

# **Lancashire Health and Wellbeing Board**

## **Better Care Fund plan**

**2022-2023**

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<b>Signed on behalf of</b> <b>Lancashire Health and Wellbeing Board</b>	
<b>By</b>	
<b>Position</b>	<b>Chair, Lancashire Health and Wellbeing Board</b>
<b>Date</b>	

<b>Signed on behalf of</b> <b>Lancashire County Council</b>	
<b>By</b>	
<b>Position</b>	
<b>Date</b>	

<b>Signed on behalf of</b> <b>Lancashire and South Cumbria Integrated Commissioning Board</b>	
<b>By</b>	
<b>Position</b>	
<b>Date</b>	

Health and Wellbeing Board	Lancashire
Local Authority	Lancashire County Council
Integrated Commissioning Board	Lancashire and South Cumbria
Boundaries	<p>Lancashire County Council upper tier authority</p> <p>12 District Councils</p> <p>Burnley Borough Council  Chorley Borough Council  Fylde Borough Council  Hyndburn Borough Council  Lancaster City Council  Pendle Borough Council  Preston City Council  Ribble Valley Borough Council  Rossendale Borough Council  South Ribble Borough Council  West Lancashire Borough Council  Wyre Borough Council</p> <p>Borders with 2 Unitary Authorities within the Lancashire footprint:</p> <p>Blackburn with Darwen Council  Blackpool Council</p> <p>Borders also with South Cumbria within the ICB footprint</p>

## **Lancashire Health and Wellbeing board**

Chair: County Councillor Michael Green

### **Organisations involved in the preparation of this plan**

Lancashire County Council

Lancashire and South Cumbria ICB

Lancashire District Councils

University Hospitals of Morecambe Bay NHS Foundation Trust

Blackpool Teaching Hospitals NHS Foundation Trust

Lancashire Teaching Hospitals NHS Foundation Trust

East Lancashire Hospitals NHS Trust

Southport and Ormskirk Hospital NHS Trust

### **Stakeholder involvement**

The Lancashire Better Care Fund (BCF) engages with stakeholders at several levels, and this is evolving with changing structures.

It is though still focused on a local level. ICB 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 local health partnerships and provider alliances.

For example, in West Lancashire stakeholders have been engaged via a number of existing groups and forums, including A&E delivery Boards and Winter Planning groups, Local Partnership meetings involving the Borough Council and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector. This engagement has mainly been around intermediate care, and it’s link to BCF. All Stakeholders took part in a series of workshops looking at future Place priorities which has included, housing, Disabled Facility Grant (DFG) and wider determinants of health and maintaining independence and wellbeing.

At a county level there are residential and domiciliary care groups run by social care commissioners, a voluntary sector group and a District Council health focussed group alongside an all District Council DFG oversight group.

As the Lancashire and South Cumbria Integrated Care Board (ICB) evolves further and embeds its structures lines of communication will change with an expectation of further strengthening of relationships with partners.

This will be seen with continuing collaboration across the four BCFs that sit within the ICB footprint. The four BCF leads have already developed a good working relationship providing mutual support, working to identify common priorities and potential for closer alignment.

## **Executive summary**

The detail of this years Better Care Fund Plan seems little changed from the previous year. However as we have emerged from the pandemic, we have begun to have the opportunity to reflect on the positive change that have been linked to the BCF.

These can be seen in the numerous examples of how the BCF is being used successfully to address its core priorities as set out in this plan.

It has also highlighted where we may have missed opportunities.

The key priorities for 2022-23 remain focussed on delivering high quality services for people that promote their independence, ensure their dignity and enable them to live their lives in the way they choose. This includes delivering high quality services that support people to remain in or return to their own homes and avoid unnecessary hospital and residential care admissions. Services and teams also support timely discharge from hospital into care and support that will allow people time to recover and fully participate in their assessments and support planning. Sufficiency of care provision and stabilisation of the market remain areas of key focus.

The timing is now right to address the key priority for Lancashire in 2022-23 to undertake a detailed whole system review and 'reset' of the use and oversight of the BCF. This will include how we spend the BCF, how we manage it and how we can use it more effectively. Planning for such a review is now underway and with BCF team support will engage with key stakeholders over the next three – six months with a clear intent to see its impact in the Lancashire BCF plan for 2023-2024.

Agreement is in place between the Lancashire And South Cumbria ICB and Lancashire County Council to uplift the minimum NHS contribution to social care by £10m in 2023/24 rising to £22m in subsequent years.

The consolidation of the 6 Lancashire footprint Clinical Commissioning Groups (CCGs) into one ICB and local Place boundary changes to mirror the Local Authority footprint both present opportunities to improve how we collaborate as a system and set out a new vision for how we will integrate.

## **Governance**

During the period of management of the covid pandemic BCF governance arrangements were slimmed down to allow for redirection of resources.

Oversight of the BCF was maintained through the Lancashire and South Cumbria Out of Hospital Cell with the programme group continuing to meet to provide oversight and low-level monitoring.

During 2022 it has been possible to rebuild the lines of scrutiny, accountability and strategic direction. This has seen connection into the Lancashire and South Cumbria Intermediate Care Programme Board and its associated Discharge to Assess (D2A) finance group with an umbrella view being taken by the Adult Social Care & Health Partnership.

As the ICB has now firmed up its governance and senior and place based leaders have been appointed these connections and lines of accountability will be formalised. The ICB has identified key officers to take on responsibilities around BCF to support this development.

The accountability of the BCF to the Lancashire Health and Wellbeing board will be maintained and developed.

A recent workshop for the Lancashire HWB provided new members with background and detail around the BCF, reiterated the boards role and sought and received the support of the whole board to take a proactive approach to the review and “reset” of the BCF in Lancashire. This reset will see a fundamental, “line by line”, review of how the BCF is used to benefit Lancashire residents.

## **Better Care Fund Plan and approach to integration**

Working in a strengths-based way is integral to our approach and ambitions in achieving quality outcomes for Lancashire residents. The focus of the integrated care work and commissioning of the Better Care Fund services and projects continue to be implemented via a collaborative approach to integrated, person-centred services across health, care, housing, and wider public services locally with strong governance processes in place.

The overarching approach is to support people to remain as independent as possible at home and to work in a partnership approach to jointly improving outcomes and opportunities for people in our neighbourhoods, those discharged from hospital, and in reducing health inequalities.

We are proud of our local approach to a joint health and social care system, and collaborative leadership is well-established. Health and Social Care Executives and Senior Managers have worked closely with stakeholders at a system level to develop and implement our strong governance and strategic and commissioning forums. The BCF plan strategic aims and objectives are threaded through our local governance processes, meetings and decision-making forums which are strongly supported and engaged with by local leaders. The Integrated Care System (ICS) and Integrated Care Provider (ICP) structures and commissioning frameworks are under development with good representation by NHS and Local Authority Leaders at relevant forums to help shape and support newly forming priorities and structures which are influenced by the BCF priorities.

For example in Morecambe Bay, Integrated Workforce is an area of greatest focus and achievements due to a collaborative, open and supportive partnership approach which has formed a range of collaborative strategic and planning forums in place across our Health and Social Care Systems. An example of this is the are joint NHS and wider Health and Wellbeing organisational partnership meetings held at Lancaster. We continue to encourage and promote the 'One Team' approach across multiple organisations to provide holistic and joined up approaches to an integrated workforce which includes the joint development & delivery training and upskilling of clinical and non-clinicians side by side and across traditional organisational boundaries (for example, RESTORE2 training and ICP training to Care Homes and to enhance the referral detail provided by locally commissioned Falls Services). This has enabled us to develop greater understanding of the role and responsibilities of different organisations and teams and additionally to explore further opportunities for innovation.

Lancashire was particularly affected by the COVID-19 pandemic with some of the highest cumulative case rates in England, especially so in Pennine Lancashire.

There was a significant impact on the health and wellbeing of its citizens and on the services that are commissioned to support people. Health and Care 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 people receive holistic care and support. Across the course of 2022-23 there continues to be an element of ongoing recovery and stabilisation of the system, with much still unknown as to the longer-term impacts of the pandemic and how this might continue to manifest across the course of the year and in particular, the winter months. Cost of living increases will also impact.

The majority of the BCF investment for 2022-23 will see a rollover of previous schemes to continue to provide essential stability to the system and ensure that services are able to deliver to their full potential and retain skilled.



The transition of CCGs into the Integrated Care Board will provide new opportunities to review and evaluate priorities and approaches to joint commissioning/integration across the health and social care system. This in itself will be a priority across 2022-23.

For 2022-23, some BCF investment has been used to enhance support to Care Homes. For example, in Pennine Lancashire, the Intermediate Care Allocation Team (ICAT) Care Home Pathway is providing an integrated wrap around health and social care response for an acute phase before transferring back onto core community services and Integrated Neighbourhood Teams. It operates both a step up and step down referral route and ensures that people residing in care homes are able to access an equitable service offer from community services. The service has been shortlisted for an upcoming HSJ Award in the category of 'Improving Care for Older People – Initiative of the Year'. This service is an example of integration and holistic assessment, utilising multi-skilled professionals within the context of a multi-disciplinary team to ensure the best outcomes for citizens.

During the course of 2022/23, Pennine Lancashire will transition to a single provider for the Intensive Home Support Service (IHSS). This will be jointly funded using both the Lancashire and Blackburn with Darwen BCFs. IHSS will provide support to the population of Pennine Lancashire in their usual place of residence, including private residences, care homes and supported living establishments. The IHSS service will assess, investigate, support and help people to avoid unnecessary admission to hospital or help people to return home from hospital where necessary. The service will provide high-quality, preventative, responsive and active nursing and therapy care, 7 days a week delivered to people in the community, proportionate to the presenting need. The service will forge close links with systems partners to deliver an integrated response. Transitioning to a single provider will ensure equity of provision across Pennine Lancashire. Previously, the service operated 7 days a week 8am-8pm in one locality and 7 days a week, 8am-10pm in another. As a result of the change, it will now operate 7 days a week 8am-10pm across Pennine Lancs and from November 2022, will move to a 24/7 service. Furthermore, due to links with the acute trust, it will ensure a higher acuity of need as well as interventions can be managed and delivered uniformly.

Across Lancashire the approach to integration and use of the BCF has engaged with a wide range of local partnerships. For example the West Lancashire Partnership is made up of partners including Health, Social Care, District Council and Council for Voluntary Service. 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 are BCF integration schemes. There have been a number of workshops that have developed local priority areas – including Wheel Workshops, which considered wider determinants of health and key preventive approaches to address inequalities and deliver improved outcomes for the local population.

In Central Lancashire the place based partnership is working collaboratively to ensure, through BCF, iBCF, Winter Pressures Grant and other winter funding, that the right services at the right time are available to support people in order to improve their outcomes, maximise their independence and ensure timely hospital discharge.

An integrated approach is used by Health, Social Care and VCSFE staff in the triaging of referrals for patients who are fit for discharge, to identify the most appropriate support to meet people's immediate needs and to ensure they meet their full potential through promoting their independence.

In Lancashire, the BCF will also support the wider integration across communities. In line with the vision set out in the Fuller stocktake report the BCF will assist the health and care system reorientate to a local population health approach through building neighbourhood teams, streamlining access and helping people stay healthy.

For example, a Fylde Coast group has been established for 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 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 Patient Activation Measure (PAM) tool will also help to identify the knowledge, skills, and confidence people have to manage their own health and wellbeing, and then for services to tailor their approach to supporting the individual. This is also linked into the additional roles reimbursement scheme (ARRS) roles for the Primary care Networks (PCNs).

The Pennine Lancashire Neighbourhood Accelerator (NA) Programme was introduced in April 2021 as a 6-month programme to support a new 'integrated care' way of working and model at PCN level. This joined up approach was developed in response to growing local population health needs and inequalities in our communities by delivering collaborative clinically led health and social care multi-agency, Voluntary Community & Faith Sector teams utilising a Population Health Management data led approach.

Building on the existing Integrated Neighbourhood Teams (INT's), PCNs coordinated and supported joint working with a wide range of partners including those external to the NHS. This approach anticipated problems before they arise and enabled broader thinking beyond medical solutions. By engaging and listening to people about what matters to them first, it meant that practitioners and individuals were able to jointly develop timely, realistic solutions to the problems that individuals experienced.

The aim of Neighbourhood Accelerator is to continue to provide an opportunity for Pennine Lancashire PCN's, GP practices, community services and the CVFSE organisations to deliver their collaborative personalized care approach as 'one team' at PCN level. This is achieved through personalised care and support planning where people have proactive, personalised conversations which focus on what matters to them, delivered through a personalised process and paying attention to their clinical needs as well as their wider health and wellbeing needs.

The focus is to help to alleviate health pressures faced by identifying those most at risk and most vulnerable in the community and by supporting patients being discharged from hospital to support them to remain health and well in their home setting. The alignment of efforts of our community health and wellbeing services to reduce the health inequalities of the local population through utilising Population Health Management (PHM) data and risk stratification tools. The programme ensures clinical and patient oversight by GP Practices/PCN Teams, Integrated Neighbourhood Teams, Social Prescribers and VCSFEE sector. The programme has successfully engaged with the 13 PCN's across East Lancashire and Blackburn with Darwen who are implementing the NA programme with buy in

from all member practices. To date over 1,275 additional referrals have been generated through the targeted approach of the NA Programme across Pennine and includes 68 GP practices utilising an anticipatory care and PHM risk stratification approach to identify and provide clinical case management.

Lancashire County Council plays a pivotal role in all aspects of the delivery of the BCF at place level. As the upper tier social care authority it has a clear view of its role and the challenges and opportunities for it and its partners:

“We are working collaboratively across health and social care around managing our intermediate care and planned care provision. The Better Care Fund is supporting our integration journey alongside the development of our Integrated Care System.

We are utilising the Better Care Fund to jointly fund provision which addresses:

- Admission Avoidance
- Carer Breakdown and Crisis Situations
- Hospital Discharge Supports
- Building provision across non-regulated care providers, such as the VCSFEE

The Better Care Fund supports our approach to integration as it is the primary joint funding mechanism for the Lancashire area. Therefore, our BCF provision has joint aims across health and care to build and sustain the right supports to enable people to remain well at home for longer and to provide the right level of support when they require it. To strengthen the connection the Lancashire and South Cumbria ICB has agreed to uplift the minimum NHS contribution to social care by £10m in 2023/23 and by £22m in subsequent years.

We are working across the system to sustainably manage our care market provision and support health providers, where it makes sense, in delivering national priorities such as virtual wards and 2 Hour Urgent Care Response. In these efforts, we maintain a focus on the person requiring the support ensuring that we are taking a strengths-based approach to their identified needs and creating the market conditions to enable the right support to be available at the right time.

## **Implementing the BCF Policy Objectives (national condition four)**

We are focussed on providing services and supports that enable people to remain in their own homes for as long as possible, are high quality and offer choice and control and promote peoples' independence. Against the backdrop of national social care market challenges, including recruitment and retention issues, Lancashire mirrors the national and regional picture. It is critical to ensure the stability of the care market and not introduce commissioning that could destabilise it.

We are continuing our ICS Intermediate Programme which aims to deliver whole system transformation which will ensure people can access the right enabling support at the right time in the right place. Joint commissioning is a key component in the programme, given the benefits to NHS and social care of getting it right, alongside improving outcomes for people who use the services. We have set up a collaborative commissioning network across the NHS and Local Authorities which will support strategic outline of these intents. Intermediate care services are funded from the BCF and as such, the BCF is pivotal in enabling the transformation and deeper integration ambitions in the Intermediate Care programme.

A strengths based approach is a key element of the services which support people to remain independent for longer, building on their assets and personal and community networks is embedded in professional practice. The Council is also undertaking a strengths based practice transformation, called Living Better Lives in Lancashire which builds on the renowned '3 Conversations Model' <https://www.lancashire.gov.uk/media/936918/care-support-and-wellbeing-of-adults-in-lancashire-our-vision.pdf>

and will be an important part of improving the personalisation and tailoring of support for people, using available community and natural assets before contemplating regulated formal support.

The recent Place boundary review in Lancashire & South Cumbria gives us improved opportunities for deeper integration, especially at neighbourhood level. There are geographical areas of Lancashire where neighbourhood integration is more advanced than others, and plans will be progressed to share good practice and facilitate improved consistency of integration across the full Lancashire footprint.

As the ICB continues to develop, one of the key areas of focus around integration is the Lancashire & South Cumbria Intermediate Care Programme. Governance structures have been established for the programme including a monthly executive board across all partners, co-chaired across health and social care. Work is underway to refresh understand of the baseline level of intermediate care each of the current Places, noting that some levelling up will be needed as the programme moves toward implementation. Carnall Farrar, the consultancy who completed the original LSC intermediate care review and analysis, have refreshed the Lancashire baseline data and assumptions, using the most up to date population data and learning and new assumptions following the covid-19 pandemic. There is recognition of the scale of transformation required and the role of the BCF in moving forward.

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

Services work in an integrated fashion 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.

Lancashire and South Cumbria has a standard operating procedure (SOP) for hospital discharge based on the national guidance. A finance interface group is in operation that supports the collaborative spend underpinning the discharge to assess processes in place. Work is underway to improve the consistency of application of the SOP, and to understand the scale of levelling up that's needed to deliver high quality discharge to assess pathways out of all four Lancashire & South Cumbria hospitals and also for Lancashire residents returning home from out of area hospitals. Although some ICB funding has been made available for D2A since the cessation of the national monies, as yet this is not pooled into the BCF. The intention is to continue to review and understand spend to ensure that discharge to assess processes may be maintained. Collaborative commissioning to ensure seamless services for people is a key component of the ICS IC programme, which in turn supports the D2A processes.

[NHS England — North West » Lancashire's Hospital Discharge Home Recovery Scheme – supporting 'home first' – Case study](#)

'Home First' is in place to facilitate hospital discharges from all 4 Acute Trusts in the LSC footprint, and also the discharge of Lancashire residents from out of area hospitals. The ethos of home first and the services and teams that work within it ensure that an integrated approach is taken, which delivers the most independent outcomes for people. For example, the Central Lancashire home first service, delivered via the Central Allocations to Health and Care (CATCH) hub enables the person's needs to be assessed in their home and the appropriate level of health and/or social care and community equipment is provided to keep them safe and supported, and give time to recover.

Also in Central Lancashire, an additional 14 general nursing intermediate care beds were commissioned in November 2021 to supplement substantive intermediate care beds in our local system. The beds were to partially bridge the acute bed deficit at the Trust and to help the local system maximise discharges. This additional capacity was extended into 2022/23 and will remain in place until 31/12/2022, whilst other plans are developed in relation to additional community bed capacity.

The BCF is also funding the voluntary sector take home and settle service for all Lancashire residents and delivered by Age UK, which supports both hospital discharge and admission avoidance. The scheme is a two tier one, with tier one being the take home and settle element and the second tier offering support for up to 6 weeks following hospital discharge with shopping, bills, confidence and befriending.

In West Lancashire the BCF is supporting Home First and discharge co-ordination via the Intermediate Care Allocation Team (ICAT).

ICAT works jointly with Discharge planning, Trust and Community services and this level of integrated working has been a key enabler to expanding the home first pathway and currently 19 people per week can be supported on the pathway. Additional winter funding has been secured to increase the number of patients that can be supported, as the home first pathway can reduce patient length of stay (LOS) by 2 days and has been important to supporting greater independence post discharge.

In 2021/22 the community emergency response (CERT) and short intensive support service (SISS) were combined in West Lancashire, 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, to become fully integrated and co-located. Integration will simplify the discharge process and align the local provision to national and ICS strategy. Due to Estates issues this priority was delayed, and so is a key priority for 2022/23. Phase 1 will be completed in September 2022, with further integration planned by end 2022/23.

Plans for developing Home First and admission avoidance schemes are considered jointly via local partnership meetings and networks. A no wrong front door approach to 2hr Community response has led to development of rapid triage assessment and redirection across partners, however this needs to be continually improved as the approach is embedded.

Further joint working and integration will be required in order to deliver Virtual wards in 22/23. Across LSC the focus of the emerging virtual wards is on frailty and supporting frail patients at home (including Care homes if this is their usual place of residence), and respiratory illness.

In Central Lancashire, health and care partners are committed to continuing to apply and embed the national 'Hospital discharge and community support guidance' and the discharge to assess process and principles contained within it, including an ethos of maximising the number of patients who are safely discharged home.

It is within this context that our 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 in order 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.

Home First and Discharge to Assess pathways were already well embedded across parts of Lancashire such as in 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.

The Fylde Coast 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 2022. The Transfer of Care Hub is a system level co-ordination centre that links together local Health & 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.

As well as covering every ward within Blackpool hospital settings, there is also cover within the Accident and Emergency department via adult social care, supporting triage functions to avoid unnecessary admissions. They have access to several well-established services, some of which operate 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 to avoid admission to an acute setting. The Rapid Intervention and Treatment Team provide a 7-day service within the referral and support pathway for Older Adults Mental Health.

In East Lancashire 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 Place 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 VCSFE).

Both East Lancashire and Blackburn with Darwen successfully applied for some BCF small grants monies 2021/22 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. The post will continue to be funded from BCF monies in 2022/23.

The Fylde Coast ICB are currently in the process of developing Virtual Wards. Virtual Wards will allow people that would have otherwise been in a hospital bed to receive elements of acute care within their own place of residence. The Acute Respiratory Illness (ARI) Virtual Ward commenced in May 2022, with further work in progress to deliver a Frailty Virtual Ward and an End of Life Virtual ward by the end of 2022.

The ICB is also developing an NHS@home offer with a small number of pilots for long term condition monitoring including respiratory and cardiac home monitoring which complement the current oximetry@home offer for covid patients. NHS@home builds on what we learnt throughout the

pandemic and maximises the use of technology to support more people to better self-manage their health and care at home.

The ICB has also responded to the impact of the COVID 19 pandemic by developing a bespoke service for people suffering from Long Covid Syndrome. This high skilled multi-disciplinary team deliver care, support and rehabilitation working together with third sector organisations to support patients to regain health and confidence.

Morecambe Bay BCF-supported programmes aimed at preventing admission to hospital are established – e.g., the Advice and Guidance model (where consultant support is available for primary care services has reduced decisions to admit patients by 7%)

<https://www.morecambabayccg.nhs.uk/about-us/publications/governing-body/governing-body-meetings/mbccg-2022-governing-body-meeting-papers/15-february-2022/2446-agenda-item-12-0-ccg-performance-report-appendix-a-1/file>

BCF funding has also supported the following community (admissions avoidance and D2A) schemes, including:

Rapid Response; Pulmonary Rehab; Therapy Services; Falls; Community Stroke service; Care Homes Support Team; Intermediate Care (dementia); 2-hr Urgent Response etc as well as Alcohol liaison and Alzheimer's Society programmes



## Supporting unpaid carers

Support for unpaid carers is of critical importance in enabling people to continue their caring role, and for new carers to have the care, information and support they need to take on caring responsibilities. The Lancashire BCF contains funding for the Lancashire Carers Services which is commissioned to support informal carers, developing carer support plans including setting out contingencies including the Lancashire 'Peace of Mind for Carers' service. It is also recognised that during and following the covid pandemic, the opportunity for unpaid carers to be involved in hospital discharge planning was more limited, due to the visiting restrictions which meant they became less visible to ward staff and as a consequence of the requirements to free up hospital beds quickly. Using the IBCF, short term funding has been identified to site carers services staff in the Lancashire ICAT/CATCH teams who have responsibility for hospital discharge and avoidance as well as access to intermediate care services, and this is improving the visibility of carers in the discharge process and supporting them to have a greater voice.

Other services commissioned as part of the Lancashire Carers service include:

- Specialist 1-1- and group support, including workers skilled in mental health, dementia, working within the black and minority ethnic (BME) community and health services
- Support to take a break including activities, courses and the Carers Caravans discounted holidays
- Respite provision through the Sitting in Service & Befriending
- Carers Help and Talk (CHAT) Line
- Information and signposting to other support services
- Support to access community, health & wellbeing services
- Volunteering opportunities
- Carers Awareness Briefings to professionals and organisations

The BCF funding supports also respite for carers, both residential and homecare for the cared for person, as well as other options which may give carers a break. The Lancashire County Council Hospital Discharge Home Recovery scheme supports unpaid carers who want to care for a loved one on discharge from hospital but there are some barriers to them being able to do so. The scheme offers short term (up to 6 weeks' worth) personal budgets to unblock the barriers and enable people to deliver informal care. The scheme has influenced national NHS England and Personal Budgets for Hospital Discharge policy and was a finalist in the 2022 Local Government chronicle awards

## **Disabled Facilities Grant (DFG) and wider services**

As the upper tier Local Authority, Lancashire County Council passports the DFG directly through to the 12 Lancashire District Councils with responsibility for housing. All Districts operate the DFG in line with the regulations, and where possible, using Regulatory Reform Orders, they use elements of the funding more flexibly.

Lancashire County Council and the 12 Lancashire Districts are commencing work to pull together a health, care and housing strategy and use of the DFG will form an integral part of that.

The long standing inclusion of District Council officers at Lancashire BCF programme group and strategic group level is critical to ensuring that the wider view of addressing determinants of health is considered in BCF planning and that the best is made of the roles all partners can play.

The BCF supports the community equipment spend, both that of complex and bespoke pieces of equipment tailored to individuals to the lower complexity items of equipment which are prescribed under the 'retail model'. Single Handed Care is a key element of the way care is planned and supported, and the Lancashire County Council Moving with Dignity team undertake single handed care assessments and support people and care providers to move to the most up to date moving and handling techniques and equipment. The Minor Adaptations service provides support to citizens who need small adaptations such as small ramps or door widening or additional stair rails in order to remain in their own homes.

In common with other localities Central Lancashire funds support from a care and Repair agency that works 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.

Morecambe Bay provides two examples of how integration with housing through Integrated Care Communities has positive outcomes.

### *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. Local, weekly service meetings enable, for example, tactical responses to expected increases in homelessness, fuel poverty, nutrition and hypothermia across autumn/winter 2022-23.

### *The Well – Lived Experience Recovery Support*

The Well is supported by Morecambe Bay CCG 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.

## **Equality and health inequalities**

Addressing inequalities and ensuring health equity is critically important. Lancashire and South Cumbria has set up a Health Equity Commission, chaired by Michael Marmot.

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 & ICB.

Its 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

The Lancashire BCF currently supports a range of services that are provided to support people to remain safe and well in their own homes and improve and maintain their independence.

The ICB Place boundary review will improve opportunities now to level up some jointly commissioned services to be delivered consistently across the Lancashire footprint.

Population Health data and the Director of Public Health's annual plan tell us that we have a mixed picture in terms of health outcomes and life opportunities across the County. -

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.