Gateshead Multiple & Complex Needs (MCN) Transformation Initiative

Interim Report
October 2020

Contents:

Professionals within Gateshead are invited to provide feedback on this report using the following link:
http://bit.ly/MCNtransform1
Feedback must be submitted by Mon 16th November

Gateshead MCN Transformation Initiative

Project Panel Review, October 2020

The Gateshead MCN Transformation project oversight panel met via Teams on October 21st to review the MCN Transformation initiative's report of initial findings (pp.3-18). Membership of the panel is presented in Appendix A.

Overall, the panel felt that the report was an accurate representation of the systemic challenges, structural inadequacies, and potential pioneering practices regarding support for people experiencing multiple and complex needs. The panel was very supportive of the work done so far and eager to aid the next stage: the development of recommendations.

Resonant themes

Panel members highlighted particular themes within the report that were especially resonant.

Comments included:

- *We need to lead with the people, rather than deal with them in an issue-based, compartmentalised way.*
- *Too much of commissioning is focused on 'recovery' – but without there being sufficient support to help people become recovery ready. There's not enough outreach and harm reduction.*
- *We need to figure out where in the system we are going to have the single conversation about the individual. Having a lead provider/professional is a good step towards this, but there has to be a location for that conversation.*
- *The existence of positive relationships does not mean that the multi-agency meeting structure is good enough.*
- *Trauma Informed responses would be helpful across the whole system and we should look at providing training to staff across the whole system.*

Constructive challenge

Panel members challenged the project team to consider a number of issues arising from the report that they considered to be salient, and important for the next phase of work.

Comments included:

- *The report is very adult-focused. The transitional stage from children to adult is not sufficiently captured, and these are some of the most complex individuals in the system.*
- *A focus on speed is important but it can lead to important bits of operational information being missed. Decisions need to be made on the best information and sometimes key information takes time to uncover. If we go too fast, we lose quality.*
- *If people feel positive about the meetings they attend, will this prove to be a barrier to innovation? Will those people resist changes to their meeting?*
- *We need to dig deeper into what exactly is meant by "the difficulty accessing/the under-resourcing of mental health services." There are many different kinds and levels of mental health support, and we should be careful not to over-medicalise.*

Next steps

The panel concluded that there is an urgent need to raise awareness about the MCN Transformation Initiative. The project team will now initiate a process to enable more people from across the Gateshead system to feed into the development of recommendations.

Gateshead MCN Transformation Initiative
Report of interim findings, October 2020

Background

The Gateshead Health and Care System conducted an initial "mapping exercise" in 2018 that identified the multiple meetings/groups taking place in Gateshead to identify, plan or discuss support for people experiencing Multiple and Complex Needs. The sheer number of these groups led the Gateshead Health and Care System Group to recognise that a further exploration of this issue was needed. That is the focus of this transformation initiative.

The aims of this Gateshead MCN Transformation Initiative are:

- *To yield new insights into the ways in which the Gateshead system is dealing with people experiencing MCN*
- *To reveal where over-complexity within the system is working against the achieving of outcomes*
- *To highlight where innovation has enabled better outcomes for those with MCN*
- *To make recommendations for the rationalising of the multiple professional contexts concerned with MCN issues*
- *To leverage improvement within the system that will benefit both service-users and professionals*

Governance and accountability

The project has been commissioned by Fulfilling Lives Newcastle Gateshead via Bluestone Consortium. The lead partner / accountable body for the project is Oasis Community Housing. The research team undertaking the work includes the Collective Impact Agency, Goodlabs Consulting and Helme Park. The project reports into a project oversight panel whose membership is drawn from the Gateshead Health & Care System board.

The initial contact point for the project is Phil Conn: **phil.conn@oasiscommunityhousing.org**

Purpose of this report

This report provides an update of work so far and our initial findings. **It is not intended as a set of recommendations for the Gateshead system** but rather to stimulate discussion to inform and direct the next phase of the work. We will provide recommendations in the next report, due early December 2020

To date, we have interviewed 28 professionals across the Gateshead system, beginning with the chairs of 12/13 multi-agency meetings on our list. We still have a few interviews that are outstanding, and the data gathered through these will be fed into the December report.

- For more information about our research methods, please contact the project team.

In order to ensure that the voices of people with lived experience are heard, we have initiated a lived experience strand of the research, meeting with the Fulfilling Lives Experts by Experience panel. In addition. plans are in place to meet with the Recovery Ambassadors from Recovery Connections, and several other key individuals identified by Oasis Community Housing and the Gateshead Recovery Partnership. We are still only in the early stages of this strand of the research, so will be feeding our findings into the December report in the first instance.

Overview of the various multi-agency meetings/groups

Name: A&E Frequent Attenders
Purpose: To review the most frequent attenders at the emergency department to try to find ways to meet their needs that prevents them from constantly returning, and to give clinicians confidence not to over-investigate frequent attenders when they present at A&E by creating a joint management plan to collectively support them.
Partners: Gateshead Health NHS Foundation Trust Service Line Manager, Assistant Medical Director, NTW Psychiatric Liaison, Domestic Violence Advisor, NEAS frequent caller team
Chair: Lindsay Surtees, Service Line Manager, Gateshead Health NHS Foundation Trust, and Neil Halford, Assistant Medical Director
Any explicit links to other MCN groups:

Name: Channel Panel
Purpose: To provide support at an early stage to people who are identified as being vulnerable to being drawn into terrorism by identifying individuals at risk, assessing the nature and extent of that risk, and developing the most appropriate support plan for the individuals concerned.
Partners: Community Safety, CNTW, Special Branch, Police, NE Counter-terrorism, CCG, Children's Services, Adult Services
Chair: Adam Lindridge, Community Safety Business Manager, Gateshead Council
Any explicit links to other MCN groups:

Name: Complex Cases Group (inc. Complex Offenders)
Purpose: To identify, assess and review the needs and risks associated with offending adults with multiple and complex needs who have disengaged, or struggling to engage with services and a different approach to helping them is required.
Partners: Northumbria Police [Inspector (Central) and Integrated Offender Manager PC]; Gateshead MBC [Community Safety Coordinator; Enforcement and Licensing Lead; Private Sector Housing]; Gateshead Housing Company [Neighbourhood Relations Team Manager, and Housing Options Manager]; NTW; Community Rehabilitation Company; National Probation Service; Gateshead Evolve [Service Manager]; Basis [Manager]
Chair: Michael Robson, Neighbourhood Policing Inspector
Any explicit links to other MCN groups: The Complex Cases Group works alongside Integrated Offender Management process to support the appropriate management of individual cases.

Name: Drug Related Deaths
Purpose: To review cases of suspected drug-related deaths to question whether anything could have been done differently with regards to treatment or care, how agencies could we help other people similarly at risk, and to consider how to provide support to the cohort around the person who has died if this is not already happening.
Partners: police, treatment services, Adult Social Care, QE hospital, Job Centre+, Probation, CNTW mental health services, Housing, and GPs' reports.
Chair: Julia Sharp, Public Health Programme Lead, Gateshead Council
Any explicit links to other MCN groups:

Name: Dual (Needs) Diagnosis
Purpose: To join the system up in terms of the workforce and commissioning in terms of Mental Health and Substance Misuse (and also added complications which could include LD, offending, etc) while also managing a dynamic support register (DSR)
Partners: TBC
Chair: Catherine Richardson, Commissioning Manager for CCG (Mental Health, LD, Autism, Dementia)
Any explicit links to other MCN groups:

Name: Integrated Offender Management
Purpose: To bring a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together. IOM helps to improve the quality of life in communities by: (1) reducing the negative impact of crime and reoffending; (2) reducing the number of people who become victims of crime; and (3) helping to improve the public's confidence in the criminal justice system.
Partners: Police and Probation Service as primary partners, supported by Gateshead Housing Company, HOST team, Gateshead Recovery Partnership.
Chair: Inspector Kelly Hetherington, supported by Paul Kelly, Northumbria Police
Any explicit links to other MCN groups:

Name: Multi Agency Adult Referral Team (MAART)
Purpose: To provide an early intervention for residents who are experiencing chaotic lifestyles, multiple exclusions and negative social outcomes for themselves, families and communities but who do not meet eligibility criteria under the Care Act and are not engaging with services.
Partners: Adult Social Care, the police, Housing, CCG, CNTW, Gateshead Recovery Partnership, probation, CRC.
Chair: Kim Harris, Safeguarding Adults Team Manager, Gateshead Council
Any explicit links to other MCN groups: Safeguarding Adults, MAPPA, MATAC and MARAC

Name: Multi-agency public protection arrangements (MAPPA)*
Purpose: Arrangements through which the Police, Probation and Prison Services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public. MAPPA is not a statutory body in itself but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a co-ordinated manner. Agencies at all times retain their full statutory responsibilities and obligations.
Partners: The component bodies for MAPPA include (1) Responsible authority; (2) Duty to co-operate agencies; and (3) Lay advisers. A Strategic Management Board operates at both the Northumbria Police Force area and Gateshead levels. The Responsible Authority is the primary agency for MAPPA. This is the police, prison and Probation Trust in each area, working together. Various agencies providing services to offenders have a 'duty to co-operate' with the responsible authority. These agencies include: health, housing, Children's Social Care, education, youth offending teams, and the jobcentre.
Chair: Northumbria Police MAPPA – Paul Weatherstone – Head of North of Tyne Cluster Gateshead MAPPA – Shirley Allen – Senior Probation Officer, National Probation Service
Any explicit links to other MCN groups: Safeguarding Adults, MARAC, MATAC

**We have yet to interview anyone from MAPPA*

Name: Multi Agency Risk Assessment Conference (MARAC)
Purpose: To safeguard victims of domestic abuse, manage perpetrators' behaviour, safeguard professionals and make links with all other safeguarding processes.
Partners: Police, LDVA service, housing (statutory responsibility), children's services (statutory responsibility), National Probation Service and/or community rehabilitation company (CRC), primary health, mental health, substance misuse service, Adult Safeguarding
Chair: Paul Goundry (works for Police in a civilian role, equivalent of Inspector), also MASH Manager, Safeguarding Department
Any explicit links to other MCN groups: MAPPA, MSET

Name: Multi-Agency Tasking and Coordination (MATAC)
Purpose: To safeguard adults and children at risk of domestic abuse and to reduce the offending of domestic abuse perpetrators, identifying and tackling serial perpetrators of domestic abuse.
Partners: The Gateshead Housing Company, Karbon Housing (Social Housing), Oasis Aquila Housing, Riverside Housing (Social Housing), Home Group (Social Housing), Domestic Violence Coordinator (Council), Independent Domestic Violence Advisor (IDVA) – DAT, Children's Services, Youth Offending Team , Gateshead Education, Community Rehabilitation Company (CRC), National Probation Service (NPS), Gateshead Recovery Partnership, Fulfilling Lives, Barnardo's (Behaviour Change), Queen Elizabeth Hospital Safeguarding, Domestic Abuse and Criminal Justice Liaison Worker (MATAC)
Chair: Denise Lloyd, Northumbria Police
Any explicit links to other MCN groups: MAPPA

Name: Safeguarding Adults Review and Complex Case Group (SARCC)
Purpose: To provide multi-agency senior, high-level oversight for high risk safeguarding adult cases, for 'complex cases' that don't meet the statutory criteria for a Safeguarding Adults Review, and to consider where harm or death of patients was caused or exacerbated by the lack of joining up between services.
Partners: CCG - Designated Nurse (Chair); Northumbria Police - Detective Chief Inspector (Vice-Chair); Gateshead Council [Safeguarding Business Manager (Co-ordinator), Adult Social Care Service Manager, MCA / DoLS Strategic Lead, Solicitor, Contract Review Manager, Community Safety Manager]; NTW - Safeguarding and Public Protection Manager; Coroner's Office - Coroner's Officer; Gateshead Health Foundation Trust – Safeguarding Strategic Lead The group can agree to co-opt members as and when necessary for specific knowledge and expertise. This may include, for example, Tyne and Wear Fire and Rescue Service, North East Ambulance Service, National Probation Service and Commissioned Provider Services.
Chair: Jill Lax, Strategic Safeguarding Lead, QE Gateshead
Any explicit links to other MCN groups: Safeguarding Adults, MAART

We have begun to create more comprehensive index of the various MCN meetings, but we are currently waiting to receive certain documents to help fill the final few remaining gaps.

Headline findings

1. The MCN groups are only one part of a complex system, and we need to pay attention to other parts too.

Here are the inter-connected component parts that we have uncovered so far:

a. The individual experiencing multiple and complex needs ('Individuals with MCN')
b. The organisation making a referral about said individual ('Referrers')
c. The individual making a decision about whether said referral gets discussed by a specific group. This person may also make the decision to re-route the referral elsewhere. ('Referral traffic controllers')
d. The MCN group
e. The organisations making up an MCN group and carrying out the support work
f. Key professionals who are well-connected across the system and are able to link specific people across organisations to facilitate multi-agency working. ('Connectors')

The importance of 'referral traffic controllers' and 'connectors' should not be overlooked. We intend to look more closely at these roles in Phase 3 and have more to say about them in the December 2020 report.

2. Many of these groups are ongoing processes rather than 'isolated meetings'

Rather than conceiving of these MCN groups as isolated meetings, it is more accurate to think of some of them as ongoing partnership processes. In some cases, such as Integrated Offender Management, the majority of the work is discussed by the professionals on a daily basis and the meeting is in many cases simply to assess progress and ratify the approach. Other meetings, such as MARAC and the police-led Complex Offenders group, follow a discrete process of: gather/share intel – discuss options - agree required actions – assign actions to profs.

3. The majority of our interviewees stated there were high quality working relationships among the multi-agency attendees of their specific meeting.

Here's what we heard from people: "We're able to simply pick up the phone and our partners are almost always available to help immediately. There's great willingness from partners to take action.", "There is a good level of trust within the group as they have been working together for a long time", and "Often knowing who the right person is to go to in another organisation and already having a relationship with that person will enable us to actually get things done – and to do the right thing for an individual."

Across the board, people reported that informal relationship structures are working well – though with the caveat that in many places they are working well *despite* the formal structures rather than because of those structures. Others spoke about trust from the perspective of blame: "We work hard to keep conversations relaxed and informal, ensuring we have a no blame culture, and everyone feels able to be open and honest". Another put this similarly, "In informal settings, people are more relaxed, more open as there's no blame, and we're all more effective."

4. Lens, scale, and perspective are vital to understand the state of the system.

If you zoom in on any specific meeting, you will find a clear process working well, good professional relationships between partners, and generally good levels of information-sharing.* If you zoom out

and look at the system at large, you will see duplication, contradiction, cases bouncing from meeting to meeting, information only being shared within narrow cohorts, learning not being widely disseminated, short-termism, cycles of crisis continuing over years, professional frustration and resignation. It has never been more important to encourage people to adopt a 'system perspective' – but there is limited evidence of this happening so far. While there is broad recognition among people that 'the system' is not working well – but this tends to be coupled with thinking that their part of the system is working well.

*As an exception to this, CNTW was frequently mentioned as often lacking representation in MCN meetings, with associated challenges to accessing and sharing important Mental Health data held on their systems.

5. Speed has been recognised as a key component in successfully helping someone.

We found a broad recognition that the longer someone with Multiple and Complex Needs is left in a situation without support, the worse their situation tends to get. Some meetings have started meeting much more frequently to allow them to respond faster to people's circumstances. The recent month-long pilot of the 'dynamic MARAC' involving daily meetings presents the most ambitious example. We await the release of the evaluation into this approach. The DRD group has also changed its approach in order to review and report findings and learning in a more timely manner, and SARCC is considering switching to a 'rapid review' format.

6. The difficulty accessing/the under-resourcing of mental health services.

Almost every interview conducted mentioned the difficulty accessing mental health services across the system. As of yet, we have not determined why this is the case. Here are some of the observations we captured:

- "Mental health support can be patchy and needs to be fought for. Having CNTW at the meeting is helpful in providing a thorough background on individuals being discussed, info on their treatment etc. However, it becomes problematic if individuals are not '<u>current</u> on CNTW's books.'"
- "One thing that is needed is a massive influx of funding for mental health services and resources. If we could catch people earlier and more quickly, we would be able to reduce the overall number and complexity of cases."
- "While we receive a lot of referrals from the police, we experience a lack of engagement from mental health services. We have found that CNTW will only attend MAART meetings if they are already working with the person being discussed."
- "A lack of mental Health support is a major constraint because the majority of the people that IOM works with have mental health challenges in one way, shape or form."

Key challenges

While our work is much more focused on how we can collectively make the system work better for people with MCN rather than simply 'diagnosing the system', some diagnosis is essential in order to target improvements. In this section, we highlight what we perceived to be the most significant systemic challenges. For the sake of brevity, we have included the other challenges we uncovered as a list at the end of this section without delving into detail. The four most significant challenges are:

1. The issue-based framing of the meetings is fundamentally problematic when dealing with people whose needs are multiple and complex.
2. The lack of communication between meetings and into the wider system.
3. Some of the same people are being discussed repeatedly in these meetings over years.
4. The difficulties of ascertaining capacity

1. Issue-based framing

The principal issue is that these MCN meetings are almost all **framed around specific, narrow issues**. Since we are looking at individuals with ***multiple*** and complex needs, it is almost inevitable given this narrow framing that some of the same individuals will be discussed at multiple meetings. Here is a summary of the meetings and their framing issues:

Meeting	**Framing Issue**
A&E Frequent Attenders	Repeat appearances at the Emergency department
Channel Panel	At risk of committing an act of domestic terrorism
Complex Cases Group (inc. Complex Offenders)	Repeat offenders
Drug Related Deaths	*Suspected* drug-related death
Dual (Needs) Diagnosis	Mental health + substance misuse (including complications which could include LD, offending etc.)
Integrated Offender Management	Prolific or other priority offenders who aren't already involved in the MAPPA process
MAART	Experiencing or at risk of abuse or neglect and don't have care and support needs + don't yet meet threshold for Adult Safeguarding intervention
MAPPA	High risk sexual and violent offenders
MARAC	High risk victims of domestic violence
MATAC	Harmful and serial perpetrators of domestic abuse
SARCC	Experiencing or at risk of abuse or neglect and have care and support needs

If, for example, an individual was a victim of domestic abuse, and mental health and substance misuse issues, and frequently attended the Emergency department seeking help, based on existing structures they could potentially be discussed at three separate meetings. Similarly, if an individual was a serial offender, a perpetrator of domestic abuse, and at risk of committing an act of terrorism, they could be discussed in at least three separate meetings.

For those who experience multiple and complex needs the issue-based framing of the meetings/groups contributes to several related problems:

a) People being objectified as 'the bearer of an issue' rather than treated as a whole person,
b) The employment of eligibility criteria for deciding whether a person's case gets discussed or not, which leads to people 'bouncing' around the system when they don't meet the criteria,
c) When information is gathered and shared in a meeting, often only information that fits with the framing of that meeting will be given attention, e.g. the Channel Panel will only look for signs of and record information related to risk of terrorism,
d) The 'incentives' or success criteria of the different groups reveal a misalignment between what may be good for the individual vs what may be good for the service e.g. When someone ceases to be a frequent attender at A&E, this may be seen to be a 'win' by that group, but it is often not clear *why* that person no longer attends – have their issues actually been resolved?

2. Lack of communication between meetings and into the wider system

Internally and individually, many if not most of these groups appear to be effective. Group members tended to speak positively about how their group works, whether that is as a reflective space for creative thinking and deepening understanding of people's lives, or as a task-and-finish group that designates and carries out actions efficiently.

However, when viewed as a whole system, the picture looks very different. Most meetings will not know if an individual who presents on their agenda is also being discussed at another meeting, nor is there a mechanism in place by which the chair of one group may determine whether another group is also considering a given individual. The actions decided at one meeting are rarely conveyed to other meetings, so there is a real danger of contradictory actions being decided at separate meetings. (At least one interviewee, Phil Conn from Oasis Community Housing, described having been in two meetings where the same person was discussed and the actions of the two meetings contradicted each other.) And, perhaps most importantly, while genuine and important learning is done within these meetings – both about specific individuals and about broader themes or trends – the meetings struggle to share this learning any wider than the people who were at the meeting, meaning the potential for improvement and innovation across the system is lost.

Related to this is the broader issue of data and information-sharing. While most groups appeared to be good at sharing information about key individuals among members of their particular group – with internal data-sharing agreements in place to facilitate this – this does not correspond to wider data-sharing between agencies. People described an unhelpful limit to what they are able to see of a person's information, and the time it takes to submit an information request and wait for a response. For example, not being able to look at mental health records because agencies use different systems. Some fast-moving (crisis) cases may be hindered from progressing due to lack of access to quite simple data, such as whether an individual is receiving mental health treatment and, if so, who is the relevant contact. Also cited was how COVID created the unique position of being able to get contact details and information of patients from health, which allowed them to proactively reach out to people. The question was raised, 'How can we do this in non-COVID times?' This is significant, and we return to it below in the 'Potential Pioneering Practice' section.

3. The same people discussed repeatedly over years

Almost all of these meetings are set up to deal with crisis conditions. They employ eligibility criteria which mean that if people's circumstances aren't currently severe enough, their case will not be

discussed. This inadvertently causes a "Come back when you're worse" situation. It also discourages any kind of long-term planning – if you're set up to respond to crises, your responsibility can be seen to end when the crisis is averted. The reality for the individuals being discussed is that their lives are constantly dropping in and out of crises.

Many of those we interviewed referred to a lack of outreach work and the absence of earlier help. The lack of funding for such services was cited as problematic. It was frequently noted that if the system will only engage with people in crisis, it is inadvertently 'encouraging' people to reach crisis point. Whilst this is an ongoing issue, we did find some good examples of pioneering practice (in next section) that are beginning to address this.

If there is one fact that tells us the current system is not working, it is that these cycles of crisis continue for years for people with multiple and complex needs. We recognise that some individuals have higher level support needs and that there is no 'silver bullet' to resolve them. However, timely and appropriate support that is well-managed through the life course ought to ensure that crisis thresholds are reached less frequently.

4. The difficulties of ascertaining capacity

In order to be eligible for support in many different parts of the system, it must first be ascertained whether a person has or lacks capacity under the Mental Capacity Act. However, there are several of issues that make this process nigh-on impossible. Firstly, substance misuse - an individual dealing with a serious addiction may not be making rational choices, but it can be impossible to ascertain what the person's level of capacity would be if they were not under the influence of a substance. This can make it impossible within current system arrangements to get the person the proper help needed. Secondly, coercive control - an individual who under the standard assessment criteria has mental capacity is actually not free to make their own choices at all because someone else is controlling their decision-making.

Other challenges that professionals raised during the interviews:

- Difficulty accessing/under-resourcing of mental health services is recognised as a problem across the system.
- Treating people as isolated individuals without looking at the wider sphere of influence within which they exist – to what extent do meetings look at networks around individuals?
- Difficulty for VCS organisations to get involved – often not invited to meetings, or invited as an afterthought
- Limited capacity for professionals to follow-up on people
- Performance measures and KPIs causing unintended problems
- Lack of understanding of other parts of the system
- Focus on compliance and being covered legally
- Culture of some of the meetings - too much blame and defensiveness and not enough trust and learning
- Professionals resigned to 'this is the way it is'
- Institutions stuck behind policy, with a narrow remit
- Central philosophical difference of approach between 'enforcement' (police, probation) and 'care/engagement' (ASC, VCS)
- Challenge of people moving to different geographical areas

Early indicators of potential 'pioneering practice'

When we talk about 'pioneering practice' we have in mind the *Forum for the Future* definition (2010):

> *Creating pioneering practice is about generating examples that demonstrate a new way of doing things. This may include new technologies, products and services, business models, changed relationships, markets or mindsets. To be pioneering it needs to:*
>
> - *represent a new approach or new thinking that takes the system in a new direction*
> - *have a clear prototype or pilot that demonstrates what success looks like*
> - *respond to a systemic question*
> - *have the potential to be scaled-up*

Below are some early indicators of potential pioneering practice both from within the Gateshead system and from further afield:

1. Speed

We know that speed/immediacy is a positive – it helps to reduce the problems caused by a long lag time between meetings and before support during which problems can escalate. A number of these meetings/groups reported moving to a more frequent meeting pattern, with one even meeting every day - "We're looking at a 'SAR in Rapid Review' format, which has been introduced nationally during COVID. This would mean, in COVID cases, we would need to complete a safeguarding review within 15 days rather than usual timescales which can take up to a year." "Meeting every three months was not working well."

2. Informality

Many interviewees cited the specific relationships they had developed in other agencies as a core reason why they were able to 'get things done' and provide support for people experiencing MCN. A large number said that these informal relationship structures were more beneficial than the formal structures of meetings (and that sometimes, the formal meetings get in the way). However, a number of interviewees described the meetings (especially the more informal, learning-focused meetings) as having been useful for having helped them develop specific relationships with key individuals in other agencies. The more informal meetings were also described as being useful spaces for peer support.

3. Local information sharing

Within each MCN meeting/group, there are existing frameworks for sharing information among the partners that appear to be working well. These frameworks and agreements do not extend beyond the limited pool of partners but could provide an excellent base for extending information-sharing.

4. Digital

The digital transition has largely been working very successfully, especially for professionals. The most common feedback has been that the transition to digital meetings has increased efficiency by reducing travel time, ensuring more consistent participation and using time within the meeting more

effectively. We also found evidence of more work happening in between meetings. It is important to note that the transition to digital has not been without problems, with certain meetings struggling because the partner agencies all used different platforms. Microsoft Teams has become the platform most commonly used. However, the Police have had difficulty with this platform which is ongoing. This has impacted the MARAC meeting which has moved to teleconference, thereby lacking the opportunity for visual on-screen presenting. More broadly, several people noted what has been lost through the lack of face-to-face contact – namely, the social fringes that are essential for relationship-building.

5. Public Service Reform prototypes

The Council's PSR prototypes were cited in several interviews as live examples of pioneering practice. The aspects highlighted included empowering frontline staff to make decisions and act flexibly, together with the removal of unhelpfully convoluted policy frameworks - "Trusting staff to be able to make judgements and be flexible in how they work with a person – this has really helped to make service users feel cared for. It has also helped staff feel more motivated"; "The freedom that team had was amazing - to just buy a phone charger if that's what was going to make a difference in that person's life. The approach of 'doing the right thing for that person' is what we need to see more of."

6. Dedicated lead professional

The impact of having a dedicated 'lead professional' to work with the client was mentioned across a variety of meetings as something that has occurred in places and has proven to be very effective. (It ensures a clear point of accountability, and helps reduce the likelihood of a person bouncing around the system.)

In a related point, having a dedicated social worker connected to the MAART process was also seen as a point of strength. By not having to go through the usual, slow channels, the MAART process was able to provide a social worker quickly to help support people experiencing MCNs. (Having dedicated staff members connected to these processes draws a sharp contrast to those parts of the system where professionals are trying to provide additional support to complex cases *alongside* their day job.)

7. Proactively reaching out to people

During the lockdown, Gateshead Council assembled a call centre team of redeployed staff from libraries, leisure centres, housing, education, and welfare who proactively reached out to people identified as potentially vulnerable. This proactive reaching out to people in communities meant connecting with many people who had never engaged with services previously but had significant levels of need. In addition to this, the Council learnt that people who work in libraries and leisure centres have an amazingly wide knowledge base and know the people in their local community and the details of their lives.

8. Creative use of legislation

The Council used the Housing Act in 'very creative ways', introducing closure notices on properties to protect individuals in the property e.g. against perpetrators of abuse – the notices meant the property

was closed to everyone other than the residents of that property. Previously, the Police have had difficulty getting injunctions under criminal law, but are now getting same outcomes using civil law,

9. Development of a 'vulnerability' marker

The *Winnie Smith Appreciative Inquiry* describes how some partners including General Practice and Gateshead NHS Foundation Trust have developed a vulnerability marker which partners recognised as being helpful. This marker could alert the practitioner to be more vigilant with respect to nonattendance at appointments, disengagement from services, who is present during any appearances and unwise decision making. This has features in common with the 'Active List', 'Watch List' and joint management plans developed by the A&E Frequent Attenders group and the *dynamic support register* (DSR) used by the Dual Diagnosis group

10. Trauma Informed Practice and Psychologically Informed Environments (PIEs)

Within our interviews, trauma-informed practice and psychologically informed environments (PIEs) were cited as examples of pioneering practice. Scotland was one of the first countries in the world to develop a robust Knowledge and Skills Framework for Psychological Trauma, which lays out the core knowledge and skills needed by all tiers of the workforce. PIEs have emerged out of the need to create psychologically informed services to meet the challenge of homelessness, but it is recognised as being relevant across a whole range of service offerings. Gateshead-specific pioneering practice is emerging in this regard, but there is also a recognition that this practice is only contained in pockets within the local system rather being system-wide.

11. Accommodation on release

We heard of a Police officer seconded into the probation service described as "doing good work with the Homeless section in Probation". Work has been done to streamline the process for getting a property upon release from Prison, as a preventative initiative. There is evidence that it is having success in "drying up supply" into the Complex Cases problem-solving group.

A COVID/digital snapshot

The majority of interviewees said the move to digital had been positive for professionals. Virtual meetings have made attendance easier, which has led to people attending meetings regularly who were unable to make it in the past. Meetings also tend to be quicker, and more to the point. Sharing information has become easier too. However, several cited "missing being able to read the room, which is something you can't easily do online" and "The lack of 'corridor conversations' means we're not currently sharing those incidental anecdotes that can unlock entire problems."

For patients and service users, we have heard anecdotally that the move to digital has been helpful for many but has left others even more excluded. This is supported by data supplied by Healthwatch Gateshead. [Note: Our work does not include any extensive engagement with patients/service users and so we are reliant on secondary sources for this insight.] A number of professionals cited how certain things (e.g. Mental health assessments) really need to be conducted face-to-face. This has led to a lengthening of waiting lists for some people, and while they are waiting their needs may escalate.

In terms of COVID innovations, aside from the move to digital, there has been a significant focus on speed, with many groups meeting much more frequently in order to solve problems faster (e.g. a 'SAR in Rapid Review' format).

COVID (by virtue of the temporary powers afforded by the Coronavirus Act) also proved a catalyst for innovative data-sharing and a focus on providing early help: "COVID created the unique position of being able to get contact details of patients from health, which allowed us to proactively reach out to people. During the lockdown, we were able to assemble a call centre team of redeployed staff from libraries, leisure centres, housing, education, and welfare. This group had an amazingly wide knowledge base. What we earnt is that people who work in libraries and leisure centres especially do massive amounts in their local community and really know the local people and the details of their lives."

COVID also resulted in homeless people having to be housed, meaning that their basic were met, and it made it easier to find people because of them having a fixed location.

While not innovations, we also discerned three important impacts of COVID:

- It reportedly had a negative impact on support networks and led to an increase in deaths.
- It caused A&E frequent attenders to come into the hospital less. The people with lower level 'cry for help'-type mental health issues have significantly decreased.
- Before COVID, there were individuals who would have accessed support on a daily basis. However, when the support was no longer available on a daily basis, people found that they could function by themselves – and this positive pathway with reduced support has continued.

Suggested next steps

1. **Gather feedback from the panel (October 21st).**

2. **Complete and feed in 'lived experience' strand of the research.**

3. **Share this report with people who have been engaged in the interviews. Collect feedback about what interviewees think of what we have reported.**

4. **Share report more widely across the Gateshead system and invite the system to tell us what they would like the follow-up recommendations to include.**

5. **Project team meet for analysis session to begin to determine potential recommendations, building in feedback from panel, interviewees, people with lived experience, and the wider Gateshead system.**

6. **Locate enthusiasts for change.**

7. **Write 'recommendations' report, due mid-December.**

Appendix A – Membership of Project Oversight Panel

The membership of the project oversight panel is drawn mainly from the Gateshead Health & Care System board, with the addition of additional members bringing perspectives from other parts of the system.

Melony Bramwell	Service Manager Adult Social Care
Alan Cairns	D/Chief Inspector, Safeguarding
John Costello	Quality Assurance and Commissioning (Gateshead System)
Iain Donnelly	Fulfilling Lives System Change Manager
Steph Downey	Director, Adult Social Care
Teresa Graham	Primary Care Practice Manager
Brendan Hill	CEO, Concern Group
Des Hunter	Expert by Experience, Fulfilling Lives
Jill Lax	Strategic Safeguarding Lead, QE Gateshead
Carole Paz-Uceira	Safeguarding Adults Business Manager
Julia Sharp	Programme Lead, Public Health
Richard Scott	Designated Nurse Safeguarding Adults, CCG
Karen Worton	CNTW Group Nurse Director