Sefton Partnership

NHS
Mersey Care
NHS Foundation Trust

Integrated Care Teams & Data Into Action Update

Health and Wellbeing Board
Sefton Place
4th December 2024.

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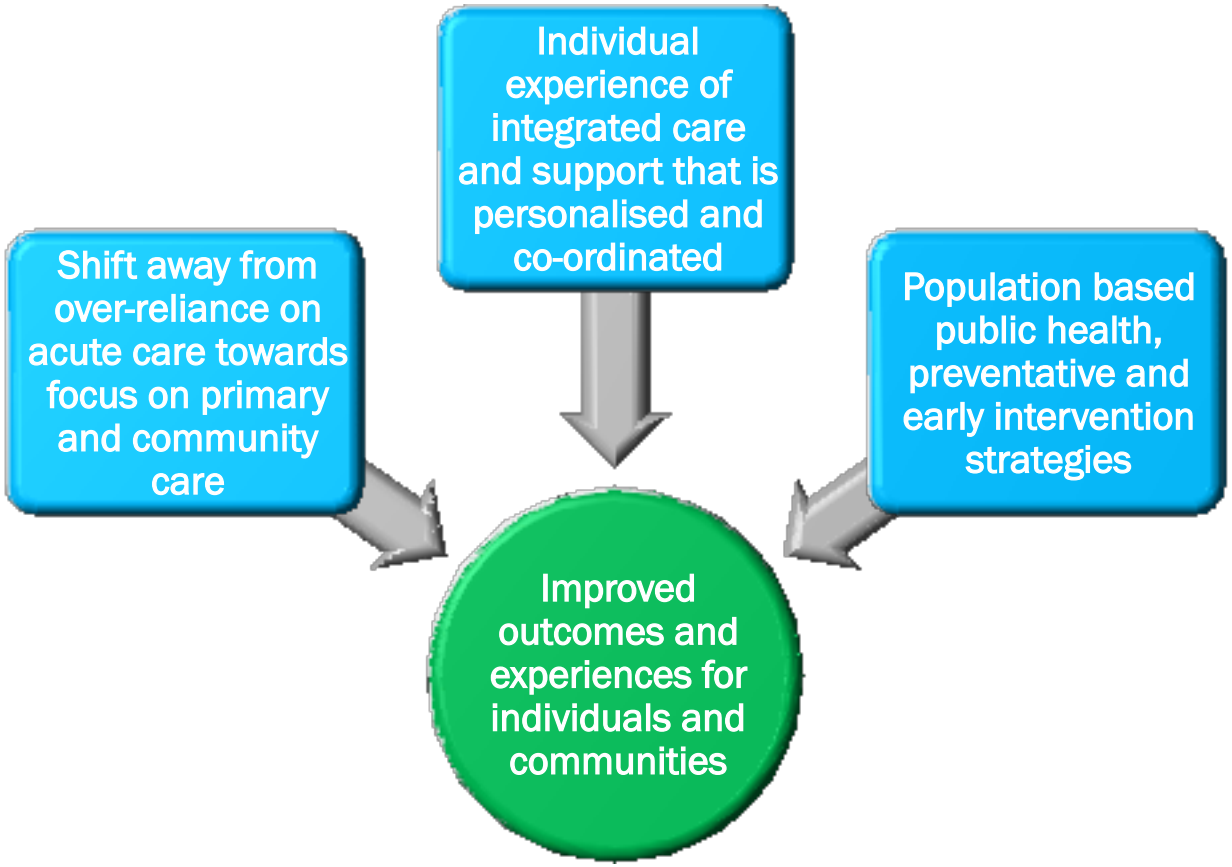
ICT Vision and Objectives

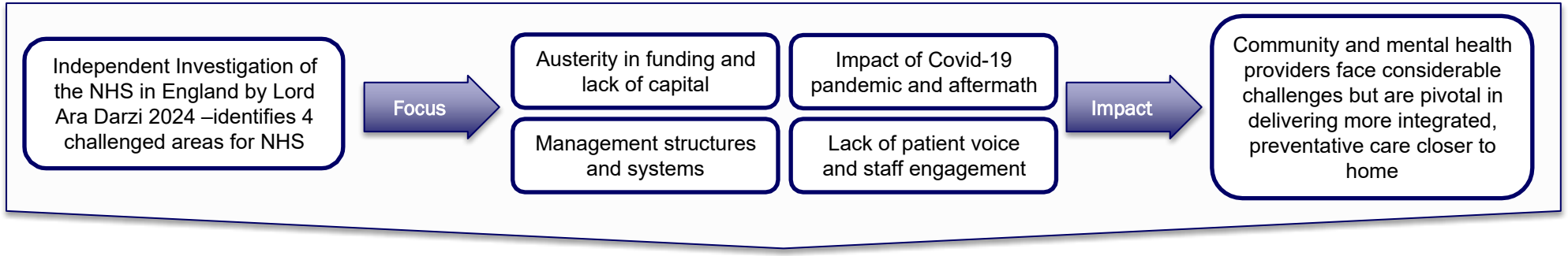


Our vision is to delver a local integrated support offer to help enable the ambitions of local Health & Wellbeing Strategies

Our aspiration will be to create a culture of cooperation and coordination between health, social care, public health, other local services and the third sector

Our ultimate aim is to improve the outcomes and experiences of individuals and communities

Integrated Neighbourhood Teams Support NHS 10-year Plan



From hospital to community

- Integrated Care Teams (ICTs) provide a community-based approach to managing complex needs and long-term conditions in community settings
- Proactive care approach reduces avoidable conditions and exacerbations leading to emergency admissions

From treatment to prevention

- Using population health intelligence and working with NHS providers, Local Authorities, voluntary sector and community groups to focus on prevention approaches with targeted communities to reduce longer term needs
- Side by Side approach to support patient co-production, alongside staff insight and workforce development

From analogue to digital

- Using CIPHA and enhanced case finding approach to support proactive care and early interventions
- Use of technology to improve access and booking
- Enabling and empowering patients through online support, virtual appointments and telehealth

ICT Model of Care

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Case Identification → Holistic Assessment → Personalised Care and Support Planning → MDT Working → Co ordinated Care → Interventio ns and Support

Person with multiple needs

Network of Support
Carer, family, neighbour, community

Very High (0.5%)
High (4.5%)
Medium (15%)
Low (80%)

Admin, BI & corporate

3 Wider specialists and MDT

Social prescrib er
Nurse
GP
Housing
ICT
OT/ physio
Mental health
Social Care
Care coordin ator

Community resources

1 **Multifactorial identification**
a. Trusted professionals
b. Risk Stratification
c. Wider integrated care team flag

EVENT

Integrated system response to needs

2 Network based dedicated core members of ICT

Core skills of the ICT
- Strength/ asset-based assessments
- Multi-disciplinary planning
- Care coordination
- Enable and link with communities
- Self-management

5 **Integrated and timely anticipatory system response**
- Rapid response and reablement
- Community team and medical support
- Self and remote monitoring
- Equipment and adaptations
- 24hr/ night care
- Step-up care
- Care Homes in-reach teams (EHCH)

4 **Harnessing community resources**

- People, family and communities
- Website and self-help tools
- Community based services
- Volunteer network

Integrated Neighbourhood Teams Support NHS 10-year Plan

Integrated Care Team: Core MDT Members

MDT **core** members are primarily from Health and Social Care and take responsibility for the functioning of the MDT and are present at each weekly/bi weekly MDT meeting.

- **ICT Care Coordinator**
- **ICT Administrator**
- **GP – As required**
- **Social Worker**
- **Mental Health Practitioner**
- **Community Matron**
- **District Nurse**
- **Allied Health Professional**
- **Voluntary Sector**

Integrated Care Team: Extended MDT Members

MDT extended members attend MDT meetings to discuss individual patients where specialist or ad hoc input would benefit the patient/service user/family. We also have clear pathways in place.

Community Geriatrician	Safeguarding	Dietician	Medicines Management
Palliative Care	Care Home Staff	Speech & Language	Employment Support
Tissue Viability	Police	Occupational Therapy	Equipment Services
Housing Association	Fire Service	Physiotherapy	Hoarding Services
Learning Disabilities	Department of work & Pensions (Pilot)		Life Rooms
Health & Wellbeing Trainer	Children's Services (Transition)		Bladder & Bowel
Longmoor House	Dementia Care Navigators		ICRAS

Integrated Care Teams and Proactive Case Finding

1. ICT Model of Care
2. DIA Impact & Feasibility Priorities
3. Specialist Targeted Work
    - Frailty, Deprivation & 50% Emergency admission risk
    - High Intensity Users (HIU) of Emergency Services
4. Potential Future Work
    - Admission risk while on in-patient waiting list/s
    - Care Home focus
    - High Intensity Users (HIU) of Emergency Services
5. Public Health Priorities – cancer screening data dashboard and waiting list data

DIA Impact & Feasibility = Priorities

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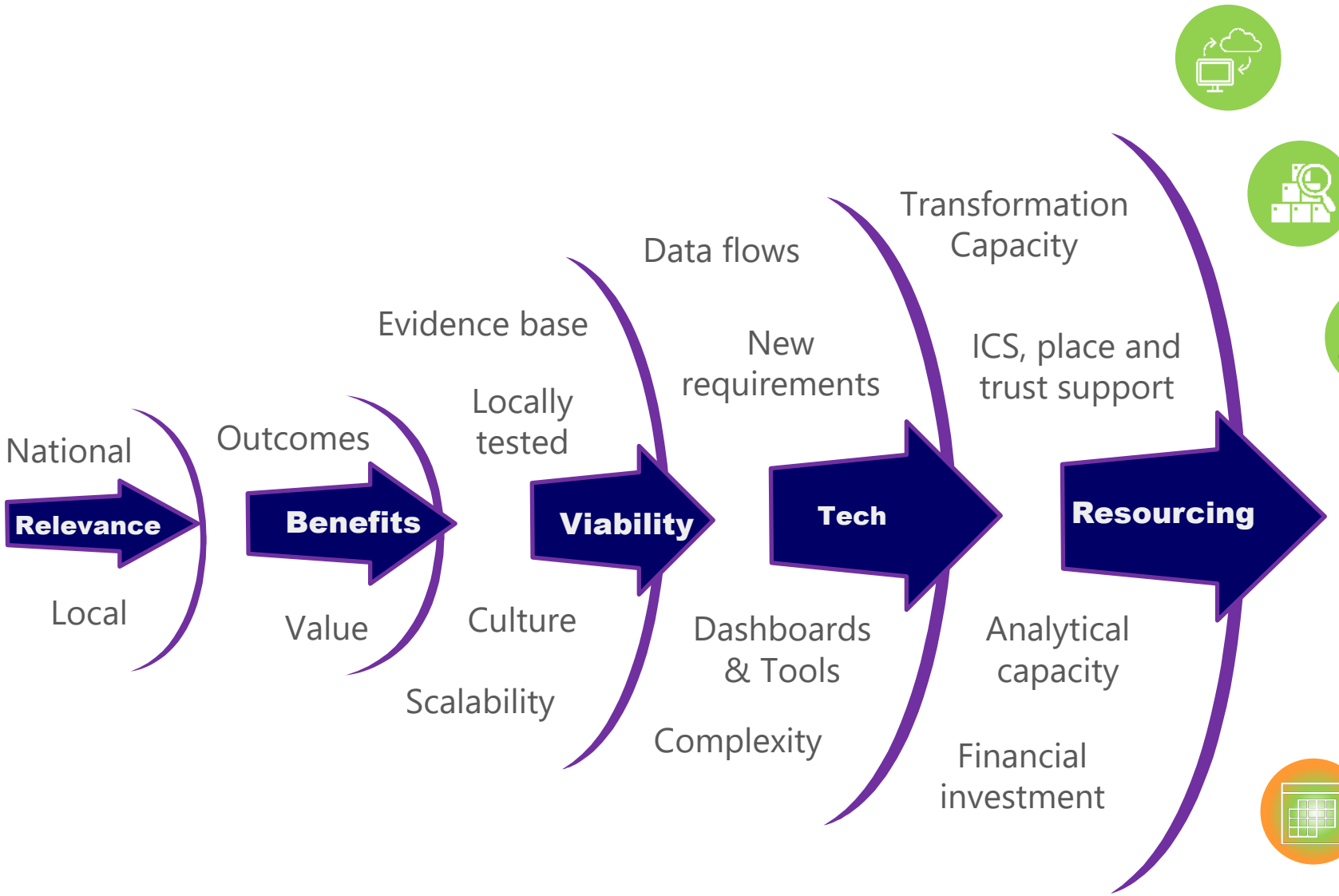
Data Into Action



Telehealth – LTC Remote monitoring

Specialist Targeted – proactive searches of vulnerable cohorts

Medicines Optimisation – optimising resources and reducing risk

Waiting List Tool – profiling and supporting patients to better effect

Community Care Teams – MDT approach supporting at risk cohorts

QOF risk stratification – prioritising cohorts for earlier annual reviews

Complex Households – reducing fragmentation and duplication

Working Criteria: ICT Enhanced Case Finding

Phase 1
November 23

- Aged 65+
- 3+ LTCs
- High GP & AED usage
- 50% AED attendance risk 6-months
- IMD 1

Place	Phase 1
Liverpool	15
Sefton	29
Summary	44

Phases 2 & 3
April - October 24

- Aged 65+
- 50% AED attendance risk 6-months

Place	Phase 2	Phase 3
Liverpool	84	105
Sefton	27	141
Summary	111	246

Phase 4 – HIU
November 24

- Aged 18+
- Liverpool: 35+ AED attends in prev 12-month
- Sefton: 14+ AED attends in prev 12-months

HIU Proposal	
Liverpool	34
Sefton	83
Summary	117

High Intensity Users

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Data Into Action

Population Explorer Tool

Demographics

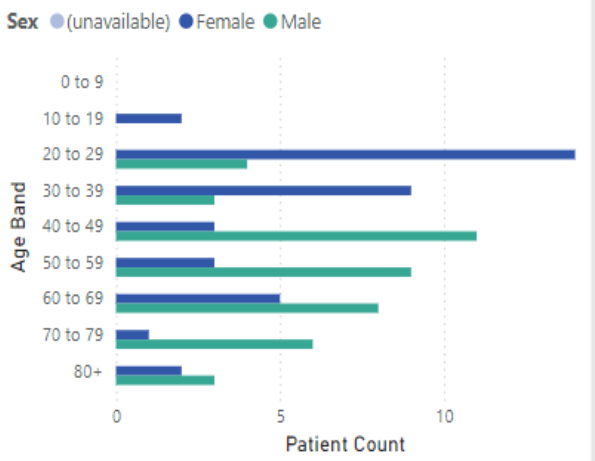
NHS

2,550,379	83	0.00%
TOTAL POPULATION	SELECTED POPULATION	% OF POPULATION

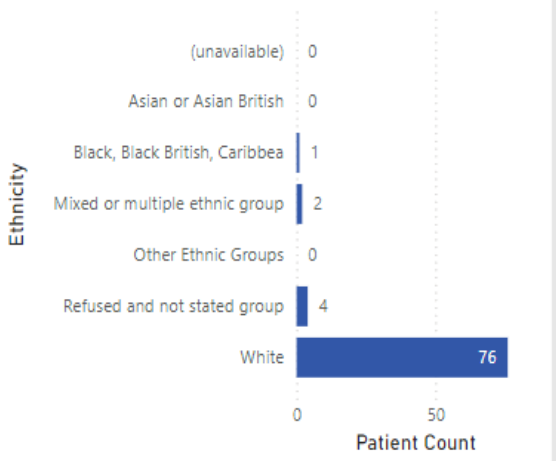
Show Filters | Clear Filters | Filters Applied

Show patient count view | Show % view | Show rate per 100k view

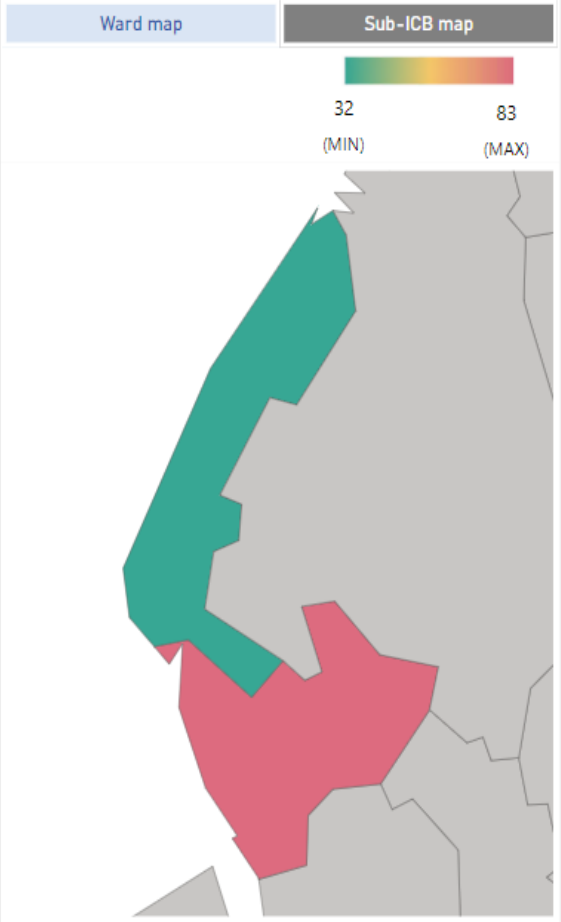
PATIENT COUNT BY AGE BAND & SEX



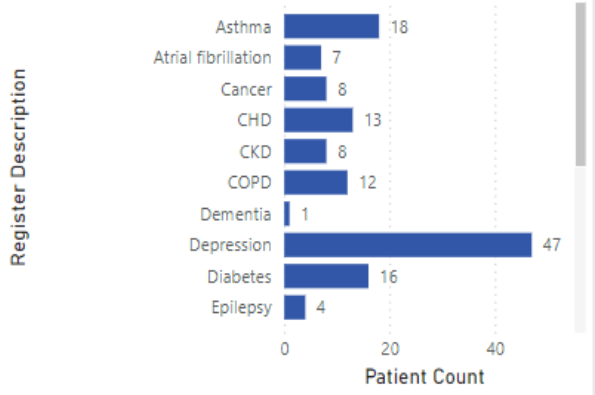
PATIENT COUNT BY ETHNICITY



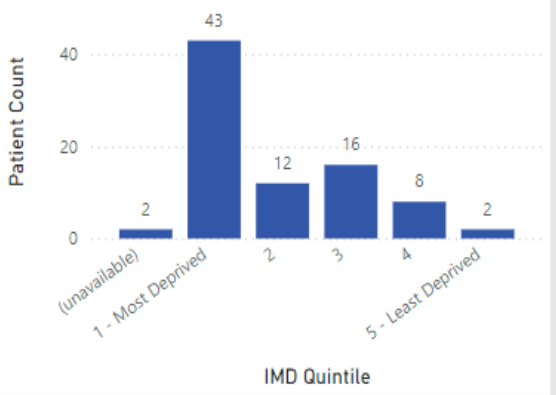
DISTRIBUTION OF THE SELECTED POPULATION



PATIENT COUNT BY QOF LTC



PATIENT COUNT BY IMD QUINTILE



Run by: david.warwick@merseycare.nhs.uk on 15/11/2024 12:12 | V2.4.2 | Data last refreshed: 14/11/2024 13:02

Graphnet

- Aged 18+
- 14+AED attends
- 83 residents in Sefton meet this criteria

Last 12- months: Cumulative activity

- 1,873 AED attends (Max 37).
- 1,340 111 Queries (Max 329)
- 2,130 999 Calls (Max 264)
- 11,709 GP encounters (Max 815).
- 1,158 NEL LoS (Max 125)

Next Steps and Considerations (1)

- Sefton Partnership Board approved the vision and importance of Integrated Care Team/Team 100 (Integrated Locality Teams) development on the 13th November 2024.

- Agreed Next Steps:
  - Undertake baseline review of current model (activity, outcomes, experience of users, performance, gaps, voices of people who currently use the services etc) November – end of February 2025
  - Develop Maturity Matrix and Integrated Care Locality / Neighbourhood Development Plan (2025- 2027)
  - Align with Local Authority Locality (neighbourhood) planning arrangements once external focus stakeholder engagement and focus agreed
  - Utilise any opportunities for additional funding that may become available as a result of NHS 10-year Plan focus on neighbourhoods
  - Re-establish the Sefton Place Operational Delivery Group which will be part of the refreshed governance arrangements. This is in hand. We also need to establish the formal link with the ICT programme and the Better at Home Programme so this can be in place as soon as possible, once this is in place and governance is right ICT Strategic group can be stood down after the next planned meeting.

Next Steps and Considerations (2)

- Proactive Case Finding: Focus on High intensity users of general practice and urgent and emergency care (in support of C&M Recovery Plan) commencing November 2024.
- Continued support to embed ICTs within the Locality across Sefton Place.
- Embed ICTs, as a hosted service, within Sefton Place (Community Care Division).
- Support the design and delivery of Integrated Locality Teams in Sefton Place (NHS Plan) via newly established system governance routes
- Consider how we can use learning from Sefton and Liverpool Places to support the development of Integrated Neighbourhood Teams in other Places within the MCFT footprint and what resources are required.
- Consider establishment of internal MCFT steering group to support further development of neighbourhood working and Trust role as anchor organisation.