Thriving Communities Together

South Cumbria

2024/25
End of Year Review

Contents

Foreword

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Welcome to our South Cumbria Place Partnership end-of-year review. For the first time, we are pleased to share a summary of some of our fantastic projects. As this is our first look back at our progress as a place partnership, we've also included a few pieces of work that commenced in the later part of 2023/24.

We live and work in a beautiful part of the world, but we face significant challenges. Some people live in highly deprived communities whilst others live in remote, rural areas. We have a high proportion of elderly residents, but we also have wide variations in life expectancy across our population.

A large proportion of our residents are living with long-term health conditions, including mental illness. However, we have a lot to celebrate. We have a wonderful sense of community and people in South Cumbria have a long history of working in partnership to tackle issues together.

Our mission for the South Cumbria place is centred around supporting and enabling communities to thrive, and we chose our priorities for 2024/25 by thinking about the needs of our residents and the common challenges facing our partners. We wanted to start to address complex, long-term challenges that cannot be tackled by a single organisation or sector working alone.

Our mission is to support and enable our communities to thrive, by working together with compassion, openness and respect, to improve the health and wellbeing of everyone in South Cumbria.

This review describes some fantastic examples of our progress across a wide range of themes including promoting independence and avoiding unnecessary hospital admissions, using our Integrated Care Communities to support our communities in a way that is tailored to their specific needs, taking specialist respiratory care out of a hospital setting and into communities, and supporting people into work, particularly encouraging young people to consider a career in health and care.

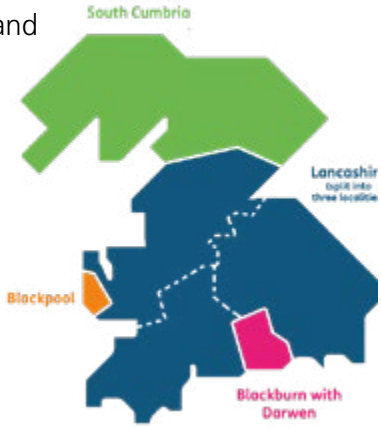
We have formalised our Place Partnership a little more this year, continuing to hold a monthly Place Partnership Forum which has covered many different topics and stayed true to our goals of being resident focused, collaborative in our design work, and delivering integrated health and care.

This year we have also established our quarterly Place Partnership Board, which bring key partners together for collective decision-making. It is evident that working relationships between professions, organisations and sectors in the South Cumbria place are strong, vibrant and highly valued, and that we share an ambition to improve the health and wellbeing of our residents. That is what makes our partnership so successful and so enjoyable to lead.

We would like to say a big thank you to everyone who has played a part in our place-based delivery this year.

Our South Cumbria place

Our place is part of the Lancashire and South Cumbria Integrated Care Board footprint. We have a resident population of over 186,000 living in a large coastal and rural footprint. Westmorland and Furness is England's most sparsely populated local authority area, which often makes it more difficult to deliver services and to provide public transport and transport connections.



- 16% of our population lives in the most deprived 20% of areas in England. In Barrow and Millom, this rises to 43%. We also have very affluent areas, with many second homes owned privately and by the holiday industry.
- There is 11- to 18-year variation in life expectancy depending on gender
- There is up to 15-years variation between life expectancy and years spent in good health for both men and women living in Cumbria.
- Our place has the highest proportion of residents aged 65+ in the Lancashire and South Cumbria system and inward migration of older people for retirement.
- 40% of our population has one or more known long-term conditions and 18% have two or more known long-term conditions.
- Suicides in Barrow-in-Furness are significantly higher than the national average at 19.2 per 100,000 people. The average rate across England is 10.4 per 100,000 people
- There are significant workforce challenges with an outward migration of young people to pursue work opportunities outside of the county.

The South Cumbria place is not co-terminus with any local authority. Since the formation of unitary authorities from April 2023, the South Cumbria place includes:

- The geography of Westmorland and Furness Council, excluding the previous Eden District.
- Some of the previous Borough of Copeland (around Millom) which is within Cumberland Council.
- Some of the previous District of Craven (around Bentham) which is within North Yorkshire Council.

We work on a 'place+' (Morecambe Bay) footprint into North Lancashire (around Lancaster, Morecambe, Carnforth) for care pathways involving our NHS Foundation Trust (e.g. urgent and emergency care, mental health), for palliative and end of life care with St John's Hospice, and across general practice through the Morecambe Bay Primary Care Collaborative.

We also work on a pan-Cumbria footprint for programmes of work involving county-wide organisations such as Cumbria Fire and Rescue Service, Cumbria Constabulary and with groups such as Cumbria Strategic Partners.

Our priorities for 2024/25

In setting our priorities for 2024/25, we considered several key drivers:

- The voice of our residents and those with lived experience
- The needs of our residents as set out in the Joint Local Health and Wellbeing Strategies of Westmorland and Furness Council, Cumberland Council and North Yorkshire Council
- The common challenges facing partners in place (which we identified through our Place Partnership Forum and our Place Partnership Board)
- The expectations of the Lancashire and South Cumbria Integrated Care Board for delivery on a place footprint
- The expectations of the Lancashire and South Cumbria Integrated Care Partnership as set out in the Integrated Care Strategy

After wide engagement, we agreed that we would work together as partners on:

- Population health and prevention
- Integrated Care Communities
- Promoting independence, avoiding unnecessary hospital admissions and reducing length of stay in hospital
- Intermediate Care
- Integrated Wellness Centre
- Mental Health
- Children & young people's mental health & emotional wellbeing
- The Bay Anchor Network
- Workforce
- Work and Health
- Barrow Rising
- Dying Well – Palliative & EoLC
- Women's Health and Wellbeing

Underpinning all of these would be engagement with our residents and communities.

Neighbourhood working tailored to support local communities

An integrated care community (ICC) is a collaborative network of health and care providers working together to deliver comprehensive and coordinated care to a specific population. The goal of an ICC is to improve health outcomes, enhance patient experience, and ensure efficient use of resources by proactively managing care and providing an integration function across different sectors, including primary care, community services, social care and voluntary organisations.

ICCs were introduced as part of the NHS Vanguard programme (2014-17) to fill a gap in delivering personalised and proactive care and to provide enabling at a neighbourhood level to ensure coordination and collaboration of effort in local communities of practice i.e. health, social care, public health and VCFSE partners working on the ground with their local populations. The model evaluated well and has been re-commissioned and grown, bottom up, to both reflect the differences in local communities and, laterally to build and grow the population health management offer in the context of existing and changing health and care offers and the assets and challenges in local communities.

Each of our Primary Care Networks (PCN) and/or Integrated Care Communities has undertaken work on outreach and inclusion projects that are tailored to the needs of their own residents. Outcomes from these project will be reviewed in early 2025/26.

Barrow-in-Furness

Barrow Primary Care Network

Barrow PCN chose to continue piloting the Enhanced Health Check approach. They have focused on residents aged over 40, living in the 20% most deprived communities and who have not engaged with their GP practice in the last 12 months. Their focus is initially on those who would benefit from an NHS Health Check or support for a long-term condition, learning disability or severe mental illness who have not engaged with the current primary care offer. They then moved on to those patients who are at risk of having undetected health needs but who are not engaging with, or seeking support from, primary care.

The PCN is using social prescribers to contact and engage with patients, delivering health check activity in the patient's home or in a community setting. This also provides an opportunity for signposting and onward referral to social or health related services and support.

Following their social prescriber contact, the patients are invited into the practice for a clinical appointment. This is offered within both core and extended hours to suit the patient.

Healthier Streets in Barrow

Healthier Streets is a collaborative project between Love Barrow Families, the University of Cumbria and the Health & Society Knowledge Exchange (HASKE) in which Barrow ICC has been a key enabler. It focused on two wards in Barrow-in-Furness which have high levels of deprivation as well as high numbers of attendances to the Emergency Department and high numbers of non-elective admissions to hospital.

Engagement with the local community identified:

- Difficulties accessing GP, partly due to digital exclusion
- Difficulties accessing dental care due to a lack of services and long waiting lists
- Mental health issues, including self-harm and substance misuse particularly amongst young adult females
- Respiratory issues such as chronic obstructive pulmonary disease (COPD), often due to poor housing conditions or smoking/vaping behaviours

Ten residents living on the targeted streets were recruited to join the project. These individuals selected their own role title as 'Community Health Development Champion' and were supported to engage with the other residents, support them, and to build trust and relationships within the community. Local residents identified priorities and activities were put in place to address these. These included litter picking, a local health festival which included some opportunities for health checks, a focus on oral health and awareness about risks associated with vaping.

There were observed improvements in the residents' health and wellbeing:

- Some residents reported a reduction in drug and alcohol use by engaging with GP about mental health issues.
- Some residents, including young people, reduced their consumption of energy drinks.
- Blood pressure checks conducted through the Be Well pop-up sessions have resulted in some residents accessing their GP for medication.
- There is more awareness amongst the community about health and wellbeing e.g. the implications of high/low blood pressure and the links with chronic obstructive pulmonary disease or stroke.
- Residents have been empowered to make changes to their lifestyles and improved their health e.g. through adopting healthier eating habits and taking regular exercise, or taking medication prescribed by the GP.
- For some residents, an increase in self-confidence has been observed, along with pride in the changes they have made.

Based on the qualitative analysis so far, Healthier Streets has aligned with national and local aims to reduce health inequalities for adults and children.

Next steps include analysis of health data during the timeframe of the project (e.g. data about Emergency Department attendances and non-elective admissions)

Happy Hopeful Hindpool

The South Cumbria place and the Barrow ICC has worked with Cumbria Police on a national, multi-agency partnership tactic called Clear, Hold, Build which is designed to tackle serious and organised crime and rebuild neighbourhoods affected by this. The challenge in Hindpool related to drug offences and county lines.

The three-phase initiative, known locally as 'Happy Hopeful Hindpool' included police action to clear target criminals and their associates, supported by a persistent police presence and intelligence led operations to hold the community. The build phase includes action by partners and residents to improve the health & wellbeing of residents in Hindpool ward, responding to health concerns, social issues and community needs.

Through the Barrow Integrated Care Community, the project has focussed on increasing awareness of support for substance misuse/recovery & mental health crisis support. The project has increased the number of residents registered with GP practices, thus increasing their access to prevention services and health and wellbeing support.

Self-harm in Barrow

There is a significant pattern of self-harm within the priority wards of Barrow-in-Furness, driven by numerous complex factors. We have focused on three key areas:

Starting Well - One school approach. This included wrapping support around families, reducing the burden of paperwork and developing a more relational approach to care services. Local stakeholders have shared information and ideas on supporting families, identified young people who are at risk of self-harm in the future, and improved education for parents and young people.

Living Well – Improve access & knowledge. The workstream focused on supporting people with known self-harm behaviours. Actions have included partnership working with SAFA (Self Harm Awareness for All), positive social media campaigns, and the development of an online community. Community champions are now being developed across all the partner organisations.

Ageing Well – Reduce loneliness & isolation. Through engaging with the community, we discovered that, alongside known patterns of self-harm within young people, there were less visible forms of self-neglect, particularly within older and more socially isolated residents. Stakeholders have come together to improve access and knowledge of local services that can provide support, increase access to activities for isolated individuals and improve access to day care and befriending services.

Mid-Furness

Mid-Furness Primary Care Network

The mid-Furness PCN focused on residents within the Ulverston East and Dalton-in-Furness wards. These residents have higher levels of deprivation, higher prevalence of long-term conditions and the poorest engagement with primary care.

The first cohort selected was patients who have not engaged with their practice to receive a learning disability, severe mental illness or Adult Health Check. The second cohort was all patients aged over 40 in these wards who have not received an NHS Health Check.

Patients were identified and triaged based on known health issues and risks. The PCN and ICC have organised pop up sessions in the Dalton and Ulverston East areas, linking with planned ICC engagement activity, including:

- The Big Baggy T-shirt Club, which is a beginners circuits class for those new or returning to exercise. Sessions are aimed at men and women with a BMI of 30 or over. The club has been such a success that there was a re-launch for Autumn, and it continued through until January 2025.
- The PCN completed 155 NHS health checks and learning disability checks in the Duddon Valley area, with individual practices supporting activities in their own footprints.
- Extended hours are being explored with PCN practices to ensure the clinical element of any health check activity is accessible to people who are unable to attend within working hours.
- The ICC/PCN is working with MIND Men's Group focusing on the SMI yearly check up.

Kendal

Kendal Primary Care Network

Kendal PCN identified a specific concern about children and their families who are experiencing higher than usual difficulties in emotional and relational stress but do not meet the criteria for CAMHS type intervention.

They used a variety of approaches to offer greater support, including:

- GP / Nurse offering appointments with a Social Prescriber who has experience of CAMHS
- The parent and child having a one-to-one consultation to understand the pressures and triggers for the child and family.
- As a complement to other available service options, families were offered the option of 'I Matter' Training focusing on their own understanding and skills to help their own child, with a follow-on offer of enrolment on an 'I Matter' course

The PCN has provided a training programme, expanding capacity within the existing 'I Matter' service. The core training mirrors the psycho/educational programme offered to parents and is delivered with a supported online programme. The PCN has started to progress to the next stage for professionals called "Relationship Health in Professional practice".

Their aim has been to address the skills gap in workforce, addressing wider workforce development need and provide a structured pathway offering an opportunity to become a Link Relationship Health Practitioner (who can identify people with readiness) or a Lead Practitioner (supporting people through the programme).

Living with long term conditions and frailty in Kendal

Kendal ICC has launched a campaign to support older adults living in supported accommodation. With the aid of supported housing providers, the team has organised a series of health check drop-ins usually in communal lounges. The team organise and promote the events alongside the scheme managers. The aim of the drop in sessions is to provide accessible and proactive health interventions.

Alongside the Older Adult Social Prescriber from the PCN, the ICC core team offers blood pressure checks, ECG screenings and tailored wellbeing advice. These sessions encourage residents to invest in their health and embrace a healthier lifestyle by promoting local support services and distributing educational materials. By bringing healthcare into familiar community spaces, this initiative empowers older adults to take control of their own wellbeing while fostering connections to wider health and social care networks.

Western Dales

Western Dales Primary Care Network and East Integrated Care Community

Western Dales PCN in conjunction with East ICC commenced the Farming Friendly Healthcare project in April 2024, with a focus on rural, farming communities.

The project aimed to:

- Listen to and engage with the farming community; establish 'what is happening for them from their perspective'.
- Identify barriers to access and consider practical solutions.
- Challenge assumptions and misconceptions.
- Ascertain how we can better support agricultural communities.
- Seek clarity on services and support available for farming communities

The team has engaged with agricultural communities via face-to-face interactions at the auction mart / agricultural sales, as well as having 'kitchen table' conversations. This has enabled people to tell their stories and made invaluable connections with interested parties and agencies both locally and nationally.

Emerging themes were:

- Addressing cardiovascular risk factors (diet & exercise)
- Considering environmental risks to respiratory health within the farming community
- Women's Health in farming
- Frailty in Farming
- Late presentation from the farming community for cancer and other long term health conditions

A report has been produced making 18 recommendations on how primary care and wider partners can improve and adapt their offer to support rural communities.

This groundwork has enabled us to build an active partnership with Lancaster University, which is planning to undertake research in this area. The overarching aim of their study is to generate new substantive knowledge about farming households, identify distinct sub-groups regarding farmers, farm households and farm business characteristics, and subsequently identify patterns in policy engagement and health vulnerabilities.

Millom

Millom Integrated Care Community

Prescribing data indicated that there were a significant number of patients who were taking a higher dose of prescribed opiate medication than is regarded as clinically safe.

General Practice, together with partners are working up a proposal to develop a local Pain Café as part of broadening the support offer to a more bio-psycho-social model. This will be supported by Cumbria Addictions Advice & Support (CADAS) and two members of staff who have accessed specialist training via 'Flippin Pain'. The ICC clinical lead has identified 'expert by experience' individuals who will work with the ICC and PCN to develop a peer led pain café which will commence in May 2025. In addition to quantitative measures of reduction in prescribing of opiates, we expect to use some measures of wider wellbeing over time to generate evidence of impact.

The Pain Café will run monthly until April 2026, and evaluation will commence later in 2025 to learn from our experiences to shape future plans.

Grange and Lakes

Grange and Lakes Primary Care Network

The Grange and Lakes PCN chose to address cardiovascular risk in hard-to-reach cohorts. These included focusing on:

- Patients who have fallen outside of the cardiovascular chronic disease review process and who are socially isolated into their homes
- Migrant hospitality workers who live and work in the Lake District but who are not registered with the GP practice and able to access local services.
- Agricultural workers, who are less likely to access services due to the nature of their work and their professional culture.
- The elderly and socially isolated. Although a more affluent population, many elderly residents in South Cumbria retire to the area but lack the community connections and support of residents who have lived in the area long term.

The PCN has carried out case finding searches and engaged with around half of the identified patients. Each patient has received a health check, which is fantastic progress.

Pain management and reducing opioid prescribing

The South Cumbria and wider Morecambe Bay area was identified as an outlier for high doses of opioid prescribing. The Opioids Aware project seeks to improve prescribing of opioid analgesia. There is little evidence that opioids are helpful in long term pain, and the risk of harm increases significantly above 120mg morphine (or equivalent) per day, without much increase in benefit.

As part of long-running work between the pain management team at University Hospitals of Morecambe Bay NHS Foundation Trust, the medicines management team at the Lancashire and South Cumbria ICB and a wide range of health and care providers in our place, there has been a significant reduction in high dose opioid prescribing between January 2022 and January 2025. Data shows a significant and sustained downward trend in opioid prescribing across the Morecambe Bay footprint.

This was achieved through:

- Regular participation and pharmacist input into the Pain Management Programme run by the acute pain nurses at University Hospitals of Morecambe Bay NHS Foundation Trust
- Collaborative working across secondary and primary care to ensure that patients initiated on reduction plans as inpatients are followed up and supported in primary care after discharge from hospital.
- Awareness sessions held with a range of health and social care professionals to advise on the use of opioids in chronic non-cancer related pain
- Work with individual practices to identify and maintain a list of prioritised individuals to support with a reduction plan

At Waterloo House surgery in Millom, there has been a massive reduction in high dose opioid prescriptions. The team focused on patients who had been prescribed high dose opioids for long-term chronic pain. Starting with an initial in-depth conversation with the patient, followed by regular contact every two to four weeks, the GP was able to initiate and complete reduction plans. To support this, opioid medication was removed from repeat prescriptions to make it necessary to engage with a healthcare professional to access further supplies.

It is anticipated that this success will be enhanced further with the start of a Pain Cafe in Millom in early 2025/26.

Supporting people to stay well at home

It is well known that unnecessary admissions to hospital and a prolonged length of stay in hospital can lead to de-conditioning in older people, resulting in an increased need for health and social care support on discharge. However, many people stay in hospital longer than necessary. This can be due to a wide range of factors. It is important that we work together as partners to ensure that people return to their usual place of residence as quickly and safely as possible as soon as they do not require consultant-led care in an acute hospital setting.

Our place partners committed to tackling this challenge through a range of projects, with a key measure of impact being the number of people who were considered medically fit to be discharged from University Hospitals of Morecambe Bay NHS Foundation Trust but who were not able to return to their usual place of residence. This work was coordinated through the Morecambe Bay Urgent and Emergency Care Delivery Board and Westmorland and Furness Council's Promoting Independence and Wellbeing Programme.

Three areas of focus were identified to reduce the c. 150 beds that were occupied on any given day by people who no longer required consultant-led care in an acute hospital setting.

University Hospitals of Morecambe Bay NHS Foundation Trust and place: 50 beds

- Therapy redesign: Improving efficiency and patient outcomes by redesigning therapy services.
- Community services: Enhancing community services to support patient care outside hospital settings.
- Integrated wellness centre / service
- Deflection strategies: Implementing strategies to manage patient flow and reduce unnecessary hospital admissions.
- Morecambe Bay Respiratory Network: long term respiratory condition management

Local authorities and place: 50 beds

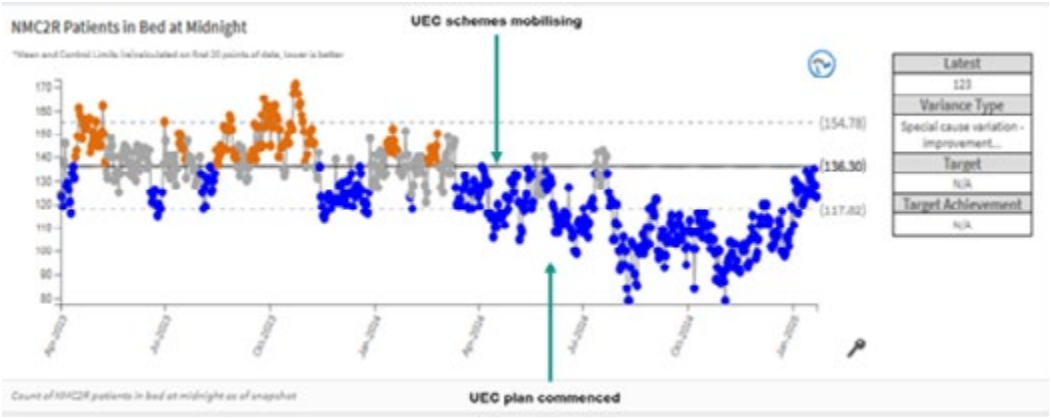
- Intermediate care: Opening 18 intermediate care beds in Barrow by August 2024 as part of the Promoting Independence Strategy.
- Hospital home care: Transforming hospital home care services to focus on reablement by December 2024.
- Supported housing: Redesigning supported housing for aging well initiatives in Cumberland and North Yorkshire.

Primary care and emergency department demand: 50 beds

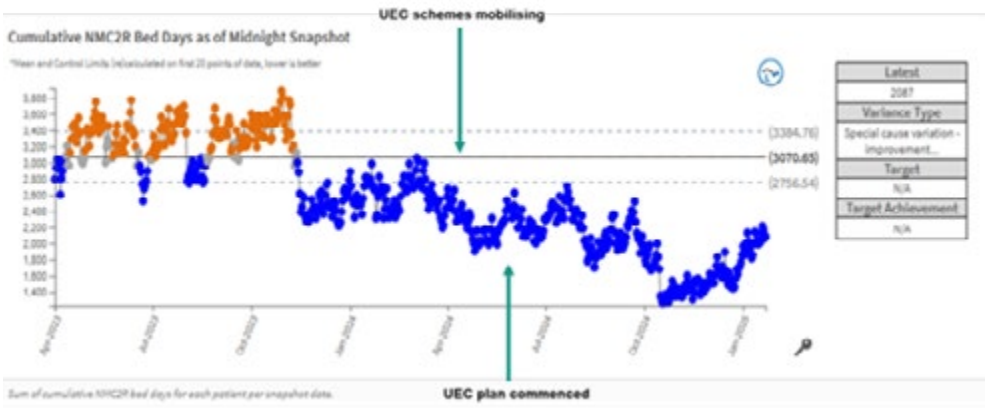
- Primary care enhancement: Addressing the 25% increase in emergency department presentations with improved primary care interventions such as acute respiratory infection (ARI) hubs.
- Strategic estate planning: Developing clinical spaces for the Additional Roles Reimbursement Scheme (ARRS) practitioners.
- Working with VCFSE: establishing 'Take Home and Settle' for South Cumbria

For the South Cumbria place team, key initiatives included the opening of Intermediate Care beds and the establishment of an Integrated Wellness Centre. Together, all of our projects across University Hospitals of Morecambe Bay NHS Foundation Trust, our councils, the voluntary, community, faith and social enterprise (VCFSE) sector enabled an improvement in the numbers of people who were in a hospital bed but no longer required acute care.

This can be seen during the summer/autumn of 2024/25 but as demand increased during the winter, the absolute numbers returned to baseline in December 2024 / January 2025.



However, the total bed days occupied by patients in a hospital bed but no longer required acute care has reduced, with the graph showing a significant reduction from 2023/24 across 2024/25.



Intermediate Care

Launched as a partnership between the NHS Lancashire and Cumbria Integrated Care Board, University Hospitals of Morecambe Bay NHS Foundation Trust and Westmorland and Furness Council, the intermediate care facility opened in August 2024. This was the result of a review which highlighted a lack of provision for people leaving hospital, but who needed a higher level of support than could be provided at home to help regain or maintain their independence.

The intermediate care bed facility, hosted by Parkview Gardens residential home in Barrow, provides single en suite rooms and is a place for people who no longer need specialist hospital care, but still require support, to regain their independence in a residential setting before returning home.

The service offers embedded therapy support to mobilise patients out of their bed and improve mobility to aid and improve their transition back to their independent place of residence and prevent further emergency admissions. The service will also provide several planned respite beds for short-term support, which will afford full time carers an opportunity a break from their caring responsibilities. Once all beds are open the service will also offer 'step-up' support for people in the community who need a short period of bed-based care, who might otherwise need to be admitted to hospital or long-term residential care.

Feedback from people staying at the facility, which has been fully refurbished, includes "how happy" they are with the "quieter and more homely atmosphere" and families are "really pleased" with their relatives' ensuite rooms and the progress made whilst at Parkview.

Between August 2024 and January 2025, 63% of people have returned to their own homes and 30% have gone to residential or nursing placements. Just 7% have been re-admitted to an acute setting. The average length of stay for those who returned home was 19.2 days and the average length of stay for those who went into long term care is 29.6 days. Early indications suggest that this initiative has had an impact on the number of people do not require consultant-led care in an acute hospital setting but remain in a hospital bed.

Integrated Wellness Centre

We partnered with University Hospitals of Morecambe Bay NHS Foundation Trust to investigate patients with multiple hospital admissions and extended stays. Our focus was on those with more than three admissions in a year and a cumulative hospital stay of over 200 days.

Our findings showed that in 2023:

- 835 people had 3 or more unplanned admissions to Furness General Hospital
- 11% of patients admitted to Furness General Hospital accounted for 28% of unplanned admissions and 31% of bed days
- 50% of readmissions occurred within 4 weeks and 75% within 8 weeks
- 52% of these unplanned admissions were from 6 postcode areas. These were areas of highest deprivation.
- The highest number of admissions was in the age groups 70–79 and 85+

This showed that we could use a highly targeted approach to understanding the reasons for multiple admissions and long lengths of stay in hospital, and to designing the support that was needed to enable people to maintain their independence and stay well at home.

With agreement from our patients, a multidisciplinary team reviewed the health, wellbeing and social circumstances of a small group, to better understand how we can work together across different agencies to support people and their families at home and avoid unnecessary and lengthy stays in hospital. We wanted to ensure that people received support earlier, to reduce the risk of deterioration and to encourage their independence.

Our analysis revealed a common starting point: falls. Each patient had experienced a fall and had carers who could have benefited from additional support. Despite being known to Age UK, none of the patients were receiving their assistance at the time. They also had multiple GP visits and frequent emergency department attendances.

By delving deeply into these cases, we identified potential preventative measures that could have avoided hospital admissions and deterioration. Key areas included:

- Bespoke Support at Home: Combining health care, carer support, therapy, and equipment to prevent falls.
- Medicines Management: Ensuring appropriate medication use.
- Social Care and Connectedness: Addressing social isolation and providing carer support to enhance overall well-being.

As a result of our findings, we tested an Integrated Wellness Service, focusing on residents who had three or more unplanned admissions to hospital in the past year. Holistic assessments were undertaken by our Integrated Care Community case workers, with regular case review meetings to agree how best to provide wrap around support. These include doctors, nurses, pharmacists, therapists, social workers and the voluntary sector. Continuity of care for the patient was invaluable in building trust and ensuring timely access to support.

The cohort of patients in the test of change was compared with a control group to study the impact on readmission rates and evaluate the effectiveness of bespoke support. For our selected cohort in the two months following our interventions,

the number of unplanned hospital admissions reduced by around 40%. We were able to signpost 50% of people to offers of support from the voluntary sector, designed to support the individuals and their carers.

Based on these findings, we have expanded and refined our approach. We are currently recruiting to a dedicated multi-disciplinary team including a clinical lead, caseworkers and pharmacy technicians, and will be fully established in early 2025/26.

Ongoing partnership working to promote independence

Building on the success of conversations at our Place Partnership Forum and Care Professionals Enabling Group, the South Cumbria Place and Westmorland Furness Council brought together partners from statutory and voluntary organisations during March 2024.

Our collaborative focus was to consider two questions:

- What needs to be true to not admit a frail person presenting at the Emergency Department with normal NEWS2 and no defined need for consultant led care?
- What needs to be true for a resident who is elderly or living with disabilities to live well and independently of Adult Social Care support?

NEWS2 is a National Early Warning Score which uses a simple system where a score is allocated to six simple physiological measurements. The score is then used to determine the severity of illness and the need for intervention.

The event marked the launch of an ongoing collaborative group, the aim of which is to address the causes of high demand in the Emergency Departments of University Hospitals of Morecambe Bay NHS Foundation Trust, whilst supporting residents to have healthy, independent lives, in line with Westmorland and Furness Council's Promoting Independence and Wellbeing Programme.

Attendees spanned organisations and roles that support residents, including the Lancashire and South Cumbria Integrated Care Board, local council (Adult Social Care, Intermediate Care, Reablement, Commissioning, Housing), general practice, Integrated Care Communities, and the Integrated Wellness Service, as well as voluntary agencies, carers, regulated care, Lancashire and South Cumbria NHS Foundation Trust and the North West Ambulance Service.

A range of next steps was agreed with some work already progressed. Further events and more detailed, focused work is planned. Regular contact will be maintained with attendees and stakeholders, including those who couldn't make the first event, to support momentum and success in this important work.

Morecambe Bay Respiratory Network

The Morecambe Bay Respiratory Network (MBRN) is a comprehensive, end-to-end, integrated care model for patients with suspected or confirmed chronic respiratory disease in Morecambe Bay. Established in 2016, the MBRN brings together a multidisciplinary team across primary, community, secondary, and voluntary care sectors. The Network is dedicated to moving more care into the community, focusing on earlier intervention and support to keep citizens living well. It has fostered innovative care across primary, secondary, and community care, extending far beyond its original aims to improve respiratory health in the population. The MBRN supports wider population health measures by providing a cohesive approach for partner organisations to liaise and work with.

Objectives

The MBRN aims to deliver respiratory care in Morecambe Bay with a community-based multidisciplinary team (MDT) model. The Network contributes to population health measures by increasing access to respiratory healthcare services for patients who struggle to use traditional services. Working with system partners, the MBRN supports efforts to reduce the harmful effects of smoking and air pollution. The objectives include improving the quality and timeliness of diagnosis and routine management in asthma, chronic obstructive pulmonary disease (COPD), bronchiectasis, and interstitial lung disease (ILD). Additionally, the Network aims to improve access to respiratory therapies such as pulmonary rehabilitation, respiratory physiotherapy, occupational therapy, and behaviour change techniques. Reducing non-elective admissions for patients with chronic respiratory disease and improving access to specialist support at the end of life for patients with respiratory illness or symptoms are also key objectives.

Ecosystem

Developing the model has involved creating an ecosystem with a shared vision across primary, community, and secondary care. Core to this are the MDTs across Morecambe Bay, establishing common objectives enabled by funding and developed metrics. It is important that colleagues enjoy the work and feel part of a supportive network.

Successes

Key to the success of the MBRN has been taking respiratory services out into communities that need them most. This has included hosting pop-up health checks in various venues from community centres to local pubs! This has encouraged people to come forward for health checks who wouldn't otherwise have engaged with health and care services.

Patients registered with MBRN practices have shown a reduction in admissions for COPD, bronchiectasis, ILD, and asthma. MBRN practices refer less to secondary care, providing specialist review in-house with direct access to testing. Patients from MBRN practices who are eligible for specialist medications in ILD get diagnosed earlier and start therapy earlier. The MBRN Education Programme is well established, bringing together teams from across Morecambe Bay for integrated education via day-long conferences each year. Supporting patient support groups is an important part of the pathway, with seven Breathe Easy groups developed across Morecambe Bay.

MBRN practices in North Lancashire and Barrow have shown a reduction in SABA medications (a reliever inhaler which is used less if the patient's condition is better controlled, and which also has high CO2 emissions) compared to those practices in South Lakes who do not currently have access to an MBRN service and across the wider Lancashire and South Cumbria footprint.

MBRN practices have also shown a bigger reduction in overall respiratory medication spend.

Left shift in respiratory care

The experience of the past eight years has taught much about integrating care and fulfilling the ask by Lord Darzi to 'left shift' care. Integration is foundational, and moving care into the community requires education, support, and development of new ways of working. The ambition is to left shift all aspects of care from diagnosis to chronic disease management to complex and end-of-life respiratory support.

The Lancashire and South Cumbria ICB has confirmed its intention to continue to embed the MBRN model across the Bay, as well as applying the learning from this model to other disease areas.

Mental Health

During 2024/25, the South Cumbria Place continued its implementation of the Community Mental Health Transformation (CMHT) programme, with a significant number of local community initiatives. The programme aligns with the wider strategic direction for mental health across the Lancashire and South Cumbria Integrated Care Board and focuses on delivering a collaborative model which is recognised as good practice.

The Community Mental Health Transformation Programme

The key components of the CMHT programme are:

- Invest and develop community teams, with a greater emphasis on therapy.
- Investment in services in the voluntary, community, faith and social enterprise (VCFSE) sector with improved links across different providers and more multidisciplinary working
- Investment in peer support organisations
- Further investment to double the number of Health and Wellbeing Coaches (HAWCs) in South
- Cumbria building on the current Public Health offer
- Investment in up to three Mental Health workers in each Primary Care Network

Aim:
To better support people with severe mental health problems in their local communities and create a more accessible and flexible system by bringing together mental health services with GP practices, social care, the voluntary sector and community groups.

Our Community Mental Health Teams have:

- Increased capacity of the workforce
- Reviewed clinical pathways to ensure CMHTs can respond to patient need
- Upskilled CMHT practitioners to enable a move from a 'monitoring' role to providing 'interventions' and treatment
- Introduced specialist practitioners to work with people who have a diagnosis of Personality Disorder
- Invested in the clinical leadership model
- Moved away from the care coordination model to a 'key worker' model, enabling better use of resources
- Introduced a clinical tool called 'Dialog Plus', enabling better care planning and measurement of outcomes
- Redesigned the physical health offer with a dedicated workforce.

Our Primary Care Networks have:

- Invested in Primary Care Mental Health Practitioners
- Been offered the opportunity for joint funding for Primary Care Mental Health Practitioners with Lancashire and South Cumbria NHS Foundation Trust.
- Completed the roll out of Band 7 practitioners and Band 5 assistant practitioners.
- Commenced the roll out of Band 6 practitioners
- Invested in eating disorder services
- Invested in rehabilitation services

Westmorland and Furness Council has:

- Established a Health and Wellbeing Team which uses a coaching approach to working with people aged over 16 who want to make positive changes
- Invested in staff to work across the Primary Care Networks to provide dedicated support to people with mental health challenges, focusing on personal resilience, socioeconomic and environmental factors, and developing person-centred plans that support people to live their 'good life'

Red Rose Recovery, our peer support provider has:

- Developed a workforce of people with lived experience who can become employed peer support workers to assist with crisis prevention, recovery and resilience for the local community.
- Offered support with confidence building, befriending and access to services

Examples of our impact and our ongoing schemes

We have worked with Mind in Furness to increase integration across a range of partners. A huge number of people have been supported through a range of innovative ways of reaching people in need of support. In just three months of 2024/25, support was available through:

- Evening Crisis Café - 129 clients with 554 attendances
- One to One support - 188 clients with1553 attendances
- Peer support - 158 clients with 558 attendances

This support has avoided Emergency Department attendances, reduced inpatient length of stay and reduced appointments with general practice.

We have a number of ongoing schemes related to suicide prevention and self-harm across all age groups, including:

- Starting Well: Greater support for families where children are self-harming and awareness campaigns within schools and dedicated school champions
- Living Well: Increasing awareness of local support offers for those considering or undertaking self-harm, with community champions
- Ageing Well: Reducing loneliness and isolation through day care services and befriending offers.

We are supporting children and young people (aged 0-25 years) by:

- Implementing the transition policy creating a patient centred not database centred pathway
- Creating a step-by-step process to ensure the transition from children and young people's services to adult services is seamless and that joint working is taking place.
- Completing a workforce review to ensure staff are trained and able to meet the needs of the young people they are supporting.

Next steps for 2025/26

We will continue our work on an all-age approach, particularly focused on implementing a 0–25 age pathway across key areas such as self-harm, suicide prevention, care leaving support, cooccurring conditions and family support structures.

We will encourage more lived experience voices as this has proved to be essential in evaluating the effectiveness and value of the mental health service offers in our place.

We will review and improve our flows both in and out of hospital to better enable individuals to access the right care at the right time and in the right place, preventing unnecessary admissions and delayed discharges and delivering enablement, prevention and early intervention in community, with increased patient self-support.

Bay Anchor Network

The Bay Anchor Network is a community of common interest where Anchor organisations collaborate to foster sustainable, prosperous, and healthy communities. The Network's purpose is to support these organisations in identifying, developing, and sharing ways to positively influence and contribute to the health and wellbeing of communities, as well as the broader social, economic, and environmental factors that support healthy living.

The Network achieves its goals by helping each organisation to strengthen its role as an anchor in the community. This is done by working through the anchor framework to make progress on various domains and identifying areas for improvement. Additionally, the Network provides a platform for organisations to collaborate on common aims, objectives, and projects.

Key functions of the network

The Bay Anchor Network enables partners to:

- Increase their understanding of social value priorities for communities and how their organisation can contribute to these priorities, either directly or indirectly.
- Mobilise collective action as opportunities arise from both internal and external sources, such as funding or research bids, to leverage change.
- Support each other in delivering agreed priorities, both individually and collectively, especially when working across different sectors to ensure complementary fit across projects.
- Share learning and best practices.

The Bay Anchor Network Charter

The vision and values of the Bay Anchor Network Charter include:

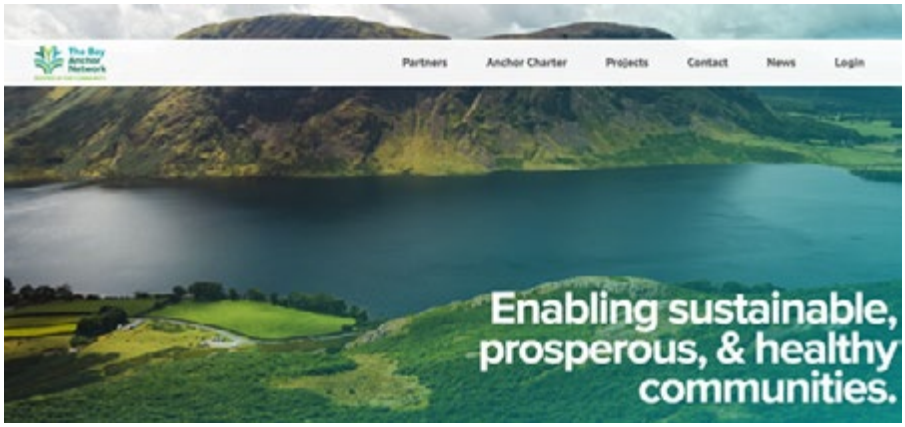
- Employing, developing, and investing in a workforce representative of the local population.
- Providing stable and fulfilling jobs, fair pay, and excellent working conditions.
- Using procurement and commissioning to create local social value and increase community wealth.
- Supporting local charities, community groups, and businesses through access to land and buildings.
- Working in an environmentally sustainable manner and influencing sustainable local practices.
- Providing access to communal green spaces and cultural spaces for every neighbourhood.
- Supporting local collaboration, listening to residents, and empowering the community.
- Purposefully addressing health and other inequalities wherever they exist in the community.

The Bay Anchor Network has made significant progress in several areas:

- Covering multiple planning and administrative footprints, allowing diverse teams and organisations to connect.
- Being self-directed, with priorities selected by the community of common interest rather than being mandated.
- Receiving sponsorship from the NHS and Local Authority, with a small operating budget secured for the next three years which we plan to use to host a number of networking events with guest speakers.
- Regularly sharing learning and opportunities between partners in a constructive environment.
- Starting to showcase and share good work and opportunities.
- Demonstrating clear examples of collaboration and impact through the Widening Access to Quality Work agenda.
- Benefiting from significant investment into areas such as Energy Coast, Defence, and Town Deals.

Development of the Bay Anchor Network website

In late 2024, the Network was supported by the former Cumbria Local Enterprise Partnership (now Enterprising Cumbria) to develop its own Anchor webpage. This has provided opportunities to share the good work of the Anchor partnership, both as individual organisations and as a network. The news section has been popular, and collaborative projects have also been shared.



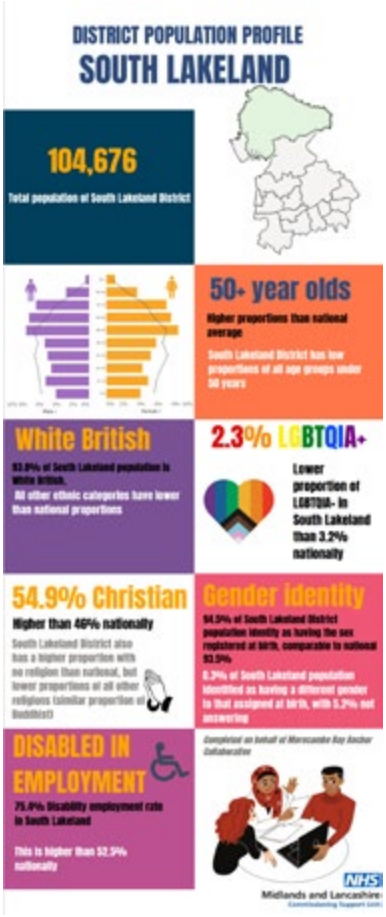
Developing Partnerships

The Network has worked on creating and encouraging wider partnerships, acknowledging that the power of Anchor organisations often lies in how they support other organisations. For example, while procurement processes may not always be within the gift of an Anchor organisation, supporting and facilitating smaller businesses with their procurement practices is something they can assist with. The Network has met with the Regional Supply Chain Network to work more closely with their partners, sharing ideas, knowledge, and opportunities in a mutually beneficial partnership.

Widening Access

The Widening Access Group aimed to understand whether the workforce of Anchor organisations is comparable to the demographics of our local population.

The group worked with the business intelligence team at the Midlands and Lancashire Commissioning Support Unit to produce local information packs based on key workforce data sets. These packs included in-depth population data for each district and enables partners to input their own workforce data to track employee demographics against local populations. This exercise provided valuable insights and informed recruitment and HR processes across our Anchor organisations.



Anti-Racism Network

Formed by Anchor Partners who wanted to tackle racism within communities, the Anti-Racism Network aims to:

- Collaborate to develop and deliver a united anti-racism campaign addressing behaviours and attitudes in the community.
- Take proactive steps to clearly articulate unacceptable behaviours.
- Raise awareness about reporting mechanisms in the community to encourage more informed data.
- Involve staff networks where appropriate to ensure lived experiences and informed viewpoints shape actions.

Looking forward into 2025/26

The Network has identified several areas of emerging opportunity and interest, including:

- Social Prescribing: Improving access to non-medical wellbeing support, supporting social prescribers, and increasing green social prescribing.
- Improving recruitment and retention.
- Workplace health: Health in all policies, active travel, women's health, mental health support.
- Social Responsibilities: Green staff champions, childcare and young family support, volunteering and work experience.
- Inclusion Health: Health and support in agricultural communities, health and wellbeing in the hospitality sector.

Workforce

During 2024/25, we continued to work across a range of public and private sector partners to attract people into work in South Cumbria, particularly to consider a career in health and care, as well as working with employers to support their workforce to stay healthy and thrive in work.

Engaging with teachers and with young people to increase awareness around the wider range of professions and career opportunities in health and care.

In March 2024, we held our second '350 Careers in Health and Social Care' event, hosted by Furness College in Barrow. The event was run as a traditional careers fair, but with a twist – each of the stalls showcased different careers within the health and social care sector, rather than featuring individual employers.

The event was organised by the Careers and Engagement Team from University Hospitals of Morecambe Bay NHS Foundation Trust with the majority of careers represented by staff from the trust, including a wide range of clinical teams. We also had representation from Lancashire and South Cumbria NHS Foundation Trust (LSCFT), Westmorland & Furness Council, South Cumbria Place, North West Ambulance Service NHS Trust, Risedale Care Homes, University of Cumbria and Lancaster University.

The event was open to local schools and colleges, and across the day we hosted around 500 students from a range of schools in the Furness area, mostly from Year 10 upwards. The students were transported to the college by coaches which were generously funded by The Bay Hospitals Charity, which was key to involving as many local young people as possible.

Everyone had the opportunity to speak with professionals across a whole range of specialist areas and find out about many aspects of health and social care that may not be widely known.

The next 350 Careers in Health and Social Care event is being held in April 2025, again at Furness College, where we are anticipating a similar number of students to attend.

We also held a 'Teacher Encounter Day' in March 2024, which provided a perfect opportunity for teachers to engage directly with employers to learn about the different career pathways relevant to their subjects, and to observe how their subject is applied practically in business.

Implementing a Personalised Work Passport to support people in employment with a disability or health condition.

The aim of this project was to bring together a wide range of supportive 'passports' into one easy-to-use document. The Wellbeing Passport aimed to enable employees to bring their "whole self" to work and to facilitate conversations with line managers about what matters to their wellbeing and how they can best be supported in work. The passport relied less on employees identifying themselves as a carer, having a disability, etc and focused more on what they needed their line manager to be aware of and what support they needed to thrive in work. We wanted to create a cultural shift in workplaces to focus on acknowledging employees are people with personal circumstances who may, at time, need additional support or adjustments.

A collaborative approach was taken to agreeing core principles and content, taking examples of great work from existing staff passports and engaging with staff networks across the organisations that are members of the Bay Wellness group.

The Wellbeing Passport has been launched in Lancashire and South Cumbria NHS Foundation Trust and will be adopted across our partner organisations.

The WorkWell Partnership Programme

The WorkWell Partnership Programme is a national initiative, led jointly by the Department for Work and Pensions (DWP) and the Department for Health and Social Care (DHSC).

The Lancashire and South Cumbria Integrated Care Board was confirmed as one of fifteen ICBs that was successful in bidding to be a WorkWell 'vanguard' within the national programme. The proposal from the Lancashire and South Cumbria ICB identified seven districts with high levels of economic inactivity that would pilot the WorkWell service, aiming to support around 5000 people over 18-months. One of these sites is Barrow in our South Cumbria place.

WorkWell is a light touch, early-intervention work and health assessment service which aims to provide holistic support to overcome health-related barriers to employment, and a single, joined-up gateway to access wider support services. Nationally, the requirements were that the service should aim to support people

aged 18 or over with a health-related barrier who needs support to remain in work, needs support managing a health condition in order to return to work from a sickness absence, or needs support to (re)start work and has been unemployed due to a health condition for approximately 6 months or less

In Barrow, we chose to focus on residents in priority wards in Barrow and employees within the BAE Systems Supply Chain Network and wider small and medium enterprises (SMEs) who do not have access to an occupational health offer in the workplace or who do not feel their occupational health offer meets their needs. The cohort of participants will therefore be drawn from people who are:

- Unemployed with a low-level health condition and who live within the Central, Hindpool and Barrow Island wards.
- Employed and currently in work, but at risk of sickness absence or leaving employment.
- Employed by an SME, but not currently in work due to sickness absence.

In designing the WorkWell service in Barrow, a core team was convened with partners including:

- Westmorland and Furness Council
- Lancashire and South Cumbria ICB, both core team and members of the South Cumbria Place team
- Department for Work and Pensions / Job Centre Plus
- MIND (Furness)
- Barrow Integrated Care Community (ICC)
- Barrow Thriving Communities Team
- Barrow Leisure Centre (MSK / Escape Pain Team)
- Inspira (employability skills expert, providing free professional careers advice and guidance across Lancashire and South Cumbria)
- BAE Supply Chain Network of SMEs
- Barrow Education and Skills Forum
- The Cumbria Local Enterprise Partnership / Enterprising Cumbria
- Healthwatch

The aim was to ensure that WorkWell was co-designed across partners, taking into account the lived experience of residents and those professions / organisations / sectors who are already engaged with and/or actively supporting those individuals who may benefit from the WorkWell service. We also used the South Cumbria Place Partnership Forum to consider a participant journey through the service, using a number of different 'personas' (based around real-life individuals in the Barrow area) to think about referral routes into the service, possible touch points with new and existing services, signposting to other support offers, and any onward referral routes.

After this comprehensive period of collaborative design work, the WorkWell service was launched in January 2025 in Barrow, based in the Barrow Leisure Centre. Led by Cumbria Health, the service has a team of WorkWell Coaches who are now offering personalised support for approximately 12 weeks which includes:

- a person-centred, holistic initial assessment to identify barriers to employment / challenges in work.
- the production of a return-to-work / thrive-in-work plan, with clear objectives that address physical, psychological and social needs – focused on individual aspirations and needs.
- advice for employers on possible workplace adjustments, with training for line managers.
- employer liaison, if the participant consents, to share the thrive-in-work plan and provide work related advice and support.
- personalised work and health support to take stock of progress and recommend further actions and activities.
- GP liaison, if the participant consents, to share the work plan and better support the Statement of Fitness for Work (Fit Note) process

Local data on the drivers for people being out of work indicated that mental ill-health and physical ill-health related to muscular skeletal (MSK) conditions were the biggest challenges facing our residents. Therefore, we have created partnerships with MIND (Furness) to deliver their guided self-help courses on themes such as anxiety, stress, loneliness, menopause etc., and the MSK service in Barrow Leisure Centre, with the intention of providing a wraparound service to support the delivery of the WorkWell pilot. Intended outcomes for WorkWell are:

- Employee returns to work or an absence is prevented
- Employee is prevented from leaving the workforce
- Employee is closer to returning to work and has the required knowledge / support in place to continue on that journey
- Participant returns to employment
- Participant is closer to returning to employment and has the required knowledge / support in place to continue on that journey
- Employers are better equipped to support employees who are off sick or who have a health condition in the workplace
- Employees feel better supported in the workplace
- More informed fit note processes
- The service joins up local services and ensures people are receiving the right support for their needs

National evaluation will take place later in 2025/26. We are keen to understand the impact on our residents as this could be a useful initiative to expand across our South Cumbria area, with support offers tailored to the needs of communities. Therefore, we are reviewing case studies and gathering participant feedback to gain valuable insight into what is proving beneficial and where we may need to make some changes.

Barrow Rising

Barrow-in-Furness is home to the nation's submarine design and build programme. It is the only place in the UK with the infrastructure, license, and skilled resources necessary to design and build nuclear-powered submarines. Barrow is central to the UK's national security strategy for decades to come. In October 2023, BAE Systems was awarded a contract to build AUKUS submarines, an international defence commitment that will take several decades to complete. This recognition highlights that submarine delivery is only possible with the right infrastructure, skills, and people.

As BAE Systems expands its workforce, we expect a significant number of people to choose Barrow as a place to live and work.

Barrow Rising is a collaborative approach that harnesses the skills, funding, and capabilities of the national government, local government, BAE Systems, businesses, and the community. This working partnership puts Barrow's community at the centre while ensuring the delivery of a vital government priority.

Crucially, it is supported by a significant financial investment of over £200 million, with dedicated funding for 'work and health' and 'social impact'.

Core objectives

- Enable and sustain the Defence Nuclear Enterprise in Barrow efficiently and securely
- Diversify and strengthen Barrow's economy and increase productivity

Strategic objectives

Sitting beneath these core objectives are a number of strategic objectives linked to the health and wellbeing of the population, and the economic prosperity of the town:

- Barrow offers prosperity to all and is a place where people love to live; recognised nationally as a prosperous and vibrant town known for its world-class engineering, heritage, nature and culture.
- The people of Barrow enjoy good health and can fulfil their potential, enjoying the best possible quality of life in strong, resilient and connected communities where people can flourish.
- Barrow offers businesses opportunities to invest and grow, encourages entrepreneurship and provides good and varied earning opportunities.
- Barrow offers a rich choice of excellent housing that is sustainable and affordable and meets the needs of a diverse community with a thriving town centre and cultural offer.
- Barrow's infrastructure facilitates its economic potential, improves connectivity, and provides confidence in its reliability.
- Barrow has a thriving education sector that creates opportunity for all and fuels its economy with increased quality, choice and routes into fulfilling careers.

Dr Simon Case, the former Cabinet Secretary and Head of the Civil Service, has been confirmed as the Chair of the delivery board. During his time in Government, Dr Case helped establish the Team Barrow partnership.

Recently, BAE Systems hosted a visit from the Prime Minister, and it was announced that His Majesty the King has agreed to confer the title 'Royal' to the Port of Barrow, in recognition of the town's undue role in guaranteeing the nation's security. Exciting times are ahead for Barrow!

Actions underway across the health, equity and wellbeing workstream

A number of projects have already been agreed, with many more to come in 2025/26:

- Workforce and population health improvement: Targeted actions that support people back into work, where health is a primary barrier.
- Increasing transformation and delivery capacity: Capacity and expertise are required to drive forward this work over the next five to 10 years.
- Anchor Network Operating Budget: To support the Anchor Network in engaging partners to support and deliver actions on a wider footprint than Barrow.
- Economic Inactivity Analysis: Commission a deep dive into economic inactivity in Cumbria which would inform both the use of the work and health fund and contribute valuable intelligence to the wider Barrow Delivery Board Programme.
- Work and Health Commission: Collaborating with local people to understand their perspectives on the barriers and opportunities to accessing quality work and to ensuring job roles create and support good health.
- Vulnerable Children's Needs Assessment: Commission a needs assessment to establish the bio-psycho-social needs for vulnerable young people, the gaps in service provision and the opportunities for integrated service redesign.
- Expanding Allied Service Capacity for WorkWell: Including: a) MSK conditions and pain management, b) Health and Wellbeing Coach (HAWC) capacity, c) Rapid access to behavioural support: Smoking, Alcohol, Drug, Gambling etc., d) Increased low level mental health support.
- Healthy and Inclusive Workplaces: Development of a Westmorland and Furness approach to healthy and inclusive workplaces, focusing on anchor organisations and employers in Barrow.
- Right-sizing Services: Ensuring that we can provide high quality and sustainable services that meet the needs of the growing population. This will include considering the estate available, and required in the future, for primary care in the heart of Barrow; mental health inpatients in Kendal and Barrow; and emergency care, maternity, diagnostics and elective care services in Barrow.

Palliative and End-of-Life Care

A local 'Getting to Outstanding' framework for palliative and end-of-life care was codesigned by commissioners, providers and patient representatives across Lancashire & South Cumbria. The local framework uses the six ambitions from the National Ambitions Framework to set out what 'outstanding' looks like for an exemplar patient journey, from the time of being identified as being within the last 12 months of life, through care and support, and into bereavement. The various components within each of the ambitions journey have been informed by the lived experiences of people receiving our local services, as well as the working experiences of caregivers delivering our services.

Local framework for delivering outstanding palliative and end of life care in Lancashire & South Cumbria

Across the Morecambe Bay footprint, an interactive, workshop-style approach was used to allow a wide range of partners and professions from the NHS, local authorities, hospices, and the voluntary, community, faith and social enterprise sector to:

- Complete the baseline self-assessment tool which enabled us to benchmark current services against the components of the exemplar patient journey.
- Identify areas for improvement and priorities for action.

There was significant overlap in the actions identified to deliver an 'outstanding' experience across the six ambitions. Our future ambitions for Morecambe Bay are therefore structured under three themes:

Compassionate Communities At home and in the workplace	Essential Enablers Maximising use of data and digital solutions	Excellent Experience Equitable and responsive care and support
• Supporting a cultural change to encourage residents, communities and our workforce to think about and talk about dying and planning for dying. • Providing equitable access to bereavement support for residents and our workforce.	• Use population health / risk stratification approaches to identify residents likely to be in the last year of life. • Knowing how we're doing - creating a system-wide view of palliative and end of life care in real time, and to measure impact retrospectively. • Maximising the use of digital solutions to capture and share information.	• Education and training for staff in identifying people reaching end of life and in communicating with them and people close to them. • Establishing a 24/7 single point of contact with onward access to holistic end of life care and support, and specialist palliative care services where needed. • Developing a future workforce that can meet required capacity and quality of care

Women's Health and Wellbeing

Attendees at our Place Partnership Forum were keen to ensure that we supported women's health and wellbeing in South Cumbria. At one of our forum sessions in early 2024, partners heard about the national strategy for women's health, as well as learning more about what the data tells us about women's health and the ICB's plans for the coming year.

We learned about the vast scope of what we mean when we talk about 'women's health' and reviewed local statistics that signpost to areas where we need to provide better outcomes for our residents.

We asked people to work in groups to identify ideas or specific projects that would improve outcomes and experience for women, with a real focus on integration of services and a more holistic approach to support across the life course.

There are fantastic examples of projects that are underway to support women's health and wellbeing, often being delivered with very little or no additional resourcing:

- Developing a growing network of like-minded women keen to improve the health of our community
- Building a network of professional women who are keen to work with other women and promote wellbeing
- Partnering with local businesses who are willing to provide venues for events (e.g., cafés / town hall etc)

Understanding and supporting menopause

In Kendal, and in some cases across South Cumbria, we have partnered with a wide range of health and care professionals and community groups to increased community knowledge and awareness of menopause. They have taken a more holistic approach to sharing information and experience and providing practical support, for example through free talks and events; setting up an online social forum; providing access to peer support and coaching; advising on nutrition; and offering yoga sessions.

We have worked with a wide range of anchor organisations and smaller businesses to increase awareness of menopause in the workplace. This has included local schools and colleges, BAE Systems, Cumbria Fire and Rescue, and local solicitors and veterinary practices.

Bay Wellness Menopause Toolkit

As part of their drive to improve staff health and wellness across Morecambe Bay, the Bay Wellness Partnership created a Menopause Toolkit to encourage organisations to look at how they support their colleagues who are experiencing menopause symptoms. This toolkit aims to help raise awareness of menopause and perimenopause symptoms and highlight how we can work together to better support our colleagues including details on how we can become menopause friendly organisations.

The Lancashire and South Cumbria Integrated Care Board commissioned a Women's Health Programme Survey which identified that women:

- Would prefer hubs to be located within health or walk-in centres, GP Practices and mobile vans in central locations with easy access for non-drivers and free parking.
- Expressed a desire for general information, self-referral options and the ability to book appointments online.
- Advised barriers to accessing services included inconvenient appointment times, lack of awareness about available services, work commitments and feelings of embarrassment and lack of confidence.

Our ambition is to create women's health hubs that provide a holistic offer to support women to be well throughout their life course, with access to a range of support offers including social activities, lifestyle and fitness advice and guidance, mental health and physical health. There is a clear desire to move to a proactive approach to wellness, rather than a reactive response to symptom management. Colocation of services will be key, along with easily accessible information via an online platform.

In 2025/26, we are planning to co-design and implement this model, aligned with areas of greatest need.

Engaging with our residents and communities

Public engagement is crucial for fostering trust, collaboration, and mutual understanding between organisations and the communities they serve. It allows for the identification of community needs, the development of effective solutions, and the creation of a sense of ownership and empowerment among residents. By actively involving the public in decision-making processes, organisations can ensure that their initiatives are relevant, inclusive, and sustainable.

Listening to the voices of our residents is a key underpinning workstream for our South Cumbria place. Our dedicated Engagement Coordinator has undertaken supported many different projects to hear from our communities and ensure that their views form part of the planning and design of our services.

Highlights from 2024/25 include:

- Facilitation of Listening Circle for third sector breakfast group. This has created a safe space for leaders to grow trust and move towards increased collaboration.
- Developing and participating in the Not-for-Profit Health Forum and providing connections in and out of the Lancashire and South Cumbria Integrated Care Board.
- Participating in a series of mental health partnership workshops organised and facilitated by the Council for Voluntary Service (CVS) for third sector providers and supporters in South Cumbria.
- Participating in the CREATE project in Barrow, supporting the engagement and employment of residents as community researchers.
- Development and promotion of the Barrow Way, a set of twelve principles which came about through the Love Barrow Coalition set up by the Local Authority and Love Barrow Together, funded by the Lankelly Chase Foundation.
- Participating in the Healthier Streets work, including running a workshop with residents to consider issues related to self-harm.
- Supporting the collaboration between third sector organisations to inform the allocation of funding through the Social Impact Fund as part of Barrow Rising.
- Involvement in the development of the Health, Equity and Well-being partnership through the facilitation of and attendance at face-to-face workshops in Barrow.
- Support for design and implementation of the WorkWell project.
- Supporting the co-production of the integrated wellness centre and the opening of intermediate care beds at Parkview Gardens.
- Regular meetings with Women's Community Matters in Barrow to support their work and to develop the Barrow Way.
- Engagement with residents in Coniston in relation to the future of the GP practice in the village.
- Engagement Carer Support Furness and an away day for Carer Support Cumbria.
- Lancashire and South Cumbria Integrated Care Board's 'Your Health. Your Future. Your Say' engagement workshop, facilitating roundtable discussions about health and care services.

Poverty Truth Commissions

Two Poverty Truth Commissions have been running in the South Cumbria place: one in Barrow and one in South Lakes. Each is focused on bringing community representatives and civic leaders together, holding regular meetings to:

- Build relationships,
- Create listening circles
- Share stories
- Identify issues from the stories to work on together

Barrow

In Barrow, the commission identified priorities around belonging in our town, children and families, and mental health and identified three projects to take forward:

- Barrow Resolve: a two- year pilot of premises in the town centre occupied and run by members of the current Poverty Truth Commission
- Community Inspirers/Citizens Representatives: A volunteering/career pathway for people with lived experience through Resolve with training for numerous roles in either support work, problem solving, care, community advocacy, etc with links to other external career pathways
- Shared Information Document: a single use tablet with an app to hold the story of a person with complex needs' life with a drop down menu for permissions of who it (or sections of it) can be shared with to mitigate the trauma and humiliation and disempowerment of retelling your story over and over again.
- Outside Looking In: Embedding lived experience in local services in a meaningful way. Outside Looking In provides an opportunity for lived experience to be invited into our local statutory, third sector and business sector

Financial support for these projects has been secured through the 'social impact' investment in Barrow Rising.

South Lakes

In South Lakes, the commission focused on understanding lived experience in a rural or semi-rural context, specifically the impact on people directly involved in the commission process, as well as services and systems seeking to respond to poverty. The identified priorities were:

- Education
- Housing and homelessness
- Veterans
- Rurality

Working groups were established to focus on person-centred services, community hubs, domestic abuse, and mental health. A group of the commissioners also worked with Cumbria Development Education Centre to create and deliver poverty proofing and poverty awareness training for Westmorland and Furness Council and wider partners

The South Lakes Poverty Truth Commission was evaluated by Liverpool World Centre. It found that Community Commissioners had increased their skills and confidence to share their lived experience and speak about poverty with Civic Commissioners and wider service providers and stakeholders. For some the impact moved beyond this to offer something more transformative. Community Commissioners increasingly recognised their power to influence wider service providers and stakeholders, to meet them as equals for collaboration and challenge them where needed.

For Civic Commissioners, the majority felt that they had increased their understanding of financial hardship, debt and poverty, and had more appreciation and skills for listening to lived experience. For some commissioners the process prompted a more transformative shift both in understanding of and perspectives on poverty, and the kind of changes to services and systems that might be needed. By the end of the commission the majority of Civic Commissioners had also increased their skills in speaking about poverty with wider stakeholders and audiences.

Our Place Partnership Forum

Established in February 2023, the Place Partnership Forum initially operated on a Morecambe Bay footprint as part of Bay Health and Care Partners. It has since transitioned to the South Cumbria footprint as part of the work of the South Cumbria place, while still working on a Bay (place+) footprint where relevant.

The purpose of the Place Partnership Forum is to share news and updates across all partners, showcase great work that can be scaled up or replicated, provide a vehicle for consultation and engagement on particular challenges, risks, asks or proposals, and work up or sense check ideas, plans or proposals around place priorities. The forum aims to increase listening and responding to the voices of residents and communities.

The Place Partnership Forum meets monthly for a half-day session, with a format that includes updates and Q&A followed by interactive workshops on one or two topics. Regular organisational and sectoral invitees include

- Cumbria Constabulary
- Cumbria Fire and Rescue Service
- Cumberland Council
- Healthwatch
- Hospices (St John's and St Mary's)
- Lancashire and South Cumbria Integrated Care Board - South Cumbria Place Team
- Lancashire and South Cumbria Integrated Care Board - named links including primary care, community services, regulated care, medicines optimisation, mental health, urgent and emergency care, workforce/OD
- Lancashire and South Cumbria NHS Foundation Trust
- North West Ambulance Service NHS Trust
- Primary care (dental, general practice, optometry, pharmacy)
- University Hospitals of Morecambe Bay NHS Foundation Trust
- VCFSE sector
- Westmorland and Furness Council

Additional invitees are included relevant to the topics in the interactive workshops.

Across the later part of 2023/24 and during 2024/25, we have discussed a wide range of topics:

- Mental health transformation
- Children and young people's mental health and emotional wellbeing
- Creation of the Lancashire and Lancashire and South Cumbria NHS Foundation Trust strategy
- Dementia
- Self-harm and suicide
- Challenges facing general practice and community pharmacy
- Fuller recommendations
- Integrated Neighbourhood Teams
- Integrated Care Communities
- Dying Well – palliative and end of life care.
- Armed Forces Covenant
- Winter planning and avoiding unnecessary admissions to hospital
- Bay Wellness
- WorkWell Partnership Programme
- Women's health
- Prescribing of opioids, including Drugs Don't Work and Pain Cafes
- The role of carers
- Population health priorities in each of our communities
- Creation of the Westmorland and Furness Council Joint Local Health and Wellbeing Strategy
- Morecambe Bay Respiratory Network
- Healthy Child tendering process
- CQC assessments

We asked invitees to provide feedback on the usefulness of the place Partnership Forum during 2024/25 via an interactive session at our forum in March 2024 and via an online survey. The feedback was exceptionally positive, with responses identifying the key themes that have made the forum useful:

- Creating a safe and inclusive space for partnership working
- Relationship building
- Increasing understanding and awareness
- Collaborative working

We will continue with our monthly forums in 2025/26 and are also planning an all-day event which will focus on hearing updates from each of our priority work programmes, offering the opportunity to showcase their achievements, share their challenges, and describe areas for further work. We plan to invite guest speakers to promote new thinking around one or more of our priority areas.

Our priorities for 2025/26

We have worked with our Place Partnership Forum and Place Partnership Board to review our priorities for 2025/26. Both noted that our 2024/25 priorities were selected because they will start to address complex, long-term challenges that cannot be tackled by a single organisation or sector working alone. They require strong partnership working and transformational change, which may need to be delivered incrementally. It was recognised that whilst we have completed several key projects during 2024/25, delivery of our work programmes will be across multiple years.

Therefore, we do not propose to change our place priorities for 2025/26.

We heard from partners that we must ensure that our work programmes are focused on:

- Listening to the voices of our residents, particularly our 'experts by experience' and responding to their needs and their perspective on 'what good looks like'
- Identifying and addressing inequalities in our place and neighbourhoods
- Increasing our work on prevention and proactively supporting people to feel well
- Understanding and supporting the relationship between being in good work and overall good health and wellbeing
- Promoting the importance of mental health and wellbeing
- Developing a more integrated workforce
- Increasing the use of digital solutions to support efficient and effective multidisciplinary working and to enable people to stay safe and well at home

Thriving Communities Together

South Cumbria