ScotPHN Health & Housing

Title of project/initiative	Community Health & Well Being Team
Contact for project • Name, email, telephone • Website of project, if available	Chris Lamont – Head of Nursing – Health Improvement and Health Inequalities Tel. -01738564202 e-mail – c.lamont@nhs.net
Which organisations are involved? • Planning/monitoring/delivery • Partners • Sponsors • Funders – how funded?	NHS Tayside Perth and Kinross Health and Social Care Partnership The team works closely with partner agencies including Local Authority, 3rd Sector and Voluntary Organisations. Clinical staff are fully, permanently funded from NHS Tayside, whilst the Project Support Workers are equally funded from NHS Tayside and Perth and Kinross Council.
Brief description of project • Rationale • Aims and objectives • Key activities • Target population • Geographical area • Start (± finish) dates	The team comprises of 2 elements; The Nurse Led service which focuses on early intervention as well as direct clinical input to individuals who require health support. The Project Support Workers who work within a Healthy Communities Collaborative remit and offer support to communities to self-manage their issues as well as support engagement into other services. The service covers the entire area of Perth and Kinross and targets individuals who are deemed the most deprived (Quintiles 1&2). This includes Homeless, Gypsy Travellers, Hard to reach, those within the criminal justice system and Refugees. The service runs Mon – Fri (8.30am 'til 4.30pm) A core element of the service is to promote early interventions and try to get these individuals engaged with mainstream services to prevent a deterioration in their well-being and possible development of Long term conditions.
Resources • Staffing • Time • Financial	The team has a funded establishment of 8.32 wte staff although there are 2vacancies within the team at present. This comprises of 5.4 clinical staff and 2.92 support workers. The team is permanently funded with an Annual budget of £288,298
Evaluation and outcomes • Reach • Impact	Historically the two elements of the service worked in isolation with a very specific remit for each. The nursing service, formally known as Central Healthcare, targeted homeless individuals or those at risk of being homeless. The Healthy Communties Collaborative worked predominantly with older people and concentrated on areas around social isolation, falls prevention etc. In March 2016 the decision was made to amalgamate the 2 teams and re brand the service as the Community Health and Wellbeing Team. This was to enhance the services role, particularly with integration being

	driven on a national level but also to target a wider demographic population due to service need. On average the service is dealing with around 500 individuals each year but it is identified that there is a significantly greater population who need to be targeted across the geographical area
Reflections on project • What was successful? • What was challenging? • What would be done differently in future?	As already highlighted the team in its current status has been in existence since March 2016, although both elements of the service have been functioning since 2003-4. The greatest 2 challenges are identification of the relevant clients. This has proved challenging due to the team being heavily reliant upon referrals through word of mouth. There is also the issue of trying to encourage mainstream services e.g CMHT's, District Nursing, Health Visiting, adult Social Work to engage with this client group and not viewing them as another services role. As outlined in the National Health and Wellbeing Outcomes 'Health and social care services contribute to reducing health Inequalities' and this should be a key element of all service, not just one service.
Next steps • What is the future of this initiative?	The team is in the process of being divided into identified geographical localities. This is in line with Perth and Kinross's Locality plan for teams. The team members are also becoming increasingly involved with individuals with Substance Misuse issues as it is identified that this is an area that envelopes many Health and social care issues.
Wider application • Is this project scalable? • Is it transferable to other areas/contexts?	I think that this service is something which could be replicated in other areas
Any further information • Reports or publications • Other reflections	Article published through the RCN in 2014 – ' Nursing at the Edge' report highlighting the work being undertaken collaboratively around women in the Criminal Justice Service which the service was involved in.  SCO-POL-Nursing-at-the-Edge-Case-Study
Person completing pro-forma	Chris Lamont
Date of completion	06/10/2016

Pro-forma for gathering information on case studies