GATESHEAD CARES People@the Heart Programme

End of year 1 report (August 2022 – December 2023)

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December 2023

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People@the Heart Report

1 Executive Summary

1.1 Purpose of the report

The People@The Heart programme 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 this 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

1.2 Progress on original recommendations

Priorities	Outcomes
People@the Heart **Signal driven apporcahes** **Learning and Improving** **Empower the workforce**	• Connecting servces and people togther has been a key componant of people@the Heart • Building relationships with partners and stakeholders • Formulation of a Programme Board for governance • Partnership agreement signed for commitment to change • Together around the Person is in development to devise a common assessment tool, lead professional process to empower front line staff to hold Multi-Disciplinary meetings and ensure accountability of services so responsibility isn't left to one person. • Referral criteria shouldn't be a mechanism to exclude, help should be available when and where is needed • Mental health Hospital pathways to enable access to rapid triage and assessment, engagement with community treatment, support prior to discharge, options for day hab • Visible recovery from those with lived experience as volunteers in hospital • Connecting services on the community to hospital to enable access to the right support e.g. diabetes support in Basis, referrals to social prescribing for people with alcohol issues so support can be received in the local community • Data Sharing agreements to share information between hospital and community drug and alcohol teams • Case study showing a reduction in reliance on emergency services. • Bringing services to the person – drug and alcohol coordinators based in the hospital, lived experience volunteers visible in the hospital. Prehab work completed prior to prison

	• Service user consultation has been completed with people in HMP Northumberland, Recovery Connections an Basis co-production group • Using expertise to inform the housing strategy around drugs management policies to empower housing teams to offer support and provide consistency across the system • People@the Heartt launch gave workers the chance to connect and be involved with their views on system change • Connecting with Newcastle services for wider regional approaches to change • Lived experience staff to offer training to clinical staff for a more human approach to treatment

1.3 Work streams

Work stream	Outcomes
• DNA's • Inappropriate use of emergency services • Prion to community transition • Hospital to community transition	• Service user feedback • Case studies • Connecting services e.g. Gateshead Recovery Partnership, Edberts House, Peer mental health services with Gateshead Trust • Implementation of 2 hospital recovery coordinators • Data sharing agreement sin place between the Trust and GRP • Pathways for direct access to dayhab and community drug and alcohol treatment for people in prison and hospital • Involvement and input from partner agencies • Improved awareness of services across the system

1.4 Feedback from services

Feedback from services has been received which has suggested the programme manager has been invaluable in linking up organisations and key people to help progress data sharing agreements. The programme manager helps keep the focus in meetings and ensures the patient is at the heart of everything we do. The introduction of People @ Heart has proved vital in bringing partners together with a common aim to address the needs of the vulnerable individual and the real benefits to this programme shows how partners are working together putting Gateshead residents' needs at the heart of what we all want, the right help, at the right

1.5 Next Steps

- Continuing to build and maintain relationship
- Connect services
- Link with independent pieces of work
- Collaborative working with Changing Futures
- Mapping to work with the most complex people using emergency services
- Information sharing

2 Purpose of the report

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- Reflect the work against initial plans and the original people@ the Heart report
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Feedback and information for completion of this report has come from the following;

- Service user feedback (Appendix 1-3)
- Staff feedback
- Data through organisational systems as available
- Personal reflections
- Interdependent project developments
- Service visits

3 Background

The original People@the Heart report, written in 2020, was completed as a result of a mapping exercise undertaken by Gateshead Health and Care system Group, completion of a scoping phase, and the development of an oversight panel where is became clear that the system would benefit on taking a different approach on how it supports people with Multiple and complex needs (MCN).

The report provided clear and precise recommendations on how we can look to improve and develop the Gateshead approach to working with people with multiple complex needs. These recommendations come under 4 main priorities, each with subsequent principles on how these priorities can be achieved;

1 – People@the heart
2 – Signal driven approaches
3 – Learning and improving
4 - An empowered workforce

The People@the Heart programme was set up to deliver these recommendations and has become the conduit to connecting services.

As outlined in the People@the Heart end of phase 1 report (December 2022) the system can be complicated to navigate, not only to those who use services but to those who work in it. On speaking to staff, people felt it was difficult to know and understand how the services all fit together and would “feel overwhelmed” by all the emerging pieces of work.

The work completed as a result of the original report recommendations, and the initial phase of People@The Heart is the development of a programme that enables services to connect. This connection enables and empowers services to deliver effectively and supports the original recommendations

A programme Board was established with representation from across the system. The Board is chaired by Alice Wiseman, Director of Public Health and Executive Sponsor of People@The Heart, supported by Kirsty Roberton, Deputy Director of Corporate Services and Transformation for Gateshead Health NHS Foundation Trust. The Board sits bi-monthly and has Terms of Reference agreed. The meeting provides an opportunity for updates, to explore news areas of development and ensures a partnership approach is maintained as well as monitoring any identified risks to the programme.

Regular updates have been made to the Gateshead Cares System Board on the progress of the programme and work completed. This has also ensured wider communication and maintained appropriate governance of the programme.

Presentations have been made at a number of meetings to promote the People@The Heart works including;

- Homeless forum
- Scrutiny Group
- Transformation Board
- Safeguarding Adults Board
- ICB management team meeting
- Community mental health

4 Progress on original recommendations

In order to assess the success of the programme to date, it is essential to do so against the recommendations of the original report. This ensures progress is measured accurately against what was initially set out to be achieve.

The following section gives an update on achievements made within each priority and principles made.

4.1 Priority 1

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

The fundamental focus of People@The Heart, is to do that very thing, keep the people who use our services at the heart of what we do, ensure that people feel involved in their care and we don't operate a system where professional decide what is best for a person. This includes looking at current MDT's where the same person can be discussed in multiple settings, all with different outcomes, none of which connect and do not have the person's needs at the central focus. We need to strive to be in a position where people are included in the decisions made in relation to their care. Current service feedback is that people will often say they aren't sure why a referral has been made, especially in a safeguarding remit.

A project 'Together Around the Person' is in development with the local authority safeguarding teams and People@The Heart to build a common assessment tool which will be based on a person identifying areas they require support with. It gives a person the right to have what matters to them put as the priority not what professional feel someone should address. The common assessment tool then enables workers to know which other professionals need to be involved with a person's care. This framework provides workers with the skills necessary and empowers them to manage cases, and, through escalations routes provides the mechanism for services to be held to account. A project overview document has been agreed and work against this plan is in progress.

4.1.2 Principle #1 - No wrong front door

It is important to note, that, following feedback from the Learning Disability and Autism service director, the term "no wrong front door" may have negative connotations for some people as they will focus on the word "no". Instead, we should use the term "Right door first time".

The current structure of services generally relies on a set of referral criteria. The process of being referred in itself can be problematic for people to manage and it is often difficult for people to know who, and why they are being referred. The criteria in place is often then seen as a mechanism to exclude people from support. This is often seen through people being unable to access support if they are deemed to be under the influence of substances, or if someone has a specific previous offense or diagnosis

A Partnership Agreement has been agreed by Gateshead Cares System Board which, in its essence agrees to working in a different way that stops people bouncing around the system. This agreement gives a system wide commitment to taking a new, proactive approach to our work.

The programme has connected services that has included 'hospital to community' and 'prison to community' which provides examples of taking a 'right door first time' approach. By developing these work streams, we have created pathways that enable people to connect with the right services at the right time. If someone is admitted to hospital, or given a custodial sentence and have issues with drugs and / or alcohol, services are able to connect more effectively to offer the right support at a time where people can be at their most vulnerable. It is essential we support people through transitional periods and offer access to the right support and care.

For those being discharged from hospital, many require social care but not necessarily at a statutory level. The work completed in the hospital to community works team supports access to support to meet need in addition to their physical health. By having this support in place we can improve quality of life and health. An example of this is people who are admitted to hospital as a result of drug or alcohol issues such as overdoses or falls. By assessing and engaging them into community drug and alcohol services, the likelihood of further overdoses and falls reduces. Where social

isolation and poor mental wellbeing are factors, support from Social prescribing and peer mental health teams can also offer support. This process looks at a person's wider level of need which is important to improve heath quality.

Another example of this principle being achieved through the programme is the connection made between the hospital alcohol team and the Edberts House social prescribing team. The hospital team are now able to make direct referrals for people to Edberts House for ongoing support. This is being extended for a similar offer for those who would benefit from peer mental health support through the Mental Health Transformation work.

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

As well having the right door first time, it is also important that it is easy and fast for people to get support and they don't feel they need to navigate their way through a complicated system.

People@the Heart has connected services to create a Data Sharing Agreement (DSA). This is between Gateshead NHS Foundation Trust and Gateshead Recovery Partnership (the local authority commissioned community drug and alcohol team). The DSA enables the services to share system access for people being initiated on Opiate Substitute Treatment so treatment can be started and continued into the community quickly and easily. The DSA also allows the hospital alcohol team and GRP staff to share information around patients who have needs around alcohol use and for the alcohol team to attend GRP's MDT. This, again makes it easier for people to get support and stops the need for people to repeatedly tell their story.

A further example of how the programme has connected services is when a request for support came to People@the Heart within the hospital regarding a patient who had previously been admitted and was vulnerable. They were unable to attend an important outpatient appointment due to financial issues. People@the Heart connected the clinician with locally commissioned and third sector services in the community to offer support to this patient. By connecting the services, a proactive approach could be taken to offer support to the patient quickly and easily. He did not have to go through lengthy or complicated referral processes. This connection will also be beneficial to future patients who are likely to be in similar situations. People@the Heart having the knowledge and relationships with the services has been central to supporting collaboration for this person and others in the future. As a result, an appointment has been made in the community for the person to be seen clinically.

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

There is a strong emphasis in the original report about using the knowledge and expertise from people with lived experience. Having a level of support from someone who has gone through similar experiences can help a person's voice be heard.

As part of the People@The Heart work, several discussions have taken place with people who have lived experience to gain a deeper understanding on their experiences of the system. One of the messages that consistently came through was that speaking to someone who know what it felt like was very powerful.

This developed into how lived experience can be brought into a hospital setting to support people and show that recovery is possible when they are feeling potentially at their most vulnerable. A lived experience volunteer role has been developed and People@The Heart supported this by connecting the Volunteer Manager and Drug and Alcohol services and peer Mental Health Manager to offer volunteer positions within the hospital. They will work collaboratively

to support people through this process in order to ensure people are able to look after their own needs and recovery journey whilst helping others.

4.2 Priority 2

4.2.1 Use signals to drive proactive outreach

Having a signal based approach has already been recognised in Gateshead as an effective method to provide help at the earliest possible point and not wait until a person reaches crisis point before help is offered.

The service reform prototypes within Gateshead Council have used signals in areas such as council tax to suggest there may be other areas of support required and have taken a proactive approach to offer help.

Service visits and feedback has reaffirmed that working in this way is the only way we can prevent crisis. People@the Heartt has worked to connect existing services in order to do this. Joint working is necessary to ensure the right help is offered and that signals are not ignored.

To give an example the programme worked with Gateshead Police to support them to work with community based services including adult safeguarding, housing and drug and alcohol teams around a case that was causing them to be concerned.
The case involved a person frequently ringing 999 to report incidents such as Facebook not working or parcels not being delivered. The person was known by the Police to be vulnerable as well as:

- Known issues around alcohol use
- lack of engagement with services for support
- Concerns around housing and potential vulnerability
- In a 12 month period they had made 66 calls of which37 turned into incidents, 29 non-incidents.
- The majority of the calls were clustered into a month period which prompted request for support

People@the Heart supported an MDT which was held with all parties involved in the persons care and a series of follow up meetings were held to discuss support options and agreements made who would be best place to offer each area of support.

As a result on this work;

- The person is now being supported by the community drug and alcohol services

- Calls have reduced significantly, in the last 4 months since the meetings were held there were reported 7 calls, 3 turned into incidents and 4 non incidents
- Positive feedback from Police around partnership working and the impact this has on resources and the ability to respond to other calls

Using the increase in calls as a signal that there were other concerns prevented further escalation. Connecting services together through the programme enabled the right support to be offered to the individual.

A second example is how People@the Heart linked the pilot completed by the Anti-Social Behaviour Team in the Local Authority. This used reports of anti-social behaviour as a signal that they may be other issues for that person. A team was formed from representatives across relevant agencies to work jointly to take proactive, alternative approach to the anti-social behaviour reports. As a result, cases were dealt with much more quickly with increased satisfaction from parties involved. Data showed a decrease in reliance on A&E and Police intervention.

4.2.2 Principle #4 - Community can help prevent a crisis

This principle highlights the need for support to be available in local communities and the importance of peer support.

People@the Heart has worked to promote services being available to people in their own communities and places that can be easily accessed when they need it. The hospital and prison transitional work shows how People@The Heart has achieved this principle. By having drug and alcohol workers available to see people when they are in hospital or in prison gives the opportunity to provide a proactive approach and engage people in support at the right time. We know from DNA data that once people leave hospital, the engagement with community drug and alcohol services is low. By having interventions completed in hospital, we are likely to see this engagement rate increase. This, with lived experience volunteers working alongside offers the additional value of peer support.

People@the Heart has also connected the hospital services with Edberts House. Edberts House offers services within peoples communities through their community houses. By making this connection and for referrals to be made whilst someone is receiving health care, supports the person to receive ongoing support in their own community with a more seamless approach. People@The Heart has connected the alcohol team with Edberts House and referrals have been made. Prior to the programme, these services were not connected.

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

The original report is very clear that, in order to have better outcomes for people we need to be able to offer help when people need it and not wait until people reach crisis point. It was recommended that a pilot be created where caseloads are small to allow more time to be spent with a person.

This approach has been taken through the Changing Futures pilot which is already running in Gateshead and has developed further to create a touchpoint within the hospital to work with the most frequent attenders. People@the Heart and Changing Futures are looking to liaise further around findings to promote, the successes that can be gained through working in this way.

The addition of Gateshead Recovery Partnership (GRP) workers in the hospital will provide the opportunity for Brief Interventions to be offered which enables support to be offered to those with low level drug and alcohol use and doesn't rely on people becoming alcohol dependent before accessing services.

People@the Heart has linked with Sunderland South Tyneside Foundation Trust around the Mental Health Transformation programme to connect with the Peer mental health workers who not only provide the invaluable peer support but offers access to support for people who may not require interventions from CNTW Community Treatment Teams. The manager of the Peer mental Health team has been involved with the People@The Heart work streams, with other community based services such as GRP and with the hospital Alcohol Teams.

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

Data sharing has been a significant feature in the programme. Two data sharing agreements have been written. The first was to work alongside the emergency services work stream. The initial aim of the DSA was to enable information regarding the top callers / attenders to emergency services to be sent to a central person in order to identify those who are most frequently using multiple emergency services. Several meetings were held with operational and IG leads across emergency services. Consent was an issue surrounding this and it was important that a person felt part of this process so we didn't contradict the Priority 1 recommendation of keeping the person at the heart of our work.

A new Together Around the Person Framework is now in development alongside the Local Authority Safeguarding team to develop a framework for MDT's. This will incorporate information sharing and support being offered based on what the person identifies as important to them.

People@the Heart has supported and connected work between Gateshead Recovery Partnership and Gateshead Trust around the initiation of Opiate Substitute Treatment (OST) for people who are admitted into the hospital. This is the first time this work has been started in the hospital. This work links with the hospital to community transition work stream and the employment of 2 recovery hospital liaison coordinators. A DSA has been agreed between CGL and GHFT to allow coordinators and hospital pharmacy staff to share system access for the initiation of OST. This will improve communication around treatment starts ad continuation in the community. The DSA is being developed to also include sharing information within the Emergency Department and with the hospital alcohol team.

People@the Heart has been central to the exploration of the Multi Agency Safeguarding Tracker(MAST) system at the request of the Director of Public Health This system can be used to help services share information. 2 demonstrations have been arranged for services to learn more about the system. Discussions have been held in the programme Board around if this system could be rolled out. This also links with the Great North Care Record. It has been identified that further consultation needs to take place to find out what services require from systems such as this. This is work that will be continued through the Board. People@the Heart has also connected MAST with Newcastle services.

4.3 Priority 3

4.3.1 Invest heavily in iterative learning to drive system improvements

It is important in this priority that there is a process to share good practise and learn from what we know. We have a series of processes in place already that enable services to reflect and learn but this is largely deficit based and doesn't allow us to learn from when things work.

Through talking to people who have used services and by getting their feedback on their experiences, it provides a mechanism to learn from what works. As part of the programme, People@the Heart has spoken to people who have achieved their goals around recovery. They identified key areas that worked and provides the wider system with a platform for learning with a positive outcome as opposed to learning from what went wrong. Some of the consistent themes were;

- A seamless transition is important – if leaving hospital one day, starting community treatment the next day is the most effective. Leaving anywhere on a Friday, especially on a bank holiday wakened is difficult
- Speaking to people who have been through similar experiences is very powerful
- Sanctions are not an effective way to encourage engagement
- Having choices explained
- Feeling like the person has a say in what happens next and understands what is going on
- Having lots of different workers and several appointments in a week can be very confusing.

This feedback has been used to develop work around visible lived experience in hospital, pathways for transitional support in the work streams and the MDT work.

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

The original report explains that we should not penalise people for not engaging with services or for missing appointments. We need to stop referring to people as non-engagers.

People@The Heart has done work to explore the use of language and is championing the end of the term "non-engagement" and is instead promoting that it is services that have failed to engage the person.

Support can often end when a person goes to prison when, in reality this is when support needs to be offered. Through the prison to community transitional work, discussions were had with a person serving a custodial sentence in HMP Northumberland, who would be returning to Gateshead on release. He identified a concern around his mental wellbeing and felt this was something he wanted to explore on release. He wanted to access support through his GP. From this discussion he was connected to the community drug and alcohol team, the social prescribing team and peer mental

health services. These connections were made prior to release and the serviced worked collaboratively to complete initial introductions prior to release.

4.3.3 Principle #8 - Study success and share it widely & Principle #9 - Every person's experience can help us learn

Service user involvement is an important part of the programme. It is easy for professionals to make assumptions that the right thing is being done. By connecting with people with lived experience, it provides confirmation that the work being done is based on what people need. Feedback from service users also provides the opportunity for them to share their experiences on what works so it can be used for further learning.

People@the Heart has engaged with people who have completed drug and alcohol treatment and subsequently become Recovery Ambassadors. This provides examples of when things work well and therefore a good basis to learn.

In addition to the ambassadors, the programme has connected with service user groups and the Gateshead Service User Forum and used this as a mechanism for feedback on what works.

Through the development of lived experience volunteer roles in the hospital which People@the Heart has initiated, we can support people who have lived experience to support other people and learn from them.

The aim in the future is to develop a "Bright Spots" meeting where services can share examples of good practise to continue our learning with a positive view.

People@the Heart has worked with the Local Authority around the work on the housing strategy. The Programme manager has knowledge around housing services and of drug and alcohol services so was able to share experiences around these areas to help shape the strategy. This specifically related to the drug and alcohol policy for supported accommodation. The policy will ensure the safety of residents, staff and the services by giving clear direction on how to best support people in accommodation services with drug and alcohol issues. Knowledge was also shared around tenancy agreements which can help keep vulnerable people safe from unlawful eviction and empower providers to manage their services.

4.4 Priority 4

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

One of the ways People@The Heart is able to fulfil this recommendation is the development of the together Around the Person framework. This will empower staff at the front line to be the lead professional for a person, to have the skills and knowledge to call and hold an MDT and for services to be accountable so that no one service is left holding risk.

4.4.2 Principle #10 - Relationships can solve problems

The report details the importance of relationships. Although informal relationships work well, this needs to be cemented with strong and trusted relationships. It is important that people are given the time to build and develop these relationships.

The People@The Heart launch gave the opportunity for workers across the system to come together. The event was provide information around the launch of the programme but also to get feedback from workers and to provide an opportunity for people to connect. The feedback for this event was positive and one of the strong messages to come out of it was the ability to have time to meet people face to face and learn more about other people's areas of work.

Many people from Gateshead with MCN will also be known to other neighbouring areas. One of the main ones being Newcastle. It can be difficult to build relationships with practitioners in the area we work and expanding this to neighbouring areas is more problematic again. People@The Heart has linked with Building Bridges Newcastle to look at common areas of work across the 2 areas and how we can work more collaboratively with a regional approach.

People@the Heart and Building Bridges Newcastle have recently sent out a staff survey to find out what people would like to see form a proposed staff day. The focus will be on learning and collaboration. Having the feedback from staff will ensure the event meets what people need. Holding the event will provide another good opportunity for people to meet, to connect and to build those essential relationships.

It is also necessary to recognise the importance of peer support as it is an effective model, those in recovery will often say they feel more supported and safe surrounded by those who are also on a recovery journey.

People@The Heart has recognised this and has worked in co-production group and service user groups as well as getting feedback from those who have used services for feedback on the system and the approach People@the Heart is taking.

This work has been progressed further with the development of lived experience volunteer role in the hospital. This is also being explored with the prison work streams to link community peers with prison mentors.

People@the Heart has connected the hospital with recovery based services as it was identified by clinicians that having input from those with lived experience could play an important role in clinical training. Dates have been agreed for this to take place in January 2024. Recovery services will also have a stand in the hospital Hub to talk to staff about the service and make those connections.

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

It is not uncommon for people to be in need of interventions for their health as a result of situation factors, e.g. a person becoming depressed or anxious due to having no money or developing a liver problem as a result of long term alcohol use, used to self-medicate a childhood trauma. People@the Heart has worked with partners to acknowledge that we need to treat the presenting issues but also explore the reasons behind it to really support a person.

One of the reasons to bring people with lived experience into the hospital to offer training to clinicians is to help promote the human approach to treatment. It is possible to medically treat an overdose and reduce the risk to life but understanding how this might feel for someone or what happened to lead up to the event is more problematic. By offering training from those who have lived experience, it provides this insight and reinforces the need to encourage access support for the situational factors in order to reduce the likelihood of the health factors happening again.

People@The Heart has started to look at discharges within the hospital, and, by working with community teams we can support that collaborating and partnership working to enable people to access help another other support needs. This can be done through raising the profile of services like social prescribing, community link workers, peer mental health, homeless and housing support, domestic abuse services, talking therapies, drug and alcohol services etc. The People@The Heart programme is able to support and strengthen these connections.

An example of this is, again the case of a patient who was unable to attend an outpatient appointment due to his finances and housing situation. By People@The heart linking him with services to help with his housing and finances, he is more likely to be to attend his outpatient appointment, keep his medical issues stable and reduce the likelihood of further admissions.

4.4.4 Principle #12 - Support those who give the support

Investing in the workforce is a key area for any service and system to be successful. People@the Heart is working to support the workface as well as the people they support.

The launch event gave workers the opportunity to give their thoughts and feedback and also to networks and connect with other services. The proposed event joint with Newcastle next year aims to have a similar outcome.

People@the Heart belongs to everyone. Service visits and speaking to front line staff is essential to ensure the voices of frontline staff are heard and they feel their views are taken into account. People@the Heart remains visible in the community by continuous service visits which strengthens existing relationships and gives staff the opportunity to discuss their views.

5 Workstreams

The following workstreams where prioritised:

Work stream	Scope	Work completed	Limitations	Future Working
DNA	Service user feedback What influences people to attend / not attend appointments Link to hospital work stream around the DNA rate at Gateshead Recovery Partnership (GRP) for hospital referrals.	Information sheet to give to service users around gathering feedback Feedback from service users from recovery Connections and basis co-production group (Appendix 3)	Trying to keep the scope manageable Time constraints of members	Outcomes for engagement to GRP for hospital referrals Further service user consultation Pilot identified for trialling a different approach to managing DNA's and offering appointments Link with the Together Around the Person work for signal based approaches.
Inappropriate use of emergency services	People using multiple emergency services when these services are unlikely to best meet need Adults Gateshead residents	Explored Data Sharing agreement and MOU for sharing details of those using emergency services **Case study completed** Known issues around alcohol use lack of engagement with services for support Concerns around housing and potential vulnerability Would call 999 for Facebook not working or deliveries not turning up In a 12 month period she had 66 calls, 37 turned into incidents, 29 non-incidents.	Data sharing constraints to merge lists of people using emergency service There are a number of MDT style meetings that currently exist, this does not want to be complicated with a further meeting	Develop a framework that empowers workers to be lead professionals Common assessment tool Escalation process that holds services to account Joint working with Changing Futures to map out complex high risk people

		The majority of the calls were clustered into a month period which prompted request for support Police had previously held an MDT but external parties had been unable to attend on the date required therefore no work had been progressed. Consent was gained by Police for a further MDT to be called with People@the Heart supporting. An MDT was held will all parties involved in the persons care and a series of follow up meetings were held to discuss support options and agreements made who would be best place to offer each area of support. As a result of this work; The person is now engaging with community drug and alcohol services Calls have reduced significantly - in the last 4 months since the meetings were held there were reported 7 calls, 3 turned into incidents and 4 non incidents Positive feedback from Police around partnership working and the impact this has on resources		

Hospital to community transition	People with drug and / or alcohol issues that come into Queen Elizabeth Hospital Gateshead residents Engagement with the commissioned drug and alcohol service	DSA to support the Opiate Substitute Treatment (OST) Guidelines to allow community and pharmacy staff to share systems access DSA to enable the QEH alcohol team to share information with GRP to benefit the patient and offer advice in MDT's Pathway for entering dayhab on discharge from hospital Connections between GRP and business unit team members in the Trust to support implementation of work 2 hospital coordinators commenced roles on an in-reach basis in the hospital to complete triages, assessments and supporting people to engage with community services on discharge. Improved knowledge and connections with homeless and housing team around statutory duties to refer Visible recovery in the hospital through developing a lived experience volunteer role profile	Time pressures Data collection is limited due to what data is recorded	Data on engagement with treatment services once hospital recovery coordinators are established in post Promotional work to raise awareness Training for new and existing clinical staff Support for the volunteer manager to ensure wellbeing of lived experience volunteers

		Service consultation around the importance of seamless transitions from hospital to community Improved knowledge and awareness of other support available in the community through the work stream. Prior to this work 0 referrals were made by the alcohol team in the hospital to the community social prescribing team but to date, 3 referrals have now been made, offering wider social support to people. Service user feedback from people who have completed dayhab (see appendix 2)		
Prison to community transition	People with drug and alcohol issues that has an impact on a person health People in HMP Northumberland Returning to Gateshead on release	Connection work with HMP Northumberland IOM and DART teams and probation staff Link lived experience with prison mentors Prehab work to be completed prior to release Feedback from lived experience (Appendix 1)	Staffing changes Baseline data has been hard to gather Difficult to identify people returning to Gateshead if they report to be No Fixed Abode	Trail the dayhab pathway Widen this work to include other local prisons Develop the process to meet the needs of women in the female prison establishment Explore the possibilities of a release hub similar to the one on Durham

		Pathway and criteria for dayhab from prison Data Jan-June 23 11 people referred to GRP, 4 recalled to prison within 12 week. Nobody released on Buvidal, a prolonged release opiate substitute treatment given by injection)) Nobody commenced dayhab direct from HMP Northumberland		

6 Services Feedback

"You are a star, very engaging and articulate with a passion for what you are trying to achieve which is a driving factor in any project."

"The role helped me liaise with other community services such as peer mental health support and community link as well as supporting me to consolidate my relationship with Gateshead recovery."

"I feel the role has made a huge difference to patient experience as my team now work more collaboratively with other services to provide that wrap around support to aid recovery. I would not have had the time to be able to look into these changes therefore I feel the role brings great value as without communication and collaboration complex clients can fall through gaps with potential catastrophic outcomes."

"It's been really helpful to be introduced to and work with People@TheHeart. In only two short months we've identified opportunities to work together to share resources and knowledge to create collaborative workshop opportunities for professionals working across the whole spectrum of multiple disadvantage."

"She has been invaluable in linking up organisations and key people to help progress data sharing agreements"

"Suzanne helps keep the focus in meetings and ensures the patient is at the heart of everything we do. Sometimes I can develop tunnel vision and Suzanne's ideas help me to see outside the box and incorporate other professionals."

"The introduction of People @ Heart has proved vital in bringing partners together with a common aim to address the needs of the vulnerable individual"

"People@the Heart has provided us with the springboard we needed to develop some are the areas of work we have wanted to do for some time and has generally improved the communication between the services. It wouldn't have been possible without this programme."

"I think there are real benefits to this programme as will show how partners are working together putting Gateshead residents' needs at the heart of what we all want, the right help, at the right"

"One thing I particularly like is her fight to bring lived experience in to the hospital. Great job Suzanne in bringing the hospital along with the times"

"it's been great to see commitment to two really important processes in particular, engaging with the people accessing services and with experience of navigating the system, and exploring opportunities associated with data system development"

"The project has helped break the mould, to encourage ownership by the right service whether it quite fits the remit or not. Certainly from a Policing perspective I have seen good examples of this which have led to a substantial reduction on our calls for service when we were never going to be the right agency to solve the problem long term"

"I can see it being helpful in improving links between other organisations for marginalised communities experiencing health inequalities and discrimination"

7 Proposed future work for People@the Heart Programme

There are some specific areas of work and ongoing priorities that People@the Heart could support which would support the successful delivery of the recommendations in the original report.

7.1 Changing Futures Alignment

There has been and continues to be synergy between the work of People@The Heart and Changing Futures. Both acknowledge that system change is necessary but is also show that sometimes the connections are relationships can be as beneficial. The aim is for this ability to connect and reduce the system barriers to become business as usual.

By connecting the work of Changing Futures and People@The Heart together, we are able to combine the benefits from each area of work for a consistent and stronger message.

Jointly, the 2 programmes can endeavour to explore on a larger scale the work around information sharing to really support those who are in most need of our services and support.

This, in turn work alongside other areas of development in the community, hubs, pop up, houses etc so we can learn from each other and share information about the people we work with.

Changing Futures outcomes have been able to demonstrate the value a worker being someone's constant, a worker who is able to take that deeper interest. The outcomes from Changing Futures, linked with the partnership building form People@The Heart can support the notion that anybody can be a lead professional but the investment form all services stops the responsibility being held by that 1 person.

Collaborative working will provide a stronger voice.

7.2 Proposed Future Work could include:

Topic	Principle	What
Women's health	Principle #2 - Make it easy and fast for people to get support Principle #1 - No wrong front door Principle #9 - Every person's experience can help us learn Principle #11 - Resist the tendency to over-medicalise people	How do we support women from areas of deprivation, with low level engagement with health provision? This especially related to women who are homeless, victims of domestic abuse, and victims of sexual exploitation. How do we work in collaboration wot existing support services to support engagement with women's health. A specialist area that would be of interest to explore, and link with the current prison to community work, is that of women in the criminal justice system, in particular those being released form prions. The North east has a large women's prison in HMP Low Newton that houses both women on remand and sentenced. In November 2023, a strategic review of health and social care in women's prison was completed which has given 8 recommendations which require a collaborative approach between health, local authorities, voluntary sectors, ICB's and lived experience to fulfil.
Work force development	Principle #10 - Relationships can solve problems Principle #12 - Support those who give the support Principle #8 - Study success and share it widely	Increase involvement by the workforce including a monthly "Bright Spots" meeting. Keeping and maintaining a skilled and experienced work force is essential to the delivery of services. Working with those with multiple and complex needs is not an easy, it is challenging and at times frustrating. We rely on people's passion for their work and commitment to keep them in posts. It isn't always possible to pay people the wages we would like so it is essential that we invest in other ways to ensure our workforce feels valued, supported and included. Through developing service champions, we can enable staff across all levels to feel involved and included in People@the Heart. We can also develop the "Bright spots" meting to share good practise and success stories. In addition to this, there are a number of ways People@The Heart could look at the needs of the workforce. Peer training already takes place, but this can be become a wider and more shared process where we to utilise the exercise we have in our system and connect front lines together to share their knowledge. By supporting workers to build their own network they can work together a wider, more integrated wider team. This can grow into a workforce that feel like it works for "Gateshead" and not one individual organisation. Feedback suggests that some services feel they are the

		ones that "get the blame" or "are left holding cases because nobody else will work with them". By connecting the workforce, this burden can shared, staff developed and trained and in turn we retain the highly experienced and knowledgeable staff that we need to delivery out services.
Information sharing	Principle #6 - We can't understand whole people if we don't share data	This has been an ongoing area that crosses so many areas of development. The ability to share information freely and give staff the confidence to do so will play a vital part in the development of services. This is area that People@the Heart could continue to work on alongside partners and information leads. The can also incorporate further work around the GNCR / MAST.
Service champions	Principle #12 - Support those who give the support Principle #8 - Study success and share it widely	To have champions in each operational service who are reprehensive of their organisation, to feedback barriers challenges and to spread the word of the people being done by People@The Heart. Service champions can help the work feel like it belongs to everybody who works in Gateshead a not just manager or strategic leads. Work can be done to embed the programme across all levels and for all to feel they have a say in how our system is shaped.
Right Care, Right Person	Principle #1 - No wrong front door Principle #2 - Make it easy and fast for people to get support	Similarly to People@the Heart, RCRP looks at people receiving the right care form the right person at right time. As this agreement comes into play, there is likely to be a demand on other services. People@the heart can support the continued partnership working to work with services to ensure that responsivity is taken by the most appropriate organisations and risk isn't left being held by one person.
Discharge planning	Principle #10 - Relationships can solve problems Principle #2 - Make it easy and fast for people to get support	Supporting the hospital around discharge planning for those with a level of social needs but not at the statutory care level. There is a significant number of people who come into hospital on multiple occasions. From liaising with the managers in the medicines team and the discharge coordinators, there are often the same names coming through for discharge with social needs that have an impact on their health. By developing discharge pathways with community services such as social prescribing and Peer mental health we can offer support in the right time using a proactive approach. By supporting people around their social care needs, there is a likelihood that we will reduce the need for further admissions. Referring to Maslow's hierarchy of needs, by supporting

		around accommodation, access to clothing etc., we can improve people's health.
Primary Care	Principle #2 - Make it easy and fast for people to get support Principle #1 - No wrong front door	A lot of the work completed so far has focused on secondary care. There is work that can be explored around primary care and how we make further connections between community and primary care and secondary and primary care. This could include how referrals for specialist care are made for people with multiple and complex needs and how we can support people to access local health services to reduce the likelihood of needing to access emergency and secondary care.
Continuing to work alongside other interdependent areas of work	Principle #10 - Relationships can solve problems	One of the consistent and strong themes and feedback from colleagues across all areas of the system is that, the system is complicated. There are so many new areas of work that are trying to achieve the same thing in a slightly different way, it is confusing to work out who they all connect. It is essential that we have a way of ensuring we communicate across services our priorities, strategies, areas of development and identify how they link wt. existing pieces of work. People@the Heart is able to support this process of sharing and connecting interdependent pieces of work. If we don't, it ends in confusion, duplication and contradiction.

Specifically for People@the Heart, it is important that it remains linked to and compliments:

- Mental Health Transformation
- Changing Futures
- Housing strategy Review
- Frequent attenders
- Safeguarding strategy
- Health and wellbeing strategy
- Health inequalities

This is not an exhaustive list. Part of the People@the Heart programme will be to keep on top of new and emerging areas of work and plan how this fits into the wider system

8 Programme Reflections

When the programme manager commenced in post, it was thought that the development of a front line service that supported people directly to engage with specialist services would be beneficial. It quickly became clear that are already excellent services in Gateshead that can provide proactive support to people when they need it exploring adding another services would likely be counterproductive and add further confusion in an already complicated system. What has been successful is the relationship building and connection of services to deliver outcomes.

Other reflections on the programme are;

- People involved have a considerable amount of day to day commitments and it is hard for people to fit in additional work and meetings
- For the leads, it's not always possible for reports / updates to be produced again due to time constraints
- The success of the work stream very much relies on people attending the meetings and committing to them
- The demands on peoples roles can make it difficult for people to commit to any additional work
- People need to feel the work being done will benefit their service and workforce or it is too hard to justify the additional demand on roles.
- It took longer than initially thought for each work stream to be established and to start and make some progress.
- Some peoples roles mean they can asked to cover / moved permanently to other departments which makes it difficult for consistency
- Interdependencies need to be identified and wider people involved to avoid duplication of contradiction
- Some data just isn't possible to gather as it isn't recorded therefore it is important to consider other ways of monitoring progress and outcomes
- Some services and more established at partnership working than others
- There have already been a lot of services developed and strategies agreed since the report was written, flexibility and adapting to need is essential
- People@The Heart relies on building and maintaining relationships, it takes time to develop and cement these relationships. The first 2 years needs to focus on this and only after that can we start to bring changes and tackle some of the issues identified.
- There needs to be dedicated role to support these connections

- Although it was suggested by a few that directory of services or a mapping process would be beneficial, most believed this would unproductive as thins would change again as soon as it was completed
- In relation to the directory, it was fed back that choice can be both positive and negative. Although it is beneficial to feel there are options, too much choice becomes overwhelming and it is impossible to know which the right service is. What is helpful, is the opportunity to connect with services and to build relationships with colleagues and peers so staff can feel empowered to make suggestions and referrals for people
- On reflection, connection is the key, people like and need to feel involved and informed. Working in collaboration is the only way to achieve change, embed what works and not be scared to stop doing what we know doesn't

Appendices

NB Case studies – people have consented to these case studies being used for this report

APPENDIX 1

System feedback 1 Mr A

Prison to community

Purpose of the meeting and the People@The Heart programme was explained. No Identifiable information will be used and accounts will be given to partners and stakeholders in the person's words to give feedback on their experiences and feeling about the support the received and the systems in place.

Meeting completed August 2023 in HMP Northumberland. DART worker also present

Background
Currently serving a license recall, This is Mr A's first sentence.

Mr A was working prior to his sentence and has a local authority property

Mr A is working with the DART team in HMP Northumberland

Presenting issues

- Previous issues with gambling that lead to alcohol and drug use. He no longer gambles but has some issues with substances. Not daily or physically dependent use but some level us psychological reliance to manage feelings and emotions.

- Has had previous offences that had often been under the influence of drugs and alcohol.

- As Mr A didn't really feel substances were an issue there were not any referrals made to community services for ongoing support.

- Mr A discussed concerns around his mental health.

Identified barriers / things that didn't work so well

- Reported to have issues around the recall and the reasons and process were not explained and didn't feel it "was a fair process". This in turn has led to mistrust of services.

- Mr A's initial response is to say something isn't a problem therefore no referrals were made to community services. This meant no support was already in place should he need it post release. Mr A stated he would be unlikely to ask for help until things had reached a crisis point due to not believing anybody could really help.

- Mr A didn't feel it would be helpful to go back to his GP needs currently. He wants to explore if he has a mental health condition and doesn't know how to get that to happen.

- Getting appointments that fit around his work can be difficult, he wants to return to full time work on release.
- Mr A feels the only way to be listened to is to “kick off”

What works well?

- Mr A is able to drive and has access to a car so appointment locations are no issue
- He is returning to local authority housing

Barriers from prison perspective

- Getting timely appointments when no clinical need
- Community services being able to speak to prisoner’s prior top release, especially when they are at work

Follow up

- Referrals made pre-release with GRP and appointments given before release
- Unable to get an appointment with Social prescribing pre-release so Mr A was to make contact on release. Phone discussions are required initially which couldn’t be done in the prison due to him working and not being to access a o phone at a time where a SP was available.
- No reply from Mr A since release to update how he has been since release.
- Phone assessment completed by GRP at planned appointment time where Mr A stated he did not feel he needed any support for drugs or alcohol at this time.

APPENDIX 2

System feedback 2 Miss B

Dayhab

Purpose of the meeting and the People@The Heart programme was explained. No Identifiable information will be used and accounts will be given to partners and stakeholders in the person's words to give feedback on their experiences and feeling about the support the received and the systems in place.

Meeting completed August 2023 in Gateshead Recovery Connections

Background

Miss B has a long history of issues with alcohol along with childhood issue around control and isolation. Through her teenage years, Miss B said she would buy peoples friendship but these people never turned out to be real friends.

In 2011 Miss B found a family member deceased. That Christmas. She started to drink alcohol to cope and manage with the trauma and ongoing health issues, she had a partner but he was working away so felt alone.

Miss B received a call to say her partner had died suddenly then suffered another family bereavement shortly after. At this point to around 8 bottles wine per day

At the worst levels, Miss B was drinking around 12 bottles a day, loneliness and isolation were big factors. She had been working but had to quit her job due to alcohol use and missing work, unable to complete tasks.

Miss B's son eventually was the one who promoted her to start accessing treatment

Presenting issues

- Alcohol addiction, physical and psychological
- Bereavement
- Childhood trauma
- Loneliness and isolation

Identified barriers / things that didn't work so well

- Miss B couldn't leave the house so even when she rang services for support she couldn't attend an appointments
- Offered group work but had a pre-conceived idea on what this would be like and didn't want to engage in it
- Covid meant initial planned detox's was cancelled
- The gap between having a residential detox and starting dayhab was a few weeks which was difficult to manage
- Miss B did contact her GP but she didn't understand the language he used, it was "all just jargon to me"
- Anxiety and worry over "looking stupid and embarrassing myself in front of professionals"

What worked well?

- Phone support available until able to attend services
- Support from her son who was able to support to attend appointments
- Support to attend groups, the groups were so helpful and supportive once she attended
- Residential detox as could only manage a certain amount of reduction in the community
- Meeting others in the same situation – no longer felt alone and could talk to others who understood
- Dayhab provided structure and routine
- Staff were flexible and supportive – Miss B was able to do zoom meetings with staff when she had to visit an unwell family member
- Ambassador course
- The detox and dayhab were arranged really quickly
- AA meetings very positive which was facilitated and supported by dayhab
- Supportive staff that had lived experience and understood
- Trauma therapy

Barriers from service perspective

- Covid
- Panel process for residential detox

Follow up

- Completed dayhab and due to graduate on 18th September
- Alcohol free since detox
- Completing the ambassador course as Miss B wants to help others who have been in a similar situation.
- Due to have 2 poems published in “recovery Voices”

“Got to want it yourself”

“I owe my life to my youngest son and to services”

Suggestions

- Need to dispel the myths about what treatment is like. Showing people pictures / videos of the buildings can help people visual and increase confidence to attend. “its not just the plonky place”
- Need support for people attend appointments
- More positive promotion e.g. leaflets, posters, ads in metro / housing magazines etc

System feedback 3 Mr C

Dayhab

Purpose of the meeting and the People@The Heart programme was explained. No Identifiable information will be used and accounts will be given to partners and stakeholders in the person's words to give feedback on their experiences and feeling about the support the received and the systems in place.

Meeting completed August 2023 in Gateshead Recovery Connections

Background

Mr C was drinking 17 cans per day, 7 days a week, he had been trying for many years to reduce but had been unsuccessful.

Mr C felt he had a lightbulb moment where "he found himself" and walked through the doors of recovery service himself for help.

It was arranged for him to have a planned detox at QEH and then start dayhab afterwards.

Presenting issues

- Long term alcohol issues
- Previous attempts to reduce had failed despite telling himself that he could do it by himself.
- Previous mental health issues in terms of not being able to cope or see a way out of addiction which resulted in a deliberate overdose in an attempt to take his own life

Identified barriers / things that didn't work so well

- Discussed previously with his GP and was given a card with the number of services to self-refer. He never made that call
- Didn't previously access services through fear and worry that "everybody would know what he was there for"
- Being told to not stop drinking suddenly gave him the justification to continue drinking
- Being discharged form hospital on a Friday over a Bank Holiday weekend with treatment starting the following Tuesday
- Being told to "just cut down a bit each day" what does this actually mean? Most of the time people have no idea how much they have had.
- Not being able to get through to GP on the phone. Mr C would go to speak to his practice directly to get an appointment

What works well?

- It all has to come from the person and they have to be ready. Mr C was able to get support when he walked through the door and asked for help
- Accessing a planned detox
- Starting dayhab so close to discharge and knowing he was being discharged with a plan
- Speaking to others who had been through similar experience "It was very powerful to see that it can be done and people understand what it feels like"
- Access to AA

Follow up

- Completed dayhab programme and remained alcohol free
- Now completing ambassador course
- Feels he has control back over his life
- Mr C would like to support others, especially those in hospital

Suggestions

- Have access to drug and alcohol workers in GP surgeries
- Look at the language and phrases we use with people and what that might mean e.g. “don’t stop drinking” “reduce a little bit”
- Seeing and speaking to people who understand works – don’t just give people a card with a number on.

System feedback 4 Miss D

Dayhab

Purpose of the meeting and the People@The Herat programme was explained. No Identifiable information will be used and accounts will be given to partners and stakeholders in the person's words to give feedback on their experiences and feeling about the support the received and the systems in place.

Meeting completed August 2023 in Gateshead Recovery Connections

Background
Miss D had a difficult childhood and was in foster care from aged 9 following a traumatic event. In her younger years she witnessed a lot of abuse and violence so believed this was normal behaviour.

As she progressed into becoming a young adult Miss D was using drugs and alcohol, self-harming and offending. She described drugs and alcohol as "her new and only best friend". As a result of this Miss D was alcohol dependent by age 23. This also resulted in her receiving an Alcohol treatment Requirement from court but she only completed this "because she had to".

Miss D had a decline in her mental health and her levels of self-harm increased and she had attempts on her life.

From this Miss D started to engage again with treatment services, an inpatient detox was arranged and was arranged to start dayhab on completion. The first 4 months also gave Miss D time to access mental health services for assessment.

Throughout her journey, Miss D had many contacts with services, crisis services, A&E attendances, admissions, arrests and community services

Presenting issues

- Long term drug and alco9hl issues
- Mental health issues – self harm and suicide
- Childhood trauma
- Care leaver
- offending

Identified barriers / things that didn't work so well

- left residential detox on the Friday of a Bank Holiday weekend and found the 3 days between leaving detox and starting dayhab difficult
- location of services and stigma of attending "that's where the smack heads go"
- triggers around locations of services – offered drugs outside of services
- waiting lists for counselling
- accessing mental health support – there was an assumption that issues were linked to substances even when Miss d was substance free. This lead to medication being effected and further decline in mental wellbeing

What works well?

- Opportunity to engage in treatment as many times needed, not just "once chance and that's it"
- AA meetings

- George street social
- Working with people who had been through it themselves “very powerful to know you’re not alone”
- Opportunities to help others when in recovery
- Understand procarti9ve GP
- Visible recovery – gives real hope to others

Follow up

- 2 years 5 moths substance free since completing dayhab
- No offending since 2019
- No calls to Crisis services or attendees at A%E since 2019
- Now fully employed by recovery services
- Supporting others to get help
- “no longer presses the f**k it button” has learnt to recognise when she needs help
- Loves being able to give something back

Suggestions

- Having the person involved with and make sure they understand plans made
- You tube videos to help people document their journey

APPENDIX 3

System feedback 5

Co-production group September 2023

Discussion held with members of a community co-production team. Members of the team have all previously used at least one service for support linked to homelessness. The members were de-briefed on the purpose of the conversation, to get honest feedback, positive or negative on the services they have used and to hear ideas on how services cold work better. All feedback is in their words and remains confidential and non-indefinable. 3 people attended the sessions plus a staff facilitator.

The question asked was for feedback about services and support available for people, especially around 4 areas of;

- Attending appointments
- Hospital to community transition
- Prison to community transition
- Using emergency services

Missing appointments

Person 1 - When you are homeless it is impossible to attend appointments, to remember when and where they are and to plan getting there. A homeless person often won't have a phone so can't call to check, can't get reminders and obviously cannot receive letters. If letters go to a care of address, they can be opened by other people and the message not passed on.

People are penalised for missing appointments when they are homeless and often punished for struggling e.g. being sanctioned at the job centre for missing an appointments.

Specific appointments should be given to people who are street homeless, it would be more helpful to just agree to make weekly contact for example.

It was helpful for appointments to be passed to Basis who then kept a record of when appointments are. The person then knows where to go and who to contact to find about any appointments coming up. "I wasn't in the right head space to plan my own appointments"

Making threats when people miss appointments isn't helpful, a sanction to benefits is a threat and doesn't help, and it just instils further fear and distrust.

When attending drug and alcohol services, being offered appointments early or late in the day was helpful as were less likely to bump into old associates.

Person 2 – would be very likely not to attend an appointment if it was somewhere new with new people. Would only go if someone there to offer support had. If you are left waiting the anxiety and fear builds which results in either walking out or kicking off and then getting asked to leave.

No issue with having to attend multiple appointments as long as they feel useful.

Services need to be accessible and easy to find, if it is difficult then it becomes to stressful and easier to just give up.

Person 3 – having a choice in when and where appointments can be is helpful alongside a text reminder. It is also important to use different ways to offer appointments, sometimes the post is slow the appointments is past before receiving the letter. Emails and online booking work form me but that's not for everyone, especially people who don't have access to technology.

The cost to attend appointments can be a huge barrier, public transport is expensive, especially if have several appointments on different days. Having appointments co-ordinated would be much more helpful or to be given a bus pass.

Being able to access services over the phone easily would help to cancel or re-arrange. Some places like the job centre, hospitals, GP can be very difficult to get through to so will give up after a while. Using texts or having a call back system would be helpful.

There needs to be flexibility on times, if a person is 5 mins late for an appointment then they won't be seen, but its ok for professional to leave someone for 30 mins +., especially in a waiting room as this can be an intimidating place to be.

Health experiences
Person 1 - Had a very positive experience when being discharged from hospital. The discharge was delayed until an appointments with Basis could be arranged and then a taxi was arranged for support to get directly to the appointments, this lead to accommodation that night.

Person 2 – negative experience from QEH after presentation with concerns around mental health.
Was taken in after a suicide attempt, she felt as if he had reached burn out due to coping with DV and caring for a son with disabilities. She felt he was left to "sort things out myself" and "nobody was listening to me, they all made decisions about me without including me". Also has negative experience with the crisis team who offered no support or ongoing help.

Didn't find GP helpful, would just offer more medication to help manage drug addiction.

"I was always been treat like nothing more than a druggie"
"Nobody chooses this life, people need to remember that"
"Words from professionals should be empowering, not judging"

The local authority kept saying they would ring to update but never did.

Prison to community transition
Person1 - Negative experience in relation to housing. Was told 2 week prior to release that accommodation was secured to be told the day before that this was no longer the case. The result was rough sleeping for a year which had detrimental effect on mental health and wellbeing..

"I didn't feel like anybody was truly listening to me"

General feedback

"Having the opportunity to be around other people who are clean helps"
"Speaking to people who know what it is like and have been in your shoes is powerful"
"Constantly having workers change and having to tell your story over and over again is a barrier – why should I have to go through this all again?"
"Letters in brown envelopes are normally bad news so unlikely to be opened, it's easier to just not know"
"Drop in services where all services are together would be really helpful"
"Access points in community venues for homeless people to access technology"
"Security guards are intimidating and often make situations worse, they aren't there to offer support, and act as another barrier which in turn increases risk"

END