IMPACT OF INTEGRATED CARE COMMUNITIES ON ACUTE SETTINGS IN SOUTH CUMBRIA

October 2020

Summary

The original definition of Integrated Care Communities (ICCs) has served the developing system within Morecambe Bay well. ICCs continue to provide local focal points for place-based partnership collaboration and are a delivery vehicle for holistic integrated care delivered by a range of providers including voluntary sector and primary care.

The further development of Primary Care Networks (PCNs) is shaping the landscape in which integrated working is developing. With this in mind, the definition defined in 2016 stands as ***'Integrated Care Communities are integrated teams of health and care workers, voluntary organisations and wider community assets who work together to practice population health with a mobilised population'.***

There are now 8 Integrated Care Communities in Morecambe Bay reflecting the geography and natural communities in existence of which 6 are within South Cumbria. In the first instance these are co-terminus with the county boundaries in which those General Practices operate. These are not unchanging and may alter to reflect local changes in communities and also have sub-communities within them.

Knowledge of their local population health profiles is now well embedded into ICC thinking and behaviours. There are now also the relevant skills in the workforce **changing interactions from being illness focussed to promoting wellness, self-directed care and self-management.**

Relationships with Urgent Care

In Morecambe Bay, ICCs have a key relationship with but are separate from Urgent Care Services. A key priority for the Morecambe Bay Health and Care Partners is to transform the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting.

This is being addressed in a number of key areas, each supported by a series of initiatives, with ICCs playing a crucial role in many of these supporting an appropriate response across the spectrum of urgent care:

Out of hospital urgent care – e.g., through supporting a 'pull approach' by supporting the active management of patients with robust care plans at the front to prevent A&E attendance and admissions by ensuring urgent response pathways are utilised appropriately to prevent decisions to admit; and through supporting the discharges of more complex conditions into the community from hospital.

Pre hospital urgent care – with access to nurses, therapists, mental health specialists, social care professionals and social prescribers, ICCs are supporting "front door" and community crisis teams and by signposting and finding alternative care, where needed, in the community.

Hospital care - flow – ICCs are supporting the delivery of high quality Reablement care through their relationships with County Councils to reduce the dependence of patients upon ongoing care and in many cases eliminate the need for support after the first few weeks of discharge, particularly when a less intensive level of care is agreed.

Developing a fully functional co-ordination offer - The roll out of the Integrated Care Allocation Team (ICAT) in Lancashire has shown benefits and a need to develop same in South Cumbria supporting timely discharges via Discharge to Assess, avoiding unnecessary hospital admissions with a focus on a range of intermediate health and care interventions to maintain the person at home.

The remaining intention is that **ICCs are protected from 'hot' work** to enable them to focus on their core business of timely intervention for anticipated need, proactive care planning and practice informed by population health which will pay dividends in the longer term.

Risk Stratification and Care Planning

Frailty as a syndrome is well recognised and continues to be a target area for the work of ICCs. Holistic Care Plans generated by ICC staff are now visible not just in community settings but also in Lorenzo by hospital staff to inform care in that setting.

Children and Young People (CYP)

All ICCs are now sighted to the health needs of its children and young people (CYP) having examined the local health profile and data illustrating use of a range of services including secondary care. All have built their relationships with a range of key local providers.

Initiatives that have been successful in the first instance include the roll out of Mindfulness Training in primary and secondary schools in Grange & Lakes ICC, IMatter project in Kendal, focussed project on supporting CYP with health needs preparing for adulthood including transition of care to adult services and Children's MDT meetings happening in a number of ICCs.

Moving into 2020-21, all ICCs will be working more closely with their Link Paediatricians. This will be exploratory in the first instance and not prescribed. However, the broad expectation is that we build on the successful work that has already been undertaken by:

- Link Paediatricians supporting ICCs to clarify their priorities for CYP; Supporting MDTs, Providing educational session at ICC PLT, work on a specific issue, e.g. respiratory or obesity
- Examining the work done through the 'Empowering Families' project in Morecambe and consider the feasibility of this being rolled out in other ICC areas including an exploration of new work roles to deliver this.

ICC Relationship with Primary Care Networks

The NHS Long Term Plan set out the ambition to actively encourage every GP practice to be part of a local Primary Care Network (PCN). The development of PCNs recognises that many people are living with long term conditions such as diabetes and heart disease, or suffer with mental health issues and may need to access their local health services more often.

In South Cumbria, with the exception of East ICC, PCNs are coterminous with ICCs. Clinical Directors have been appointed; in some instances ICC Leads have added this to their portfolio; in others, the roles are separate.

Key Roles

Each ICC has an allocation of Clinical Leadership and a Development lead. These roles have further developed this year. Now that PCNs have become established, each one has appointed a Clinical Director and we see the partnership between these 2 roles being crucial to the delivery of their respective objectives that include.

- Development of a clear annual plan for the ICC including targets for achievement on the core functions of an ICC as well as local innovations and initiatives
- Monitoring targets and reporting performance that is visible in the system. This includes the use of new **'non-traditional' measures to reflect wellbeing**, independence and high functioning teams.
- Achievement of their goals and reflecting on performance, learning and continuously looking for ways of improving
- Reporting on activity and performance, participating in a wider review of the system and supporting new Bay wide initiatives to develop and embed these in their local areas
- Understanding of the resources at their disposal and the key features of the local population they serve
- Supporting engagement activity with the local community

As a Bay wide team, the ICC Development Leads then ensure that the ICCs reflect and contribute to the local priorities for health and social care**, focusing on population health, self-care and self-management and early detection and prevention.**

Governance

The governance arrangements for ICCs continue with two ICC Oversight Groups, one each in Lancashire and South Cumbria. The frequency of these meetings has reduced to bi-monthly with two 'all ICC' events per year. The Oversight groups report to the Integrated Services Management Board for Bay Health & Care Partners

ICCs continued objectives:

- Take a Population Health Management approach, using research and evidence to improve outcomes of care through:
    - Risk Stratification and targeted assessment & interventions
    - Anticipatory Care Planning & Personalised Care approaches to health and wellbeing
    - The promotion of self-care

- Demonstrate the quality of services and standardise the most effective pathways of care through
    - Multidisciplinary team working
    - Use appropriate data to measure and monitor performance

- Sustain and embed quality improvement methods to enhance patient outcomes through
    - Recruiting, developing, maintaining, and supporting a quality proficient workforce
    - Ensuring sufficient technical resources and building a culture that supports improvement.

Central to these objectives are:

Multi-disciplinary Team meetings

Multidisciplinary Team meetings (MDTs) are now well established in ICCs. These have developed in each to reflect areas of need; MDTs for frailty, mental health and children and young people are in place in ICCs. In 2020-22 we will work to introduce Mental Health and Children's MDTs on a practical basis and evaluate these on a number of counts including the impact on patient care (improved self-care, reduction of inappropriate use of services) and how they serve to improve the function and integration of the teams themselves. We will also work to support MDTs for people with diabetes to ensure that diagnosis and glycaemic control are optimised, that referrals to secondary care are avoided, that HbA1c targets are met and that the risk of hypoglycaemia is reduced. Work in this area has potential to reduce unnecessary clinical appointments in general practice, out-patient/other hospital activity.

Community Engagement

Building a culture of partnership with patients, people and communities is vital to the success of ICCs and PCNs. ICCs have made community engagement a key element from the very beginning as they embarked on a shared vision to building their understanding of their population's health needs and co-designing personalised care.

ICCs are well integrated with local partners and active participants in local events where there is the opportunity to promote key messages, undertake opportunistic screening and signposting and support a variety of engagement models for all people at all stages of their health and well-being "career". Examples include:

Engagement Model	People who are generally well or with good wellbeing	People who have Long Term conditions (LTC) and or Social Needs	People with complex LTC(s)/ social needs and/or disability
Children and young people	Working with schools and youth organisations, 100 mile challenge, Empowering Families	Drug and alcohol workers, drop-in sessions in school holidays, volunteering opportunities,	Furness Parent Carers, North Directions Website,
Working age adults	Primary care navigation roles, social prescribing, targeted interventions e.g., weight control, health fairs, farmers markets	Health and nutrition clinics, MDTs, IAPT, Farmers' Markets	Community Centre/ Advocacy Focus /
Older people	Supporting wellness through groups and volunteering	End of life care for diagnoses other than cancer, neuro rehab, MBRN, working with councils to support the provision of social care	Care home teams, South Lakes Dementia Hub

Self-Care

Health Coach training has been delivered to key individuals service teams. Over 100 staff had opportunity to undergo this 2 day training. We will roll this out to partner agencies and schools over the next three years to increase community activation and self-care as measured by the PAMS

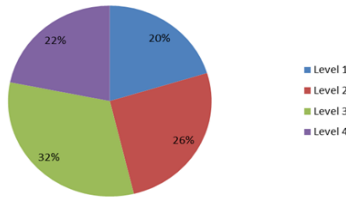
(Patient Activation Measurement Tool). Results to date show positive outcomes

Patient Activation Measures (2019-20)

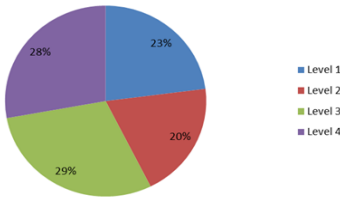
Team	Assessment	Level 1	Level 2	Level 3	Level 4	Total
S Cumbria GP Practices	1st	64	82	101	69	316
N Lancs GP Practices	1st	26	17	31	81	155
UHMB Community Staff	1st	119	224	153	70	566
Total		**209**	**323**	**285**	**220**	**1037**
S Cumbria GP Practices	Repeat	14	12	18	17	61
N Lancs GP Practices	Repeat	7	4	1	2	14
UHMB Community Staff	Repeat	27	55	76	46	204
Total		**48**	**71**	**95**	**65**	**279**

In the context of the Personalised Care Programme aiming to support people of all ages and their carers to manage their physical and mental health and wellbeing, it is recognised that people who have the knowledge, confidence and skills to manage their own health tend to have better health outcomes than those who have a more passive approach. PAMs measure this– whilst the number of re-evaluated patients is small, the proportion of patients reporting higher levels of activation on re-assessment is increasing.

Levels of patient activation at first assessment



Levels of patient activation at repeat assessment



Integration with Local Authorities

ICC Leads have developed working relationships with local authorities, ASC and Public Health identifying key priorities that the ICC can directly support:

- Improved identification, recognition and assessment of carers
- Increased use of assistive technologies as part of a strengths based approach
- Increased identification (and support) for people who are likely to fall
- Developing integrated preventative and community based mental health and well-being
- Supporting a population health approach to service planning

There is agreement that Councils will provide and Morecambe Bay Health Care Informatics (MBHCI) will receive data relating to Reablement and Carers and that these will be incorporated in to a new performance report. Targets for increases will be set per ICC as part of this.

Reablement Service Cumbria County Council Number of Assessments Completed - Qtr 4 2019/2020 Route of Access

	Barrow & Millom (Barrow Only)	Barrow and Millom (Millom Only)	Central Lakes & Grange ICC	East Lakes ICC	Kendal ICC	Ulverston, Dalton & Askam ICC	Grand Total
January	50	9	34	14	27	19	153
Community	46	5	24	10	19	16	120
Community Bed	1						1
Hospital	3	3	10	4	6	3	29
Not Recorded		1			2		3
February	33	14	30	15	24	24	140
Community	27	6	18	10	20	22	103
Hospital	3	6	10	5	2	2	28
Not Recorded	3	2	2		2		9
March	47	17	34	22	35	24	179
Community	33	14	29	15	24	18	133
Community Bed	3				1		4
Hospital	7	3	3	5	7	3	28
Not Recorded	4		2	2	3	3	14
Grand Total	130	40	98	51	86	67	472

Outcome of Assessment

	Barrow & Millom (Barrow Only)	Barrow and Millom (Millom Only)	Central Lakes & Grange ICC	East Lakes ICC	Kendal ICC	Ulverston, Dalton & Askam ICC	Grand Total
January	50	9	34	14	27	19	153
Reablement Plan	28	4	23	11	23	18	107
Reablement Inapproriate	10	4	9	2	2	1	28
Reablement Refused	12	1	2	1	2		18
February	33	14	30	15	24	24	140
Reablement Plan	22	8	24	12	17	18	101
Reablement Inapproriate	7	5	1	2	6	5	26
Reablement Refused	3		5	1		1	10
Moved/Other Circumstances	1	1			1		3
March	47	17	34	22	35	24	179
Reablement Plan	28	12	19	16	26	17	118
Reablement Inapproriate	9	1	7	5	6	1	29
Reablement Refused	7	2	6		3	3	21
Moved/Other Circumstances	3	2	2	1		3	11
Grand Total	130	40	98	51	86	67	472

Councils indicated that a reduction in Falls is in their plans. We know from work in the Frailty Group that issues relating to falls prevention are complex and we will work with our Public Health colleagues to determine what data we use to set a target.

Patient / Citizen Level Outcomes

We are utilising a brief assessment of wellbeing to reflect improvement of wellbeing in our population. In line with measures in use in our County Council services, we have implemented the use of WEMWBS in projects that run in ICCs to see if this can offer an aggregate view of how ICC work is contributing to citizen wellbeing.

Targets

The Population Health Approach of the South Cumbria ICCs is unlikely to deliver high level reductions in Emergency Frailty Admissions within year; our strategy is a longer term investment into the health of our communities at scale.

A program has been developed which will use the rolling 12 months activity levels to adapt trajectories to each ICC's level of activity (i.e. If a certain GP or ICC practice has 5% of the total Non-Elective Admissions over the last 12 months then that trajectory will be 5% of the monthly trajectory going forward).

This method requires a marked shift in the way in which performance is considered: because of constant population changes, particularly the student population, individual ICC trajectories cannot be fixed in time nor will these trajectories be necessarily linear; rather the overall, Bay-wide change will have to be considered. In addition, trajectories will need to be reconsidered on a quarterly basis in order keep ICC performance relevant within the context of the overall trajectory set by BHCP. This method should maintain a manageable portion of the overall trajectory for each ICC, but will require a step away from a traditional approach to performance management arrangements and a step towards a consideration of improvement.

Subsequently ICCs will then be able to measure the impact of any change and evaluate its worth.

ICC Supporting COVID Protect/COVID Care
Homeless Support

In March 2020, NHS England and Improvement and Public Health England recommended an approach to triaging, assessing and accommodating homeless people. In response to this, multi-disciplinary teams of colleagues from across housing, social care, health, other public sector and voluntary, community, social enterprise and faith sector organisations have worked together in multi-disciplinary and multi-agency teams in South Cumbria.

Our current estimate is that to date **more than 1,472 homeless people have been accommodated** across Lancashire and South Cumbria and **more than 374 health assessments** have taken place.

The response to COVID-19 has seen closer working between ICC/partners in local areas at pace, with excellent examples of effective multi- disciplinary teams working and there is a strong desire to continue to build on this.

Council	**Total number of homeless people accommodated**
Barrow-in-Furness Borough Council	72
Lancaster City Council	95
South Lakeland District Council	29
Overall total number of people accommodated in Morecambe Bay	**196**
Total number of health assessments carried out in Morecambe Bay	**152**

Taking a common approach and sharing learnings has allowed processes and pathways – such as multi-disciplinary teams - to be embedded in a larger number of areas than might otherwise have been achieved, such as **managing to secure speedy discharge for patients with complex multiple needs.** It has helped engage different parts of the health and care system, opening doors to encourage trying something new.

Getting everyone round the online table

From the council point of view, health service colleagues did an excellent job, which only they had the power to do, in pulling together support, initially via weekly meetings that included mental health, social services, hospital, prison services, drug and alcohol agency. It was challenging because many of the problems aired were long-standing; they weren't all solved but the willingness to be honest and face them co-operatively was amazingly good practice

Staying connected

The council worked closely with the police, the voluntary, faith, community and social enterprise sector, health and agencies. In recovery, those connections are still being used. Health/ICC colleagues are working out how to continue to use their connection with the volunteer hubs, lived experience group members are offering to support individuals to the new multi-disciplinary teams, police and health are coming to drop ins organised by council officers for some of the previously homeless people. Relationships are good and everyone involved in supporting homeless people is better able to do their job now than before the COVID-19 crisis.

Housing Needs Officer

Partnership working has come into its own through this work. Although some individuals have not responded, the majority have grasped this opportunity by the horns and they have thrived, making real inroads into a transformation that is seeing them reducing and even coming out of addiction, some have now got relationships with their families for the first time in many years. They look and feel healthier too. Everything possible needs to be done to ensure that the support to these and future vulnerable individuals is there and available if we are to have any hope of breaking the cycle that they find themselves in.

Summary

With their in-depth knowledge of local issues that can lead to health inequalities, partnership's built up over the last 4 years, ICC will continue to gather the evidence to support the developments of "what works well" for sustainable community-led health and well-being.

ICC Case Studies:
Kathy is a frail, elderly lady who lives at home with her husband (main carer). Following a fall at home, she was referred to the ICC Case Manager by GP.

After holistic assessment:

- **Advance care plan** put in place including daily support and respite care
- **Cardiopulmonary resuscitation discussed**: patient opted not to be resuscitated, nurse discussed with GP to complete adequate paperwork
- **Falls assessment completed**: acute cause of fall ruled out, patient agreed to a 'life line' care alarm

- **Occupational therapy referral to adult social care**: chair raisers, struggling with bed transfers, husband lifting patient at times, difficulty holding cutlery- affecting dietary intake and needs assessment for any aids
- **Physiotherapy referral**: Very poor gait, high falls risk requiring assessment for walking aids around the home
- **Review visit**: schedule
- **Main outcome:**
- Home situation for Kathy and husband substantially improved and made more safe
- Hospital admission avoided

Case Study – Mindfulness in Schools

- Grasmere Primary School working with a project called "The Present".
- Builds awareness of their own bodies through what they feel, see and hear both within themselves and around them.
- Difficult at first to close their eyes or be aware of their bodies, but through practice they have begun to enjoy these moments "being there" and not being concerned with others
- The exercises move on to how to focus, choose and connect and what is happening while they are doing these activities and which part of the brain they are using.
- The project is introduced through a story that follows two children. Every two weeks a new part of the brain is discussed and then they do activities that use that part of the brain.
- After each activity, they share experiences and are learning to listen to each other and be patient while waiting. They're learning new words to describe thoughts, feelings and sensations and grow in their own self-awareness and enjoy these activities together.

Our Integrated Care Communities

Name	Grange & Lakes Integrated Care Community
Key description	Grange & Lakes is a mainly rural ICC with a population of 32,562 served by 7 dispersed GP practices and is coterminous with the PCN. There are pockets of deprivation and an increasingly elderly population with 1 in 3 living alone and many accessing multiple services. By 2041 36.91% of the population will be aged 65+. Rates of limiting long term illness/disability, rate of falls and admissions for elective hip replacements are worse than the England average. There is a transient population working in tourism and high second home ownership. Travel times to key services are longer than the England average.
Key partners	Grange & Lakes ICC works with multiple partners including: • Community Pharmacists • LCFT – Mental Health • Local Authorities (Parish, Town, District and County) • MBCCG – Population Health • NWAS and Community First Responders • UHMB – Community Care Group • Rapid Response • Third Sector and community interest groups such as Rotary, AgeUK South Lakeland, Grange & Peninsula Wellbeing Group
Key areas addressed / achievements in 2019-20	• Case Management Team fully staffed • Health checks established at Ulverston Farmers Market • Bounce Back Clinics showcased at EPIC event and shortlisted for GP award; evaluated, refreshed and continued for a further year. • Commenced working on System Transformation Project to redesign future workforce skills and competencies • Mapping community assets with Age UK South Lakeland to support social prescribing • Health & Wellbeing Coach (HAWC) led Social Surgeries piloted in Grange and Ambleside • Mindfulness rolled out to schools • First community wellbeing fair held in Windermere • Pharmacists undertaking medication reviews in care homes • 12-week OTAGO Falls Prevention classes set up through RVS • Park Run launched in Ambleside • AF project – increased recorded prevalence of AF and rates of anticoagulation.
Plans for 20-22	• Develop population health related projects e.g. a Men's Wellbeing Project. • Continue to support community projects in Windermere, Ambleside and Grange (e.g. community lunch club, transport review, wellbeing event and an arts and crafts social prescribing project with Lakeland Arts). • Work with RVS to support participants of OTAGO classes to maintain wellbeing on completion of classes

	• Continue to populate the Compass Events diary to support social prescribing working closely with social prescribers and promote use of technology to support frailty work • Continue with System Transformation Project engaging with wider stakeholders to support mapping of patient pathways and skills and competencies required to develop new roles. • Evaluate Mindfulness in Schools project and share learning across Morecambe Bay • Dying Matters cross-bay events • Deep dive into ED attendance/admissions data for young people

Name	**Kendal Integrated Care Community**
Key description	Kendal ICC is centred on the Cumbrian market town of Kendal and is inclusive of several small neighbouring villages and parishes. Kendal ICC has a population of around 37000 people who are registered at one of our 3 GP practices. We have a high number of care home beds compared to other ICCs in Morecambe Bay.
Key partners	Key partners include: • People's Café • The Lighthouse • Cumbria County Council • Space to Create • NWAS • SLDC • St John's Hospice • Growing Well • South Lakes Dementia Hub • The Well • Outside In • South Lakeland Age UK • Headway Cumbria Constabulary
Key areas addressed / achievements in 2019-20	• Loneliness Prevention Lunch Bunch with the People's Café charity. Our case management team identifies older people who are isolated, successes seen in increasing individual's confidence and wellbeing. • Regular Farmers Health clinics at local auction mart. This is well attended by a 'hard to reach' population, many health needs identified and signposted. • I Matter Families emotional health project-new website, rolling programme continues and community support group now established • Flood group-Primary Care collaborative plan linked in with local multiagency strategy to support flood victims. • Chronic Fatigue support group set up at Lighthouse Charity with HAWCS • Addiction and Suicide prevention multi agency groups formed
Plans for 20-22	• Explore how the new ICC hub space can benefit the PCN, wider partners and people of Kendal. • Plan and host two population health events with Cumbria County Council and Kendal Leisure Centre and wider partners. • Evaluate the effectiveness of Loneliness Prevention Lunch Bunch with the People's Café charity. • Continue our work at regular Farmers Health clinics at local auction mart and share learning with other ICCs. • Continue to increase uptake both I Matter Families emotional health project - within Kendal ICC and Bay wide.

	• Work with Kendal Flood group to create a response plan including role of primary care in this. • Investigate how best to support the mental health of flood victims and rescuers. • Evaluate the Chronic Fatigue support group and how we can develop our relationship with the Lighthouse team. • Work with partners to develop and deliver multi-agency training on joint addiction and suicide prevention training

Name	**MID FURNESS Integrated Care Community**
Key description	Mid Furness (Ulverston, Dalton & Askam) ICC is a mainly rural ICC with a population of 25,836 and has pockets of deprivation. It has 4 GP practices and is coterminous with the PCN. The older population is projected to increase and working age population to decrease. There are a greater % of patients on GP registers with hypertension, asthma, diabetes and dementia than the national average and the rate of deaths from stroke is far worse than the national average. There are also high levels of childhood obesity.
Key partners	Key partners include: • GP Practice staff, nurses and patient groups, Social Prescriber, Case Management Team • LCFT – Mental Health • Local Authorities: Town Councils; SLDC (Housing); Cumbria County Council (Reablement, Education) • Community Development/Public Health, Libraries, Adult Social Care, HAWCs, Police, Fire & Rescue) • Ulverston Healthy Town Group & UlverSTEM • Third Sector and community interest groups – AgeUK South Lakeland; RVS; Ulverston MIND; Rotary; Food Banks; Carers Support South Lakes; St. Mary's Hospice; Ford Park • Better Leisure (GLL) • Residential Care homes
Key areas addressed / achievements in 2019-20	• Health checks established at Ulverston Farmers Market • Health & Wellbeing (HAWC) led Social Surgeries working well • Series of health cafes set up e.g. Menopause and Men's Health • MIOLI (Move it or lose it) classes established at Ulverston Health Centre • UlverSTEM – attracted 2,600 – promoted various health campaigns • Admissions project commenced - reducing length of stay in hospital • Care Home Project – proactive education to increase hydration and reduce UTIs etc. • Working closely with PCN social prescriber to develop a database to support social prescribing work
Plans for 20-22	• Promote use of Compass Hub events diary for social prescribing • Further health checks for farmers at Ulverston Auction Mart • Embed use of PAM tool • New diabetes project (focus on awareness and prevention)

	• Set up Mental health Café with MIND/Ford Park • Set up 'Friends' (dementia) cafe/events at Hospice • Joint Community Wellbeing event in July with Better Leisure including Mental Health activities aimed at C&YP • Promote falls prevention in residential homes • UlverSTEM 3 – bigger and better • Dying Matters cross-bay events • Deep dive into ED attendance/admissions data for young people • Intergenerational Project between primary schools and care homes

Name	**Barrow and Millom Integrated Care Community**
Key description	Barrow-in-Furness is an urban/suburban costal town on the South West Cumbrian peninsular. Offering an exceptionally high quality of life for those in work but with pockets of deep deprivation and areas that require sustained partnership support. Millom is a small geographically isolated town in West Cumbria. Millom has a good general practice a 9 bed community hospital and 3 care homes. The focus of the ICC in Millom is to build Population Health that goes beyond integrated care and service delivery. Barrow and Millom are both part of Barrow and Millom Primary Care network and issues in both areas have some commonalities and will work closely together. Our ICC approach is based on complete transparency – everything we do is shared and communicated with the communities. Data from Millom informs we have higher than average Diabetes type2 in our school children, smoking is still a major risk factor, high levels of social isolation and numbers of complex families. ED attendances are also higher than average for our Children. The total population for Barrow and Millom ICC is 68,542 comprising of 60,713 resident in Barrow and 7,829 in Millom
Key partners	**Barrow and surrounding area** • Integrated Community Care Team – Case Management, District Nurses, Physiotherapist, Respiratory, Heart Failure, MacMillan, Diabetes, Mental Health, First Steps, Alis Team, • Cumbria County Council – Community Development team, Fire Service, Library, Adult/Children's Social Care, Park View Nursing Home, HAWCs, Reablement Team, Active Barrow • Barrow Borough Council • Barrow Police • BAE Systems • Furness Carers **Millom** • League of friends and active health action group • Partner with all provider community based services • Copeland and Cumbria Council –Public Health Leads, Community Development team, Fire Service, Library, NWAS • Adult/Children's Social Care • Care Homes • Mind • Community Voluntary groups • Age UK • Primary & Secondary Schools • 3rd sector agencies

Name	Barrow and Millom Integrated Care Community
	• The Well/MIND/Unity • Women Community Matters • Love Barrow Families • Furness Homeless Shelter • Many 3rd sector and community agencies • Cumbria Voluntary Services • Frailty – falls pilot, MDT (consultant now engaged) • Many other 3rd sector agencies • Millom Alliance Community health action group
Key areas addressed / achievements in 2019-20	**Barrow and surrounding area** • Respiratory – Support Hub, Respiratory MDT now fully inclusive across Barrow/Millom (MBRN) • Dementia Hub • Egerton Court Hub – addressing mental health & substance misuse • Mental Health - MDT's, Thriving Business Thriving Community • Community Integration – Ormsgill & Barrow Island • Children & Young People – link in with FESP & substance misuse for KS2, sexual health education into all secondary schools in Furness (apart from one) • Health Coaching for Partners – The Well, Mind & Life Leisure Staff • Population Health Events across the town **Millom** • Living Well – soft exercise facility developed within community settings/ hospital to support frail elderly • Monthly education sessions – at risk groups CVD/Diabetes • Peer-led community based Mental Health support - Peer Led Hope and Cope Bereavement support • Closing the gap – continued targeted Interventions such as Health checks with our farming community and children and young people • Population Health Management tools - deep dive into ED data • Support to HAWC development of surgeries within Millom • Anticipatory care planning for those at risk of admission • Re-launch of "Around the Combe" – community managed publication supporting Well Being and Good health – distributed to every household
Plans for 20-22	**Barrow** • Long Term Conditions – cardiac rehabilitation, exercise on referral programme Life Leisure **Millom** • Empowering our communities focusing on their strengths and talents • Diabetes & complex families MDTs

Name	Barrow and Millom Integrated Care Community	
	• CYP – mental health, physical activity, Complex families MDT • Mental Health – Suicide Aware Barrow, Continue with Mental Health MDT's • Community/Neighbourhood Integration – Hindpool Community • Love Barrow Together - Social Isolation, Good Neighbourhoods Setting up other support hubs in community	• CYP – mental health, physical activity • Carer Support • Local work on wider determinants of health • Supporting opportunities for shared training and shared learning with our community such as Health Coach Training • Use WEMBS to measure our cup of well-being and strive to improve outcomes

Name	East	
Key description	The geography of East ICC is rural, with approximately 30 miles along the south border of the geographical footprint. 8.2% of patients registered to GP practices in East ICC are aged 80+ years compared to 5.9% across MBCCG. Across Morecambe Bay, East ICC has a higher than Morecambe Bay average of prevalence of LTCs.	
Key partners	Representatives from: • Adult Social Care • Carnforth and Milnthorpe and The Western Dales PCNs, • Children's Mental Health Services • Cumbria County Council (Development Officers) • District and Parish Councillors	• GP Surgeries • Local Third Sector Organisations • Morecambe Bay CCG • St. John's Hospice • UHMBT
Key areas addressed / achievements in 2019-20	Care Plan Clinics; joint clinic with Chronic disease nurse for patients requiring reviews, saved 2 hours 30 minutes and ~100 miles of travelling for staff, and only one appointment required for the patient. 100% of patients reported that it had been useful to discuss their wishes about the future and felt empowered to know what action to take in the event of a health and/or social crisis. 75% reported better understanding of how to manage their health conditions. Care Homes Service: a proactive service for acute clinical assessment need. Where possible, prevention of escalating health concerns of residents. Shared learning and development with the care home teams being central to the programme. During 2019/20, supported 82% of care homes to become familiar with and utilise STRATA as a means of referral. The service is currently supporting care homes to become more confident with completing care plans with residents, seeking support from clinical nurse specialist when required. 176 GP advice or visit requests, and 45 District Nursing visit requests have been avoided as a result of contact with the care home nurse.	

	Community Engagement events; have been held in Kirkby Lonsdale and Arnside. At Arnside, Dr Cheung (Arnside Surgery) was present at the event for 'sofa chats' and nurse was present to provide flu jabs and health checks. Children and Young People; Supported Dr Cathy Betoin and Cumbria County Council to secure funding for training of school staff who are currently running the "I Matter" program in school. Good links to Kent Estuary Youth Worker and plans for further collaboration in 2020-22.
Plans for 20-22	• Close working between ICC and both PCNs. • Build a full case management team. • Producing better quality care plans. • Reducing unnecessary hospital admissions. • Joint working between health, social care services and 3rd sector • Support our population to better manage their health and wellbeing. • Supporting our regulated care sector working with the frail elderly. • Improving our links with children and families work stream, including better working to provide mental health and wellbeing information and support across our local schools