in the assessment and management of persons diagnosed with COPD.

NPT Locality organised the disease-based training programme in collaboration with Astrazeneca UK Limited and opened up the opportunity to all those involved in managing patients with chronic respiratory disease; attendees on the two day course included pharmacy and physiotherapy colleagues as well as nurses from primary care, secondary care and community services.

A vibrant energy was evident in the room as participants gathered for their second day in anticipation of their renowned speaker, Tracy Kirk, winner of the highly prestigious British Journal of Nursing, Nurse of the Year Award.

Pictured: Course participants; speaker Tracy Kirk; and organisers Astrazeneca UK Limited.

As well as the obvious educational benefits of the programme an additional and intentional aim was to enable a clear understanding of how individual roles coalesce with those of other healthcare professionals caring for the same patients.

This opportunity for integration was summed up by Nicola Sullivan, Sister in the Medical Assessment Unit at NPT Hospital who said *"it's nice to see the different perspectives of practice nurses who are involved in dealing with the same patients as me and to be able to appreciate other's boundaries and restraints."* Practice Nurses, such as Adele Jones of Morrison Road GP Practice, Afan Community Network, welcomed the opportunity to share experiences with colleagues from other practices and Respiratory Specialist Nurse Practitioner, Moira Bell agreed that the course has improved collaboration and therefore the quality of care *"...closing the gap between primary and secondary care in our Locality."*

By Krysia Groves, Afan Network Planning lead

YouTellUs™

YouTellUs is a new and very exciting way for you to tell us what you think about the public services you receive and play a part in improving them for the future. It's open, honest, easy to use and available to all.

ABMU has started a 'Changing for the Better' programme and YouTellUs will be helping us by getting your views on our plans, our services and, if you are a patient, how your health has been affected by the care we provide. Don't worry if you are not a patient! YouTellUs still want you to take part. Your views are just as important and we still want you to tell us things!

To find out more log on to www.youtellus.org

Please let us have your views about the newsletter. If you have any comments or suggestions for improvement or would like to submit an article, we would love to hear from you.

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