Living better lives in **Lancashire**

2024/25 End of Year Review

1. Introduction

Established in 2022 with the inception of Integrated Care Boards, Lancashire Place emerged from the reorganisation of boundaries previously overseen by Clinical Commissioning Groups. Amidst ongoing changes, the Lancashire Place team has collaborated with partners to dismantle organisational and navigational barriers, to improve the lives and life outcomes for our 1.2 million Lancashire residents.

Executive Summary

The Lancashire Place Partnership has made significant strides in delivering integrated health and care services across the region. This annual report highlights our key ambitions, achievements, and milestones to date, showcasing our commitment to improving the lives of Lancashire residents.

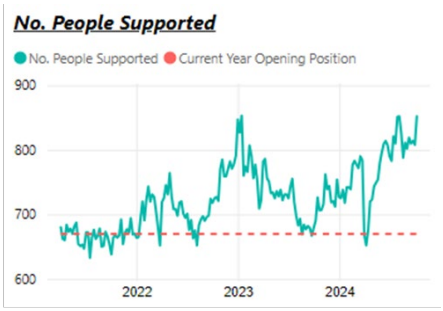
We have specifically focussed on addressing mental health in North Lancashire with the launch of the 'Help is Close' campaign focusing on key triggers for poor mental health, such as debt, loneliness, addiction, bereavement, and change. This campaign included posters, social media messaging, and promotions in community spaces to signpost people to help and support available in their local area via the Lancaster Service Directory and access to the LSCFT Initial Response Service for mental health. We also commissioned Lancashire MIND to deliver a programme in schools and higher education establishments, providing virtual workshops and face-to-face delivery to support students' mental health. On going support through a 'next steps' programme delivered by BEESAFE (a collaboration between two local young people's mental health charities) was also commissioned to provide additional support to those not currently in mental health services or young people's groups who provided similar services. Whilst a full evaluation of the campaign will be concluded later in the year, we have to date engaged with 11 out of 14 schools across Lancaster District and had over 7,000 visits to the 'Help is Close' webpage.

"This is incredible work. You and your team should be so proud. The HELP IS CLOSE campaign will undoubtedly save precious lives and give so many a second chance." Mike Palmer, 3 Dads Walking.

An example of the feedback received on the young persons mental health education initiative.

Our efforts in intermediate care have led to the full implementation of the 'Lancashire Model of Intermediate Care,' resulting in significant cost savings and efficiency improvements. A new Short-Term Support Service has been implemented and increased the number of people being supported by 24% since April 20204, and the utilisation of **373 Virtual Ward beds** across LSC with occupancy currently running at 70% - 80% against the 80% national target. Urgent care responses have also increased with Circa **2,700 referrals a month** and **94% of referrals receive a response within two hours**, against the national target of 70%, **73% step-up** (hospital avoidance) & **27% step-down** (hospital discharge).•Circa **17,000 people a year are now admitted** to a virtual ward who receive the service for 4.5 days on average.

We have Established a targeted work programme to address Not Meeting Criteria to Reside (NMC2R) cases and developed an Integrated Brokerage Model to broker care at a consistent price across Lancashire.



The graph shows the upwards trend of Lancashire people benefitting from the service changes- **an increase of 24% since April 2024.**

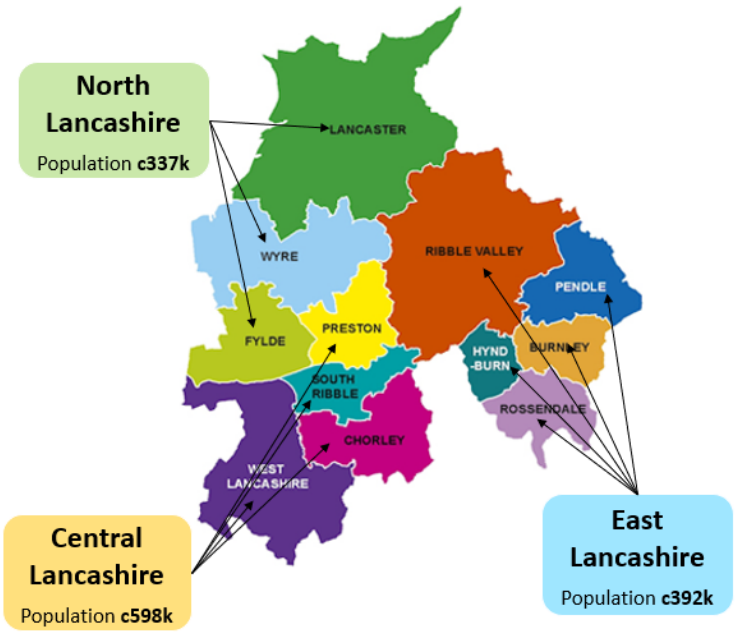
The Lancashire Place Partnership has prioritised reducing health inequalities and prevention through a joint unit between Lancashire County Council's Public Health and the ICB Population Health Team. We have focused on aligned procurement, design, and delivery of NHS Health Checks and Enhanced Health Checks. Additionally, we are developing ten district-level Health and Wellbeing Strategies, ensuring a long-term approach to improving health outcomes.

Our achievements include the successful delivery of the 24/25 agreed District Health and Wellbeing Partnership priorities, the implementation of a new Short-Term Support Service, and the establishment of a targeted work programme to address Not Meeting Criteria to Reside (NMC2R) cases. We have also made progress in integrating leisure, health, and activity offers across Lancashire, with a focus on improving quality and outcomes in personalised care.

Looking ahead, we remain committed to our vision of delivering integrated, high-quality health and care services that meet the needs of Lancashire residents. We will continue to innovate, collaborate, and build on our successes to create a healthier, more resilient community.

Thrutch Gorge Tunnels ('The Glen'), Waterfoot.

2. Lancashire Place



The Lancashire Place is the largest of the four 'Place' footprints within the Lancashire & South Cumbria Integrated Care Board (ICB) with a **population size of 1.3 million**

The Lancashire Place is aligned to the Lancashire County Council footprint. Being as big as some ICB's, we operate across three Localities which are based on the footprint of our 12x District Councils:

- **North Lancashire** (pop c337k)
  - Lancaster, Fylde & Wyre
- **Central Lancashire** (pop c598)
  - Preston, Chorley, South Ribble & West Lancashire
- **East Lancashire** (pop c392)
  - Burnley, Hyndburn, Pendle, Ribble Valley & Rosendale

2.a Our Vision

Living Better Lives in Lancashire:

Our ambition is to help the residents of Lancashire to live longer, healthier and happier lives

We will do this by improving health and care services through integration and addressing health and wellbeing inequity across the Lancashire Place

Lancashire Place is one of four places which together form the geographical area covered by Lancashire and South Cumbria Integrated Care System. Lancashire Place is uniquely further divided into three localities, North, Central, and East which have a collective total of 10 district Health and Wellbeing Partnerships, bringing together our 12 District Councils and wider partners in collaborative delivery of localised services.

In a collaborative effort to enhance health and wellbeing outcomes for the people of Lancashire, the Lancashire County Council (LCC) and all 12 District Councils have been working closely with Health, under the leadership of Dr Sakthi Karunanithi, Director of Public Health. This joint initiative has identified several key priorities, including housing with an early focus on Disabled Facilities Grants, addressing mental health and housing issues, and improving and integrating leisure, health, and activity services.

2.b Lancashire Place Partnership (LPP)

The Lancashire Place Partnership operates as a collective forum where Members bring their diverse mix of skills and experience, independence, and scrutiny to ensure appropriate challenge and collaboration. Members work together to build better relationships between health, social care, local government organisations, and other partners, while listening to and acting on the needs and concerns of the communities they serve.

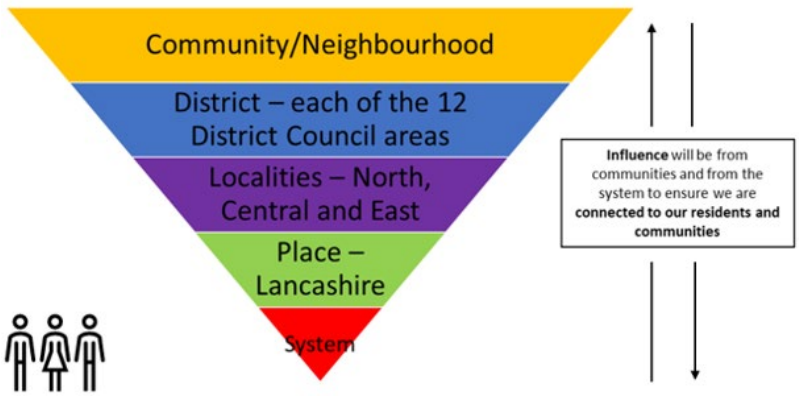
We have sought to adopt an asset-focused culture, emphasising the strengths of residents, workforce, and communities, and empowering them to thrive. Strategic knowledge of the Lancashire system is shared among Members to deliver improvements for residents, overseeing the design and delivery of integrated services across localities and neighbourhoods. The diverse mix of skills and experience within the forum ensures robust but effective challenge throughout the Partnership. Collective responsibility is a key focus, with an emphasis on health inequalities, prevention, and earlier intervention to reduce demand for formal services.

Members collectively ensure the effective use of public funds in the interests of Lancashire residents and uphold the shared vision and objectives of the Partnership. They are committed to improving the lives of Lancashire residents, willing to innovate and create conditions for real change. The forum holds place-based providers to account for delivering high-quality services, achieving national standards, and removing unwarranted variation.

We have committed to working in an integrated way by working to deliver on our four priority ambitions:

We work together as equal partners, respecting the diverse organisational cultures and promoting trust among all parties.

This collaborative spirit enables us to build strong relationships between health, social care, local government organisations, and other partners.



We prioritise the needs and concerns of the communities we serve, actively listening and responding to their voices. Our asset-focused culture emphasises the strengths of residents, workforce, and communities, empowering them to thrive.

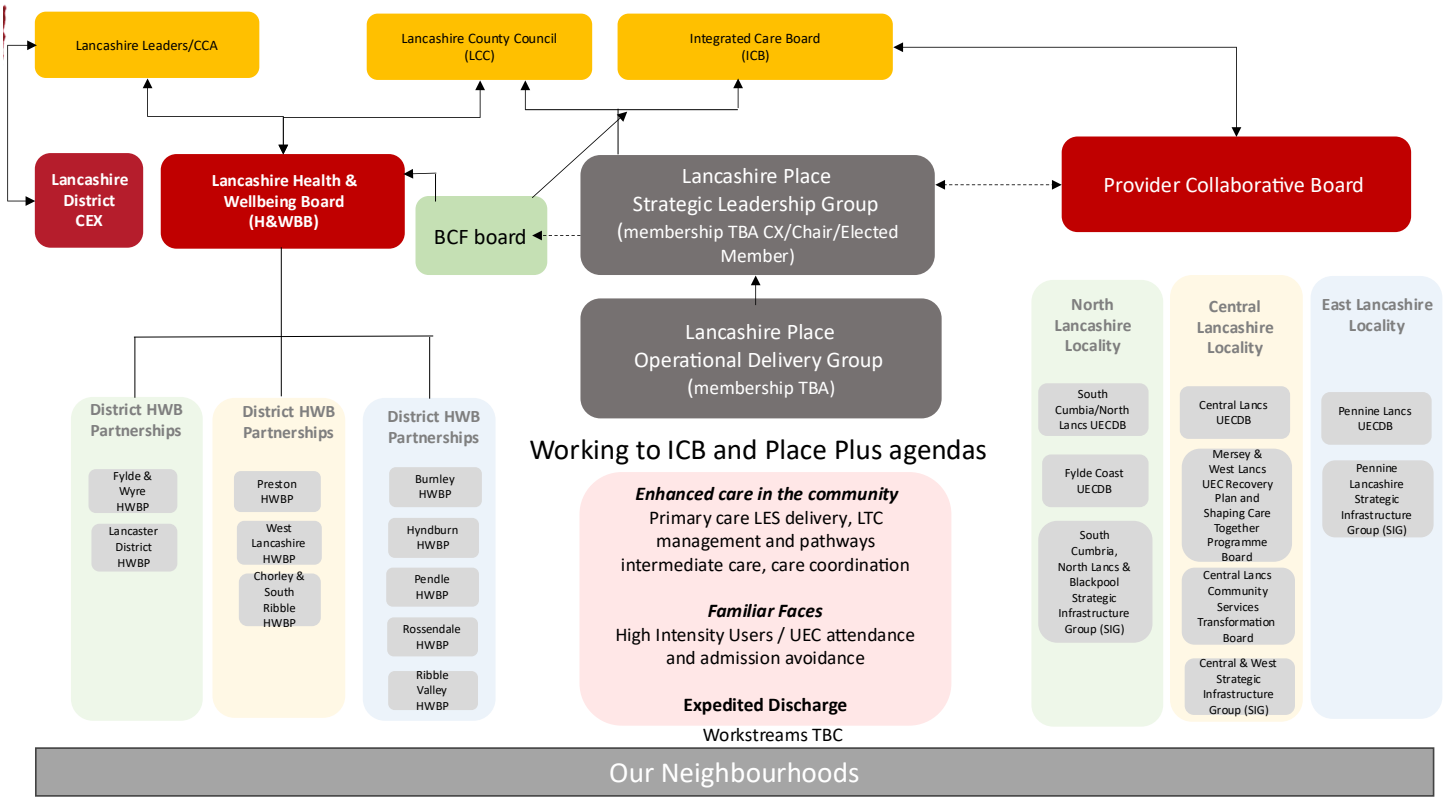
2.c LPP Partner Members

Role	Substantive position	Organisation
Chair	County Councillor with portfolio for Health and Wellbeing (Chair of the ICP and Lancashire HWB)	Lancashire County Council
Vice-Chair	Chief Nurse	Integrated Care Board
Director of Health and Care Integration (Lancashire)	Director of Health and Care Integration (Lancashire)	Lancashire County Council/ Integrated Care Board
Nominated Representatives		
Nominated representative for Lancashire County Council	Legal, HR, Democratic Services (Executive Director of Resources)	Lancashire County Council
Nominated representative of District Councils for Health and Wellbeing	Chief Executive	Preston City Council
Primary Care in Lancashire	Associate Medical Directors Primary Care (x2- shared role)	Integrated Care Board
Nominated representative for the Lancashire and South Cumbria Provider Collaborative Board	Chair	East Lancashire Hospitals Trust
Nominated representative for the Lancashire and South Cumbria Hospice Collaborative	Corporate Services Director	Queenscourt Hospice
Nominated representative for the Care sector in Lancashire	Locality Manager	Skills For Care, Lancashire and South Cumbria
Nominated representative for the Voluntary, Community, Faith and Social Enterprise Sector in Lancashire	Chief Executive Officer	Lancaster District Community and Voluntary Solutions
To ensure the voice of Lancashire residents is represented	Chief Executive	Healthwatch
Role specific Membership		
Associate Director of Finance		Integrated Care Board
Director of Adult Services (Interim)		Lancashire County Council
Director of Public Health		Lancashire County Council

2.d LPP Governance

Operating under a distributed leadership model, the Partnership has clear roles and responsibilities, working together as equals. Members make decisions that further the strategic ambitions of the Lancashire Place, operating a collective model of accountability. They maximise the use of place-based financial allocations and collective resources for the greatest benefit of residents, supporting and enabling strategic decision-making.

Governance structure



Lancashire Health and Wellbeing Board

The Lancashire Place Partnership has held several joint meetings with the Health and Wellbeing Board. These sessions have provided us with a valuable opportunity to discuss areas of mutual interest, including the Joint Strategic Needs Assessment and the Better Care Fund.

We will continue to examine how the Better Care Fund is managed and utilised by LCC and the ICB and with ongoing reviews underway by both organisations this will remain a substantial area of interest for the Lancashire Place.

District Chief Executives

In collaboration with the Chief Executives of our District Councils, we have undertaken significant work to adopt the optimal model for the Disabled Facilities Grant. This ensures a consistent approach and the dissemination of best practices. We have also examined the top ten reasons why individuals contact social care, agreeing on a coordinated approach through district networks to invest in services that prevent, reduce, and delay the need for statutory Adult Social Care.

A photograph from the Ryelands estate community project

2.e Listening to and engaging our communities

The Your Health, Your Future, Your Say roadshows took place across each of the 3 localities within Lancashire. Members of the ICB Executive, Clinical Leaders and our Integrated Place Leaders facilitated the public engagement sessions which took place between September- November 2024. Residents were invited to share their views on health services in their local area and hear more about work taking place to improve health and wellbeing in each of the 12 Districts of Lancashire. Feedback from these events contributed to the refresh of the Lancashire Place Plan for 2025/6 and helped to shape the delivery of District level Health & Wellbeing priorities.

Elected Members represent our local communities on a range of Council Committees across Lancashire at both a County and District level and it is vital that we engage with them regularly to help to form and shape delivery of our Lancashire Place and District Health and wellbeing priorities. Throughout 20204/25, we engaged the following Committees:

- Lancashire County Councils Health Overview & Scrutiny Committee
- Lancaster District Council Overview & Scrutiny Committee
- Wyre District Council Overview & Scrutiny Committee

A range of engagement activity regularly takes place through our District Councils and on a hyper local level through the work of our system partners working in an integrated way at neighborhood level.

Whilst the data and intelligence we have helps us to prioritise our key areas of focus for our Lancashire Place Plan, a key priority for us in Lancashire is ensuring that the voice of our residents and people with lived experience is heard and helps to shape our delivery.

Lived Experience

A key priority for us in Lancashire is ensuring the voice of our residents and people with lived experience is heard

"Our pathways and processes are complex"

"We cannot financially sustain growth at the current rate"

"Multiple professionals commissioning, leads to confusion and inequity"

"Our offer is not consistent, and doesn't cope well with surges in demand"

"We need to grip our capacity and use it effectively"

"Our service offer is not well articulated or understood, and we don't communicate well enough with people on the service"

"Our data and information is not robust, including demand and capacity"

"There is a changing Health and Social Care landscape, and we need to be ready and flexible enough to meet it"

"Our service offer is not as inclusive as it needs to be"

"We need to review our skill mix and our workforce offer across health and social care"

healthwatch Lancashire

- ✓ We are working with Healthwatch to undertake work with people with lived experience and ensure they play a key role in shaping our future service delivery

NHS IMPACT Improving Patient Care Together

- ✓ A system-wide event in partnership with NHS IMPACT took place on 27th June which focussed on transforming community care in Lancashire and South Cumbria. This event provided a space to think about how we could create the conditions to improve resident experience and outcomes and further develop place plans for community transformation.

A selection of photographs from the Inclusion health and health equity work in Primary Care Networks in Burnley

3. District Health and Wellbeing Partnerships: priorities and outcomes 2024/5

Health & Wellbeing Partnerships contribute to Keeping People Safe and Well at Home

Lancashire Place works with 10 district partnerships across Lancashire involving key system partners including Adult Social Care, Acute, Community Services, Primary Care, Police, Fire, VCFSE, Hospices, and the 12 District Councils, working together to address issues such as homelessness, loneliness, suicide prevention, and best start in life.

3.a Delivery in North Lancashire

Integrated Place Leader:

Heather Woodhouse

Clinical & Care Professional Lead:

Dr Tony Naughton

Lancaster District

The Lancaster District Health & Wellbeing Partnership has implemented the 'Health Inclusion Approach' to improve health outcomes and reduce inequalities. This approach includes the development of an innovative 'Reach Model', which focuses on meeting people where they are and building trust to improve health outcomes. A Community Conversations Group has been developed to listen to the community and support delivery.

Cardiovascular Disease Management

Significant progress has been made in managing cardiovascular disease (CVD), the leading cause of premature mortality in deprived areas. The Lancaster Primary Care Networks (PCNs) have achieved notable improvements in the percentage of people identified and receiving optimal treatment for hypertension, atrial fibrillation, and cholesterol since 2019. The average cardiovascular risk score in Lancaster PCNs is 4.1%, well below the high-risk category.

Enhanced Health Checks

In the past 12 months, 169 enhanced health checks have been conducted, resulting in an annual income gain for residents of £181,000 through partnerships with the Citizens Advice Bureau (CAB). These checks have led to increased referrals to various services and targeted respiratory care for high-risk individuals.

Community Conversations

The strategy group for community conversations in North Lancashire has focused on delivering person-centred insights, reducing duplication, and improving outreach to vulnerable communities. Success stories highlight personal health improvements and the positive impact on individuals' lives.

Respiratory Care

‘Focused wards’ and a range of workstreams have been established to address respiratory conditions in Lancaster. Initiatives include the implementation of PCN Health Inclusion approaches and empowerment of families through community development.

Children and Young People (C&YP) Prevention and Early Intervention

Key initiatives include weekly health and fitness sessions, blood pressure checks, and support for children involved in weekly activities. The Ryelands Estate in Skerton West has supported 88 households with housing issues, preventing 90% from eviction. Health & Wellbeing Days in schools have benefited 759 children.

Building Community Resilience

Integrated Care Communities (ICCs) play a crucial role in supporting local needs and care coordination for people aged 18+. Key initiatives include the Poverty Truth Commission GP Training, Saturday Smear Clinics, and the Bay PCN Local Investment Fund, which provides £17.5k funding for community grants. Bay PCN has been recognised nationally for their innovative work, receiving a visit in December 2024 from Rebecca Gale, Assistant Director, Primary Care Network for the NHS Confederation who wrote a blog on not underestimating the return on investment of relationships and the relational working in action: Morecambe Bay was referenced as a great example of this.

A mental health suicide prevention initiative has been launched across Lancaster District. The campaign addresses key triggers for poor mental health and promotes the LSCFT Initial Response Service and the Lancaster Service Directory. This work also includes an educational awareness and resilience programme in schools focusing on fostering positive mental health and accessing appropriate support which is provided by Lancashire MIND and 'next steps' programme for those needing additional and ongoing support through BEESAFE (a collaboration between two local young people's mental health charities).

The "Help is Close" campaign has been launched across the Lancaster District. This initiative aims to raise awareness and direct individuals to available support and advice through the Lancaster Service Directory and the mental health Initial Response Service (IRS) provided by LSCFT. To date, we have seen over 7,000 visits to the 'Help is Close' webpage and delivered support to 11 local schools and colleges.

Community Space

Lancashire Place has supported the development of a children's Playground and Community Space on the Ryelands Estate. Ryelands Estate faces challenges related to housing repairs, the physical environment, anti-social behaviour, and community wellbeing. The Ryelands Project brings together residents, Lancaster City Council, and local stakeholders to co-design improvements to the Ryelands Estate. The initiative is grounded in extensive community engagement, including with children and young people, and is structured around a phased development plan. This begins with the transformation of the existing playground into a modern, inclusive space, followed by enhancements to the multi-use games area and the creation of a new community hub. By placing the community at the heart of the process, the partners are helping to build a healthier, more resilient neighbourhood that reflects local priorities and supports long-term wellbeing. More information about this project can be found on the YouTube video here: https://youtu.be/vDUqhgk5Tsg and on the Lancaster Service Directory here: https://lancastercvs.org.uk/community-action-networks/

Integrated Care Communities (ICC's) across Lancaster District are successfully bringing together a range of system partners to work together to support the needs of our local communities and improve health and wellbeing outcomes.

Familiar faces
Over the past 12 months, the Bay Integrated Care Community Familiar Faces Multi-Disciplinary Team (MDT) has demonstrated significant positive benefits and progress. The MDT has effectively reduced A&E usage and non-elective admissions, achieving an average reduction of 3.9 attendances per person and cost savings of £2537 per person. The virtual format of the MDT has facilitated close and integrated relationships among partners. An evaluation undertaken recently shows a sustained reduction in attendance and costs over 12 months post-discussion, with a notable 89% decrease in attendances and a 98% reduction in costs in the same month 12 months post-MDT discussion. These achievements highlight the MDT's impact on improving patient outcomes and reducing healthcare costs, contributing to the overall success of the initiative.

Fylde and Wyre

Fylde & Wyre Health and Wellbeing Partnership

The Fylde & Wyre Health and Wellbeing Partnership has made significant strides in addressing the demand for adult social care services and meeting the needs of our residents. By strategically targeting the Adult Social Care Prevention Fund towards the priorities of the Health and Wellbeing Partnership , and by providing additional capacity through the Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector, we have successfully reached our most disadvantaged communities. This approach has provided alternatives to prevent, reduce, and delay the demand for formal adult social care services.

Adult Social Care: 'Reduce, Prevent, Delay'
In collaboration with Lancashire County Council (LCC), we have identified the wards of Jubilee, Rossall, and Garstang as the areas driving the highest demand for adult social care services.

Reasons for Contacting the Service
The top three reasons for residents contacting the service are:

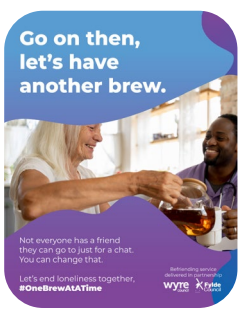
1. General support to maintain well-being (Request for Service/Request for Assessment)
2. Mental health support (Mental Health Act Assessment)
3. Carers support (Carer Assessment)

Addressing These Demands
To address these demands, we have allocated:

- £37,000 to District Councils to support the Befriending Scheme
- £10,000 to Wyre District Council to provide VCFSE infrastructure support
- £55,000 to the VCFSE sector for initiatives aimed at addressing the top reasons for contact

These efforts reflect our commitment to enhancing the well-being of our residents and ensuring that they receive the necessary support and services.

Supporting older adults to stay well: Befriending Service
Now available in the Fyre and Wyre Districts, this service aims to combat social isolation and loneliness. Befriending coordinators are now in place and actively recruiting volunteers. The #OneBrewAtATime campaign has been launched across the District. The development and implementation of a Befriending Scheme and Coordinator will support individuals in maintaining their well-being.



Universal Priorities and services delivered

Respiratory Care
The focus on respiratory conditions includes the implementation of Primary Care Network Health Inclusion approaches and support from the Population Health Investment Fund. The 'Proactive Care' and 'Respiratory' work programmes have been successful in Fleetwood, which serves as an 'Exemplar' ward.

Healthier Fleetwood
Established in 2016, Healthier Fleetwood is a community initiative that supports residents' physical and mental health. It connects residents to services, local groups, and activities, and has been a model for best practices in community health.

Wyre Moving More Strategy
This collaborative strategy aims to support increased physical activity across the borough, promoting healthier lifestyles among residents.

Addressing Damp & Mould
Efforts to address damp and mould issues have been undertaken through enforcement in private rented homes and the Government Healthy Homes Project, ensuring safer living conditions for residents.

Active Wellbeing Suite
The establishment of the Active Wellbeing Suite at Thornton Leisure Centre, featuring a social gym facility with power-assisted weights, has provided residents with accessible fitness options.

Care and Repair Provision
Through the Care and Repair provision, approximately 400 people have been supported with an additional £1,000 in benefits, offering cost-of-living support for older and disabled residents.

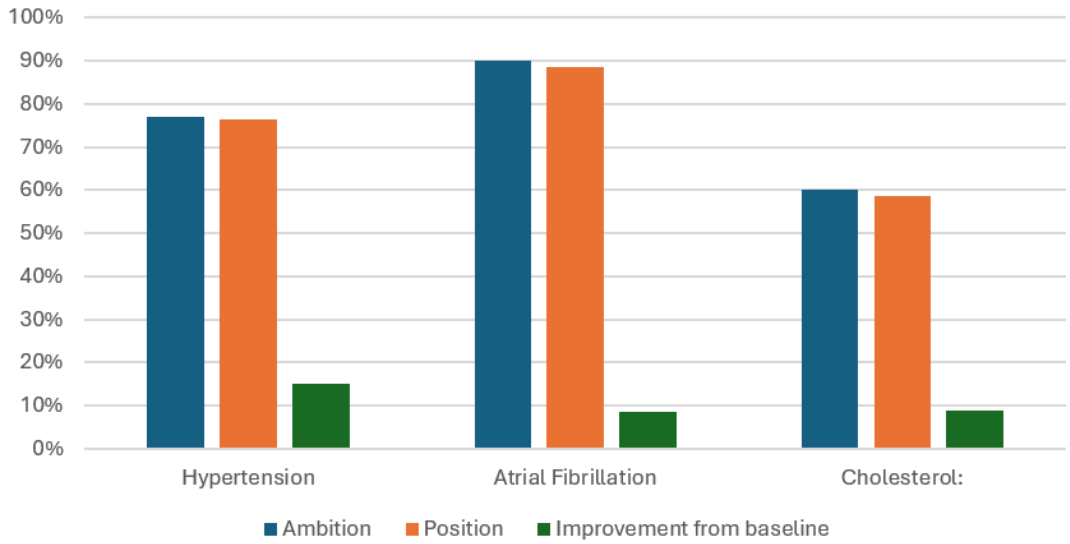
Wellness Programmes
Initiatives such as weight loss programmes, open to all, and free community yoga sessions for women, have been implemented to promote physical and mental well-being.

Health Inclusion Approach
The Fylde & Wyre District PCNs have adopted the 'Health Inclusion Approach' to reach underserved communities and improve health outcomes. This approach prioritises Core20 PLUS5 communities and includes the establishment of a Community Conversations Group to listen to and support the community.

Children and Young People and Emotional Health and Wellbeing
This initiative supports children and young people to access low-level support and intervention and prevent deterioration whilst waiting to access formal mental health services.

Cardiovascular Disease Management
Significant progress has been made in managing cardiovascular disease (CVD), the leading cause of premature mortality in deprived areas. The Fylde & Wyre PCNs have achieved notable improvements in the percentage of people identified and receiving optimal treatment for hypertension, atrial fibrillation, and cholesterol since 2019. The average cardiovascular risk score in Fylde & Wyre PCNs is 8.24%, well below the high-risk category.

The **Fylde & Wyre Primary Care Networks (PCNs)** have significantly increased the percentage of people identified and now receiving optimal treatment for their condition since 2019.



Enhanced Health Checks

In the past 12 months, 1,197 enhanced health checks have been conducted. Initiatives include monthly health inclusion meetings, training for social prescribers, and collaborations with Fylde Coast Medical Services and Cancer Care Support. A coffee morning pilot has also been implemented across multiple GP practices.

Weekly Supper

A programme that regularly supports 30 people with nutritious meals, contributing to improved health and well-being.

Lifestyle Support and Prevention

The development of an alcohol strategy to reduce effects and impact on the individual, families and wider community is part of the ambition of lifestyle support and prevention initiatives in North Lancashire. External discussions have taken place with wider stakeholders across the district to understand what services are available and where the gaps are in relation to the plans for the Health & Wellbeing Partnership to develop an Alcohol Strategy.

3.b Delivery in Central and West Lancashire

Integrated Place Leader:

Sarah James

Clinical Care Professional Lead:

Lizzie MacPhie

Chorley and South Ribble

Chorley and South Ribble Health and Wellbeing Partnership

The Chorley and South Ribble Health and Wellbeing Partnership has been dedicated to improving the health and wellbeing of the local community through various initiatives and collaborative efforts. This partnership includes local councils, NHS, and various community organisations working together to address key health challenges and promote a healthier lifestyle.

Key Achievements and Work Summary:

Early Years and School Readiness
Focused on improving early years outcomes, including school readiness and child health. Initiatives included antenatal and postnatal services, health visitors, and family hub services. The partnership also worked on specific school readiness initiatives and targeted parenting support.

A focus on Chorley and South Ribble in Early Years resulted in the development of Lostock Hall Family Wellbeing Centre to support new parents, children and wider families with a range of social and wellbeing activities
Chorley Health Mela for families delivered in one of the leisure centres, with over 40 health checks taking place.

Active Lifestyles for Mental and Physical Health
The partnership supported the co-location of health and leisure services to improve the connection between physical activity and health services. The 'Escape pain' project has been successfully implemented across three leisure centres: West View, Chorley West Way, and Leyland Leisure Centre. Since the programme's inception in November 2024, a total of 150 participants have benefited from its offerings, demonstrating its positive impact on the community.

Physical Activity Clinical Champion Training has been delivered to a significant number of clinicians, with 250-300 clinicians trained at Central PLT and an additional 60 clinicians trained within the integrated MSK service. This training initiative aims to enhance the promotion of physical activity within clinical settings. The GLL Healthwise programme has received a steady stream of referrals from the MSK service, following a successful engagement event. Additionally, the programme is linking with the Workwell initiative, with an education event planned for September to raise awareness and promote referrals and signposting from the MSK service.

Cancer Prehab and Rehab Pilot
Collaborated with Lancashire Teaching Hospitals NHS Foundation Trust on a pilot programme to support cancer patients through prehabilitation and rehabilitation. The programme aimed to improve physical and mental health, aiding faster recovery from surgery and treatment. Cancer Prehab has seen the successful launch of football sessions, and recent funding has been secured to support recruitment and training, scheduled for September. The bi-monthly catchups have proven to be an effective means of maintaining momentum and ensuring progress.

Community and Place Investment
Invested in local towns and green spaces and funded 25 community organisations through the UKSPF Community & Place Grants Programme. The partnership also delivered quarterly workshops to support third sector organisations and foster collaborative working.

Social Prescribing Service
Implemented a social prescribing service to address multiple needs from a single point of connection. This service supports health and wellbeing issues, as well as wider determinants such as housing and financial advice. The service has received significant investment and has shown positive impacts on mental health, economic inactivity, and tenancy sustainability.
The 24/25 social prescribing model has delivered over 5,995 hours of direct support and 430 signposts / referrals to 88 partner organisations. 73% clients have reported a reduction in loneliness and 96% have reported an increase in wellbeing.

Preston

Preston Health and Wellbeing Partnership
The Preston Health and Wellbeing Partnership has made significant strides in improving health and wellbeing across the community. This collaborative, multi-agency approach includes the City Council, NHS, and Voluntary, Community, and Faith Sector Partners, working together to understand and track health and wellbeing metrics, agree on joint priorities, and deliver impactful initiatives. It is developing an overarching Health and Wellbeing Strategy to set the long-term direction for the city and HWBP and a bespoke Physical Activity Strategy to encourage partner collaboration on initiatives to keep residents active and healthy.

Key Achievements and Work Summary:

Support for Rough Sleepers
Local GP practices collaborated with The Foxton Centre, the City Council, and other organisations to provide better-coordinated health and wellbeing support for rough sleepers across Preston. From July to March, the model has which has generated 450 clinical consultations, 83 newly registered patients and 98 admission avoidance contacts

Proactive Commissioning
Driven by local needs, the partnership has focused on healthy weight, work well, and adult social care support.

A primary care health service has been developed for our rough sleeping populations based out of Foxton Centre, a local VCFSE charity. This has provided a much needed first point of contact for heath needs for this population, and to date over 70 registrations have been made with the practice.

Focus on Lea and Larches Priority Ward
Local GP practices actively identified and provided focused support to patients identified as frail and/or living with respiratory conditions to prevent increased hospital admissions. As a result, 123 individuals who received a Healthy Home Assessment felt it helped them live safely and independently at home, with 93% reporting improved mental health through reduced anxiety and worry.

Reducing Health Inequalities
Initiatives such as suicide prevention, cancer screening, and co-location of services have been implemented to address health inequalities in Ribbleton and St Matthews.

Leadership on Cross-Cutting Issues
The partnership has contributed to initiatives such as the Preston Regen Board, Future Hospital Programme, Sport and Physical Activity, Marmot city, Living Wage City, City of Sanctuary, and Recovery City.

West Lancashire

West Lancashire Health and Wellbeing Partnership

The West Lancashire Health and Wellbeing Partnership has been actively working to improve the health and wellbeing of the local community through various initiatives and collaborative efforts. This partnership includes local councils, NHS, and various community organisations working together to address key health challenges and promote a healthier lifestyle.

Key Achievements and Work Summary:

Reinvigorated Partnership
The partnership has gathered data, insights, and had conversations with the communities to develop a common purpose and shared goals. It provides governance and oversight to significant programmes and themes such as the UKSPF Health Inequalities Oversight Group, Healthy Weight Environments, and Physical Activity.

Addressing Health Inequalities
West Lancashire faces various health inequalities, including life expectancy, disease rates, smoking, alcohol, overweight/obesity, deprivation, and poverty. The partnership has focused on addressing these issues, particularly in Skelmersdale, which is identified as a significant area of disadvantage.

Making Every Contact Count (MECC):
The MECC approach encourages health and well-being providers to use the opportunities that arise during their daily routine interactions with clients, patients, friends, and family to have conversations about how they might make positive improvements to their health or wellbeing. MECC also provides a means of maximising the benefit from existing resources for improving population health. For example, it can include advice on low or no-cost activity, such as persuading parents to walk their children to school or, as part of physical activity advice, encouraging increased use of existing community resources such as leisure centres and swimming pools. MECC can also help by engaging those who would not have otherwise engaged in a 'healthy conversation' or considered accessing specialised local support services, such as for weight management.

Best Start in Life
The partnership has targeted key areas to maximize life chances, such as smoking/vaping prevention, suicide/self-harm prevention, skills and aspirations of young people, family hubs, and dental health. These initiatives aim to improve health and wellbeing outcomes for children and young people.

Neighbourhood-Level Services
The partnership has identified three distinct neighbourhoods: Northern Parishes, Ormskirk, and Skelmersdale. It aims to deliver a wide range of services at the neighbourhood level, both by the Council and its partners. Population Health 'Deep Dive' reports have been prepared for each neighbourhood to shape delivery based on a deeper understanding of specific needs.

Health and Housing
Recognition and acknowledgement of the unequivocal link between health and housing with the aim of driving actions to improve the quality of our housing and to tackle homelessness. – the 24/25 project has included delivery of a health and housing programme, which has generated 40 attends of healthy homes training and a contract for healthy homes assessments.

Health and Housing Initiatives The partnership has implemented various health and housing initiatives, including addressing damp and mould issues, supporting frail individuals to live at home, and providing homelessness and mental health support. These initiatives aim to improve living conditions and prevent hospital admissions.

Integrated Working
The partnership has established the West Lancs Integrated Leadership Team, a multi-disciplinary team working across the borough to deliver joint priorities. This includes developing new system-wide pathways for podiatry, virtual wards, and reviewing paediatric attendance at the emergency department.

Community and Place Investment
The partnership has invested in local towns and green spaces and funded 25 community organisations through the UKSPF Community & Place Grants Programme. Quarterly workshops have been delivered to support third sector organisations and foster collaborative working.

3.c Delivery in East Lancashire

Integrated Place Leader:

Jackie Moran

Clinical Care Professional Lead:

Santhosh Davis

Burnley

Burnley Together Initiative

Burnley Together was established during the COVID-19 pandemic as an integrated response to support the community. It has since evolved to focus on improving the health and wellbeing of Burnley residents. The initiative has seen significant collaboration among various partners, leading to the development and delivery of several priorities and projects.

Key Achievements and Work Summary

Childhood Nutrition
The Childhood Nutrition project in Burnley seeks to better understand the causes of food insecurity and poor nutrition for children living here. Rising childhood obesity rates and food insecurity are common across the country and the long term solution involves wider societal change, however through better understanding the barriers and opportunities to improving secure access to nutritious food the Burnley Together Partnership is confident that it can make real improvements for the families in Burnley in the here and now. A working group including a wide range of partners from health, education, physical activity and academic research have been working together to gather collective intelligence on the picture in Burnley and to gather best practice guidance. Three key opportunities have been identified and task groups are being established; one focussing on distilling the guidance into a simplified set of messages that resonate with Burnley residents about eating well, a second to look into deeper dialogue with the community about barriers and opportunities around behaviour change, and the last to look at maximising the opportunity of free school breakfast to ensure a nutritious offer is accessible to all school age children.

Inclusion and Health Equity
Burnley has seen a fantastic response from Primary Care Networks (PCNs) with initiatives such as health and wellbeing classes in schools, outreach clinics for vulnerable populations, and additional investment in community champions. These efforts aim to address health disparities and improve access to care for disadvantaged groups.

Increased Physical Activity
Working with partners across Burnley to encourage outdoor activities Projects such as "Beat the Streets" and the creation of community hubs like the Chai Centre and C&F Hubs have been implemented to encourage physical activity, improve overall health and reduce childhood obesity.

Housing and Respiratory Health
Recognising the link between poor housing conditions and respiratory illnesses, initiatives have been launched to improve living conditions for families in deprived areas and to target health services increasingly in these communities. In additional to improving residents lives directly, the aim was to share knowledge across organisations to better understand the population need for future commissioning and to improve linkages and referral rates between core services in Burnley. This approach has resulted in a more joined up offer for patients and residents and seeks to provide more timely, proactive and effective intervention to ultimately reduce attendance at GP and A&E.

We identified those with respiratory conditions who may be living in damp, mouldy houses and where our council or local housing association can improve these conditions. Given the housing stock in Burnley and the prevalence of respiratory conditions this could make a great impact.

Hyndburn

The Hyndburn Way is a comprehensive approach to improving health and wellbeing in Hyndburn through systems leadership, community engagement, and collaboration among various sectors and organisations. It emphasises the importance of building trust, fostering innovative ideas, and creating a supportive environment for leaders to work together effectively. Overall, the Hyndburn Way aims to create a healthier and more connected community by leveraging the strengths of various stakeholders and promoting a collaborative and supportive environment.

The Hyndburn Way focuses on several key areas, including bringing together leaders from different sectors to plan goals, offer support, and build trust, enhancing the role of voluntary, community, and faith sector organisations, and developing comprehensive pathways to provide holistic and integrated support to residents.

Key Achievements and Work Summary

Educational Attainment and Best Start in Life
Hyndburn has focused on increasing educational attainment and providing the best start in life for children. This includes working with partners to improve educational outcomes and addressing behaviour choices related to long-term conditions such as smoking, alcohol, and physical activity.

Service user pathway improvements
The service user pathways in Hyndburn have been designed to provide comprehensive and integrated support to residents. These pathways collectively aim to enhance the health and wellbeing of Hyndburn residents by providing targeted support and fostering collaboration among various sectors and organisations.

Pathways include various initiatives such as Community Action Network (CAN), Young Persons (YP) Mental Health Research, Hoarding, Food, Family Hub, BPS, Young Persons Social Prescribing, Green Social Prescribing, Household Support Fund, DFG, and the Hyndburn Hub Directory. Each of these initiatives aims to address specific needs within the community and ensure that residents have access to the necessary resources and support. The CAN initiative focuses on providing coordinated and accessible services to residents, while the Young Persons Mental Health Research aims to understand and address

the mental health needs of young people in the area. The Hoarding initiative involves cross-sector collaboration with a stronger focus on statutory providers to address hoarding issues. The Food initiative highlights local examples of food support, whilst the Family Hub provides a central point for families to access various services.

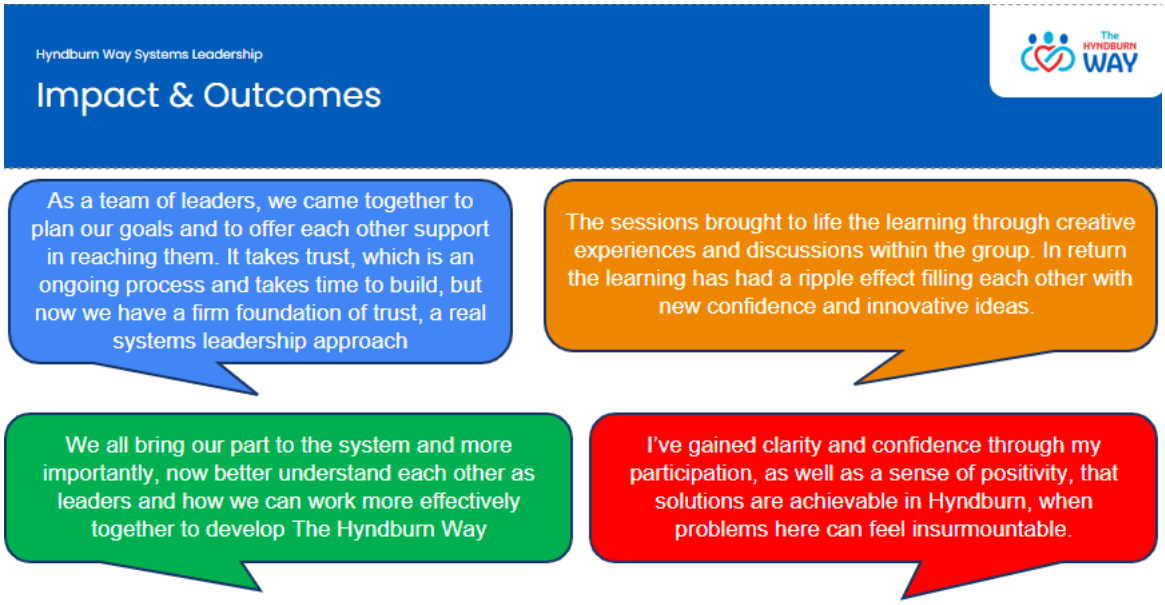
The BPS initiative facilitates practitioner-to-practitioner support, and the YP Social Prescribing initiative works to unlock barriers and provide resources for young people. The Green Social Prescribing initiative is part of the Active Environment Strategy, promoting outdoor activities and environmental engagement. The Household Support Fund, supported by the ICB, offers financial advice and data sharing to assist households in need. The Hyndburn Hub Directory provides a comprehensive list of available services and resources.

Organisational and Leadership Development

The Hyndburn Way has emphasised organisational and leadership development through systems leadership, action learning sets, mentoring, and collaboration with Sport England. This approach has fostered trust, collaboration, and innovative ideas among leaders. Participants have gained clarity, confidence, and a sense of positivity, believing that solutions are achievable for the challenges in Hyndburn.

System Leadership

The Hyndburn Way is a partnership of like-minded organisations aiming to improve the health and wellbeing of the people of Hyndburn. With the support of the NHS Leadership Academy, a programme has been developed to encourage system leadership across the borough, moving partners away from parochial organisational boundaries. This programme has resulted in a joint focus on the use of the Hyndburn Pound, directly bringing an additional half million pounds into the borough for the improvement of health and wellbeing for its residents. The indirect consequences of this investment are currently being mapped to assess the wider impact for the borough and its residents and to learn lessons for future improvements.



Using the NHS Leadership programme to develop system leaders in Hyndburn has led to a joint focus on the use of the Hyndburn Pound and has brought another half million pounds into the borough for the improvement of health and wellbeing for its residents.

Governance and Infrastructure
The governance and infrastructure for health and wellbeing in Hyndburn include various committees and partnerships, such as the Accrington Town Centre Board, CVS Mentoring, and the Health & Wellbeing Partnership. These structures support strategic planning and community engagement projects.

Community Engagement
Enhancing community engagement through initiatives like the Hyndburn Way, which focuses on systems leadership, community capacity building, and promoting civic pride.

Early Diagnosis of Cancer
The early diagnosis of cancer is crucial for improving treatment outcomes and survival rates. In Hyndburn, several initiatives have been implemented to enhance early cancer detection. One notable programme is the NHS Lung Health Checks, which began in March 2023. This potentially life-saving health check targets current or former smokers aged between 55 and 74, offering a free 'MOT for your lungs'. The programme involves a 10-minute consultation with a trained healthcare professional, followed by a low-dose CT scan for those identified as being at risk of lung cancer. This initiative has already benefited over 24,500 people in Lancashire and South Cumbria, with some receiving life-saving treatment for conditions that might have otherwise gone undiagnosed.

More recently, a programme of work has been undertaken to identify and recruit 'community champions' from underserved groups of our population, these champions have been offered training and support to better understand the early signs and symptoms of cancer and on how to have conversations with people who might be experiencing these symptoms. This has been coordinated by the Hyndburn and Ribble Valley Council for Voluntary services, alongside training offered to practice based champions with the partnership aim of linking up support to help people not only to receive more timely diagnosis, but also to 'be with them' along the full length of the treatment pathway into recovery.

Dr John Howells, clinical lead for Targeted Lung Health Checks, emphasised the importance of early diagnosis, stating, "Early diagnosis saves lives." The programme is expected to diagnose around 9,000 early-stage cancers across the UK, offering the opportunity for earlier interventions, including curative surgery. The success of this programme highlights the importance of proactive health checks in identifying and treating cancer at an early stage.

Biopsychosocial model
Social Prescribers, befrienders, community connectors – it almost doesn't matter what we call them - there are lots of people in the community who are performing very similar roles. The Hyndburn Way invested in training and education for these individuals and brought them together to share thinking and build collaboration and support systems across the Borough. These people now understand the theory behind behaviour change, understand their role in supporting that change and have more confidence to discuss

these issues with the people who ask for their help. The wider impact of this training will be assessed as part of the system leadership review.

Increasing vaccination uptake

Hyndburn Borough Council has actively engaged with the community to encourage vaccination uptake. An online survey conducted by the council received over 2,300 responses, with 59% of participants indicating they would get the vaccine when it is their turn. The council has also consulted with local voluntary and community organisations to understand the information needs of residents regarding the vaccination programme. This collaborative approach aims to address concerns and provide clear, accessible information to support informed decision-making.

Frailty Prevention

Efforts have been made to identify residents at risk of becoming frail and provide pre-emptive support through home adaptations and other measures to prevent frailty.

Pendle

In 2024, the Pendle Health and Wellbeing Partnership Board achieved significant progress in improving health outcomes for the local community.

Key Achievements and Work Summary

Shaping Integrated Service Delivery

The partnership led system change by developing a Community Hub in Nelson to co-locate community organisations, social prescribers, and community health services. This initiative aimed to create a centralised location where residents could access a variety of services, fostering a more integrated and efficient approach to community support.

Additionally, the development of a diagnostic health hub was explored as part of the Nelson Town Deal. This exploration focused on enhancing local healthcare infrastructure to provide better diagnostic services to the community. Efforts were also made to maximise the use of public estates to enable an integrated approach to service delivery across health, leisure, PBC, and community and voluntary sectors. By leveraging public estates, the partnership aimed to create a cohesive network of services that would better meet the needs of residents.

These initiatives have contributed to the overall improvement of health and wellbeing in Pendle, demonstrating the commitment of the Pendle Health and Wellbeing Partnership Board to addressing health inequalities and promoting community-led approaches.

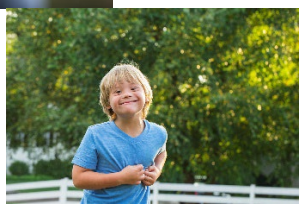
Improving Health Outcomes for Children and Young People

The "Beat the Streets" initiative was launched to encourage physical activity among children and young people. This program aims to foster a healthier lifestyle by promoting regular exercise and active participation in various physical activities. By engaging children and young people in fun and interactive ways, the initiative seeks to instil lifelong habits of physical fitness.

The Healthy Weight Declaration was implemented to promote a holistic approach to healthy weight services. This declaration emphasises the importance of addressing all aspects of weight management, including nutrition, physical activity, and mental well-being. By adopting a comprehensive strategy, the initiative aims to support individuals in achieving and maintaining a healthy weight.

The "Together an Active Pendle" programme was rolled out, focusing on active places and the "Recipe for Health" initiative. This programme is designed to create environments that encourage physical activity and healthy living. The "Recipe for Health" initiative complements this effort by providing resources and guidance on nutritious eating and overall wellness.

Faith sector mapping and the ICB CVS Small Grants Scheme were introduced to improve communications and networking opportunities. These initiatives aim to strengthen the connections between various community and faith-based organisations, enhancing their ability to collaborate and support the health and well-being of residents. By fostering better communication and providing financial support, these programs contribute to a more cohesive and effective community health network.



Pendle has a three-pronged project to improve outcomes for CYP. Using multiple programmes, such as 'Beat the Streets', 'Up and Active' and developing 'Fruit Routes' in Schools to generate a social movement to encourage healthy eating and lifestyles. There are also plans to raise educational attainment and increasing readiness to learn and to reduce hospital admissions, with a focus on under 5's.

Improving Health Outcomes for Bradley Residents

The Long-Term Town Plan for Nelson was developed to support community capacity building and create a healthier living environment. This comprehensive plan aims to enhance the overall well-being of residents by fostering a sense of community and promoting sustainable living practices.
The "Together an Active Pendle" initiative was extended to include active practices and Bradley Community Conversations. This extension aims to encourage physical activity and open dialogue within the community, fostering a more engaged and healthier population.

Additionally, a scheme to reduce demand on adult social care was developed, involving young people in its delivery. By engaging the younger generation in the provision of care, this scheme not only addresses the immediate needs of the elderly but also promotes intergenerational solidarity and understanding.

Ribble Valley

Overview

Ribble Valley is ranked within the top 50 least deprived districts in the country. Despite this, there are still significant issues linked to rurality, access to healthcare, and pockets of deprivation. The district has a better-than-average life expectancy, but cases of hypertension are higher than the national average. The area has an older population compared to other neighbouring communities, leading to increased demand for health and social care services. Smaller but significant pockets of deprivation exist, with increased levels of poor health particularly among lower-income families.

Key Achievements and Work Summary

Social Isolation and Mental Health
Initiatives have been implemented to address social isolation and improve mental health within the community. These efforts aim to create connected communities where individuals feel supported and engaged.

Community Support Groups
Establishing support groups for individuals experiencing social isolation and mental health challenges. These groups provide a safe space for people to share their experiences and receive support from peers and professionals.

Mental Health Awareness Campaigns
Running campaigns to raise awareness about mental health issues and reduce stigma. These campaigns aim to educate the community about the importance of mental health and encourage individuals to seek help when needed.

Access to Mental Health Services
Improving access to mental health services by collaborating with local healthcare providers. This includes offering counselling services, mental health workshops, and support for individuals in crisis.

Connected Communities
The partnership has focused on building connected communities to enhance social cohesion and support networks. This includes various community-led projects and activities designed to bring people together and foster a sense of belonging.

Community Events and Activities
Organising events and activities that bring people together, such as community fairs, sports events, and cultural festivals. These events promote social interaction and help build a sense of community.

Volunteer Programmes
Encouraging community members to volunteer and participate in local initiatives. Volunteer programmes provide opportunities for individuals to contribute to their community and build meaningful connections.

Neighbourhood Networks
Creating networks of neighbours who support each other, especially the elderly and vulnerable. These networks facilitate communication and cooperation among community members, ensuring that everyone has access to the help they need.

Neighbourhood networks seek to combat loneliness, social isolation and the associated mental health issues these create.

Rossendale

In 2024/25, Rossendale has made significant progress in promoting physical activity and supporting healthy weight through a place-based, preventative approach. The Lancashire Place Partnership has prioritised the development of a comprehensive physical activity and sports strategy, alongside a healthy weight action plan, both shaped by local data and community engagement.

Key Achievements and Work Summary

Rossendale's approach is rooted in data-driven planning, targeting priority wards and aligning with broader system goals to reduce health inequalities. Leadership from the ICB and Rossendale Borough Council has been instrumental in shifting the culture towards proactive, community-led wellbeing.

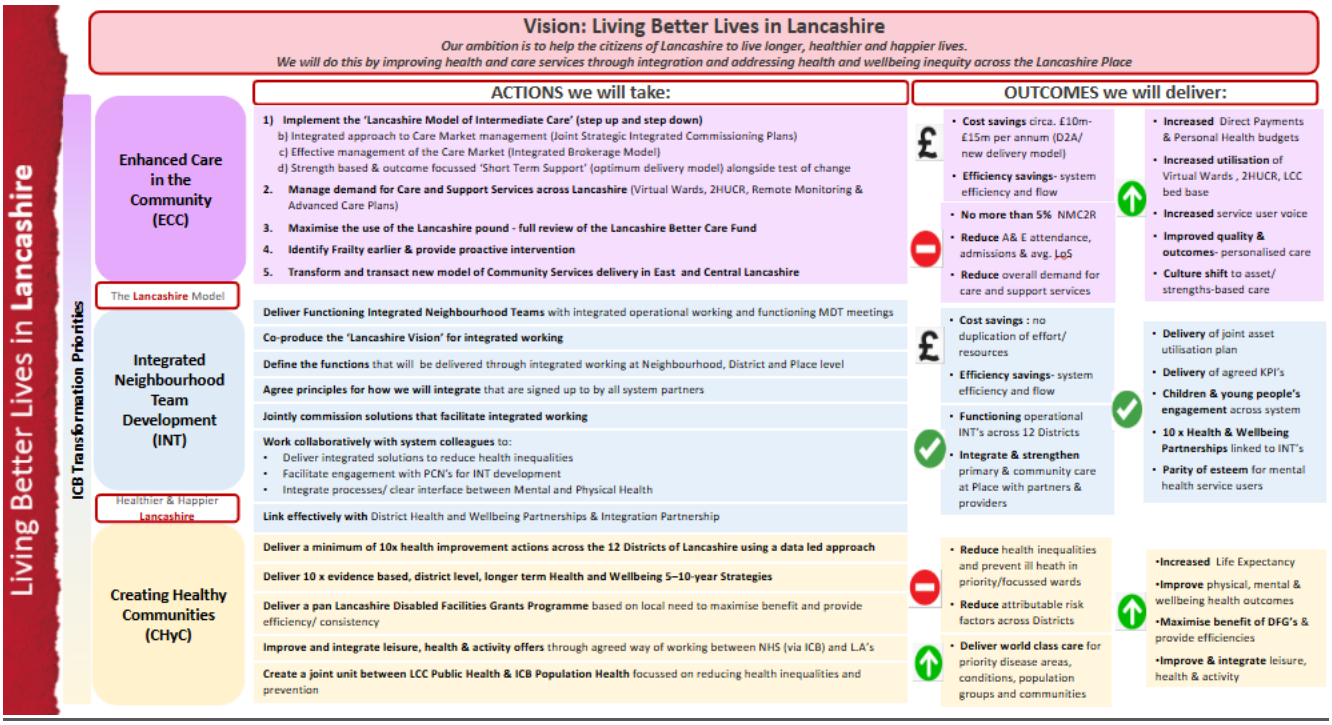
Physical Activity ad Education

Key initiatives include the rollout of community programmes such as 'Up and Active', and 'Fruit Routes' in Schools, which have helped foster a social movement around healthier lifestyles. These efforts are complemented by integrated service models, including the co-location of public health and allied health professionals within leisure centres, and the launch of a prehabilitation programme for cancer patients to improve recovery outcomes. Rossendale has taken significant amounts of data from all partners to develop their strategy for the next five years which will guide partnership working and help reduce obesity in the borough.

4. Interface with Lancashire & South Cumbria Integrated Care Board (ICB)

The following transformational workstreams, consist of projects which span all 12 Districts under the 3 localities- North, Central & West, and East Lancashire.

4.a Lancashire Place Business Development Plan on a Page 2024-5



4.b Place implementation of key transformational workstreams

i. Enhanced Care in the Community

The key deliverables that we committed to within this workstream were to implement the 'Lancashire Model of Intermediate Care' consistently across the whole of Lancashire, manage demand for Care Services across Lancashire, conduct a full review of the Lancashire Better Care Fund, and introduce a new model of community services delivery across East Lancashire and Central Lancashire. Additionally, we aimed for the earlier identification and proactive management of frailty.

The projected outcomes and impacts of these initiatives were intended to deliver cost savings and efficiencies through the implementation of a new delivery model and the application of the Discharge to Assess (D2A) protocol. Efficiency savings were anticipated through system efficiency and flow, with a target of no more than 5% NMC2R. We aimed to reduce A&E attendance, admissions, and average length of stay, as well as the overall demand for care and support services. Increased direct payments and personal health budgets, along with the utilisation of virtual wards, a two-hour urgent care response (2HUCR), and the Local Authority (LCC) bed base, were also projected. Furthermore, we sought to amplify the service user voice in the design, ongoing configuration, and implementation of local services, improve quality and outcomes in personalised care, and foster a culture shift towards delivering asset and strengths-based care with a competence-first approach.

Key achievements to date include the full alignment of the Lancashire Place Plan, which is now contributing to the delivery of four Urgent and Emergency Care Delivery Boards (UECDBs) and Urgent and Emergency Care (UEC) Improvement Plans across Lancashire and South Cumbria (L&SC).

An Integrated Brokerage Model via a new Pseudo Dynamic Purchasing System has been established to broker care at a consistent price across Lancashire. A targeted work programme to address the high number of No Medical Criteria to Reside (NMC2R) cases has commenced, featuring joint efforts between the University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT), South Cumbria Place, and Lancashire County Council (LCC). This includes the launch of a 'Test of Change' at Dolphinlee Care Home. The new model of community services delivery in East Lancashire has been successfully completed. The targeted work programme to reduce NMC2R across the UHMBT footprint, alongside South Cumbria and LCC, is demonstrating a positive impact. NMC2R has reduced by 4.7%, and the average length of stay has decreased by 31% for the Q3 position. Delays attributable to LCC have reduced from 27 to 20.5 people per day. The 2HUCR utilisation stands at 95% for Lancashire, against a target of 70%, and Virtual Wards Utilisation has increased by 29.8% since June, with current occupancy Lancashire-wide at 292 from 205.

We have successfully implemented the 'Lancashire Model of Intermediate Care'. A new Short-Term Support Service, which includes the Living Well at Home Service, the Wellbeing & Early Intervention Service, and 'Ask SARA' - an online self-assessment to help direct older and disabled people to impartial advice about aids and adaptations to help with activities of daily life. Users of ‘Ask SARA’ can link to over 10,000 products in the Living Made Easy marketplace, many of which can be immediately purchased from online retailers and delivered to their door. This service has helped 197 people remain at home, marking a 24% increase since April 2024.

The Ask SARA portal has demonstrated significant engagement and impact in Lancashire and South Cumbria from March to May 2025. Visitor statistics reveal a consistent influx of users, with total visitors ranging from 635 to 711 per month. Notably, the number of reports completed saw a sharp rise in April,

increasing by 75% from March, indicating growing user trust and utility. The visitor-to-report ratio also improved, reaching 40% in April, further underscoring the portal's relevance and accessibility.

Referral traffic accounted for the majority of visits each month, with the Lancashire County Council website being the top referrer, highlighting effective local promotion and integration into council services. Mobile access dominated device usage patterns, reflecting the importance of mobile-friendly design in reaching users. Geographic data showed a high share of visitors appearing to originate from London due to the use of a London-based VPN by Lancashire County Council staff, masking the true location of users.

Content engagement aligned closely with the needs of individuals seeking support for independent living, with frequently accessed topics including falls, using the toilet, furniture and chairs, wheelchairs, preparing food, bathroom safety, and caring for someone. These topics reflect core needs in community equipment and minor adaptations, aligning well with the portal's purpose. In summary, the Ask SARA portal is proving to be a valuable digital resource, with strong engagement metrics, high-quality referral traffic, and alignment with user needs, all pointing to a successful implementation.

Better Care Fund reviews have been completed, and the Lancashire BCF Board is currently being refreshed and reconvened for 2025/26, with outputs from the reviews informing the forward plan. An Intermediate Care Group for Lancashire has been established to share best practice and support consistent improvement across the region. A programme to increase the time-limited bed-based offer in Central Lancashire has been launched, with targeted work commenced across Fylde Coast and Pennine Lancashire to support 'keeping people safe and well at home' and 'effective discharge and community support' offers. LCC, LSCFT, and LHT are also collaborating on a joint approach to single-handed care.

The D2A review has been completed for Lancashire, and the outputs are being used to inform future improvements through the Lancashire Intermediate Care Group. Based on Q3 data from Dolphinlee, there has been a 45% reduction in the length of stay compared to Q1, with further reductions anticipated in Q4. More patients are being discharged within six weeks, while those staying over eight weeks have decreased. Additionally, Q3 shows a significant increase in discharges to home with packages of care support, a rise in transfers to residential care, and a slight decrease in hospital readmissions.

ii. Integrated Working in Neighbourhoods

The key deliverables within this workstream included defining the vision for the 'Lancashire Model of Integrated Working' across the system, mapping current provision, and collaborating with partners to enable the delivery of a shared care record. Our goal was to have two districts in Lancashire fully operational with integrated working, functioning MDTs, and appropriate representation at the HWB Partnership by the end of 2024/25. Additionally, we aimed to work jointly on solutions which benefit our residents, facilitate integrated working, and optimise partner resources through integrated commissioning and asset utilisation plans.
We have been working to operationalise INTs in two districts, with a strategy to incrementally roll this out across all twelve districts. Our focus has been on integrating and strengthening primary and community care at Place with partners and providers, delivering a joint asset utilisation plan, and achieving the agreed KPIs.

Key achievements to date include holding a workshop with the Fylde and Wyre Health and Wellbeing Partnership and the West Lancashire Health Partnership Leadership Team, identified as two of our forerunners, to advance the iterative model for Lancashire. We have mapped existing provision and identified areas for improvement with wider partnership members. The vision for the Lancashire Model

of Integrated Working has been agreed and mapped against the planning guidance, and a new mobilisation plan for all areas is being developed. Work on the development of the shared care record is underway across partners, led by the ICB Digital team and partners. Two districts (Fylde & Wyre and West Lancashire) have been mobilised and are meeting regularly to progress this workstream.

It is important to highlight that whilst we have a vision for the optimal model of Neighbourhood Integrated working within Lancashire Place, the availability of community resources varies significantly due to historical funding and the development of supporting infrastructure. This variation impacts the implementation of the Lancashire model at a local level, as there are considerable differences across localities.

iii. Creating Healthy Communities

The Lancashire Place Partnership has committed to delivering a Lancashire-wide Disabled Facilities Grants Programme based on local needs to maximise the benefit of the fund and provide efficiency and consistency across Lancashire. Additionally, we have supported further integration between Lancashire County Council's Public Health and the ICB Population Health Team, focusing on reducing health inequalities and prevention. The year one priorities for this initiative included Health Checks and Social Prescribing. We have also aimed to improve and integrate leisure, health, and activity offers across Lancashire by developing an agreed way of working between the NHS (via ICB) and Local Authorities (Upper Tier and District level). Furthermore, we have established ten evidence-based, district-level, longer-term Health and Wellbeing Strategies spanning five to ten years.

In terms of achievements, we have successfully delivered the agreed District Health and Wellbeing Partnership priorities across the twelve districts of Lancashire by working collaboratively with local system partners. This includes a minimum of one priority per partnership, developed using a data-led approach. Key milestones to date include the completion of the DFG review, which has completed the baselining and research, with the final report completed and recommended to the Health and Wellbeing Board. Progress between public health and population health has focused on the aligned procurement, design, and delivery of NHS Health Checks and Enhanced Health Checks.

The leisure workstream has completed the baselining of the current offer and the funding streams/projects in existence, looking at assets, services, leadership, and partnerships. It is working on the impact measures of the current offer, as well as identifying strengths and gaps. District-level priorities have all been agreed upon, and work plans are in place, with delivery at different stages. Baselining from the Leisure Review and the Disabled Facilities Grant Report has been shared with the nominated District Chief Executives and both were received positively. Discussions and forward planning are ongoing, including the implementation of the recommendations from the DFG report and creating a proposal for the transition of health services such as therapies into leisure facilities.

During this year, we have focused on the aligned procurement, design, and delivery of NHS Health Checks and Enhanced Health Checks. Progress has not been made in all areas on district-based health and wellbeing strategies, partly due to capacity and partly due to a recognition that this may not be required at a local level. Connectivity to the Lancashire strategy is planned for the year 2025/26.

5. Other Pan Lancashire priority areas of focus

i. Urgent and Emergency Care

The Lancashire and South Cumbria ICB Urgent and Emergency Care strategy guides the transformation of urgent and emergency care services over the next five years to enable people living in Lancashire and South Cumbria to access the care and support that best meets their needs.

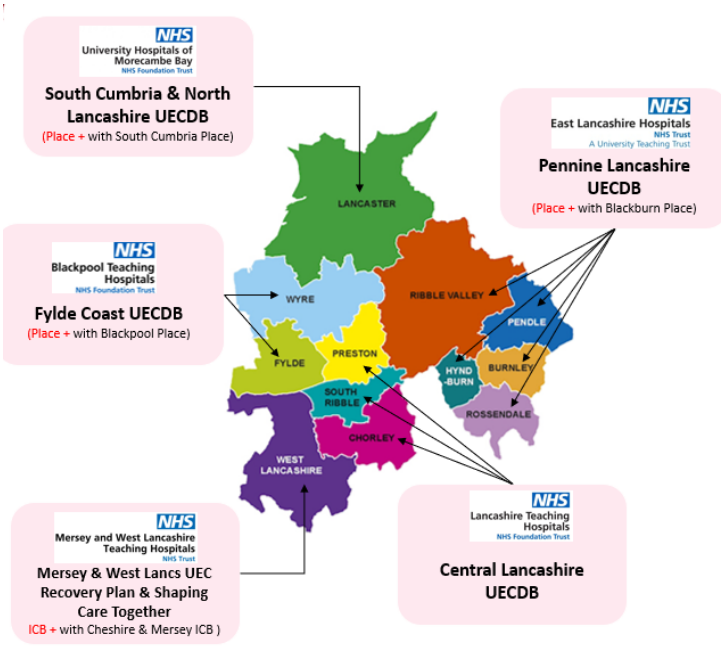
The UEC (Urgent and Emergency Care) workstream is dedicated to enhancing the efficiency and effectiveness of emergency care services. This initiative focuses on optimising patient flow, reducing waiting times, and improving the overall quality of care.

The vision is to create an urgent and emergency care system that enables people to easily access the right care and support at the lowest level of intervention, delivering better outcomes and affordability. The focus is on adapting the urgent and emergency care system to meet increasing demand, ensuring high quality, timely, safe, and affordable care, enhancing preventative care, addressing local community needs, and embracing innovation.

Our five aims are:

- Adapt our urgent and emergency care system so that it is fit for the future to meet increasing demand
- Ensure people can access high quality, timely, safe and affordable care, in the right place by the right professionals
- Enhance preventative and proactive care to reduce avoidable contact with emergency care
- Address the needs of our local communities
- Embrace opportunities for innovation

Urgent & Emergency Care Delivery Boards (UECDBs)



UECDBs are partnerships responsible for the delivery of Urgent and Emergency Care Services. There are four UECDBs across Lancashire & South Cumbria (L&SC) with separate arrangements for West Lancashire. These boards are based around the four Acute Hospital Footprints within L&SC ICB. The boards work on a Place+ footprint with the other L&SC ICB Places (Blackpool, Blackburn and South Cumbria). Lancashire Place, due to its size and scale, is part of all UECDBs. LSCFT, the mental health provider, is also part of all these boards.

In Lancashire we have focused on improving health and care services through integration and addressing health and wellbeing inequities. The "Living Better Lives in Lancashire" vision aims to create a comprehensive, responsive, and integrated urgent and emergency care system that meets the needs of the local population through innovative approaches and collaborative efforts.

All Districts across Lancashire have workstreams established to reduce length of stay (LoS) in hospitals and to reduce those who are medically fit for discharge staying in hospital longer than necessary. Not meeting criteria to reside (NMC2R) data is used to assist getting people home as soon as they are medically able to leave hospital with the right support level for them to manage independently at home.

North Lancashire
NMC2R at UHMBT has reduced overall by 5.3% which is an improvement of 19% (baseline avg Jan-July was 24.6% (148 people). This is now at 19.3% (116 people) which is a reduction of 31.5 people per day), a testament to the joint working between LCC Adult Social Care, UHMBT and in partnership with colleagues from South Cumbria Place and Westmorland and Furness Council since July 24. Whilst this position has deteriorated slightly over the winter period, we are still working hard to maintain a reduced NMC2R position. Improvement of 25% for NMC2R delays attributable to LCC at UHMBT (the baseline was 27%, and the current average is 20.2). The average Length of Stay (LoS) also reduced by 31% at UHMBT.

Central Lancashire
'Improving our time-limited bed-based offer' work programme established with a workstream focused on market shaping, improving the admissions process to bed-based care, improving the community support offer available and ensuring person centred care is provided across the central Lancashire bed base. 'Developing a joint approach to single handed Care' joint work programme between LCC, LHT, LSCFT.

East Lancashire
Workstream established with a focus on call before convey, and care home support. Frequent attenders/High Intensity Users data being gathered, analysed and support being offered.

ii. Respiratory

The Lancashire Place Partnership has identified Improving Respiratory Health as a key priority within its broader strategy to reduce health inequalities and deliver proactive, community-based care. a commitment to integrated, place-based delivery of care. This includes aligning respiratory work with other key transformation areas such as frailty, urgent care, and enhanced community support. The partnership is also working closely with public health teams to ensure that respiratory interventions are embedded within broader prevention and health improvement strategies.

A central initiative is the deployment of Acute Respiratory Infection (ARI) Hubs, which have been strategically located across Lancashire to meet expected demand. These hubs provide same-day assessment and treatment, primarily for upper respiratory conditions, and are accessed largely through self-referral or GP referral. Between November and January, the hubs delivered 14,000–17,000 appointments per month, with patient feedback indicating that 28% would have otherwise attended A&E—highlighting the hubs' role in reducing system pressure and improving access.

The ARI model is being evaluated for further development, with discussions underway about transitioning to a Primary Care Network (PCN)-led model in the next year. While the hubs have successfully diverted patients from emergency care, fewer than expected were referred to smoking cessation or social services, prompting a review of referral pathways and data capture.

Focused Wards Respiratory
In the Lancaster District, we are committed to collaborating with our vulnerable communities to identify and support individuals with respiratory conditions. By focusing on the wards with the highest standardised emergency admission ratios, we aim to improve health and wellbeing outcomes through targeted interventions and support. Our goal was to improve health and wellbeing outcomes through targeted interventions and support, focusing on the wards with the highest need.

Six wards with the highest standardized emergency admission ratios for respiratory conditions were identified. These wards are Poulton, Westgate, Skerton West, Harbour, Heysham North, and Overton. Workshops were conducted in with collaboration with vulnerable communities and key stakeholders to ensure that the interventions are tailored to their specific needs. From this a set of action plans were

developed to focus on reducing urgent care visits and admissions related to respiratory conditions. Task groups aligned with these plans report into the Health & Wellbeing Partnership.

iii. Frailty

Frailty: Advancing Integrated, Preventative Care Across Lancashire Place

In 2024/25, the Lancashire Place Partnership prioritised frailty as a key area of transformation, embedding it within a broader strategy to deliver proactive, integrated care. Through the Pennine Lancashire Frailty Programme, over 4,500 additional care plans and Clinical Frailty Scale (CFS) assessments were completed in the first half of the year, supported by training for more than 1,100 staff across Primary Care Networks in Blackburn with Darwen and East Lancashire.
The programme's second phase focused on anticipatory care, enabling earlier identification and support for individuals with mild to moderate frailty. This included direct referral pathways to Older People's Rapid Assessment (OPRA) services and the development of a step-up/step-down model for care homes, in collaboration with the voluntary, community, faith, and social enterprise (VCFSE) sector.

Collaborating with Care Homes focusing on early identification and assessment of frailty in high-demand areas.

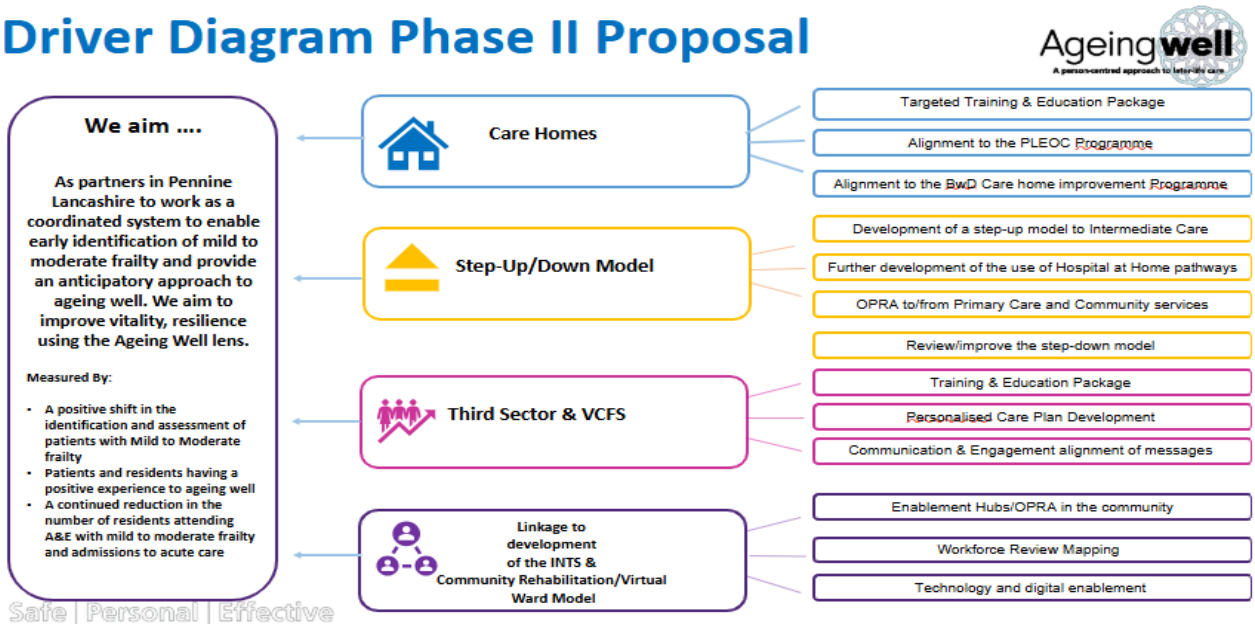
Engaging with NWAS, IHSS Hospital @ Home, Age UK, Voluntary Sector, and Integrated Neighbourhood Teams.

Following NHSE guidelines to provide care and support for residents with moderate or severe frailty.

Frailty also featured prominently in the Lancashire Model of Integrated Working, with multidisciplinary and neighbourhood teams supporting residents to remain independent at home. Preventative initiatives, such as targeted home adaptations in Rossendale, further demonstrated the partnership's commitment to reducing avoidable admissions and supporting ageing well.

Key achievements include:

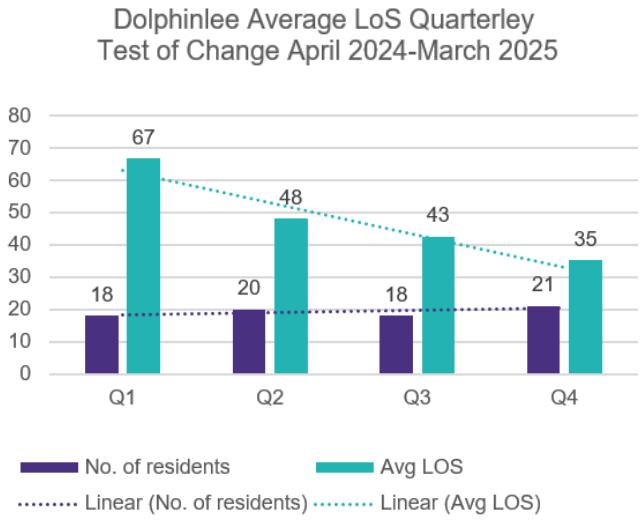
- **4,500+ care plans** and Clinical Frailty Scale assessments completed.
- **1,100+ staff trained** across Primary Care Networks.
- **New referral pathways** established to Older People's Rapid Assessment (OPRA) services.
- **Step-up/step-down models** introduced in care homes.
- **Neighbourhood teams** mobilised to support independence at home.
- **Home adaptation initiatives** launched in targeted areas like Rossendale



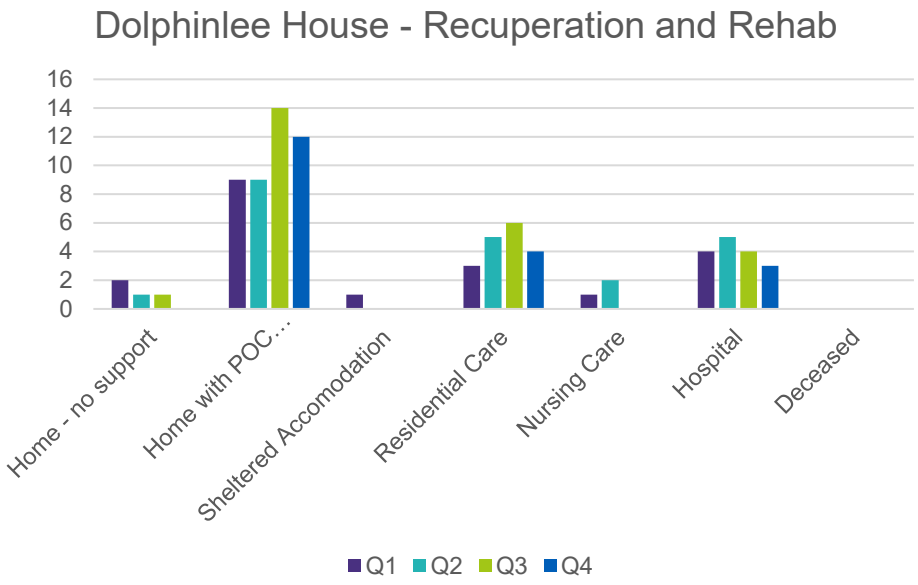
Dolphinlee Test of Change

The Dolphinlee project, initiated in July 2024, aimed to enhance the quality of care and improve operational efficiency at the Dolphinlee intermediate care facility in Lancaster District, North Lancashire. The project focused on the 13 physical health beds within the facility, with the primary objective of reducing the average length of stay (LoS) and addressing discharge challenges.

Key improvements included the streamlining of multiple multidisciplinary team (MDT) meetings, which now incorporate Age UK and Health and Housing workers from LCC, and the adoption of best practices from Parkview Gardens in South Cumbria. The project also saw enhancements in the admissions process, documentation, and information sharing, which significantly reduced delays in discharge from the hospital. Additionally, the physical rehabilitation environment and available equipment were improved, and a comprehensive staff training programme was implemented.



The project yielded several positive outcomes. The average LoS was reduced by 48%, from 9.5 weeks to 5.0 weeks, with ongoing plans to further reduce it to the optimal 4 weeks. The data indicated a steady increase in the number of patients being discharged within 6 weeks and a decrease in those staying over 8 weeks. Furthermore, there was a notable increase in the number of patients being discharged home with support, and a decrease in hospital readmissions. These outcomes are visually represented in the accompanying graphs, which illustrate the reduction in LoS and the positive trend in discharge times.

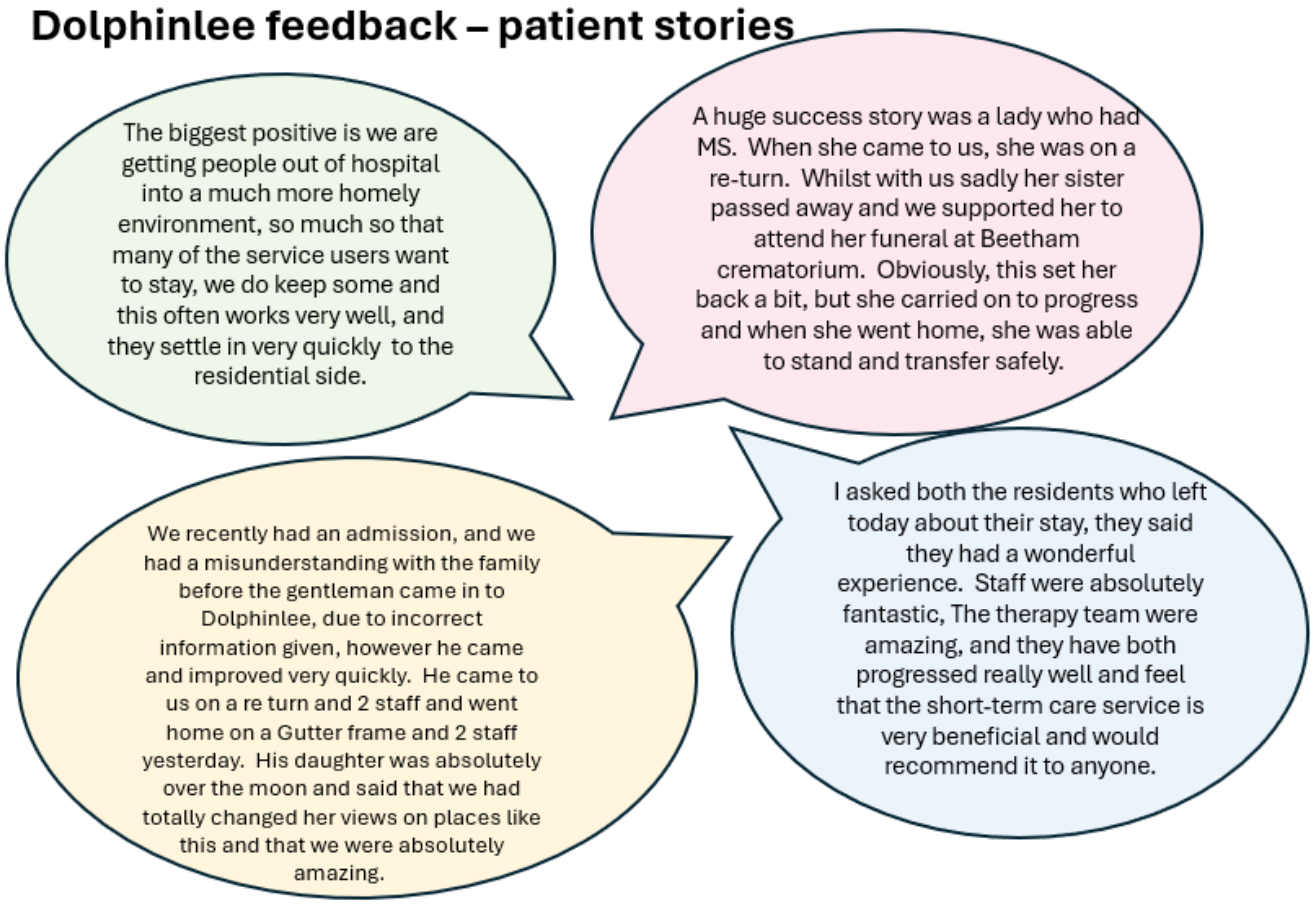


Q3 and Q4 outcome data is showing an increase in people being discharged home (with POC support) with 1/3 more people in Q3 than Q2 this is maintained in Q4.

There is an overall increase in those going from Dolphinlee to residential care and a small decrease in hospital re-admissions.

Evidenced by these figures the appropriate cohort is being supported by Dolphinlee as very few people are returning home without support and there are also fewer going into nursing care.

Feedback from the project has been overwhelmingly positive, with significant improvements in joint working relationships and communication among staff, residents, and their families. The project has also fostered a culture of continuous improvement and shared learning, ensuring that Dolphinlee remains a model of excellence in intermediate care.



6. Learning review

6.a Impacts and outcomes summary

Reflecting on the past year, it is evident that our collaborative efforts have significantly advanced health and wellbeing outcomes in Lancashire. The joint initiatives, such as the ESCAPE PAIN programme, Cancer Pre-Hab, Physical Activity Clinical Champion Training, and GLL Healthwise, have demonstrated the power of partnership in addressing community health needs. These programmes have not only provided direct benefits to participants but have also fostered a culture of engagement and collaboration among various stakeholders.

One of the key lessons learned is the importance of early and proactive intervention. The success of the NHS Lung Health Checks in Hyndburn underscores the value of early diagnosis in improving treatment outcomes and survival rates. This initiative has shown that targeted health checks can lead to life-saving interventions, highlighting the need for similar proactive measures across other health areas. Additionally, the emphasis on organisational and leadership development through systems leadership, action learning sets, and mentoring has proven to be effective in fostering trust, collaboration, and innovative ideas among leaders. This approach has equipped participants with the clarity, confidence, and positivity needed to tackle the challenges in Hyndburn and beyond.

As we move forward, it is crucial to continue building on these successes by maintaining strong partnerships and fostering a collaborative approach to health and wellbeing. By leveraging the lessons learned and the positive outcomes achieved, we can ensure that Lancashire endeavours to become leader in promoting health and wellbeing for all its residents.

We would like to extend our heartfelt thanks to all our partners, communities, and residents for their unwavering support and collective efforts in achieving these remarkable outcomes. Your dedication and collaboration have been instrumental in driving positive change and improving the health and wellbeing of our community.

Photographs from the Ryelands community project.

6.b Continuous improvement: lessons learned and key takeaways for 2025/26

	Key Component	Details
1.	Integrated Care Communities	Learning from successful practices like Integrated Care Communities (ICCs) in North Lancashire can shape our Lancashire Integrated Working model.
2.	Joint Ownership	Joint ownership of neighbourhood projects fosters collaboration and addresses resident needs.
3.	Delegation of Funding	Delegation of funding through locality partnerships focuses efforts on outcomes.
4.	Partner Capacity	We must align partner capacity to impact Lancashire effectively.
5.	Health and Wellbeing Partnerships	Our HWBPs have been crucial at the district level for creating healthy communities and addressing health inequalities.
6.	Strong Partnerships	Strong partnerships, relationships, and trust are essential to overcome local barriers.
7.	Context-Specific Approaches	What works in one place may not work in another. Learn and test accordingly.
8.	Cross-Boundary Work	Cross-boundary work is challenging when priorities differ.
9.	Role of District Councils	District Councils play a critical role in supporting health and wellbeing's wider determinants.
10.	Common Purpose	Sometimes commitment to a common purpose is more important than additional funding.
11.	Partner Motivation	Partners must be willing and motivated to collaborate on projects.
12.	Common Understanding	Ensure common understanding of terms like “Integrated Neighbourhood Teams” across different areas by establishing clear definitions first.