VANGUARD: Better Care Together (Morecambe Bay)	
Case study:	**Garstang Integrated Care Community**
	
Purpose:	One of the key elements of the Integrated Care Community (ICC) is our aim to put the patient at the heart of their care and wrap services around them as needed. Garstang has a population of approximately 18,000 – it is a large rural area with 26.9% of the population aged 65 or older. (The average life expectancy is 79.6 & 83.2 years for men and women respectively).There are two GP surgeries which are co-located in a health centre, working alongside a community nursing team. The area is located served by three separate hospital providers. The majority of patients travel to either Lancaster or Preston, with Blackpool being chosen predominantly for heart related conditions. The Garstang ICC was set up: • To identify and then proactively manage patients identified at being at high risk of developing further debilitating conditions • To reduce the length of hospital stay and allow people to recover in the community where appropriate by reducing unplanned admissions and allowing early hospital discharge • To enable Garstang to be a care community which supports safe self-care in the community

How it works:	The ICC meetings are supported by partners within the Better Care Together Vanguard. The core integrated care team includes providers of hospital (secondary) care, Mental Health, Wyre Council Services, Police, Fire and Voluntary Sectors. A development day was organised to further develop the core integrated team. This aimed: • to build trust within the core team and partner organisations; • to build commitment and reinforce the objectives of the team; • to identify and resolve any areas of conflict; • and to begin to develop a clear working mandate
Success so far:	Two band 5 nurses have been recruited to act as Care Coordinators, with a month long induction to build relationships with other members of the Integrated Care Community. A culture of trust and respect has been developed within the ICC to allow the team to work together for the patient, with discussions taking place on individual patients as well as about the overall system. A 'Garstang Unmet Needs Assessment Tool' has been undertaken by the Care Coordinators, this is an holistic assessment which works across four areas. Medical, Social, Allied Medical (eg physiotherapists or occupational therapists) and Community. This is highlighting areas of need for the integrated care team. Work has been undertaken to encourage self-care, with a focus on social isolation in a rural and elderly population – for example developing integrated IT systems to allow co-ordinated care between organisations. An example of how this works is below: - Mr Smith (not real name) is 76 years old. He lives alone in his own house. He struggles with mobility due to a previous stroke and heart failure. He has care input but struggles at night time with mobility. The care coordinators have added a commode, discussed lifeline and a key safe to help improve access. Mr Smith was referred to care and repair (Wyre council service) to install these. A GP appointment was arranged to deal with concerns about his memory. When admitted to hospital the Care Coordinator facilitated Mr Smith's discharge by ensuring a follow up GP appointment was booked and that his medication trays were all in sync.
Lessons learnt:	We are looking to replicate across all 12 Integrated Care Communities in north Lancashire and south Cumbria

	Co-ordination and working with different parts of the community is the key to success Much of the work is still in the early phases – but patients are receiving more co-ordinated care, and more care in the community, and staff are better-informed about their patients.
Key contact:	GP John Miles j.miles@nhs.net Helen McConville Helen.McConville@lancashirenorthccg.nhs.uk