Lancashire and South Cumbria VCFSE Alliance

NHS Lancashire and South Cumbria Integrated Care Board

UEC Programme Evaluation

Report Framework

SPRING NORTH

COLLABORATION + INNOVATION = IMPACT

The Integrated Care System (ICS) committed 2% of the Winter Pressure funding for 24/25 to the VCFSE sector to support reducing unnecessary attendance at UEC and/or to facilitate safe and supported discharge from hospital. The Alliance selected 2 pilot areas, BwD and Blackpool to test and learn from the inclusion of the VCFSE sector in supporting system partners with an equal split of the funding to both areas.

Following an open bidding process, Spring North were appointed as the managing organisation for this work. Consultation was undertaken with place partners in the 2 areas to identify the target populations based supporting evidence of need, we are pleased to share the outcomes and delivery impact achieved by our VCFSE delivery partners.

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Executive Summary

As Chair of the VCFSE Alliance for Lancashire and South Cumbria, I am proud to present this impact report, which highlights the outcomes of a pioneering investment by the Integrated Care Board (ICB) into the Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector. This funding marked a significant shift in the use of Urgent and Emergency Care (UEC) resources, redirected to test community-based models aimed at keeping people well and independent in their homes throughout the winter period.

The ICB's strategic investment supported three targeted programmes of work in Blackpool and Blackburn with Darwen, each addressing distinct but critical health and wellbeing challenges faced by vulnerable populations.

In Blackpool, the programme focused on supporting individuals with respiratory infections, asthma, COPD and other on-going breathing conditions. Through a partnership-driven approach, residents were supported to remain at home through practical interventions, ensuring homes were adequately heated, nutritious food was accessible, and people remained connected to their communities through local hubs. This holistic approach tackled the wider determinants of health and helped reduce isolation, a key risk factor for deteriorating health.

In Blackburn with Darwen, two programmes were delivered, the first focused on people living at risk of falls and the second aimed to support people with complex needs. By mobilising community assets and VCFSE expertise, the initiatives provided timely, preventative support that helped people avoid unnecessary hospital admissions and remain safely at home during the most challenging months of the year.

Together, these programmes demonstrate the power of integrated, community-based solutions led by the VCFSE sector to deliver measurable outcomes and relieve pressure on acute services. This work provides a compelling case for continuing and scaling community-rooted models that put people's needs, dignity, and independence at the heart of our health and care system.

The VCFSE Alliance has the capacity to work strategically with health and care partners as part of our integrated system and the VCFSE sector in Lancashire and South Cumbria has the skills, experience, knowledge and most importantly the reach into communities to support people to stay safe and well in their homes.

Finally, I like to express my thanks to VCFSE colleagues who contributed to the Task and Finish Groups to design these programmes of work, to Place Based colleagues who supported the implementation and helped mobilise this work at pace, and to colleagues at the ICB who have worked in partnership with the VCFSE Alliance over many years and were instrumental in this investment in our sector.

"The VCFSE Alliance has the capacity to work strategically with health and care partners as part of our integrated system"

Tracy Hopkins, Chair
VCFSE Alliance Lancashire & South Cumbria

Overview of the UEC pilot programme and its strategic objectives

The VCFSE UEC Winter Programme 2024–25 was developed in direct response to increasing system pressures during winter months a time of peak demand and significant strain on health and care services.

Its strategic purpose was to deploy community-led, preventative interventions that could reduce avoidable hospital admissions, ease system-wide demand, and improve access to the right care at the right time.

This programme aligned with the LSC Urgent and Emergency Care Strategy 2024–2029, which emphasises the transformation of urgent care services by strengthening community provision, enhancing prevention, and integrating the voluntary, community, faith and social enterprise (VCFSE) sector as a core partner within a whole-system approach. Central to this vision is the recognition that improving UEC is not only about scaling clinical capacity but also about embedding trusted, local VCFSE solutions that help people stay well and receive urgent care closer to home.

The VCFSE sector is explicitly recognised in the strategy as a key strategic partner, uniquely positioned to deliver preventative and post-crisis support at neighbourhood level. Rooted in communities, these organisations bring lived experience, cultural competence, and deep local knowledge. They offer trusted relationships, understand the barriers people face, and provide flexible, place-based services that integrate effectively with statutory care pathways. Whether through early intervention, support during a crisis, or helping people recover and stabilise after an episode of urgent care, VCFSE partners can deliver vital support that bridges gaps in the system.

This pilot programme specifically focused on three cohorts known to contribute disproportionately to UEC demand when left unsupported:

- Adults with respiratory conditions, particularly COPD, in Blackpool
- Individuals facing multiple disadvantage in Blackburn Central Ward
- Older adults at risk of falls in Darwen

These populations often experience compounding challenges social isolation, housing insecurity, long-term conditions, and poor access to timely care which increase the likelihood of presenting at A&E. Through tailored engagement, risk identification, and integrated support, the programme aimed to intervene before escalation, reduce inappropriate UEC use, and promote sustainable behaviour change.

The overarching objective of the VCFSE-led delivery was to support the UEC system by engaging individuals early and enabling easy access to the right care and support, at the earliest and most appropriate level of intervention. The aim was to meet people's needs in a timely, effective, and cost-efficient way preventing deterioration, avoiding hospital admissions, and reducing pressure on the system during a critical period of the year.

This programme not only delivered short-term relief but also demonstrated how VCFSE organisations can play a long-term role in transforming urgent and emergency care, building local resilience, and improving outcomes in the communities they serve.

Headline impacts and key findings across the three Lots

The 2024–25 VCFSE UEC Winter Programme delivered measurable, community-led impact across three thematic Lots, demonstrating how VCFSE organisations can effectively engage at-risk populations, reduce reliance on emergency services, and support people to access the right care at the right time.

Headline Outcomes

16,517

individuals reached through a range of social media, awareness campaigns, health messaging, leaflet drops and information sharing.

4083

The project identified and engaged with **4083** HIU between November and March, through **684** outreach events, drop-ins and planned sessions.

1,172

individuals received tailored, 1-1 dedicated support across three high-risk cohorts

51.8%

of participants reported a shift in behaviour, indicating they would now seek help from non-emergency sources (e.g. GP, pharmacy, community support) instead of going directly to A&E

793

CORE20PLUS5 assessments completed, with **391** targeted referrals made into additional CORE20PLUS5 health and wellbeing pathways

Community outreach, trust-building, and personalised engagement enabled timely and appropriate support, contributing to admission avoidance and reduced system strain

Lot-Specific Highlights

The UEC Winter Programme was delivered across three distinct Lots, each targeting a specific population group with known high levels of urgent and emergency care use. While the focus and delivery models varied, all three interventions shared a common aim: to provide early, accessible, and personalised support that prevented escalation and reduced the need for urgent emergency care. The highlights below capture the core achievements and distinctive features of each Lot, demonstrating how targeted, community-led action can respond to local need and contribute directly to system-level impact.

Lot 1:
Respiratory Support (Blackpool)

Over 7,000 people
reached through widespread awareness campaigns

864 individuals
supported through assessments, triage, and 1-1 interventions

- The project addressed both clinical and non-clinical factors influencing respiratory health such as food poverty and housing conditions while aligning closely with local health services to reduce duplication and meet unmet need

Lot 2:
Multiple Disadvantage (Blackburn Central Ward)

Over 6,942 people
reached through widespread awareness campaigns

147 vulnerable individuals
supported through direct 1-1 dedicated support

- Delivered targeted support to vulnerable adults and families at highest risk of UEC usage
- Built trusted, trauma-informed relationships through outreach and place-based working
- The programme worked collaboratively with local partners toaddress underlying drivers of crisis demand and provide coordinated, non-clinical support for people not engaged with other services

Lot 3:
Falls Prevention (Darwen)

Nearly 2,402 older adults
reached through care home outreach and community communications

161 individuals engaged
in structured 1-1 prevention planning following falls risk assessment

- The project focused on frail individuals in care homes, at home, or active in the community combining proactive outreach, identification, and personalised intervention to reduce falls and escalation into UEC

Key Cross-Cutting Findings UEC Avoidance and Behaviour Change

Throughout delivery, a number of consistent themes emerged across all three Lots, revealing what works when it comes to reducing avoidable demand on urgent and emergency care services. These findings highlight the unique strengths of VCFSE partners in delivering timely, place-based interventions and in influencing the behaviours, choices, and conditions that often drive A&E attendance. The insights below demonstrate how community-led, needs-responsive models can actively support UEC avoidance while laying foundations for scalable system transformation.

Community-based prevention works

Localised, VCFSE-led interventions provided early, accessible support that helped individuals manage their needs before they escalated to crisis. By intervening upstream through triage/assessments, advice, and wraparound care partners diverted people from inappropriate or avoidable A&E attendance, supporting admission avoidance in real time.

Trust and relationships were essential

VCFSE partners were already embedded in their communities, with long-standing, trusted relationships. This enabled them to quickly identify and engage individuals who were either reluctant to seek help or disengaged from statutory services. These trusted touchpoints allowed for early conversations and interventions that prevented health deterioration and the need for emergency care.

Integrated delivery strengthened outcomes

Delivery partners collaborated closely with system partner teams, housing providers, care homes, and VCFSE and social care to provide seamless, joined-up support. This reduced duplication, accelerated referrals, and allowed people to access timely, coordinated care avoiding system bottlenecks and reducing the likelihood of urgent presentations.

Established, flexible, needs-led models drove responsiveness

All partners delivered through highly adaptive models that responded to the specific needs of their target populations whether that was respiratory support, falls risk, or complex disadvantage. These models were responsive to changing community pressures and individual circumstances, ensuring people received the right support at the right moment, reducing unnecessary reliance on accessing urgent care.

Increased awareness of UEC alternatives

Targeted communication, myth-busting, and personalised guidance improved people's knowledge of where and how to access alternative, safe and appropriate care. As a result, 51.8% of those supported reported they would no longer default to A&E when in need, instead choosing primary care, 111, pharmacy or community services, further demonstrating direct impact on behaviour change and future demand reduction.

Lessons are transferable and scalable

The programme generated clear, actionable learning about how to structure, resource, and deliver community-led interventions that meet urgent care objectives. These insights can be lifted and applied to other geographic areas or tailored to address new thematic priorities supporting system transformation beyond the winter period and contributing to the wider goals of the UEC Strategy 2024–29.

Earlier Deployment of Preventative Support is Essential

One of the clearest lessons to emerge from this winter programme is the critical importance of deploying preventative support well in advance of the peak winter period. While the programme achieved strong outcomes in a compressed delivery window, many partners reflected that earlier mobilisation starting in late summer or early autumn would have enabled more gradual and sustained engagement, better preparation of communities, and stronger cumulative impact.

A phased, lead-in approach would allow time to build trusted relationships with individuals before crisis hits, particularly for those with chronic health conditions or complex needs. Earlier engagement could also help to stabilise risk factors such as respiratory flare-ups, social isolation, or housing insecurity before colder weather exacerbates them. This model would not only improve health outcomes but also reduce system strain more predictably and proactively.

In addition, earlier mobilisation would allow for greater opportunity to establish robust referral pathways and operational partnerships with system actors such as NWAS, GPs, Integrated Neighbourhood Teams (INTs), and primary care networks. This would ensure clearer understanding across the system of what each VCFSE offer entails, how to refer appropriately, and what criteria apply. It would also support the development of operational agreements that embed these models more fully into local care coordination and crisis prevention frameworks.

There is also strong potential to explore the development of an Alliance-wide UEC single referral portal, acting as a centralised mechanism for managing and coordinating incoming referrals from GPs, health professionals, and wider system partners. This would not only simplify access to community-based support but could also serve as a practical solution to GDPR-compliant information sharing, supporting more seamless triage, tracking, and feedback loops across sectors.

Moreover, sharing key winter health messages earlier around flu/COVID vaccinations, self-care, and appropriate service use could help shift public behaviour ahead of pressure points. Earlier signposting to alternative services (e.g. pharmacies, 111, community support) would support more informed choices and reduce the likelihood of people defaulting to A&E when facing uncertainty.

What's needed is a year-round, low-intensity preventative presence, which gradually builds community readiness and resilience, rather than a short-term burst of support delivered under crisis conditions. Embedding VCFSE partners into this longer-term rhythm of prevention would allow for smoother, more scalable demand management, stronger system integration, and connected public heading into winter.

The Critical Role of the VCFSE Sector in UEC Transformation

As health and care systems work to transform urgent and emergency care, the role of the VCFSE sector has never been more critical. National policy recognises the VCFSE as a strategic delivery partner uniquely positioned to engage communities, address health inequalities, and deliver preventative, place-based support that complements statutory services. Their deep local insight, trusted relationships, and agility enable them to reach people early, respond flexibly, and reduce avoidable demand on overstretched UEC services.

National and Local Context

- UEC Strategy 2024–29 calls for whole-system transformation, with a stronger emphasis on prevention, community-based care, and demand management.
- VCFSE integration is recognised nationally as key to tackling inequalities, managing demand upstream, and delivering care closer to home.
- At a local level, systems like Lancashire and South Cumbria have placed increasing emphasis on place-based partnerships where VCFSE organisations bring lived experience and credibility that statutory services cannot replicate alone.

Rationale for VCFSE-Led Interventions

- Traditional UEC services are not designed to address the root causes of frequent A&E attendance such as isolation, poor housing, low health literacy, or trauma.
- VCFSE organisations specialise in non-clinical prevention: early help, navigation, behaviour change, and supporting wider determinants of health.
- By working upstream, VCFSE interventions reduce escalation into crisis, lower repeat UEC usage, and support more sustainable outcomes over time.

Evidence of VCFSE Reach, Agility, and Engagement

- VCFSE organisations reach those least likely to access formal services people who are disengaged, marginalised, or mistrustful of statutory care.
- Their agility allows them to respond quickly to emerging needs, adapt delivery models, and provide holistic, person-centred support without bureaucracy.
- In the Winter Programme, this included:
  - Reaching >7,000 residents in Blackpool with respiratory messaging
  - Delivering trauma-informed support to individuals facing multiple disadvantage in Blackburn
  - Engaging older adults across Darwen through care home and community channels

Added Value: Complementing Statutory Services

- VCFSE partners do not duplicate statutory services they fill critical gaps, especially in prevention, early engagement, and recovery.
- Their community knowledge and flexibility allows for faster mobilisation and better targeting of those at risk of poor outcomes.
- Through strong relationships with GPs, PCNs, care homes, housing and mental health services, VCFSE organisations act as the "connective tissue" of the system.
- They help people navigate complexity, access appropriate services, and avoid inappropriate A&E attendance or avoidance.

Tackling Health Inequalities and Managing UEC Demand

- VCFSE organisations are uniquely placed to address inequalities working in areas of deprivation, with minoritised communities, or those facing intersectional disadvantage.
- By embedding themselves in place, they understand cultural context, build trust, and challenge the systemic barriers that drive disproportionate UEC usage.
- Their role is not just responsive but transformative contributing to more equitable access, smarter use of resources, and a more sustainable health system.

Funding Mechanism and Partner Selection

To support the delivery of the UEC Winter Programme, non-recurrent funding of £420,000 was made available through LSC VCFSE Alliance the Lancashire and South Cumbria Provider Collaborative (the Alliance). Recognising the importance of VCFSE sector leadership in the delivery of preventative, place-based interventions, the Alliance initiated a competitive process to identify a capable VCFSE infrastructure organisation to serve as the anchor delivery partner. Following this process, Spring North was selected to lead the programme based on its proven track record in strategic contract management, health equity programmes, and system-wide delivery oversight.

Funding Model

The total programme funding was allocated as follows:

£20k
Contract management and programme oversight (Spring North)

£200k
Lot 1: Respiratory Support in Blackpool

£132k
Lot 2: Support for Vulnerable Adults and Families in Blackburn

£68k
Lot 3: Falls Prevention for Older People in Darwen

Spring North developed a clear delivery specification for each Lot, based on system intelligence, local needs, and urgent care priorities. A robust Expression of Interest (EOI) process was launched, underpinned by published eligibility criteria, transparent scoring matrices, and rigorous due diligence checks. A total of 11 EOIs were received, with funding awarded to six VCFSE organisations selected for their strong local presence, quality of delivery model, and alignment with the target outcomes of each Lot.

Selected Delivery Partners

Lot 1 Blackpool (Respiratory)

- Citizens Advice Blackpool and Groundwork
- Chosen for their combined reach into vulnerable communities, experience delivering respiratory-related support, and strong referral relationships with primary care and housing teams.

Lot 2 Blackburn Central Ward (Vulnerable Adults and Families)

- 180 Project, Red Rose Recovery, and Thomas
- Selected for their embedded work with individuals facing multiple disadvantage, trauma-informed models, and lived experience approaches to engagement and support.

Lot 3 Darwen (Falls Prevention for Older People)

- Age UK Blackburn with Darwen
- Chosen due to their extensive local infrastructure, strong track record in supporting older adults, and close integration with care homes and local authority services.

Each selected organisation entered into a formal Service Level Agreement (SLA) with Spring North, who provided ongoing project management oversight, data infrastructure, and quality assurance throughout the programme. This model ensured funding was deployed efficiently, delivery aligned with local UEC priorities, and impact was captured consistently across all three intervention areas.

Spring North as the Anchor Organisation

Spring North played a central role in the design, mobilisation, and oversight of the UEC Winter Programme, acting as the lead accountable body and strategic delivery partner. Appointed through a competitive selection process, Spring North brought its expertise in contract management, system alignment, and place-based programme delivery to ensure the effective implementation of all three Lots.

Contract Management, Coordination, and Compliance

Spring North provided end-to-end programme coordination, from initial project design through to delivery assurance and performance monitoring. This included:

- Developing delivery specifications and a clear framework for each Lot
- Managing the Expression of Interest (EOI) and provider selection process
- Drafting and issuing Service Level Agreements (SLAs) with delivery partners
- Overseeing delivery milestones, compliance, outputs, outcomes, case studies, and financial accountability and monthly reporting.

Support Provided to Delivery Partners

To enable rapid and effective mobilisation, Spring North provided a package of practical and strategic support to all funded partners, including:

- A dedicated programme co-ordinator to maintain communication, provide troubleshooting, and act as a link to wider system partners
- Development of a shared data infrastructure and dashboard to ensure real-time performance tracking and consistency across delivery sites
- Templates and guidance for monitoring, evaluation, and reporting, helping partners focus on delivery while ensuring data quality and alignment with programme outcomes

Strategic Alignment with System Partners

Spring North ensured the programme was closely aligned with local Place Boards, Integrated Neighbourhood Teams, and the broader strategic priorities of the Integrated Care Board (ICB) and Lancashire & South Cumbria Provider Collaborative. By capturing granular data and sharing real-time insights, the programme enhanced system intelligence and informed decision-making across partners.

Delivery was intentionally integrated with primary care, housing, and social care services, reducing duplication and strengthening care pathways. Acting as a trusted system broker, Spring North built effective bridges between the VCFSE sector and health commissioners, clearly demonstrating the value of integrated, preventative models in managing urgent care demand and improving population health outcomes.

Lessons for Future Commissioning

Spring North's role as an anchor organisation revealed several important lessons for future commissioning. First, investing in infrastructure such as coordination, data systems, and oversight can deliver significant system value and reduce risk, even with modest funding. Second, VCFSE partners are capable of delivering high-impact work at pace and scale when supported with flexible funding, clear guidance, and responsive infrastructure. Third, joined-up delivery is not only possible but highly effective when enabled by an intermediary that understands both system priorities and community delivery

Commissioning models should embed real-time learning and adaptability; Spring North's use of shared dashboards, live feedback loops, and collaborative reflection helped create a culture of continuous improvement.

Together, these insights demonstrate the value of a dedicated, VCFSE-aligned anchor organisation one able to manage complexity, promote equity, and deliver accountable, community-rooted programmes on behalf of the system.

Operational Learning

The initial payment structure, which required partners to operate in arrears, created early challenges for the VCFSE sector, particularly around cash flow and covering upfront project setup costs. This approach was not well aligned with the financial realities of smaller community-based organisations. In response, a 25% advance payment was introduced, which proved critical in enabling partners to mobilise quickly and deploy resources effectively from the outset. Similarly, the original reporting requirements were not appropriate for the sector, relying too heavily on metrics that didn't reflect the nature or value of VCFSE delivery. By working collaboratively with partners, a more meaningful and proportionate set of reporting metrics was developed. These have allowed organisations to better evidence their impact while reducing unnecessary administrative burden, strengthening the case for continued and expanded investment in VCFSE-led provision.

Sustained impact, longer term delivery

A key lesson from this pilot is the VCFSE sector's unique ability to rapidly mobilise and deliver high-impact interventions in a short space of time. Within just six months, partners were able to engage communities, build trust, and influence behavioural change – outcomes that typically require sustained effort. This reinforces the sector's strengths in reaching underserved populations and delivering person-centred, preventative support. However, it also highlights a significant opportunity, if funding were made available over a longer period, or strategically aligned beyond short-term winter pressures, the same infrastructure could drive even greater long-term impact. Future commissioning approaches should therefore consider shifting from short-term reactive funding to sustained investment in preventative models that draw on the VCFSE sector's agility, insight, and community reach.

Increased budget allocation to the Alliance

This year's delivery has demonstrated the significant value the VCFSE sector brings to urgent and emergency care when trusted and resourced to do so. Despite receiving only 2% of the overall budget (£420,000), Alliance partners delivered meaningful community-level impact, reaching people early, reducing pressure on statutory services, and driving behaviour change. This evidences the sector's ability to deliver at scale and at pace. A key lesson is that increasing the budget allocation to the VCFSE would unlock even greater impact, enabling more strategic, preventative delivery rooted in local knowledge and trusted relationships. Future funding models should reflect this, positioning the VCFSE not as a peripheral partner but as a central component of the UEC system.

Increased targeted interventions

Full access to the ICB SIS system would have enabled partners to deliver more targeted and accelerated support to vulnerable individuals and families by providing real-time data to inform interventions. While this lack of access did not prevent meaningful engagement, thanks to partners' deep knowledge and understanding of their local communities it limited the ability to pinpoint need at a more granular level. Access to SIS would have enhanced delivery by adding a layer of precision, ensuring that support could be directed more swiftly and effectively to those most at risk.

Project Overview by Lot

Lot 1
Respiratory Support in Blackpool

Project Overview

The project's primary aim was to keep people out of hospital during the winter period by providing targeted interventions and support to adults in Blackpool suffering from respiratory conditions, particularly COPD. The initiative involved a comprehensive outreach and engagement strategy, alignment with existing respiratory and health services, and the development of community-based support networks.

The project focused on addressing both clinical and non-clinical factors affecting respiratory health, such as food poverty and housing conditions. It also promoted preventive health messaging around vaccinations and collaborated with other local partners to avoid duplication, offer added value, and address unmet need.

QR CODE

Watch the video here

"We've engaged with lots of vulnerable people supporting them to avoid going to hospital, changing behaviour and giving them alternatives."

Mike, Community Development Manager, The Grange

Delivery Partners: CAB Blackpool and Groundwork

Awareness

7,173

Reached through targeted health messages and resources

Identifying

918

People were identified as being higher risk of UEC admission

Engagement

1,659

Directly engaged with the project

Direct Support

864

People recieved direct 1-1 support

Impact (at 50% admission avoidance)

432
Estimated admissions avoided

£316,656
Cost savings from avoided admissions

£69,120
Demand management savings (at £80pp)

£385,776
Total cost savings

Narrative Insight

CAB and Groundwork's strong community presence enabled them to reach significantly more people than projected and engage individuals facing layered disadvantage. Their ability to respond to unmet non-clinical needs (e.g., housing disrepair, fuel poverty) strengthened respiratory resilience, directly reducing hospital risk. Coordination with health services ensured strategic alignment and reduced duplication.

Really strong working relationship with the ARI hub, link worker space set aside at the hub, ensuring an accessible and visual presence. Embedded delivery in the heart of The Grange.

Citizens Advice Blackpool

The project began with planning and recruitment, focusing on assembling and training Winter Support Link Workers. Training included mandatory courses, specialized link worker training, and shadowing experienced colleagues. Additionally, qualified benefit and general advisers were brought in to support the initiative.

CAB link workers provide daily support at the Acute Respiratory Infection (ARI) Hub at Whitegate Drive and in community spaces across Blackpool. While some clients seek basic information, others require comprehensive support, including benefit advice, assistance with damp homes, fuel and food vouchers, and referrals to mental health services.

Emerging patterns indicate common issues such as unclaimed benefits, difficulty affording heating and healthy food, and concerns about damp housing. These challenges have a significant impact on clients' health and well-being.

Groundwork

Groundwork's project has primarily been cantered around the community hub, where they welcome an average of 300 visitors weekly from both the local area and beyond. Groundwork have adopted a dual approach: providing one-on-one support while also hosting large information sessions and sharing resources through social media.

While their primary focus is on those who attend the centre, Groundwork also works closely with BCH and their Neighbourhoods team to support individuals in need who may not visit in person.

A key issue they've observed is the struggle of former smokers who switched to vaping but now find themselves using it more frequently than they ever smoked. Many perceive vaping as a "healthier" alternative, yet they find it difficult to quit.

Through social media campaigns, information sessions, and drop-in events, they aim to raise awareness and educate the local community on this growing concern.

£ See how we worked out the cost saving

Lot 2
Support for Older People to Reduce Falls – Darwen

Project Overview

The project's aim was to reduce avoidable falls and hospital admissions among older adults in Darwen. It focused on frail individuals living at home, in care homes, or active in the community. The intervention combined proactive outreach, risk identification, and direct support to reduce injury and avoid escalation.

QR CODE

Watch the video here

"We supported Dorothy who has fainting episodes, we helped to get her equipment, which has made her feel much safer, reduce her risk of falls at home"

Linda

Delivery Partners: Age UK Blackburn

Awareness

6,942

Reached through targeted health messages and resources

Identifying

205

People were identified as being higher risk of UEC admission

Engagement

162

Directly engaged with the project

Direct Support

147

People recieved direct 1-1 support

Impact (at 50% admission avoidance):

81
Estimated admissions avoided

£59,253
Cost savings from avoided admissions

£12,960
Demand management savings

£72,213
Total cost savings

Narrative Insight – Age UK Blackburn

Age UK leveraged its long-standing community infrastructure and referral pathways to provide highly targeted support. Engagement-to-support conversion was the highest of all three projects, reflecting their ability to reach those most at risk. Many of those supported were identified through care home links or community navigation services.

Have established strong partnerships with NWAS through their collaboration with Progress Lifeline's lifting service. This has led to successful training sessions for care home staff and participation in the Care Homes Forum, generating interest and engagement from multiple care homes

One significant outcome is the involvement of a Senior Paramedic, seconded to improve falls prevention in care homes across Lancashire and South Cumbria. They are now also working with the BwD Falls Task & Finish group to develop and implement key priorities, helping to streamline efforts to reduce unplanned hospital admissions due to falls.

Age UK's engagement with grassroots community groups has progressed well, with initial efforts focused on cascading falls prevention information within their networks. A recent falls awareness training session, attended by 15 community group representatives, was well received and is expected to enhance outreach to older individuals who may not typically access support services.

Early project findings indicate that most participants receiving direct support are from Darwen East. Additionally, Care Network's mailout to eligible residents in Darwen has generated a strong response.

£ See how we worked out the cost saving

Lot 3
Multiple Disadvantage in Blackburn Central Ward

Project Overview

The project's primary aims were to keep people out of hospital and reduce frequent UEC usage during winter by supporting individuals aged 20–64 in Blackburn Central Ward facing multiple disadvantages. The cohort had high UEC attendance but did not meet the threshold for Changing Futures.

The project worked collaboratively with local partners to identify and address the underlying drivers of UEC demand, refer individuals into appropriate services, and support them with non-clinical needs through a joined-up local offer.

QR CODE

Watch the video here

"We supported a mum with a child with asthma who normally always went to A&E when her child had a bad attack, with our direct support she now uses 111, contacts her GP and since our support her child has been stable with no A&E attendances, mum feels much more confident now to support her child"

Emma

Delivery Partners: Thomas, 180, and Red Rose

Awareness

2,402

Reached through targeted health messages and resources

Identifying

860

Directly engaged with the project

Engagement

279

Directly engaged with the project

Direct Support

161

People recieved direct 1-1 support

Impact (at 50% admission avoidance):

140
Estimated admissions avoided

£102,373
Cost savings from avoided admissions

£22,320
Demand management savings

£124,693
Total cost savings

Narrative Insights

The Central Ward vulnerable adults and families project in Blackburn was delivered by 180 Project, Red Rose Recovery, and Thomas, with delivery launched quickly following SLA award in October 2024 and operational by early November. The project focused on engaging adults and families with multiple and overlapping needs such as homelessness, substance misuse, mental ill health, and social isolation many of whom were disengaged from mainstream services but high users of urgent and emergency care.

Delivery was rooted in trauma-informed and peer-led approaches, enabling flexible, personalised support and trust-building with some of the most marginalised individuals in the community. Outreach targeted known hotspots across Central Ward, including St Anne's Church and Primary School, where language barriers, cultural factors, and low awareness of healthcare options were common.

While many individuals were open to initial conversations and triage, follow-up engagement proved challenging, particularly among those experiencing entrenched disadvantage or mistrust of formal services. Staff responded to multiple safeguarding concerns, including incidents requiring police or adult social care involvement, and adapted delivery to support those in crisis through harm reduction, emotional support, and multi-agency referrals. The team also highlighted the need for earlier training and stronger operational links with GPs, NWAS, and mental health services.

Despite the short delivery window, the project established vital foundations for future integrated support reaching people who were previously invisible to the system and offering consistent, non-judgemental help at the earliest point of need.

View Kings Fund insight analysis

£ See how we worked out the cost saving

180 Project

The 180 Project provides weekly community activities, including a Community Kitchen, Mobility & Mindfulness sessions, CrossFit classes, the Known Women's Hub, and Youth Football. These initiatives create safe spaces for open discussions, self-care, and early intervention.

The project focuses on Galligreaves, Bank Top, and Wensley Fold to strengthen community resilience through signposting and befriending support.

Key challenges addressed include mental health struggles, food poverty, and family dynamics. Additionally, barriers to accessing healthcare - such as long waiting times and limited awareness of support schemes - highlight the need for better resource navigation.

Thomas

Thomas aims to reduce pressure on A&E by engaging the community through drop-in sessions, mini health checks, and wellbeing activities at soup kitchens and late-night food events. A partnership with St. Anne's Church and St. Anne's Primary School has enabled direct engagement with families, providing health assessments and signposting to relevant services.

Additionally, collaboration with Together Housing allows for home visits to assess and support vulnerable tenants.

Red Rose Recovery

Red Rose Recovery focuses on supporting individuals facing multiple disadvantages, particularly those struggling with substance misuse and mistrust in services. Efforts have been directed at rebuilding trust through direct engagement, collaboration with healthcare providers, and partnerships with local organisations.

A significant challenge is overcoming scepticism due to past negative experiences, which affects service engagement. Through consistent, empathetic outreach, the project is gradually reconnecting individuals with essential services such as GPs, rehabilitation programs, and community support in Blackburn and Darwen.

Demonstrating Cost Benefit and Behaviour Change

View Kings Fund insight analysis

This programme supported 1,172 individuals across three high-need cohorts, using structured assessment tools to gather baseline data on their prior use of urgent and emergency care. A significant proportion reported that A&E was their default option when unwell often due to low awareness of alternatives, barriers to accessing primary care, or a lack of trust in services. Following targeted community-based support, 51.8% of participants said they would now choose a different route, such as their GP, pharmacist, or local support network, rather than presenting at A&E.

This reported behaviour change forms the basis of our cost-benefit assumption, conservatively estimating that 50% of supported individuals avoided an emergency admission, based on previous known behaviour. To quantify the impact, we used financial proxies from **The King's Fund, applying an average cost of £733 per avoided admission factoring in ambulance conveyancing, A&E attendance, and basic treatment.** Based on this model, the programme delivered an **estimated £582,682 in system savings**, alongside significant non-financial value through improved health literacy, earlier intervention, and reduced system strain during a critical period. This evidence highlights the potential of VCFSE-led interventions to deliver both financial and preventative impact as part of a more sustainable UEC model.

1,172
Individuals supported

£582,682
System savings

51.8%
Participants said they would now choose a different route

50%
Supported individuals avoided an emergency admission

CORE20PLUS5: Identifying and Responding to Wider Determinants of Health

Alongside the targeted urgent and emergency care interventions delivered through this programme, Spring North and its partners developed a simple but effective screening tool aligned with the NHS CORE20PLUS5 framework. The aim was to capture wider factors contributing to vulnerability and risk, going beyond presenting health issues to assess the social and clinical determinants that often underpin high UEC usage.

This screening tool was used consistently across all three Lots, enabling delivery partners to identify intersecting health inequalities and tailor their support accordingly. In total, **793 CORE20PLUS5 assessments** were completed during the delivery period. These assessments provided valuable insight into areas such as mental health, smoking status, respiratory conditions, and hypertension, ensuring that support was both preventative and holistic.

As a result of these assessments, **391 targeted referrals** were made into wider services and support pathways, helping individuals access the right care at the right time and potentially reducing future reliance on urgent care services. Referrals were made into both clinical and non-clinical pathways, depending on identified needs.

Breakdown of Referrals by CORE20PLUS5 Themes

117	Respiratory Disease
94	Mental Health – Severe Mental Illness (SMI)
81	Smoking Cessation Support
67	Hypertension
32	Cancer Support
0	Maternity

This data highlights the value of embedding CORE20PLUS5 into community-led delivery, enabling early identification of high-risk factors and creating opportunities for more integrated, personalised, and preventative health interventions. In doing so, the programme aligned closely with national health inequality priorities and contributed to the system-wide ambition of reducing preventable UEC demand through upstream support.

Referrals made following CORE20PLUS5 assessments were directed to a wide range of services across the health, care, and community sectors, ensuring a holistic response to individuals' needs. Many were referred to primary care services, including GP practices and nurse-led clinics for respiratory reviews, blood pressure checks, and mental health support. Pharmacies played a key role in smoking cessation, medication reviews, and hypertension screening. Individuals were also linked into community health services, such as respiratory rehab teams, talking therapies, and blood pressure management programmes.

A number of participants were connected to social prescribing link workers, who facilitated access to wider wellbeing support, financial advice, and healthy living activities. Referrals were also made to VCFSE providers and local charities, including cancer support organisations, bereavement services, and peer-led mental health or substance misuse groups. Where appropriate, individuals were referred into local authority teams or Integrated Neighbourhood Teams for housing, adult social care, or debt and welfare advice.

Finally, many were connected with community-led support groups, such as walking groups for respiratory health or peer networks for those living with long-term conditions. This comprehensive network of referral pathways ensured that individuals received targeted, joined-up support—addressing not just clinical needs but the wider determinants of health that often drive UEC use.

Spring North

Monitoring, Data Systems, and Dashboards

A core strength of the UEC Winter Programme was the robust and coordinated approach to data collection, monitoring, and insight sharing, led by Spring North. From the outset, a bespoke monitoring and evaluation framework was developed to capture the full scope of activity across all delivery partners. This included both high-level engagement metrics and granular data on individual outcomes, ensuring a clear understanding of reach, effectiveness, and impact.

Spring North designed and implemented a custom data system that enabled partners to record a wide range of activity types, including:

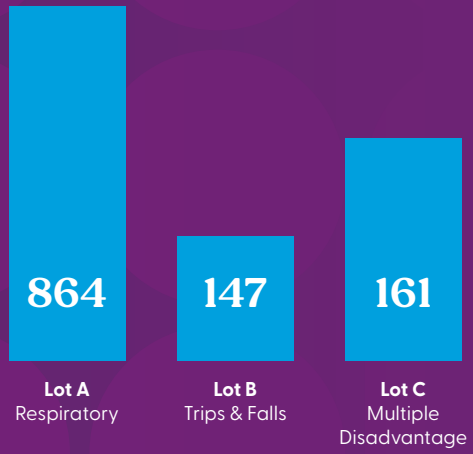
- People reached through awareness and health messaging campaigns
- Individuals identified as high-intensity users (HIUs) by ward-level geography
- Numbers engaged through drop-ins, workshops, support sessions, events, community health stands, and outreach activities
- In-depth data on individuals receiving ongoing 1-1 support through dedicated support plans, following structured individual needs assessments

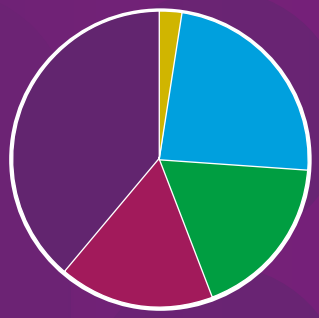
Demographic breakdown of participants across all lots

As part of the UEC delivery, we developed a dedicated reporting system to capture a comprehensive range of data, enabling us to monitor activity, outcomes, and reach in real time. This system provided valuable insights across multiple dimensions, including demographic information, service engagement, and signposting activity. Below is a demographic overview of project participants by age, gender, and ethnicity; however, our data collection extends further to include detailed information such as participant locality, types of support provided, and the nature and frequency of signposting to additional services.

1171 **Total Participants Directly Supported**

Participants by Lots





Age Range

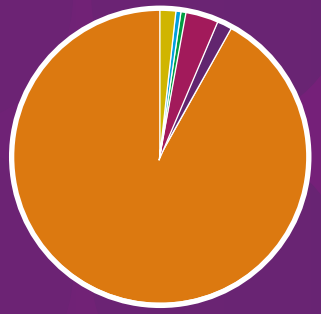
- 18-24: **31**
- 25-40: **269**
- 41-50: **199**
- 51-64: **200**
- 65+: **473**

Breakdown by Gender

668 Female

499 Male

4 Other



Ethnicity

- Asian or Asian British: **22**
- Black, African, Caribbean or Black British: **9**
- Mixed Ethnicity: **9**
- Other Ethnic Group: **46**
- Prefer Not to Say: **20**
- White: **1066**

The system also captured participants' previous urgent and emergency care behaviours, such as A&E attendances and ambulance use, right down to the postcode level, providing a highly localised view of risk and need. This allowed for real-time analysis of engagement hotspots and the ability to trace change over time.

All delivery partners contributed to a shared data infrastructure linked to live dashboards maintained by Spring North. These dashboards offered real-time insight into delivery performance, enabling timely adjustments to location, outreach method, or referral pathways based on emerging trends. This data-led flexibility allowed for a far more targeted delivery model, ensuring that resources were directed where they were most needed, and that delivery remained responsive to community needs.

The dashboards also played a vital role in identifying gaps in local pathways, for example, where links to housing, social prescribing, or mental health support were weak, enabling Spring North and partners to take corrective action and strengthen cross-sector referrals. All referral and signposting activity were logged, including connections to non-health services such as finance and debt advice, food banks, housing support, vaccination clinics, peer support, and community groups.

Data collection combined quantitative metrics (e.g. engagement volumes, demographics, referrals, self-reported behaviour change) with qualitative insight, including case notes, individual feedback, and reflections from delivery staff. Demographic data, age, gender, ethnicity, and locality was consistently gathered and disaggregated by delivery partner to support more targeted equality analysis.

Spring North played a central role in ensuring data consistency, quality, and insight sharing across the programme. Weekly and monthly reporting cycles allowed partners to reflect on performance, adjust delivery in real time, and contribute to a shared understanding of what was working. The dashboard provided not only live delivery figures but also allowed tracking of trends over time, giving the system an accurate and evidence-based view of emerging needs.

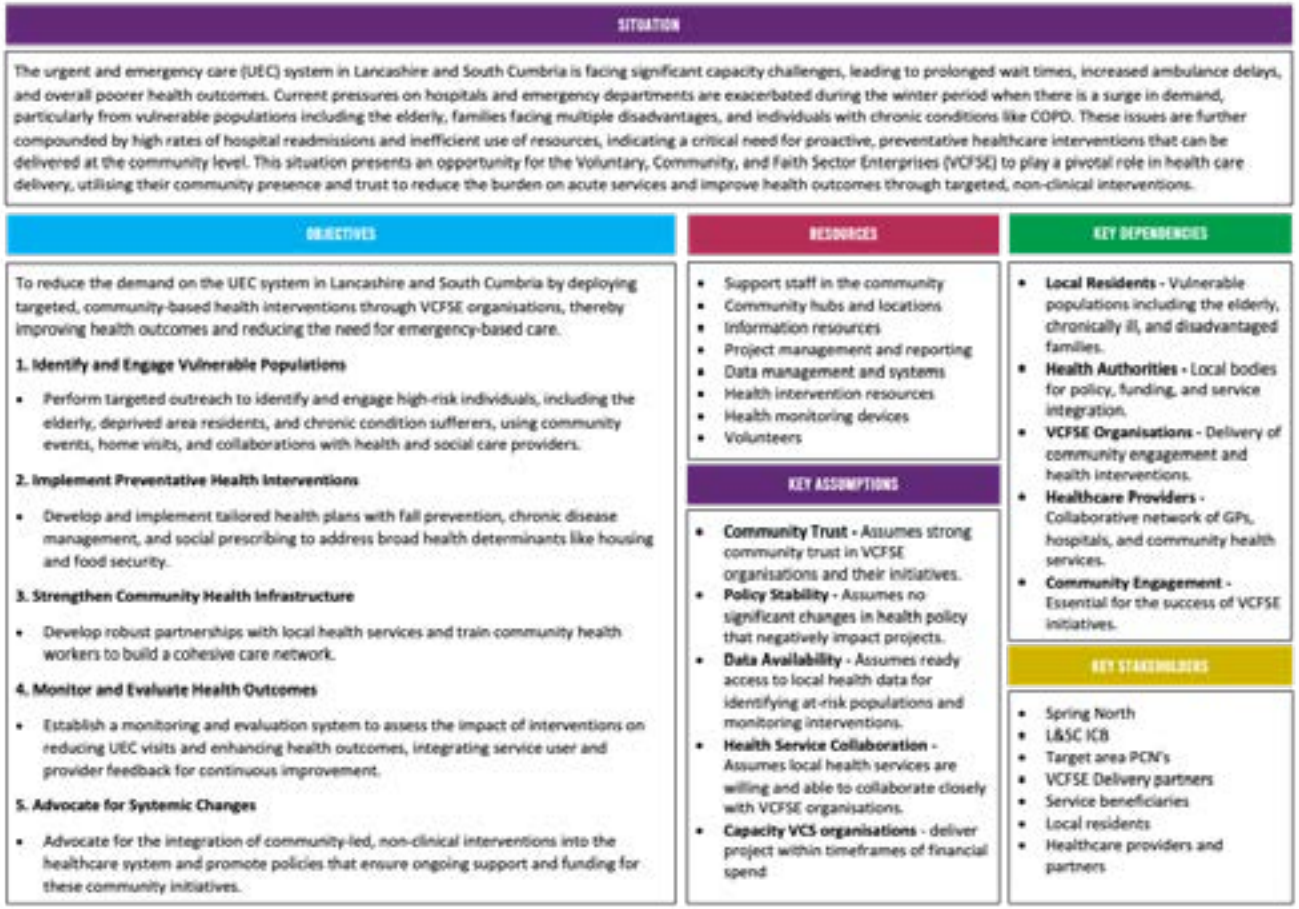
This approach not only ensured accountability but also helped partners learn from one another, refine their interventions, and collectively improve outcomes across the UEC pathway.

Theory of Change Development

As part of the programme's evaluation and learning approach, a draft Theory of Change (ToC) was developed and refined throughout delivery. Rather than being a fixed, pre-designed framework, the ToC evolved in real time, shaped by engagement with service users, insights from frontline delivery staff, and feedback from system partners. This iterative process made the ToC a live learning tool, helping partners better understand the complex needs of their cohorts and how their interventions contributed to reducing demand on urgent and emergency care services.

The ToC provided a shared framework for all three Lots, Blackpool (respiratory), Blackburn (vulnerable adults and families), and Darwen (falls prevention) to articulate their intended inputs, activities, outputs, and short- and long-term outcomes. It clarified the role of community-based interventions in early identification, risk reduction, and behaviour change, while helping delivery partners focus their efforts on activities most likely to generate impact.

By mapping the link between preventative activities and admission avoidance, the ToC enabled partners to develop more targeted delivery models, sharpen their outcome reporting, and make clearer distinctions between outputs (e.g. sessions delivered, people engaged) and outcomes (e.g. behaviour change, increased confidence, system navigation). This helped guide decisions on delivery focus, staffing, referral pathways, and community engagement strategies, as well as foster a shared language across the partnership.



SITUATION

The urgent and emergency care (UEC) system in Lancashire and South Cumbria is facing significant capacity challenges, leading to prolonged wait times, increased ambulance delays, and overall poorer health outcomes. Current pressures on hospitals and emergency departments are exacerbated during the winter period when there is a surge in demand, particularly from vulnerable populations including the elderly, families facing multiple disadvantages, and individuals with chronic conditions like COPD. These issues are further compounded by high rates of hospital readmissions and inefficient use of resources, indicating a critical need for proactive, preventative healthcare interventions that can be delivered at the community level. This situation presents an opportunity for the Voluntary, Community, and Faith Sector Enterprises (VCFSE) to play a pivotal role in health care delivery, utilising their community presence and trust to reduce the burden on acute services and improve health outcomes through targeted, non-clinical interventions.

OBJECTIVES

To reduce the demand on the UEC system in Lancashire and South Cumbria by deploying targeted, community-based health interventions through VCFSE organisations, thereby improving health outcomes and reducing the need for emergency-based care.

1. Identify and Engage Vulnerable Populations

- Perform targeted outreach to identify and engage high-risk individuals, including the elderly, deprived area residents, and chronic condition sufferers, using community events, home visits, and collaborations with health and social care providers.

2. Implement Preventative Health Interventions

- Develop and implement tailored health plans with fall prevention, chronic disease management, and social prescribing to address broad health determinants like housing and food security.

3. Strengthen Community Health Infrastructure

- Develop robust partnerships with local health services and train community health workers to build a cohesive care network.

4. Monitor and Evaluate Health Outcomes

- Establish a monitoring and evaluation system to assess the impact of interventions on reducing UEC visits and enhancing health outcomes, integrating service user and provider feedback for continuous improvement.

5. Advocate for Systemic Changes

- Advocate for the integration of community-led, non-clinical interventions into the healthcare system and promote policies that ensure ongoing support and funding for these community initiatives.

RESOURCES

- Support staff in the community
- Community hubs and locations
- Information resources
- Project management and reporting
- Data management and systems
- Health intervention resources
- Health monitoring devices
- Volunteers

KEY ASSUMPTIONS

- **Community Trust** - Assumes strong community trust in VCFSE organisations and their initiatives.
- **Policy Stability** - Assumes no significant changes in health policy that negatively impact projects.
- **Data Availability** - Assumes ready access to local health data for identifying at-risk populations and monitoring interventions.
- **Health Service Collaboration** - Assumes local health services are willing and able to collaborate closely with VCFSE organisations.
- **Capacity VCS organisations** - deliver project within timeframes of financial spend

KEY DEPENDENCIES

- **Local Residents** - Vulnerable populations including the elderly, chronically ill, and disadvantaged families.
- **Health Authorities** - Local bodies for policy, funding, and service integration.
- **VCFSE Organisations** - Delivery of community engagement and health interventions.
- **Healthcare Providers** - Collaborative network of GPs, hospitals, and community health services.
- **Community Engagement** - Essential for the success of VCFSE initiatives.

KEY STAKEHOLDERS

- Spring North
- L&SC ICB
- Target area PCN's
- VCFSE Delivery partners
- Service beneficiaries
- Local residents
- Healthcare providers and partners

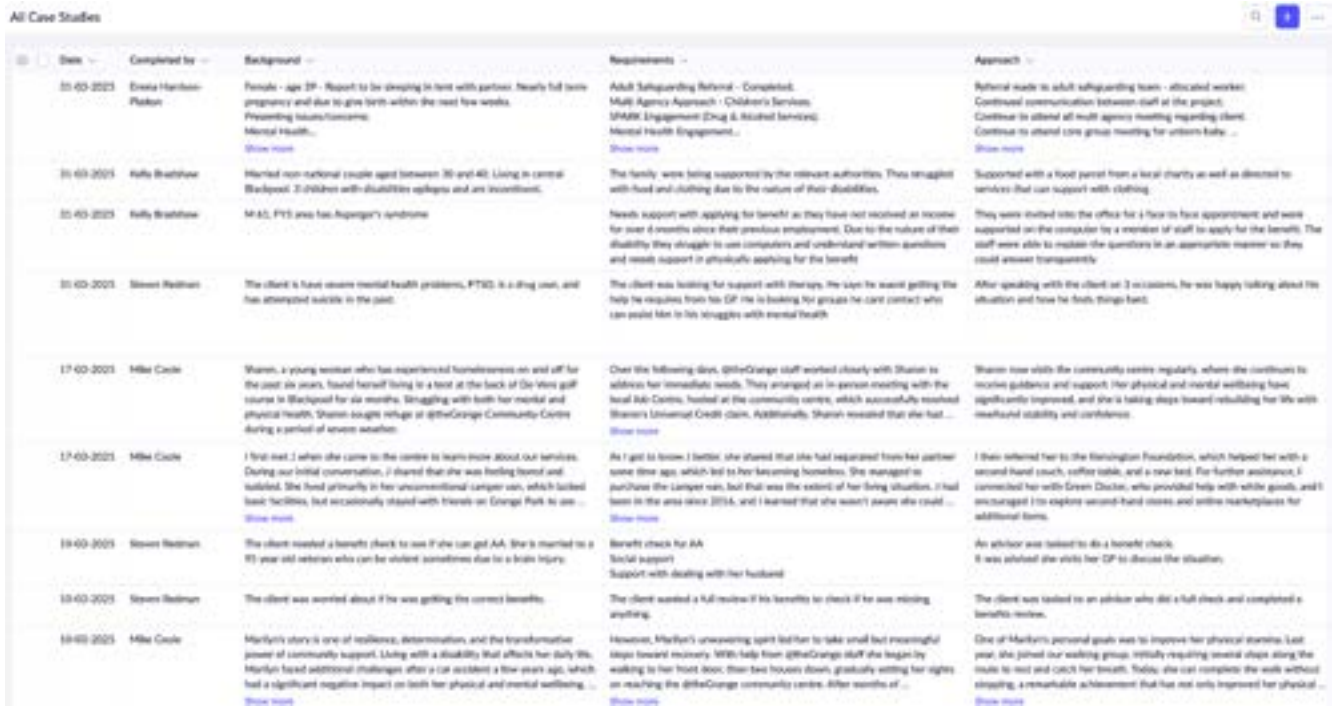
While still in a draft form, the ToC has proven to be a valuable foundation for future programme design, offering a clear structure for monitoring impact and capturing the added value of VCFSE-led models. With further refinement, it could serve as a core tool to support future UEC commissioning, enabling both funders and delivery partners to track performance, evaluate effectiveness, and drive continued improvement across community-led urgent care prevention efforts.

Service User Case Studies and Feedback

The real impact of the UEC Winter Programme is best understood through the voices and experiences of the people it supported. During the delivery period, over **200 pieces of feedback** were gathered from service users, offering valuable insight into how timely, community-based support changed lives, improved wellbeing, and helped people navigate crisis points more safely.

Alongside this, delivery partners collected a wide range of detailed case studies across all three Lots, Blackpool (respiratory health), Blackburn (vulnerable adults and families), and Darwen (falls prevention for older people). These case studies illustrate not only the complex needs individuals presented with, but also the tailored interventions provided, and the personal outcomes achieved. They demonstrate how behaviour changed, trust was built, and meaningful improvements were made in health, confidence, and system navigation.

The examples shared are just a few from the broader pool of stories that reflect the programme's impact, each one a powerful reminder of why accessible, preventative, and person-centred support is essential in reducing the strain on urgent and emergency care.



Case Studies

“Before, I didn’t know where to turn. I’d panic and end up in A&E. Now I’ve got support, a plan, and people I trust to help me through.”

180 Adult Mental Health Crisis (Female, mid 30s)

A woman began attending our Community Kitchen and Women’s Hub after being referred by a friend. Initially withdrawn and hesitant to engage, she eventually opened up about experiencing overwhelming anxiety and panic attacks. She shared that during previous episodes, she had called 999 or visited A&E out of fear, unsure of where else to turn.

Through regular attendance and informal conversations, she was introduced to our mental health support pathways. We supported her to complete a self-referral to a local talking therapy service and encouraged her to speak with her GP about medication options. She also began attending weekly mobility and mindfulness sessions and accessed peer support.

Approach

Our team provided ongoing emotional support and practical help navigating the healthcare system. We worked with her to create a personal plan for managing future crises, including helpline numbers, breathing techniques from the sessions, and a trusted contact from our team to speak with in moments of distress.

Results

Since engaging with the project, she has not accessed urgent care services. She reports feeling more in control of her mental health and has shared her story with others in the group, encouraging them to seek early help. Her GP and therapist now provide ongoing support, and she continues to attend activities in the community.

CAB Blackpool

Client was 54 years old, lived with her son who had learning difficulties. She had experienced a serious chest infection in early 2024, so was concerned about becoming unwell again over the winter and not being there to look after her son. She said the spell in hospital had been awful for her and the worry of being ill again was affecting her mental health. In January 2024 she was taken to hospital due to breathing difficulties. Client first accessed the Link Worker service in December and was seen twice before Christmas. This involved a referral to energy advice services.

Requirements

Client was in need of help heating her home. Her son's learning difficulties meant they both spent a lot of time at home and she was struggling to make ends meet financially. Last year, she was concerned about the cost of her heating so only heated the house for an hour a day.

Approach

The referral to energy advice meant the client could receive vouchers to top-up her meters, could access food vouchers and home energy insulation advice. The client was also given two heated throws to help stay warm at home.

Results

The client was able to stay well at home and she described the throws as a life saver for her and her son. She had also started to engage with a local community hub at South Shore since the Link Worker had introduced her to this and was going there on Mondays and Thursdays to socialise and have a warm drink.

The client would have probably ended up in hospital again in Jan/Feb 2025 without this intervention and she was so gretaeful for the support she'd received for her and her son that meant they could remain at home; safe and warm.

Client was also more active and able to get out as the warmer weather started in March, this will contribute to her remaining in better health throughout the year, having more resilience over the winter and better mental health.

Groundwork

We have been supporting YO for the past three years, providing a range of assistance, including counselling, food aid, housing support, and more. YO had been in a very controlling relationship for several years, which significantly impacted her confidence. She had smoked for decades, using it not only as a habit but also as a coping mechanism for the stress she endured.

Over the years, YO had visited urgent care multiple times due to poor breathing, worsened by her smoking. In December 2024, she spoke with the Stop Smoking team at the centre. With the staff's support, YO created a plan to quit smoking for good. We're delighted to share that YO hasn't had a cigarette since mid-December the longest she's ever gone without smoking and she hasn't needed to visit urgent care at the Vic since.

"The heated throws were a lifesaver for both me and my son. Without the support we got, I'd have ended up back in hospital. Now we're warm, supported, and I've even started going out again."

AGE UK BWD

Jo, a 70-year-old man from Darwen South, has experienced a decline in his health, limiting his mobility and independence. Previously active in sports and social activities, he now rarely goes out. He lives in a second-floor flat, where his daughter has recently moved in to support him. Although Jo manages daily tasks, he struggles with mobility around his home, relying on furniture and door handles for support.

Challenges Identified

- Difficulty getting up from his low-settee.
- Holding onto walls, radiators, and furniture for stability while moving around his flat.
- Struggles to safely access his shower, requiring support.
- Using the sink and radiator for balance when using the toilet, increasing his risk of falls.
- Narrow hallway without adequate handrails for safe movement.

Support Provided

Referral to Adult Social Care Independent Living Service, which installed:

- Handrails on both sides of the hallway for safer movement.
- Grab rails in the shower to aid entry and exit.
- A grab rail and toilet raiser for improved toilet accessibility.
- Provided home exercise routines to strengthen mobility and prevent falls.
- Active Ageing Co-ordinator visit to provide guidance and encouragement in completing exercises.

Outcome

Jo feels significantly safer and more confident in his home, reducing his risk of falls and preventing potential emergency care visits. The adaptations have made a noticeable difference in his mobility, allowing him to move around with greater ease. He continues to engage in home exercises regularly, reporting increased strength and stability.

Jo expressed appreciation for the support, service, and communication he received, crediting these interventions with improving his quality of life and reducing his risk of and need for urgent medical attention.

“The changes in my flat have made a world of difference, I feel safer, stronger, and more confident moving around. It’s helped me stay independent.”

AGE UK BWD

Mr P, a 70-year-old man with a heart condition and mobility issues, struggled with shortness of breath and difficulty using the stairs in his first-floor flat.

Support Provided

- Identified the need for a second banister rail to improve safety.
- Arranged installation through Care Network's Safe Trader scheme.
- Provided falls prevention resources and an exercise-at-home guide to support mobility.
- Conducted a benefit check to explore financial support options.

Outcome

Mr P now moves around more safely, reducing his risk of falls and potential hospital visits. The preventative measures have enhanced his independence and confidence, decreasing his likelihood of needing urgent care services.

His positive feedback highlights the effectiveness of early intervention in improving well-being and reducing emergency health risks.

"Before, we'd have rushed to A&E, but this time we had the right advice, got quick help from our GP, and our child was back at school the next day."

180 PROJECT

Preventing A&E Reliance Through Community Support

A seven-year-old child with a history of asthma experienced breathlessness at school, prompting parental concern. In the past, the parents would have immediately taken the child to A&E due to anxiety. However, thanks to information and guidance from Neighbourhood Network and Linked Tree, they were aware of alternative care pathways.

Instead of visiting A&E, we advised the parents to contact 111, which led to an immediate GP consultation. The GP issued a prescription for a blue inhaler, provided a treatment plan, and outlined further steps if symptoms worsened. An asthma review was also scheduled to ensure long-term management.

As a result, the child improved within an hour, returned to school the next day, and avoided an unnecessary A&E visit. The parents felt empowered, reassured by the support available in the community, and confident in managing future health concerns appropriately. This case demonstrates how awareness and early intervention can reduce unnecessary pressure on urgent care services while ensuring effective treatment.

THOMAS

Preventing A&E Visits Through Holistic Support

A male, Asian British client experiencing homelessness, substance use, and declining mental health frequently considered visiting A&E for warmth and shelter. He struggled with depression, stress, and anxiety, lacked a support network, and reported feeling unsafe on the streets. His substance use (heroin and crack) and housing instability made employment impossible, and he had concerns about his physical health, particularly breathing issues due to exposure to the cold.

Intervention & Support

THOMAS provided comprehensive case management, addressing key issues to reduce the client's reliance on emergency services:

Housing: Initial attempts to secure council housing were unsuccessful due to previous evictions, but a Bridge to Home referral led to securing private accommodation through Pendle Homes.

Physical & Mental Health: A health check at THOMAS revealed no major concerns, but the client was advised to consult a pharmacy for a second opinion. A referral to TIME was made for mental health support, and the client was encouraged to attend a GP appointment for a medication review and well-being discussion.

Substance Use: The client was supported in engaging with SPARK and receiving harm reduction interventions, improving his stability.

Safety & Well-being: With stable housing, the client no longer felt unsafe. He also gained access to essential services and support networks, reducing isolation.

Results

The holistic support enabled the client to avoid unnecessary A&E visits, as he no longer needed to seek warmth or emergency assistance. This resulted in:

- Secured stable housing and reported feeling settled.
- Attended his GP and pharmacy, confirming no immediate health concerns.
- Engaged with drug and alcohol support services, working toward recovery.
- Became more independent, no longer needing food provisions from THOMAS.
- Received continued well-being support, including help obtaining essential household items.

The client expressed gratitude for the intervention, highlighting how structured support reduced his crisis situations, preventing A&E visits and fostering long-term stability.

"Without THOMAS, I'd still be on the streets or in A&E, now I've got a roof over my head, support, and a chance to move forward."

SPRING NORTH

COLLABORATION + INNOVATION = IMPACT

Lancashire and South Cumbria VCFSE Alliance

NHS Lancashire and South Cumbria Integrated Care Board