ST HELENS BOROUGH COUNCIL

ST HELENS CARES

NHS Cheshire and Merseyside

Care Communities Strategy Presentation

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15th April 2024

St Helens Care Communities - Background

Across St Helens who we serve:

- 180,000 residents and 196,000 patients on GP lists
- 26th most deprived Local Authority in England
- Approximately 25% of our residents live in the 10% most deprived neighbourhoods in England
- 38% of our population have multiple long term health conditions and are being identified in younger age groups

Within St Helens, we have:

- 31 GP practices across 4 Primary Care Networks (PCNs)
- 4 Care Communities aligned to our 4 PCNs
- 7 Council localities covering 18 wards
- Range of professionals across Community nursing services, Mental Health, Contact Cares, Social Services, Voluntary sector, Housing, Schools, Hospitals, Public Health, Police, Fire, Library…

Leading to the generation of our Vision and Objectives

Our Vision:

A way of working together in a truly multidisciplinary way… → ..to deliver the right personalised care/support for a whole of person approach (not just treating the symptom)… → ..and ensuring a seamless journey through healthcare and social support services in St Helens Borough.

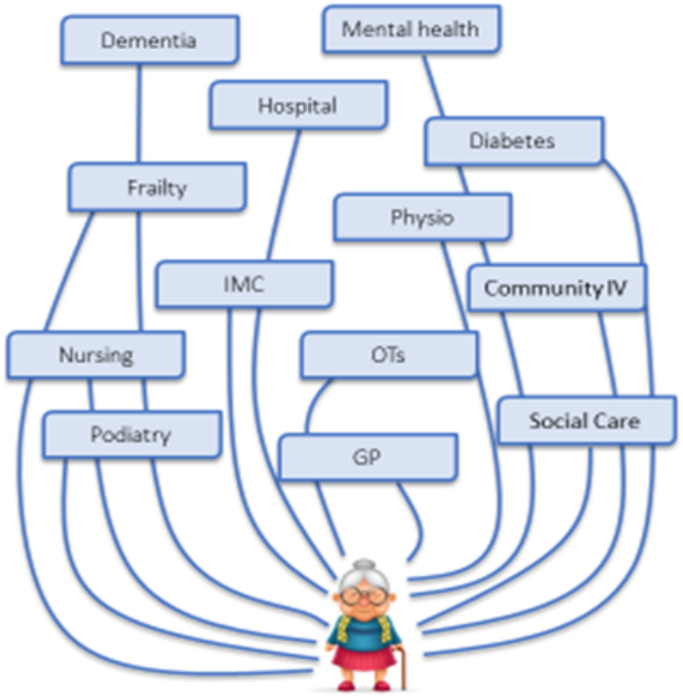
Our Objectives:

- ***Professional Groups of people working effectively together for the benefit of patients***
- ***To work proactively as well as reactively***
- ***Access relevant information in a timely manner***
- ***Holistically produced useful care plans***

St Helens Care Communities – the reality

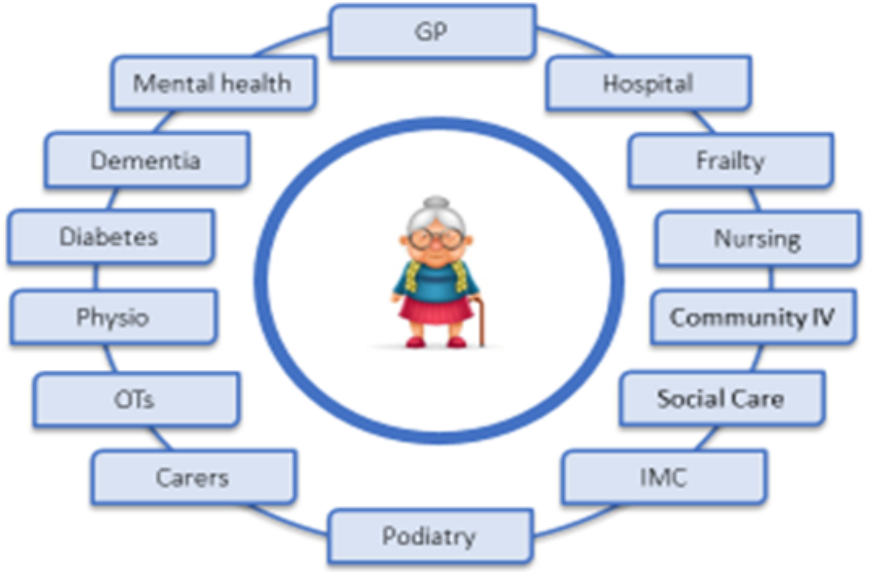
The Reality: Within St Helens, many of our most complex patients and residents access a range of services in an uncoordinated manner with little sharing of knowledge between the professionals who deliver these services.

Moving from this…



The change required

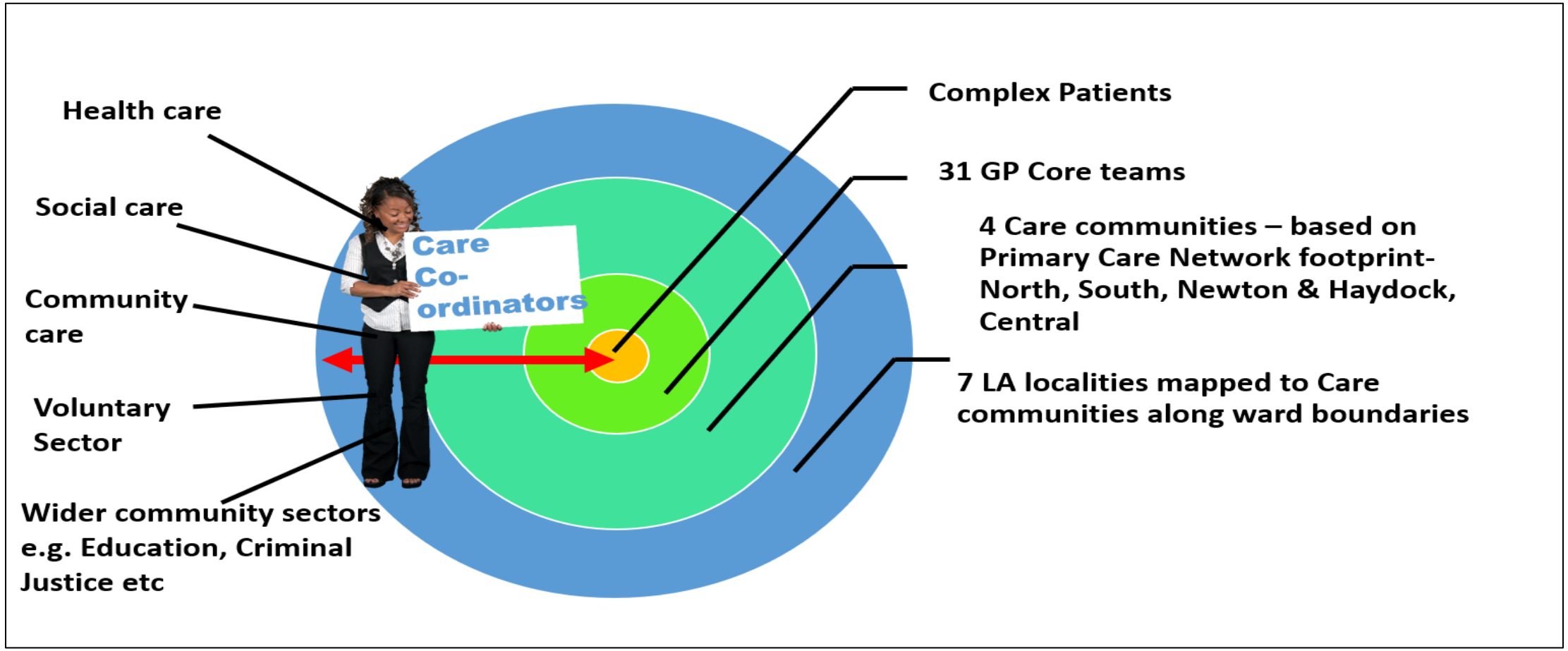
To this…



Outcome: Delivering an experience that is better for our patients/residents and better for our staff

St Helens Care Communities - Our Model

Aim: A model that has our complex patients at its centre, wrapping around the key professionals and forming strong local multi-disciplinary teams aligned to our four Care Communities and seven localities across St Helens.



St Helens Care Communities – Our Core Teams

Approach: Operating through clearly defined **GP based core teams**, AND **Care Community core teams** across Central, Newton & Haydock, North and South AND named **Care Co-ordinators** joining these teams together seamlessly.

GP based Core team

GP - based Core Team Phases 1&2

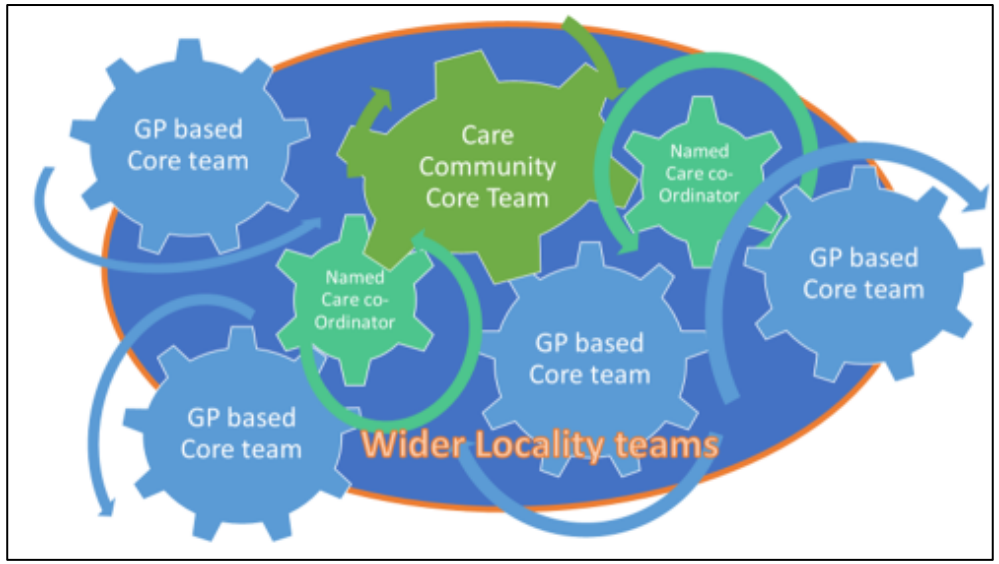
- GPs
- Practice Staff (PNs HCAs, Medicines Management team etc)
- PCN ARRS Roles (FCP, social prescribers, frailty practitioners etc)
- Practice linked District Nurse
- Practice linked Community Matron
- Practice linked Health visitor
- Practice linked Mental Health worker
- Practice linked social prescribers/wellbeing services
- Named drug & alcohol worker
- Practice Linked Care Co-ordinator

Named Care co-Ordinator

Care Community Core Team

Care Community Core Team Phases 1&2

- GP (relevant to patient)
- Contact Cares/Care co-ordinator – linking to boroughwide specialist services
  - Named Proactive Care Support worker
- Named Senior Community Matron
- Named lead Community Nurse
- Named Social Care Link worker
- Named Voluntary Sector Link worker
- *Locality Co-ordinator*
- *?MacMillan co-ordinator*



Outcome: Aligning our teams and staff across health, care and wider locality resources for the benefit of our residents.

St Helens Care Communities – Our Approach (1 of 2)

Phases 1 and 2: Building the right foundations:

- ✓ Bringing people together to generate a shared awareness of understanding
- ✓ Bringing people together to build relationships, understand their services and access to services

PHASE 1: Identifying the core GP & CC core teams: Jan- April 2023

PHASE 2: Core teams building relationships & working together: April – Oct 2023

PHASE 3: Linking in the wider Teams: Oct 23 – Jun 24

Accountability / Governance / Focus

- ✓ A dedicated Design Group / SROs
- ✓ Securing Clinical and professional leadership
- ✓ Agreement on Vision / Objectives
- ✓ Development of Operating Model

Communications

- ✓ Dedicated newsletter
- ✓ Organisation of Engagement events

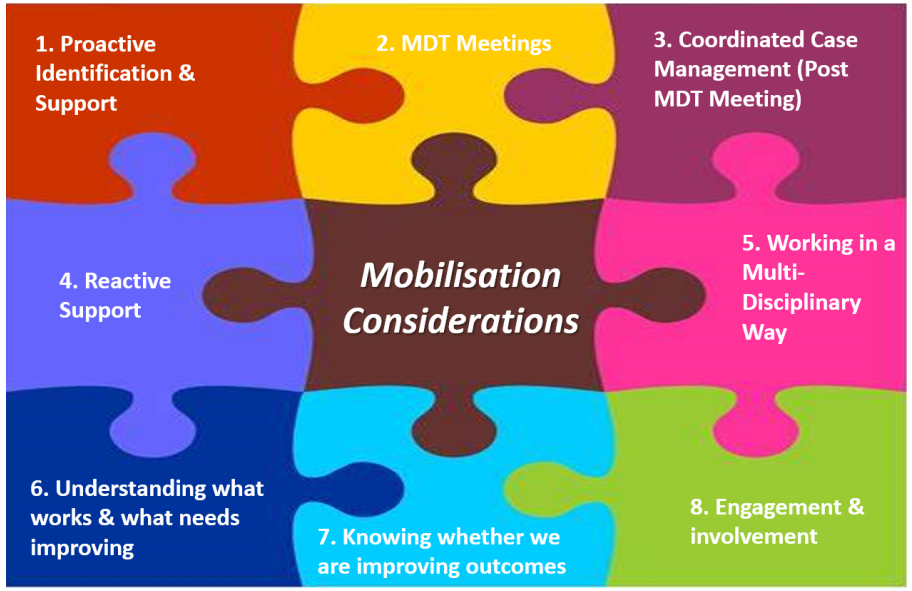
Roles / Responsibilities

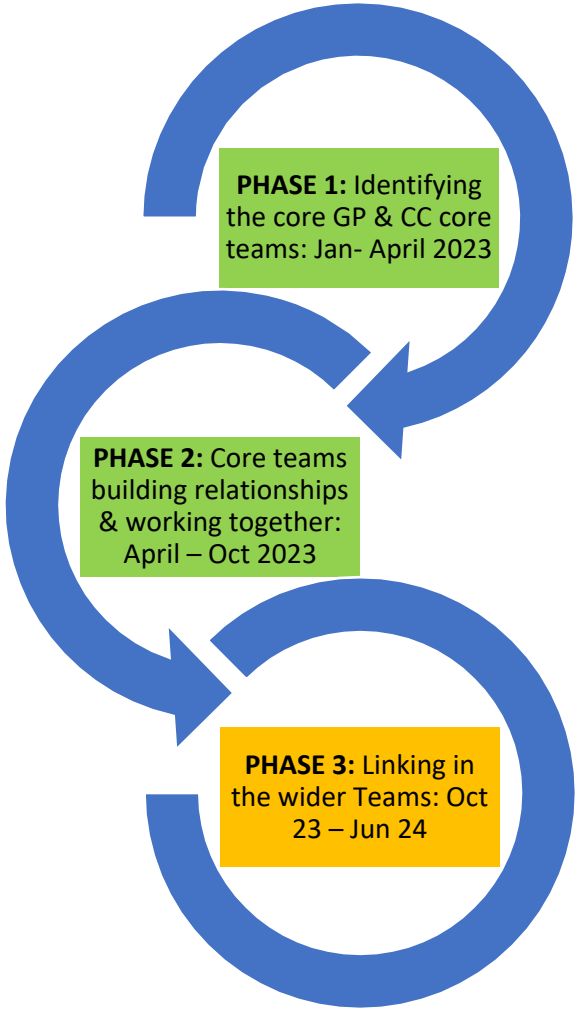
- ✓ Identification of Care Coordinators
- ✓ Identification of Core Teams

St Helens Care Communities – Our Approach (2 of 2)

Phase 3: Mobilisation / roll-out:

- ✓ Identifying which Care Communities are ready and how ready – working through the key mobilisation considerations:





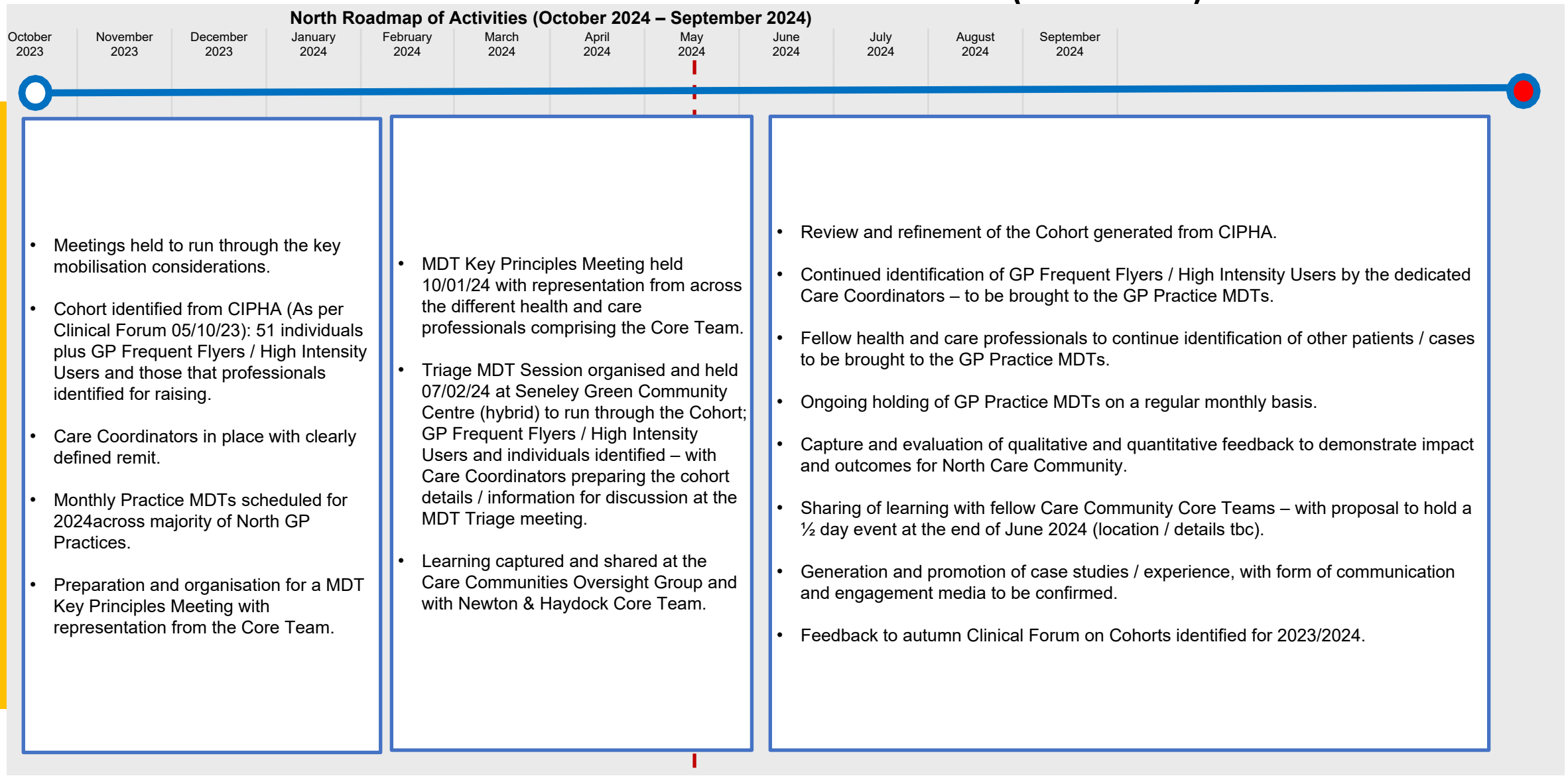
Linking in the wider teams including:

- ✓ Housing
- ✓ Education
- ✓ Police / Criminal Justice
- ✓ Fire

Aligning with key programmes including:

- ✓ Complex Lives
- ✓ Localities
- ✓ Cheshire & Merseyside ICB

St Helens Care Communities – North (1 of 2)



St Helens Care Communities – North (2 of 2)

North Care Community Triage Meeting overview

- ✓ Logistics: hybrid meeting for flexibility and cater for different locations.
- ✓ Running order: agreed in advance based on numbers, attendee's availability.
- ✓ Information: brought by Care Coordinators for the GP practices they cover.
- ✓ Intelligence: invited from relevant Core Team Members as individuals were discussed i.e. what was known / how e.g. from Adult Social Care, Change Grow, Live (CGL), Mental Health, Social Prescribers etc…

What worked well	What could be improved / considered / questions generated…
✓ Professional representation / participation at Triage meeting ✓ Preparation of information for the Triage meeting ✓ Structure used to work through the Practice / cohort lists ✓ Richness of discussion at the Triage MDT ✓ Ability to cross-check / reference professional intelligence ✓ Recognition that other parties could contribute e.g. Housing ✓ Enhanced knowledge of services available for access for immediate person being discussed or wider family member impacted by the situation e.g. The Carer's Centre ✓ Ability to identify those required for Practice MDTs and not	❖ The criteria that generated the list – "Known to Social Care" – as this appeared to pick up from a wide range of association e.g. family / siblings / previous history / MH assessment ❖ Broadening of invite as appropriate to other professional colleagues e.g. housing (Torus); Complex Lives etc. ❖ "The list" itself – whether opportunity to generate via subject / theme area ❖ Opportunity through a MDT discussion to not focus on a "sole / specific aspect" but the "whole of the person's requirements and what could potentially improve their lives

St Helens Care Communities – Newton & Haydock

Mobilisation / Roll-out commenced: building upon the experience / learning from North Care Community

Backdrop Preparation (January 2024)

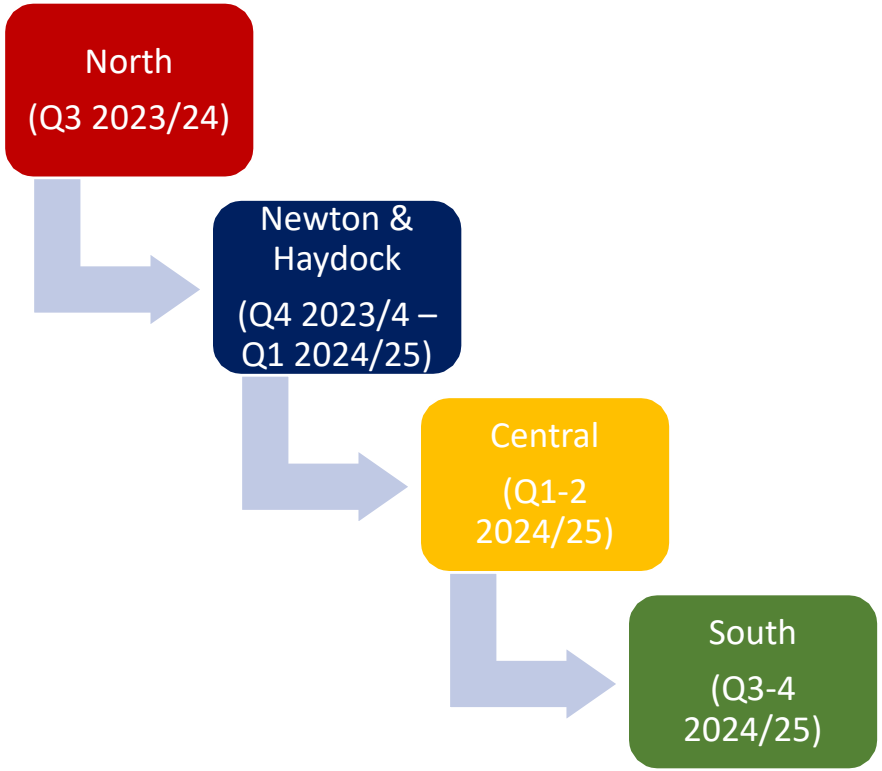
- ✓ MDT Key Principles Meeting held 10/01/24 with representation from the immediate Core Team.
- ✓ Cohort to be identified (as per Clinical Forum 05/10/23).
- ✓ Care Coordinators in place with clearly defined remit.
- ✓ Monthly MDTs agreed to be scheduled from February / March2024 onwards.
- ✓ Learning to be gleaned from North Care Community experience / progress.
- ✓ Understand any limitations e.g. access to SCR / training requirements.

Progress Update (February – March 2024)

- ✓ Representatives from Newton & Haydock attended the North Triage MDT Session held 07/02/24 as Observers to understand the process and what worked well / what could be improved.
- ✓ Team meeting held 14/02/24 to share the process followed and agree preparations ahead of their Pre-triage meeting.
- ✓ Schedule of MDT dates for all GP Practices progressed.
- ✓ Access requirements to CIPHA database identified and arranged and Cohort re-run.
- ✓ Preparation progressed for Triage meeting to be held April 2024 and commencement of MDTs.

St Helens Care Communities – Roll-out / next steps

Making Care Communities a reality through a stepped approach to mobilization / roll-out across St Helens:



Wider Mobilisation / Roll-out involvement / plans:

- Involvement of Housing colleagues
- Discussions with colleagues from Education and Children's Services around their potential involvement and timing of such
- Identification of any wider service representation and cooperation

Next steps from mobilisation / roll-out:

- Capture of learning and sharing – what went well/even better if
- Capture of activity – MDTs held and patients / cases discussed
- Outcome from MDTs – referrals / cases resolved
- Organisation of a learning event – June 2024
- Writing up of case studies – throughout 2024 / 25
- Capture of St Helens experience in research report
- All Care Communities to be up and running by 31/03/2025