Appendix 1

Lancashire and South Cumbria Integrated Care Partnership

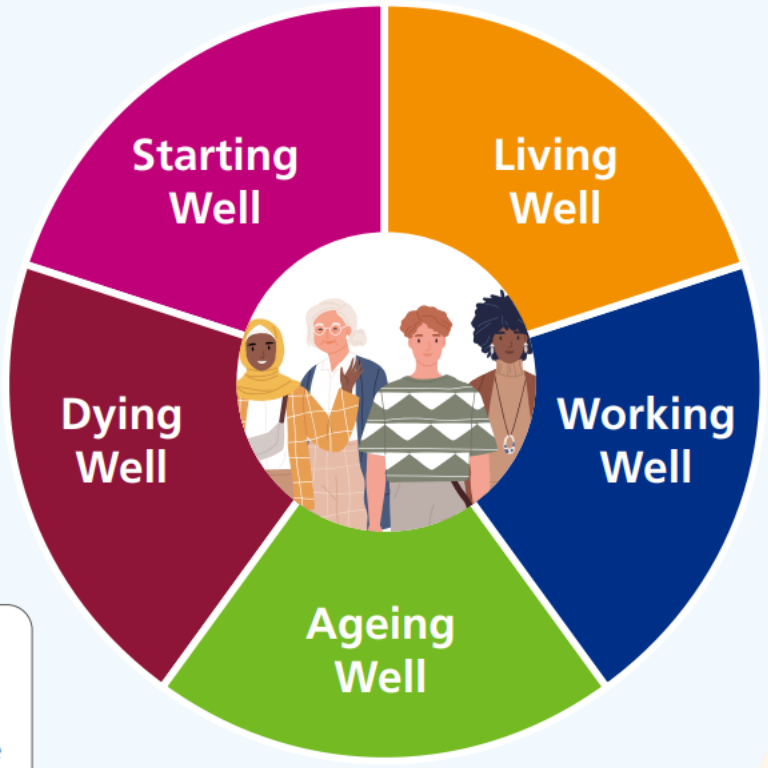
Lancashire and South Cumbria Integrated Care Strategy

Programmes and Case Studies: Examples against the Life-Course Domains

Our priorities

Our priorities reflect the different stages of life that everyone goes through.

Give our children the best start in life, supporting them and their families with problems that affect their health and wellbeing, and getting them ready to start school.



Reduce ill health and tackle inequalities across mental and physical health for people of all ages by understanding the cause of these unfair differences.

Encourage all our residents to feel comfortable in talking about planning for dying, and to be well-supported when a loved one dies.

Increase ambition, aspiration and employment, with businesses supporting a healthy and stable workforce and employing people who live in the local area.

We know that many people will be living their lives across several different parts of this life course at the same time. It is important that we make sure the connections between these are easy to navigate.

Support people to stay well in their own home, with connections to their communities and more joined up care.

Starting Well

We will give children the best start in life by supporting those who need help the most to tackle health inequalities. We will help children and families to be healthy and well, and help our children be ready to start school.

Our Themes	**Integrated support for families** - Providing joined-up support for children and their families.	**Reducing health inequalities** - Taking action on the differences in access to services and health and wellbeing outcomes for children and their families.	**Achieving full potential** - Supporting all children to be as healthy and well as they can be by their third birthday.
	← **Develop family hub networks to provide integrated support to families** →		
Our Key Actions	• Plan and deliver joined up services and teams to provide individual care and support to children and their families, including parental carers and young carers • Develop a 'Start for Life' offer across Lancashire and South Cumbria, that is planned with parents and families. It will include maternity services, school nurses and education, with a focus on mental health and wellbeing, support during pregnancy and infant feeding and health visiting.	• Support and encourage families to breastfeed their babies wherever possible. • Reduce childhood obesity. • Reduce smoking in pregnancy. For all of these we will provide targeted help for those who need most support and for those who experience the greatest **health inequalities**.	• Help children and families to get ready to start school, including supporting new parents and creating places at home where children can learn. • Develop a healthy child programme, with joined up health and development services including community paediatrics and therapies. • Support the families of all pre-school children with additional needs, including access to appropriate professionals and sharing information across health and children's social care services. This will include support for families that include parental carers and young carers.

Supporting infant feeding

The Lancashire and South Cumbria Infant Feeding Network comprises infant feeding leads for maternity, community services, local authority and public funded peer support services, working together to implement the Lancashire and South Cumbria Infant Feeding Strategy so that all expectant and new families are fully informed about their baby feeding choices, receive support that is culturally appropriate and meets their individual needs, and are fully supported in their decisions.

Research confirms the importance of breastfeeding in preventing ill-health and developing close and loving relationships which leads to better health outcomes for babies and families. Support when new families find breastfeeding challenging is essential, so the Network has trained 25 healthcare professionals to provide expert support to families navigating breastfeeding challenges, working with maternity units, in community settings and specialist infant feeding clinics.

Breastfeeding rates across the UK are lower in more deprived areas, when compared to less deprived areas, which further contributes to health inequalities. The reasons for this are complex but often involve practical barriers and lack of adequate support, so the Network is also working with communities to support better public knowledge around infant feeding.

Case Study

Health Visitor referred a patient to the specialist infant feeding team who had been supported by the Midwife and health visitor but was experiencing maternal pain on feeding to the point where mother did not feel she could carry on. Specialist infant feeding practitioner provided virtual consultation and followed this up with a home visit due to severity of pain and emotional distress of mother. This mother and baby had moved in with grandparents after fleeing a domestic abuse situation. Breastfeeding was important for many reasons but particularly as a Muslim family. The practitioner was concerned about both feeding and maternal mental health.

Support was given in the home and pain improved. Mother and baby then attended a specialist clinic run the practitioner at their local family hub, a peer support group and midwifery clinic. This led to them attending the support group long after their feeding issues had resolved. The mother went on to successfully exclusively breastfeed past 18 months. The mother sent a text thanking the practitioner for the support on return to work as she did not feel they would have made it so far without the infant feeding team tailored support.

Case Study: supporting parents from the Trans community

Dad, Assigned Female at Birth, and husband preparing for their second child's arrival enquired around colostrum harvesting with their Mental Health Midwife. Midwife assisted with appropriate terminology (breast/chest, vagina/genitalia). Infant Feeding Team discussed colostrum banking and skin-to-skin contact after referral from Midwife. Plans were made for the elective section, antenatal appointments and postnatal care. While not planned, this baby received human milk from Dad up to 9 weeks of age, at times feeding from the chest.

Smoking in pregnancy

Numbers of women entering maternity services as a smoker has not significantly decreased, however there has been a significant reduction in smoking at time of delivery across Lancashire and South Cumbria from 13.9% at March 2022 to 7.59% at March 2025.

During this time, a maternity-led, tobacco dependency service, has been introduced across Lancashire and South Cumbria so that people receive the same type and level of support no matter where they live.

Services were made easier to navigate and access with clinics held in Family Hubs and GP practices to encourage uptake and dedicated teams were employed, trained to nationally-recognised standards to provide behavioural support and nicotine-replacement therapy.

Case Study

Service user was 17 years old and disclosed she had autism and ADHD. She was in an abusive relationship with an older man and was very scared and anxious. She was 3 months pregnant at the initial meeting in a Family Centre and asked for support to stop smoking during pregnancy.

Regular consultations were held at the Family Centre initially but moved to a hospital setting at her request. The service user would text upon arrival at the hospital and be collected from the foyer to avoid anxiety caused by the busy waiting room.

A tailored smoking cessation programme was provided in addition to anxiety and mental health support, by the same practitioner, keeping close links with the perinatal mental health team, her social worker and midwife.

The practitioner provided emotional support attending the mid-pregnancy scan appointment, as she was too anxious to attend alone. The service user was encouraged to bring another trusted adult to appointments to help with her anxiety and to retain the information shared during consultations.

Over the course of seven months, the service user engaged in the programme despite her challenges. The tailored approach and collaborative efforts helped her navigate a difficult pregnancy with a strong network of support. We were able to provide flexible and personalised care to support this vulnerable individuals during pregnancy.

Living Well

We will work together to prevent ill health, tackle inequalities across mental and physical health, and understand the cause of these unfair differences. We will enable people of all ages, including children and young people, to experience improved health and wellbeing, especially those living in our most deprived areas and those experiencing the greatest inequalities.

Our Themes	**Supporting people who are already mentally or physically unwell** - taking action on earlier diagnosis, providing better support to people living with their onditions and stopping them from getting worse, especially those people who have the greatest **inequalities** in access, experience and	**Supporting our residents to make healthy lifestyle choices, especially people who have the most unfair differences in their health.**	**Understanding the causes of poor health and care** - Working together to tackle the things that have an impact on health and wellbeing.
Our Key Actions	• Make it easier for people to get long-term conditions and cancers diagnosed • Ensure that we know our residents with existing long-term conditions and support them, their families and their carers with more joined up care that supports the person, not the condition. • Provide better help to our residents who have mental health needs, learning disabilities and/or autism, and their carers, with a focus on improving access to support for those experiencing the greatest **health inequalities**. • Make it easier to know who our **unpaid carers** are, better understand their roles, and give better support for carers of all ages.	• Address the things that lead to reduced life expectancy and reduced healthy life expectancy (such as smoking, obesity, inactivity, drug and alcohol consumption). • Build on the resources and strengths of specific communities to help residents access the services and support they need to develop strong and resilient communities • Make it easier to find emotional and mental wellbeing support. • Increase the number of people having immunisations, screening and NHS health checks.	• Focus on things that have an effect on health and wellbeing such as fuel poverty, standards of housing, homelessness, and things that lead to complex social needs. • Support large organisations to improve the wellbeing of the local population and ensure that they add a positive impact for local people. • Increase community involvement in action on the social determinants of health and wellbeing • Get in touch with our residents who experience, or might experience, loneliness to make sure they feel part of our communities. • Increase the visibility of action to address health inequalities in the way we create public policies for example through utting money into things that will support residents, transport, digital access and environmental policy.

Heart health

The ICB led CVD programme focuses on reducing cardiovascular disease (CVD) across Lancashire and South Cumbria by targeting the detection and management of atrial fibrillation, high blood pressure, and high cholesterol. The programme aims to address these issues through a comprehensive strategy that includes monitoring and targeting unwarranted variation, supporting a system-wide response, enabling system leadership, and increasing public education.

The programme has seen several initiatives, such as the Community Stroke Teams project, the Barbers pilot, and the Optum pilot, which involves blood pressure checks in opticians. These initiatives aim to find and manage high blood pressure in various community settings. Additionally, the programme has developed resources like the statin myth-busting document and the Healthy Hearts leaflet to educate the public and healthcare professionals. The programme brings together various subgroups focusing on different aspects of CVD prevention, ensuring a coordinated and holistic approach to tackling CVD in the region.
Supporting the shift to prevention rather than treatment, the ICB, working with general practice, undertook a case finding project to try and identify anyone with unknown hypertension, to prevent later presentation with increased and more damaging health issues.

A lead VCFSE provider, Heartbeat, was identified and tasked with providing BP testing in local wards across Lancashire & South Cumbria. The Wards were outlined through a large Health Inequalities (HI) data piece from the MLCSU Business Intelligence team. They pinpointed where HTN prevalence was low but emergency admission for Myocardial Infarction or Stroke were high (missed prevention opportunities) against 29 other HI indicators.

This led to 16 Wards for Heartbeat, working with other community embedded charity organisations, to focus on providing free, easy to access BP and pulse testing.

Working in this way, resulted in almost 400 BP tests being taken on the doorstep of the communities identified, with 23.4% of those tested requiring further intervention for possible Hypertension, as well as almost 30 people being identified for having possible atrial fibrillation.

Supporting and identifying carers

The Integrated Care Strategy includes a collective pledge to identify those with caring responsibilities and to provide appropriate information and support to improve the health and wellbeing of carers and the people they care for.

The Lancashire and South Cumbria Carers' Partnership Group exists to bring together organisations and those with lived experience who have an interest in improving the lives of unpaid carers across Lancashire & South Cumbria. The group provides a forum for sharing learning and seeks to identify activities or pieces of work that would benefit from collaborative approaches at system level.

The role of unpaid carers in supporting those with complex needs and taking away pressure away from the NHS infrastructure is widely recognised. There are multiple programmes being implemented across Lancashire & South Cumbria which seek to identify carers and ensure they get access to appropriate support and information.

One example is the work of Lancashire Carers Service which is delivering Targeted Carer Awareness sessions within general practice. The sessions have been delivered to over 400 healthcare workers in GP surgeries to enhance the confidence, capacity and capability of staff to recognise and support unpaid carers, many of whom remain hidden.

The ICB and Upper Tier Authorities jointly commission support services targeted at young carers to ensure they have access to information and practical and emotional support.

These services include:

- Barnardo's (Lancashire)
- Blackpool Carers Centre (Blackpool)
- Child Action North-West (Blackburn with Darwen)
- Carers Support Cumbria

Case Study

Joel, aged 16 is a young carer who has been supported by Barnardo's since September 2024. He is a young carer to his mother who suffers with mental health problems and PTSD. She relies heavily on Joel for support and Joel also supports his younger brother who is autistic. Joel lives with his grandparents for part of the week to give him a break. Joel is in year 11 and taking his GCSEs. He suffers with his own mental health and worries about his mother when he is away from home.

Joel has received one to one support where he is able to talk about his own feelings. He attends events with a theatre group which he looks forward to as he is able to mix with like-minded young people. Joel was recently a guest speaker at an event on Young Carers Action Day where he delivered a passionate and touching speech to an audience of young carers and professionals.

The support he has received has helped him to realise that he isn't alone in his caring role and he has been able to open up about his feeling and make new friends. He enjoyed speaking at the recent event and has said he would like to be more involved in similar events in the future.

Improving early cancer diagnosis

Improving Cancer Outcomes through Community Engagement

Cancer Alliance partnership with Spring North to deliver a small grants programme to raise awareness of the signs and symptoms of cancer, encourage timely help-seeking, and promote screening uptake. 18 voluntary, community, faith and social enterprise partners are reaching people in their communities across Lancashire and South Cumbria through the funding of creative, targeted projects. Since delivery started in December 2024, the projects have engaged more than 183,000 people. Participant feedback shows that 90% of people responding to the evaluation survey felt more confident about accessing screening and 99% felt more confident in recognising the signs and symptoms of cancer. The Cancer Alliance is planning to further build on this partnership with Spring North and the VCFSE sector using 25/26 SDF funding and plans to enhance reach through targeted public awareness campaigns.

Healthwatch Blackpool is working with the Cancer Alliance and partners in Blackpool to undertake comprehensive listening across the town to understand what people in Blackpool know and think about cancer. This includes knowing cancer signs and symptoms, screening programmes, and how to get help or support. These insights will be used to inform improvement work in Blackpool; the Cancer Alliance has allocated 25/26 SDF funding to support delivery of these improvements.

Cancer Care Charity

LSC Cancer Alliance is working with Cancer Care Charity in Lancaster, Morecambe and South Cumbria to undertake a programme of community engagement aimed at increasing awareness of signs and symptoms of cancer and encouraging timely help seeking. Local people have engaged with the development phase of the project which has captured the voices of people with lived experience of cancer to create campaign materials to be shared at future community events and via outreach.

A partnership between the Cancer Alliance, Hyndburn Rural PCN, Hyndburn Central PCN and Hyndburn and Ribble Valley CVS is undertaking targeted engagement to improve cancer signs and symptoms awareness and timely help-seeking across the district. Training has been delivered to staff from across partner organisations to improve confidence in having conversations about cancer. Outreach events have been delivered, and the CVS is leading on developing and implementing a 'Community Champions' model to reach communities that are often missed by traditional communications activities, including the local Gypsy, Roma and Traveller community and Muslim women's groups

Admission avoidance - targeted VCFSE support

In 2024-25 the ICB worked with the VCFSE Alliance to invest in community-based schemes to manage demand for urgent and emergency care over the Winter period. The Alliance selected 2 pilot areas – BwD and Blackpool – to test and learn from the inclusion of the VCFSE sector in supporting system partners with admission avoidance schemes.

Schemes included:

- Community connectors/ Link Workers engaged to work alongside the Acute Respiratory Infection (ARI) Hub in Blackpool.
- Falls Prevention and support for frail elderly in Darwen.
- Outreach in Blackburn town centre and surrounding areas to vulnerable individuals and families, including those who frequently attend A&E

Early evidence is demonstrating the impact that person-centred and holistic approaches can make , with more than 2,000 individuals benefiting from the scheme in just five months. Case studies are demonstrating the ways in which earlier intervention can help to manage demand more effectively, avoiding the need for acute and more costly services.

Case Study

Mrs C, accessed the Blackpool Acute Respiratory Infection (ARI) Hub in December and was referred to a respiratory link worker. Last winter she became unwell and ended up in hospital with flu. She was living in a cold flat and worried about money.

She met with the link worker and said that she did not have enough money to heat her home and eat healthily. She said she was worried about fuel bills, and this was having a negative impact on her mental health. The link worker reassured her that help was available and looked at her income and expenditure. A Winter support grant was applied for and awarded, as well as items that would help her to stay warm whilst she was at home; heated throw, warm bedding. A voucher for food was given to her to help with her shopping bill. Following this initial support, a referral was made to Citizens Advice for a benefit check and the adviser was able to establish entitlement to pension credit.

Pension credit was awarded at £78 per week making her £4056 better off each year and meaning next December she will get the Winter Fuel Allowance of £200. This meant she was able to stay well at home throughout the colder weeks of December and January and is likely to remain well over subsequent winters. The link worker has continued to work with her to help her access groups and activities in her local community. On Valentines Day she attended a coffee morning at a community centre and intends to keep going to this every Friday.

Working Well

We will increase ambition, aspiration and employment across Lancashire and South Cumbria, with businesses of all sizes and across all industries supporting a healthy and stable workforce and employing people who live in the local area.

Our Themes	**Young people** - supporting young people to feel more interested in their future careers, helping them to gain life skills needed for work, and encouraging them into jobs with good career opportunities.	**Skills development** - supporting people of working age into stable and healthy workplaces, and helping individuals, particularly from disadvantaged communities, to gain confidence and skills to help them to compete for jobs as equals.	**Wellbeing at work** - creating workplaces and cultures that encourage good health and wellbeing, identifying the signs of ill health and wellbeing early and offering support where needed.	**Businesses supporting communities** - encouraging large organisations and local businesses to support social and economic development in their local area.
Our Key Actions	• Support young people to develop the skills and confidence to achieve their full potential. • Deliver a single Health and Care Careers and Engagement Service, working more closely with schools and colleges. This would include a broad range of activities and programmes, including work experience and placements. • Health and care organisations will work together to get the most out of apprenticeships and make sure they are a good route into a career in health and care. • Have more ways to get into health and care training roles, working with higher education organisations to keep training places available for local residents.	• Deliver a broad range of programmes that help people to get a job across health and care organisations, especially for people from disadvantaged communities. • Create more volunteering opportunities that give people the skills and experience to help them get a stable job. • Make sure that unpaid experience is a recognised route into a career in health and care services. • Develop programmes that provide re-training and career change opportunities for all people of working age.	• Large organisations (known as **anchor institutions**) support the wellbeing of their employees. They provide good occupational health and wellbeing services and contribute to the wellbeing of the population through preventing ill health. • Small and medium size businesses in all industries can access schemes that support wellbeing in the workplace and are encouraged to create healthy working environments. • Residents with **long term condition**s are supported into employment to improve their health and mental wellbeing. • Working carers are supported to balance work with their caring responsibilities.	• Build on the success of **'social value'** or **'community wealth building'** approaches that are already in place by encouraging local businesses to commit to creating healthy workplaces and supporting the development of local communities,including the creation of 'healthier high streets' within our **neighbourhoods**. • Encourage businesses to set up in Lancashire and South Cumbria, with a commitment to the health and wellbeing of residents and communities. • Create 'health for wealth' champions both across our smaller communities and across the whole of Lancashire and South Cumbria.

WorkWell Vanguard Programme

WorkWell is a vanguard programme funded through the Joint Work & Health Directorate, that aims to help people with health conditions to start, stay and succeed in work. The programme is available for people with physical and health problems that are not complex but are affecting their life, either through their ability to work or look for work. It is anything that is causing the person recent problems.

Participants have access to a Work and Health Coach and together they agree realistic and reasonable next steps that can form part of a personalised support plan. Work and Health Coaches consider the full range of available local support and provide signposting, tailored to individual need.

The partnership programme is led by L&SC ICB and delivered in 7 areas across Lancashire and South Cumbria including:

- Barrow in Furness
- Blackburn with Darwen
- Blackpool
- Burnley
- Lancaster
- Preston
- West Lancashire

Case Study

A 61-year-old male was referred to Work Well after being unable to continue with a manual retail job after surviving bowel cancer and having a stoma, an experience that left him feeling significantly distressed. The combination of unemployment and health concerns, and the stigma of having a stoma exacerbated his stress and anxiety about the future. He had modest savings of £16,000 which he wanted to protect for his retirement.

A WorkWell Coach worked collaboratively with him to develop a personalised Work and Health Plan using the 'WorkStar' assessment tool that addressed both his financial situation and his employment prospects. After conducting research on benefit entitlements, The WorkWell Coach discovered that he could potentially qualify for New Style Employment and Support Allowance (ESA), and Personal Independence Payments PIP. In parallel we worked with him to review his skills and talents, write a new CV and access training in administrative roles. He is now feeling more confident in himself despite the physical and mental health challenges he faces, and aims to be back in work soon, feeling positive about his options in doing so.

The Bay Anchor Network

The Bay Anchor Network was established in 2020/21 as a community where Anchor organisations could collaborate to enable sustainable, prosperous and healthy communities. The purpose of the Network is to support Anchor organisations to identify, develop and share how they can positively influence and actively contribute to the health and wellbeing of communities and the wider social, economic, and environmental factors that support healthy living.

The Network achieves this by supporting each organisation to improve and strengthen its own role as an anchor in the community by working through the anchor framework to make progress on each of the domains and identify improvements they can make. It also provides a space in which organisations can collaborate on common aims, objectives and projects which anchors can work on jointly.

The Network enables partners to:

1. Increase their understanding of the social value priorities for our communities and how their organisation can best contribute to delivery of these directly or indirectly.
2. Support each other on delivering agreed priorities individually and as a collective, particularly when working across different sectors can encourage complementary fit across projects.
3. Share learning and best practice.
4. Mobilise collective action as opportunities arise from both internal and external sources, such as funding or research bids, to leverage change.

Members of the network sign up to a charter, this sets out the key vision and values. This is supported by a progression framework which allows members to self report and demonstrate progress against the agreed areas of common interest and an ambition. The vision and values statements are:

The Bay Anchor Network
ROOTED IN THE COMMUNITY

1. Employing, developing and investing in a workforce that is representative of our local population.
2. Providing stable and fulfilling jobs, fair pay, and great working conditions.
3. Using procurement and commissioning to create local social value and increase community wealth.
4. Supporting local charities, community groups and businesses through access to land and buildings.
5. Work in an environmentally sustainable way and influence sustainable local practices.
6. Providing access to communal green spaces and cultural spaces for every neighbourhood.
7. Supporting local collaboration, listening to residents and community power.
8. Taking a targeted approach to where and how our collective resources are used.
9. Purposefully and deliberately addressing health and other inequalities wherever they exist in our communities.

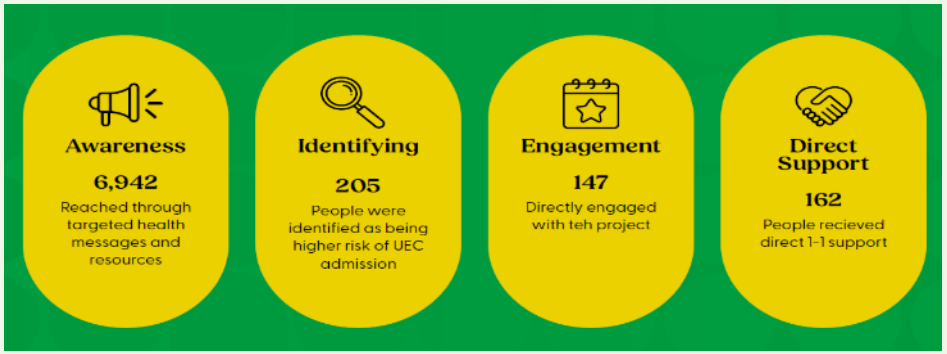
Ageing Well

We will provide high quality care that supports people to stay well in their own home and make sure our services work together. We will support our ageing population to live more active lives and to feel connected to their local community.

Our Themes			
	Integrated support for older people - providing joined-up support for our most vulnerable and frail residents, their families and their carers.	**Choice and control** - making sure support is in place when circumstances change for an individual or their carers, supporting individuals to be as independent as possible.	**Healthy ageing** - keeping our maturing population mentally and physically active as well as involved in and contributing to their communities.
Our Key Actions	← Develop older people's hubs to provide joined up support to older people across all themes →		
	← Jointly manage the care sector market to there are high-quality options for residents who need care including use of digital services where suitable →		
	• Plan and deliver joined up services and teams that meet our residents' needs and provide care designed for each person, supporting their physical and mental health and wellbeing and helping people to stay in their own home. • Make sure there is a simple way to access support to reduce the number of people in crisis, recognising and supporting the contribution of carers. • Create a service that helps our most vulnerable and frail residents, including regular health checks, a falls service, and more support for dementia. • Make sure people know about all of our services that can support residents, their families and their carers.	• Make sure our offer includes care to help people to get back on their feet as well as longer term care provision. • Provide accessible information about what care is available, when and how to access this, including details about costs and funding options that are easy to understand and follow. • Help older people to use technology to support their health and wellbeing.	• Make sure that we know who is at risk of becoming frail and support a range of community activities to meet different needs and interests, encouraging self-care through better understanding, and developing and maintaining people's skills. • 'Live longer better' - supporting residents to access information and support to maintain and make the most of their own health and wellbeing. • Connect residents, their families and their carers to lead active, healthy and positive lives, to plan ahead for old age and think about things that can be arranged in case their needs change or their health gets worse. • Services will focus on what people can do for themselves, what their families and wider networks can do, and what the wider community can do, rather than just looking at whether a person needs their service.

Support for Older People to Reduce Falls

- Age-UK used its long-standing community infrastructure and referral pathways to provide highly targeted support around falls prevention and awareness for over 65's in Darwen.
- Many of those supported were identified through care home links or community navigation services.
- Established strong partnerships with NWAS through collaboration with Progress Lifeline's lifting service which led to successful training sessions for care home staff and participation in the Care Homes Forum
- 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 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 has 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.



81 estimated admissions avoided	**£59,253 cost savings from avoided admissions**
£12,960 Demand management savings	**£72,213 total cost savings**

The Integrated Wellness Centre, Barrow-in-Furness

The Integrated Wellness Service is a pilot programme supporting a targeted cohort of patients developed in partnership with University Hospitals of Morecambe Bay NHS Foundation Trust, South Cumbria place team, primary care and local VCFSE partners. The Centre supports individuals within the community, following an emergency attendance at Furness General Hospital, or those who are at risk of their health deteriorating and requiring hospitalisation. It provides intensive, holistic wrap-around support and a responsive action plan, tailored to the individual to maintain their health and independence at home. This is having real impact and enabling the shift from hospital to community-based treatment.

In the first two months of the pilot programme there was a 90 per cent reduction in re-admissions and an over 85 per cent reduction in length of stay for the patients. Much of this has been achieved independently of social care by better medicine management and therapy. The pilot demonstrated that by early focussed interventions, individuals can retain their independence within their own home and avoid unnecessary hospital stays, which enhances quality of life, and the quality of care received, whilst reducing the burden on health and social care resources.

The ICB's Commissioning Intentions for 25/26 make a commitment to embedding the model across Lancashire and South Cumbria.

Core Elements:

- Highly targeted – age, geography, triggers/risk factor
- Rapid – in response and in evaluation
- Multi-disciplinary – various professions, organisations, sectors
- Beyond ill-health – considers social factors

Case Study

Mr P, who participated in the pilot of the scheme in the summer of 2024, had an underlying health condition identified by his GP (postural hypotension). Following a referral by the Integrated Wellness Centre for an urgent review of medication, after their initial assessment in Mr P's home.

The early diagnosis allowed for Mr P to be treated within his own home and prevented complications associated with his diagnosis, (most commonly falls) which would have likely resulted in a hospital visit and admission.

Care Sector Improvement

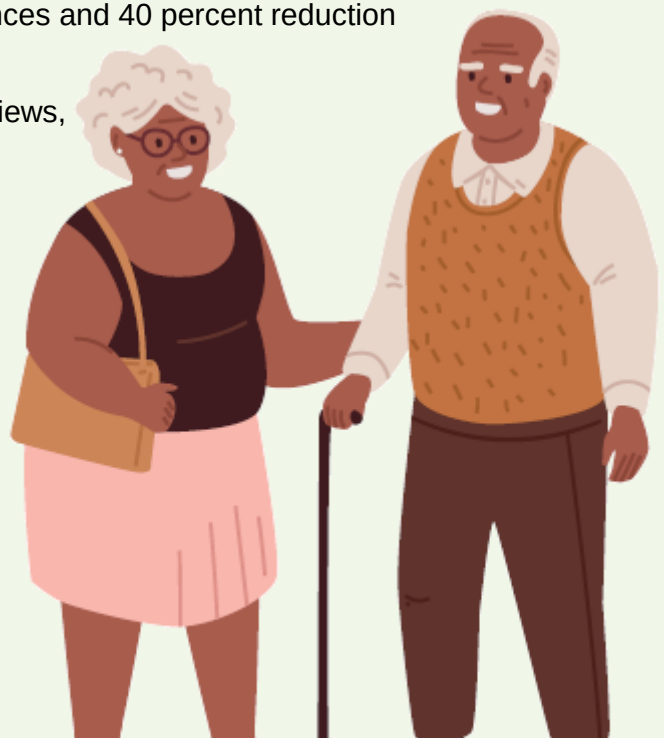
Care home quality improvement has been identified as a strategic priority both nationally and is a focus for collaborative action in Blackburn with Darwen.

The area has a high number of care homes rated as ‘requires improvement’ by the Care Quality Commission (CQC) and higher than average hospital attendances from those living in residential and nursing homes.

The Place Based Partnership Board delivered a multi-agency programme of work in 2024-25 to drive improvements, which included engagement and training of care home staff.

Data collected between July 2024 – March 2025 shows;

- 60 percent reduction in hospital attendances and 40 percent reduction in hospital admissions
- An increase in structured medication reviews, with 62% of residents reviewed by January 2025
- Improving quality, with a 12% increase in the number of beds rated ‘good’ by the CQC, since September 2024



Albion Mill Case Study

Patient Background: A 79-year-old female who lives alone suffered a fall at home, resulting in a fractured left humerus and neck of femur. She was admitted for surgery.

Rehabilitation: Four weeks post-surgery, she was transferred to Albion Mill for rehabilitation. The patient set her own Person Reported Outcome Measures (PROM) with support from the Therapy Team.

Multidisciplinary Team (MDT) Approach: Using a MDT approach, several actions were identified to improve outcomes and facilitate discharge.

Discharge Process: An environmental visit was completed by Therapies, and the patient was ready for discharge, being mobile and independent with a frame. Reablement support was provided four times daily, and she was discharged with Age UK Home and Settle.

Length of Stay: The patient had a length of stay in Albion Mill of 41 days.

Dying Well

We will encourage all of our residents, across all age ranges, to feel comfortable in talking about and planning for dying. We will support our residents, their families and their carers to be well supported when a loved one dies.

Our Themes	**Talking** - Encourage our residents to feel comfortable with talking about death and dying.	**Planning** - End of life care will be made more personal regardless of where someone lives or their condition.	**Supporting bereavement** - Outstanding support for people who have lost a loved one, their families and carers with an approach that meets their individual needs.
Our Key Actions	• Compassionate conversations – helping people understand how important it is to think about death, talk about death and plan for it. • Make sure more people are supported to have end of life conversations • Support a consistent approach to understanding when people are coming towards the end of their life, regardless of where they live or their needs.	• Create ways in which health and care professionals can support planning for people near the end of life, including what to do in an emergency. • Support partners to promote end of life care conversations and plans, and bereavement support with our communities. • Make sure there is more planning for advanced care, including training volunteers.	• Bereavement services are easy to find in our **places** and that everyone can access the same levels of support across Lancashire and South Cumbria. • Create Bereavement Improvement Plans to develop knowledge, skills and confidence within our communities.

Hospices Together

All the adult and children hospices in Lancashire and South Cumbria (LSC) have come together to form Lancashire South Cumbria Hospices Together (LSCHT).

The aim of Hospices Together is to make working with our hospices easier so that we can jointly:

- Improve quality, coverage and choice of care; giving people their best end of life
- Develop capacity and quality of care with families and communities
- Reduce burden on health & care providers
- Improve education and training for palliative care across our system
- Make our operations and delivery more effective and efficient

Hospices Together will work in partnership and integrate where it brings improvement

Lancashire and South Cumbria
Hospices Together
THE HOSPICE PROVIDER COLLABORATIVE

Last Days Matter

Last Days Matter is a public-facing, free education initiative run by hospices in Lancashire and South Cumbria. It offers short, accessible training sessions for people who may be supporting someone approaching the end of life – including families, carers, and frontline staff in both health and social care. It currently operates in selected localities but has ambitions to be scaled across the entire ICS geography.

The programme seeks to:

- Equip individuals with the confidence and knowledge to talk about death and dying
- Encourage personalised care and informed choices through basic awareness of advance care planning (ACP) and end-of-life considerations
- Help people understand what to expect and how to offer support in the last days of life
- Reduce preventable hospital admissions through better planning and support at home
- Beneficiaries include patients, informal carers, VCFSE groups, care home and domiciliary care staff, and the wider public.

The training was developed by St John's Hospice with support from many community partners and is now being delivered from Scotland to Cornwall and via 6 Hospices across LSC. It was shortlisted in Civil Society's Charity education project of the year.

Getting to Outstanding

Statutory health and social care organisations, local authorities, hospices, the voluntary, community, faith and social enterprise sector and independent sector partners, alongside Marie Curie and NHS England worked together to review palliative and end of life care, across Lancashire and South Cumbria against the "Ambitions for Palliative and End of Life Care" framework.

The framework is not mandatory but is widely recognised as good practice. It aims to improve how death, dying, and bereavement are experienced and managed, through six Ambitions;

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help

Following this, local priorities were identified including an increased focus on the early identification of patients at end of life and encouraging people to discuss and document their wishes for future healthcare, known as Advance Care Planning (APC).

ACP can significantly impact the place of death, with those having an advanced care plan more likely to die in their preferred location.

In April 2025 we started recording the number of people with Advanced Care Plan in place when identified as being at end of life. This will help us to improve access and quality of care and provide targeted training and support where it is needed.

What we did…

- ✓ Encouraged the early identification of patients at end of life and regular multi-disciplinary palliative care meeting to discuss and share information
- ✓ Worked with GPs to improve and streamline Advance Care Planning
- ✓ Developed training and education resources to support staff
- ✓ Encouraged and incentivised GPs to offer Advance Care Planning discussions and seeking consent to share plans so that hospices, hospitals and district nurses can provide care in line with individuals wishes.

Learning and emerging themes

As part of a review of delivery against the Integrated Care Strategy, Partnership members were asked to draw out themes that contributed to the success of programmes and led to positive impacts and outcomes. These will be at the forefront of future planning and collaborative approaches and will be reflected in the forthcoming Integrated Care Strategy Review document.

Accessibility – thinking differently about how we work with residents and communities	Engagement and codesign rooted in lived experience	Partnership working underpinned by trusted relationships	Bottom up – supporting/funding existing community assets
Effective communication between teams/multi agency approach	Paying attention to the wider determinants of health – holistic approach – tackling the causes of ill health as well as the symptoms	No ‘wrong front door’ - helping people to connect to the right support regardless of the entry point	Digital innovations
Combination of interventions – not one ‘magic solution’	Prevention focused and earlier intervention	Development of key enablers, such as integrated neighbourhood teams	Working with the VCFSE sector to reach target communities