# Lancashire Better Care Fund Plan

# 2021-2022

## Lancashire Health and Wellbeing Board

NHS East Lancashire Clinical Commissioning Group

NHS Chorley and South Ribble Clinical Commissioning Group

NHS Fylde and Wyre Clinical Commissioning Group

NHS Greater Preston Clinical Commissioning Group

NHS Morecambe Bay Clinical Commissioning Group

NHS West Lancashire Clinical Commissioning Group

Lancashire County Council

## Contents

## Summary

| | |
|---|---|
| **Health and Wellbeing Board** | **Lancashire** |
| **Local Authority** | **Lancashire County Council** |
| **Clinical Commissioning Groups** | **Chorley and South Ribble**<br>**Greater Preston**<br>**Morecambe Bay**<br>**West Lancashire**<br>**East Lancashire**<br>**Fylde and Wyre** |
| **Boundaries** | **Lancashire County Council upper tier authority**<br><br>**12 District Councils**<br><br>**Burnley Borough Council**<br>**Chorley Borough Council**<br>**Fylde Borough Council**<br>**Hyndburn Borough Council**<br>**Lancaster City Council**<br>**Pendle Borough Council**<br>**Preston City Council**<br>**Ribble Valley Borough Council**<br>**Rossendale Borough Council**<br>**South Ribble Borough Council**<br>**West Lancashire Borough Council**<br>**Wyre Borough Council**<br><br>**Borders with 2 Unitary Authorities within the Lancashire footprint:**<br><br>**Blackburn with Darwen Council**<br>**Blackpool Council**<br><br>**Borders also with South Cumbria within the STP footprint** |

## Authorisation and sign off

| | |
|---|---|
| **Signed on behalf of**<br><br>**Lancashire Health and Wellbeing Board** | |
| **By** | |
| **Position** | **Chair, Lancashire Health and Wellbeing Board** |
| **Date** | |

| | |
|---|---|
| **Signed on behalf of**<br><br>**East Lancashire Clinical Commissioning Group** | |
| **By** | |
| **Position** | **Chief Officer,**<br>**NHS East Lancashire CCG** |
| **Date** | |

| | |
|---|---|
| **Signed on behalf of**<br><br>**Fylde and Wyre Clinical Commissioning Group** | |
| **By** | |
| **Position** | **Chief Officer,**<br>**NHS Fylde and Wyre CCG** |
| **Date** | |

| | |
|---|---|
| **Signed on behalf of**<br><br>**Greater Preston Clinical Commissioning Group and Chorley and South Ribble Clinical Commissioning Group** | |
| **By** | |
| **Position** | **Chief Officer, NHS Greater Preston CCG and Chorley and South Ribble CCG** |
| **Date** | |

| | |
|---|---|
| **Signed on behalf of**<br><br>**Morecambe Bay Clinical Commissioning Group** | |
| **By** | |
| **Position** | **Chief Officer, Morecambe Bay Clinical Commissioning Group** |
| **Date** | |

| | |
|---|---|
| **Signed on behalf of**<br><br>**West Lancashire Clinical Commissioning Group** | |
| **By** | |
| **Position** | **Chair, NHS West Lancashire CCG** |
| **Date** | |

| | |
|---|---|
| **Signed on behalf of**<br><br>**Lancashire County Council** | |
| **By** | |
| **Position** | |
| **Date** | |

## Executive Summary

The Lancashire Better Care Fund plan for 2021/22 was created against a backdrop of the ongoing Covid-19 pandemic, an emergency response to managing patient flow and a move to changes in NHS structures.

It has been a period when partnership working, and collaboration has been seen at its best but also been most tested.

The Better Care Fund plan has been a place of stability with the services it has delivered at the core of delivering support to those most vulnerable and in ensuring service continuity.

Although pre pandemic there were aspirations for significant change and acceleration in the integration of health and social care in Lancashire it has not been possible to pursue those at any pace. The lessons learned over the last year+ and the networks and relationships created will be will though be invaluable in growing and achieving those aspirations.

This plan shows that in all locations across Lancashire that the principles behind the better Care Fund have been applied to provide valuable services that are robust and delivering agreed outcomes

Each partner has the autonomy to shape its services and spending plans. Each ICP level plan looks different but also shares more in common with others. This reflects the level of collaboration at a county level and beyond.

There has grown a strong sharing of learning across BCF partners and across BCF boundaries in Pennine Lancs, Fylde Coast and Morecambe Bay for example around Discharge to Assess and Home First. This stands Lancshire and its neighbours in good stead for greater cooperation as the ICS comes into existence.

The restart of the Lancashire and South Cumbria Intermediate Care programme will now give the opportunity to meaningfully reshape investment in integrated service to support people to remain at home and avoid hospital admissions.

The priorities for the remainder of 2021/22 are to:

- Keep current services safe and consistent
- Use learning of the past year to shape plans for 2022/23
- Tackle health inequalities through the sharing of data and information through a population health management approach
- Provide the shape of future BCF spend through the Intermediate Care Business Case
- Provide monitoring against the BCF metrics that meaningfully shows barriers and success
- To explore opportunities to work more collaboratively with neighbouring BCF areas using existing ICP connections.
- Confirm new governance arrangements or BCF and Intermediate Care Programmes.

## Stakeholders

The Lancashire BCF engages with stakeholders at a number of levels.

This is primarily at ICP level where ICP /CCG leads engage with their “home” acute trust, District councils, voluntary and community organisations and patients and service user groups. This is through bodies such as A&E delivery boards, local health partnerships and provider alliances.

At a county level there are residential and domiciliary care groups run by social care commissioners and a voluntary sector group.

While the Covid-19 pandemic has resulted in less formal contact with all stakeholders around BCF the structures have morphed to deal with the immediate challenge while retaining the relationships and networks that will help as new arrangements come into being.

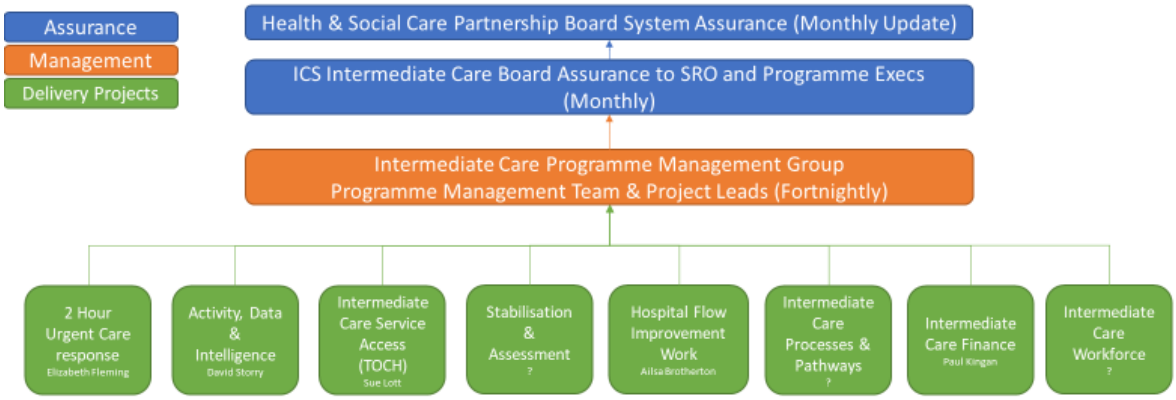
## Governance

Prior to the onset of the Covid-19 pandemic considerable progress had been made in shaping the direction of travel and supporting structures for integration across health and social care in Lancashire. This approach known as Advancing Integration had in place governance that incorporated the BCF, the Intermediate Care Review programme and the wider approach to integration. Of necessity the resources with the Advancing Integration board were directed elsewhere. Oversight of the BCF has been managed through the Lancashire and South Cumbria Out of Hospital Cell. The programme group has continued to meet providing oversight and low-level monitoring.

As we now move to recovery the governance arrangements are being strengthened but now with greater emphasis on ICS/ICP configuration.

This will be led by a Health and Social Care Partnership Board that will have oversight of the BCF through an Intermediate Care Board. BCF will sit within the Intermediate Care finance group. There is already in existence a D2A ICS level finance group whose membership is made up of a CCG Chief Finance Officer, CCG Director of Performance and Delivery, social care senior managers and health and social care commissioners.

The graphic below sets out the proposed structure.




The links with and accountability to the Lancashire Health and Wellbeing board will be maintained although it is anticipated that as BCF plans across the ICS align that a common assurance process can be put in place across all Lancashire and South Cumbria Health and Wellbeing Boards.

At ICP level there are established partnership arrangements in place across the health and social care economy, that contribute to the governance and delivery of joint initiatives which impact on the BCF and beyond. These include the A&E Delivery Boards and Place Based Partnership Boards.

Each ICP / CCG provides leads programme managers for the Better Care Fund. Not surprisingly they are in the main also those involved in the Intermediate Care Programme so ensuring a consistency of narrative and direction of travel.

In addition, there are also BCF dedicated finance leads in each partner organisation. The BCF pooled fund is managed by Lancashire County Council with agreed finance schedules and invoicing in place.

**Intermediate Care Programme**

The Lancashire and South Cumbria Intermediate Care programme was paused for a period during the Covid-19 pandemic.

It had grown out of a review of Intermediate Care Services, the bulk of which BCF funded, carried out in 2019.

The programme was formally restarted in March 2021.

Its aims are that:
By 2026 anybody in Lancashire & South Cumbria

- Who no longer need to be in hospital
  or
- Who would have been admitted to hospital because of a lack of options to get better at home
- Will instead receive:
  - Urgent Response & Assessment
  - Reablement & Rehabilitation
  - Recuperation & Recovery
  - Respite
  - At Home, supported by new dedicated home-based support and recovery services
  - Working alongside local communities
  -

Discussions are ongoing around amending the scope of the Intermediate Care Programme to include the aspects around 2 Hour Rapid Response and Implementation of the Hospital Discharge Policy.

Changes are to be made to the Intermediate Care Business Case that will be presented to the ICS Strategic Commissioning Committee soon. The business case will set out the need for significant additional investment and clarify the role of the BCF in this.

**Overall Approach to Integration**

Our BCF plans recognise that we are still in a significant period of change, emerging from the pandemic, alongside moving to an Integrated Care System, and therefore reflect the need to flex and adapt to the changing landscape to ensure alignment across wider local system plans.

The Better Care Fund provides the opportunity to improve the lives of some of the most vulnerable people in our community, placing them at the centre of their care and support, and providing them with integrated health and social care services, resulting in an improved experience and better quality of life. The aim is to deliver effective, efficient, high quality and safe integrated care to enable residents to live longer and live better.
BCF funded services contribute to a wide range of integrated services and support integration and linking of uni-professional services across ICP footprints. The aim across 2021-22 is to solidify and further embed these services, with a focus on prevention, proactive and reactive care models and safe and timely discharge from hospital.

In Morecambe Bay local priorities for 2021/22 continue to focus on current workstreams and priorities including:

Prevention and Early Intervention: Focus on prevention and early intervention to support people to remain independent in their own communities for as long as possible

Community Services / Place Based Delivery: We have continued to progress integrated place-based delivery models (including integrated neighbourhoods) through the ICCs and a continued focus on developing thriving communities

Hospital Discharge/Flow: Refinement and improvement of Discharge to Assess and 'Home First' model, embedding the outcomes from ongoing improvement work

Example:

Launched in December 2020, the hub has ensured that 400 people have avoided coming to hospital and continued to be cared for in their residence.

The hub runs seven days a week and consists of specialist frailty clinical specialist assessors and referral coordinators who give expert advice and support to clinicians attending a person with frailty. Those clinicians using the service are from primary care, North West Ambulance Service and the community services team at University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT).

Clinicians attending a person at home can ring the hub where admission avoidance is clinically appropriate or when the individual has capacity and declines a recommended admission or the individual (or their representative) wishes to remain in their permanent place of residence. The hub can also be used if the clinician wishes to avoid hospital admission but would welcome a supportive conversation or help to reach a decision and/or access support available in the community including Rapid Response.

A GP from North Lancashire said: "It's brilliant. I have been so impressed by this service - how quick and easy it is to refer patients who are in the precarious zone between home and

hospital. Long may this service continue. I would have admitted patient to hospital if the Frailty Coordination Hub was not available.".

Fylde and Wyre CCG are key partners in the adoption and delivery of the Fylde Coast Self-Care Strategy 2017-2020. Prevention and self-care are at the heart of this strategy, which requires all partners across the Fylde Coast to look at innovative approaches to address the health inequalities that exist in our communities whilst responding to the prevalence increase in long-term conditions, including those with multi-morbidity. We have already made good progress in working towards a vision of achieving greater levels of integrated services and self-care across the Fylde Coast. This work will be further embedded within the delivery of the new models of care neighbourhood teams, and the Primary Care Networks (PCNs), which became operational in July 2019.

The organisations which commission and deliver services are becoming more joined-up across geographical 'places'. Primary care networks have been developed by geographical areas with populations of between 30,000 to 50,000. Fylde and Wyre current have 4 Primary Care Networks. A Fylde Coast group has been established for the PCNs to discuss and coordinate their work for areas such as mental health and community integration. This approach brings groups of GP practices together with community health services, social care, mental health services, voluntary and third sector, and others, to provide a joined-up health and wellbeing services. Working together in this joined-up way, the teams can make a complete assessment of a person's health, wellbeing and social needs and liaise with their colleagues to make sure they receive the right support.

A Standard Operating Framework is currently being developed to align the neighbourhood teams across the Fylde Coast as part of the community integration. This recognises that an integrated, multi-disciplinary approach is central to designing patient-centred care plans and goals. This includes the development of a unique non-clinical role of a 'Health and Wellbeing Support Worker'. Use of the PAM tool will also help to identify the knowledge, skills, and confidence an individual must manage their own health and wellbeing, and then for services to tailor their approach to supporting the individual. This is also linked into the ARRS roles for the PCNs.

The voluntary, community, faith, and social enterprise sectors (VCS) provide a rich range of activities, including information, activities, support, advice, and advocacy. They deliver vital services with paid and volunteer expert staff. The NHS Five Year Forward View recognised that they are often better able to reach under-served groups and are a source of advice for commissioners on needs. They are essential partners in Empowering Patients and Communities in health and care and are an important aspect of the development of integrated prevention and self-care strategies in Fylde and Wyre. The VCS Lead is integral to the Integrated Primary and Community Care Transformation, and VCS services are a key part of the Standard Operating Framework model.

Pennine Lancashire has been particularly affected by the COVID-19 pandemic with some of the highest cumulative case rates in England. This has had a significant impact on the health and wellbeing of its citizens and on the services that are commissioned to support these individuals. Services are working together to support both citizens and each other, including

the sharing of resources and the use of multi-skilled professionals and multi-disciplinary teams to ensure that citizens receive holistic care and support. Clearly across the course of 2021-22 there will be an element of ongoing recovery and stabilisation of the system, with much still unknown as to how the pandemic will continue to manifest across the course of the year and in particular, the winter months.

From a primary and community care perspective, Pennine Lancs is undertaking a Population Health Management pilot which is centred on prevention. The process uses combined data to identify the need for health and social care services by a specific population. The pilot aims to reduce the number of avoidable admissions from Care Homes and for older people unable to leave their own homes, living with moderate frailty. In addition to this, East Lancashire has established nine Integrated Neighbourhood teams (INTs) which are responsible for jointly planning health and social care for residents aged 18 years plus who have multiple needs. They provide effective, efficient, high quality and safe integrated care to enable local people to live well for longer and reduce, delay and prevent unplanned admissions to hospital or residential care.

The INTs utilise a strengths-based approach to ensure that assessment and care support is holistic, multi-disciplinary in nature and actively works with the individual to promote their wellbeing and achieve their goals.

The West Lancashire Partnership is made up of partners including Health, Social Care, District Council and CVS. To enable this integrated working a Provider alliance has been formed which has been asked to work on 3 priority areas for integration. These are 2hr Community Response, Transforming Intermediate Care and Out of Hospital Urgent demand. Of these priorities, two BCF integration schemes.

Neighbourhood working has been introduced, but these now need to adapt to support emerging PCNs and population health approaches to risk stratification and population health. Further steps to integration are required to ensure there are fully integrated teams, that join up population intelligence capability, and health and local authority planning, including joint commissioning, transformation and at-scale change programmes, quality improvement, service delivery and empowered communities.

To enable to 2hr response, community services will work with Social Care, DFG and housing, to prevent admissions and respond rapidly. There will also need to be greater integration with Mental Health and the emerging IRS (single point of contact) for mental health across the ICS.

In the West Lancashire ICP, there will need to be integration between the discharge planning team, ICAT and community intermediate care nursing and therapy teams. There is a short-term plan to co-locate and integrate these teams to become the transfer of care/care co-ordination hub that is outlined in the ICS plan and national discharge requirements. The BCF is the main enabler to this work, as all the teams are funded via the BCF, and the BCF in Lancashire has been the main forum to plan and develop the Lancashire wide approach and strategy

At a county level it has been recognised that integrated services created through the Better Care Fund have proven their value and where there are uncertainties about future funding

these should be removed. Lancashire County Council has agreed to take on the future, permanent, funding of a number of Intermediate Care Assessment Team services where potential short-term funding through iBCF put them and importantly their staffing at risk. This has cemented those services into core delivery and provided both service users and staff with certainty and reassurance.

**Supporting Discharge**

In response to the Hospital Discharge imperatives, health and social care implemented a jointly commissioned discharge to assess (D2A) pathway to ensure appropriate capacity was in place to respond to the demands of the pandemic. Strong system leadership has continued to jointly design, implement and redeploy resources to support rollout of the D2A/Home First model. The system has worked jointly to support providers throughout the pandemic, ensuring we have consistent messaging and a central coordination point for management of issues with the development of a care home support hub, Public Health, Infection control and Quality/Safeguarding Teams providing training and guidance. Similarly, there has been substantial admissions avoidance work including the extension and expansion of community and domiciliary care teams

- We have implemented the criteria to reside in our hospitals
- We have increased community and social care and community support capacity
- We have ensured daily discharges are maximised and continued to pro-actively troubleshoot system issues through our steering groups and MADE events
- We have continued to develop our integrated care home medicines optimisation services in line with EHCH requirements, reviewing those at greatest risk, to support early discharge and prevent readmission for those residents in care homes or assisted living

Over the next 6 months partners will build on this good work and lessons learned (locally, regionally and nationally) to develop a sustainable, equitable and resilient D2A pathway and intermediate care/reablement model that incorporates our patient and service user feedback, is outcomes focussed and financially sustainable. We will review our system capacity for intermediate care and review and improve the commissioning framework for D2A beds to ensure that the system has the flexibility to adjust what we commission in response to unplanned events.

On the Fylde Coast the Urgent and Emergency Care Transformation Programme is primarily looking at improving the way patients move throughout the hospital, improving waiting times in the emergency department and tackling delays when discharging patients out of hospital to home or to other care settings. The schemes within the Better Care Fund align and support the programmes' key priorities of 'admission avoidance' and 'return to home'.

The Transfer of Care Hub (TOCH) went live from Monday 6th September. The Transfer of Care Hub is a system level co-ordination centre that links together all local Heath & Social Care services to aid timely discharge from hospital. It consists of multi-disciplinary & interdisciplinary working, encompassing contribution from, and access to, a wide range of services including community, primary care, social care, housing & the voluntary sector. It will develop timely & person-centred discharge plans for individuals based on the principles of "Home First," recognising the complexities of positive risk taking & maximising independence. The Hub will bring together the current Discharge Services and co-locate them in one central area on the Acute site to streamline processes and increase collaborative working.

The first step to improve patient flow is the role of the Discharge Facilitator's (DF's). They are based on each ward of Blackpool Teaching Hospital. They gather pre-admission information for each patient and documenting it on Ward Tracker. It is then possible to anticipate who may need intervention from TOCH. The DF's ensure all Estimated Dates of Discharge are updated and discussed at board round and monitored these throughout the patient journeys, adjusting them as patients' needs change. They also provide patients the Discharge Information Pack developed so patients and their families feel fully informed throughout the whole discharge journey and know who to contact at what stage.

When the patients no longer meet the criteria to reside an anticipated 50% of patients will be able to go home straight from the ward, pathway 0.

For the remainder that need some health or social care support in the community (pathways 1's, 2's and 3's), the DF's will support the wards in completing the Strata referral into TOCH. Step 4 is the problem solving, decision making, triage process where patients are allocated to an appropriate discharge pathway by a health and social care professional.

TOCH work in 2 huddles with one focusing on our pathway 1 patients so those going home, and the other focusing on pathway 2 and 3 patients which is the rehab and placement patients.

As well as covering acute wards there is also cover within the Accident and Emergency department with adult social care supporting triage functions to avoid unnecessary admissions. They have access to several well-established services operating on a 7-day basis, such as the Rapid Response Service, Rapid Response Plus and our residential intermediate care facilities. These teams have direct access to Council funded short term intensive domiciliary support avoid admission to an acute setting. he Rapid Intervention and Treatment Team provide a 7-day service within the referral and support pathway for Older Adults Mental Health.

In Morecambe Bay**:**
Rapid Response is made up of different health and social care professionals including Nurses, Physiotherapists, Occupational Therapists, Assistant Practitioners, Therapy Assistants and Administrators.

Rapid Response is for people who do not need acute hospital admission but need support to recover from an acute illness or an accident. The aim of RR is to help prevent people from having to go into hospital or a care home unnecessarily for the purpose of admission avoidance and to support people on their discharge from hospital, where appropriate, to help them continue their acute recovery regain and maintain as much independence as possible.

REACT are based at the Royal Lancaster Infirmary and assess patients within the first 48 hours of admission or in ED to support with Rapid discharge back into the community to receive their treatment if this is appropriate. They work closely with the Frailty pathway and ICAT (Social Care) to support admission avoidance and can commission crisis care and refer onto Community Teams to facilitate a discharge.

In Central Lancashire, health and care partners are committed to continuing to apply and embed the national 'Hospital discharge and community support: policy and operating model'

and the discharge to assess process and principles contained with it, including an ethos of maximising the number of patients who are safely discharged home.

It is within this context that the placed-based partnership is working collaboratively to ensure, through BCF, iBCF, Winter Pressures Grant and other winter funding, that we have the right services available to support patients on their optimum pathway to improve their outcomes, maximise their independence and ensure timely discharge.

These services include low level services such as hospital aftercare to support pathway 0 discharges; additional CATCH, Home First, Crisis Support and Reablement services with a clear aim of increasing the volume of pathway 1 discharges where an individual needs care and support; and bed-based rehabilitation services in relation to pathway 2 discharges.

Our commitment to improving outcomes for people being discharged from hospital is exemplified by the fact that the local authority and clinical commissioning groups have jointly agreed further recurrent and non-recurrent funding in relation to pathway 1 related services and the place-based partnership is working together to mobilise the additional workforce.

An integrated approach is used with Health and social care being involved in the triage of referrals for patients who are fit for discharge

A clinical triage process completed by both Health and Social Care staff to identify the most appropriate destination on discharge to meet the patients' needs to ensure they meet their full potential and promote independence for all patients. The options may be the patient's own home without or without a care package or therapy input, residential rehab unit, D2A bed or residential care.

For those patients returning home our Home first service enables the patient's needs to be assessed in their home and the appropriate level of care is provided to keep them safe at home.

It increases the home first slots to allow patients where Home is deemed to be safe discharge to be discharged with the right level of care and equipment to maintain them safely at home and avoid further admissions It allows for Integrated working to ensure that the triage looks at all the patients' needs both Health and social care.

It is important to emphasise that the CCGs and the acute trust work closely together to best manage patient flow admission avoidance and to discharge. As a large trust with a number of specialisms it is not only busy but also faces challenges through patient flow in its specialist pathways. Currently Chorley and South Ribble and Greater Preston CCGs are taking the following actions to support the trust.

1: Discussions are being held with LTHTR to confirm the actions to achieve a reduction down to the England average Length of stay.

2: Discussions are also being held to confirm a stretch target that LTHTR will work towards and the timescales for achievement. This is within the overall Lancashire target.

3: Weekly reports are being produced by LTHTR to understand the drivers. This will form part of the improvement programme launched by the Trust on 03/11/21.

In West Lancashire the primary focus for supporting discharge is the Southport and Ormskirk Hospitals Trust there has developed a good relationship with the trust that has accelerated the integrated approach to manging discharge.

In West Lancashire ICP the BCF is supporting Home First and discharge co-ordination via the Intermediate Care Allocation Team. The BCF is also supporting the therapy roles required for Home First, these are Health employed posts, deployed and working with the ICAT Social Care team. The BCF is also supporting the voluntary sector take home service, which supports patients to go home from A&E, from the wards and helps patients on the Home First pathway with shopping, bills, confidence and befriending.

In 2020/21 the focus was on establishing a West Lancashire Social Care ICAT (allocation Team) to enable co-ordination of Home First and increase the number of patients able to access the Home First pathway. This is now in place and working jointly with Discharge planning, Trust and Community services. Community Therapists, funded via BCF, support the take home element of Home First. However further integration is required.

In 2021/22 the plan is to build on the success of CERT and SISS in West Lancashire, by combining these nursing and therapy teams, so they are more responsive. These teams will form the 2Hr Community response in West Lancashire. This new team will also integrate with Discharge planning and ICAT (Social Care Intermediate Care allocation team), to become fully integrated and co-located. This is a key step to aligning resources and integration for discharge, but also step up and admissions avoidance. Integration will simplify the discharge process and align the local provision to national and ICS strategy. This is one of the Key priority areas for the West Lancashire Partnership and PAG (Provider Alliance).

The Better Care Fund is used to fund a number of hospital discharge initiatives across Pennine Lancashire, either partially or in their entirety. These services range from Pathway 0 through to Pathway 3 and include both hands on care, access and navigation of intermediate care services and assessment and care planning services.

Services work in an integrated fashion across the ICP footprint to ensure that discharges are facilitated in a safe, timely and effective manner. Services include both short and medium term options and seek to promote the independence of those that use them utilising a Home First and Discharge to Assess ethos.

Home First and Discharge to Assess pathways were already well embedded across Pennine Lancashire prior to the implementation of the Hospital Discharge and Community Support: Policy and Operating Model and work has continued to further improve access and flow through the various pathways; Better Care funded services are central to the delivery of this.

Age UK deliver a Hospital After Care Service which supports people with lower-level needs that might otherwise fall through gaps in services. This service has continued to be provided in its entirety throughout the pandemic and has even seen an increase in activity across all localities. The service is typically accessed by people on Pathways 0 and 1, however, can also be used by people discharged on Pathways 2 and 3 where this is required. The service will typically support people with social and domestic tasks including, finances, shopping, cleaning, cooking and housing. They provide people with vital links into the wider community enabling them to maintain and sustain their place in the community.

Home First and reablement services primarily support people on Pathway 1 and include a focus on assessing people in their own familiar home environment as opposed to in an acute/community hospital setting which can often result in a false presentation and lead professionals to over-commission care which can have a negative impact on a person's level of independence. Home First and reablement are goals driven services which support a person in a strengths-based fashion, enabling them to achieve the goals that are important to them.

Pathway 2 services funded via the Better Care Fund include some community hospital provision as well as residential rehabilitation and sub-acute bedded provision in a community setting. These services provide an option for people who are not yet ready to return to their own home to further recover and rehabilitate with access to a range of professionals to support their health and care requirements. People within some of these services will be case managed by services that benefit from elements of BCF funding including the Intermediate Care Allocation Team in East Lancashire and the Intermediate Tier Team in Blackburn with Darwen. These teams also support people on Pathway 1, ensuring that health and care needs are assessed and reviewed in line with the persons care and support plan.

Access to most of these services is via a Trusted Assessment Document (TAD). Work is ongoing to digitalise the TAD which will support more effective integration across all services.

Professionals from across the ICP meet on a twice weekly basis to escalate and resolve any operational issues that might impact on safe, timely and effective discharge. The group also plans at an operational and strategic level to ensure continuous improvement and to support activity and flow during key periods throughout the year, such as Winter planning. There is also a monthly Intermediate Tier Delivery Board which is attended by all partners (acute trust, community providers, both local authorities, both CCGs and VCFS).

Both East Lancashire and Blackburn with Darwen successfully applied for some BCF small grants monies earlier in the year and have utilised this to fund a shared post across both Local Authorities and East Lancs Hospitals Trust. This post provides a dedicated resource to manage the Home First transport, including the scheduling, coordination and booking of patient journeys. This has led to a reduction in the number of cancelled Home First slots which has had a positive impact on both patient experience, in-hospital flow and the use of resources. This is a further example of how partner organisations seek to integrate and align services to ensure equity of access across the ICP footprint.

**Disabled facilities Grants**

Traditionally there has been little use of Disabled Facilities grant allocations beyond district councils' provision of grants services.

This year though, Lancashire County Council has commenced discussions with District Councils across the County on a test of concept to site some housing expertise with the Intermediate Care Allocation Teams (ICAT). This will focus initially on people being discharged from hospital who may have housing related challenges such as homelessness, rough sleeping, have home hazards or self-neglect in unsanitary or unsafe housing conditions. We're hoping to commence it across this winter.

This is a pre cursor to some wider innovation work that was started pre pandemic. This is to look at the potential for more innovation within the use of the DFG and flexibilities. LCC is to partner with Foundations (The National Body for Home Improvement Agencies in England) to help take this forward – this will link with NHS colleagues to explore joining up housing, social care and health in a housing related coordinated strategy.

Fylde and Wyre CCG work closely with the District Councils and Lancashire County Councils to ensure an integrated approach to health, care and housing.

This integrated approach is also key to the urgent and emergency care work programme we have on the Fylde Coast.

As part of the Primary Care Network work programme, council colleagues are now part of the process for reviewing local services and health inequalities. This includes developing a community integration model with local health and social care services.

In Central Lancashire the CCGs fund support to Preston Care & Repair, a non-profit organisation that provides practical support and independent advice.

Preston Care and Repair work with older, vulnerable and disabled people and anyone with a long-term health condition that affects their mobility or independence in their home by giving impartial advice and practical help including Handyperson & Minor Works services; Healthy home checks to improve home safety and security, advice and assistance with larger adaptations and home repairs; Practical support to people returning home from hospital etc.

The county wide jointly funded telecare home response and assisted lifting service helps support independent living in a person's home of choice.

In Morecambe Bay the integration of housing with health and care services is a crucial element to supporting the outcomes of the BCF and housing colleagues are actively integrated with commissioning arrangements. Integrated Care Communities (ICCs) – ICCs were established in Morecambe Bay in 2014 as part of a 10-year journey to localise care. Bay ICC is led by a Bay PCN GP and Clinical services manager. It provides a local focal point for place-based partnership collaboration and is a delivery vehicle for holistic integrated care delivered by a range of providers including voluntary community and faith sector, secondary and primary care.

Example: homelessness in Lancaster

Sustaining rough sleepers is a challenge and an effective Health and Wellbeing partnership has been created bringing Lancaster local authority, NHS and criminal justice departments together. The focus of this group is to develop bespoke health pathways to improve access to health services and improve the health of the homeless population, recognising that other groups, particularly the Homeless Advisory Group and Homelessness Forum, are working on the wider housing, economic and welfare issues. MBCCG also directly support Carers Link and n-compass work in partnership to deliver The Lancashire Carers Service to provide support across the CCG footprint.

Example: The Well – Lived Experience Recovery Support

The Well is supported by MBCCG BCF funding and is a Lived Experience Recovery Organisation (LERO) founded in 2012. With hubs across the North West, they provide support to more than 700 people every year who are facing complex and often interdependent problems including substance misuse, mental ill-health, long-term physical conditions, homelessness, trauma, and offending behaviours. There are over 2,500 members across the North West which offer a range of services including supported housing, mutual aid support and a social activities programme to work with people inside and outside the prison establishment. Since 2019 and through lockdown, the Well has worked with 3,645 people.

**Equality and health inequalities**

As we move towards the delivery of integration and integrated care through the Lancashire and South Cumbria Integrated Care System, we will aim to adopt its vision within the Lancashire BCF:

*Together we can make things better*

- The partnership of organisations working across the Integrated Care System have agreed a clear purpose for our work together.
- This will happen in neighbourhoods, local places and across the whole of Lancashire and South Cumbria. Our vision for Lancashire and South Cumbria is that communities will be healthy and local people will have the best start in life, so they can live longer, healthier lives.

At the heart of this vision are the following ambitions:

- We will have healthy communities
- We will have high quality and efficient services
- We will have a health and care service that works for everyone, including our staff.
- Our vision for Lancashire and South Cumbria

In your neighbourhood and community

- Health and social care will work together to support your social needs, physical and mental health and wellbeing
- You will be supported to care for yourself where you can, including using digital technology
- Community groups and local teams, including your GP, will work with you
- You will be encouraged take an active role in managing your own health and wellbeing and to support others in your community.

In your local area

- Most care will be locally delivered, managed and planned
- We will make the best use of all the expertise and staff skills available to us
- We will talk to you and your community about how best to provide care
- You know best what you and your community needs.

*Population Health Management*

We will shape the BCF development and delivery through using Population Health Management, where we can use information which is already held about people to look at the best way to help people live longer, providing personalised care tailored to their needs. One example is using data to identify people who have multiple long-term conditions and understanding the ways in which they can be supported to prevent complications and live independently. This approach will be developed across Lancashire and South Cumbria to make a real difference to people's lives. This approach is recognised as leading the way in starting to improve outcomes, reduce inequalities and address the broad range of individual, social and economic factors affecting the health of local people.

As we better understand the needs and wishes of the population, we will better focus resources on these.

We will also use better the data that is available to us to shape services and expectations about service access and use. For example, the data that shows the difference in Length of Stays in acute settings between younger and older patients and between those from white and ethnic minority backgrounds along with their discharge destinations.

Our BCF plan has not changed significantly in its content over the last year. However, as services have rolled forward or been renewed, they have been and will continue to be subject to the scrutiny of such processes as Equality Impact Assessments and patient experience review.

Each partner in the Lancashire Better Care Fund is clear on expressing its desire to recognise and respond to protected characteristics in individuals and communities.

*Health Equity Commission (HEC).*

All BCF partners are committed as members to the Lancashire & South Cumbria Health Equity Commission (HEC).

The HEC aims to provide local organisations, partners and Integrated Care Partnerships the support to make health inequalities and the 'prevention agenda' our joint priority and provide them with a clear voice in the region & ICS.

Its initial scope is:

- Influence all LSC partners in mobilising care to reduce health inequalities and its role in the economy
- Focus on the social determinants for health, with reference to poverty/deprivation, building on the work of the health focus in the Local Enterprise Partnerships and the Greater Lancashire Plan & equivalent Cumbria plan
- Creating healthy and sustainable places and communities with a focus on empowerment of people in decision-making that shapes policy at neighbourhood, place and system
- Creating good/healthy workforce and a focus on technology and innovation that supports prevention to aid economic recovery
- Important times of life, in particular giving children and young people a good start in life with a focus on the first 1000 days