Way Forward

High Intensity Use of Urgent and Emergency Care Programme

Final Report

May 2026

healthwatch Wirral

Executive Summary

Purpose and scope

Healthwatch Wirral's Way Forward programme is a non-clinical High Intensity Use (HIU) intervention designed to support people who frequently attend urgent and emergency care, typically as a result of long-term conditions, health anxiety, trauma, and broader social determinants of health. The service provides personalised, community-based coaching and system navigation to reduce avoidable use of Emergency Department (ED) and non-elective admissions (NELs), while improving confidence, wellbeing and access to appropriate services. This report summarises the delivery, outcomes and learning from the *Way Forward* HIU pilot. It is intended to support Integrated Care Board (ICB) decision-making on ongoing commissioning, scale and spread of interventions, and the development of system pathways for people with complex needs who frequently use urgent and emergency care.
The work with high intensity users of emergency departments is required through NHS operational planning guidance and should be through community-based interventions, rather than limiting support to Emergency Department episodes alone.

Service model (Way Forward)

- **Non-clinical, community-based:** personalised 1:1 coaching focused on prevention, behaviour change, and empowerment (rather than a hospital-led clinical model).
- **Holistic support:** addresses wider determinants including housing instability/unsuitability, debt, bereavement, loneliness, and social isolation alongside physical and mental health challenges, and long-term conditions.
- **System navigation:** supports access to the right service first time (such as community or voluntary support, or GP, UTC, or walk-in centres where more appropriate), attendance at planned appointments, and delivery of Making Every Contact Count (MECC) through joined-up working.
- **Trusted relationships:** consistent contact enables confidence-building and reduces anxiety-driven escalation to emergency services. The model does not create dependency but focuses on behaviour change and individual's making informed decisions.

Financial outcomes

- **Attendance Reduction:** Emergency Department attendances of people who received interventions reduced by **52.7%** on average.[1] Non-elective admissions reduced by **52.88%**.[2]

[1] Pre-intervention (12-months prior) cohort attendance n=490. Post intervention cohort attendance n=232. Total clients who received interventions n=22, over a staggered period of 12 months.
[2] (In the first 6 months only. NEL data was only tracked for active clients from March to November 2025 due to staff and resource capacity).

- **Cost Avoidance: £107,070** cost avoidance from reduction in emergency department attendances.[3] **£22,761** non-elective admission cost avoidance, totalling to **£129,831** (does not include full NEL cost avoidance, or any ambulance conveyance cost avoidance)
- **Value for money**: Budget for 15-month project: **£65,075 (£52,060 per year).** Net savings (£129,831-£65,075) = **£64,756**, (99.5% return on investment). For every £1 invested, **£1.99** was saved.

System outcomes

- **Emergency Department:** reduced attendance, frees up frontline resources.
- **Acute admission:** fewer non-elective admissions, increasing inpatient capacity.
- **Ambulance services:** reductions in calls and conveyances.
- **Mental health services:** improved appropriate referrals to community-led support for underlying needs, reducing crisis use.
- **Primary care:** reduced inappropriate demand while improving relationships and access between GPs and patients.
- **Community health and social care:** improved relationships and access to appropriate pathways and practical support.
- **VCFSE sector:** enhanced community connections and support.

Key learning

- **Model and delivery:** positioning must be consistently preventative, community-based, and non-clinical; clinical delivery in hospital settings risks disengagement and unmet outcomes – **becoming treatment rather than prevention**.
- **Pathway gaps:** the cohort has highlighted potential gaps in provision for cardiovascular and respiratory exacerbation management and post-diagnosis support, and necessity for connecting hospital patients with health anxiety support outside of secondary care settings.
- **Continuity matters:** breaks in support can contribute to re-escalation and increased avoidable service use for some individuals.
- **Measurement opportunity:** regular attendance data, a live attendance tracker (including NWAS call/conveyance data) and inclusion of post-closure outcomes would strengthen evaluation and inform commissioning decisions.
- **Long term commissioning:** Initial commissioning period of 15-months too short to establish effective system reductions and continuity of support to individuals.

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[3] Figures are based on NHS Tariffs 2025/26 (£418 A&E attendance; £2,529 non-elective admission; £367 ambulance conveyance. Cost avoidances were calculated by comparing pre-intervention attendances across the full cohort (n=490) with attendance rates across programme period (n=232) and applying tariff costs. All figures represent estimated costs. They do not include projected cost avoidance beyond the project period, such as the impact of relapse or the sustained reduction in help-seeking behaviour.

Support and Pen Portraits

Examples of non-clinical support provided

- **Access to primary care:** liaised with GP practices to support access to appointments, including alternatives to online-only booking routes where these created barriers.
- **Co-ordinating planned care:** supported people to understand letters, keep track of investigations, and attend scheduled appointments (including, where appropriate, attending appointments alongside the individual).
- **Social prescribing and community support:** facilitated access to social prescribing (ARRS) and helped people engage with community groups and activities to reduce isolation and improve wellbeing.
- **Alternative urgent care options:** provided clear information on local urgent care options and what to expect, building confidence to use services appropriately (e.g. walk-in/urgent treatment services) and understanding escalation routes, if needed.
- **Anxiety and self-management support:** provided practical tools such as breathing techniques, coping strategies and details of out-of-hours support for people experiencing high levels of anxiety, including health anxiety.
- **Financial and cost-of-living support:** provided intensive help with debt issues contributing to stress/anxiety, including budgeting support, completing referral/applications to debt advice and energy support schemes and successfully negotiating affordable repayment arrangements with suppliers.
- **Volunteering and meaningful activity:** explored suitable volunteering opportunities and supported practical steps (e.g. applications and references) to help people build routine and purpose.
- **Adult social care access:** supported referrals for social care assessments and helped individuals secure practical support at home (e.g. help with shopping and household tasks).
- **Housing and healthy home support:** signposted and referred into housing/healthy homes support where accommodation was impacting health (e.g. damp/mould) and helped individuals to keep track of contacts and next steps using a range of formats.
- **Bereavement support:** identified bereavement as a driver of distress/health anxiety and made referrals/signposts to bereavement counselling and related support.
- **Community connector referrals:** linked people into neighbourhood-based connector services to strengthen informal support networks.
- **Goal setting and behaviour change:** worked with individuals (and, where relevant, support staff) to identify personal goals and practical steps to improve wellbeing and reduce crisis-driven service use.

Pen Portraits

The following pen portraits are based on a mixed sample of individuals who engaged with the intervention. All information that could enable identification has been anonymised in accordance with confidentiality and information governance requirements.

Name: John

Age: 65-79

Prior to intervention

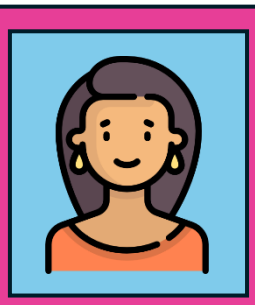
- High use of ambulance services and A&E driven by untreated health anxiety
- Multiple long-term conditions compounded by bereavement and social isolation
- Limited engagement with primary care and community services
- Low self-management capability and high reassurance-seeking behaviour

What we did

- Delivered consistent, relationship-based support to build trust and engagement
- Introduced practical self-management tools (e.g. breathing techniques, anxiety plans)
- Actively redirected care to primary care and community-based support
- Encouraged and supported GP engagement and explored supported housing options

Outcome

- Sustained reduction in inappropriate emergency service use during engagement
- Improved use of primary and preventative care pathways
- Increased patient capability and reduced dependency on crisis services
- Demonstrated need for continuity to sustain reduced demand on urgent care



Name: Amy

Age: 25-49

Prior to intervention

- Frequent emergency admissions linked to complex physical health conditions
- Trauma-related anxiety around hospital environments
- Difficulty managing both physical and mental health needs

What we did

- Took a holistic approach, addressing trauma, anxiety and suspected autism
- Built trust through consistent engagement
- Supported attendance at community art and singing groups
- Arranged extended GP appointment and care planning

Outcome

- Greater understanding and confidence in using health services
- Improved community engagement and wellbeing
- Reduction in ED attendances

Name: Will

Age: 65-79

Prior to intervention

- Learning disabilities and high health anxiety following cardiac issues
- Frequent ED attendance due to fear and uncertainty
- Difficulty accessing GP appointments and alternative urgent care
- Increased health anxiety whilst no occupying time

What we did

- Liaised directly with GP to remove access barriers
- Provided clear information on walk-in centres, UTC and ED alternatives
- Assisted with housing and financial support, like overdue bill payments
- Help with application to volunteer at a charity shop

Outcome

- Improved understanding of appropriate care pathways
- Reduced reliance on ED for reassurance
- Increased confidence in accessing non-emergency services
- Occupies time better with volunteering role

Name: Mark

Age: 80+

Prior to intervention

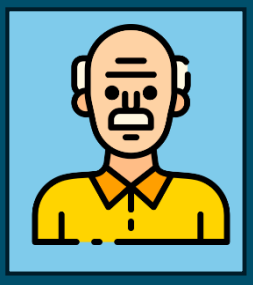
- Frequent ED attendance due to anxiety about unexplained chronic headaches
- Low mood, depression and health preoccupation

What we did

- Weekly coaching focused on anxiety management and self-regulation
- Introduced breathing techniques and solution-focused approaches
- Supported attendance at Wirral Mind Fountain Project groups
- Helped navigate health appointments and attend extended GP review

Outcome

- Rapid reduction in ED attendance early in intervention
- Improved coping with symptoms and reduced anxiety
- Increased confidence, mood and engagement in daily activities



Name: Francis

Age: 65-79

Prior to intervention

- Frequent ED attendance driven by profound isolation
- Limited social contact and support
- Difficulty sustaining engagement
- Complex mental health needs

What we did

- Provided regular, relational contact and conversations
- Explored befriending and social connection options
- Arranged social care assessment

Outcome

- Substantial reduction of ED use
- Ongoing daily social care support for household tasks
- Long-term 1:1 non-clinical support needed

Name: Kath

Age: 65-79

Situation prior to intervention

- Multiple long-term conditions including COPD and visual impairment
- Unsuitable housing exacerbating health problems
- Frequent hospital admissions and difficulty navigating services

What we did

- Acted as consistent point of contact and intermediary
- Linked client with Healthy Homes Wirral and RNIB
- Supported management of appointments and communications
- Assisted with medical notes, housing support, community service referrals

Outcome

- No reported inappropriate ED
- Increased appropriate use of primary and community care
- Improved confidence and reduced anxiety
- Ongoing vulnerability following project end

Recommendations

- **Model clarity:** Positioning must be consistently preventative and community-based; framing as a hospital model risks disengagement and unmet expectations.
- **Long-term condition pathway gaps:** the cohort has highlighted potential gaps in provision for cardiovascular and respiratory exacerbation management and post-diagnosis support.
- **Health anxiety pathway:** Establish a pathway that identifies health anxiety and anxiety-related ED attendances, and the appropriate referral opportunities back into Primary Care from the hospital, as well as VCFSE services, mental health practitioners, and social prescribers.
- **Continuity matters:** Breaks in support can contribute to re-escalation and increased avoidable service use for some individuals.
- **Referral opportunity:** Project experienced significant delays and low number of referrals. During the 12-month pilot (March 2025-2026), 58 referrals were received due to strict criteria and staffing capacity. No new referrals were received after 24 October 2025, resulting in under-utilisation of capacity and extended time spent on the active caseload, postponing closure of some clients.
- **Measurement opportunity:** Project did not receive live attendance data, and a performance dashboard of client hospital activity was never established. A live attendance tracker, frequent attendance updates, live performance measurements including increases and decreases in hospital activity, would have improved efficiency of project. NWAS (ambulance service) call and conveyance data would have strengthened evaluation and informed commissioning decisions. NWAS did not have the resources to dedicate to sharing data regarding active or closed clients. Strong data tracking is essential to project success.
- **Established Multi-Disciplinary Teams:** Efficient Multi-Disciplinary Teams will offer links between clinical support based on the needs of the cohort, non-clinical community and primary care representatives, and those delivering the HIU project including leads and coaches. MDT role and purpose will adapt to the needs of the individuals and should have the best interests of them as the core focus.

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