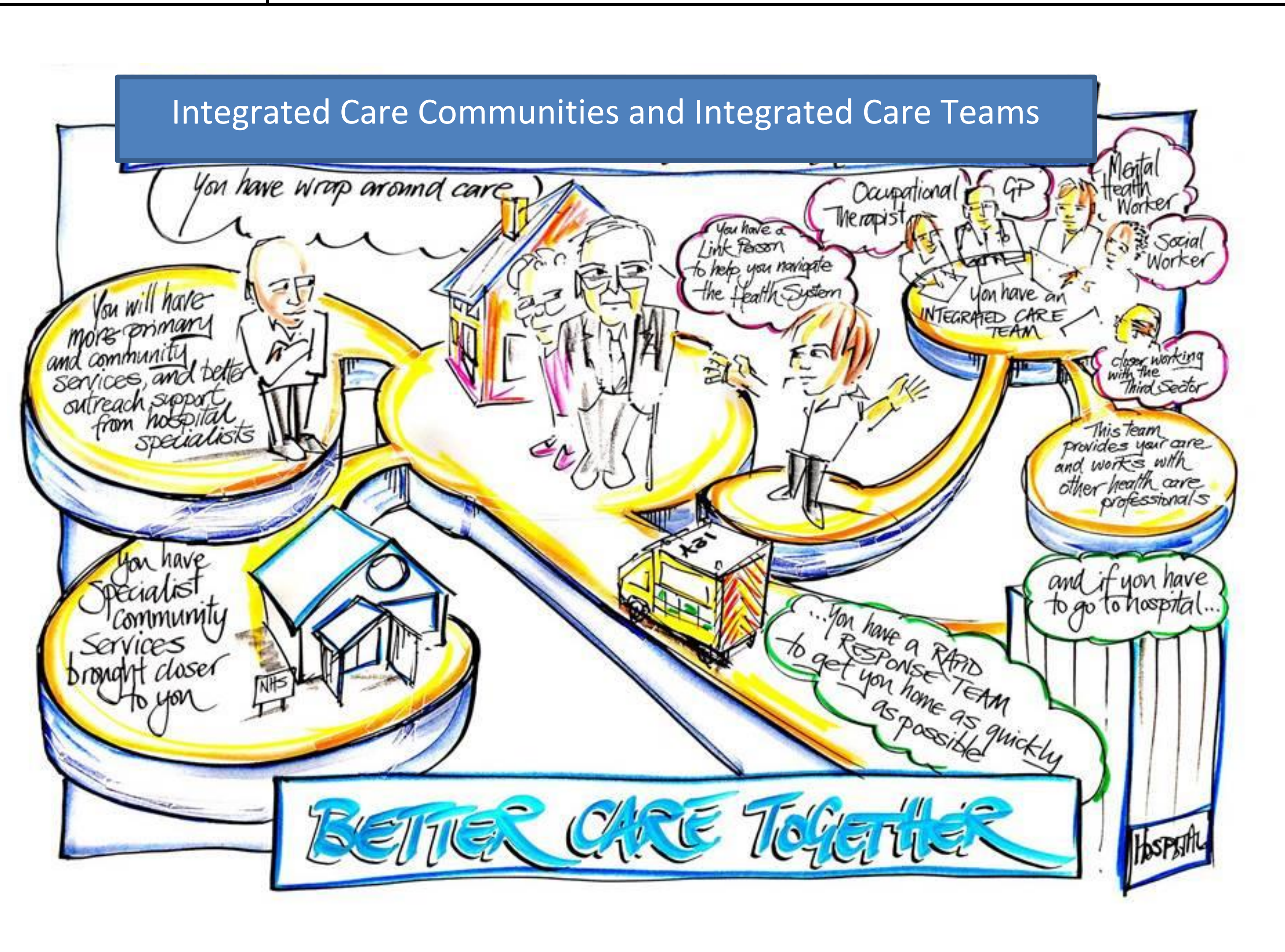
VANGUARD: Better Care Together

Case study:	**Integrated Care Community (ICC) Development** **This case study includes the role of an operating framework; how the framework supports integration between GP practices and community services; consistent ways of working; and how ICCs are working to look after more patients in the community and avoid hospital admissions**



Purpose:	Integrated Care Communities (ICCs) are integrated teams of health and care workers, practicing population health with a mobilised population i.e. communities that develop and lead initiatives to improve their health and wellbeing. Based on natural communities of between 10,000 and 70,000 people, ICCs bring together primary, community and social care workers into one single integrated team working to a common purpose: improving the health and well-being of the local population. ICCs are the key component in the Better Care Together model for delivering care closer to home across Morecambe Bay. An ICC is made up of a multi-disciplinary team of health and social care professionals, third sector organisations, and patients. Working collaboratively in an ICC, these teams will address the care needs of a clearly defined population and seek to create a new relationship across providers and users of services to improve engagement in, and experience of, care.

	There are 12 Integrated Care Communities in Morecambe Bay reflecting the geography and natural communities in existence. In the first instance these are co-terminus with the boundaries in which those General Practices operate (and therefore ICCs represent clusters of between one and six practices). These are not unchanging and may alter to reflect local changes in communities and are also likely to have sub-communities within them e.g. in south Cumbria, the East ICC has five community villages/small towns.
Context:	Central to the concept of ICCs is a belief that Primary Care is the first port of call for people who have health care needs and an ambition that health and care needs should be delivered as close to home as possible by an integrated core team of health and care staff who work in that that community. The core ICC team (one per ICC), in turn are supported by dedicated responsive services that cover a larger geographical area, who can be deployed in the event of a rapid or significant change in condition that necessitates highly intensive input; diagnostics or access to technical care that can only be delivered by specialist teams, possibly in a hospital setting. More specialist community services that need to operate at scale can also be drawn in to ICC. The work of the ICCs will be informed by evidence - having detailed understanding of the health and care needs of its population. The main focus of the core ICC team are people within local communities that have on-going or more complex care needs, and are at highest risk of deteriorating and risk of hospital admission. The wider local population within a community will continue to receive their care through routine primary care and patient-activated self-care. In addition to the core health and care services provided within an ICC, a key part of the concept is also encouraging the development of healthy and activated communities, and health and care partners working closely with community groups and the voluntary sector to promote wellbeing initiatives. Identifying the target cohort for ICCs be achieved by production and triangulation of data from a range of sources: GP datasets; secondary care data; public health intelligence. This will form the basis of risk stratification, planning and mobilisation of the ICC and wider resources in the ICC community. It is expected that the core ICC teams will primarily focus on the cohorts of people that are considered at risk with the assistance of risk stratification tools such as the Electronic Frailty Index, supplemented by information from the Aristotle tool, which indicates trends and patients who are high users of services ICCs will engage with the wider system and will grow to accommodate colleagues working in new ways. This may be a change from uni-disciplinary to multidisciplinary; multi-disciplinary to interdisciplinary, single agency to multi-agency and hospital-based to system-wide. ICCs will work with the wider system to identify opportunities to utilise technology to bring diagnostics, health monitoring and specialist consultation in to their ICCs. ICCs will learn and grow to develop identity, autonomy and take delegated responsibility for resources over time. The vision is that ICCs will form the population-health locality based component of the Morecambe Bay Accountable Care System. A Population Health approach will be informed by the different needs, health inequalities

and focus areas of each ICC.

The steps to today - what did we do and why?

ICCs began their inception following successful integrated working initiatives in the community of Garstang, inspired by their aim to put the patient at the heart of their care and wrap services around them as required. The Garstang ICC was setup to:

- Proactively manage high risk patients
- Reduce the length of hospital stay by reducing unplanned admissions and allowing early hospital discharge
- Enable Garstang as a care community to support self-care in the community

Two band 5 nurses were recruited to act as Care Coordinators, with a month long induction to build relationships with other members of the ICC. A culture of trust and respect was developed within the ICC to allow the team to work together for the patient.

A Garstang Unmet Needs Assessment Tool was been undertaken by the Care Coordinators, with a holistic assessment that worked across four axes: Medical, Social, Allied Medical and Community: thus highlighting areas of need for the service.

Links were also created between EMIS Web and Community system with Care Coordinators being able to access Social Services Liquid Logic system to aid care for patients.

What did we do?	Why?
We ensured the ICCs were clinically led by ensuring it was clinicians who co-produced the ICC model of working	It is vital that there is a cross-organisation understanding of the rationale behind the development of the role and that there is clinical ownership
We encouraged people to work differently with what they have with aspirational, yet SMART, targets	So that all ICCs were clear of the role they play in reducing lengths of stay in hospital beds and inappropriate admissions (where safe and appropriate) rather than relying heavily on additional resources so that the ICC model is sustainable.

Early commitment to 1-2 sessions per week for a lead GP to provide a strategic overview and encourage partnership working at an operational plus local level	This gives the needed leadership as well as encouraging partnership working with other leads such as Fire, Police, Mental Health etc.
The financial and operational commitment to employ care co-ordinators from existing Bay Health and Care Partner provider teams	These substantive roles that encourage working without boundaries make them more attractive and so aid recruitment and retention
Providing appropriate project management and 'Plan, Do, Study, Act' (PDSA) support – many ICC team members are clinicians so need project management support	Project management support with planning and implementation of the projects, maximises clinician time with their patients and public. It also builds commitment, encourages networking and brings people together.
Investment in Information Management Technology e.g. QLIKview, the 'Aristotle' risk stratification tool to identify vulnerable people, high risk patients and patients needing end-of-life care, and for those patients who are frail elderly the EMIS e-frailty tool, which can also be used to support the risk stratification process.	This gives real time data rather than historical data so that operational staff can monitor performance more accurately and triangulate data to improve the care pathway
Follow local, national and international exemplars e.g. in Morecambe Bay, fellow Vanguards, the Spanish Alzira model etc.	To learn from, and follow best practice to gain efficiencies and improvements
We invested in staff engagement as we needed to ensure that people working in the ICCs knew they were empowered to work differently. This was supported by a budget for backfill for clinicians, although much work took place "out of hours" thanks to clinicians' goodwill.	The benefit is seen in teams of people working without boundaries with a holistic approach to care.
Access to the necessary prevalence information to engender a common set of priorities for all 12 ICCs whilst enabling each individual ICC to develop its own objectives specific to their area e.g. in Barrow there is a particular focus on respiratory care, in Kendal a particular focus on living with frailty.	Together with community profiling and engagement support, this means ICCs can better understand their local communities demographics, assets, public concerns etc.
We put into place the necessary leadership and governance e.g. a clinical lead per ICC and an ICC Steering Group to work with all 12 ICCs	This aids understanding of scope, objectives, decision making and quality assurance
Encouraging pilot projects that are intelligence-led and enable people to rally around e.g. in Barrow in Furness ICCs, colleagues have worked on the design and delivery of an improved respiratory care pathway, supporting the community-led Furness Wellness days etc.	The benefit of these pilot projects are that teams can, and do, build on early wins.
Encouraged networking opportunities to	The benefit of this cannot be

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<tr><td>build up a knowledge of “on the ground” assets to strengthen asset building e.g. Cumbria County Council Health and Wellbeing Coaches (HAWCS) who work to keep people safe and independent at home.</td><td>underestimated –developing and building on relationships means that people know who to contact so that the care pathway can be speeded up and reach out to include colleagues who have expertise in different areas.</td></tr>
<tr><td>Co-producing a Core Operating Framework that gives clear objectives, leadership and governance guidance to support integration between primary, secondary and community care.</td><td>This also allows guidance for consistent ways of working e.g. a common approach to care planning.</td></tr>
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<td>Existing infrastructure</td>
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1. <u>Each ICC has a clinical lead and core membership</u>
The Clinical Lead is typically a General Practitioner (GP) or a senior member of clinical staff who has authority and leadership status within the community represented. Core membership will be made up of the natural health and care partners who are present in the ICC such as primary, community, and secondary care, Adult Social Care (ASC), ambulance, mental health, Allied Health Professionals (AHPs) etc who’s work contributes towards the major health and care issues that relate to that particular ICC population. The make up of the core team differs according to the health needs of that population and the skill mix of staff. For example some staff models are a result of building on an existing configuration and some grow to reflect the needs and availability of staff. There is not a single ‘recipe’ and it is important to note that in some areas the different providers offer different roles, so one works with what ‘is best’ for that area e.g. in one geographical area the model may involve a Community Matron, in another the model may involve a District Nurse.
Membership of the wider ICC will have broad representation of additional NHS partners, public, private and third sector that operate in that ICC area and whose work contributes to the health and care needs of that population and is not prescribed e.g. domiciliary care workers.
Each ICC has a senior link person (a clinician such as a senior nurse or AHP) based in secondary care to facilitate integrated working; this enables the reduction of duplication, mixed messages and the ability to make the most of different areas of expertise and system knowledge.
2. There is a <u>Core Operating Framework</u> to provide the necessary objectives and monitoring, governance, structures and lines of delegated responsibility so staff are clear what the objectives are plus what is in and out of scope. ICCs work as a team, using risk stratification, case managers and case co-ordinators to determine “priority patients”, this in addition to core objectives such as long term condition management and supporting community-led health initiatives etc.
3. <u>A meeting schedule</u> with set days and times so that people have the necessary six weeks’ notice to attend so that cover can be found, so that clinics do not need to be cancelled. The meetings are held monthly with a work plan and agenda that relates to core objectives. The meetings encourage multi-disciplinary attendance e.g. staff from Local Authority, community, primary care, mental health, children’s services etc. Multi-disciplinary working naturally occurs in between meetings e.g. consideration and care
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	for people with complex needs. 4. Physical space for co-working is advantageous e.g. colleagues in the fire services offer regular hot desk space so that people know "who to go to, on what day" e.g. knowing that a wellbeing worker or social worker is on-site on a certain day greatly assists cross organisational working. A number of ICCs have co-located staff e.g. Garstang, Millom and Carnforth, in other areas space is at such a premium that co-location presents a challenge 5. Support for workforce planning, recruitment and Human Resources issues. For example clear recruitment processes including opportunities for continuous professional role development to aid retention. This includes clarification of health system working, transfer of skills and portfolio working. 'New roles' have developed such as case managers and case co-ordinators, for others it may be a blending of roles e.g. a community matron role now involving closer working with a hospital discharge team. 6. Shared information drive where people can access documents to prevent "re-inventing the wheel" and learn from best practice. 7. Leadership and ICC leaders forums, which enable ICC, health, social care and other partner leaders to come together to address issues, share practice and receive feedback from the ICC and the Community Services Steering Group and Bay Health and Care Partners Leadership Executive.
Data implications	Data can acts as both a barrier and an opportunity e.g. There are different IT systems across Morecambe bay; primary care use eMIS, the hospitals use Lorenzo and all are affected by Information Governance requirements. The appointment of a Chief Information Officer for Bay Health and Care Partners seeks to better integrate and make better use of information across the health system. Nonetheless, access to, and intelligent use of data is important in establishing ICCs, e.g. Acquiring data re: prevalence, demographics, Joint Strategic Needs Analyses, etc. Workforce data: considering what is available now, what is needed for the future, what is attractive to potential employees, recruitment and retention and how to offer different services while protecting 'fragile' service areas. Quality of data: the importance of good business intelligence cannot be underestimated.

	Sharing of data: to enable integrated care records that smooth the patient care journey. Data set: Following joint development across Lancashire North and South Cumbria there is an agreed data set underpinning care plans consistent across Morecambe Bay ICCs. ICCs will produce and use a ten tab patient summary; this is strengthened by the production of either a 'supported care plan' which is an end of life care plan or an 'anticipatory care plan' for those at risk. The ten tab patient summary and completed supportive care plans are available via a gateway and appropriate data sharing agreements e.g. University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) via Lorenzo, community service providers, out-of-hours GPs and hospices.
How it works: setting out the four key steps of integrated care	All ICCs are working strategically to look after more patients in the community and avoid hospital admissions by delivering holistic and integrated care. Staff have been empowered to take on and manage or close cases based on a combination of those presenting as a) highest need through risk stratification, b) flagging up through admission registers or c) urgent direct referral from GPs. Specific criteria have not (as yet) been set to allow staff to match a targeted response to the capacity available at any one time. The emphasis is very much on navigation through the system rather that direct care with an overriding goal of self-care as soon as practicably possible or referral to long term condition teams. Risk stratification tools and "soft knowledge" help to identify people to particularly focus on. The final clinical accountability/ responsibility remains with Primary Care – often through a named GP and Patient Care Administrator. The four steps if integrated care are as follows:: 1. Risk stratification and care plans ICCs in conjunction with GP practices as part of their ICC role are responsible for identifying patients who are most at risk of unplanned admission, readmission and Emergency Department attendances and to provide a more personalised support to these patients to help them to better manage their health via the development of care plans. No such 'risk score' has been developed to date. The broad categorisation of mild, moderate and severe with the EFI is being used to prioritise those with potential for greatest impact i.e. those coded as moderate - as severe should already be, or soon will be, known to the system and already under the care and supervision of clinical staffs. Preventative work with moderately frail people therefore forms the key cohort for ICC staff. ICCs are as a rule of thumb concentrating on the top 3-5% of the at risk population – depending on resources within each locality.ICC's across Morecambe Bay are producing care plans to support vulnerable patients identified as 'at risk' identified through the risk stratification process as above. 2. Care co-ordination and case management

	Care co-ordination and case management for those people who are within the cohort of patients identified as 'at risk', whether this is on a short term basis, or where other services are introduced to support on an on-going basis or on a long-term basis because of the issue which is present. Note: in this health system, 'care co-ordination' means the functions and roles that are developing in responses to risk stratification, pro-active care planning and catalysing development of the ICCs. Each area has named Care Co-ordinators or Case Managers who undertake assessments/ Care Planning with individual patients and will be known to them by name for direct contact. Direct Care is however a misnomer as the emphasis is very much on the role assisting navigation through the system rather that direct care with an overriding goal of self-care as soon as practicably possible or referral to long term condition teams. 3. <u>Increased self-care and prevention through community engagement</u> Self-care: ICCs are supporting increased self-care through a number of initiatives including different approaches to consultation such as motivational interviewing, identifying health and well-being champions who can support and promote self-care, identifying and supporting the development of peer led programmes and partnering with community and third sector colleagues to develop and deliver effective, integrated self-care support services that will offer the public appropriate support. 4. <u>Frailty and Long Term Condition Management</u> Frailty: The role of the ICCs in the Frailty Pathway encompasses the following functions: o Risk Stratification – the focus is currently on the elderly, in the future it will include younger frail patients with learning disabilities, neuro-degenerative diseases or long term conditions. o Care Coordinators within each ICC leading on the assessment of frail individuals with a patient centred approach to understand the capacity of the person and how they wish to live their life. o Integrating primary and community care to ensure seamless care and to reduce duplication. Through this integrated approach ICCs are monitoring their frail population for deterioration, escalating support in order to avoid admissions for conditions that can be safely managed at home or at the patient's normal place of residence. Long Term Condition Management: Integrated Care Communities are working to improve the management of Long Term Conditions (LTC) through a number of initiatives including improving the self-care of individuals with long term conditions with a view to, in some cases, reversing disease and in other cases introducing better self-care management, utilising all the resources of the ICC to proactively manage the condition in the community and liaise and co-ordinating with secondary care to allow care to be transitioned between the ICC and the specialist teams as

	appropriate.
Staff implications: different ways of working	An Integrated Care Community has a core team, and a virtual team who become part of the team as needed. A core team would usually include roles relating to care co-ordination; case management and care navigation. A virtual team based in different locations across the Morecambe Bay health system includes for example community teams of nurses and physios, district nurses, heart failure nurses, palliative care nurses, tissue viability nurses, continence nurses and diabetes nurses etc. Virtual team staff are brought into the core team on a case by case basis. To date ICCs have been led by clinical leaders supported by a number of others within the ICC, the CCG (Clinical Commissioning Group) and BCT (Better Care Together) teams. Going forward the following is suggested as a leadership team for each ICC: • Clinical lead (GP) • Nursing or other clinical lead (e.g. a Therapist) • Managerial lead (e.g. Practice Manager) • Social care (to be agreed and further understood). Work to date has led to a number of emerging roles in the ICCs and there is 'real time' learning taking place on how to design meaningful and fulfilling new job roles, and how to recruit, train, support and retain people in these roles. It is important to learn from this experience and begin to recognise and use the learning from across the whole system to move forward in understanding these new roles. A key feature of ICCs development will be shaping, and at times re-shaping, the workforce to most appropriately reflect the present and future needs of that population. The health system will support the development, evolution and evaluation of such roles. An ICC workforce strategy and recruitment strategy is under development. Collaborative working across primary, secondary, mental health and social care organisations is identifying new ways of working that contribute to the population health of their ICC. For example there are Local Authority IWS Workers [Integrated Wellbeing Service] in Lancashire and HAWCS [Health and Wellbeing Coaches] in Cumbria as well as continued working with third and voluntary sector services, and members of the community. This is an example of how health and care providers are working together across boundaries and footprints to align their work rather than formally changing

	waiting for organisational boundaries to change. ICCs consist of employees of several organisations working together, and whilst the ultimate aim may be single entities of some form, which are able to manage their own finance, workforce, quality and governance issues themselves, they are not yet ready for this at the time of writing. However, in the interim they are supported to make some of their own decisions within a suitable framework.
Key ICC stakeholders	Key ICC stakeholders include: • Secondary care • Primary care • Community care • Mental health • CCGs • Ambulance services • Third Sector • Service users • Local authority • Public Health • Providers of nursing and residential care – it is worth remembering that often these two sector often provide more beds locally than an acute hospital • Local elected representatives

Engagement and networking	Meetings, forums and networking time are crucial as they help build up relationships that are not easy to broker on email and phone. Changes to the NHS over the years have seen a number of restructures so it is important to have face-to-face time to establish or re-join working relationships. An example would be the face-to-face time, which has enabled the bringing together of occupational therapists, the Home Improvement Agency and Fire Service to look at primary intervention as well as re-ablement. Protected Learning Time (PLTs) can assist with this. Empowering people and communities: the ICC approach to community engagement and community development is to focus on improving the health and wellbeing of our communities and organisations to build resilience by empowering people and communities e.g. identifying those assets in the community e.g. people, organisations, skills, knowledge and opportunities that are already there, improving social capital and building social networks particularly with the community, voluntary and faith sector, in addition to connecting people and assets.
Resources include	• A financial framework with recurrent funding to ensure sustainability • System wide support – e.g. ICCs are inextricably linked to secondary care so each ICC has a senior acute care link person • IT to assist agile working e.g. laptops, mobile phones • Flexible working policies to aid staff recruitment and retention • Physical space for co-production and co-working • Support for engagement activity with the staff of the newly formed ICC staff, and with the local community so they can support ICCs and population health • Support for organisational and culture development (this is given via the Bay Learning and Improvement Collaborative) • Organisational memory
Success so far:	• Joined up working is more motivating and fulfilling for staff – relationships are being made which mean that staff can work more effectively such as fast tracking patients e.g. by linking secondary care, community and Adult Social Care occupational therapists. Another example includes streamlining the patient care pathways e.g. dietetic referrals are changing so that trusted assessors can make direct referrals without GP intervention. • ICC Community based care co-ordinators are routinely networking with hospital-based discharge co-ordinators to streamline and fast track patient journeys so that patients can go home sooner. Their systematic and pro-active approach reduces risk where feasible, aids the management of long term conditions, encourages safe self-care and allows the patient the time of a one-to-one holistic assessment. When ICCs are supported by patient administrator's patients and care co-ordinators can better prepare themselves to maximise the benefits of the one-to-one time.

	• ICC Care navigation is crucial to success as they signpost and navigate people to the most appropriate part of the system whether it is another statutory organisation, third sector, IAPT, the Home Improvement Agency, the Fire service etc. • Staff are speeding up response and turnaround times with effective use of technology and tele-health to enable agile working. • Secondary care consultants are starting to offer community based clinics in these specialities: respiratory, geriatric and paediatric care. This is embryonic work and we await further feedback. • Non-elective admissions and bed days have consistently been falling since September 2016 when measured as a Moving Annual Target (MAT)
Lessons learnt:	• Due to a number of restructuring programmes it can be difficult to keep abreast of who is "operationally working the patch". With hindsight we would have invested more heavily in building relationships with mental health and Adult Social Care colleagues earlier. Joining the dots between people and organisations is crucial to kick starting, and maintaining integrated care. People need to be given time to do this. Domiciliary, care and nursing home colleagues are important to the success of Better Care Together initiatives. There are more nursing, care and 'home' beds than acute hospital beds so it is important to look at solutions for these staff groups such as upskilling where appropriate and ensuring they have parity of esteem and consider themselves part of the ICC team – even if they are not one of the ten Bay Health and Care Partners. There is an additional piece of work under way to explore how CCGs can further support the regulated care sector: this is reliant on further developing existing relationships, building new relationships, being aware of different cultures, different perspectives and perceptions etc. • Telehealth can play a greater role e.g. for appropriate self-care such as managing exacerbations in respiratory illnesses. We will continue to learn from the progress of the Lancashire and Cumbria Innovation Alliance (LCIA) Test Bed pilot which is using telehealth with frail elderly groups. • Clinical teams need to be prepared to work differently, often without additional resource but using what they have differently • Estates planning – staff working in the same building facilitates team working. • The vast majority of staff enjoy the chance to work differently – it is important to clarify to staff that they have the freedom to act differently and to think 'health system' not 'organisation'. • Resources need to flow differently – to avoid inappropriate hospital admissions resources need to move from secondary care to ICCs: this shouldn't be contentious: it's about accountable care i.e. 'one team, one T-shirt'. • Above all: the patient remains at the heart of ICC work: one December an elderly gentleman: Dennis was found by a neighbour, the gentleman had been lying on his cold kitchen floor for hours. Dennis had no family to look after him,

	was a proud man, a confused man and “didn’t want to be any trouble”. The ICC is there to make sure that everything possible is done to avoid this happening to him again - through risk management to give him a proactive and robust care plan, which may include appropriate self-care tools, rapid response and care co-ordination if it does happen again. If we get this right Dennis will be living in a mobilised community where his neighbour and other individuals will have initiatives in place so that Dennis doesn’t have to be on his own for days on end – in his armchair or on the kitchen floor. N.B. Dennis is the name chosen to maintain the anonymity of the above patient
Key contact:	Hilary Fordham – hilary.fordham@morecambebayccg.nhs.uk