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Newcastle Gateshead

People @ the Heart

Gateshead multiple and complex needs transformation initiative

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"Our welfare state is not fit for purpose. This once life-changing project is out of kilter. It has become a management state: an elaborate and expensive system for managing needs and their accompanying risks."

Hilary Cottam, *Radical Help*

Contents

Acknowledgements

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Overview

In common with so many other parts of the UK, the system of support for people with multiple and complex needs in Gateshead is broken. Within this report, we try to describe what a better, healthier system would look and feel like, that is, a system working well both for those it serves, and for those working in it and with it. We present an approach that puts '**People @ the Heart**' by combining a series of drivers for change. The approach is not intended to be a work plan, though it does include specific priorities, principles, and practices that we believe ought to be adopted to improve the effectiveness of the system. Ultimately it provides a 'big picture,' whilst recognising that more work needs to be done to translate that picture into reality.

Where we started

In late 2018, the Gateshead Health and Care System Group conducted a 'mapping exercise' that identified 12 multi-agency meetings and groups taking place in Gateshead to identify, plan or discuss support for people experiencing Multiple and Complex Needs (see table on p.21). ('*Multiple and complex needs'* can include mental ill health, homelessness, drug and alcohol misuse, offending, family breakdown, and other issues.) Professionals within these groups often didn't know of other groups that existed, and therefore didn't communicate between groups. This meant that the same individuals could have their situations discussed in multiple contexts, sometimes, we were told, with contradictory action plans being agreed. The proliferation of groups and the confusion and lack of coordination between them led to the commissioning of this work. Its aims were:

- To yield new insights into the ways in which the Gateshead system is dealing with people experiencing multiple and complex needs (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 to rationalise the multiple professional groups concerned with MCN
- To leverage improvement within the system that will benefit both service-users and professionals

How we proceeded

Our work commenced with a short Scoping phase that involved meeting with the Gateshead Health and Care System Board, at which it was agreed that a project oversight panel would be established. The panel included 13 representatives of public sector agencies, VCS organisations as well as an 'expert by experience'. The inclusion of the 'expert by experience' was important as we recognised the centrality of learning from Lived Experience and sought to pay attention to these perspectives within our work, believing these perspectives to hold equal validity to those of professionals within the system.

Following this we moved into three distinct phases of research activity, as below:

Identify	Clarify	Codify
We interviewed the chairs and various members of the different MCN groups to understand those groups, their responsibilities, any pioneering practices they had observed, and the constraints, gaps, and problems associated with the MCN groups.	We pulled together the picture of the system we had heard from all the groups, and discussed this in focus groups with a much wider group of stakeholders from across Gateshead (including several groups of people with Lived Experience) to test the accuracy of what we had gathered and to seek ideas for how to make improvements.	We finalised our recommendations based on the previous feedback of how to make the system work better for people experiencing multiple and complex needs. This publication represents the final iteration of the 'Codify' stage.

During each stage, we met with the oversight panel to plan and review.

Where we arrived

Gateshead's system of support for people with MCN can either be designed and structured around the person concerned, or it can be designed and structured around professional concerns. It cannot do both, not primarily. At present, the system is built primarily around professional concerns. Operating in this way means that people are segmented according to the issues or themes they present. This makes sense in terms of enabling different organisations to specialise in different issues or themes. Unfortunately, living human beings are not so easily dissected. Many people who experience one issue (e.g. mental health) also struggle with other related issues (e.g. substance misuse). Any system that is not designed and structured around the people it is intended to serve is inevitably going to clash with and exacerbate people's needs, and leave those people feeling confused and worse.

Our primary recommendation – Priority One – is that the Gateshead system commits to doing what is necessary to transform itself into a system that is structured around people.

We refer to this as 'People @ the heart.'

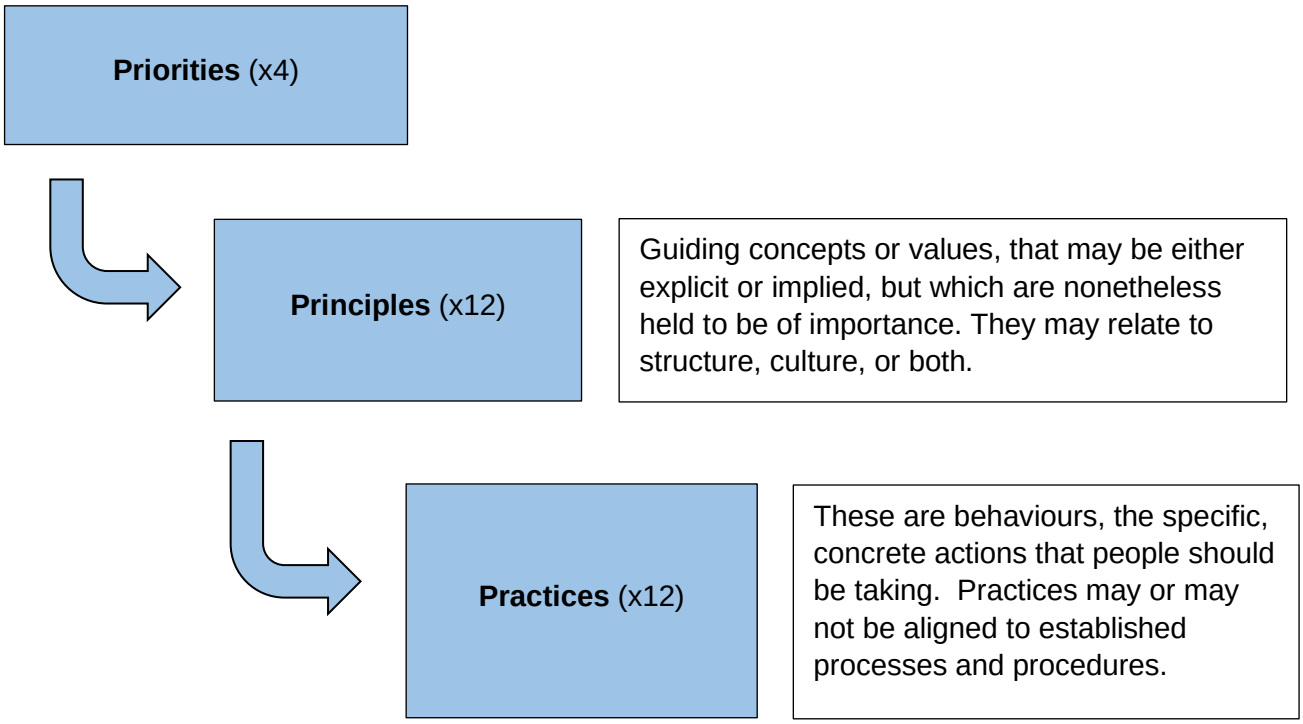
Supporting this central priority, we recommend three subsequent priorities:

Use signals to guide proactive outreach[1]

Invest heavily in iterative learning to drive system improvements

Empower and support the workforce

Sitting underneath these four **priorities**, we have articulated 12 **principles** that we believe will provide the building blocks of a transformed system, to be effected through the corresponding examples of **practices**.



On the following pages we will explain the model (priorities + principles + practices) in more detail. Firstly, we want to explain the evidence base that contributed to the creation of this approach.

[1] Signals can be patterns, connections, incidents, outliers or trends, often found within data. See p.15.

Our Evidence

The voice of people with Lived Experience

When we began this piece of work, we sought clarification that the goal was not simply for us to recommend how the 12 professional MCN meetings could work together more efficiently. We were pleased to receive reassurance that Gateshead was looking for something deeper, something that sought to produce the best possible long-term outcomes for people with multiple and complex needs.

Early on, through engagement with Lived Experience groups, we found that there are times when the current system of support for people with multiple and complex needs actually hurts the very people it is trying to help. We found numerous examples of the complexity of services and support making matters worse for them.

Here are a few of the quotes we have drawn from our interviews:

- "I got to the point where I felt I had to harm myself to be considered for support from the NHS."
- "My GP would refer me to services but the services would write back to say they couldn't help."
- "I had to fight for support from a service to keep helping me when I had a relapse recently. It feels like I was being punished for having a relapse rather than being empathetic and supportive at a point in time when I needed it most."
- "Having to tell my story over and over again is painful. It's like ripping off a plaster every time, it hurts and the wound takes longer to heal."
- "There's a guy I used to see who kept coming to A&E. He'd commit small acts of self-harm, so he could ask for bandages and get some support from doctors and nurses."
- "I got a call asking if I wanted to set up an appointment. I told them that I was too terrified to leave the house. Yes, I wanted help, yes, I needed help, but I just couldn't commit to an appointment because my life was too chaotic."
- "On those days when you feel more in control of your life, it would be nice to be involved in those discussions. The meetings seem to be confidential, but at the end of the day it is about you. Plans get organised for you without your input, but at the end of the day it is the person that knows themselves best and what they require to turn the life around."

Of course, this harm is not being done intentionally, nor is it a product of professional negligence, nor of practitioners' failure to care. The Gateshead system is made up of good people trying to do the right thing. However, the current system is not fundamentally structured around the inter-connected needs of the whole person. It is structured around professional concerns. Any system that does not fundamentally pay attention to the inter-connectedness of people's needs risks exacerbating those needs. If we want to get serious about preventing the sorts of harm indicated above, we need to get serious about fundamentally reforming the system and building it around whole people.

Broad consensus among practitioners

When we began this work, we expected to find a range of perspectives, and an appetite for some moderate improvement. However, what we found was a broad recognition among practitioners in Gateshead that 'the system' is not working well. For example, people told us that:

- Almost all of these meetings employ forms of eligibility criteria which mean in practice that if an individual's circumstances aren't currently severe enough, their case will not be discussed. This inevitably produces a "Come back when you're worse" effect. It also discourages any kind of long-term planning – if services are set up to respond to crises, then responsibility can be seen to end when the crisis is averted. The reality for the individuals being discussed is that their lives are constantly edging in and out of crises. (It is important to note that some of the criteria are mandated by national statutory legislation. The way forward must be to develop a system that meets statutory legislation, but is not constrained by it.)
- Many of the practitioners 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.

Very few people felt current arrangements to be working well, with broad agreement that there is considerable room for improvement. Indeed, it is fair to say that there is an appetite for doing things radically differently. We heard that where things ***are*** working well (e.g. quality of professional-professional relationships), they are working well ***despite*** the formal structures rather than because of those structures.

If there is one fact that tells us the current system is not working, it is that people with multiple and complex needs experience cycles of crisis that continue for years. 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 far less frequently.

As we sought to identify barriers to change we came across something of a paradox. While most people told us they felt the system as a whole is not working well at all, *they felt that their part of the system is working well*. Making sense of this is a question of perspective - if you zoom in on any specific MCN meeting, you will find agreed policies and procedures, good professional relationships between partners, good levels of information-sharing, and people genuinely trying their best. Yet, zooming out to look at the whole system, there you will see duplication, contradiction, cases bouncing from meeting to meeting, limited information sharing, learning not being widely disseminated, short-termism, cycles of crisis continuing over years, 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.

Some indicative comments we heard during the process included:

- "It's more about the meetings than the person at the moment."
- "If someone's not ready to engage with services, professionals may withdraw from the process. We need to do the groundwork of building a relational foundation with the people."

- “The sharing of client information has to improve - we need systems that talk to each other as the lack of access to information makes everything harder.”
- “Why are decisions being made by people whose sole interaction with the person is reading a form about them?”
- "I think we do very little for people, other than protect them for a little while."
- “A lot of services don't work very practically - we need go to where people are rather than insist they come to us.”
- “We don’t get much feedback on outcomes for people – are we achieving anything?”
- "It's not 'What's wrong with them?', it's 'What's happened to them?' and 'What help do they need?'
- “Digital meetings on Teams are one of the good things to come out of COVID. Online notes should become easier to access too – but these systems aren’t yet accessible to each agency.”
- “We have to disrupt the pathways by which people escalate into the groups. We need to find a mechanism to identify the triggers.”

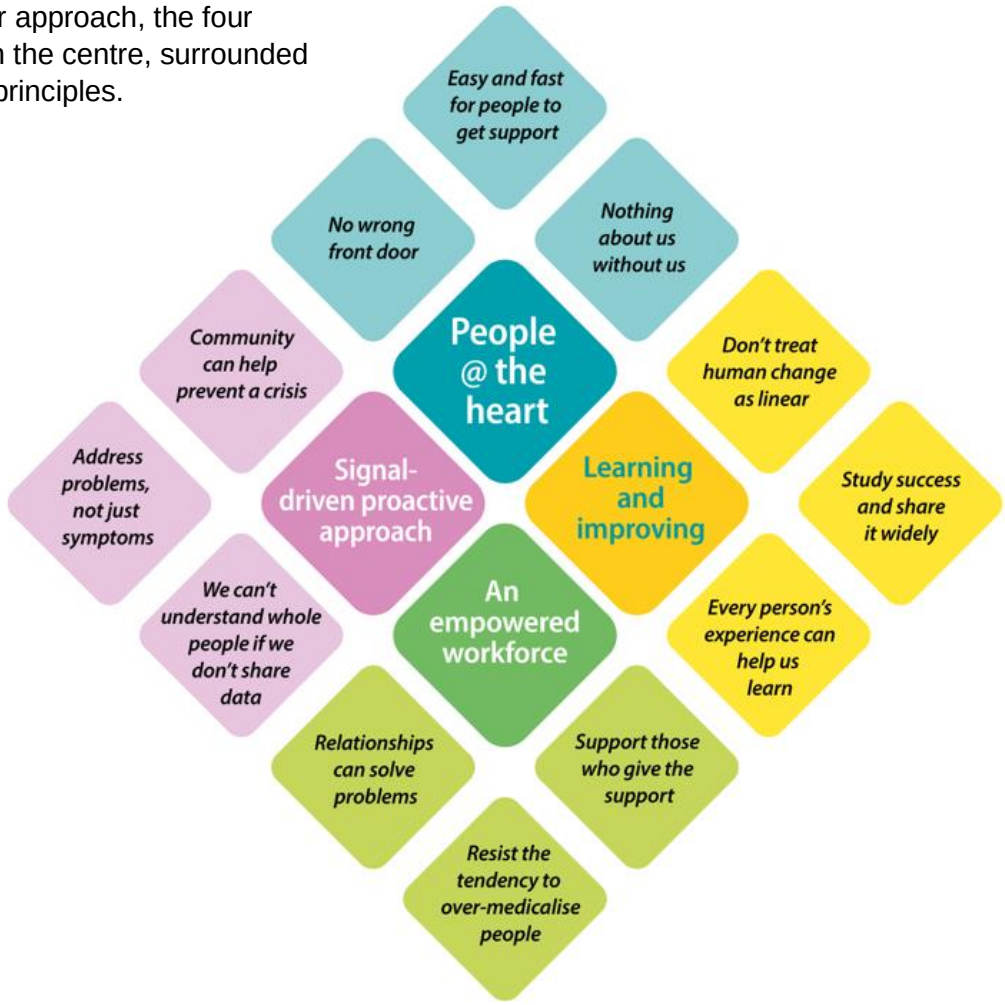
Our Recommendations

While we began this piece of work looking at a tangled network of meetings that seek to support people with multiple and complex needs, our recommendations are much broader and deeper than simply attempting to untangle these meetings. During the project we explained to the panel that we could not in good conscience simply recommend a range of 'tweaks' designed to bring about marginal efficiency gains. Rather, in keeping with what we heard again and again from both practitioners and people with Lived Experience, there are critical flaws in the entire culture and structure of the system.

As noted earlier, we can either design and structure our support systems around a person or we can structure them around professional concerns. It is not a question of balance, but of priority. One must come first. At present, the MCN system is built around professional concerns. There is a logic to this, as it allows organisations to specialise and aims at 'efficiency'. However, failing to attend to the inter-connectedness of people's needs risks exacerbating those needs, and, ultimately, doing unintentional harm while trying to do good. If we want to get serious about preventing the sorts of harm indicated above, we need to get serious about fundamentally reforming the system and building it around people.

Our headline priority is that the Gateshead system commits to doing what is necessary to transform itself into a system that is structured around people.

Here is our approach, the four priorities in the centre, surrounded by the 12 principles.



This approach comprises four central priorities. First and foremost: 'People @ the heart', followed by three supporting priorities: 'Signal-driven proactive approach,' 'Learning and improving,' and 'An empowered workforce'.

Principles and practices

Our working method involved substantial person-to-person interaction as a means of gathering the evidence we needed. Reflecting as a team on the material generated by our phone calls, video calls, virtual focus groups, and even some face-to-face meetings, we recognised the presence of both principles and practices. As we began the sorting and categorising of the evidence, we began to see that there was clear distinction between principles and practices, as well as a relationship between them.

- By **principles** we mean a guiding concept or value, that may be either explicit or implied, but which is nonetheless held to be of importance. The principles tend to have relevance across a broad range of contexts and applications. There is a sense in which the principles operate at a more fundamental level than policy as they represent people's gut feeling about the way things ideally should be. Principles are 'guiding lights' that should help shape discrete practices without actually being a discrete practice. They don't tell us what to do, but they should serve as a constant reminder of the *sort* of things we need to do or *how* to do them.
- By **practices** we mainly mean behaviours - the specific, concrete actions that people can actually do. We found that practices may or may not be aligned to certain processes and procedures. Where they are, we were interested to hear about those parts of the system within which practitioners seemed to enjoy a reasonably wide latitude with respect to the actions they might take, contrasted with areas in which action might be more narrowly defined and prescribed. (This is essentially the subtext to our recommendation about an *empowered workforce.*) It is necessary to bring this work to the level of concrete practices and actions, and so we have referenced some key practical recommendations that we feel the system should adopt. Many further changes to practices will emerge should our recommended approach be adopted, but these will look very different in different parts of the system, and it's up to those parts to determine what their concrete practices of reform will look like, based on their in-depth knowledge.

From an early draft containing around 20 principles, we were able to consolidate and prioritise to arrive at the final set of 12. In building the final model, one of our most challenging tasks was the association of the 12 principles to the four priorities, as there were many overlaps. Our final model was therefore created using an approach of 'best fit', with many of the principles clearly having relevance to more than one of the priorities. The colour scheme used in the final model essentially indicates this best fit, but hard lines have not been drawn connecting the elements to one another.

Each priority is supported by three guiding principles. Each principle is supported by an example of a practice through which the principle could be effected.

Priority 1:

Restructure the Gateshead system, and reorient the culture, to have People @ the Heart

We feel it necessary to keep stressing that a choice needs to be made about whether we primarily structure our support systems around whole people or around professional concerns. At present, we have a system that is built primarily around professional concerns, and this risks harming the people that it intends to help.

It is important to recognise how deep that structuring around professional concerns goes. Even the original brief for this piece of work is framed primarily around professional concerns:

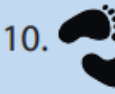
> *"A mapping exercise has identified the multiple meetings/groups taking place in Gateshead to identify, plan or discuss support for people experiencing Multiple and Complex needs. In light of this, the Gateshead health and care system group acknowledged the need to look into this further with a view to ultimately providing a more integrated and streamlined approach to reduce duplication, provide a better service offer for people experiencing multiple and complex needs and better support the workforce."*

Here is what a brief structured around people could have said:

> *"People with multiple and complex needs are not getting the type of support they need. Cycles of crisis frequently continue for years. People are being objectified as 'the bearer of an issue' rather than treated as a whole person. People 'bounce' around the system because the employment of specialised eligibility criteria decides whether a person's case gets discussed or not, and these criteria are issue-shaped rather than person-shaped. The use of eligibility criteria means 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. If the system will only engage with people in crisis, it is inadvertently 'encouraging' people to reach crisis point. We need to look into this further with a view to ultimately providing a system that works better for the people who need it most."*

Even the term 'multiple and complex needs' is framed from the perspective of a system that wants to be able to delineate needs in single, simple boxes to allow for professional specialisation. People do not work like that. Issues are not neatly delineated from other issues but all bleed together. Rather than beginning with professional concerns and questions of efficiency, one of our conceptual starting points was to take the perspective of a person and imagine what a system would look like that's designed around them. Drawing heavily on the conversations we've had with people with Lived Experience, here's what that looks like, coupled with what we think this requires of practitioners:

Working together = Walking together An Example Journey

1. 	2. 	3. 	4. 	5. 	6. 	7. 	8. 	9. 	10. 

The Person Supported

There's a high likelihood that someone reaches out to me and offers me help before I go looking for it. There is some form of positive outreach in place, based on a combination of 'signals' or existing relationships I have (e.g. libraries and leisure centres)	When I need help, it's easy and obvious who I can go to for help. I don't have to travel across the borough to A&E because it's the only place open, but there is support available on my doorstep. It's some place safe and open where I can just drop in.	Wherever I go, I don't get turned away or told 'we can't help you.' Nor do I have to go through a lengthy assessment process. Instead, it's friendly and kind – a cup of tea and a chat. The person I meet seems genuinely to care about me and my circumstances. I begin to trust and develop a relationship with this person.	This person is able to provide some immediate practical support for me. If I can't afford to pay my heating bill, they immediate put some money in the meter for me. This gives me immediate positive feedback that it was right for me to reach out, that things are going to get better for me now that I have done.	I can continue to rely on the person I have bonded with. They become my 'lead practitioner' meaning I'm passed around a series of 'specialists.' I don't need to tell my story again and again, repeating the pain, rather, when they introduce me to others, I let them share relevant details of my circumstances. They explain to me in advance who I should meet and why, helping to manage my expectations. They show respect by reminding me I don't have to meet anyone I don't want to.	I am not rushed into treatment or pushed to 'recover'. Instead, I am actively encouraged to 'go at my own pace.' If all I want to do for weeks is to come in for a cup of tea and a chat, I am able to do that. I am reassured that support is available for the long-term. I am helped to gradually build alternative coping strategies.	However, nor am I put on long waiting lists, and just told to bide my time until support becomes available. If I'm ready for additional help now, people understand that a six-month delay might cause me to relapse.	I understand that multi-agency meetings are likely to help me get the support I need, but these are only driven by my lead practitioner. If my lead practitioner needs to pull in other people, or to have conversations where perhaps it's best if I'm not there, this is explained to me in advance and I consent to this taking place. All decisions are made between me and my lead practitioner. People show understanding that decisions being made about me without me feel like harm to me. Having a voice and being listened to is fundamental to my wellbeing.	Rather than just dealing with professionals all the time, I am also connected to other people like me who have been through what I am going through. These people are able to speak from experience, as well as give me a kick up the backside when they think that's what I need. (Over time, I am given the opportunity to play this role for others.)	If/when I stall or relapse, I don't get judged or punished. I don't get labelled 'a non-engager' or 'service-resistant'. Instead, I am treated with empathy, consistency and understanding.

The Practitioner Supporting

I have a posture of openness, actively listening to a range of voices located in different parts of the system. In this way I maintain awareness of emerging issues and ways in which the support my service offers can be best directed.	I understand the significant barriers that people face when seeking to get help, both practical (i.e. transport problems) and psychological (i.e. anxious about new people and new places).	I keep in mind that my job involves real people, not cases, service-users, etc. Therefore, in my interactions with those needing my support I will deal human-to-human. I will practice this principle even when I may be under constraints of time pressure.	In each interaction I hold the short and long term in creative tension, asking myself what I can do to ensure they leave an interaction in a better condition than they arrived. I see how small gestures lay the path towards more substantial and enduring outcomes being achieved.	My aim is not to hand people on to someone else as quickly as possible. Rather I see the importance of 'walking alongside' them, ensuring that they are introduced to the right people at the right time in the right way.	I'm very careful not to coerce cooperation by exploiting the power differential I have as a professional within the system. When I have to challenge someone it will be on the basis of a good relationship and their knowing I have their best interests at heart.	I recognise that waiting lists are problematic and will work with colleagues across the system to provide people with appropriate support at their time of need.	Where I have taken a lead practitioner role I will make the most of multi-agency working to achieve the best outcomes. Where multi-agency meetings are necessary I will find ways to ensure that my clients voice is heard and that they play a key part in decisions and action plans involving them.	I am committed to staying up to date in terms of my knowledge of peer support opportunities available to people experiencing different types of complex issues. I see the importance of my role as an introducer to these groups, networks and fellowships.	I know that relapse can be a vulnerable and dispiriting time for people. I will set aside any personal disappointment I may feel and focus on minimising harm and restoring stability.

We offer this imaginary support journey as an example of the kind of thinking that will lead to successful outcomes for people being supported within the Gateshead system. The more people for whom these ten descriptors are true, the more we will succeed. This is what we mean by 'People @ the Heart'.

From this work, we have extracted three core principles: 'No wrong front door', 'Make it easy and fast for people to get support', and 'Nothing about us without us'.

- **Principle #1 - No wrong front door**

What this means: When someone comes to a service asking for help, they are not turned away because we don't deal with 'their issue', nor are they 'bounced' to another part of the system, with the risk of becoming lost on the way. This means being prepared to ask people a range of questions that cover a wider terrain than the specific service to which someone has presented. When someone has come for help, we treat that as a sacred responsibility and pull in the specialist help that they may need, holding on to them throughout. This will require much greater networking between organisations, different relationships between organisations, and potentially even different funding arrangements.

Note: For each principle, we offer a corresponding practice. Each practice is intended to be an example of one sort of action that would instantiate the principle. No practice is intended to be a complete explanation of the principle – each principle is much broader than any single practice.

Practice: *Since services are currently fragmented and set up around specific issues, create 'System connector' roles, people whose job it is to hold relationships across the whole system, to facilitate connections, and to help practitioners connect to specialist help whenever needed. (These could be new roles or they could be a new focus of existing roles.)*

- **Principle #2 - Make it easy and fast for people to get support**

What this means: As well as there being no wrong front door, once people come through the front door, staff need to be empowered to make timely decisions that will improve lives, including making early offers of informal help. Taking the time to sit down, chat, and have a cup of tea with a person can make the world of difference. We have to stop 'assessing to exclude'. Staff need the freedom to make fast decisions that are in a client's best interests without being bound by red tape, as small, fast wins can have a big impact.

Practice*: Create and publicise a 'Blue Teapot' scheme – where institutions display publicly that they are a place where you can ask for help regardless of what that help is for.*

- **Principle #3 - "Nothing about us without us"**

What this means: At present, most of the existing MCN meetings take place without the people who are being discussed even knowing that they are being discussed. Discussions about an individual need to happen only if the person or a chosen representative of theirs is present so that their voice is a core part of decision-making. We also need to introduce the concept of 'experts by relationship' and to make the

space for these people to play a fundamental supporting role. For example, one member of the Lived Experience group spoke about how her mother's loving support and intervention had played a big part in her recovery, especially at times when she was struggling to engage for herself, yet often her mother was not welcome at meetings and professionals were not interested in dealing with her.

Practice: *Create 'lead practitioner' and/or 'expert by relationship' roles, whose responsibility it is to understand, support, and represent the person in support system contexts, and to help the person be involved as much as they choose. (This role would also need clear support and structure around it, so that people don't become the one 'holding' all of the risk with an individual/situation.)*

Priority 2:

Use signals to drive proactive outreach

Many of the professionals and practitioners we spoke with clearly described the need to work with people sooner and earlier. They clearly see that a system that will only engage with people when they are in crisis actually drives people into crises. ("I got to the point where I felt I had to harm myself to be considered for support from the NHS.")

It is universally recognised that preventing a crisis is better than any crisis management – it is less traumatic for the individual, it is less time consuming, it is less costly. It is also universally recognised that there is worryingly little provision of prevention services. Anything that can be done to offer help to people *before* they reach crisis point will be hugely beneficial to both individuals and the demands placed on crisis services. Covid-19 has given us a very recent example of this. The outreach into communities during lockdown was particularly eye-opening. It revealed significant levels of need within people and families who were 'previously unknown to services.' By finding ways to help these people before they reached crisis point, the system was able to stave off a potential ticking time bomb.

If the Gateshead system is to get serious about proactive outreach to prevent crises, it needs a mechanism by which to determine who should be the focus of such outreach. Fortunately, we have a nationally-recognised precedent on our doorstep. The Public Service Reform prototypes led by Mark Smith of Gateshead Council and partners have already used signals to guide outreach. In the Council Tax prototype, non-payment of Council Tax was treated as a signal that there were other issues in this person's life, and this was followed up with an outreach phone call inviting the person to a chat with an offer of help and support. This work proved phenomenally successful at helping

people to avoid reaching crisis point and to disentangle themselves from the knot of issues with which they had been struggling.

We recommend that the Gateshead system works collectively with the data they already generate and identifies a handful of signals that indicate a person or household is likely to be heading towards crisis point. Once we have identified who might need help, we can reach out in new and creative ways with a general offer of informal help and support rather than the tried-and-failed practice of assess-and-refer.

- **Principle #4 - Community can help prevent a crisis**

What this means: There needs to be a broadening of our thinking about where support can come from and what support is. At present, we have a very medicalised and formal approach to support, weighed down with assessment criteria and specialisms. The response to Covid-19 has shown us the extent to which support for local communities can come from previously-unexpected and much more informal places. Staff from libraries and leisure centres who already knew their local communities well were redeployed to offer informal support, with tremendous results. The emergence of community-based Mutual Aid groups who got stuck into helping with shopping and prescription delivery in the very early weeks of the pandemic helped to stave off a potential crisis across the borough.

Our interviews with people with Lived Experience have stressed the importance to them of peer support and how having someone 'like you' walk with you can often do as much to help you as any formal intervention.

Practice: *Train personnel working in locally-embedded institutions like libraries and leisure centres to engage in proactive outreach work.*

- **Principle #5 - Address the problem, not the symptoms**

What this means: We've already described how current systemic arrangements tell people to 'come back when you're worse'. There is an unfortunate corollary to this, which is 'leave before you're better'. A number of practitioners we spoke with expressed dismay at their limited capacity to follow-up on people. Where people met the rigid eligibility criteria for support, practitioners were able to provide the support mandated for their presenting issue – and typically nothing more. Practitioners are given neither the time nor the freedom to dig deeper, learn more about what is driving the presenting issues, and help people resolve the core problems. So, the problems don't go away, and people tend to re-present with new or repeat symptoms at a later date. Signals will highlight symptoms, but this needs to be coupled with the capacity to help people address root causes.

Practice: *Create a local pilot where team-members have smaller caseloads and are enabled to spend more time and dig deeper with each person, e.g. the QE Horizon midwife team.*

- **Principle #6 - We can't understand whole people if we don't share data**

What this means: At present, our system built around professional concerns fragments people according to issues. If the system were dealing with robots rather

than people, it would be stripping them for their parts. Switching metaphors, every institution holds a piece of that person's puzzle, but no-one has the whole. If we are to get serious about putting people at the heart of our approach, we have to find new ways to share data across organisational boundaries to help us develop a rich, nuanced picture of a whole person. (Note: this importantly has to be coupled with connecting with the person themselves and their 'expert by relationship'. We mustn't fall into the trap of thinking data=person.)

Practice: *Play Snap! – As a very basic first step, MCN Groups should share their case lists with one another. If data protection presents issues then lists could be anonymised, using an agreed common identifier such as 10-digit NHS number. In this way it will become possible to identify when individuals are having their cases discussed in multiple forums, and to reduce the risk of disconnected or contradictory action plans emerging.*

Priority 3:

Invest heavily in iterative learning to drive system improvements

We want to offer a higher quality of more effective care and support that has people at the heart, but this in itself is not enough. Each individual's case may potentially reveal something new, with a wider application. Therefore, a mechanism or series of mechanisms are required that allow learning from each person's experience and offer the opportunity to adapt the system iteratively on the back of what we have learnt. We must learn from each case where are the barriers or snags, how we can make systemic adjustments to prevent these from hurting the next person, and also what's working well and how we can spread these positive lessons.

It is important to stress at this stage that almost every institution thinks that it already 'does learning'. However, a Gateshead inquiry run by the Collective Impact Agency last year found that most organisations actually treat learning as a luxury that they rarely have time for. They are so busy with 'the doing', they rarely have time for learning. As such, we must resist the temptation to think that this recommendation is small, because it would in fact require some major reorientation.

Also, during our engagement with members of the Safeguarding Adults Board, research from the VKPP (vulnerability knowledge and practice programme) was brought to our attention. As part of this 'What Works' initiative from the College of Policing the VKPP research team analysed 126 child and adult statutory reviews of death and harm. They found that statutory reviews are designed to investigate what relevant agencies and individuals involved could have done differently to prevent death or significant harm. This means that the review focus is (understandably) on 'what went wrong' rather than

'what went right'. The VKPP refers to this as a 'deficit model' of learning. We agree, and believe that if this model of learning is dominant the system's learning will be limited. More effort needs to be made around sharing good practice about what works.

At present, we do focus on what went wrong, partly because some processes such as serious case reviews will only come to prominence when a case does go wrong. Often when things do go well, agencies don't want to expend the resources to understand why. We have to refocus our learning away from avoiding failure and towards promoting excellence.

Another component of learning should be to try to capture data in respect of return on financial investment, for early intervention. By building a financial case alongside the human case, we will be able to prove the benefit of those investments in a way that I more likely to persuade budget holders.

- **Principle #7 - Don't treat human change as linear**

What this means: Our interviews with people with Lived Experience revealed numerous incidents of services punishing people for relapsing, cutting them off from support because they are no longer 'moving in the right direction.' The reality of human beings is messy, and the reality of recovery is that it is anything but a straight line. We heard many examples of services being required to treat recovery as linear, with KPIs that identified relapse as failure – both for the individual and the service. We need to move right away from this sort of thinking. Trauma-informed services don't penalise relapse, in fact they do the opposite. Relapse can be a time when people are most vulnerable. This is therefore the time to redouble efforts. A trauma-informed workforce across the system would enable this (see more on this below).

Practice: *If people stall or relapse, do not label them as 'a non-engager' or 'service-resistant', but instead give them renewed support.*

- **Principle #8 - Study success and share it widely**

What this means: It is possible to operate within a mindset of identifying problems then locating solutions to those problems. This has its place, but it can also be a recipe for mediocrity. If the aim is to avoid problems, then the heights of excellence will remain out of reach. Therefore, as well as solving problems, the system needs a concerted focus on identifying when things go really well, and why. Highlighting these stories, studying them to learn why things went so well and how these lessons can be applied to other parts of the system is vital. Aligned to this must be robust mechanisms for sharing these lessons far and wide. It is not enough to keep successes in-house to become little more than part of an organisation's annual report. We need organisations to be clamouring to share their positive insights with one another.

Practice: *Create a monthly 'Bright Spots' forum in Gateshead, where any member of the system can present or listen to what has been working well.*

- **Principle #9 - Every person's experience can help us learn**

What this means: Within all professions there is a tendency to think in abstractions, to speak about deprivation indexes or rates of inequality. This sort of quantitative data

is important, but the current extreme focus on this sort of data is probably part of what has produced a system that does not have people at its heart. If professionals want to get serious about the system having people at the heart, and want to revitalise methods of learning, then every individual's experience should be treated as something valuable that can teach something new and therefore must be captured and shared.

Practice: *Create new reflection spaces (potentially modelled on the After Action Review process) for practitioners and people to help the system learn from experiences, and link these to the 'Bright Spot' conversations and the Peer Support network.*

Priority 4:

Empower the workforce to respond to the humans in front of them

If people are to be placed at the heart of our system, then the workforce need to be freed from inhibiting factors, giving them the freedom and the support to respond to the individual in a way that is tailored and appropriate to that individual's needs. Genuine decision-making power would need to be placed in the hands of front-line staff. Staff would need to be trusted to use their judgement about what is best for this particular individual. This would require a cultural shift across institutions, a reversal of years of over-reliance on process, procedure, compliance and control.

- **Principle #10 - Relationships can solve problems**

What this means: From our interviews, across the board people reported that informal relationships between practitioners are working well. As a system, we need to consciously foster the development of strong and trusting relationships between practitioners, as this is what has been found to effectively get things done. However, beyond this, we also need to recognise that being able to develop a trusting relationship with a person in a support role is one of the most effective means for helping a person in need. The work required is not just about 'services.' Caring and 'being there' for someone is often as effective as any formal intervention, so we need to find ways of freeing up the workforce to be able to develop relationships with the people they are supporting. This is about getting bureaucracy and procedure out of the way rather than anything else. As Mark Smith (Gateshead's head of Public Service Reform) has observed, "Public services are broken; public servants are not." Peer support is also a model that seems to get results. For example, those in recovery often say that they make more progress by spending time with those who are also on a recovery journey but several steps ahead of them. This helps to make their own recovery feel within reach.

Practice: *Create new Peer Support networks - those in recovery often say that they make more progress by spending time with those who are also on a recovery journey but several steps ahead – this helps to make their own recovery feel within reach.*

- **Principle #11 - Resist the tendency to over-medicalise people**

What this means: The demand for acute Mental Health services often stems from situational factors (economic, environmental, relational) rather than clinical factors. Or, perhaps more accurately, the situational may be driving the clinical. For example, someone presents with extreme anxiety because they have no money, cannot feed their child and face eviction; factors that have precipitated the fragility in their Mental Health. When this individual had enough money, they were not anxious. Mental health support therefore can only be a partial solution, the focus ought to be on stabilising the financial situation.

Practitioners we spoke to emphasised how important it is for those who are dealing with people in distress, especially those who are challenging to services, e.g. presenting as angry, irrational or hysterical, need to be handled by staff who are trained to solicit, as best they can, information about the underlying factors contributing to the emergence or re-emergence of episodes/periods of decline in health and wellbeing.

Practice: *Train the workforce in Trauma-informed practice and Psychologically-informed Environments. The work of Fulfilling Lives in this area is seen as important as are other examples operating in the voluntary sector – e.g. the Oasis Community Housing 'Basis' project.*

- **Principle #12 - Support those who give the support**

What this means: COVID has laid bare the toll on front-line practitioners, with record numbers being off work on sick or stress leave. This has made many organisations think afresh about what they are doing to look after their workforce. It is not enough to manage the tasks and the volume. There needs to be a serious increase in actively caring for 'the people who are doing the caring' – and this only needs to increase if our other recommendations are embedded.

Practice: *Create peer support spaces for practitioners, spaces where practitioners can come together to air and share their challenges, struggles, and provide reassurance and help to one another. This time should be rigorously protected by managers.*

And what about the MCN meetings?

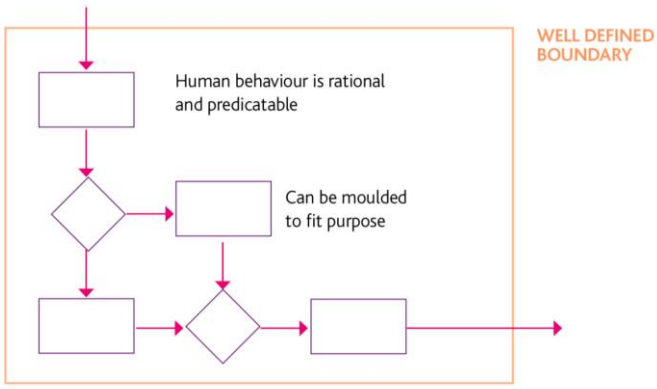
As stated in the introduction, this project was preceded by earlier work, in late 2018, consisting of a mapping exercise that identified 12 multi-agency meetings and groups taking place in Gateshead (see table below). Each had common characteristics of identifying, discussing and planning support for people experiencing Multiple and Complex Needs. During the 'identify' phase of this project we did consider options that might produce a more integrated and streamlined approach to these meetings, by reducing the risk of duplication, etc.

A&E Frequent Attenders	AMSET (Adult Missing, Sexually Exploited and Trafficked)*	Channel Panel	Community Safety Complex Cases (Problem-Solving)
Drug Related Deaths Review	Dual Needs/Diagnosis	Integrated Offender Management	Multi Agency Adult Referral Team (MAART)
Multi Agency Risk Assessment Conference (MARAC)	Multi-Agency Tasking and Coordination (MATAC)	Safeguarding Adults Review and Complex Case Group (SARCC)	VIP (vulnerability, intelligence, problem solving)

Key: Black = MCN groups engaged with during this project.
**AMSET no longer exists as it merged with MAART*

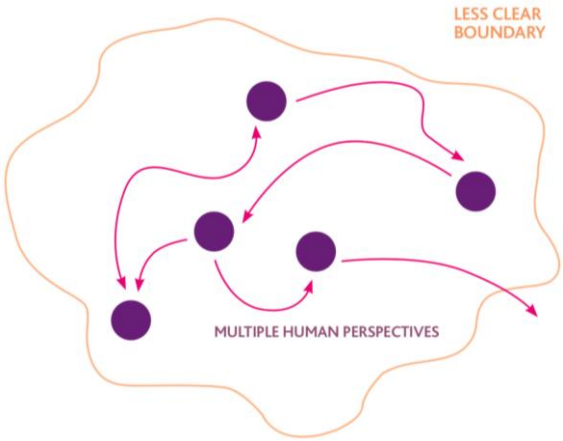
From our interviews and focus groups we found that potential case duplication within the web of MCN meetings was a symptom of deeper issues. We could have recommended, *hypothetically*, that meetings A, B and F ceased, while meetings C and D combine into a single meeting, but such a recommendation (essentially taking a 'hard system' approach – see below) would not resolve the deeper problems e.g. treating people as bundles of discrete issues, with each issue requiring its own meeting and action plan. This led directly to making 'People @ the Heart' the number one priority, with the corresponding need to develop an entirely new way of thinking and acting, concerned with whole people.

Hard System



- The system is a fixed reality

Soft System



- The system is a fuzzy-edged social construct

From *Systems Change* (NPC/Lankelly Chase, 2015)

Therefore, the priorities, principles and practices we have set out are intended to assist the professionals who form the system as a social construct ('soft system' approach – see above), to think and act differently. Five of the 12 practices we recommend have immediate implications for the MCN meetings:

- The fact that the overwhelming majority of these meetings do not include the person being discussed nor a representative speaking on their behalf led to the 'Nothing about us without us' principle.
- The 'System Connector' and 'Playing Snap!' practices would both, in different ways, help the Chairs of each meeting know when a particular individual is being discussed in more than one MCN meeting.
- The presence of Lead Practitioners should entail that no discussion of an individual takes place without the Lead Practitioner representing the person's views, which would in turn reduce the number of conversations happening about any individual.
- The 'Use signals to drive proactive outreach' priority should over time reduce the number of people reaching crisis point, which should in turn reduce the number of individuals referred to MCN meetings.
- The system-wide focus on using signals and iterative learning should avoid the temptation for parts of the system to set up new MCN meetings to meet unmet need, as we have seen happen on several occasions.

If we take these practical steps such as investing in 'System Connector' roles and ensuring each person has a 'Lead Practitioner' or an 'Expert by relationship' supporting them, combined with a significant drive toward in proactive outreach to prevent people from reaching crisis point, we believe that the network of MCN meetings will organically evolve and begin to change its shape. Volume and duplication of cases will reduce. Some meetings will cease to be needed. Others may meet less frequently or combine with others as demand drops off.

Next steps

We believe that the future of the Gateshead System does not have to repeat the past. Whilst the demands of the Covid-19 pandemic have been physically tiring and emotionally draining, the disruption has also created a momentum for positive change. Things that did not seem possible before suddenly seem achievable. The recommendations within this report represent a clear agenda for reform that is radical in its vision of the future whilst being incremental in its approach to change.

The transformation that we are proposing - to shift to becoming a system that truly has 'People @ the Heart' - will not be an overnight revolution, but rather a process over a number of years requiring a determined shift to the model of working we describe. Each of the principles and practices we have presented will on its own create improvement. Together, the cumulative effect will be a transformed system, and more importantly, transformed lives.

We have deliberately made a number of concrete recommendations that any part of the Gateshead system could institute tomorrow. For example:

- Create 'System Connector' roles, people whose job it is to hold relationships across the whole system, to facilitate connections, and to help people connect to specialist help when needed.
- Create 'Lead Practitioner' and/or 'Expert by relationship' roles, whose responsibility it is to understand, support, and represent the person as an 'expert by relationship,' and to help the person be involved as much as they choose.
- Play Snap! – MCN Groups should share their case lists with one another in an anonymised form, using an agreed common identifier such as 10-digit NHS number.
- Create a monthly 'Bright Spots' forum in Gateshead, where any member of the system can present or listen to what has been working well.
- Train the workforce in trauma-informed practice and psychologically-informed environments.

Phase 2?

This document represents an attempt to consolidate, organise and critically reflect upon what we heard from people across the Gateshead system. It should however be noted therefore that this document is not the only outcome of this initiative. Perhaps more significant is the fact that more than 100 people across the Gateshead system have contributed to it and are supportive of the ideas it contains.

We think that if the MCN initiative is ultimately to lead to transformation of the system then some clear next steps need to be undertaken:

1. The priorities, principles, and practices need taking back to the 100 people engaged across the system with a request for practical ways in which these could be embedded in their context.
2. Additional key people across the system will need be to identified and engaged with, people willing to act as the owners and drivers of these reforms. Owing to

the scope of these recommendations, we need all agencies to buy into the reform if it is to succeed.

3. The chairs of the existing MCN meetings need to be supported to engage with these recommendations and find ways to begin to adapt their meeting structures and focus to help overcome the problems that have been identified.
4. A 'System Signals' group should be established, tasked with pulling in data from different parts of the system, identifying signals that suggest someone is escalating towards crisis, and then sharing this information with the relevant parts of the system so that action can be taken.
5. New system-wide learning forums should be created, to generate real-time insights into what is working, to be shared quickly and easily across the whole system.
6. A cohort of around six individuals with multiple and complex needs who are already in contact with the Gateshead system should be identified as participants in a 'walking alongside' study. This will reveal the points at which their experiences provide opportunities to improve the system in ways consistent with the 'People @ the Heart' model. In this way, working with live cases, and a range of partners and practitioners the barriers and dysfunctions in the present system can be resolved. If the system can produce better outcomes for this cohort, there will be a tremendous opportunity to learn and feed back to the wider system. Then we can look at the next six, then the next, then the next…

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