N O R T H N O R T H A M P T O N S H I R E

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DRAFT

Proactive Care

Spring Social Prescribing
PCN Link Workers
Ageing Well
Support North Northamptonshire (SNN)

A NEW *sense* OF PLACE

Integrated Care Northamptonshire

Summary

- Purpose of this Review
- Current strategic context
- Challenges & Opportunities
- Overview by Function, Offer & Theme
- Current models in place – (PCN Linkworkers; Spring; Ageing Well, Support North Northants)
- Questions for the System
- Next Steps

Purpose of this Review

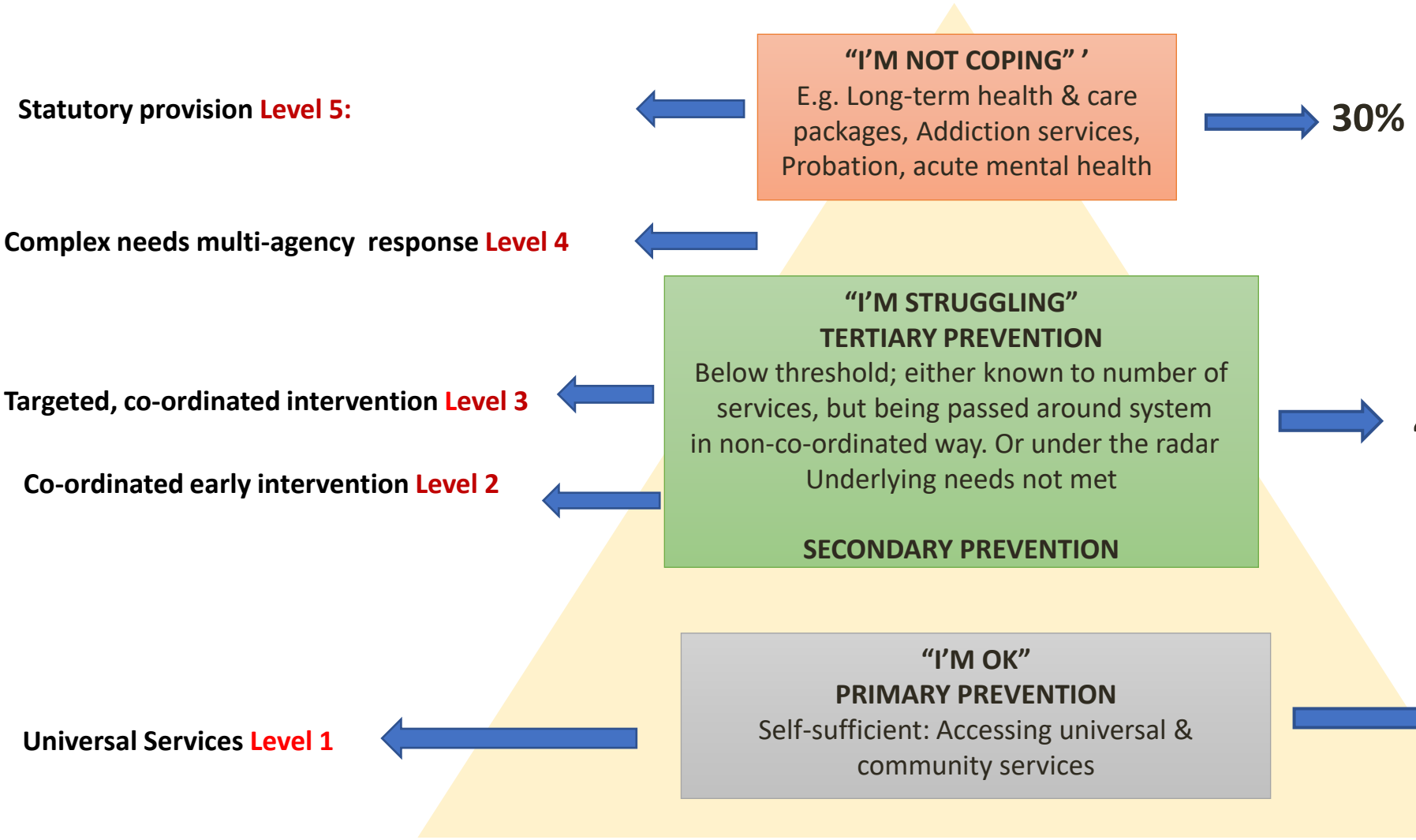
- Address the live dialogue in the system about the purpose, function & intended outcomes of existing proactive care models
- Emphasise that prevention is fundamental to the LYBYL Strategy as set out in emerging Prevention Framework
- Recognition that the funding for current models is time limited and under review
- Recognition that these services could be better aligned to meet whole population need
- Identify the opportunities to do more together and to inform future investment
- Agree what we are trying to achieve collectively through a System-wide proactive care model
- Agree and provide System commitment to next steps

Strategic Context

- All these models arose in response to identified service gaps but at different times over last 4 years
- Emergence of ICS Place Programme since SP models were introduced = new governance (Place Delivery Boards/ new VCSE governance)
- General Practice Alliance is working with PCNs to look at future options for Primary Care SP, as funding will be in base budgets for GP Practices from April 2024
- Disaggregation of Public Health may affect future contract arrangements
- SNN only funded until end April 24- Sustainable Case for Change for Yr 2 presented start of Feb 2024
- SPRING is funded until 2025/6 but from reserves or other funding that will no longer be available
- ICS to commit to and undertake work towards agreeing on future models during 2024
- NHSE guidance on Proactive Care indicates target group should be those with moderate to severe frailty. The Northamptonshire ambition through the LBYL strategy takes a broader approach to independence and wellbeing, including working with residents with emerging and mild frailty, who are not yet at statutory thresholds.

Target group/s

Estimated % of Demand of Population*



SNN operates primarily L3 & 4 with some 5

Ageing Well operates L3 & 4 Over 65s

SPRING operates primarily at L2, with some L3

PCN SP operates L2 & 3

* Based on research across GM 2016-17

A NEW sense OF PLACE

Integrated Care Northamptonshire

Challenges & Opportunities

- SP as a concept is proven & presents opportunity for cost avoidance & demand reduction, ie VFM through economy, efficiency and impact, rather than savings
- SNN provides wider co-ordinated support for people who are unable to meet stringent thresholds & where there are complex, multiple needs which would escalate if people were not supported. Its also provides an opportunity for demand management & cost avoidance
- Ageing Well enables people over 65 to access services & support & prevent needs escalating; & provides opportunities for preventing hospital admissions & readmissions; & managing demand.
- All current models are at operational capacity but are not meeting all need- despite their impact bed occupancy is still at 102% - what else needs to be done?
- The current models may be working with same people thus distorting evaluation and impact
- Need to understand needs, outcomes & impact from across the current models and gaps to inform future strategic decisions
- Not all models yet have independent evaluation. Not all evaluations will be using the same economic /benefits framework or a baseline data set adopted by the whole System
- Models overlap in some functions, but not necessarily duplication as targeted at different levels in the triangle of need
- To align models more closely & ensure the reviews of current models achieve this
- To embed in strategic approaches from key stakeholder organisations & in the new Place programmes
- Impact SP has on VCSE is seen as key to any future model- VCSE needs to be funded to provide the wrap around support but is in a great place to provide further capacity to reduce demand in the System
- Both Primary Care Link Workers and Spring models need services to connect people to in communities
- To work more holistically with VCSE through new Place governance

Overview by Function & Offer

Function	PCN Linkworkers	SPRING	SNN	AGEING WELL
Key Function descriptor		A Link Worker-led service offering a personal consultation and/or motivational interview and providing a range of support, in the community & in some cases commissioned, to supplement mental and physical health and wellbeing prevention & treatment services through a wide range of non-clinical social, emotional or practical schemes.	Person-centred, strengths based, and outcomes focussed. The service co-ordinates support, navigates pathways, enables access to support networks and builds greater levels of personal and community resilience by increasing capacity in the VCSE to collaborate and provide wrap-around support.	Proactive care model and a multi-disciplinary team providing a range of interventions – SPOA, Age Well teams, Support groups, classes, Befriending, Support to care homes
Who for	Any patient referred by Primary Care	U65s and predominantly O18s with two or more diagnosed LTCs. Some exceptions where intensive users of H&C services for non clinical reasons	Anyone over 18 inc. if they have children. On average 3 types of different interventions per person.	Over 65s predominantly with frailty
Eligibility Criteria	None	Has at least one diagnosed Long Term physical health condition secondary criteria include social isolation; low-level MH issues; carer role. Average 12m interventions	None- No wrong door & no eligibility criteria to ensure people in need have access to support average 3-4 types of different interventions per person.	Over 65, those who need short interventions; more intensive 121 support 3-6m; complex needs 6m or more
Cost and Funding streams	ARSS ringfenced until 31/3/24	£9.5m over 5 years - ICB/Councils (PH) with grant from Life Changes Fund	£520k yr 1- COMF/HIAA, Lottery £450k yr 2 – tbc	Better Care Fund
Timeline for funding	Not ringfenced from 1/4/24, decision by GP Practices	LCF grant ends October 2024; ICB/Council funding estimated to end 2026 when financial caps reached	Business Case for Yr 2 funding to Place Board 5/2/23	Secured for 24-25 but at reduced amount?

Overview by Function & Offer

Function	PCN Linkworkers	SPRING	SNN	AGEING WELL
Lead Agency & Sector	Primary Care	Delivery model = Bridges Outcome Partnership, Social Investor	Support Northamptonshire, VCSE – core partners	Primary Care
Outcomes set against LYBL	Personalised proactive care, lessen burden on system	Demand reduction in primary care; A&E and unplanned admissions	Outcomes framework links directly to LYBL	
Reach- annual throughput	tbc	1150 starts in 2023 25% referrals via Primary Care 95% clients have 1 or more diagnosed LTC 83% clients showing av 5.1 pt improvement on WBS at 6 mths (92%, 8,4 @ 12 mths) WEMWEBS 98%, 19.2 @ 6 & 98% 22.9 @ 12	Projected full year 500 across North Northants.	400 new cases per month,
Statutory services involved	Health, ASC	All NHS statutory services and Councils	Currently 90 plus partners involved inc. ASC, Housing, EMAS, Police, NFRS, Primary Care	Health- emergency care services
Impact and VFM (economy/ efficiency / effectiveness- how to id common metrics?	GPA evaluation	UoN evaluation Interim report now available (Feb 2024)	Quarterly Impact reports for June to Aug and Aug to Dec 2023, intended independent evaluation during 2024	5% reduction in unplanned admissions

Summary Overview by theme…

Theme	PCN SP	SPRING	SNN	Ageing Well
Knowledge of groups and activities in the community	Yes	Yes & run free groups across the county based on participant's needs / interests, as well as gaps in existing community offers. Database of local services maintained and mapped for data purposes as onward referrals to assess demand & efficacy.	Yes. Working with over 80 partners to date and co-ordinates support with them to achieve outcomes. Close alignment and collaboration. Identifying unmet needs which partners can mobilise around to meet and link with LAP developments.	Yes
Financial Inclusion (Benefits. Housing /Debt advice)	Signpost only	Was just signposting but recent agreement made with Accommodation Concern	In service Benefits Advisors, all service users get a full benefits check and wider support to access benefits.	No
Collaboration with breadth of VCSE	signpost only	Around 50% of clients are referred on to multiple VCSE organisations. Little collaboration with sector - would support development of a VCSE led-triage and safe-services approach	Yes- led by the VCSE, high number of VCSE organisations involved in delivery, capacity building is in the model based on community need and strong links to VCSE Governance	Pull in other support when needed eg Bridge
Embedded in VCSE	No, link workers operate mainly within GP Practices & NHS	Delivery partners include Age UK Northamptonshire & Northamptonshire Carers	Managed, overseen & hosted by core VCSE partners	Delivery partners include Age UK, Alzheimers Society, NH Carers, NBCT, NSport
Funding for service users	No funds	Wellbeing Activation Fund of average £100 pp – for activities that prove beneficial to improving someone's health and wellbeing	Hardship fund in place & direct access to Household Support Fund	No funds
Community based & offers home visits	No, f2f at GP Practices	Community based in groups. Don't do home visits as standard as we encourage people to be able to leave home to attend groups. Home visits for assessment based on individual needs	Yes home visits are core part of the model to build trust and confidence and enable people to receive support required.	tbc

Summary Overview by theme cont'd…

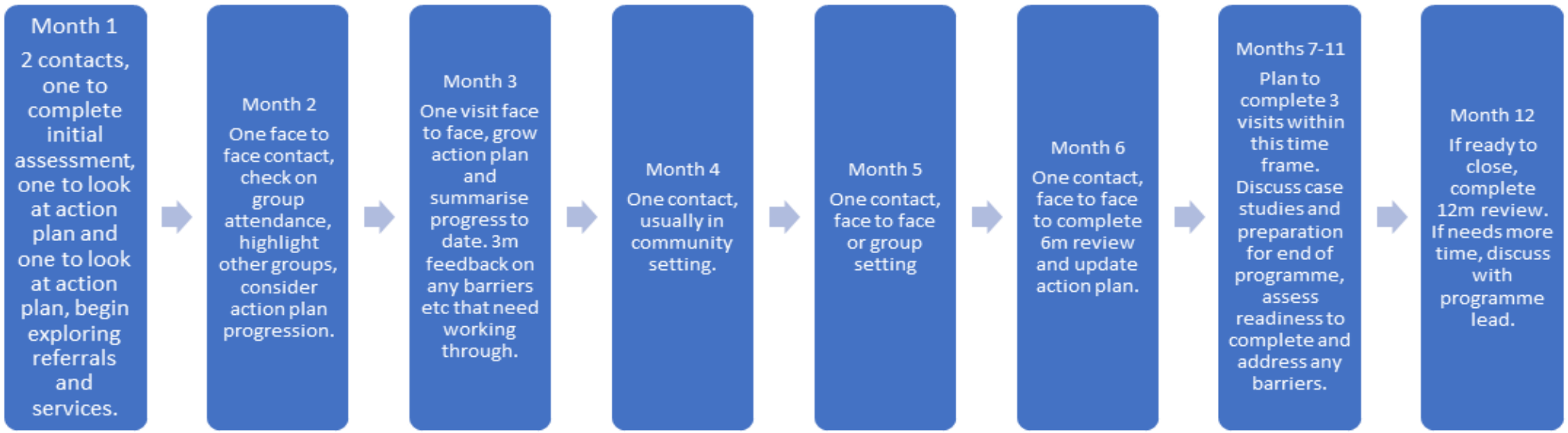
Theme	PCN SP	SPRING	SNN	Ageing Well
Full holistic assessment 1:1 and outcomes focused	Yes- wellbeing star in use	Yes & goal-focused, usually 1:1, but some group assessments. Wellbeing star & WEMWBS used at start, 6m & 12m	Yes, 121, use of outcome framework scale 1-5, linked to LYBL , SWEMBS, at start, 3-4month review and aim for closure.	Yes
Case management & co-ordination across system	No, work with people generally for up to 12 weeks, f2f, telephone & signposting.	Record client journey via case management system, including outcomes. Support clients to attend local community groups to build social capital & increase self-efficacy. Telephone, video, group and face to face support.	Yes, work with people to reach outcomes quicker & support coordinated fully including CATCH (mdt) meetings with multiple partners.	Yes via mdt approach
Caseload expectations per worker	Often about 60 a month as quick turnaround expected	Maximum caseload of 85 dependent on intensity of support required. Supported by Spring Community roles (not case holders)	20-22 at often higher levels of need, although some cases are managed by partners co-ordinated with SNN support	tbc
Referral routes	Via all clinical staff & self-referrals	Any sources in the community, NHS, VCSE, Statutory Services & self-referrals. Current focus on increasing number via Primary Care. Strong stakeholder relationships with all referrers to manage suitability of referrals	Any source including self-referrals, VCSE, & eventually all statutory partners	Via GP practice staff, urgent care services, Adult Social Care
Link to Place Programme	tbc	Under development as part of Business Case production	Directly aligned- intel from SNN will inform LAPs & clients mapped against LAP boundaries	Under development

Primary Care Link Workers

- Will form part of baseline funding for Practices from 24-25. Practices will choose whether to continue. (May not change significantly during 2024-25)
- Each PCN awarded funding to employ Linkworkers. Model differs Practice to Practice
- GPs refer patients to linkworkers (self-referral mechanisms in some GP practices)
- Linkworkers assess & can signpost to local services that they are aware of as appropriate
- Linkworkers also run groups and provide 1-2-1 support but less intensively than SPRING
- Some concerns about professional isolation of Linkworkers
- However its strength in that it is embedded within Statutory services
- Has ready access to health and care personal data through shared care records
- Makes referrals to SPRING for longer term support
- No funding to support activities to which patients are signposted
- Impact on Primary Care being monitored by GPA

- Multi-Funding partnership – Northamptonshire Councils (Public Health); ICB; Life Chances Fund; Bridges Outcomes Partnership (Social Investor)
- PH and ICB funding not secured post 2026
- Contract between Councils and Life Chances Fund; Contract between Councils and Spring
- Section 75 Agreement between Statutory Organisations
- Last Life Chances Fund grant payment will be September 2024
- Continuation decision needs to be made at least 12 months before programme end date
- Bridges Outcomes Partnership are the social investment partner who designed the SPRING brand and model and established the Social Enterprise
- Local Delivery Partners (Age UK; Northamptonshire Carers; GPA) who host Spring Link Workers
- Outcomes-based model with aim to reduce demand on primary and secondary care
- Currently cohort-focussed on individuals diagnosed with multiple Long-Term Conditions
- Average 12 month intervention, person centred, connects people with support services in their community
- Empowers, activates and enables people to be more self-sufficient
- Wellbeing Activation Fund available to individuals to 'seed-corn' fund group-based social activities
- Scaleable design
- Takes referrals from Primary Care and self-referrals
- Being evaluated by UoN- Interim report available Feb 2024

spring
SOCIAL PRESCRIBING IN NORTHAMPTONSHIRE



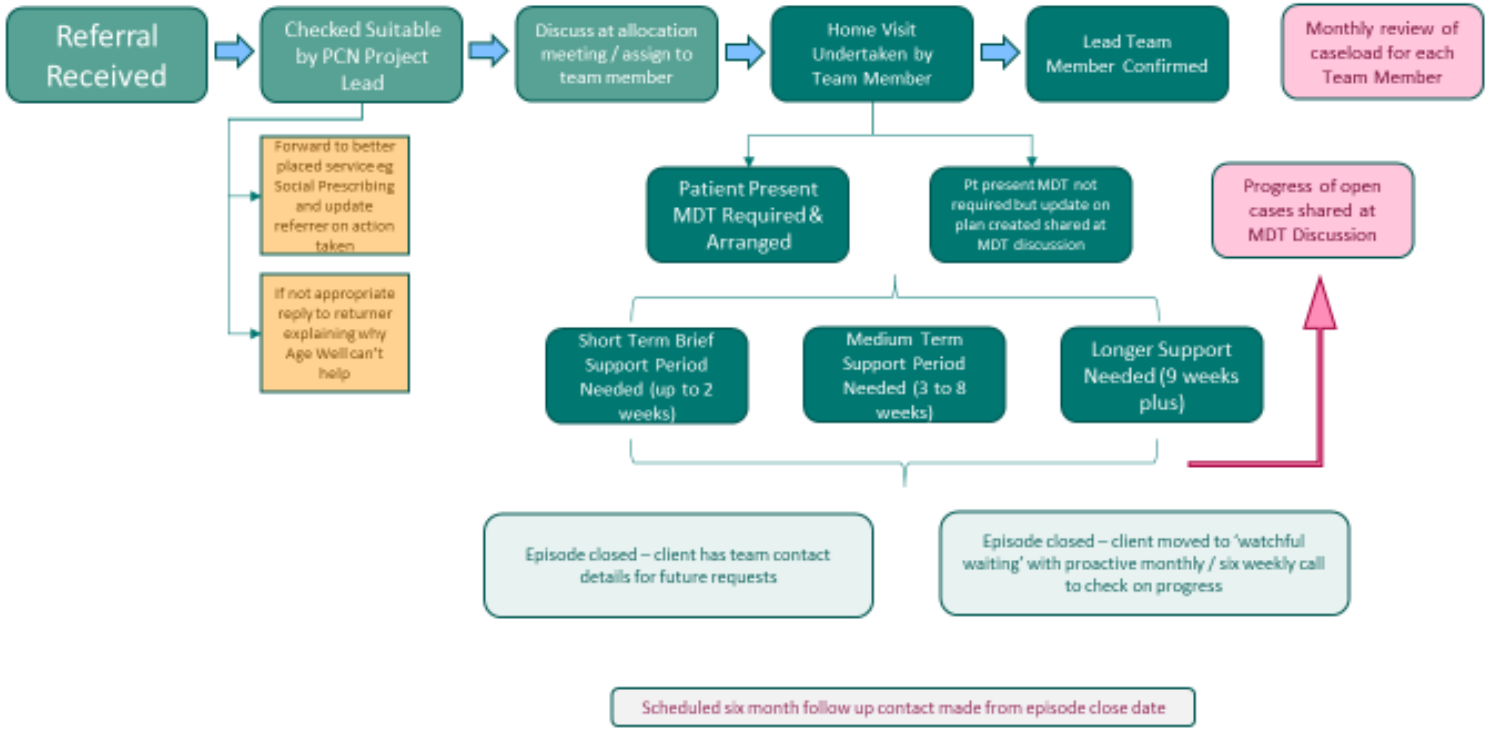
AGEING WELL

- Better Care Fund rolling programme, but delivery is scaled back currently due to financial constraints
- Aims to reduce demand on Primary Care, working with patients experiencing frailty
- Aged Well teams aligned to all 16 PCNs
- Team members from Age UK, Adult Social Care, Community Trust, Northamptonshire Carers and Alzheimer's Society
- Provides collaborative care home support
- Uses MDT model in some PCN/LAP areas, but not all
- Aimed at 3 different cohorts all aged over 65: those who need short interventions; more intensive 121 support 3-6m; complex needs 6m or more
- Provides long term condition Peer Support Groups; targeted strength and balance classes; extended GP-led reviews, Befriending, Rapid Response, Assisted Tech solutions
- Circa 400 new referrals each month, MDT discussion for all and circa 100 have extended GP led review
- Reaches approx. ¼ of those with moderate frailty (estimated at 9000 people in total)
- Not resourced to support those with low frailty (estimated at 23000 people)

AGEING WELL

PCN Age Well Referral Management Process

Integrated Care Northamptonshire



Support North Northants (SNN)

Tackling poverty, overcoming health inequalities, building healthier and resilient communities

- Cover North Northants only
- Embedded in North Place Programme and aligned to work of LAPs and CWFs
- During 2023-24 whole system test & learn pilot, to provide co-ordination & collaboration across VCSE, with statutory partners, to provide personalised, bespoke intensive 3m average 121 case-co-ordination, using MDT (CATCH) meetings, intervention plans and wrap-around support, for residents who are struggling to access or navigate the system & get the outcomes they seek at the right time, in the place and in the right way.
- Year one cost £520k funded by Public Health, Health Inequalities and Lottery. Year 2 proposed costs £450k
- Tertiary Prevention/Targeted intervention for more complex cases
- Outcomes framework developed which measures service user journey and links to ICS Strategic outcomes, including measuring cost avoidance and demand reduction
- Connecting people to community support and building resilience is part of the model
- Pilot includes funding VCSE organisations to host core team and to commission new services from VCSE based on emerging need (e.g. to date includes home repairs & maintenance, hoarding, low level mental wellbeing services
- Takes referrals from professionals (pilot has focussed on Adult Social Care, Housing Assoc's, VCSE) and self referrals
- Expansion of pilot includes referrals from PCN link workers & SPRING, specialist hoarding project, more emphasis on building resilience in VCSE and working with frequent fliers from A&E.
- First 2 quarter impact reports are available for June-Nov 2023. Sustainable Case for Change developed for North Place Board Feb 2024
- At current pilot resource levels estimated annual cases throughput will be 500 in 2024-25

No door is a wrong door

Support North Northants

Co-designed with people, whole system approach

SNN POINT OF ACCESS
1 phone number/online

The person

Person-centred conversation 1-2days

Information & Support

Close

CATCH Team

CATCH TEAM

Other partners involved & who will contribute identified

Identify primary partner

Weekly collaboration meeting between VCSE & statutory partners

SUPPORT PLAN
(Person centred, strengths based and outcomes focussed)
3-6months

REVIEW in 3 months

Agreement to continue support

Closure in 3 months

Outcomes achieved

Time taken measured

Develop case studies

SERVICE USER FEEDBACK

Pathways to other Support & Services

Align with existing Services- Identify system efficiencies

Build personal & community resilience & connections

Building Resilience and Networks of Support (Wider VCSE partners)

Key Questions for the System

Are we serious about embedding proactive care and delivering at scale?

How do we align and integrate these proactive care service models sustainably?

- Impact SP has on VCSE which is seen as key to model…. but does the funding sufficiently invest in VCSE to build capacity & resilience?
- Is it about volume or throughout or quality of support?
- Is it for everyone or just those with long term conditions?
- How to make it sustainable and embed and normalise as BAU?
- How we ensure SP helps people navigate the System, not just add to complication and confusion?
- Are we trying to: Reach people already known to services to provide more co-ordinated wraparound support… Or Reach people not known to services to prevent escalation.. OR BOTH?
- How do you upscale to achieve bigger impact?
- What might we have to stop funding to invest in this?
- How do we jointly commission a future model across the ICS?

Next Steps- The Ask – TIME

1. Time to Develop a Transformation Programme based on a Logic Model & aligned to Prevention Framework, to identify:

- What outcomes we want?
- What does success look like?
- What is the art of the possible
- How do the current models contribute to this? What do the evaluations tell us? Gaps?
- Who currently funds what?
- Options for future System-wide model/s
- Investment required

2. Resource commitment to support the Transformation programme (people/expertise/data)

3. Ensure there is a parallel evaluation programme for each of the current models inform the Transformation programme

4. Agree governance route for the work

Next Steps

- Discuss with both DPHs- completed 260224
- Take through North & West Place Delivery Boards
- Take through Internal Agency Governance Boards e.g. (ICB, PH, VCSE)
- Take through Population Health Board to ensure alignment to the emerging Prevention Framework
- Commit resource for Transformation programme
- Scope/develop Transformation programme
- Take through ICB in May 2024