ICC Workforce

Dedicated ICC staff have a range of skills enable them to undertake activities and work with wider partners to catalyse new ways of working: they fulfil the following functions:

Care Coordination - oversight of the community-level care management processes to facilitate entry to the community service system

Case management – to systematically integrate community services around the needs of individuals. It is a targeted, community-based and proactive approach to care that involves case-finding, assessment, care planning, care co-ordination and - in time-limited interventions – case closure.

Personalised and integrated care planning - to address an individual's full range of needs, taking into account their health, personal, social, economic, educational, mental health, ethnic and cultural background and circumstances. It recognises that there are other issues in addition to medical needs that can affect a person's total health and well-being.

Care navigation is a further function that serves to manage and optimize the delivery of care inside and outside the clinical setting; coordinating care with patients, gathering information for the patient's visit, and partnering with the physician, nurses, and care team to deliver the highest levels of efficient health and social care. Key to this role is the ability to signpost to other groups and organisations.

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. The focus of Barrow ICC is to build Population Health that goes beyond integrated care and service delivery. 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 **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

Name	Barrow and Millom Integrated Care Community
	Care, Park View Nursing Home, HAWCs, Reablement Team, Active Barrow • Barrow Borough Council • Barrow Police • BAE Systems • Furness Carers • 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 • Care Homes • Mind • Community Voluntary groups • Age UK • Primary & Secondary Schools • 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 • Frailty MDT's well established with support from local Geriatricians • Population Health Management – Severe & Enduring Mental Health pilot • 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 **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

Name	Barrow and Millom Integrated Care Community	
	Leisure Staff • Population Health Events across the town	health – distributed to every household
Plans for 20-22	**Barrow** • Long Term Conditions – cardiac rehabilitation, exercise on referral programme Life Leisure • CYP – mental health, physical activity, Families MDT, Operation Fuschia, Young Health Champions (Health Coaching for our champions), Under 18 Alcohol Admissions, Mindfulness in Schools, Continue to support mental resilience in schools, FESP - Voice of Our Children Book of experiences during lockdown • Increasing physical activity in deprived wards, making this exclusive to all, funding from Sport England • Supporting families – alcohol/substance misues • Mental Health – Suicide Aware Barrow, Continue with & Egerton Court Hub • Community/Neighbourhood Integration and projects with Ormsgill & Barrow Island • Love Barrow Together - Good Neighbourhoods • Continue with current support Cafes in community – Respiratory, Dementia & Neurological and also develop – Learning Disabilities, Osteoporosis & Endometriosis • Discharge planning & triaging identified patients • 12-week Otago Fall Prevention • MDT's continuing – Frailty, Mental Health & Respiratory • #Love Barrow – social revolution Barrow supported by Hilary Cottam. Reducing health inequalities in Barrow. • Harri Bus November 2020 engaging with people in our community liaison with 3rd Sector Partners	**Millom** • Empowering our communities focusing on their strengths and talents • Frailty, Carers, Mental Health and Safeguarding MDTs • 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 • "Get Millom Moving" a targeted exercise programme for those who have 3 LTCs • Micro-commissioning with 9 groups from the community offering health & wellbeing projects by the people for the people • HARRI bus in October 2020 focusing on quitting smoking, diabetes and obesity • Mini health MOTs being done in the community by the Case Management Team