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NHS Trust

Community Division

Medicine for Members -10 July 2019

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Objective of Session

- Show breadth, depth and complexity of Community Division
- Opportunity to meet some of the team
- Share recent progress and success

Divisional Goal

To ensure people receive best practice care at the point of delivery and that no person is admitted to an acute setting unless unavoidable.

- We will achieve this through
  - Continuous improvement of Community Divisional services to enhance the experiences and outcomes for the Island population
  - Implementing creative solutions to allow funding to follow the person to sustain enhanced community services
  - Enhancing the use of technology across the division
  - Focusing on prevention and early intervention, including building people's own resilience and support networks
  - Wrapping services around the person to support their needs
  - Improved partnership working with primary care and voluntary and independent sector partners

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The Community Leadership Team

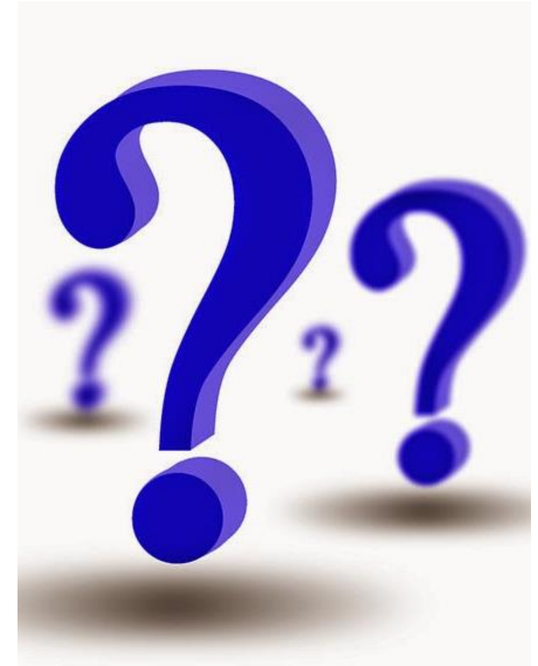
- Alice Webster – Director of AHP's, Community Services, Midwifery & Nursing
- Nicola Longson – Deputy Director of Out Of Hospital Services
- Jennifer Edgington, Emma Pugh, Lucy Abel, Mark Rawlinson, Pieter Joubert, John Mckie, Natasha White – Management Team.

Community Nursing Service (incl. Continence)	Tissue Viability Service	0-19 Service	Sexual Health Service	Regaining Independence Service
Community Clinics	Occupational Therapy	Physiotherapy	Orthotics	Prosthetics
Podiatry	Speech & Language Therapy	Dietetics	Assistive Technology	Multiprofessional Triage Team

Community Division - Facts

COMMUNITY

Quiz



The Community Division

1. What is the % of the Island's population supported in Community at any one time?

A. 2% B. 44% C. 17% D. 25%

This amounts to over 62,000 people

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2. How many Whole Time Equivalent staff members work within Community Services?

A. 200 B. 300 C. 400 D. 500

We have 449 staff; approximately 150 are registered nurses and 120 are registered AHPs

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3. How many Professions/ specialities are there within Community Services?

A. 15 B. 25 C. 40+ D. 30

This covers different professional groups e.g. Dietitian, Health Visitor, District Nurse and specialities such as respiratory PT, acute OT and paediatric SLT

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4. How many hours per day are provided by Community service staff to the acute areas?

A. 112   B. 370   C. 58   D. 199

This includes OT, SLT, Physiotherapy and Dietitians

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5. Scope of partnership working. How many different partnerships do community work with?

A. 25 B. 15 C. 75+ D. 48

This includes services and agencies within health, social care as well as commissioners and voluntary/independent sector

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6. On average how many patient contacts are provided per month by the Division?

A. 3,200 B. 18,500 C. 15,200 D. 6,000

This will be a combination of home visits, outpatient appointments, telephone consultations and will soon include tele-swallowing (swallowing assessment via video link

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7. How long can a patient contact last within Community Services?

A. 5 - 20 minutes

B. 20 - 60 minutes

C. 60 -120 minutes

D. All of the above

Contact times vary per discipline, setting and specialism and clinical need e.g. a community nursing phlebotomy visit may last 20 mins; an OT home visit could last over 2 hours.

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8. How many visits per day does Community Nursing staff make to administer insulin?

A. 35 B. 135 C. 75 D. 110

This figure reflects the remaining patients who require visits following self-care programmes, family supported care or administered by other carer

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9. How many community beds are managed by Health services in the Community?

A. 25 B. 50 C. 62 D. 8

We manage 50 Community Rehabilitation beds within 3 Nursing Homes across the Island

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10. How many patient record systems do Community Services use?

A. 1 B. 11 C. 5 D. 9

For example, Community are currently using: Paris, System One, E care Logic, Patient Centre, Symphony, Adastra, SharePoint, Paper Notes - Over 60% of our services are still using paper records

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11. John is 58 years old, has a spinal injury at C1 making him paralysed from the neck down. He is ventilated, has a catheter and requires bowel management several times a week. He requires all personal care and has 2 x carers 24 hours a day. He needs support to maintain his airway and oxygen saturation levels. This gentleman lives at home. How many emergency hospital attendances and/ or admissions has he had over the last 5 years?

A. 17 B. 128 C. 0 D. 3

Where do we deliver services?

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- Technology-Enabled Care
- Sexual Health Service
- Orthotics & Prosthetics
- 0-19
- Community Clinics
- Podiatry
- Occupational Therapy
- Physiotherapy
- Community Rehab
- Speech & Language Therapy
- Dietetics
- Crisis Response
- Community Nursing

Where do we deliver services?

NHS Isle of Wight NHS Trust

Technology-Enabled Care
Sexual Health Service
Orthotics & Prosthetics
0-19
Community Clinics
Podiatry
Occupational Therapy
Physiotherapy
Community Rehab
Speech & Language Therapy
Dietetics
Crisis Response
Community Nursing

- Community Nursing
- Continence Service
- TEC
- Memory Service
- Community Respiratory
- Physiotherapy
- RACR

Mavis

- Podiatry
- Orthotics & Prosthetics
- Dietetics
- Community Rehab
- OT
- Physio
- Nursing
- ILS

Fred

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Sophie

- Sexual Health
- ILS

Mandy

- SLT
- Dietetics
- EMH
- John Cheverton Centre
- Assistive Technology
- Voluntary Sector
- ILS

Dan

- CAMHS
- Children's Therapy
- Scholl Nurse
- MSK Physiotherapy

Esme

- Health Visiting
- 0 – 19 Services
- Dietetics
- Children's Therapies
- ILS

Who do we support?

Impact so far….

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- Integrated Localities supported 336 people in 2018-2019; 1-2 new community connections made for each person referred
- Diabetes amputation rates 5.8 per 10,000,compared to national average of 8.2. We have consistently had the lowest major amputation rates of our neighbouring 9 Wessex areas over a number of years
- 62% of staff seen by Physio in Occupational Health believe having physiotherapy prevented them from going off sick. This scheme has the potential to save the equivalent of £216K sick days a year

Impact so far….

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- TEC support is now live in 14 care homes across the Island (an additional 10 live within the next few months)
- Regaining Independence Service created – Integrating the NHS Community Rehab Team and Local Authority Reablement team with a Single Point of Access.
- Piloting musculoskeletal first point of contact in 5 GP surgeries. Patients see an advanced Physio Practitioner instead of a GP
- Dietetic first point of contact appointments for babies with cows milk allergy.

Next Steps

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- Further refine Community Divisional Leadership Team and Divisional Governance Structures
- Focus on technology
- Implement Strategy for Community Division
- Clearly understand demand to enable capacity review
- Drive integration with Primary Care through Primary Care Networks
- Drive forward prevention and early intervention work including Localities

Questions?