DRAFT VERSION

Lancashire and South Cumbria Integrated Care Partnership

Integrated Care Strategy

2023 - 2028

Version 3.3

Version	Date	Comments
1.0	6.1.23	For review by ICP members
2.0	13.2.23	For review by Readers Panel
3.0	17.2.23	For review by Strategy Development Group
3.1	20.2.23	For review by Health and Wellbeing Boards
3.2	21.2.23	Slight amendments to text
3.3	3.3.23	Final amendments before public engagement

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Foreword

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Our **Integrated Care System** was formed on 1 July 2022, with the creation of the new **Integrated Care Board** and **Integrated Care Partnership**. This strategy is an important action of the Integrated Care System and describes how our partners will work together to improve the health, care and wellbeing of people in Lancashire and South Cumbria.

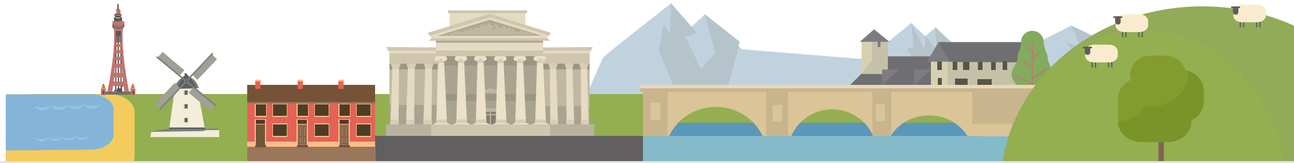
This strategy has been developed during a challenging time for health and care services. The pressures we face are not only present in Lancashire and South Cumbria, but they are sometimes made worse by what is happening in our area. Almost a third of our residents live in very disadvantaged areas with the effects of poor health and **inequalities** getting worse over time. We want people in Lancashire and South Cumbria to live longer, healthier, happier lives than they currently do.

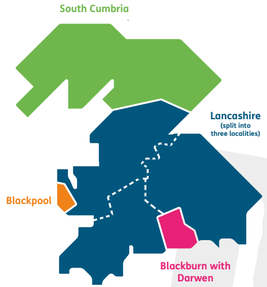
Our Integrated Care System is committed to improving the health and wellbeing of people. To achieve this, a wide range of partners are working together to improve access to health and care services, to help individuals make choices that will improve their own health and wellbeing, and to deal with the root causes of poor health. Recognising the links between the things that affect health and people's overall wellbeing is a big part of how we will support people to remain healthy and well.

In this strategy we will explain what we aim to do as an Integrated Care System. The document will describe the difference we can make by working together. We have decided as a system to only focus on a few specific priorities. This means we can make the biggest impact together.

Most of the activity to integrate care and improve health and wellbeing will happen by organisations working together in our places and through integrated teams working together in our neighbourhoods. It is here that we will put residents at the centre of what we do, listening to their experiences and perspectives, and acting on what we have heard.

By working together, we can be healthier, wealthier and happier.





1. Introduction

An introduction to Lancashire and South Cumbria

There are nearly 1.8 million people living in Lancashire and South Cumbria, with almost a third of our residents living in some of the most disadvantaged communities in England. We know that people living in Lancashire and South Cumbria have different needs, experiences, aspirations and opportunities. They also have different day to day lives, different things that affect their health and wellbeing, experience the impact of healthcare differently and are likely to have shorter lives depending on where they live.

We are committed to improving the health and wellbeing of the people of Lancashire and South Cumbria, getting better health and care outcomes, reducing health inequalities, and providing the best care at the right time to enable people to live healthy and fulfilling lives.

Access to health and care services is very important to residents, as is the way different services work together to make them easier to use, and the quality of these services. There are other things that affect people's health and wellbeing. These include the choices people make, such as healthy eating and exercise, their experiences of education, housing, employment and their surroundings. Recognising the links between these is a big part of how we will support people to remain healthy and well.

We cannot just aim to provide an increasing range of services that meet everyone's needs when they are ill or in need of support. We need to change the way we identify and respond to the health and wellbeing needs of our residents, including the way we plan and deliver health and care services. We have to do this to deal with the inequalities that we see across Lancashire and South Cumbria and to meet the increasing demands that come with an ageing population with a high level of **long term conditions**. We must increase our focus on the promotion of good health and wellbeing, meeting individual needs whilst also stopping ill health from happening in the first place. This will help communities to support themselves and build on the things that already help them to be healthy, wealthy and happy.

We want to develop our health and care system in a way that builds on the strong sense of community that we saw during the COVID-19 pandemic and the significant resources that we have across our region. We will put our residents at the centre of what we do, working with communities to help people to stay healthy in ways that work for them. With an overall focus on preventing ill health and targeted support where it's most needed, we will reduce the unfairness some people experience in accessing care. Our partners will come together to support our residents into employment, and we will encourage businesses of all sizes to understand their role in adding to the health, wellbeing and wealth of their employees and the wider community.

The health and wellbeing of our population

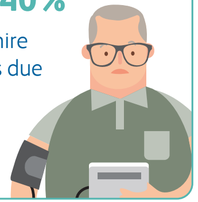
We face a number of challenges in Lancashire and South Cumbria which have a direct impact on people's health and wellbeing.

The percentage of people living in fuel poverty and unable to afford to heat their homes, is higher than the national average: **13%** for Lancashire and South Cumbria whilst the national average is **10.6%**.

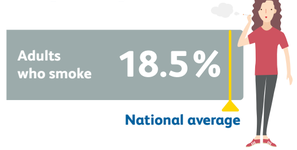
Nearly a third of our residents live in some of the most deprived areas across England.

Only around a fifth of adults are meeting the recommended levels of physical activity.

Approximately **40%** of ill-health in Lancashire and South Cumbria is due to smoking, physical inactivity, obesity and substance misuse.



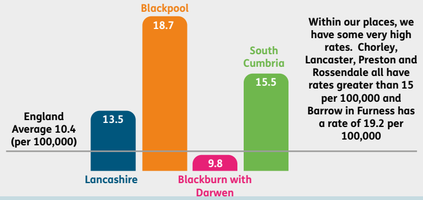
18.5% of adults smoke, the national average for England is **17.2%.**



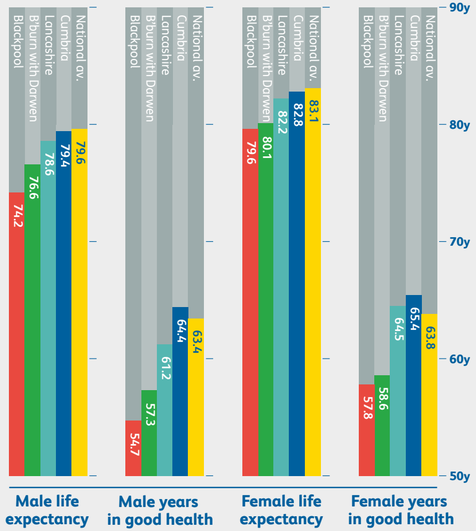
As a result, many of our health and wellbeing outcomes do not compare well against the rest of England:

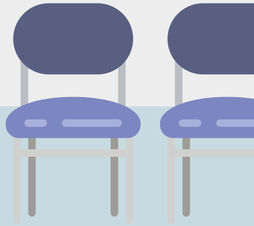
- Life expectancy in Lancashire and South Cumbria is lower than the national average, and there is a significant level of unwarranted variation in the number of years people can expect to live a healthy life.
- Healthy life expectancy and disability-free life expectancy is predicted to be less than the expected state pension age of 68 years for children born today - in some neighbourhoods, current healthy life expectancy is 46.5 years.
- The main causes of ill-health are cancer, conditions relating to the heart and lungs, mental health, and conditions relating to the brain and nervous system. Around 21,000 people have five or more long term health conditions in Lancashire and South Cumbria.
- The estimated prevalence of common mental health disorders is higher than the England estimate.

Suicide rates are significantly higher than the national average



Within our places, we have some very high rates. Chorley, Lancaster, Preston and Rossendale all have rates greater than 15 per 100,000 and Barrow in Furness has a rate of 19.2 per 100,000





Our residents have shared their thoughts about living and working in Lancashire and South Cumbria

Lancashire

"I like living in Lancashire, I'm from the south originally and I think it's a really good place to live".

"There's a lot around to do. Everything's quite close by. Lancashire is actually pretty easy to get around. There's a lot, not just in Preston but around surrounding areas, so it's nice."

"I love living in Lancaster. I work in Kirkby Lonsdale, so I get a lovely drive to work every morning. Beautiful surroundings, lovely people."

"Healthcare is probably at its worst at the minute. I'm struggling at the moment with dentists and mental health."

"It just feels like there should be one NHS hub for everything that they can get information from."

"I like the community"

South Cumbria

"It's a lovely part of the world to live in. Very lucky to be as close to the Lake District as we are. Really lovely to live in Barrow. Really lovely community."

"I'm really passionate about living in Cumbria, particularly Barrow in Furness, I think it's an amazing place to live. I think we've got so many good, positive things about it and I love living here."

"I love living in Barrow, I'm originally from Barrow, it's got a big place in my heart. It's got great people and it's a great place to work."

"The only negative is waiting for an appointment it can sometimes be lengthy. Once you're actually there the service that you get is great."

"It's a lot of telephone appointments now and I think you can't diagnose certain things over the phone."

"We've had some difficulties over the past couple of years accessing primary care."

Blackpool

"I moved to Blackpool in 1989. At the time it was reluctantly from the south of England, but since moving I've found I've had more opportunities, met nicer people, and on the whole received better medical care."

"The reason I like Blackpool is because we're like family and without the culture, it wouldn't be Blackpool."

"What matters to me is making services a bit better, because of my transition and also my special needs with my autism because it also makes me anxious. What could be better is also waiting times for GPs."

"To make sure that anything I complain about is looked into and just to be accepted as a person, irrespective of my age would help me live a healthier life."

Blackburn with Darwen

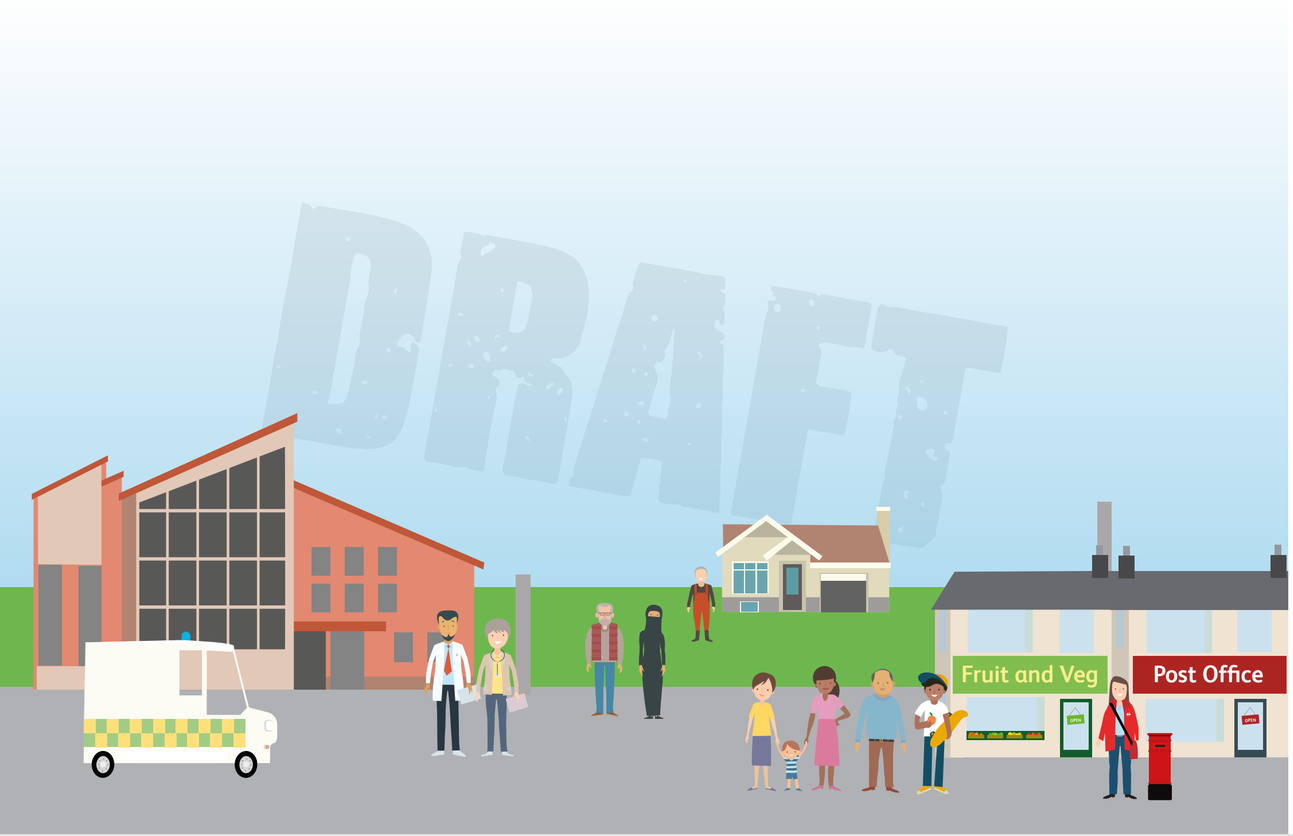
"Considering Blackburn isn't a very big town, I think we're quite lucky to have a lot of the facilities and services that we do have here. From a living perspective, everything's on your doorstep. It's readily accessible, it's all within walking distance as well."

"It's alright around here. The people are usually quite nice. There's plenty of things to do in Blackburn if you look hard enough."

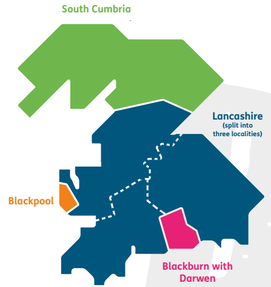
"I've lived in Blackburn for the majority of my life. I've moved away a few times but I always find myself coming back, because it's home".

"What I do quite like about Blackburn is there's a lot of networking and a lot of partnership working with organisations that do work closely together."

"From my own personal experience, I think support and understanding of mental health conditions is lacking. When you present yourself as really struggling, or you need support, the support isn't really there for you."



2. Geography



Number of people living in each place

- Blackburn with Darwen - 163,000
- Blackpool - 153,000
- South Cumbria - 311,000
- Lancashire - 1,180,000

Total - c 1,800,000

Integrated Care Systems were formally established across England through the Health and Care Act (2022). They were set up to plan and deliver joined up health and care services and to improve the lives of people who live and work in their area.

Our Lancashire and South Cumbria Integrated Care System covers:

The entire geography of

- Blackburn with Darwen Borough Council
- Blackpool Council
- Lancashire County Council with its twelve district councils

The South Cumbria part of our system covers:

- The geography of the newly created Westmorland and Furness Council, without the Eden District.
- Some parts of the Borough of Copeland which sit within the newly created Cumberland Council.
- Some parts of the District of Craven which sit within the newly created North Yorkshire Council.

This means that we need to work with some local authorities and providers of health and care services who are outside of our borders.

Within the Lancashire and South Cumbria Integrated Care System there are four **places**:

Blackburn with Darwen

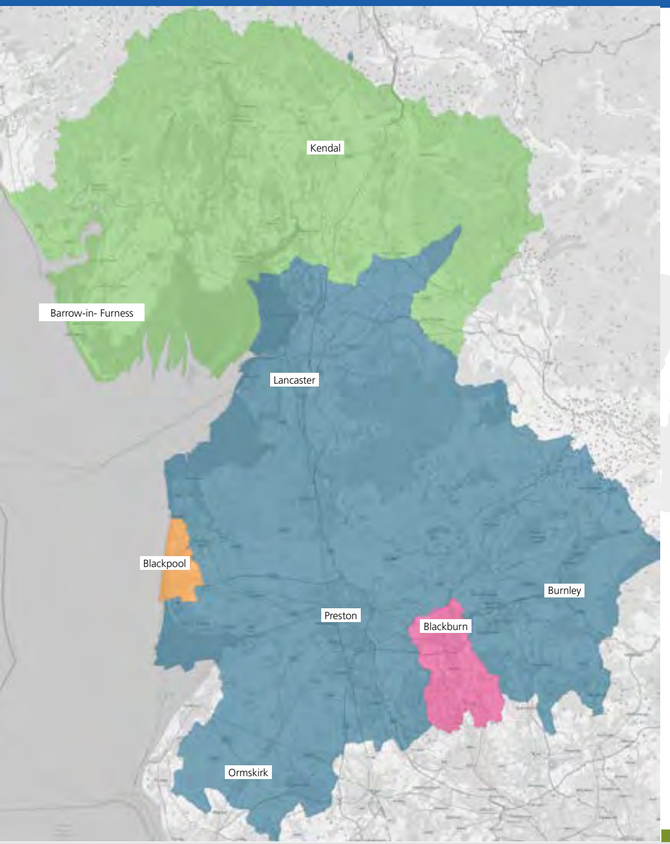
- A semi-rural borough with small urban areas around the towns of Blackburn and Darwen, and several small rural villages and hamlets.
- A multicultural borough, the area is home to many people with diverse ethnicities and identities.

Blackpool

- An urban coastal area, with a thriving tourist economy and a strong sense of community.
- With high levels of deprivation and a **transient population**, Blackpool residents have some of the most difficult health needs in the country.

South Cumbria

- A mixture of coastal and rural areas, with some wealthy and some disadvantaged communities.
- The area stretches from Barrow-in-Furness, a busy shipbuilding town and port, and Millom on the west coast, through South Lakeland with its rural, land-based and thriving visitor economy, across to the area around Bentham in North Yorkshire.
- This is England's most sparsely populated local authority area, which makes it hard to deliver services, and to provide public transport and transport connections.

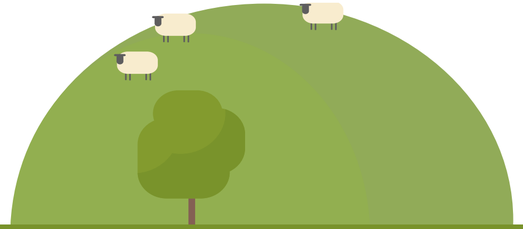


Lancashire

- A varied place from the high moorland of the South Pennines to the flat expanse of the Fylde Coast and the countryside of the Ribble Valley and Forest of Bowland.
- A combination of urban areas including Preston and Lancaster, former textile towns such as Burnley, coastal resorts and market towns.
- A mixture of wealthy and disadvantaged communities. In the more rural areas, poverty and social exclusion happen alongside people living in luxury. Large areas of deprivation can be found in East Lancashire, Morecambe, Skelmersdale and Preston.

Lancashire covers a large area and a large population. Within this place there are three **localities**, each of which is responsible for planning and delivering services:

- North Lancashire
- Central and West Lancashire
- East Lancashire



3. Our partnership and the wider health and care system

The work of our Lancashire and South Cumbria Integrated Care System takes place through several different partnerships across different areas and for different reasons:

Our Integrated Care Partnership

Our Lancashire and South Cumbria Integrated Care Partnership brings together a number of partners to agree the same ambitions and build shared strategies across Lancashire and South Cumbria. These partners include health, local government, the voluntary, community, faith and social enterprise sector, education organisations, people that represent local businesses, **Healthwatch** and our residents.

We believe that our Integrated Care Partnership can make a real difference to the lives of our residents by working together with a shared purpose and agreeing to use our joint resources to achieve our goals.

To be successful our partners need to agree a set of common goals.

The Integrated Care Board

Our local Integrated Care Board is known as NHS Lancashire and South Cumbria Integrated Care Board.

The Integrated Care Board is the NHS organisation that is responsible for developing a plan to meet the health needs of the population, managing the NHS budget and planning local health services.

The Integrated Care Board includes members from **NHS trusts and foundation trusts, local authorities, primary care**, mental health, the **voluntary, community, faith and social enterprise sector** and Healthwatch, so that all of the health and care needs of the population can be considered. The Integrated Care Board brings these representatives together to focus on population health, and make sure the health and care needs of the communities in Lancashire and South Cumbria are met. Its plans and decision-making will reflect the shared ambitions and strategies of the Integrated Care Partnership.

Our four places

Within each of our places we are forming **place-based partnerships**. These partnerships include representatives of health, local authority, voluntary, community, faith and social enterprise organisations, independent sector providers and the wider community, and work together to plan and deliver services. They also work together to make sure our services are joined up to improve health and wellbeing outcomes for the population, prevent people from being unwell and reduce **health inequalities** across our neighbourhoods. Depending on the specific needs and priorities of each place, there may be other sectors and organisations that are involved in these partnerships.

Our places will be the engine room, driving delivery of the Integrated Care Strategy.

Leadership of our places is covered by both health and local government. Together these leaders will focus on the **integration of services** and supporting people to live a healthier life, designed to meet the needs of residents in that place. By working in places, we will enable decisions to be made as close as possible to where people live and work. Certain decisions will be made by the places instead of the Integrated Care Board and the relevant local authorities. This will allow places to determine how resources are used to achieve the best outcomes for our residents and the best value for money.

Our places will sometimes work together where it makes sense to do so. This may be because they are working with an organisation that provides services to more than one place, such as our NHS trusts and foundation trusts, or because work is already happening on a footprint that is different to our place boundaries, for example the way some of our GPs work together.

Our places and neighbourhoods mean that our residents, their families, their carers, and wider communities can be at the centre of our integrated working. Most people's day to day care and support needs will be planned and delivered within a place and its neighbourhoods.

Our neighbourhoods

Neighbourhoods are where communities come together to shape and integrate health and care services, but also to address the things that have an impact on their health. The exact size and shape of neighbourhoods is agreed locally within places. This is because each neighbourhood is different – they are based around footprints that make sense to communities, often related to specific towns or villages, or centred around resources available within a community.

Integrated working in these areas will include district councils, community groups and organisations, primary care services and wider health and care teams which will come together to form neighbourhood teams.

Our neighbourhood teams will enable us to address health inequalities and ensure our communities have the appropriate services to help them to remain well and to access support when required from local teams.

4. Working in partnership with our residents

Our Integrated Care Partnership puts our residents at the centre of what we do, treating everyone with equal respect and dignity, listening to people's experiences and different viewpoints, and acting on what we have heard. We will ensure that the voices of our residents, patients, families and carers are heard and valued across our neighbourhoods, places and system. Together we will create a culture of wellness, with shared responsibility for our individual and collective health and wellbeing. We will:

Listen and understand

Understand a community's needs, its experience of health and care, and its ambitions.

Start engagement and community participation early when developing plans and provide feedback to people and communities on how their views have made a difference to decisions and activities.

Plan together

Co-produce and redesign services and tackle system priorities in partnership with people and communities.

Put the voices of people and communities at the centre of decision-making and governance at every level of the Integrated Care System – in neighbourhoods, in places and across the system.

Learn from what works well and build on the strengths and resources of all partners

Build relationships

Help to support strong connections across all our communities, particularly those who have previously felt excluded or who have been affected by unfair and unequal chances in life.

Work with our local Healthwatch organisations, the voluntary, community, faith and social enterprise sector and our district councils as important partners who are well connected to our communities.

Communicate well

Provide clear and accessible information about our vision, our plans and our progress, to help people understand what we are doing, how we are doing it and to build trust.

Empowering our communities

We will work with our communities to create and build effective partnerships to help health and care organisations understand what needs to happen to benefit individuals, families and communities.

This means we need to put communities at the heart of decision-making in our places, with meaningful community involvement that leads to real change.

We will listen to local residents and make sure that the voice of communities leads to local action. The role of the voluntary, community, faith and social enterprise sector is vital in this approach. These organisations and groups are of different sizes and do different types of work, but they all work closely with individuals and communities, particularly people that we don't often hear from, or people who are living in our most disadvantaged areas and experiencing the most unfair differences.

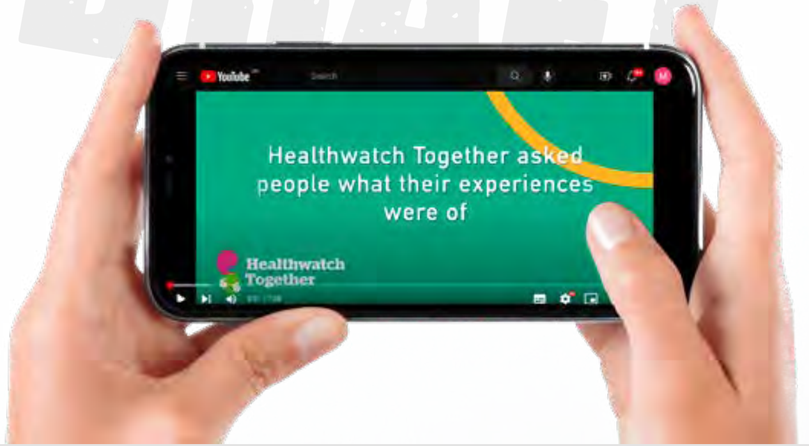
We will move towards an '**asset approach**', which builds on the resources and strengths of specific communities and encourages residents to take action for themselves. This includes using community development approaches to have regular conversations with residents. This will help to understand the services and support they need to develop strong and resilient communities, and strengthening community involvement in action on the social determinants of health and wellbeing, supported by data which reflects their concerns and is accessible and useful for them.

How the views of residents have shaped our strategy

We have used a number of methods to ensure the views of the people in Lancashire and South Cumbria have been included throughout this document. We used the Joint Strategic Needs Assessments that our local authorities have written because they provide a detailed picture of the current and future needs of our local communities.

The **Joint Strategic Needs Assessments** do not describe all of our population health and care needs, due to limitations in data and information. Some people, such as unpaid carers and those who face social exclusion can often be missed because, for example, they are not registered to receive health services, or they do not recognise that they have a health or care need.

Therefore, we have also engaged with our residents directly through online surveys, "on the street" engagement events, and specific resident-focused groups to ask them about our ideas. This has been supported by Healthwatch (an independent voice that makes sure NHS leaders and other decision makers listen to resident feedback and improve standards of care), our local health and care organisations, and our voluntary, community, faith and social enterprise organisations.



Scan Me

5. Our vision

We will use a small number of measures to help us understand how we are doing

1. **Early years development**: How many of our children have achieved the expected levels of early learning goals at age five. These goals are linked to related to personal, social and emotional development, physical development, communication and language, mathematics and literacy.
2. **Years in good health**: The average number of years that a person can expect to live in good or very good health.
3. **Avoidable mortality**: The number of deaths per 100,000 people (aged under 74 years) that could have been mainly avoided. This may be through preventing ill health, through earlier identification of ill health, or more effective health and care treatment.
4. **Unemployment rate for the working age population**: The number of people (aged 16 years and over) without a job, who have been actively seeking work and are available to start work.
5. **Life satisfaction**: The average score of survey respondents (aged 16 years and over), when asked how satisfied they are with their life.

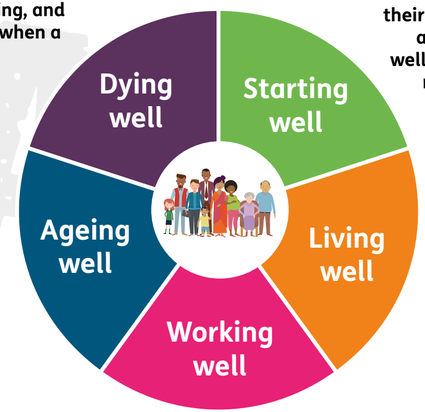
We know it may take a number of years for us to see a real difference in these measures, so we will also be tracking more detailed measures in each of our places, so that we can see what differences we are making with our communities.

6. Our priorities

We have used a life course approach to describe our priorities:

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

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



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

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

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

Starting well

We will give children the best start in life by taking a targeted approach to tackling health inequalities and vulnerabilities. We will also help all 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

1. 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
2. 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

1. Support and encourage families to breastfeed their babies
2. Reduce childhood obesity
3. 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.

1. Help children and families to get ready to start school, including supporting new parents and creating places at home where children can learn
2. Develop a healthy child programme, with joined up health and development services including community paediatrics and therapies
3. 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.

Case study

Holly was aged two and was accessing her entitlement to an early years childcare place through a local nursery. Some worries were raised by Holly's mum about her behaviour. She had noticed that Holly deliberately banged her head on the floor and would run away whilst out in public.

A referral was made by Holly's speech and language worker to the early help service.

The early help link worker supported the Special Educational Needs Coordinator in Holly's nursery to bring together the speech and language team and the health visitor to assess the family needs. Using an early help assessment, they worked with the family to establish a support plan.

Holly was given some extra support in nursery and her parents built a good relationship with the nursery team, accessing some parenting support through Empowering Parents Empowering Communities and the family also started to access some support from Aiming Higher.

Both parents report that Holly is doing better and that they no longer feel that they are failing as parents.

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 also 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.

	Supporting people who are already mentally or physically unwell	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
Our themes	Taking action on earlier diagnosis, providing better support to people living with their conditions and stopping them from getting worse, especially those people who have the greatest inequalities in access, experience and outcomes.		Working together to tackle the things that have an impact on health and wellbeing
Our Key Actions	1. Make it easier for people to get long-term conditions and cancers diagnosed 2. 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. 3. 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. 4. Make it easier to know who our unpaid carers are, better understand their roles, and give better support for carers of all ages.	1. Address the things that lead to reduced life expectancy and reduced healthy life expectancy (such as smoking, obesity, inactivity, drug and alcohol consumption) targeting those experiencing the greatest health inequalities. 2. 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 3. Make it easier to find emotional and mental wellbeing support, especially for people who are at greatest risk of experiencing health inequalities. 4. Increase the number of people having immunisations, screening and NHS health checks, especially people that are experiencing the greatest health inequalities.	1. 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. 2. Support large organisations to improve the wellbeing of the local population and ensure that they add a positive impact for local people. 3. Increase community involvement in action on the social determinants of health and wellbeing 4. Get in touch with our residents who experience, or might experience, loneliness to make sure they feel part of our communities. 5. Increase the visibility of action to address health inequalities in the way we create public policies for example through putting money into things that will support residents, transport, digital access and environmental policy

Case study

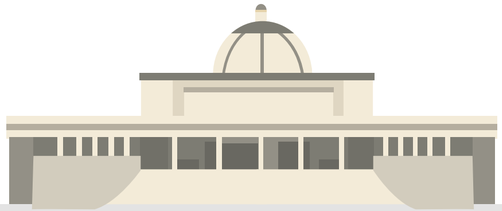
Fleetwood is a disadvantaged coastal community with life expectancy rates significantly below the England average. There is a high prevalence rates of all long-term conditions, but particularly depression, drug and alcohol addiction, obesity, respiratory diseases, and cardiovascular disease. There are low school attainment levels and high rates of unemployment, especially for those aged 18 to 24.

Three key elements are now in place across the town to improve health outcomes and address the wider determinant of health.

Integrated management of illness, both acute and long term: A wide range of health and care services are working together as one team to address the key health issues in the town. This is co-ordinated via Fleetwood Primary Care Network and includes General Practice, community nursing, urgent care, mental health services, addiction services, community pharmacy, dental and eye care services.

Joint working to support community development: Partners across health, local government, education, housing, department of work and pensions, and local charities have come together to support improved access to education and training in the town for those aged 18 to 24, as well as supporting young people on universal credit into employment. There is also a focus on those with mental health and addiction issues. A multi-agency leadership team, "Future Fleetwood", supports this work and is part of Wyre Council's Regeneration Framework.

Resident empowerment: Healthier Fleetwood is a resident-led social movement aimed at improving the health of every resident in the town. Its aims are to empower residents to take control of their own health, their own lives, and their own community. It connects residents to each other and to partner organisations to understand what really matters to people, and to encourage people to get involved in local groups and activities, supported by the Primary Care Network Social Prescribing Link Workers. This is increasing self-confidence and helping to overcome social isolation, one of the main drivers of ill health.



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

1. Support young people to develop the skills and confidence to achieve their full potential.
2. Deliver a single Health and Care Careers and Engagement Service, working more closely with schools and colleges and planning a broad range of careers activities and programmes, including work experience and placements.
3. Health and care organisations working together to get the most out of apprenticeships and ensure these are a good route into a career in health and care.
4. Make sure there are more ways to get into health and care training roles, working with higher education organisations to keep training places available for local residents.

1. Deliver a broad range of employability programmes across health and care organisations, targeting those from disadvantaged communities and those who suffer inequalities in achieving successful employment
2. Create more volunteering opportunities that give people the skills and experience that are useful for securing stable employment, and ensure this is recognised as a way into a career in health and care services
3. Develop programmes that provide re-training and career change opportunities for all people of working age

1. Large organisations act as ‘anchors’ in each place, supporting the wellbeing of their own workforce through good occupational health and wellbeing services, and contributing to the wellbeing of the population through preventing ill health
2. Small and medium size businesses in all industries can access schemes that support wellbeing in the workplace and encouraged to create healthy working environments.
3. Residents with long term conditions are supported into employment to improve their health and mental wellbeing.
4. Helping working carers to balance work with their caring responsibilities

1. 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.
2. Encourage businesses to set up in Lancashire and South Cumbria, with clear visibility of their commitment to the health and wellbeing of residents and communities.
3. Create community and regional ‘health for wealth’ champions.

Case study

Louise came to Citizens Advice Blackpool for help with financial problems that had built up over several years. Louise had been in and out of work as casual contracts ended and seasonal work stopped over the winter months.

Citizens Advice Blackpool provided debt advice that enabled Louise to start on a clean slate. Louise was keen to get things back on track but had not worked for a while due to confidence issues and health problems including depression, hypertension and diabetes.

Louise started as a volunteer at Citizens Advice Blackpool and was supported to achieve the Generalist Adviser level certificate. Not only did this boost her confidence, it enabled Louise to consider paid employment. After applying for some part-time administrative jobs locally and not having any success, a role in Administration and Finance came up at Citizens Advice Blackpool. Louise was successful in securing the role and has worked part-time for almost three years now. Her confidence has increased further and the flexibility the role offers has enabled Louise to improve her IT skills and manage her health conditions alongside the demands of the role.

Louise is hoping to step away from the need for welfare benefits and move into full-time, secure work in the future.

Ageing well

We will provide high quality care that supports people to stay well in their own home, making sure our services work together. We will also 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

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

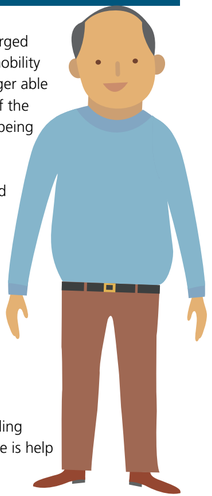
Our Key Actions

1. 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.
2. Make sure there is a clear and simple way to access support to reduce the number of people in crisis, recognising and supporting the contribution of carers.
3. Create a service that helps our most vulnerable and frail residents, including regular health checks, a falls service, and more support for dementia.
4. Make sure people know about all of our services that can support residents, their families and their carers.

1. Ensure the offer includes care to help people back on their feet as well as longer term care provision
2. Provide more 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

1. Ensure that we know those who are at risk of becoming frail and/or 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.
2. 'Live longer better' - supporting residents to access information and support to maintain and make the most of their own health and wellbeing
3. Connecting 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 health gets worse.
4. Services will focus on what people can do for themselves, what their families and wider networks can contribute, and what the wider community can contribute, rather than just 'assessment for services'

Case study



Rahul was referred to Age UK from the frailty team, after having been discharged from hospital after two stays relating to pneumonia, dizziness and reduced mobility following a fall. Although supported by family and friends, Rahul was no longer able to get around his house and undertake activities such as getting in and out of the bath. He had lost a lot of confidence and was feeling quite down, as well as being frustrated and anxious about his future abilities.

Age UK talked to Rahul about how he was managing now and how he would like to feel in the future. They worked with a range of partners to arrange provision of a 'Lifeline' to enable Rahul to call for help quickly and easily if needed. They also arranged rapid installation of a stair lift and a bath raiser, and facilitated conversations with his carer to agree that Rahul would plan for bathing whilst his carer was present in the house. Support was offered in completing forms to secure Attendance Allowance, which helps to pay for his ongoing care and support.

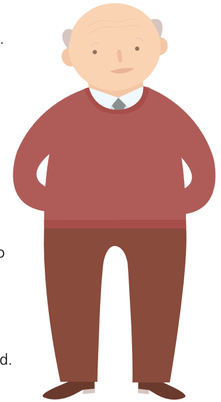
Rahul now feels a lot safer in his own home, his confidence has started to increase, and he is sure that this will grow further as time goes on. He has changed from being anxious and agitated, to being engaging and chatty, feeling much more positive about sharing his needs and fears and knowing that there is help if he needs it.

Dying well

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

Our themes	Talking	Planning	Supporting bereavement
	Encourage our residents to feel comfortable with talking about death and dying	End of life care will be made more personal regardless of where they live or their condition.	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	1. Compassionate conversations) – helping people understand how important it is to think about, talk about, and plan for dying through community communications campaigns 2. Make sure more people are supported to have end of life conversations 3. Support a consistent approach to understanding when people are coming towards the end of their life, regardless of where they live or their needs	1. 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 2. Support partners to promote end of life care conversations and plans, and bereavement support with our communities 3. Make sure there is more planning for advanced care, including training volunteers	1. Bereavement services are easy to find in our places with a plan to make sure that everyone can access the same levels of support across Lancashire and South Cumbria 2. Create Bereavement Improvement Plans to develop knowledge, skills and confidence within our communities

Case study

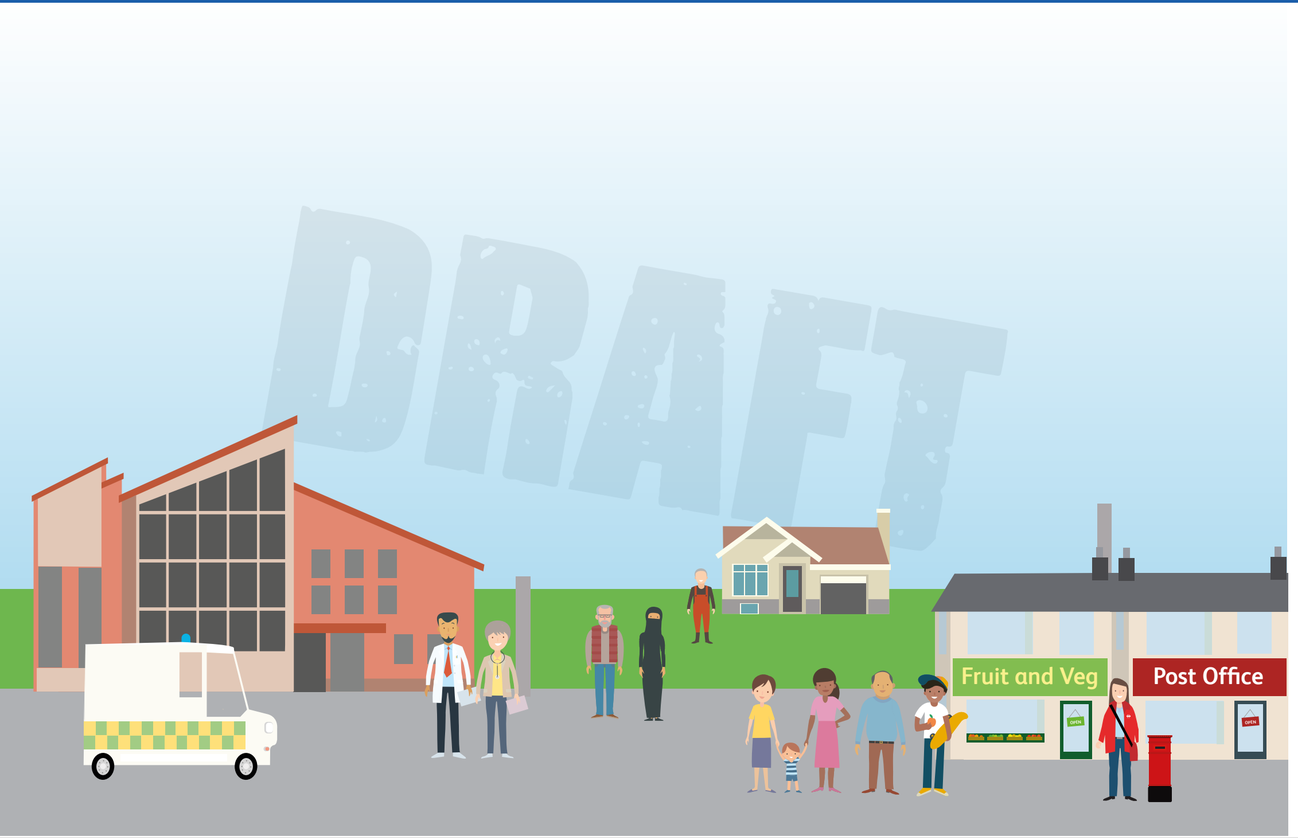


Jack was in his 70's when he received an unexpected life-shortening diagnosis which left he and his family very little time to plan for his death. He had a younger wife and children of primary school age but was clear that he did not wish to discuss Advanced Care Planning. Jack's wife felt sure that this would be helpful and was becoming increasingly anxious about her husband's reticence.

With the support of St John's Hospice, Jack and his family were encouraged and enabled by a multi-disciplinary team of Clinical Nurse Specialists, Hospice at Home, Family Support, Respite and Inpatient Ward teams to have these important discussions. A Care Plan was agreed, including an emergency home care plan as the family did not wish Jack to spend his last days in hospital. This was shared with all partners.

Close working between our end of life community teams and district nurses meant that colleagues could provide continuity of care. The Care Plan enabled Jack and his family to have their wishes and beliefs respected.

Jack's children were supported by the Forget Me Not Centre with their pre-bereavement and post bereavement journey, and continue to spend time at the Centre. This builds on the Hospice's outreach work with schools so that all parties can support children through such a challenging time. Jack's wife was also supported with her bereavement and has since become an advocate for the Hospice, speaking openly about the care her family received and the positive difference made through having her family's wishes met.



7. Key underpinning themes

One Workforce

We know that changes happen through the work of people, and the people in our workforce are the most important part of our services. We also know that the people who work in health and care are not just those who work for providers of health and care services. Individuals working in the voluntary, community, faith and social enterprise sector play a very important role in supporting people's overall health and wellbeing in lots of different ways.

In addition to the important things that we have said we want to do in our Working Well section of this strategy, our system is focused on creating 'one workforce' across health and care. We want to see better organisation of the recruitment, planning, development and support for our staff across health, adult social care, local government, the voluntary, community, faith and social enterprise sector, and volunteers.

'One workforce' will meet our population's health and wellbeing needs and make sure our residents are given choice and control about how their care is planned and delivered. To succeed we need to plan the future health and care workforce together rather than simply considering individual organisations or sectors. Our work will include practical activities to enable our staff to transfer their skills and knowledge between the NHS, public health and social care, as well as creating roles that can support care coordination across organisational boundaries. This will enable our workforce to work together more easily in places and in neighbourhoods, building teams that include primary care, community care, social care, acute care, mental health, public health and the voluntary, community and faith sector.

Supporting unpaid carers

We know that **unpaid carers** play a vital role in supporting people in our communities. We also know that carers are a very diverse group of people. For example, there are large age differences, and they support people with a wide range of different caring needs. This can mean that they experience personal challenges, and it is important that we support them as best we can.

Young carers usually support family members, either one or both parents, or their siblings, who have additional caring needs. This might result from a long-term disability, long term condition or an acute illness. It also often relates to social circumstances, for example children of drug or alcohol dependent parents. Young carers often experience multiple disadvantages, through less time available to focus on their education, or to spend time with their friends, and often also experience other disadvantages due to their personal circumstances.

Adult carers include working carers and parents and grandparents providing support to their own children and grandchildren, sometimes into adulthood and including those with physical care needs, learning disabilities or severe and lasting mental illness. It also includes carers providing support for older adults, particularly elderly family members who need support for the normal functions of daily living, for example if a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life. Carers often experience poorer health themselves, and regularly say that the experience of care for their loved one, and indeed for themselves, could be improved.

We will develop a **Carers Charter** for Lancashire and South Cumbria, which will set out how we want to improve understanding and appreciation of the role of carers and get better support for carers in the future.

We will help health and care providers, in partnership with voluntary sector organisations, to become better at identifying carers and providing more health and wellbeing support to them and to the people that they care for. We will improve our data on carers and on the ways in which we share information about carers through electronic health records. This will enable knowledge to be readily available and individual support to be provided.

Digital resources and use of information

We know that technology can support our residents with their health and wellbeing and can help our workforce to provide health and care services in a better, joined up way. We also know that people have different levels of access to devices in their home or that they can access in the community, and that some people are more confident in using these devices to access information or to monitor their own health and wellbeing than others.

By making the best use of our community resources and technology, we can deliver better health and care services closer to home, across a wider range of different health and care professions all focused on an individual, and in a more timely way. When we plan for this, we will design our services alongside our residents, to make sure that we use technology in a way that works for everyone.

Our partners collect a lot of information which we can use to understand the needs of our residents, to find out what is affecting their health and wellbeing, to learn how our organisations can work well together, to improve the quality of our services, and to hear about how our residents feel about their experiences of living and working in Lancashire and South Cumbria. There is much that we can do to use this information to help us plan our services better, and to make sure we make a difference where it is most needed.

Our buildings

We know that our health and care services are provided from a huge number of different buildings, some of which are not in a good state of repair or easy to access. We also know we can use our buildings better to bring teams together in neighbourhoods and places, which leads to more joined up services for our residents.

By making the best use of our public sector buildings, we can get the most out of our collective resources. This includes working with our communities to plan and deliver joined up services that are in the right places and encouraging the voluntary, community, faith and social enterprise sector and local communities to use our buildings and estates to help support health and wellbeing.

As a system, we can develop building spaces and help communities to improve their wellbeing in ways that work for them. There are many examples where the use of space within buildings has supported communities to manage their own health and wellbeing, and we must look for more ways like this to use our buildings in the best possible way.

Our commitment to sustainability

The Lancashire and South Cumbria Integrated Care System is committed to playing its part in tackling climate change, reducing our environmental impact and being leaders in achieving net zero carbon emissions.

The Health and Care Act 2022 means that the NHS has to reduce its carbon emissions and environmental impact. The NHS is aiming to be the first healthcare service in the world to reach net zero on carbon emissions by 2040, which will be delivered by partnership working with other organisations across the system, and with staff and residents. Our local authorities already have clear plans to achieve a carbon net zero ambition.

Across our Integrated Care Partnership, we will work together to get the most out of working together to tackle climate change through the delivery of **sustainable** health and care services.

We know that the more we do to reduce carbon emissions, improve air quality and promote green spaces that are home to a wide range of plants and wildlife, the bigger the positive impact on our population's health and wellbeing.

8. Further reading

Oversight and ongoing review of this integrated care strategy is the responsibility of the Lancashire and South Cumbria Integrated Care Partnership.

This strategy describes our ambitions for what we can achieve as an Integrated Care System. It explains the difference we can make by working in a joined up way. It doesn't aim to replace or duplicate existing strategies and activity that is already underway in the system – instead this strategy aims to link together what is already happening and describe what we are all trying to change and improve together.

Examples of other documents that are relevant to this strategy are:

- A hopeful future: equity and the social determinants of health in Lancashire and Cumbria
- Blackburn with Darwen Joint Health and Wellbeing Strategy
- Blackpool Joint Health and Wellbeing Strategy
- Cumbria Joint Health and Wellbeing Strategy
- Lancashire Joint Health and Wellbeing Strategy
- Lancashire 2050 - A strategic framework for Lancashire

All partners will have a role to play in implementing the strategy, as individual organisations and sectors, but also through a number of formal partnerships that already exist in our neighbourhoods, places and across the system

9. Glossary of terms

Asset approach – using the strengths and abilities of people and communities as a resource to make improvements, such as encouraging people to share their views and experiences of local services so that they can be improved.

Carers Charter – a document that is developed alongside carers and sets out how carers and health and care staff will work together to provide the best possible care. These types of documents usually set out commitments that carers can expect when involved in the care and treatment of their relative or friend, as well as how a carer can share their knowledge and experience of their caring responsibilities.

Health inequalities - the unfair and unacceptable differences in people's health that happen because of where we are born, grow, live, work and age.

Healthwatch - an independent voice that makes sure NHS leaders and other decision makers listen to resident feedback and improve standards of care.

Inequalities – when a service or approach is better for some people and not others, for no reason other than their circumstances.

Integrated Care Board (ICB) – an NHS organisation that is responsible for planning and delivery of NHS services in a specific area. The ICB is responsible for the spend and the day-to-day running of the NHS.

There are 42 ICBs across the country and our ICB covers the region of Lancashire and South Cumbria.

Integrated Care Partnership (ICP) – a group of organisations and representatives that work together to improve the care, health and wellbeing of the population. There is a legal duty for the local authorities and the NHS to form this partnership, however other partners are involved such as the voluntary, community, faith and social enterprise sector, independent businesses and education.

Integrated Care System (ICS) – when we use this phrase, we are talking about the whole health and care system across Lancashire and South Cumbria.

There are 42 ICSs across the country. Within each ICS there is an Integrated Care Partnership and an Integrated Care Board.

Integration of services – this involves the coordination of different services and organisations working together to make the health and care system easier to navigate and also to stop things from being done more often than they need to, for example shared records across services means that a patient only needs to be asked questions once and different health and care professionals could see that.

Joint Strategic Needs Assessments - a process where local authorities and organisations that plan and deliver health services look at the current and future health, care and wellbeing needs of the local community to inform local decision making.

Local authority/local authorities – an organisation that is part of the government that is responsible for all the public services and facilities in a particular area.

Locality/localities – Due to the size and population of the Lancashire Place, it has been split into three localities to make sure that decisions can still be made at a very local level. The localities are: North Lancashire, Central and West Lancashire and East Lancashire

Long term condition - a condition that a person will live with for a long time because it can't be cured but can be controlled by medication and therapies.

Neighbourhoods – areas based on local populations of between 30,000 and 50,000. Neighbourhoods, in some instances, may align with Primary Care Networks and Integrated Care Communities.

NHS trusts and foundation trusts - an organisation within the NHS that serves a geographical area or a specialised function.

Place/places – in Lancashire and South Cumbria there are four places: Blackburn with Darwen, Blackpool, Lancashire and South Cumbria.

Place-based partnerships - planners and providers work together across health, local authority and the wider community, to take collective responsibility for improving the health and wellbeing of residents within a place.

Primary care - the first point of contact for healthcare for most people. It is mainly provided by GPs (general practitioners) but also includes community pharmacists, opticians, dentists and other community services.

Social value - how we make social, economic and environmental benefits for our population in addition to providing health and care to make the most positive impact on the lives of our communities to improve health and wellbeing.

Sustainable – something that can continue to be delivered over a long period of time.

Transient population - people who only stay living in one location for a short period of time before moving on.

Unpaid carers - anyone who cares, without being paid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support. This can be for a few hours each week, or it could be 24 hours a day, seven days a week.

Voluntary, community, faith and social enterprise sector – also sometimes referred to as the third sector, these organisations are often in the heart of the community, delivering services and sharing the voice of service users, patients and carers.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