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Lancashire and South Cumbria VCFSE Alliance
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Project Specification Brief

Project Title: Integrated Care Coordination Support for All-Age Patients in North Lancashire

Funding Source: UEC Capacity Funding for VCFSE-led Schemes

Funding Period: 7 months (September to March) – 1 month setup, 6 months delivery

Maximum Budget: Up to £100,000 (non-recurrent grant funding)

Geographical Focus: Lancaster, Morecambe and Carnforth ICC footprint, with a focus on patients linked to the Royal Lancaster Infirmary

EOI Submission Deadline: Friday 15th August 2025 COP.

Project Overview

The project aims to reduce unplanned hospital use through coordinated wraparound support for all-age patients, with a particular focus on admission avoidance. The project will deploy non-clinical, community-based Care Coordinators to work alongside health and care services, including Transfer of Care Hubs, Integrated Care Communities (ICCs), Urgent Community Response, and PCN MDTs, to connect patients with relevant VCFSE services and community assets to manage wider determinants of health, reduce readmission risk, and promote recovery and independence.

The Voluntary, Community, Faith and Social Enterprise (VCFSE) sector plays a vital role in supporting people to stay well, independent, and connected within their communities. In the Lancaster district, VCFSE organisations are embedded in local neighbourhoods, often reaching individuals who are isolated, vulnerable, or facing multiple disadvantages.

The sector brings trusted relationships, local insight, and flexible, person-centred support, making it ideally placed to:

- Identify people early who are at risk of poor health or avoidable hospital use.
- Offer practical and emotional support that prevents crisis.
- Help people recover well and stay safe at home after a hospital discharge.
- Tackle the wider social factors that affect people's health and wellbeing.

This model will enable effective partnership working between the VCFSE and those statutory health services listed above to help to reduce demand through a holistic, preventative, asset-based approach.

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Purpose of the Service

To work collaboratively across the Lancaster district to:

- Identify and support people who are at risk of unnecessary hospital admission or frequent use of urgent and emergency care (UEC).
- Provide personalised, community-based support that helps people stay well and reduces reliance on urgent care.
- Focus efforts on reducing health inequalities, especially for those in the **Core20PLUS5** cohorts and others most at risk of poor outcomes.

Key Deliverables

1. **Community-Based Care Coordinator Model**
   Objective: Deliver a VCFSE model of care co-ordination aligned to ICCs to prevent avoidable admissions to hospital.

   Deliverables:

   - Recruit and deploy Care Coordinators to work with all-age patients known to Royal Lancaster Infirmary and ICC Teams who are at risk of a hospital admission.
   - Work alongside ICCs to establish referral pathways into the service.
   - Optimise referral pathways from acute wards, discharge teams, and PCNs.

2. **Improved Connection to Community and Voluntary Sector**
   Support Objective: Improve uptake and engagement with non-clinical support addressing social, emotional and practical needs.

   Deliverables:

   - Provide updated information to the Lancaster District Directory of local support services (e.g. housing, food, benefits, transport, peer support, social inclusion).
   - Proactively refer and support all-age patients and carers, known to Royal Lancaster Infirmary, to access appropriate services to avoid admissions to hospital.
   - Capture and monitor outcomes of support accessed (e.g. avoided reattendance, improved wellbeing).

3. **Multi-Agency System Navigation Objective:** Ensure coordination between health, care and VCFSE services.

   Deliverables:

   - Attend relevant MDT meetings, including 'Familiar Faces' MDT across ICC, PCN and acute settings.
   - Act as liaison between health professionals, social care, and community support.
   - Implement shared action planning and feedback loops to continuously improve service coordination.

4. **Targeted Work with High Intensity Use Patients (HIUs) Objective:** Reduce repeat A&E attendances or avoidable admissions among people with complex non-clinical needs.

   Deliverables:

   - Identify HIU cases suitable for community support intervention.
   - Co-develop support plans with individuals to reduce escalation and reliance on acute services.
   - Track impact and engagement over time through case review and qualitative feedback.
   - Identify individuals at risk of becoming known to High Intensity Use services earlier in their journey and offer proactive, non-clinical support and guidance to prevent escalation.

5. **Recruitment and Training of Community-Based Volunteer Supporters Objective:** Extend peer-based capacity to support individual's post-discharge.

   Deliverables:

   - Recruit and train Volunteer Health Champions to support Care Coordinators, support sustainability.
   - Offer befriending, check-in calls, and low-level support for individuals.
   - Deliver group awareness sessions on self-management, condition understanding, and local support options.

6. **End of Project Learning and Recommendations Objective:** Build understanding of how the VCFSE sector can contribute to a future neighbourhood health model.

   Deliverables:

   - Work with Spring North to co-produce a final report outlining:

- Service activity, outcomes, and insights.
- Value of VCFSE-led coordination in managing demand.
- Recommendations for scaling or sustaining.

Expected Outcomes

- Reduction in avoidable readmissions through early, tailored, non-clinical support.
- Improved care coordination and system navigation for individuals.
- Increased and sustained engagement with community and voluntary sector resources.
- Strengthened relationships and integrated working between VCFSE and NHS providers.
- Improved patient empowerment, self-management, and confidence.
- A measurable impact on reducing health inequalities within the Lancaster district, especially among Core20PLUS5 cohorts.
- Learning to inform future models of care across ICC footprints.

EOI Evidence Requirements

Organisations must demonstrate:

- A clear care coordination model tailored to the Lancaster, Morecambe and Carnforth ICC area.
- A track record of working with the 'Familiar Faces' MDT and commitment to attend these meetings as part of this work.
- Experience of working with health partners to reduce unplanned hospital use, or care navigation.
- Capacity to deploy skilled staff or volunteers rapidly.
- Understanding of the local health and care system, including PCNs, ICCs, and UCR pathways.
- Experience in managing and evaluating community health interventions.
- A data collection and reporting approach that tracks a patient throughout the entirety of this project and evidences outcomes, impact, and learning.
- They are in possession of (or can quickly action) the DPIS toolkit and have (or quickly acquire) an ODS code for data sharing.

End of Project Summary & Reporting

Organisations will work with Spring North to produce a final report no later than four weeks after the project ends, covering:

1. **Findings** – what was achieved, where gaps remain.
2. **Learning** – insights into what worked and how improvements can be made.
3. **Impact** – outcomes for individuals, families, and the system.

4. **Recommendations** – Practical guidance to inform future neighbourhood care models.

The report must include narrative, case studies, and visual data, accessible for system stakeholders and funders. Spring North will coordinate and support an impact report and short videos for sharing.

Delivery Deadline for Final Report:
w/c 20th April 2026