

# UEC Impact Report

2025/26



Lancashire and  
South Cumbria  
**VCFSE  
Alliance**



**Lancashire and  
South Cumbria**  
Integrated Care Board

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# Introduction

**As Chair of the Lancashire and South Cumbria VCFSE Alliance, I am pleased to introduce this year's Impact Report, showcasing the collective achievements of our sector in supporting communities across Blackburn with Darwen, Blackpool, Lancaster and Morecambe.**



This is the second consecutive year that the ICB has invested Urgent and Emergency Care (UEC) funding directly into the VCFSE, and the results once again demonstrate the value, reach and impact of community led solutions in keeping people safe and well at home.

Building on the learning from winter 2024–25, we have expanded the programme geographically and strengthened the model through deeper collaboration, improved referral pathways and a more coordinated system response. The role of the VCFSE Alliance in overseeing this work has been critical, ensuring effective governance, quality, and appropriate approaches across diverse localities. I would also like to acknowledge the vital contribution of Spring North as managing agent, whose leadership, monitoring and operational support have enabled partners to deliver at pace and scale.

The outcomes achieved this winter speak for themselves. More than **18,000 people** received support, with **86% living in the most deprived Core20 areas**, demonstrating our continued focus on tackling health inequalities. Through targeted early intervention, the programme helped avoid **7,950 A&E attendances** and **1,870 ambulance call outs**, while supporting **2,310 people** before their situation escalated into crisis. Our work also played a crucial role in improving patient flow, with **1,120 individuals supported within 72 hours of discharge**, and **87% remaining stable at home after 30 days**.

Beyond system pressures, the programme delivered meaningful improvements in people's lives: **78% reported better mental wellbeing**, **64% felt less lonely**, and **72% experienced improved financial stability**. These outcomes were made possible by the introduction of **14 community hubs**, the activation of **14 new community hubs**, and the delivery of more than **42,000 individual interventions**, ranging from home visits and welfare advice casework to social prescribing and wellbeing support.

The financial case is equally compelling. This winter's activity generated an estimated **£2.27 million in direct NHS savings**, delivering a return on investment of **£5.40 for every £1 invested**. These savings reflect not only avoided activity, but the wider system benefits of a stronger, more resilient community infrastructure.

What this report demonstrates is clear: when the NHS and VCFSE work in genuine partnership, we can deliver targeted, preventative, person centred support that reduces pressure on urgent and emergency care while improving outcomes for those who need help most. The achievements set out in the following pages are a testament to the dedication, innovation and deep community insight of our VCFSE partners across Lancashire and South Cumbria.

As we look ahead, the VCFSE Alliance remains committed to strengthening this model, deepening integration, and ensuring that community based support continues to play a central role in our system's approach to winter resilience, neighbourhood health and beyond.

**Tracy Hopkins, Chair**  
VCFSE Alliance Lancashire & South Cumbria

# Foreword

**Firstly, I am really pleased to be able to introduce this report and the collaboration which is improving the lives of people in our communities to reduce urgent demands on services in some of our communities where there is the greatest need.**



It demonstrates the positive vision for health and care which can be achieved when we create the right environment for close working with partners. When we are grounded in local community insights and driven by a shared determination and desire, we can improve health outcomes and reduce health inequalities in the communities we serve in Lancashire and South Cumbria.

We continue to face some of the most significant health inequalities in the country, alongside rising urgent and emergency care pressures, unwarranted and historic variation in access to services, and a tough financial climate that demands careful stewardship and bold choices. Yet these challenges do not weaken our ambition – they sharpen it. They strengthen our resolve to lead a strategic shift from reactive, hospital centred care toward prevention, early intervention, neighbourhood based models, and integrated, person centred support. Achieving this requires innovative thinking and strong partnerships.

This report demonstrates the impact we can make for individuals in our communities when we enable innovation and trust in our partnerships with the voluntary, community, faith and social enterprise sector. It outlines an example of how we can target investment to strengthen neighbourhood health, transform clinical pathways, build resilience and prevention of ill health, and fundamentally shift resources towards models of care that deliver long term health and social value.

We know that real transformation happens through relationships. We can achieve great things through partnerships that bring together community organisations, local leaders, clinical leaders and residents around shared goals. As a health and care system we will be looking for more opportunities to create the conditions that enable innovation, foster collaboration and support partners to deliver the highest standards of care.

Finally, I would like to say a huge thank you to all the voluntary, community, faith and social enterprise colleagues who have helped to achieve the impact which is set out in the report. You deserve to be proud of the impact you make, and I am convinced that if we continue to build on this, working alongside our dedicated staff in NHS, local authorities, social care and community services, we can make a real difference for the health and care in our communities.

**Aaron Cummins, Chief Executive**

Lancashire and South Cumbria Integrated Care Board

# What This Programme Did

## and Why It Matters

This report covers the work delivered across Lancashire and South Cumbria between April 2025 and March 2026 under the UEC VCFSE Alliance Programme. The short version: eight voluntary and community sector organisations worked alongside the NHS to stop people ending up in A&E when what they actually needed was a warm home, help with a debt letter, or someone to check in on them.

The numbers are significant. But behind them are real situations – an older woman who kept falling because she couldn’t afford to heat her home properly, a man calling 999 multiple times a week because he had no other way to manage his mental health, a family three days from eviction. These are the cases this programme was built for.

### At a glance:

|                             |               |
|-----------------------------|---------------|
| People supported            | 18,420        |
| A&E attendances avoided     | 7,950         |
| Ambulance call-outs avoided | 1,870         |
| Direct NHS savings          | £2.27 million |
| Return on investment        | £1 → £5.40    |

These figures are conservative estimates based on NHS reference costs and established VCFSE evaluation methodology.

# Programme Overview

The programme's starting point was a straightforward observation: a significant proportion of people presenting at A&E or calling 999 don't have a clinical need. They have a social one. They're cold, scared, in debt, isolated, or in the middle of a family crisis – and they have nowhere else to turn.

The programme was designed to get ahead of those moments – or catch them early – by ensuring that community support was accessible, joined up, and embedded in the same referral pathways as NHS services.

## What we set out to do

Reduce avoidable A&E attendances by addressing the underlying causes of crisis presentations

Reduce pressure on ambulance services, particularly from frequent callers

Support safe discharge and reduce length of stay by providing practical home support

Build community capacity to absorb and manage non-clinical crises

Improve wellbeing and independence for people at risk of crisis

## Who we worked with

The programme, using a community-based approach, focused on people whose circumstances put them at high risk of avoidable UEC demand – older adults living alone, frequent A&E attenders, people in mental health crisis, families under acute financial pressure, and individuals dealing with housing instability or poverty. 85% of people supported on the project live in IMD (Index of Multiple Deprivation) Core20 areas.



# Partnership and Delivery Model

One organisation cannot do this work alone. The strength of this programme has always been the depth of the partnership – eight organisations, each with genuine expertise and community presence in their area, working to a shared purpose. The partnership focuses on building strong local connections by delivering clear messaging, coordinated activities, and accessible information. It also provides guidance, referrals, and health checks to support the needs and wellbeing of the community.

## Spring North Programme management, evaluation, and system coordination

### Lot 1 – Respiratory Support in Blackpool

|               |                                                                       |
|---------------|-----------------------------------------------------------------------|
| Blackpool CAB | Welfare benefits, debt, and housing crisis support                    |
| Groundwork    | Practical home support, fuel poverty, and environmental interventions |

### Lot 2 – Support for Older People to Reduce Falls in Blackburn West

|                              |                                                                  |
|------------------------------|------------------------------------------------------------------|
| Age UK Blackburn with Darwen | Falls prevention and home independence services for older adults |
|------------------------------|------------------------------------------------------------------|

### Lot 3 – Multiple Disadvantage in Blackburn Central

|                             |                                                                                            |
|-----------------------------|--------------------------------------------------------------------------------------------|
| 180 Project                 | Mental health support and behaviour change work                                            |
| St Luke's Church, Blackburn | Community outreach, vulnerable people and families, food provision, and essentials support |

### Lot 4 – Integrated Care Coordination Support for All Age Patients in North Lancashire

|                            |                                                              |
|----------------------------|--------------------------------------------------------------|
| Age UK Lancashire          | Discharge support, home checks, and loneliness interventions |
| Stanley's Community Centre | Family support and community crisis response                 |

# Key Achievements

Across the year, the programme delivered the following:

**7,950**

A&E attendances avoided

**1,870**

ambulance callouts avoided

**2,310**

people supported earlier,  
before their situation  
escalated into a crisis requiring  
emergency services

**3,245**

acute bed days prevented

**1,120**

individuals supported within  
72 hours of hospital discharge

**78%**

reported improved  
mental wellbeing

**64%**

reported reduced feelings  
of loneliness

**72%**

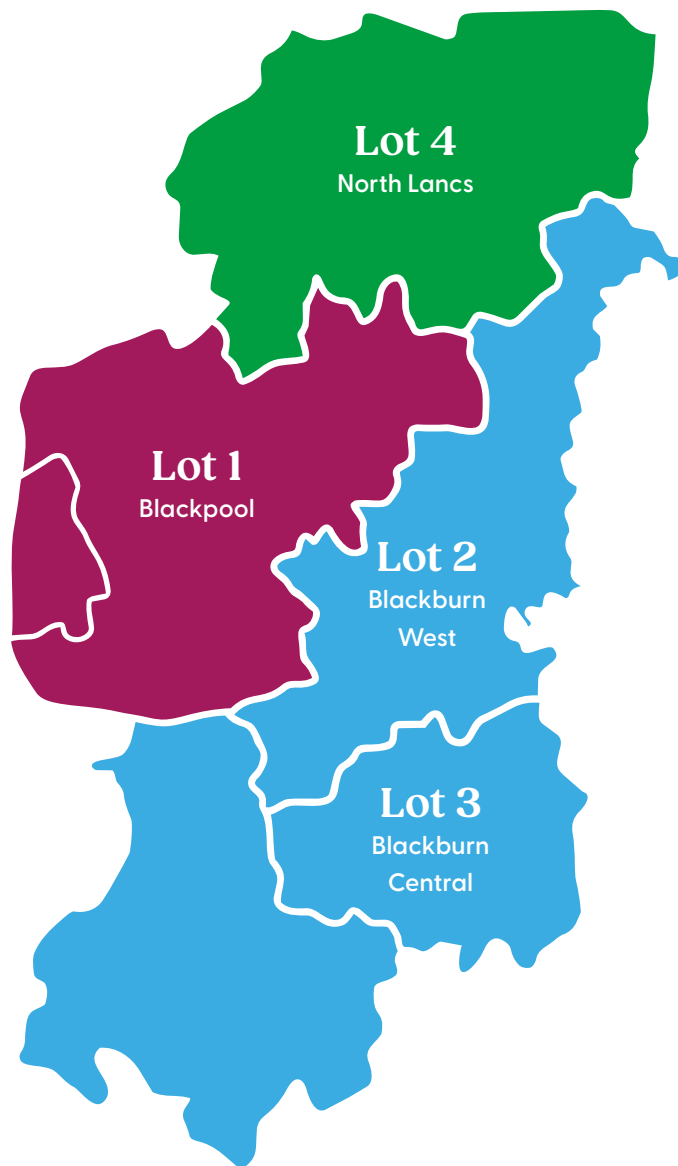
reported improved  
financial stability

**14**

community venues  
used to expand reach

The programme's impact has been driven by a strong focus on early intervention, rapid response, and holistic support. By identifying people before their needs escalated and stepping in quickly—often within hours—the team was able to prevent thousands of avoidable A&E attendances and ambulance callouts. Close partnership with hospitals meant individuals were contacted within 72 hours of discharge. Alongside this, tailored emotional, social, and financial support improved wellbeing, reduced loneliness, and strengthened financial stability for many. A reduction in GP appointments has been achieved through alternative support methods; education on the Ill service, local pharmacy array of services, social prescribing and direct, intensive support.

We know these outcomes are reliable because they're based on consistent data recording, follow up checks, and validated wellbeing measures. Spring North's bespoke case management systems tracked every intervention, while feedback from participants, volunteers, and NHS partners confirmed the changes people experienced. The evidence reflects a combination of recorded activity, professional verification, and direct participant insight—giving confidence that the results are both meaningful and robust.



## Lot 1 Blackpool

A&E attendances avoided: **2,966**  
 Ambulance callouts avoided: **735**  
 People supported earlier: **646**  
 Acute bed days prevented: **424**  
 Individuals supported within 72 hours: **535**

## Lot 2 Blackburn West

A&E attendances avoided: **102**  
 Ambulance callouts avoided: **41**  
 People supported earlier: **98**  
 Acute bed days prevented: **116**  
 Individuals supported within 72 hours: **28**

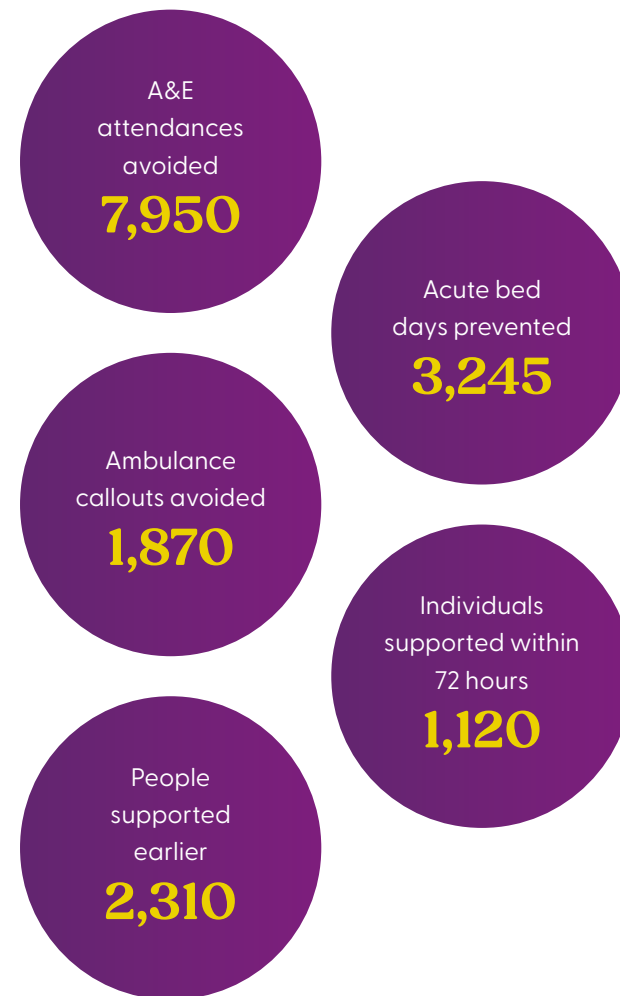
## Lot 3 Blackburn Central

A&E attendances avoided: **1,758**  
 Ambulance callouts avoided: **471**  
 People supported earlier: **850**  
 Acute bed days prevented: **513**  
 Individuals supported within 72 hours: **207**

## Lot 4 North Lincs

A&E attendances avoided: **3,124**  
 Ambulance callouts avoided: **623**  
 People supported earlier: **716**  
 Acute bed days prevented: **2,192**  
 Individuals supported within 72 hours: **350**

## Totals of all delivery areas



# What Was Delivered

## Outputs



**18,420**

people supported in total



**46,000+**

engagements delivered



**1,980**

advice and welfare sessions



**3,400**

wellbeing and social  
prescribing sessions

## Measurable outcomes



**43%**

reduction in repeat A&E  
attendance among people  
receiving targeted support



**38%**

reduction in 999 calls  
among frequent callers



**52%**

reported improved ability  
to manage their own health  
and wellbeing

# Financial Impact and Return on Investment

Using NHS reference costs and established public sector valuation methods, we calculated the following savings:



**Overall return on investment:  
for every £1 invested, this  
programme generated £5.40 in value**



# Four Cases That Illustrate the Work

**These are real situations, anonymised.  
They're included because statistics only go so far.**

The following case studies represent typical examples of the support delivered every day by our VCFSE partners. While the interventions may appear simple, they reflect a consistent, community-focused approach that is making a measurable difference across the system.

Through timely, person-centred and wraparound support, these services are helping to reduce unnecessary attendance at urgent and emergency care, avoid hospital admissions, and ease wider system pressures. Just as importantly, they are supporting individuals to better understand and manage their own health and wellbeing, leading to sustained behaviour change over time.

Each case study demonstrates that it is often these straightforward, trusted interventions, delivered in the right place, at the right time, that have the greatest impact. Collectively, they highlight how everyday support from the VCFSE sector within communities is contributing meaningfully to improved outcomes for individuals and a more sustainable health and care system.



## Case 1

### Falls and fuel poverty



An older woman living alone had been having repeated falls. A referral came in from her GP practice and AgeUK Lancashire carried out a home assessment. What they found wasn't primarily a medical issue: her home had trip hazards throughout, the lighting was poor in key areas, and she was rationing her heating to the point where she was sometimes too cold to move safely. The team arranged minor adaptations, connected her to the warm home scheme, and set up daily welfare check calls. She had no further falls. She didn't attend A&E once in the following six months.

## Case 3

### Family in crisis



A family with young children was three days from eviction. They were behind on rent, had significant debt, and the pressure had brought the family to breaking point. Stanley's Community Centre coordinated debt advice, emergency food support, and family mediation. The eviction was avoided. There was no safeguarding escalation. The children remained in school. The family made no A&E presentations during the period of support.

## Case 2

### Frequent 999 calls



A man in his forties was calling 999 multiple times a week in mental health distress. He wasn't in immediate danger – but he had no other way of managing what he was experiencing and no one to call. The 180 Project worked with him intensively over eight weeks: behaviour change support, a peer mentor who'd been through something similar, and a crisis plan he'd had a hand in writing. By week eight, the calls had stopped entirely. That's not a small thing for the individual or for ambulance services.

## Case 4

### Respiratory concerns



A 57 year old woman from Blackpool, living with COPD and unable to afford adequate heating, was referred by our link workers to the Little Van of Warmth. Through this, she received a heated throw and food vouchers, giving her immediate comfort and reducing the risk of her condition worsening. This support helped prevent further COPD exacerbations, a reduction in her social isolation, improved wellbeing, and avoidance of hospital admissions.

# Impact on the Wider System

**Beyond individual outcomes, the programme contributed to measurable improvements across the UEC system:**

- Reduced pressure on A&E departments, particularly during periods of high demand
- Improved ambulance availability, with fewer non-emergency calls tying up resource
- Faster discharge and better patient flow, supported by community-based aftercare
- Reduced demand on primary care, with people better able to self-manage
- Stronger community infrastructure, with 14 community venues accessed
- More effective integration between NHS and VCFSE sectors, with improved referral pathways

# What We've Learned

A year of delivery uncovers things you can't know in advance.

## Getting in early works

The cases where the programme had the greatest impact were almost always ones where referral happened before the person had reached crisis point. Late-stage intervention still has value – but it's harder, more expensive, and the outcomes are less consistent. Earlier referral pathways need investment.

## VCFSE organisations reach people statutory services don't

This isn't a criticism of statutory services – it's a structural reality. Community organisations often have pre-existing relationships, local presence, and a different kind of trust. Some of the people this programme supported had actively avoided NHS contact for years, apart from attending A&E, creating relationships back with local health provision is key, GP, pharmacies etc.

## Data sharing remains a bottleneck

The quality of referrals improved significantly over the year as NHS staff became more familiar with partner organisations and what they could offer. But information sharing between systems is still more difficult than it should be – and that slows down response times and creates duplication. This needs a structural solution, not just goodwill.

# What We're Recommending for 2026/27

**Based on what's worked this year and where the gaps are, we're recommending the following:**

- Increase investment in VCFSE-led UEC prevention – the return is demonstrably strong
- Expand frequent attender support across all localities, not just the areas covered this year
- Embed VCFSE partners formally within discharge pathways rather than relying on informal referral
- Fund a proper shared digital referral and data-sharing infrastructure
- Scale fuel poverty and home safety interventions – the link to avoidable emergency demand is direct
- Develop a shared outcomes framework across the ICS so impact can be measured consistently year on year



# Conclusion

**The argument for community-based UEC prevention no longer needs to be made on principle. This programme has made it on evidence.**

**18,420 people supported. Nearly 8,000 fewer A&E attendances. A return of £5.40 for every £1 spent. A set of partner organisations that have deepened their expertise, extended their reach, and embedded themselves more firmly into the NHS referral ecosystem.**



COLLABORATION + INNOVATION = IMPACT



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