Evaluation of NENC ICB funding 2022/23 – 2024/25 to support multiple and complex health care needs

Background and findings

NIHR | Applied Research Collaboration North East and North Cumbria

Newcastle University

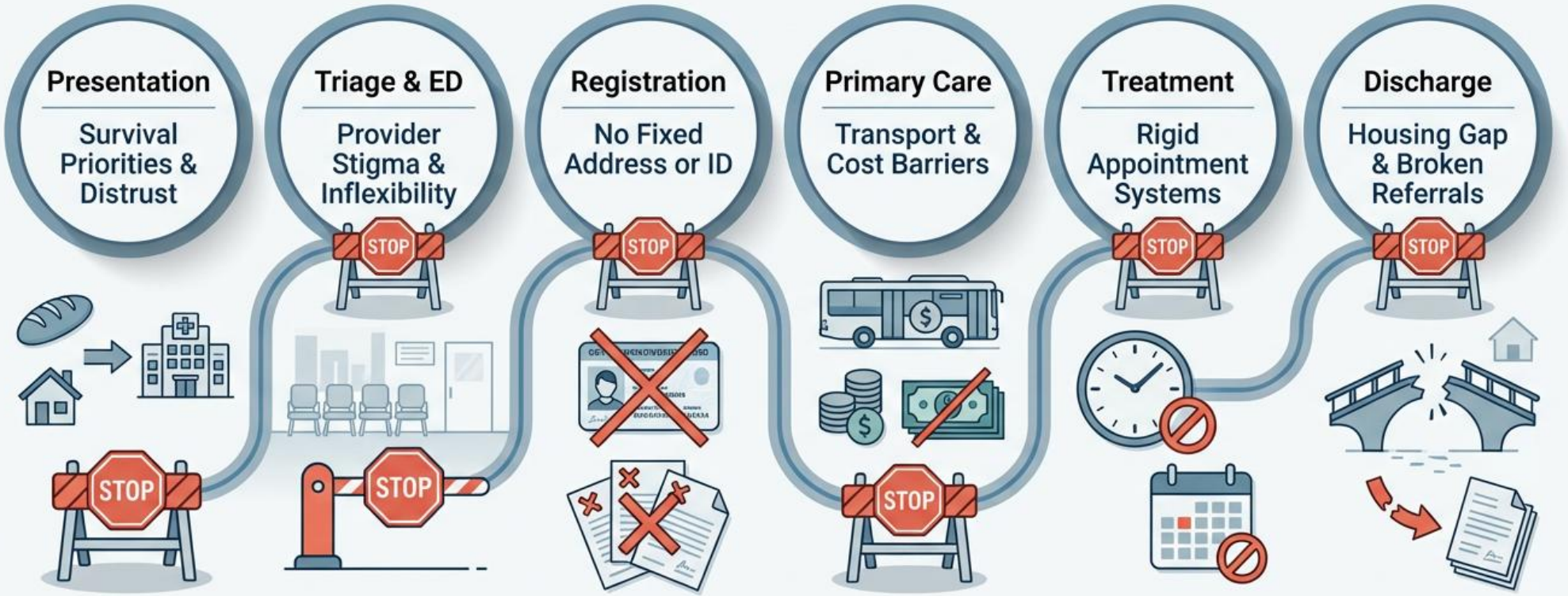
What is the problem?

The North East and North Cumbria (NENC) has high rates of:

- People with multiple complex health care needs
- Unmet health care needs (health, social care, housing, employment)
- Emergency care and A&E attendance
- Poor engagement with services



Healthcare Barriers for People with Complex Needs (Homelessness, Substance Use)

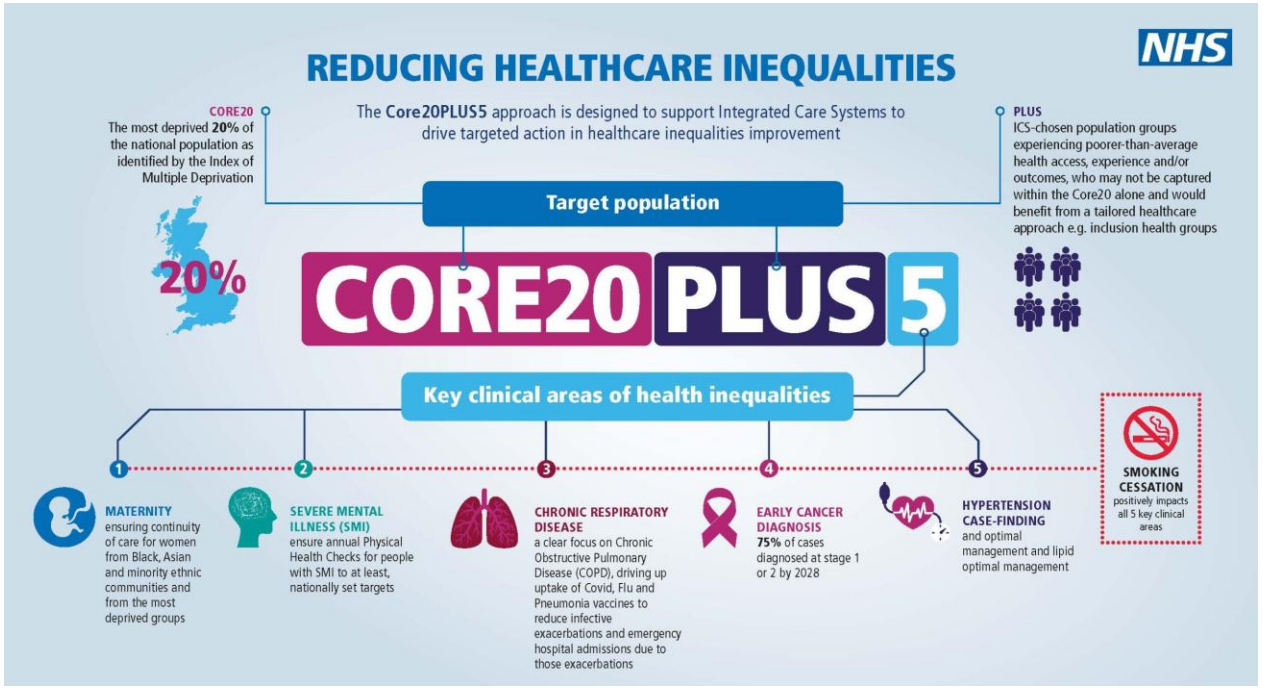


Legend: Barrier/Roadblock; Healthcare Journey Path

Image generated by Scispace.com AI

NENC ICB funding

- Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities.
  - Key component is to target specific action to Inclusion Health Groups
- The NENC Integrated Care Board (ICB) allocated £3m per annum of funding to 13 local authorities (LAs) from 2022/23 – 2024/25 to support people with multiple and complex needs (MCN)
- Each LA locally designed and delivered projects or services to support people with MCN access healthcare services
  - Primarily focused on those misusing drugs or alcohol and those with mental ill health



Evaluation aim and objectives



Aim:

To understand the use, impacts, and value of, as well as learning derived from, NENC ICBs Multiple and Complex Health Needs funding 22/23-24/25

Objectives:

- Establish how programme funding was used across LAs (target services, populations, outcomes) – including how these decisions were made.
- Identify new or novel initiatives or opportunities that this funding has enabled.
- Explore system level impacts of the programme including health and care integration, unintended consequences, and spillover effects.
- Establish plans for sustaining the services beyond the programme.

Data collection

- Desktop review
- Qualitative interviews and focus groups
- Ripple Effects Mapping workshop

Study participants



Thirteen LAs in the NENC

Interviews/focus groups

- Seventeen participants

Ripple Effects Mapping workshop

- Six participants

Participants roles included:

- Public health and commissioning roles

How did LAs decide how the funding should be used?



- Specifically commissioned research to identify local needs and inform future service design
  - Lived experience central to research and service development
  - Behavioural insights work
- Targeted service development based on public health intelligence and routine data analysis
  - Proactive interventions developed
- Collaborative and multiagency approaches

Participant quotes

"The first thing we did was to commission some research in that area… We allowed ourselves the time to really do the research to make sure we were meeting needs and not just the needs we thought were there" (ID17).

"We've done significant work as well within our Drug and Alcohol Recovery Service around voice of lived experience. We're really, really well versed in that, and we do a lot of consultation with that client cohort"(ID01+02).

How was the funding used?

Projects and Services

- 25 new services or projects
- 9 services expanded



Housing Insecurity and Homelessness

- Rough sleepers
- Risk of homelessness
- Seeking housing support

Substance Use

- Drugs and Alcohol misuse
- Tobacco and cannabis use in maternity

Targeted populations

Healthcare Access Barriers

- High use of out-of-hours care
- Less likely to attend healthcare

Vulnerable Groups

- Veterans
- Asylum seekers/refugees
- Contact with criminal justice system
- Young people
- Living in Deprived Areas
- Plus5 Populations
- Mental ill health in deprived areas



Some services and projects that were funded:

- Outreach/in reach/key workers – health/wellbeing advice and screening
- Mental health support/primary care support (asylum seekers/young people)
- Health and Wellbeing coaches
- Development of service directory/training/resources/toolkits
- Insights work
- Data system flagging patients seeking OOH care meeting CORE20+5 criteria
- Enhanced wound care provision
- Respiratory clinics within Drugs and alcohol services/primary care
- Social prescriber
- MASH/multi-disciplinary hub
- Single point of access teams
- Healthcare navigators

Participant quotes

"We've had lots of health buses over the years, vaccination buses, screening buses. This is totally different. It's a primary care bus with relational support embedded on, so we've got relational support workers" (ID17).

"We decided that the respiratory offer was something we'd like to look at and work with the ICB to say, "What could we offer?" But also work, very clearly, with primary care to ensure we're not putting a service in place of what they should be doing in terms of primary care, but enhancing... "What else could we do to enhance that without replicating what primary care are doing?" We don't want to replace the service" (ID05).

Service implementation challenges

- Delays in receiving the funding
- Short implementation timing
- Staff recruitment
- Data sharing, procurement, and system setups
- Differences in working practices
- Sustainability of services



Participant quotes

"...bureaucracy and data agreements are the thing that have taken the longest to get signed off, the training, and the delivery, and things like that" (ID01).

"For example, restrictions in working hours because a service is used to working in such and such a way, it would need to be between 8:00 and 6:00 or whatever...(ID15+19).

" I think there was a time lag in people getting the funding, initially, so you're already partway through" (ID05).

Service implementation facilitators

- Targeted service development
- Collaborative and multiagency approaches
- Staff passion and commitment
- Inclusion of lived experience
- Innovative outreach and engagement strategies
- Embedded researcher



Participant quotes

"The team's can-do mindset and strong relationships with partners have encouraged collaboration and joint working, which has been key to its impact" (ID01+02).

"I think the research helped to give us that, that context and background to know what we needed to focus on and then we could look at the data to say, "Right, okay, yes, they both align with each other…I think actually doing that research at the beginning, because it was localised research, really helped, so that was really helpful for us" (ID18).

Reported outcomes





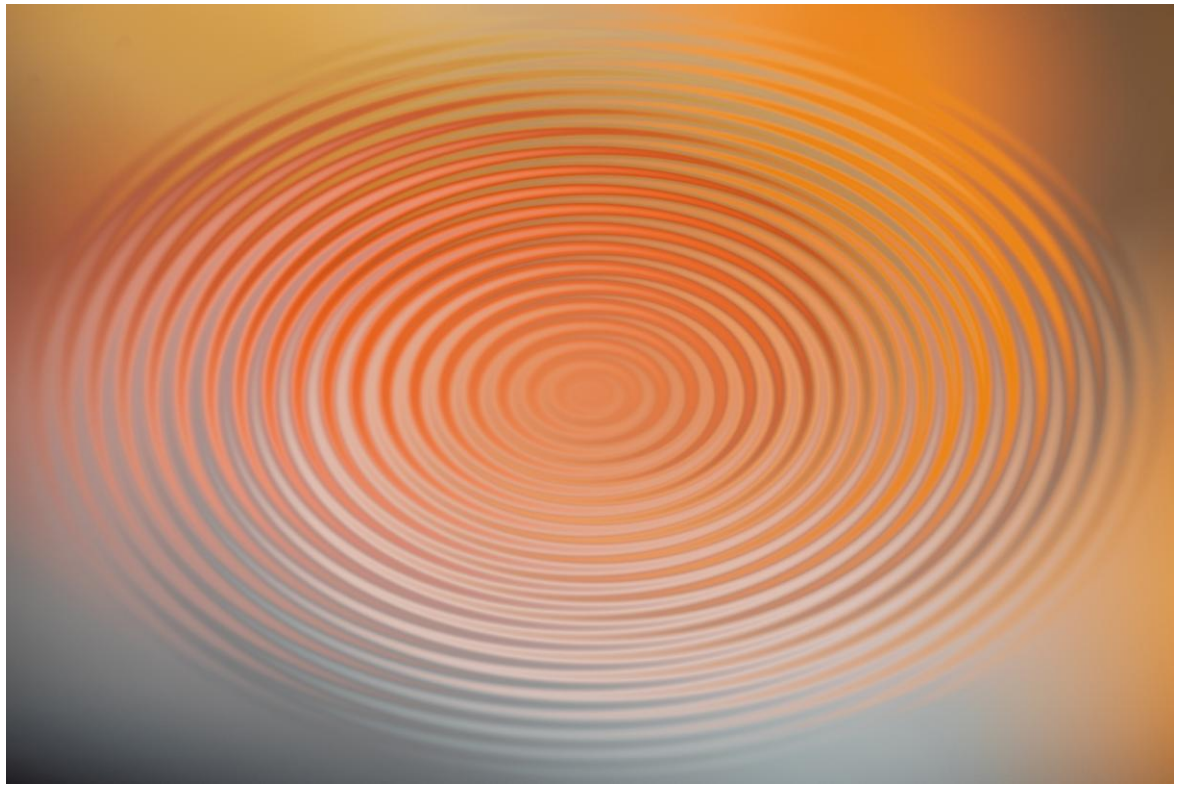
Who has received help from the funding/initiatives?

- Those with high unmet needs
- Those who do not access healthcare services
- Those with complex needs (risk of homelessness, rough sleepers, drugs and alcohol misuse)

Impacts

- Reductions in 999 and 111 calls, outpatient DNAs and in emergency admissions.
- Increase in planned elective admissions for needed care
- Evidence that people have been registered or re-registered GPs.
- People identified with health problems receiving treatment, including a case study of one service user at risk of losing a limb that has been saved.

Ripple Effects Mapping Workshop



Providing wider context to the story

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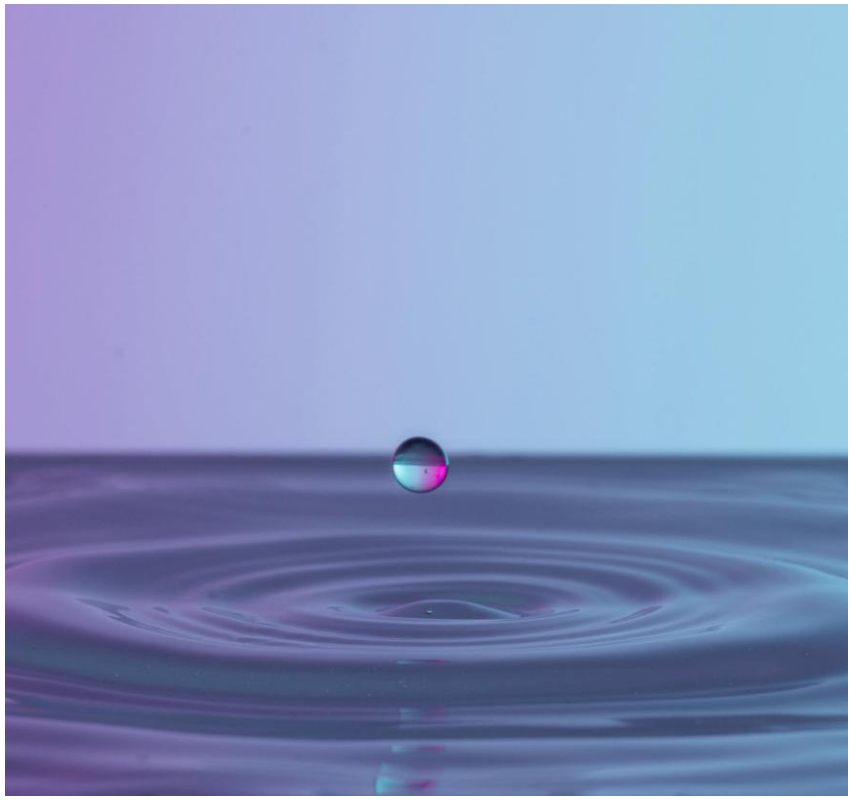


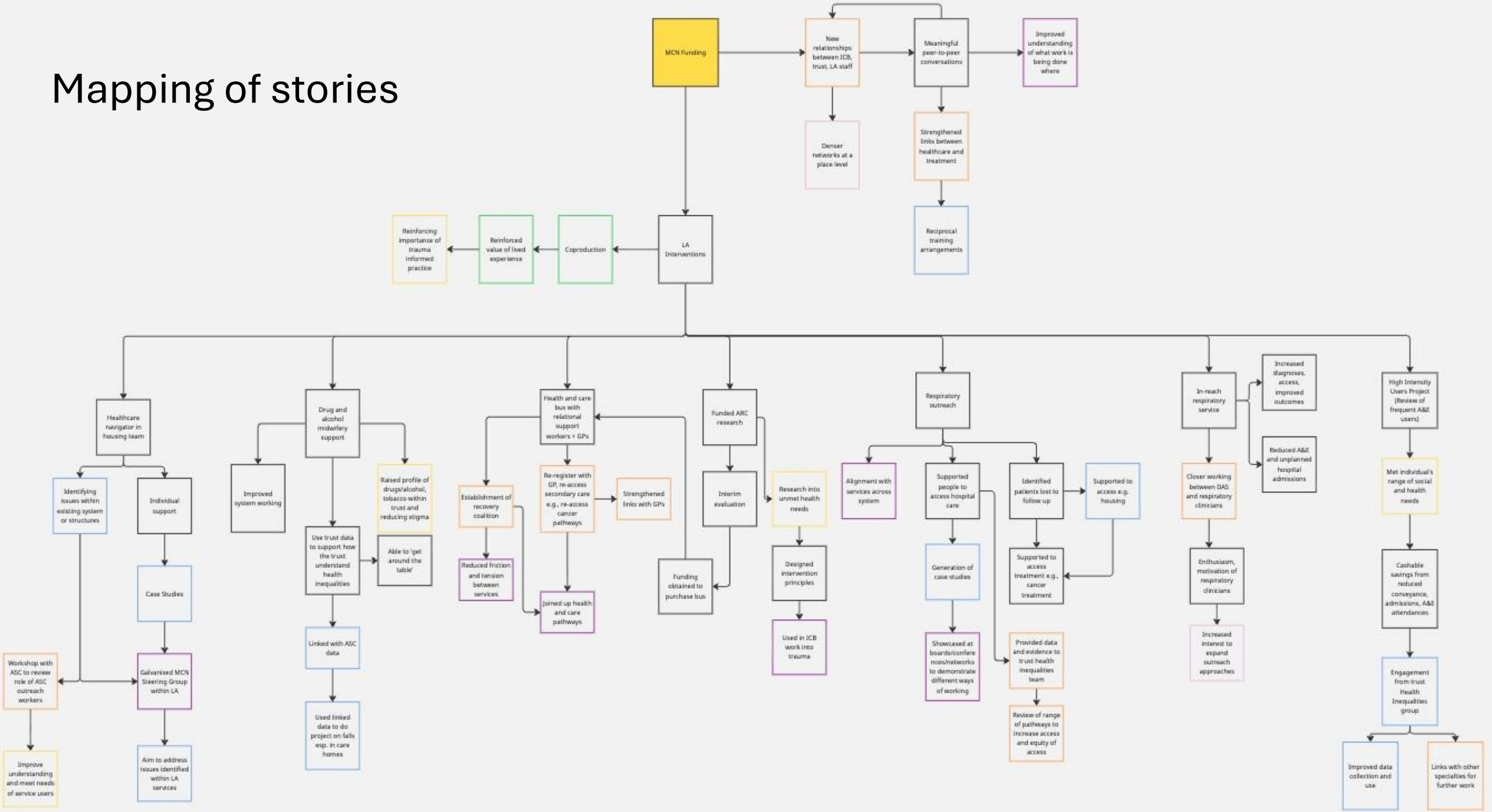
Ripple Effects Mapping

- Traditional impact evaluation tends to capture change according to pre-specified outcomes

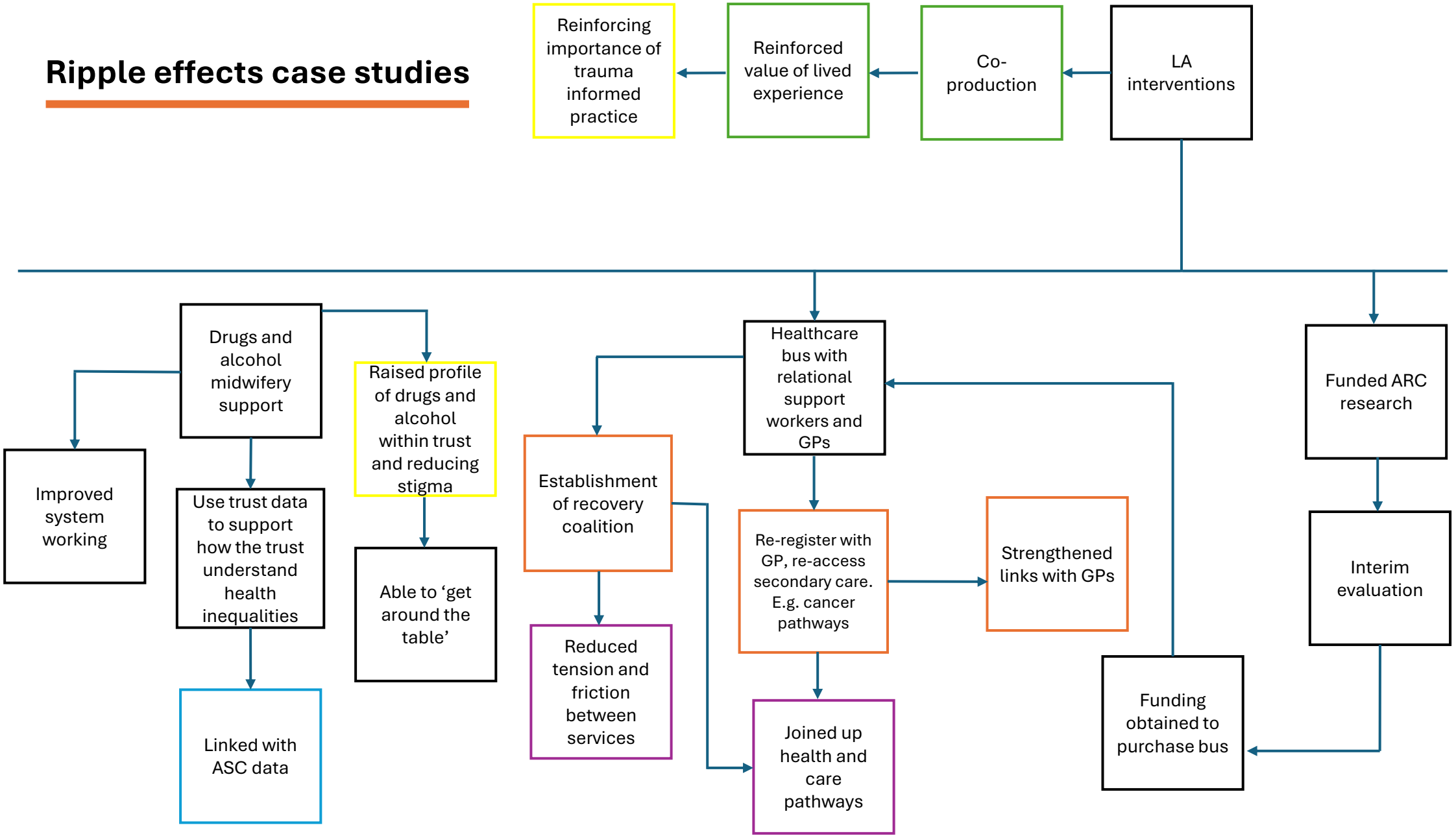
- **Ripple Effects Mapping** can explore things that are often missed by traditional evaluation methods
  - Capacity building
  - Adaptation of the system
  - Spread of ideas
  - Alignment with other agendas

- **Aim**: To explore system level impacts of the programme including health and care integration, unintended consequences, and/or spillover effects

Mapping of stories



Ripple effects case studies



Ripple Effects Outputs

Changes in practice and attitudes

•The programme challenged conventional views of health, highlighting that health extends beyond clinical care to include housing, social care, and other determinants.
•Addressing health inequalities often requires targeted, assertive adjustments rather than wholesale system change.
•Case studies have been instrumental in demonstrating successes across boards, networks, and conferences, highlighting new ways of working.
•Data-driven improvements have emerged as a major outcome, including enhanced access and cross-referencing of health, social care, and hospital data.

Highlighting the needs of a specific population

•A major ripple effect has been raising the profile of drugs, alcohol, and tobacco issues, alongside tackling stigma in partnership with the trust.
•Also highlighted is the importance of trauma-informed practice, reinforcing both prevention and the need to understand challenging behaviours in context.

Appreciating co-production and importance of lived experience

A key takeaway has been the reinforced importance of listening to lived experiences alongside quantitative data.

Working towards/ aiming for a neighbourhood health model

•One initiative has driven a fundamental shift toward a neighbourhood health model focused on community assets, mutual aid, and peer support rather than traditional commissioning.
•The fund empowered Public Health teams, closely connected to local communities, to design tailored services, particularly for the most complex and marginalized individuals whose needs often go unmet by the NHS.
•A key outcome has been the development of a genuine co-production and co-design model, now embedded within the neighbourhood health framework and serving as a blueprint for future work.

Strengthening of links/ collaboration between services

•The initiatives have fostered collaboration between previously competitive commissioned services, creating a strong coalition and reducing friction. This approach has enhanced partnership working across primary and secondary care, housing, and community services, while promoting co-production and shared training opportunities.
•The programme opened new channels for dialogue, enabling Public Health to engage with the Trust's Health Inequalities Group and influence approaches to drugs, alcohol, and tobacco.
•Ripple effects include stronger integrated pathways, workforce development, and unexpected relationships, such as linking ED departments with Public Health teams.

Enhancing of systems approaches/ thinking

•Initiatives have generated extensive learning around addressing multiple complex needs through system-wide approaches.
•Initially focused on the drug and alcohol treatment sector, the model now spans housing, benefits, mental health, and broader system work.
•The fund has facilitated workforce training across sectors, reciprocal learning, and uncovered cultural norms that influence collaboration, fostering genuine system change.
•These ripple effects have reconnected fragmented parts of the system, promoted sustainability, and demonstrated the value of responsive, innovative approaches to tackling inequalities through integrated, collaborative working.
•The initiatives demonstrated that success depends on strong collaboration between Public Health teams, community partners, and the voluntary sector, not on short-term, at-risk funding. However, this work is not solely about large financial investments; it is about fostering system integration and brokering stronger links between services to deliver lasting impact.

Key takeaways



The funding increased visibility of drugs, alcohol and tobacco issues while reducing stigma through partnerships across primary and secondary care.



The work reinforced the importance of incorporating lived experiences alongside quantitative evidence.



Projects challenged narrow definitions of health, showing that wellbeing depends on housing, social care and other social determinants beyond clinical services. case studies displayed these new approaches across boards, networks, and conferences.



The funding empowered public health teams with strong community connections to design tailored services for marginalised individuals with complex needs often unmet by mainstream NHS provision.



The funding enhanced partnerships between primary and secondary care, housing, and community services. this enabled integrated pathways, shared training, workforce development, and unexpected connections—such as linking emergency departments with public health teams.



Initiatives generated learning on addressing multiple complex needs through whole-system approaches, including cross-sector workforce training, reciprocal learning, and uncovering cultural barriers to collaboration.

Recommendations

- **Strengthen links between health, housing, and social care services**. Commission integrated multiagency hubs and aligned pathways rather than siloed services. Effective interventions addressed housing, benefits, employment, and social determinants together to support the drivers of health beyond clinical care.
- **Use funding initiatives to drive systems change for unmet needs**. Structure funding mechanisms to incentivise innovation, service transformation, and sustainable system strengthening rather than only short-term service delivery outputs.
- **Embed co-production and lived experience throughout**. Prioritise meaningful involvement of people with lived experience in service design, delivery, and evaluation.
- **Enable flexible, locally-tailored approaches within national frameworks**. Allow local Public Health teams close to communities to design services that address specific population needs rather than imposing rigid national models.
- **Commit to multi-year funding cycles with adequate implementation timelines**. Short-term funding undermines relationship-building and service effectiveness for populations with complex needs. Fund programmes with realistic timelines that account for procurement, data sharing agreements, recruitment, and partnership establishment before delivery expectations begin.

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