Torbay and Southern Devon NHS
Health and Care
NHS Trust

The Preventative Community Project /Community Hub

A revised delivery model:

The revised delivery model is a staged approach to delivering the original vision.

Stage one the six month pilot from 18/2/13 to 31/8/13

The 0 to 19 health team consist of Health Visitors, School Nurses, Public Health Staff Nurses, Community Nursery Nurses, Health Visitor Assistant, Student SCPHN and Life Style Workers.

Other practitioners that work in the Hele & Watcombe area have linked with the health team these have included, Midwives, Police Officers, PCSO's, Street wardens, Sanctuary Housing staff and Action for Children, Children Centres staff. Two workshops have been run on the 21st January and the 12th February to facilitate joined up working including a session facilitated by Helen Thorn on information sharing across agencies.

There are other professionals and agencies that work in Hele and Watcombe that will also be involved in the project.

The 0 to 19 health team remain GP and school attached with an additional responsibility for the geographical areas of Hele & Watcombe.

The health team is based on two sites Barton Health Centre and Union House 4th floor this is an interim arrangement while additional space at Barton Health Centre or a more suitable site can be located. All clinical work will be undertaken at Barton Health Centre or other community venues in Hele and Watcombe. Other professionals and partner agencies are not collocated with the Health team.

A health visitor coordinator has been identified, Donna Harding who will link with the local community and partner agencies that work in the Hele and Watcombe area. The coordinator will attend the Hele and Watcombe tasking group that currently runs monthly at the Hele Angels centre and link with both the Hele and Watcombe Community Partnerships and the wider voluntary sector.

The coordinator role is supported by a Senior Lifestyles worker Trudi May helping the team make links with Hele and Watcombe communities.

The coordinator will bring the information back to the health teams weekly meeting to discuss and consider actions to address health issue's identified by the local community.

A joined up approach to issues identified by the local community will be addressed across agencies in partnership with the community. This will be taken to the project's steering group who consist of a lead for each partner agency and the two Community Partnership's for further discussion and planning

If a family is highlighted as requiring an early intervention then the coordinator will liaise with the named practitioner for that family. Level 1 support will be coordinated by the named practitioner and a referral will be made to the Safeguarding HUB if the threshold criteria reach level 2 or 3 as described in the Child's Journey.

Stage Two

A positive evaluation and option appraisal may result in this service model being rolled out across the Specialist Community Public Health Nursing Teams in Torbay.

The 16 Community Partnerships' in Torbay would be aligned to a 0 to 19 Specialist Community Public Health Nursing Teams. A best fit model would be developed for each team with Community Partnership's, GP practices and local schools.

Each team would have a different level of resource dependant on need positively discriminating towards deprived areas. The Health Visitor caseloads will be weighted according to the Sarah Cowley Model. Ref 1

An option for the delivery of Stage two could consist of a step approach choosing an additional Community Partnership, instead of a complete roll out across the Trust. This would fit with the Health Visitor 2015 proposed increase in Health Visitors; the proposed increase is staged at several points in the year up to 2015. Currently the majority of new Health Visitors are recruited following completion of the SCPHN training in September and February of each year.

Stage Three

The Specialist Community Public Health Nursing 0 to 19 team would deliver a service to a defined geographical area. Each team would already have an identified Community Partnership Area they have been responsible for and begun working with local partners and community groups. The SCPHN 0 to19 team would have gained knowledge obtained from stage 2 that would inform the formation of new geographical caseloads.

References

- Cowley S and Bidmead C, *Controversial Questions (Part One): What is the Right Size for a Health Visiting Caseload?*, Community Practitioner, 2009; 82 (6): 18-22

Objectives and outcome measures for the Preventative Community Project (Community HUB)

1. **To pilot a preventative (early intervention) community team in the geographical areas of Hele and Watcombe Torbay.**
   a. **Integrating and amalgamating Health Visitors, School Nurses, Midwives and Lifestyle Workers into the local community and community services (piloting the delivery of health services from community venues, such as the Acorn Centre and the Watcombe Community Centre,)**
   b. **Agreeing the focus, functions and common systems of the Community Hub team.**
   c. **Develop the staff and pilot new ways of working, to accommodate the needs of the pilot service and service user.**
   d. **The team will develop a "record log" to capture a variety of change aspects during the pilot, such as change in ways of working, issues and risk identified/encountered and attempting to capture the community spirit. This should be completed periodically (weekly) and owned / governed by the team coordinator and presented to the steering group.**

2. **To pilot a service model to deliver a community capacity building approach, in partnership with the Hele and Watcombe communities and other agencies to;**
   a. **Improve the health outcomes to children and young people**
   b. **Identify the needs of the community in relation to current gaps in service delivery and identify a system / process/ service to address that need (e.g. School Nurses could identify girls in the local community who did not have their HPV vaccine and there for run a local catch up campaign to eliminate this gap)**
   c. **Build on community strengths, capacity and relationships. To further develop opportunities for volunteers in the service provision.**
   d. **Investigate the potential to reduce the duplication in service delivery (e.g. the Health Visitors working with early years education at the 2 year review and the HV 2.5 review) to deliver a lean, integrated services with partners.**
   e. **Use closer relationships with partners to identify early when families need support providing support at level 1 under the Child's Journey - therefore building on an early intervention, prevention strategy. Capturing good practice in case studies across agencies.**

f. **The identification of adult and young carers and sign posting to appropriate support networks.**

3. **To build on existing relationships with the community and community groups e.g. Hele Angel and the Chairs of both the Hele and Watcombe Community Partnerships other community groups and individuals.**
   a. **To research the current Community Partnership leads and other community leaders**
   b. **Develop a way of working with these groups over the lifetime of the pilot**
   c. **To work in partnership with the community groups to identify health need within the community, so inform service delivery.**

4. **To pilot and review the development of a 0 to 19 team in health, through integrated working with Health visitors and School Nurses in the pilot Hub.**
   a. **Perform a team (HV, SN, Midwives and partner's) S.W.O.T analysis prior to pilot initiation based on this objective (this will aid with the final pilot report and also provide a comparator for the final team (HV, SN, Midwives & partner's) S.W.O.T analysis.**
   b. **Pilot the removal of boundaries between Health visiting and School Nursing.**
   c. **Identify and pilot new opportunities to deliver Public Health Agendas together.**
   d. **Develop a communication strategy for the community to build closer relationships and help with the development of an awareness of all services provision with the Hele and Watcombe areas.**
   e. **To pilot the Band 5's Public health Staff Nurse working across both Health Visiting and School Nursing.**
   f. **Perform a final S.W.O.T analysis (HV, SN, Midwives & all partner's) including outcomes achieved) from this objective and compare with the initial S.W.O.T analysis created at the start of the pilot.**
   g. **Deliver a report / option appraisal in the 0 – 19 initiative.**

5. **To deliver a final project appraisal report, evaluating the pilot and making recommendations for the potential Bay wide roll out of the model. This report will include an Option Appraisal, to inform the future development of the service.**

Christine Timmon
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19/03/13