People@the Heart

End of year report December 2023

Purpose of the report

People@The Heart is a 2 year programme which commenced on 1st August 2022. There has been a considerable amount of work completed in the first year and the report sets to do the following;

- Review the work completed in the last year (2022-2023)
- Reflect the work against initial plans and the original People@ the Heart report
- Detail outcomes from the agreed 4 work streams
- Provide feedback from services on their views of the programme
- Explore the future of People@the Heart and how it can develop to continue to support the wider system

Priority 1 – People@the Heart

- **Restructure the system -** Framework for "Together Around the person", Information sharing
- **No wrong front door** – Right door first time, partnership agreement, pathways for access to services
- **Making it easy and fast for people to get support** – DSA, outpatient follow up in the community
- **Nothing about us without us** - Service user feedback, lived experience volunteers

Priority 2 – Signal driven approach

- **Use early signals to drive proactive approach** – connecting services for early interventions Case study from Northumbria Police and wrapping support around the person based n 999 calls
- **People in the community can help avoid crisis** – access to drug and alcohol workers in hospital, connecting Edberts House with Alcohol hospital team
- **Address the problem not the system** – link with other initiatives e.g. Changing Futures, mental Health transformation, Peer support
- **We cant understand whole people if we don’t share data** – DSA’s, MAST, OST initiation

Priority 3 – Learning and improving

- **Invest heavily in interactive learning to drive system improvements** – Service feedback to build a platform for sharing learning, shaped lived experience and visible recovery
- **Don’t treat human change as linear** – connecting people with services through periods of transition to take a preventative approach e.g. prison work
- **Study success & every person experience can help us learn** – service user feedback, recovery ambassadors, shaping the housing strategy, lived experience volunteers

Priority 4 – An empowered workforce

- **Empower the workforce to respond to people** – people with lived experience to form part of clinical training, networking opportunities through launch and joint Newcastle networking event, peer support
- **Resist the tendency to over medicalise people** – human approach to treatment, lived experience alongside OST initiation work
- **Support those who give support** - launch, staff survey, networking events, service visits, service champions

Work streams

- DNA
- Inappropriate use of emergency services
- Hospital to community transition
- Prison to community transition

- Scope, work completed, limitations and future pans identified for all the work streams and detailed within the report
- DSA's
- Case studies
- Service connections
- Pathways for transitional support
- Integration of lived experience

Case study 1 – service connection and signal based approach

- Frequent 999 caller for Police support often for issues that were not criminal e.g. social media not working, deliveries not arriving.
- In 12 months 66 calls, 37 turned into incidents, 26 non incidents
- Previous attempts to hold MDTS failed
- Services committed to a further MDT with consent form the person
- Outcomes have been that the person is now engaging with drug and alcohol services, social care and housing teams and 999 calls have significantly reduced in the 4 months following the meeting only 7 calls were made, 3 incidents and 4 non-incidents. Positive feedback gained from Police around effective partnership working and the impact on their resources.

Case study 2 – Prison release

- Male serving recall in prison. Worked with DART team but refused referral to community drug and alcohol teams. Previous issues with gambling, cocaine and alcohol use. Also identified as having concerns around mental wellbeing. Mistrustful of services due to previous negative experiences.
- Person didn't feel there was any point in accessing support again on release as it hadn't helped before therefore nothing was in place for release. he has turned down offers of support. He works full time therefore getting appointments was problematic.
- On revisiting the options available and providing the DART worker with information on support available, person agreed to referrals being made to social prescribing, community drug and alcohol services

Service user feedback on the system

- Flexibility of services is important
- Speaking to people who know what it is like is very powerful
- Having support in place ready for release or discharge from hospital without any gaps makes a big difference
- Need support to attend appointments
- Locations of services is important
- Need to remove the stigma of going to services
- Need to feel listened to
- Not being able to get through to GP practise, health centres on the phone
- When your homeless its impossible to attend appointments or remember when appointments are
- Making threats e.g. sanctions, recall etc. isn’t helpful
- Attending multiple appointments isn’t a problem as long as they feel useful

Service feedback on Programme

- Invaluable in linking up organisations and key to help people progress data sharing agreements
- Helped to keep the focus in meetings and ensures the patient is at the heart of everything we do
- It has made a huge difference to patient experiences as my team now work more collaboratively with other services to provide that wrap around support
- The introduction of People@the Heart has proved vital in bringing partners together
- The project has helped break the mould, to encourage ownership by the right services

Summary of key points

- Allowed connection of key services to provide wrap around for people with MCN, which was the main aim of the programme.
- A specific programme that supports services to connect and interdependent strategies to be linked benefits across the system
- Information sharing agreements have allowed services to work together and removed barriers to access to services for people when they need it
- Focused on the connection of services for the ling term gain of people. Learning for this can shape future models to follow this way of working

Proposed future working for People@the Heart

Gateshead Care Board will agree future priorities of focus which could include;

- Women's health – supporting women's health which aligns to health inequalities and health and wellbeing strategy.
- Changing Futures alignment – shared learning on working with the most complex people and development of further data sharing
- Workforce development – Bright spots meetings and networking
- Discharge planning – linking health with community services to support discharges
- Primary Care – supporting access and referrals top secondary care for people who are likely to miss appointments.