South Cumbria Mental Health Transformation Project

An introduction to Integrated Care Communities for VCFSE [Voluntary Community Faith & Social Enterprise]

This briefing is in response to feedback from a recent gathering of mental health providers in the third sector, often known as VCFSE. We are working together to improve the flow of information so that community-based organisations can better collaborate with NHS teams. This information has been compiled by someone with lived experience as a service user, volunteer and staff member within the third sector who values working with ICCs. We have gathered information from local ICC postings on social media and NHS & community websites; presented in the hope that it will help VCFSE volunteers and staff members better understand how they can work alongside ICC partners.

What is an Integrated Care Community (ICC): 'Integrated Care Communities (ICC) are integrated teams of health and care workers, voluntary organisations and wider community assets who work together with an aim of promoting and maintaining community independence, improving quality of life, reducing the risk of hospitalisation and supporting earlier discharge from hospital. All GP registered patients are eligible, if you have been in hospital recently; or visited your GP more regularly in the last few months, due to your long-term illness you may be referred to the ICC. Source: **https://www.uhmb.nhs.uk/our-services/services/integrated-care-communities**

ICC teams are staffed by UHMBT [Univ Hospitals Morecambe Bay] NHS Development Leads, Case Managers, Care Navigators and Community Nurses. They work closely with Clinical Leads from local GP partnerships and virtual Multi-Disciplinary Teams [MDT], other NHS teams, Social Prescribers, Local Authority [e.g. Health & Wellbeing, Housing, Community & Social Work Teams] & VCFSE teams as appropriate to the needs of the person being supported.

Page 1 - summary of key people, contacts and the range of opportunities to get involved.

Pages 2 to7- one-page summaries on each of the six ICCs based in South Cumbria with links to staff, websites & social media. You may wish to share the page relevant to your team.

S Cumbria ICCs	**Barrow** Page 2	**Mid Furness** Page 3	**Millom** Page 4
Lead	**Maxine Baron** maxine.baron@mbht.nhs.uk	**Jenny Riley** jenny.riley@mbht.nhs.uk	**Jenny Riley** jenny.riley@mbht.nhs.uk
Admin contact	**% M Baron** barrow.icc@mbht.hs.uk	**Andrea Gregson** admin.midfurnessicc@mbht.nhs.uk	**Jenny Riley** jenny.riley@mbht.nhs.uk
MDTs & Liaison	Family & YP, Frailty. YP & Adult MH, Respiratory 3rd Sector Liaison meetings All MS Teams monthly	Frailty Health Inequalities group ICC Refresh working groups	To be confirmed in next edition
S Cumbria ICCs	**East** Page 5	**Grange & Lakes** Page 6	**Kendal** Page 7
Lead	**Vacant**	**Sally Holmes/ Vivian Appleyard** sally.holmes@mbht.nhs.uk vivian.appleyard@mbbht.nhs.uk	**Cara Stride** cara.stride@mbht.nhs.uk
Admin	**Sue Frame** Easticc.admin@mbht.nhs.uk	Admin.GrangeandLakesICC@mbht.nhs.uk	Kendal.icc@mbht.nhs.uk
MDTs & Liaison	To be confirmed in next edition	To be confirmed in next edition	To be confirmed in next edition

E&OE: Information sourced from UHMBT, LSCICB & Compasshub.com websites; ICC Newsletters & Facebook postings. Amendments, additions or correction requests to michael.cassells@mindinfurness,org.uk

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About Barrow ICC Barrow in Furness

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. The population health approach is about reducing health inequalities, intervening earlier to reduce avoidable ill health and supporting people in their own homes, drawing on the existing resources in the system, new ways of working and connecting with community assets.

Barrow ICC serves patients registered to GP practices in Barrow Primary Care Network.

VCFSE organisations are invited to participate in MDT's, Monthly Liaison Meetings and community initiatives to tackle health inequalities, poverty and promote health & wellbeing. The ICC partners work closely with the Local Resilience Group, Healthy Streets initiative, BeWell pop up wellbeing events, Health Happier Hindpool, Community Prosperity Partnership, Priority Wards Working Group, Furness Youth Work Partnership & Community Health Wellbeing & Equity Partnership.

Barrow ICC Aims

The focus of the ICC is to ensure that the people of Barrow are supported to improve their own health and wellbeing, and that when people are ill or need support, they receive the best possible joined up care. The ICC helps empower people to take an active role in their health and wellbeing and supports people to manage long-term conditions such as dementia at home with the right support. 'Barrow ICC supports people to plan and coordinate ways to meet health and social care needs support people to look after their health as much as they can to stay well. recognised when people are running in to difficulties to ensure they get the right help'.

How Barrow ICC Works:

Our team visits people in their homes to gain an understanding of their living situation and to document the person's views, wishes and needs. A comprehensive plan is developed to encompass how they would like to be cared for as their health and care needs advance.

Often this includes in-depth discussions around sensitive issues such as hospital care, resuscitation and where the person wishes to be cared for at the end of their natural life. We also work closely with our community teams, primary care teams, Social Prescribers & VCFSE groups.

Barrow ICC supports peer support groups on Dementia & Long-Term Health Conditions

Based at: Fairfield Community Office, Fairfield Lane, Barrow in Furness

Development Lead & main contact: **Maxine Baron** ICC Development Lead

For Newsletter enquires, MDT referrals & membership, Liaison meeting membership

Email: maxine.baron@mbht.nhs.uk **Tel:** 01229 402578

Case Manager: Jaqui Davies Jacqueline.Davies1@mbht.nhs.uk **Clinical Lead: Dr Ashish Kshetrapal**

Website: https://www.uhmb.nhs.uk/our-services/services/integrated-care-communities

Social Media: https://www.facebook.com/barrow.icc

Newsletter: Canva link from **Maxine Baron**. Promotes partner information

MDTs: Frailty, Family & YP, Mental Health & Respiratory Monthly via Teams

Liaison Meetings: Monthly via Teams, recording & transcript provided.

About Mid Furness ICC Dalton, Ulverston & Broughton

 E&OE: Information sourced from UHMBT, LSCICB & Compasshub.com websites; ICC Newsletters & Facebook postings. Amendments, additions or correction requests to michael.cassells@mindinfurness,org.uk

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Mid Furness ICC serves 30183 patients registered to 4 GP practices; Ulverston (HC) Health Centre (Murray), Dalton, Ulverston Community & Duddon Valley.

VCFSE organisations are invited to participate in MDT's, Monthly Liaison Meetings and community initiatives to tackle health inequalities, poverty and promote health & wellbeing. The ICC partners work closely with Ulverston Resilience Group. Mid Furness ICC is undergoing a 'Refresh' of priorities through working groups with statutory & VCFSE partners meeting bi-monthly. Loneliness Cafes are held in Askam and Men's group, attended by Mind in Furness meets monthly in Ulverston HC.

Mid Furness ICC Aims to:

- Understand the problems and set clear goals for improvement
- Focus on all determinants of health, not just healthcare
- Generate shared accountability for improving Population Health
- Empower people and communities to develop their capabilities
- Embed health equity as a core part of our population health strategy

How Mid Furness ICC Works:

- An integrated team of health and social care professionals, Social Prescribers & VCFSE working across boundaries, with a common goal and clear purpose.
- Develops projects which tackle conditions such as: frailty, respiratory disease, diabetes, mental health and cardiovascular disease.
- Identifies communities within our ICC population who we can support to manage their own health.
- Considers the wider determinants of health and engage with our communities to establish their needs and what will make them happier and healthier and more active.
- Evaluates the effectiveness of our work and learns from the feedback from our patients, communities and stakeholders

Based at: Ulverston Health Centre, Stanley Street, Ulverston, LA12 7BT

Contact Name: **Andrea Gregson** Administrator **Email**: admin.midfurnessicc@mbht.nhs.uk

For Newsletter enquires, MDT referrals & membership, Liaison meeting membership

Development Lead: **Jenny Riley** **email:** jenny.riley@mbht.nhs.uk

Case Manager: **Karen Roberts** email: karen.roberts@mbht.nhs.uk

Clinical Lead: **Dr Alison Johnston** email: **alison.johnston16@nhs.net**

Website: https://www.morecambebayccg.nhs.uk/get-involved/integrated-care-communities

Social Media: https://www.facebook.com/search/top?q=mid%20furness%20icc

Newsletter: Canva link from **Andrea Gregson**. Promotes partner information

MDTs & Liaison : Frailty MDT. Meetings with VCFSE include Bi-monthly ICC Refresh working group. Health Inequalities themed meetings

About Millom ICC Millom, Cumberland District

 E&OE: Information sourced from UHMBT, LSCICB & Compasshub.com websites; ICC Newsletters & Facebook postings. Amendments, additions or correction requests to michael.cassells@mindinfurness,org.uk

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Integrated Care Communities are integrated teams of health and care workers, Social Prescribers & voluntary organisations and wider community assets who work together to practice population health with a mobilised population.

The population health approach is about reducing health inequalities, intervening earlier to reduce avoidable ill health and supporting people in their own homes, drawing on the existing resources in the system, new ways of working and connecting with community assets.
Millom ICC works across Millom, Haverigg & The Green area.

Millom ICC aims to:
- Understand the problems and set clear goals for improvement
- Focus on all determinants of health, not just healthcare
- Generate shared accountability for improving Population Health
- Empower people and communities to develop their capabilities
- Embed health equity as a core part of our population health strategy

How Millom ICC works:

A joint project between Millom Network Centre (MNC) and Millom Integrated Care Community (ICC) utilised the NHS Population Health Investment Funding to help over 1600 residents stay well during the winter months.

Based at: Millom Community Hospital**,** Lapstone Rd, Millom LA18 4BY

Development Lead & main contact : Jenny Riley Tel: 01229 402800.

For Newsletter enquires, MDT referrals & membership, Liaison meeting membership

Email: jenny.riley@mbht.nhs.uk

Case Manager/ Community Nurse Lead

Clinical Lead:

Website: https://www.uhmb.nhs.uk/our-services/services/integrated-care-communities

Social Media: To be confirmed in next edition

Newsletter: To be confirmed in next edition

MDTs: To be confirmed in next edition

Liaison Meetings: To be confirmed in next edition

About East ICC Arnside, Milnthorpe, Sedbergh, Kirkby Lonsdale and Bentham areas

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East ICC is a team of NHS health care professionals based in local surgeries covering a large geographical area including Carnforth, Arnside, Milthorpe, Kirkby Lonsdale, Sedbergh and Bentham - and areas in between. GP practices include Park View Surgery, Ashtrees (North area), Lunesdale Surgery, Sedbergh Medical Practice and Bentham Medical Practice.

East ICC's aim is to maximise individuals' full potential, independence and well-being and help to make sure your wishes are heard. We access many sources of support and information from within the health sector, the voluntary sector and social care, as well as wider community assets. This can include signposting as appropriate to local groups and statutory agencies.

East ICC goal: To promote independence, awareness of health and well-being, reduce the risk of hospitalisation, and support people when they are discharged from hospital.

How East ICC works:

- Kirkby Lonsdale Breathe Easy Group monthly meetings at Lunesdale Hall
- Companionship Café quarterly in St Thomas' Church Milnthorpe
- Work closely with partners in Western Dales PCN
- Regular participant in community wellbeing events, alongside partners including CVS, Age UK and Carer Support S Lakes.
- Close links with neighbouring Carnforth ICC [carnforth.icc@mbht.nhs.uk]

Carnforth ICC Newsletter link https://www.canva.com/design/DAGfXOF6bPo/MaAGjgH4ZZ9iQ-OsTmSwYw/view?utm_content=DAGfXOF6bPo&utm_campaign=designshare&utm_medium=link2&utm_source=uniquelinks&utlId=h1ec8eeac57

Contact Name: Sue Frame Tel 01539 777297

For Newsletter enquires, MDT referrals & membership, Liaison meeting membership

Email Easticc.admin@mbht.nhs.uk

Development Lead: Vacant To be confirmed in next edition **email** via admin

Case Manager: Catriona Devaney **email** Catriona.devaney2@mbht.nhs.uk

Clinical Lead: William Lumb **email** Williamlumb@nhs.net

Website: https://www.morecambebayccg.nhs.uk/get-involved/integrated-care-communities

Social Media: https://www.facebook.com/EastICC

Newsletter – for Canva newsletter link please contact easticc.admin@mbht.nhs.uk

MDTs: - for MDT details please contact easticc.admin@mbht.nhs.uk

Liaison Meetings via admin

About Grange & Lakes ICC Grange over Sands & nearby villages

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Grange & Lakes ICC works across organisations in a defined geographical area with a population of c.32,500 people.

Grange & Lakes ICC Aims to:
- Understand the problems and set clear goals for improvement
- Focus on all determinants of health, not just healthcare
- Generate shared accountability for improving Population Health
- Empower people and communities to develop their capabilities
- Embed health equity as a core part of our population health strategy

How Grange & Lakes ICC Works:

- An integrated team of health and social care professionals, work closely with the community, working across boundaries, with a common goal and clear purpose.
- Develop projects which tackle conditions such as: frailty, diabetes, respiratory disease, mental health and cardiovascular disease.
- Identify communities within our ICC population who we can support to manage their own health.
- Consider the wider determinants of health and engage with our communities to establish their needs and what will make them happier and healthier and more activated.
- Evaluate the effectiveness of our work and learn from the feedback from our patients, communities and stakeholders.

Based at: Grange Medical Practice, Kents Banks Road, Grange over Sands, LA11 7DJ Tel: 01539 777252

Contact Name: Sally Holmes & Vivian Appleyard

For Newsletter enquires, MDT referrals & membership, Liaison meeting membership

Email sally.holmes@mbht.nhs.uk or vivian.appleyard@mbbht.nhs.uk

Development Lead: To be confirmed in next edition

Case Manager/ Community Nurse Lead

Clinical Lead: To be confirmed in next edition

Website: https://www.morecambebayccg.nhs.uk/get-involved/integrated-care-communities

Social Media: not current

Newsletter: To be confirmed in next edition

MDTs & VCFSE liaison meetings: To be confirmed in next edition

About Kendal ICC Kendal & surrounding area

 E&OE: Information sourced from UHMBT, LSCICB & Compasshub.com websites; ICC Newsletters & Facebook postings. Amendments, additions or correction requests to michael.cassells@mindinfurness,org.uk

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How Kendal ICC Works:

Kendal ICC works across organisations in the defined geographical area of Kendal and the surrounding parishes to improve the overall health and wellbeing of local people.

The focus of the ICC is to ensure that the people of Kendal are supported to improve their own health and wellbeing, and that when people are ill or need support, they receive the best possible joined up care.

The ICC helps empower people to take an active role in their health and wellbeing and supports people to manage long-term conditions such as dementia at home with the right support.

What Kendal ICC Does

Our team visits people in their homes to gain an understanding of their living situation and to document the person's views, wishes and needs. A comprehensive plan is developed to encompass how they would like to be cared for as their health and care needs advance. Often this includes in-depth discussions around sensitive issues such as hospital care, resuscitation and where the person wishes to be cared for at the end of their natural life.

Our core team has recorded over 350 such plans that are shared with other professionals involved in the person's care.

Based at: The Ferguson Centre, Gillinggate, Kendal LA9 4JE Tel: 01539 777300

Contact Name: Cait Lambert Administrator

For Newsletter enquires, MDT referrals & membership, Liaison meeting membership

Email Kendal.icc@mbht.nhs.uk

Development Lead: Cara Stride **email:** cara.stride@mbht.nhs.uk

Case Manager Alison Buckley

Lead Nurse: Alison Nicholson

Clinical Lead: Dr Amy Lee

Website: https://www.morecambebayccg.nhs.uk/get-involved/integrated-care-communities

Social Media: https://www.facebook.com/profile.php?id=61561935045416&__tn__=-UC-R

Newsletter: To be confirmed in next edition

MDTs & VCFSE Liaison : To be confirmed in next edition

 E&OE: Information sourced from UHMBT, LSCICB & Compasshub.com websites; ICC Newsletters & Facebook postings. Amendments, additions or correction requests to michael.cassells@mindinfurness,org.uk