Place-based Partnership

Blackburn with Darwen

2024/25
End of Year Review

Contents

Foreword

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Welcome to the Blackburn with Darwen Place-based Partnership end of year review where we are delighted to have the opportunity to celebrate and share some of the incredible work that has been undertaken by our colleagues over the last year.

We have a long history of joined up working in Blackburn with Darwen, and this year has been no different. We have seen our partnerships and relationships continue to grow and strengthen through our collaborative ways of working. Our shared vision and ambitions which focus on delivering integrated health and care, continue to keep people safe and well at home. Despite some financial and organisational challenges, we have made some significant advancements over the last year. We have focused on improving community wellbeing and addressing local needs, as well as seeing benefits in areas like urgent and emergency care, end of life care, and community care.

People living in Blackburn with Darwen face a number of challenges, with exceptionally high levels of deprivation. Life expectancy rates remain below national levels, with considerable variation between the most and least deprived areas of the borough.

But we remain proud to be part of Blackburn with Darwen. It is a place where vibrant towns are surrounded by glorious, rolling countryside; where a strong heritage is celebrated with an exciting new cultural scene. It is a place with an 'anything is possible' attitude, with a deep sense of community pride and with powerful partnerships as a force for good.

This review describes some amazing examples of progress in delivering our key priorities. Including knowing our people and using their insight and experiences alongside our own population insight and data, to better understand the needs of our communities.

We have delivered better joined up services, reviewed our integrated neighbourhoods, looked at our intermediate care offer, delivered quality improvements within the care sector, and we have grown and supported our workforce. We have also overseen a successful shift of adult physical services and children's mental health services between providers.

Our Place-based Partnership Board, which brings key partners together for collective decision-making, continues to meet monthly and is the "engine-room" behind our collaborative delivery. Our partners come together with a shared commitment to improve the lives of the residents of Blackburn with Darwen and we recognise that, as a partnership, we have the power to ensure we are effective, caring and safe, not only for our patients, residents and communities but for our colleagues too.

We want to thank everyone for their continued hard work in striving to make a difference to our residents' health and wellbeing and for making sure their experience when using our services is a positive one.

Our ambitions and priorities for 2024/25

Blackburn with Darwen (BwD) Place has defined its key ambitions for its Place-based Partnership (PBP). These ambition statements act as a unifying purpose that underpins the work of our PBP moving forward. We have three key ambitions, these are:

- Our people – "we will work with our residents to improve health outcomes and quality of life, for a happier population".
- Our model of care – "we will deliver seamless, all age, mental, physical and social care and support where and when people need it".
- Our partnership – "we will have a single Blackburn with Darwen system delivering better health and care within our allocated budget".

In Blackburn with Darwen place, the PBP Board is well established and includes a wide range of leaders from different organisations and sectors. The Board has enabled us to co-design and deliver on our ambitions across our key work programmes. Our programmes have been focussed on delivering with our people across integrated services and life course improvements and developing our partnership.

In setting priorities for 2024/25 the Blackburn with Darwen place partners reviewed the content of the existing Joint Local Health and Wellbeing Strategy for the borough, along with commissioning plans for adults, public health and children and young people. There is absolute alignment to the Health and Wellbeing Board priorities and those of the LSC Integrated Partnership, and our PBP is recognised as the key delivery vehicle for delivering health and care integration across the life course of residents in Blackburn with Darwen. Examples of our work in 2024/25 are included within this report.

Creating healthy communities

Public involvement is an essential part of making sure that effective and efficient health and care services are delivered; by reaching, listening to, involving and empowering our people and communities, we can ensure that they are at the heart of decision making. Our Blackburn with Darwen PBP is committed to putting our population's needs at the heart of all we do and co-producing service delivery wherever we possibly can.

Family hub engagement

An engagement programme with families in Blackburn with Darwen was developed collaboratively between the ICB's engagement team and the family hub engagement and co-production lead.

A number of engagement sessions were held across the borough's four family hubs to listen to parents and carers experiences when using local health services and any barriers and challenges they encounter. Feedback received from these sessions were shared with the relevant ICB commissioners and place-based leads for them to consider when planning future services.

Other sessions involved speakers from the health sector including school nurses and GP practice nurses to discuss the childhood vaccination programme, pharmacy services to explain their services particularly around Pharmacy First and, finally, a number of sessions with the clinical lead from the school-based mental health support teams.

Supporting our residents through winter

Our Partnership Insight, Communications and Engagement Group focuses on working with networks and community groups to ensure people are informed about accessing appropriate services and around things they can do to support their own health and wellbeing.

Ahead of Winter 2024, the group developed a number of resources, relevant to Blackburn with Darwen, to help communicate messages to residents. They worked with volunteers, community leaders, councillors and staff from community organisations and groups to help them share important messages when they were in contact with people who were vulnerable or more likely to benefit from support from health and care services.

Two additional documents were also developed this winter with key messages to support mental health wellbeing and 'Beat the Winter Blues'. One for staff and organisations to use which contained tips for starting a conversation about mental health, with links to various support lines, including who to contact when a person may be in crisis and tips to share on ways to benefit mental wellbeing. The resident

focused version was similar, in that it provided information about mental wellbeing and the organisations who could provide mental health support when needed.

Blood pressure and atrial fibrillation checks

Six of the seven members of the ICB's place-based engagement team have been provided with blood pressure and atrial fibrillation (AF) training by Blackburn with Darwen Council health and wellbeing team. In addition to this training, the health and wellbeing team also provided blood pressure monitors and an atrial fibrillation device along with an app to record findings.

Equipping the engagement team with the skills and ability to check the blood pressure and heart health of members of the public while in the community engaging with the public is an opportunity to make every contact count and, as well as gaining insight into their experiences, help those individuals to avoid health problems as a direct result of the contact.

Currently 94 individuals have had their blood pressure checked along with AF monitoring. These have been conducted via drop-ins at the family hubs, children's centres, Deaf Village North West, as well as at a church coffee morning in Brindle (some of the congregation are residents in Blackburn with Darwen).

Of those supported, 12 were advised to seek further clinical advice for their blood pressure. No AF was detected in those monitored.

Encouraging members of the public and patients to start a conversation about their health and use of health services can be challenging without an incentive or something to draw them in. We know a small chat can lead to big change so this will provide the opportunity to make every contact count and have active discussions.

Your health. Your future. Your say.

The ICB has developed a vision and plan for recovery and transformation through working in partnership across the health and care system. This is for a high-quality, community-centred health and care system by 2035 focused on 'well care' rather than 'sick care' by prioritising prevention, wellbeing and early intervention.

To support an honest and open dialogue with members of the public, a programme of public engagement took place across the region to share the challenges faced by health and care services, opportunities for improvement and to listen to views of

local people about what is important to them. Insights were also gathered through an ICB perception survey, an Integrated Urgent Care (IUC) survey and targeted engagement with health inclusion groups.

In Blackburn with Darwen the perception survey showed 47 per cent of respondents thought the NHS was providing good services locally and 36 per cent disagreed.

At the Blackburn with Darwen face-to-face roadshow, the majority of attendees were very supportive of the work being demonstrated in the area and spoke very favourably about the Place team and the ICB.

Issues raised in conversations were:

- Support for the VCFSE: The link with the VCFSE sector was applauded and the
- value of this work was very much emphasised. People said there should be more investment in this type of work.
- Mental health: The feeling was that mental health services were not as good as they could be in the area.
- Services in the community: This was raised as part of discussions around social care and how there needs to be more provision for this.
- Navigation: People said there was not enough information about what services were available.
- Housing: This was raised as a big issue as a pre-determinant of health and where the quality of housing was the problem. The suggestion was to encourage council services to do more to remove mould or dampness in houses to help improve health.
- Support for children: Not just in the case of mental health but also support in schools.

This feedback has been used by the Blackburn with Darwen Place Team to inform delivery plans for 2025-2026.

Celebrating Blackburn with Darwen Community Network – 1 year on

The Blackburn with Darwen VCFSE sector are a key partner in our Place Partnership, with all partners recognising the strength in the sector's adaptable, innovative and flexible delivery which provides invaluable support for thousands of our residents, day in, day out.

The Blackburn with Darwen Community Network is the representative body for all Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations operating in the borough. The Network has been developed through engagement with the sector and other partners including the local authority and the Blackburn with Darwen place team. A new board – currently 11 people from local organisations

– was recruited in July 2024. Vicky Shepherd, Chief Executive of Age UK Blackburn with Darwen, was appointed as Chair of the Network Board in January 2025, Vicky is also the vice-chair of our PBP.

The Community Network engages with its members through a range of mechanisms including quarterly forum meetings with an agenda of current issues, development discussions and networking; and a range of thematic groups focussed on particular issues, with current examples including a digital inclusion network, disabilities network, supporting the diverse communities in Blackburn with Darwen and a housing group.

It is estimated that there is approximately 1000 VCFSE groups operating in the borough, ranging from small volunteer-led groups which focus on one area or issue, to local charities providing a range of support for particular communities or cohorts of people, to regional or national charities which provide services for local people. The sector is diverse, however, this means it is well placed to support the improved health, wellbeing and quality of life of people in Blackburn with Darwen, covering every sector and need. As a network, they have a strong focus on engaging with communities and ensuring this insight and engagement influences and informs decision making about service commissioning and delivery.

A key priority of the Community Network board is to support the development of further opportunities for the sector and its role in supporting health and wellbeing across all the key workstreams and priorities of the Place-based Partnership which include mental health and wellbeing, neighbourhood health and care models, prevention and population health and reducing health inequalities. Current examples of development work include small grants to engage communities to support the further roll out of the WorkWell employment programme, and work with the Digital Inclusion network to maximise opportunities through the Governments new Digital Action Plan.

The Network have developed a refreshed process to identify and support the VCFSE sector to be represented on all key strategic and decision-making bodies in Blackburn with Darwen, with the aim of strengthening the voice of the sector and ensuring that their work on engaging and supporting local communities can be fed into all relevant discussions and decisions.

WorkWell Blackburn with Darwen

WorkWell is a free service designed to support people to stay healthy and active in work. It's a pilot programme across Lancashire and South Cumbria – Blackburn with Darwen are one of seven districts where WorkWell is available.

It's been developed as part of the Government's plan to help people with physical and health conditions that are not complex but are affecting a person's life - either affecting their ability to work or look for work. This could be things like:

- feelings of being overloaded with life and so experiencing stress or feeling overwhelmed and needing space to talk;
- musculoskeletal (MSK), back or knee problems, or other discomfort and muscular problems;
- life changing circumstances affecting confidence, skills and aspirations.

As part of the offer, individuals will have access to a work or health coach who will offer individualised support for up to 12 weeks and help create some clear objectives that address individuals' physical, psychological and social needs.

Since delivery commenced in October 2024, the following have been identified:

- 39% of current referrals are from Primary Care;
- 67% of people referred that live in Blackburn with Darwen are from our priority wards;
- mental health is coming through as the primary health barrier, closely followed by musculoskeletal conditions.

We are working with Local Primary Care (LPC) to actively case-find patients in receipt of fit notes to offer WorkWell support.

Below are some examples of people supported through WorkWell BwD.

Female, age 48, currently employed but off sick due to ankle fracture. Workwell referral received via Physio Team at Barbara Castle Way:

"Following a face to face appointment with a Health and Wellbeing Coach and completing the Work Star Assessment, it was established that her focus was exercise, with an end goal of returning to work and feeling fitter. 1 to 1 support was put in place and key goals identified, the lady is now attending a 12 week exercise programme which is accelerating her recovery and improving her wellbeing."

Male, age 25, left his job due to stress and then struggled with applications for new roles due to having dyslexia:

"Your support has been invaluable in helping me shape my career goals. You assisted in improving my CV by giving it more structure, ensuring it was tailored for the types of roles I was applying for at Blackburn College. You also helped refine the terminology used and made sure I met the specific criteria for these positions. Additionally, you conducted a health check to assess how I was feeling throughout the process and set achievable targets, which helped me stay focused and motivated. Thank you for your assistance."

Supporting our local carers

We are acutely aware of the extraordinary role unpaid carers play in our community - a role that is often undervalued and unseen. Our unpaid carers, diverse in every aspect, from young individuals aged 5+ juggling education with caring responsibilities to adults tirelessly supporting family and friends, are an integral part of our society. Recognising this, the Place Partnership supported the development of a Blackburn with Darwen Carers Strategy and action plan to drive delivery of key pieces of work for 2024-2028.

Our commitment as a Place-based Partnership goes beyond recognition. It encompasses providing accessible, flexible services tailored to the unique needs of young carers and adult carers in our borough. From financial support and respite care to health and wellbeing services, we are dedicated to enhancing the quality of life for all our carers. We understand their challenges - the social isolation, the financial hardships, and the physical and mental toll caregiving can take. By working closely across the health, care and the VCFSE sector, we will ensure that services for carers are seamlessly integrated with the broader health and social care landscape. The strategy is our roadmap to making Blackburn with Darwen a place where carers and those they care for can thrive and professionals are clearer of their roles. Key actions have been agreed for delivering the Strategy in 2025, these include:

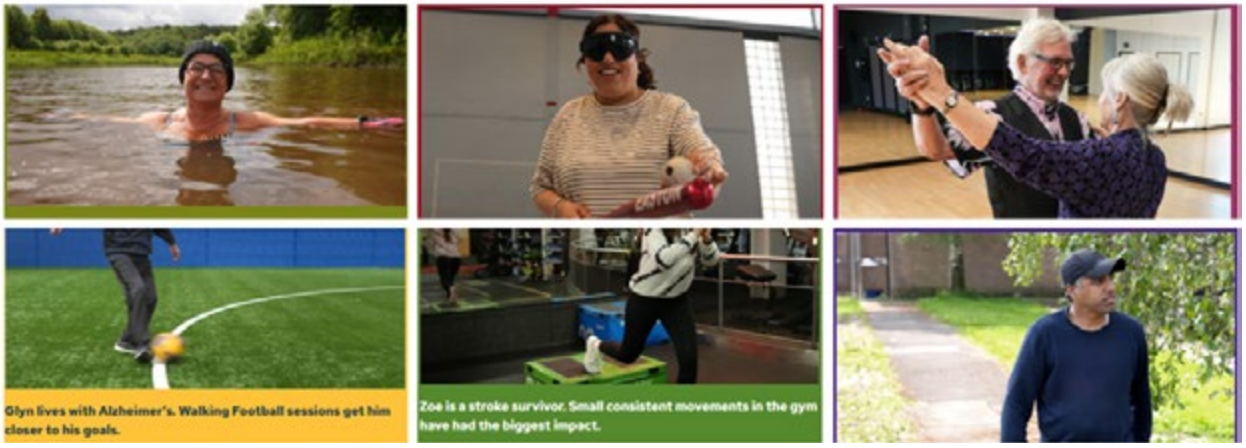
- Understand the needs of seldom heard groups.
- Increase identification of hidden Carers, including Young Carers
- Ensure up to date information, advice and guidance is accessible to carers and that support is available for those in seldom heard groups or who cannot attend the Carers service face to face. Ensure any information is available in digital and non-digital forms.
- Create a Communications/engagement plan to celebrate Carers
- Support Carers to access information about work opportunities that can fit around the Carer role
- Complete the NW ADASS Carers self-assessment to inform future plans
- Explore opportunities to develop a Carers MOT health Check, including Young Carers
- Increase understanding of the respite offer in BwD for both children and adults, identify how this compares to other boroughs and where there are opportunities for improvement.
- Develop a directory/space of Services and Activities.

We are undefeatable

In June 2024, Together an Active Future and the We Are Undefeatable national team joined forces to invite local community groups and partners to launch the localised Blackburn with Darwen We Are Undefeatable campaign.

We Are Undefeatable is a national campaign led by leading health and social care charities. The aim of the campaign is to inspire and support people living with a long-term health condition to be more active.

The Blackburn with Darwen campaign features local residents, and signposts to local services. From boxing and wild swimming to cycling and walking, these inspiring individuals showcase the diverse ways to be active, regardless of your condition. Those such as Chris, who lives with Parkinson's disease and moves more through walking-football with support from Mind2Muscle.



Supporting our Children and Young People

Blackburn with Darwen Children's Services judged as "Good"

Our children's services at Blackburn with Darwen Council are critical partners in our Place Partnership.

In April 2025 Ofsted judged Children's Services in Blackburn with Darwen as 'Good' in a glowing report, following their three week inspection in March. They described the new leadership as 'strong, highly visible and supportive, open, honest and respectful' and praised its 'injection of energy and pace' that has brought about significant improvements in the service.

Strong partnerships were highlighted for praise after inspectors witnessed a 'palpable pride and collaborative culture': the report recognised that "Strong agency partnerships are enabling children, care leavers and their families to be well supported and make progress and there is a relentless focus on children and care leavers' lived experiences." The innovative network of Family Hubs and Children's Centres are praised for their early help. And while there has been a significant increase in contact and referrals, systems ensure that they are responded to swiftly and with experience.

Place partners being the best "Corporate Parents" we can be

As corporate parents, public sector organisations can shape the lives of care experienced and looked after children and young people by listening to what they want and need and taking the right decisions to make sure that they are getting what they need to do their best.

The ICB's dedicated Designated Nurses and Doctors for children in care and care leavers provide dedicated strategic responsibility for developing, delivering and auditing high quality health services for these children and young people. The Designated Nurses are a key partner in the Blackburn with Darwen Children and Young People's Partnership and work closely with the local authority and other place partners to lead and influence change across the health and social care system around the health and wellbeing of children in care and care leavers.

The council, along with partners, will soon launch the Care Leaver Covenant which is a commitment made by the private, public and voluntary sector organisations to provide support for care leavers aged 16-25 to help them to live independently.

The partnership will aim to create meaningful opportunities for care leavers in five key areas and support care leavers to access opportunities relating to:

- Independent living
- Education, employment and training
- Safety and security
- Mental and physical health
- Finance

Lancashire and South Cumbria's career and engagement team, supported by the Designated Nurses, have consulted with each of the local authorities and care leavers. Scoping exercises were undertaken to formulate a gap analysis of career and employment opportunities across the system which has resulted in NHS career leads now contributing to the existing local authority work, providing expertise and signposting from an NHS perspective; locally this includes representation from ELHT and LSCFT. Plans are in place to strengthen this work further in 2025 through an established system wide steering group and the Place-based Partnership members have committed to exploring how they can help support and sign up to the Covenant.

The Place-based Partnership Board has also committed to:

- acknowledging that Children in our Care and Care Leavers are a population with specific health needs, similar to those with protected characteristics, and that this should be recognised in commissioning and service delivery arrangements, in line with the ICB Children in Care and Care Leavers Health strategy and the council's Corporate Parenting strategy;
- ensuring that all opportunities are taken to build participation and the voice of Children in our Care (CioC) and Care Leavers (CL) into commissioning decisions and service design and delivery as part of the borough's co-production approach.

Supporting a focus on peri-natal mental health through our Family Hubs

Historically 25% of mothers and 10-20% of fathers experience poor mental health, these numbers increased to 59% due to factors like COVID-19 and the cost of living. This affects approximately 4,000-10,000 people in Blackburn with Darwen alone. Additionally we know that 1 in 10 parents struggle to bond with their baby, and 71% of parents desire more support with bonding.

Poor peri-natal mental health can lead to various issues, including poor mental and physical health for the child, attachment disorders, cognitive and behavioural difficulties, and increased risk of Adverse Childhood Experiences (ACEs).

In Blackburn with Darwen a number of support services have been developed and commissioned including:

- **Lancashire Women**: Provides 1:1 peri-natal therapists, baby bonding and attachment groups, and signposting to family hub activities.
- **Dad Matters**: Offers 1:1 and group peer support for dads, focusing on wellbeing and baby bonding.
- **Home Start PMH Peer Support**: Emphasizes supporting families with training on parent-infant mental health.
- **Lancashire Mind Together after Loss**: Provides therapy and peer support for those who have experienced baby loss.

There are also various training programs and resources available to support parents and professionals, including:

- **Parent Infant Relationship (PAIRS) Service**: Offers support for parents to bond with their baby.
- **Baby Massage and PEEPS Groups**: Provides early parenting support and sensory rooms.
- **Talking Therapies**: Offers 1:1 therapeutic interventions with low waiting times.
- **Reproductive Trauma Service**: Supports those experiencing anxiety and depression due to birth trauma or baby loss.

The peri-natal mental health lead for Blackburn with Darwen now attends our Primary Care Neighbourhood meetings on a regular basis, in order to raise awareness of issues surrounding peri-natal mental health and support that is available for families. This has led to a much greater understanding for our primary care representatives and other members of our neighbourhood workforce.

Children and young people's emotional and mental health and wellbeing

In line with the ICB's strategic ambition for children and young people's mental health service transformation, the Blackburn with Darwen Place Team led the development of a business case to transfer the child and adolescent mental health services provision (CAMHS) for Blackburn with Darwen and East Lancashire, from its current provider (East Lancashire Hospitals Trust) to Lancashire and South Cumbria Foundation Trust (LSCFT). The intention behind this transfer was to realign clinical service provision to the provider with the specialist mental health expertise with the aim of supporting improved outcomes for patients and seizing benefits from clinical integration.

A six month post-transfer report, presented to the ICB, outlined a number of key impacts from the transfer:

- The number of CYP supported by the service (both new and total numbers) has increased by 3.3% in the 2024/25 period (194 more people)
- Referral to assessment waiting times have decreased by 0.4% and ELCAS has consistently achieved 100% for all assessments to be held within 4 weeks (which is an improvement on the 2023/24 average)
- The percentage of CYP with paired outcomes has averaged at 77.8% for the year to December and an average of 48.4% have shown meaningful improvement

Mental Health Support Teams (MHSTs)

MHSTs across Blackburn with Darwen and East Lancashire support primary schools, high schools, special schools, colleges and Pupil Referral Units (PRUs). The MHSTs provide direct, ongoing mental health and wellbeing support that includes:

- Evidence based interventions, Cognitive Behavioural Therapy (CBT), creative problem solving for children and young people with mild to moderate mental health conditions including anxiety, depression/low mood, sleep problems, panic attacks, specific phobias and behavioural and emotional regulation
- The teams also provide guidance around coping with issues such as exam stress and bullying, concerns related to historical self-harm and injury – learning to cope/new strategies, concerns related to current non-life threatening self-harm/injury – basic harm reduction, assessing risk and management advice. Children who require more specialist interventions will be directed to the child psychology service or have direct access to the ELCAS core team
- Emotional difficulties that are secondary to autistic spectrum disorder or ADHD or learning difficulties
- A consultation request for support process that ensures children and young people receive the right support to meet their needs
- One to one and group sessions, assemblies and whole class support
- Education, advice and training to staff within schools, with support for the mental health lead within each school or college
- Working with schools to implement their whole school approach developing a positive ethos and culture for pupils and families, promoting good mental health and wellbeing across the school
- Advice to school and college staff and liaising with external specialist services to help children and young people to get the right support and remain in education
- Parent led sessions as groups or 1:1s
- Parent education sessions e.g., the internet and the impact on mental health

The teams work with children, young people and families from a variety of backgrounds and aim to provide a culturally sensitive service.

In Blackburn with Darwen, we are committed to ensuring all of our children and young people have access to the best support possible and as a result of additional investment, the MHSTs are now supporting 99% of eligible education settings in the borough, reaching approximately 91% of the pupil population. The long-term goal is for all pupils to have access to mental health support in schools by 2029/30. By March 2025, MHSTs were expected to cover over 50% of pupils in England so it is a fantastic achievement that our Blackburn with Darwen MHST's are considerably above the planned trajectory.

Integrated working in neighbourhoods

Within BwD, neighbourhood integration is supported through our Better Care Fund which is part of our joint commissioning arrangements with the local authority and aligns to our neighbourhood health model. Following our neighbourhood review in 2023/24 work has been ongoing to deliver improvement plans through collective ownership and accountability across partners.

Anticipatory care planning through our INTs is key to enabling people to stay safe and well at home wherever possible. During 2024/25 there has continued to be a focus on anticipatory care planning for people with frailty, in line with ICB and place-partnership priorities. Each of our INTs are now working to ensure that 50% of their case load discussion includes frail elderly residents. Additionally, relationships with primary care have been enhanced through regular practice level meetings during which patients are identified who may benefit from a referral into the INT.

Delivering ageing well through our neighbourhoods is a key priority and in support of this, an Ageing Well (frailty management) model has been designed by our BwD clinical and care professional forum, involving resident facing practitioners. The model uses the Lancashire and South Cumbria Ageing Well framework and Clinical Frailty Scale (CFS) to provide consistent terminology across all professional and as the basis our population health management stratification. Our model has been designed to meet the needs of people at all stages of the CFS, ensuring a focus on proactive and preventative care at each stage. The care provided within neighbourhoods is pivotal to delivery of the frailty model as we continue to evolve our neighbourhoods during the next twelve months.

The work of our INTs has expanded in 2024/25 to support local people with complex needs thanks to our highly experienced and skilled Clinical Complex Case Managers (CCMs) and Complex Case Support Workers that commenced in early 2025, as a result of additional investment through the BCF and UEC Capacity and Investment Fund. The four CCMs are now core members of INTs, working alongside the INT Clinical Co-ordinators and health, care and VCFSE members.

Performance dashboards for have been developed for our INTs and Clinical Complex Case Managements which now include the CFS score. These dashboards are distributed to PCNs and other neighbourhood practitioners, along with social prescribing activity, on a quarterly basis so that progress, caseload mix and outcomes can be monitored.

Key outcomes supported by our integrated neighbourhood working include:

- 50% reduction in emergency hospital admissions due to falls in people aged 65 and over (Quarter 1 24/25 vs Quarter 3 24/25, 23/24 data not available due to EPR implementation)
- 6.5% reduction in emergency re-admissions within 90 days (2024/25 compared to 2023/24)

Blackburn with Darwen Social Prescribing Service

In Blackburn with Darwen, Social Prescribing Link Workers are fully embedded into our INTs and play a key role in bringing together health, social care and community services to offer co-ordinated, patient centred care. The service focuses on connecting people to non-clinical services that address the social and economic determinants of health and plays a crucial role in the success of INTs. Through working alongside primary care colleagues, social prescribing has also been embedded into the care navigation route during 2024/25 and the service has supported primary care staff to explore the wider social needs of patients as part of enhanced health checks.

Our social prescribing services has seen a year on year growth in referrals over the last three years with an increase of 13% from 2023/24 to 2024/25. In 2024/25 the service received 1,844 referrals and local people have been linked to 110 agencies for much needed support. Of those referred for support, 57% of people had their initial outcomes met.

During 2024/25 there has been significant growth in the BwD Social Prescribing Alliance, which provides a network of local health, care and VCFSE neighbourhood practitioners who come together to support people referred for social prescribing. The Alliance has a live membership of over 400 people/groups, with an average of 40 members attending in person meetings every six weeks. Amongst the success of the Alliance to date is an increased knowledge about local provision, stronger relationships and an increase in appropriate referrals into services.

Improving care and support for people at the end of their life

A key part of the Pennine UEC recovery plan has been to improve end of life care and support in Blackburn with Darwen, aligned to the Getting to Outstanding Palliative and End of Life Care action plan. Throughout the year a significant focus has been on increasing the early identification of people who may be approaching the end of their life and ensuring they have the opportunity to express their wishes as regards to their future care. In support of this, the Blackburn with Darwen Place Team were able to secure UEC capital and investment funding to provide additional capacity for general practice and East Lancashire Hospice, to support early identification and multi-agency care planning.

The following improvements have been seen in 2024-25:

- 10% increase in the number of people with an advance care plan in place
- 10% increase in the number of people dying in their preferred place of care
- Contribution to a 49% reduction in admissions for people approaching the end of their life (across the whole of Pennine Lancashire from quarter 3 2023-24 to quarter 3 2024-25)

Supporting our Urgent and Emergency Care system through integrated neighbourhoods

As part of a pilot approach to support high-intensity users of the Royal Blackburn Hospital Emergency Department, the four INT Complex Care Managers have utilised a population health data approach to identify the needs of local people, undertake comprehensive assessments and create collaboratively designed personalised care plans which meet the physical, emotional, and social needs of patients. From a sample of data taken from 1st July – 31st December 2024 of the top 100 attenders at the hospital emergency department, 40 of the 100 patients were from BwD and 60 were from East Lancashire. The total number of attendances within this period equated to 1,482 with 11,799 hours of time spent in the department. Over 60 of the 100 patients frequently presented with mental health issues, self-harm, overdose, alcohol/substance misuse and/or homelessness and the average age was 41 years of age. Based on the data, two cohorts of patients were identified for Complex Case Management intervention:

Cohort 1- Patients attending the hospital emergency department with no primary mental health condition and no indication of any physical health or other wider social determinants of health.

Cohort 2 - Patients attending the emergency department with 5-7 attends in the last 6 months who had at least one attendance in the last 30 days and diagnosed with a primary health need such as diabetes, respiratory (including COPD), Cardiac (heart failure, heart disease) or falls.

The work of the CCMs in supporting these cohorts has been positively received by health and care professionals, family and friends. This is attributable to a host of things including effective rapport and relationships with patients and collaboration with multidisciplinary neighbourhood team members. Early indications are that this approach is reducing unplanned attendances of the two cohorts by up to 60%. Going forward, the role of INTs will be critical to the mainstreaming of this approach and the success of earlier intervention and prevention.

Delivering effective mental health and wellbeing support

Mental health support is well embedded within our integrated neighbourhoods and this has developed further through the establishment of an Enhanced MDT for people requiring more intense mental health support. Our delivery is supported by a Mental Health Neighbourhood Practitioner Network which meets regularly to build relationships and align pathways/processes between a broad representation of services including Associate Psychological Practitioners, Mental Health Practitioners, Adult Social Care Mental Health Social Workers and Public Health. Partnership working through the network has enabled relationship and understanding across services to be developed.

A new Blackburn with Darwen Mental Health and Suicide Prevention Strategy

The strategy which will describe our ambitions and vision for mental health and suicide prevention in Blackburn with Darwen for the next five years will cover all ages – children, young people and adults. It will outline six priorities that we want to achieve and under each of those priorities will sit an action plan for delivery across sectors.

In order to inform development of the strategy, a six-week engagement period took place during June and July. This included an online survey, and targeted focus groups which included staff from mental health services, people with lived experience, children and young people, older adults, people bereaved by suicide, people seeking asylum, and people from learning disability and autism groups.

In total, approximately 300 people have shared their views and thoughts on this strategy. People told us they wanted:

- An inclusive and comprehensive mental health service
- A holistic approach to mental health care
- Clearer referral criteria
- Person centre care is a must
- Training for everyone
- Support for vulnerable individuals
- A system that addresses need early on

Delivering enhanced care in the community

Building an enablement focused intermediate care model

Hospital admissions have continued to increase year on year with demand exceeding capacity. Increased hospital admissions have further placed significant pressure on out of hospital social care services to rehabilitate residents back into their own homes. Blackburn with Darwen has higher than average utilisation of discharge to assess beds and as a result admit more patients into care homes following a hospital admission. Once admitted into a care home, patients often deteriorate, losing their independence and have repeat hospital admissions.

Health and care partners across Blackburn with Darwen acknowledge that the key to successful, sustainable change is only possible through an integrated model of intermediate care that (a) provides a seamless transition between the hospital and community and (b) identifies those in crisis and provides wrap around care that avoids admission into an acute setting. Partners within the PBP Board have agreed to develop an enablement focused model of intermediate care, that provides an equal balance of step up and step-down care, providing a rapid response, through therapeutic/strengths based clinical and social support for people to maintain their independence and keep them safe and well at home. The model will bring together a unified community team response including adult social care reablement support, social prescribers, occupational therapy, physiotherapists and nurses accepting referrals from acute settings, GPs, NWAS, Integrated Neighbourhood Teams and the voluntary sector. The model focusses on people, their strengths and assets and how best to meet their needs.

A multi-partner programme board has been established, to drive the delivery of the agreed model. Improvements so far are already demonstrating impact through a reduction in utilisation of discharge to assess beds and an increase in community step-up referrals. The full development and mobilisation of this work will be a key priority for the PBP in 2025/26 and it is anticipated that phase 1 which delivers a co-ordination hub for step-up and step-down care will be live by the 1st November 2025.

Test of change for intermediate care at Albion Mill

Albion Mill is facility in Blackburn that aims to provide high quality, person-centred, short-term, bed-based intermediate care to people who have been admitted from the community (step up) and to those being transferred from hospital (step down). A new collaborative service delivery model has been piloted during 2024/25 which aimed to take a more reablement/enablement approach to the care provided. The service model was developed as a delivery partnership between East Lancashire Hospitals NHS Trust (ELHT) as lead operational provider, Blackburn with Darwen

(Blackburn with Darwen) Borough Council, and Shifa Surgery, commissioned through the Better Care Fund by Lancashire and South Cumbria Integrated Care Board (ICB) and Blackburn with Darwen Borough Council. The pilot approach is part of the Blackburn with Darwen community model of care, which has been developed and forms a key part of our Enablement model.

A 12-month pilot/ proof of concept was scoped and delivered through the Place-based Partnership, which saw the service operating from the first floor of the Albion Mill building with 15 beds available (13 beds + 2 apartments). An evaluation of the pilot approach was finalised at the end of March 2025, and initial indications suggested that the new model of delivery has been consistently well utilised, is receiving positive feedback from patients via the Friend and Family Test and has led to a reduction in hospital attendances from residents at the facility. Agreement has been made to continue the test of change for a further 12 months, to support the full development of the enablement model and to further consider value for money.

Collaboration to drive improvements for our care sector residents

Care home quality improvement is a strategic priority both nationally and locally. At the start of 2024, it was identified that Blackburn with Darwen had a high number of care homes rated as 'requires improvement' and higher than average hospital attendances from those living in residential and nursing homes.

In response to this, the Place Based Partnership Board put in place a multi-agency programme of work to drive improvements to standards within the homes and also to prevent hospital attendances and admissions. Since the programme was established, delivery has focussed on:

- Setting system wide strategic direction for care home quality improvement
- Increasing utilisation of out of hospital services and roll out of call before convey and never say no programmes
- Roll out of an engagement project to enhance knowledge, training and development across care home staff
- Development of a combined data and intelligence dashboard to improve risk prioritisation and enable proactive monitoring and support
- Work with Primary Care around improving delivery of the Enhanced Health in Care Homes framework including the pilot of physical ward rounds

Improvements in 2024-25 include:

- In terms of quality, there has been a 12% increase in the number of beds rated 'good' by the Care Quality Commission, since September 2024
- A 20% reduction in hospital attendances between June 24 and March 2025 and these continue to show a decreasing trend
- Unplanned hospital admissions for care sector residents have also reduced by 15% for the same time period
- A 10% increase in intermediate care allocation team (ICAT) referrals between September 2024 – December 2024
- An increase in structured medication reviews, with 62% of residents reviewed by January 2025

Supporting Urgent and Emergency Care (UEC) recovery

The delivery of integrated health and care in Blackburn with Darwen has the key aim of supporting residents to remain safe and well in their own homes and as such is critical to managing demand on our urgent and emergency system. Blackburn with Darwen PBP is a key delivery vehicle for out of hospital programmes within the Pennine Lancashire urgent and emergency care recovery plan. During 2024/25 work has progressed to support three key groups of residents to remain safe and well at home namely those aged over 65 with some level of frailty; those residents who live in care homes and those approaching the end of their life.

Key achievements for each of these workstreams have already been referenced within this report, however the culmination of all of our delivery has led to a reduction in UEC attendances and admissions particularly, over the winter period. When compared to winter 2023/24 there have been 179 less attendances and 67 less admissions for those aged over 65, which represents just over a 2.5% reduction. Through 2024/25 as whole there was also a 15.3% reduction in unplanned admissions for all adults. Learning from our delivery will be utilised in shaping the Pennine winter plan for the up-coming year.

UEC Community Programmes

The Integrated Care System (ICS) committed 2% of the Winter Pressure funding for 24/25 to the VCFSE sector to support reducing unnecessary attendance at UEC and/or to facilitate safe and supported discharge from hospital. The Lancashire and South Cumbria VCFSE Alliance selected 2 pilot areas, Blackburn with Darwen and Blackpool to test and learn from the inclusion of the VCFSE sector in supporting system partners with an equal split of the funding to both areas. Following an open bidding process, Spring North, based in Blackburn, were appointed as the managing organisation for this work. Consultation was undertaken with place partners in the 2 areas to identify the target populations based supporting evidence of need.

This pilot programme specifically focused on three cohorts known to contribute disproportionately to UEC demand when left unsupported:

- Adults with respiratory conditions, particularly COPD, in Blackpool
- Older adults at risk of falls in Darwen
- Individuals facing multiple disadvantage in Blackburn Central Ward

Support for older adults to reduce falls in Darwen

The aim of the project delivered by Age UK Blackburn with Darwen and Care Network, was to reduce avoidable falls and hospital admissions among older adults in Darwen. It focused on frail individuals living at home, in care homes, or active in the community. This short term project, mobilised within 4 weeks, combined proactive outreach, risk identification and direct support to reduce injury and avoid escalation.

Age UK leveraged its long-standing community infrastructure and referral pathways to provide highly targeted support. Engagement-to-support conversion was the highest of all three projects, reflecting their ability to reach those most at risk. Many of those supported were identified through care home links or community navigation services. Strong partnerships were also established with NWAS through their collaboration with Progress Lifeline's lifting service. This has led to successful training sessions for care home staff and participation in the Care Homes Forum, generating interest and engagement from multiple care homes

One significant outcome is the involvement of a Senior Paramedic, seconded to improve falls prevention in care homes across Lancashire and South Cumbria. They are now also working with the Blackburn with Darwen Falls Task and Finish group to develop and implement key priorities, helping to streamline efforts to reduce unplanned hospital admissions due to falls.

Age UK's engagement with grassroots community groups progressed well, with initial efforts focused on cascading falls prevention information within their networks. A recent falls awareness training session, attended by 15 community group representatives, was well received and is expected to enhance outreach to older individuals who may not typically access support services.

In terms of impact from the project:

- 88% of people rated the service they received as very good and 100% said they would recommend the service to friends and family.
- 15 residents benefitted from improvements in their homes from funding made available through this project, who were not eligible for any statutory support.
- The exercise guides, equipment and one to one physical activity guidance worked well for people to maintain doing exercises in their own homes to help support strength and balance
- 66% of people reported an improvement in their mental health and wellbeing following support

"The support, service and communication has been brilliant. It has helped re-build my confidence and I feel safer at home. Having those few things added in my flat has made a difference and has helped with my mobility, I have been fine doing the exercises and still do them most days and feel some improvement"

Support for people facing multiple disadvantages in Blackburn Central Ward

The project's primary aims were to keep people safe and well away from hospital and reduce frequent, avoidable UEC usage during winter by supporting individuals aged 20–64 in Blackburn Central Ward facing multiple disadvantages. The project worked collaboratively with local partners to identify and address the underlying drivers of UEC demand, refer individuals into appropriate services, and support them with non-clinical needs through a joined-up local offer.

The Central Ward vulnerable adults and families project in Blackburn was delivered by 180 Project, Red Rose Recovery, and Thomas, with delivery launched quickly following the award in October 2024. The project focused on engaging adults and families with multiple and overlapping needs such as homelessness, substance misuse, mental ill health, and social isolation many of whom were disengaged from mainstream services but high users of urgent and emergency care.

Delivery was rooted in trauma-informed and peer-led approaches, enabling flexible, personalised support and trust-building with some of the most marginalised individuals in the community. Outreach targeted known hotspots across Central Ward, including St Anne's Church and Primary School, where language barriers, cultural factors, and low awareness of healthcare options were common.

While many individuals were open to initial conversations and offers of support, follow-up engagement proved challenging, particularly among those experiencing entrenched disadvantage or mistrust of formal services. Staff responded to multiple safeguarding concerns, including incidents requiring police or adult social care involvement, and adapted delivery to support those in crisis through harm reduction, emotional support, and multi-agency referrals. The team also highlighted the need for earlier training and stronger operational links with GPs, NWAS, and mental health services.

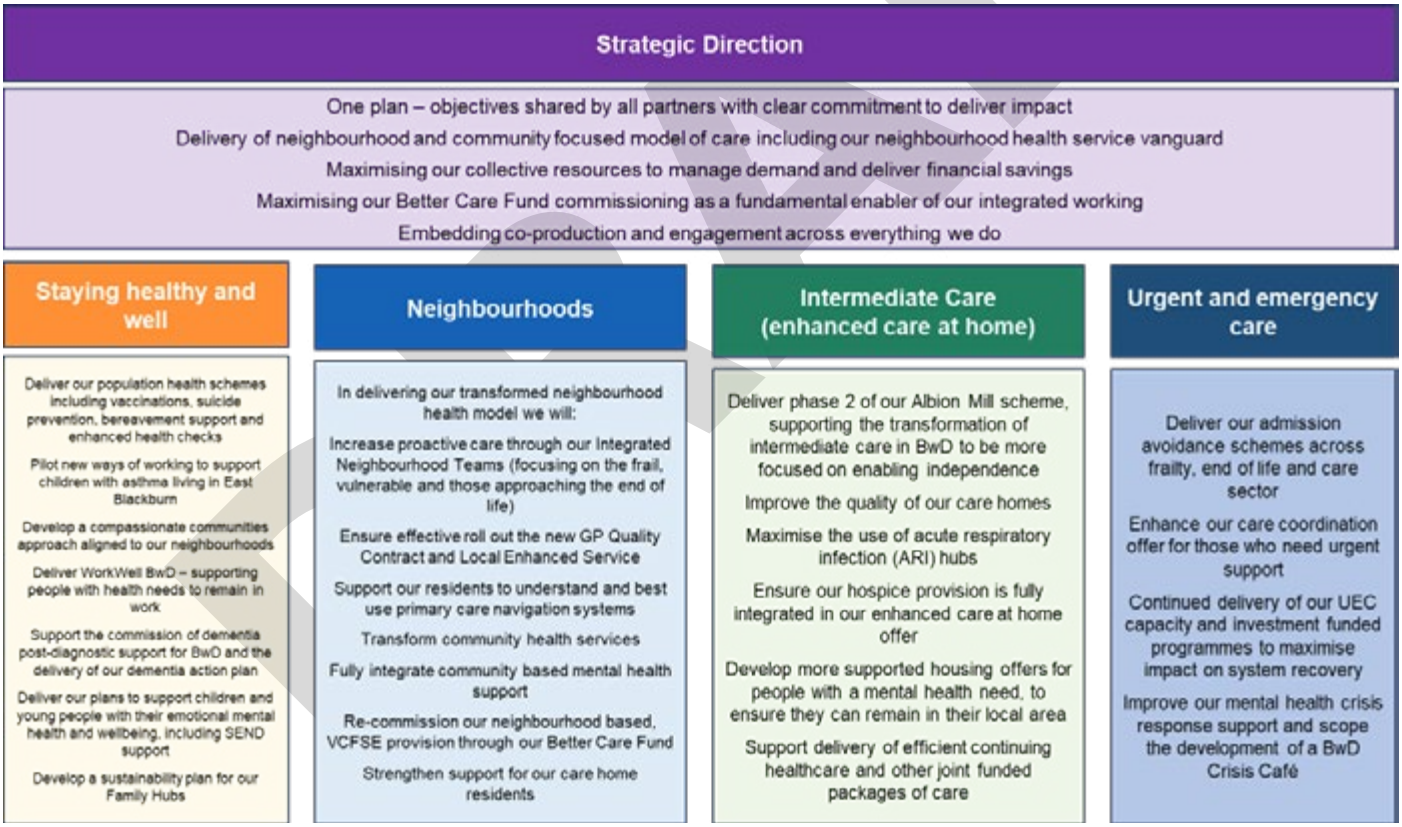
Despite the short delivery window, the project established vital foundations for future integrated support reaching people who were previously invisible to the system and offering consistent, non-judgemental help at the earliest point of need.

"Without THOMAS, I'd still be on the streets or in A&E, now I've got a roof over my head, support, and a chance to move forward."

Our priorities for 2025/26

In April, the Place-based Partnership reaffirmed their ambitions and agreed key priorities for the delivery of health and care integration in 2025/26, as an evolution of our delivery this financial year.

It was recognised that partners continue to face multiple complex financial challenges, further compounded by potential large scale structural changes across key NHS organisations. Therefore, to ensure effective delivery across the coming year, it was recognised there is an even greater need for stronger integration across the system. In confirming the delivery priorities, the PBP Board recognised the alignment with the Lancashire and South Cumbria ICB 2030 Roadmap and national Neighbourhood Health Guidance. The high level summary delivery plan for Blackburn with Darwen, including our place commissioning intentions is below.



Appendices

Appendix 1: Blackburn with Darwen Integrated Neighbourhood Team Case Study

West PCN – Quarter 2, 2024

Background:

Kevin is an 86-year-old man who lives with his 83-year-old wife Nancy. Nancy has a diagnosis of Dementia. Kevin was referred into INT by his GP. The referral stated that Kevin is Nancy's sole carer and there is no family nearby. He is not taking prescribed medication and is anxious about their new life.

Summary of medical, social and physical conditions:

Kevin has a heart condition which worries him but this is well controlled with medication and his healthy lifestyle. He does not take any other regular medication. He is his wife's main carer and at times is struggling with this. The INT Clinical Care coordinator (INT CC) contacted Kevin to discuss the referral and find out what support Kevin needed. Kevin explained that he is struggling to sleep as he overthinks when in bed.

He had been prescribed medication from his GP to help him sleep however he told his GP he was not taking them as he was worried that he would not hear Nancy if she woke up. Through careful questioning it became apparent that this was not the real reason Kevin was not taking his medication. Kevin had read the drug information leaflet and had convinced himself that he would become addicted to them.

Kevin's main concerns were about his caring role. He was worried about what would happen to Nancy if he were to become ill. He opened up that he has no time on his own. He loves gardening but does not get to do it as often as he used to. Kevin declined a referral to Adult Social Care as he did not want carers involved. The INT CC discussed the option of a carers assessment to look into respite support or a sit in service. He accepted a referral for this.

Kevin said that they were managing well. He explained that Nancy can wash and dress herself and is able to complete household tasks such as dishwashing, ironing and laundry. Kevin explained he does the cooking.

Kevin makes sure that they leave the house daily and that they are aware of some of the groups for dementia patients such as singing for the brain. Nancy goes for a walk on her own around the local park. Kevin can watch her from the bedroom window so knows she is safe. The INT CC discussed the greenhouse project at Witton Park with Kevin and he was interested in attending but would wait until Spring. Kevin was known to the Social Prescribing Service due to a previous referral into the team.

INT Weekly Meetings:

The INT Clinical Coordinator had an open and honest conversation with Kevin regarding drug safety and explained that the GP would not have prescribed the sleeping tablets if they did not think that he needed them. The CC offered to ask the GP practice pharmacist to discuss his medication, but Kevin did not want to bother them. He did feel more comfortable and said that he would try taking them. A discussion also took place about groups that are held at Witton Park that both Kevin and his wife Nancy could attend.

Support was offered from the Associate Psychological Practitioner (APP) to explore improving his sleep hygiene however Kevin declined.

Age UK BwD arranged to visit Kevin and Nancy in their home. The case worker discussed a range of services including Wayfinders, respite care and their local advice and information service. Kevin and Nancy were interested in their memory maker groups and other activities. Attendance allowance was discussed as Nancy was not receiving this. Kevin was hesitant about applying but it was explained to them that Age UK Advice and Information service would be able to support in applying. It would also mean that they could have a weekly cleaner rather than fortnightly.

Adult Social Care made telephone contact with Kevin he declined a social care assessment when called.

The Carers Service arranged a visit. They discussed Kevin's worries and explored options. The case worker produced a plan that gave Kevin peace of mind. He was given details of a care agency who could provide emergency support. It was at this point that Kevin accepted contact from Adult Social Care to discuss respite options.

Social Prescribing made contact. Kevin declined any support from social prescribing as he was happy with the social activities he already undertook.

INT Neighbourhood Approach:

The INT approach ensured that Kevin felt that he had been listened to, his concerns addressed and supported.

It not only improved his wellbeing but Nancy's too. He felt that he had more support in his caring role. He was given peace of mind. He created a care plan for Nancy should he become unwell which gave him a sense of control over the unpredictable future. He was made aware of the services within BwD who could support them in the future and was given information on how to self-refer if needed.

*All names have been changed to protect anonymity.

Appendix 2: Q3 Case Study for INT - Social Prescribing

Patient was referred into Social Prescribing due to having persistent low mood and not leaving the house.

When the allocated Social Prescribing Link Worker made initial contact with the patient the patient explained that they had not left the house for "a few weeks" due to a severe cold. On further discussion however it became apparent that his overall mood was low and this was contributing to poor motivation. The patient gave consent for the link worker to also have contact with their daughter and was able to gain some more background information including the families concerns about his wellbeing.

The link worker worked collaboratively with the patient to explore options to help improve their mood and motivation. A range of opportunities were discussed and it was established that the patient would be interested in attending a men's group run by Age UK on Wednesday afternoons. The patient had some initial reservations as to how well they would cope given their hearing impairment but was reassured once the link worker explained that she would make contact with the group prior to him attending.

The patient has now begun to attend the sessions and has integrated well with the group. This has had a subsequent knock-on effect of the patient re-engaging with sessions he previously attended as well including catching up with friends once a week for lunch and travelling by bus to Blackburn or Clitheroe twice per week to go shopping.

Following discussions with the family the link worker also discussed the patient's low mood and tendency to experience depressive symptoms. The patient consented to a referral to the Mental Health Practitioner for a face-to-face appointment in January 2025.

The link worker has also made further contact with the patient's daughter in order to provide information on the Carer's Service should this be required in the future.

The patient has been really appreciative of the support provided to him. He feels much more motivated and positive in his outlook and now feels he has regular activities and a routine which can help to sustain his mood and is looking forward to his Mental Health Practitioner appointment in the New Year giving him opportunity to discuss any mental health concerns.

Appendix 3: BwD Community Power and Health Creation in Ash Grove

Why is community power and development so important?

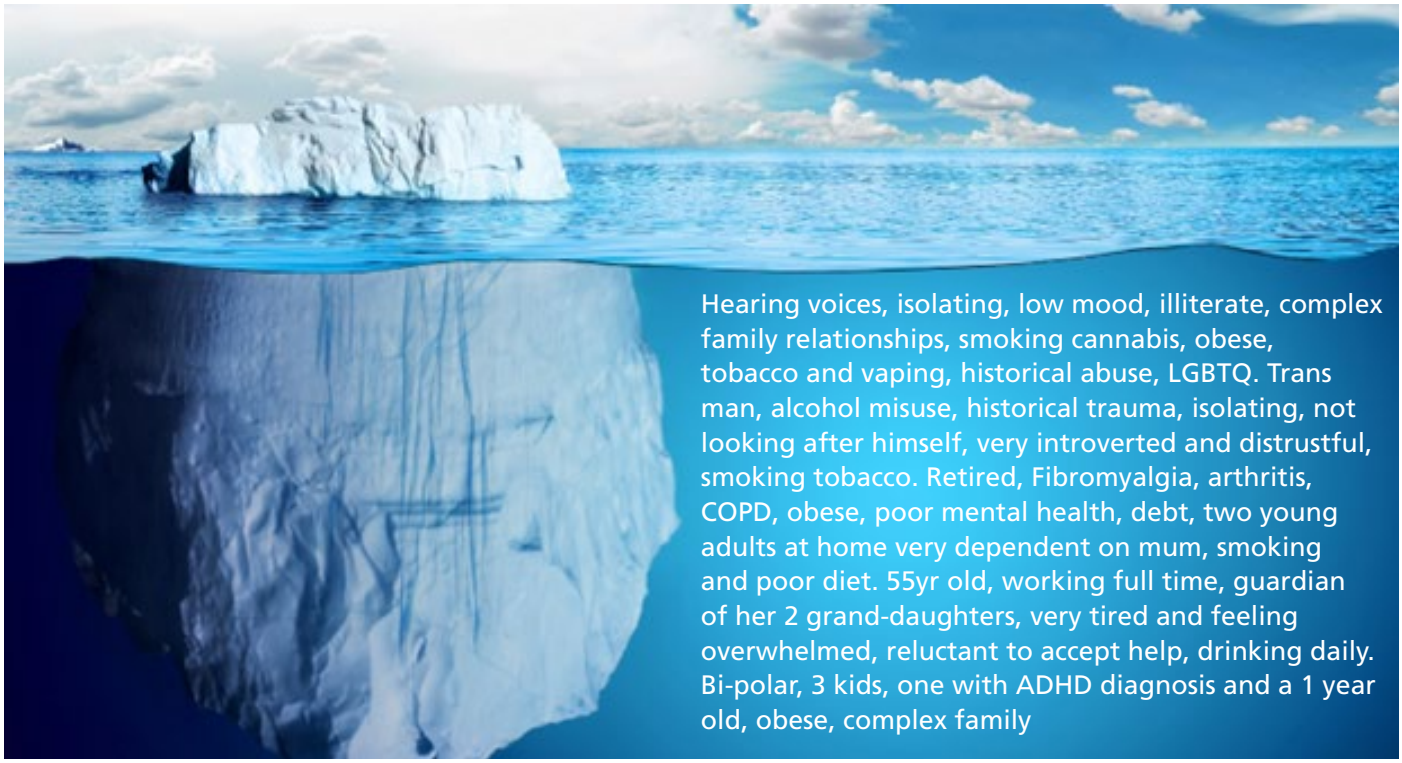
- Doing 'to them', removes any opportunity for their learning, development, ownership and pride, and will likely stop when you step away.
- Supporting them to do it for themselves, builds a wealth of positive impacts such as improved self-esteem, confidence, new skills, purpose, motivation, pride and status in their community. The ripple effect could change lives beyond their own.
- They already have the answers, capacity and in-depth knowledge about their community including how to influence them
- They need to set the priorities, pace and be encouraged to plan and lead.
- The feeling of power breeds courage, experimentation, change and inspires hope in others.
- Investing in them could have long term impacts on community aspirations, education, health, lifespan and employment. We are contributing to potential community elders of the future…
- Their stories, voices and achievements are powerful when used alongside health data when you want to influence system change

Priority Ward

- White British / Refugees and Asylum seekers
- Hilly terrain and poor transport links
- Private rental terraces and social housing estate
- High unemployment, poor MH, low levels of education, poverty, co-morbidity, deaths considered preventable.
- A little forgotten about...
- *Of all wards in BwD, highest rates: BMI, childhood obesity, Complex LTCs, Multiple co-morbidity, Depression, Epilepsy, Heart failure and emergency admissions for injuries in 15–24-year-olds
- *Of all wards in BwD, 2nd highest rates: Osteoporosis, injuries due to falls, respiratory and housing issues, asthma, COPD, Dementia and Stroke

*source Aristotle

The complexity: tip of the iceberg



The Inspiration – tip of the iceberg

I've learned that people will forget what you've said, people will forget what you did, but they will never forget the way you made them feel.

~ Maya Angelou

Hearing voices, isolating, low mood, illiterate, complex family relationships, smoking cannabis, tobacco and vaping, historical abuse, LGBTQ.

Trans man, alcohol misuse, historical trauma, isolating, not looking after himself, very introverted and distrustful, smoking tobacco.

Fibromyalgia, arthritis, COPD, obese, poor mental health, debt, two young adults at home very dependent on mum, smoking and poor diet

55yr old, working full time, guardian of her 2 grand-daughters, very tired and feeling overwhelmed, reluctant to accept help, drinking daily.

Bi-polar, 3 kids, one with ADHD diagnosis and a 1-year-old, obese, complex family

Priority Ward: Bottom-up approach

1. Meet them where they're at, in every respect.
2. Become a familiar face, get to know their needs, plans and interests
3. Start scanning the footprint for links and support
4. Capture their priorities (take into account any feedback from the wider community too) and agree owners
5. Facilitate catch ups for updates…move at their pace.
6. Encourage, encourage, encourage
7. Link up with (services) individuals who, like you, 'get it' and will invest, guide
8. Keep it fun and friendly
9. Harness the influencers, volunteers and individuals making it happen - they will encourage the rest.
10. Start to incorporate health aspects
11. Establish them as community experts and involve them in co-production of health and wellbeing projects
12. Reflect on their progress and development and celebrate their success

Their agenda..

- Monthly One Pot wonders – cooking and connecting
- Community Listening events
- Volunteer & Helper facilitated sessions / development
- Bingo, Diamond Art, Jumble sales
- Community Litter Picking Group
- Satellite - Patient Participation Group (PPG)
- MH peers support group
- Health & Wellbeing Group (obesity) Co-production
- Training: MECC, Walk Leader, Food Hygiene, Safeguarding etc.
- Cycling Hub, Learn to ride, Bike Repairs!, Road Safety.
- Links with Healthy Weight Network – influencing strategy
- Adult Reading & community volunteers -
- Gardening group – purpose, MH, responsibility and extra space!
- Resistance Bands Exercise class (train the trainer)

The Challenges..

- Colleagues not involved may not understand the complexity of what you are doing and the time it will take, so keep them updated on what you're learning and achieving
- Be prepared for the long haul – this is a journey, pace yourself
- Volunteers usually represent the community in every sense – be prepared for the moments of crisis
- Take care of yourself – some of the situations you deal with can take an emotional toll.
- You need to be available when they're delivering, be a part of their experience..

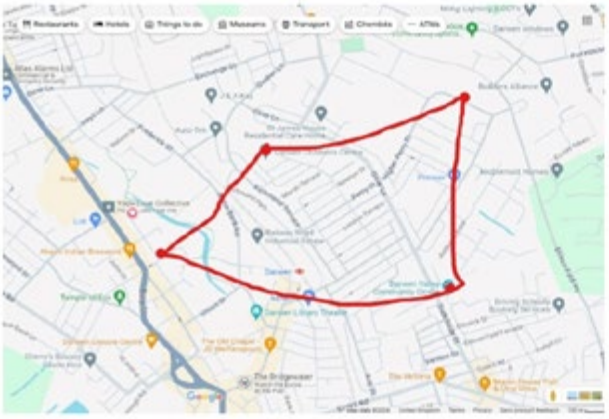
- Getting individuals through DBS checks can seem impossible sometimes
- You have to follow their lead and pace – which can be tough
- Council culture – can be tough, judgmental, lack self awareness, individuals can be shut down in terms of accepting help and suspicious of services.
- Consideration of people not being able to read, write or not having English as first language does take a lot of extra effort and work arounds
- Communities in deprived areas, tend to sit behind doors, you need to figure out ways to draw them out so you can get to know them.
- A WhatsApp group is a really good way of staying connected and supporting when needed (privately or in group)
- Seek out transport opportunities.

There may be times when you feel a bit of a fraud, remember this is a critical part of the work we need to do, and takes time, skills and resilience.

To make Population Health effective, our 'Places' need the intelligence as much as our communities need our investment and understanding

Winning moments…

Linking key locations:



Ash Grove Community Centre

Darwen Family Hub

Darwen Asylum and Refugee Enterprise (DARE)

Darwen Valley Community Centre

Darwen Community Helpers

Derwent Hall

Connections…

ARC	Regional Lead Creative Health	DARE	Healthwatch	Diocese of Blackburn	BWD Integration team
LSCFT MH	Practice Managers	Healthy Weight Lead	Social Prescribers	One Voice	Spark
Wellbeing team – Activity Lead	180 Project	Darwen Family Hub	Jubilee Tower Credit union	Rough sleeper team	Street Outreach
BWD Public Health	Mee Maws	Adult Learning	Chip-in	HICL- QOSH	BwD Housing
Red Rose Recovery Roots	East Lancs Hospice	Witton Park Greenhouses	Reaching Communities	ELHT Research and Development Lead	Care Network
St Lukes	Vulnerable women Lead	BWD Litter picking scheme	CVS	Local Councillors	Carers Service
TAFF	Together Housing	BwD Foodbank	RE:FRESH Team	Diabetes Peer Support	Darwen PCN
St James Over Darwen	Changing Futures	Kairos Housing	Food Alliance	CAD Central	Pop-Health core team

Place-based Partnership

Blackburn with Darwen