

# Modernising the Community Nursing workforce

## A whole systems approach

### A programme of refreshment for community nursing staff

#### A little about us

The Jurassic coast in Dorset is a great place to live for patients and staff. Many people migrate or retire to Bournemouth and Poole and enjoy a good quality of life. However in time some are widowed and there are high numbers of lone pensioners.

Perceived by many as an affluent area, housing costs are high and there are pockets of acute deprivation, where families struggle to make ends meet. There are many students in the area and the attractions of the nightlife of Bournemouth result in drug and alcohol problems

Bournemouth and Poole PCT has recently formed under Commissioning a Patient Led NHS from the former Bournemouth Teaching PCT and Poole PCT.

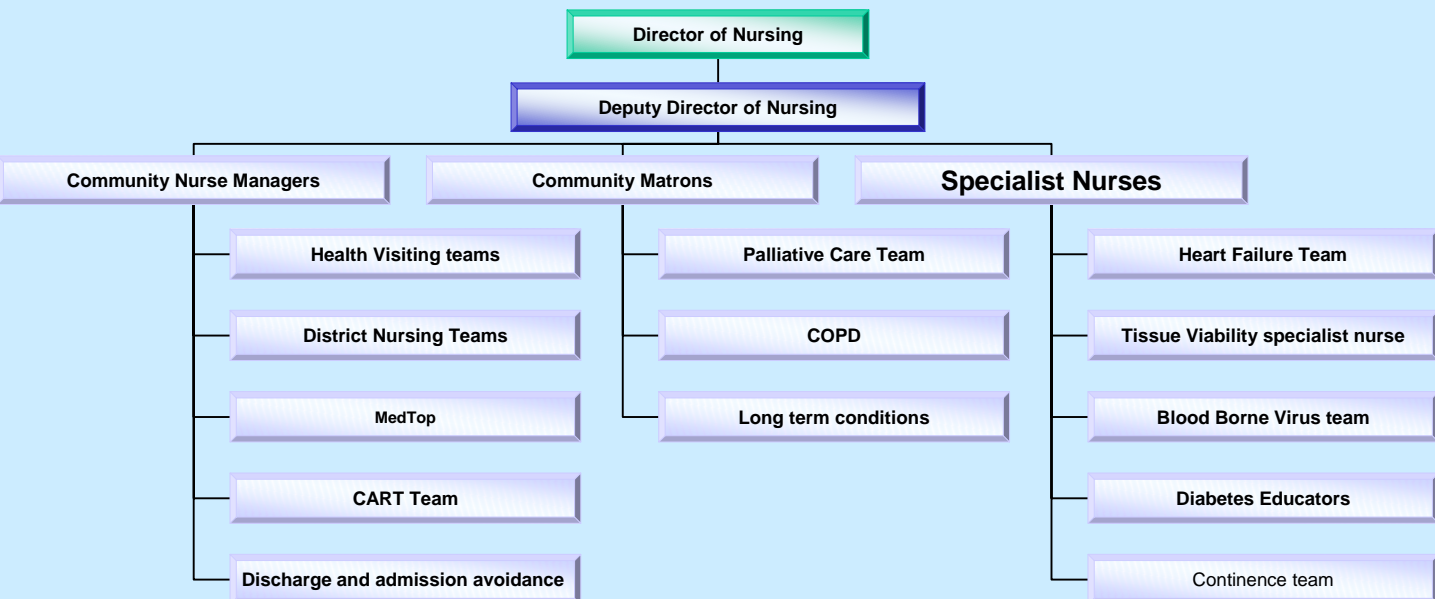


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#### A stable workforce

We are an energetic organisation with which has developed many innovative services. The loyalty of our staff is very important to us. As a Teaching PCT we are very conscious of the need to support workforce development to ensure patients receive modern treatment from highly skilled staff. This view has underpinned our modernisation programme which has swept through community nursing over the past 4 years as a Teaching PCT. We believe that changes in Community nursing teams have encouraged people to develop their full potential. We have aimed to optimise individual and team contributions to individually focussed care.



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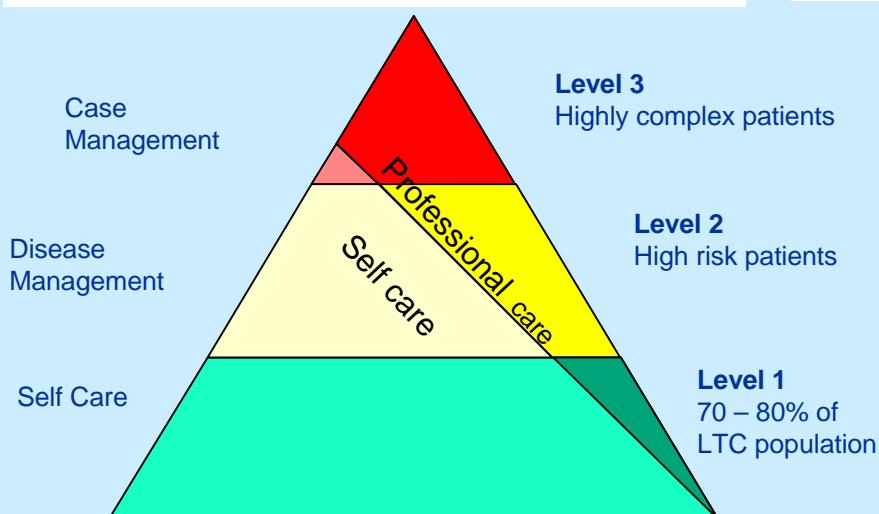
### Chronic Disease Management Strategy

#### Managing Long Term Conditions

Helping people with long-term conditions is approached by the Primary Care Trust in a **whole systems manner**. Underpinned by the "Choosing Health: Making Healthy Choices Easier" we are building support for people with long-term conditions to make healthier choices about diet, physical activity and lifestyle. Cultural change is required to work differently, with greater efficiency in services that are more responsive to patient requirements

#### Bournemouth HealthLink

Provides a single point of contact to help local people to become more physically active, stop smoking or lose weight to improve their health and quality of life. Bournemouth HealthLink is a partnership initiative between Bournemouth Teaching Primary Care Trust, Bournemouth Borough Council and Bournemouth University.



#### Local Targets

- To reduce by a total of 17,056 bed days by 2008 (equates to approximately 50 beds)
- 9 Community Matrons in Bournemouth by 2007
- Reduce delayed transfers of care to 1%

#### Expert Patients Programme

The Lay lead self management programme for all people living with long term conditions is considered integral to treatment

Expert Patient Programmes are running regularly across the locality. A single point of access for self referral is available. All EPP Tutors have attended a course and completed the national training programme



Winner at the Teaching PCT's Annual Awards ceremony, Expert patient Tutor Lesley Burton

#### Optimal Self Care

The Clinical leadership for self Care project aimed to develop clinical leadership that would champion the benefits of self care. A programme of training for professionals in the use of the clinicians handbook is being rolled out across Dorset and Somerset. The key benefit is a proactive approach to self care for Long Term Conditions. The "Promoting Optimal Self Care" handbook is available on the DOH Long Term Conditions website



#### Community Matrons

They are nurses who are case managers for patients with complex conditions and high intensity needs. Their role has been developed within Bournemouth Teaching PCT, collaborating with the acute hospital and Bournemouth University and the model rolled out across Dorset and Somerset

They provide case management that is user/carer led, maximises choice and improves quality of life for patients.

The Community Matron provides high level skills to assess physical, social and psychological needs, co-ordinate, manage and evaluate the package of care.

Community Matrons have the authority to mobilise services, refer and order investigations.

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### Intermediate Care

#### New Developments for Autumn/Winter 06

Intermediate Care in Bournemouth has the exciting commitment to expand The Community Assessment and Rehabilitation Team (C.A.R.T.) is a joint initiative between the PCT, Social Services and Acute sector, to provide rapid assessment and short term care within peoples homes to reduce hospitalisation. The team is due to expand services to provide the prevention of inappropriate admissions, or rapid response to all five localities which should have a direct influence on the number hospital admissions that our older people have had to endure. The team is very keen to undertake this development because so many of our patients much prefer to stay at home. We shall be working closely also with the A&E department at RBH and the out of hours service to include accepting new patients at week-ends.



*The Integrated Discharge & Admission Avoidance team ensure patients are discharged in a safe and timely way*

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### Specialist Services

#### Blood Borne Virus Project

Hepatitis C will be a major national health issue in future with intravenous drug users most at risk. The Blood borne virus MOT team is made up of two Health Advisors, Liver nurse specialist and the GUM (Genito-urinary medicine) nurse. They visit drop-in centres to offer advice, testing and vaccines to help prevent syphilis for working girls and Hepatitis A, B and C. Around 70% of those tested have been found to be Hepatitis C positive and have been followed up with help to get treatment.

#### Palliative Care

The Community Palliative Care Team has been operating since February 2004. The Team is made up of various health professionals - a multi-disciplinary team – consisting of a Community Matron, nurses, a number of health care assistants and an OT. They provide extra support to adult patients who suffer from cancer or non-cancer life-limiting illnesses. There has been significant expansion recently and it is now possible to avoid 300 - 400 hospital deaths per year and enable a good death and patients to choose to die at home

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*Blood Borne Virus Project lead Trevor Kelly*



#### Continenence Service

The East Dorset Continenence Advisory Service is held nationally as a model service. It was one of the first continence services in the country to appoint a director of continence services. The service aims to make the best use of its specialist nurses by focusing on education, assessment and treatment rather than just containment. Where products are necessary, the aim is to provide good quality products within the resources available. The continence service helps to keep people out of hospital by helping them to remain living at home. The service has 3000 clients and receives over 600 calls a month

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### Developing Clinical Skills

Audits of clinical skills across primary care and community nursing has resulted in the implementation of a graded skills training programmes based on Skills for Health competency frameworks in Long Term Conditions



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### Tissue Viability

The Nurse-led Leg Ulcer Clinic has been set up as a teaching service within the PCT to enable staff to learn from the highly qualified Tissue Viability Specialist Nurse and Lecturer Practitioner. Val Douglas recently achieved her MSc in tissue viability at Hertfordshire University and passed with distinction, winning a university award for outstanding achievement.



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### Fit for Purpose Roles

#### Accelerated development in Primary Care

Developing the role of Health Care assistants as assistant practitioners in Chronic Disease Management has released the time of qualified staff. The structured training programme was initially completed with HCAs in GP practices and then rolled out to all Community HCAs. They are now equipped to undertake a wide range of clinical tasks.



*Judy has trained our HCAs in a range of clinical skills*

#### A week in the life of the Assistant Practitioner in CDM

- Assists GP in the Diabetic and COPD clinic
- Runs Blood Pressure and Cardiac clinics alternating with senior nurse. This has replaced qualified nursing hours.
- Involved in the prevention and promotion of health and referring to local support services.
- Assists with the running of the lifestyle groups.
- Carer's nurse lead for the surgery and Co-facilitator for local Carer's group
- NVQ 3 and Competencies complete
- Future plans: To assist with the management of chronic disease in the community and practice nursing teams.



*Our staff need to be competent to help patients with long term conditions*

### COPD Community Matron

The Pulmonary Rehabilitation Programme started in November 2004. This course is run by the Primary Care Specialist COPD Nurse and is for people who have mild to moderate lung conditions. It runs over 7 weeks with a 2 hour session each week where 1 hour is dedicated to exercising and 1 hour to education. It is a planned programme that improves exercise tolerance, decreases breathlessness and provides further knowledge about the condition. People undertaking the course have a choice of 2 venues, either the Littledown Centre or the West Howe Community Centre. The courses have proved to be extremely popular and they will continue to run regularly as a part of the Chronic Disease Management Programme.

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