Complex Lives

Partner Briefing– June 2022

The Belfast Agenda

Living Here Board

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Complex Lives

Whole System Model

Mobilising One Vulnerability Model: One Mission, One Team

1. The Challenge

In early 2019, a CEO-led Strategic Leadership Group (SLG) with a collective mandate was established under the auspices of Community Planning to mobilise a whole system approach to supporting vulnerable/ at risk people caught in a vicious cycle of homelessness, addiction to alcohol and/or drugs, poor mental and physical health, and offending behaviour, in Belfast. These are people who live complex lives - often underpinned by trauma, yet they are expected to navigate and engage with a very complicated and confusing system of siloed services and support. The chaotic nature of how they live and how that impacts on them, their families and society as whole means that they tend to generate significant resource pressures for those partners tasked with providing a response (directly and indirectly) and hence the overall public purse.

Figure 1: A 'Spin Cycle' for vulnerable people and for services.

The aim of the whole system approach is to simplify the way we work and create a model whereby we can use everyone's experience, skills and energy in a more joined up and impactful way – mobilising a 'one vulnerability model' to address the challenges of people living 'complex lives'. The work has been informed by a tried and tested 'Doncaster Complex Lives' whole system model of integrated care and support that has been adapted to suit Belfast's context.

2. The Approach

The whole system approach has brought together the breadth of statutory and voluntary and community agencies and services working across housing, health, and criminal justice in a shared, agreed, and sustainable way of working to engage and support vulnerable people and improve outcomes.

Since October 2019, partners have been coming together on a weekly basis as a Multi-Disciplinary Team (MDT) to collectively develop, test and deliver on the new Complex Lives Model within Belfast that aims to: -

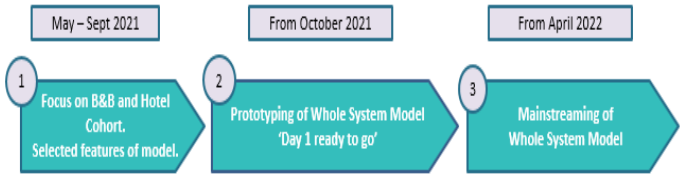
- Support the recovery, resettlement, and social inclusion of vulnerable people.
- Connect and build trust with people – using existing positive relationships with services.

- Work together as a multi-agency, multi-disciplinary team to develop an individualised plan for each client, with the voice of the service user at the centre of this.
- Provide a trusted key worker to stay with people throughout their journey.
- Provide initial stability and appropriate accommodation with wrap-around support.
- Help people re-integrate into community life by enabling positive connections and improving life experiences.

This work has been built on a lot of the excellent practice and front-line core services that already existed across agencies and services. It is not about creating a new service layer, but about unblocking barriers to delivery, integrating and pooling existing resources and skills, and building a shared system that enables collaboration rather than competition, and which most of all delivers positive coordinated wrap around support and outcomes for people who need it most.

The model is being taken forward in three phases, as outlined in figure 3. The aim now is that from June 2022 Complex Lives will secure the additional funding required to be upscaled to full implementation phase. This phase will operate for the next 4 years under the oversight of the SLG and community planning in Belfast and the hope is that by 2026 the model will be successfully evaluated proving the case for mainstreaming and thus becoming 'business as usual' for the service delivery partners involved.

Figure 2: Three-phased approach



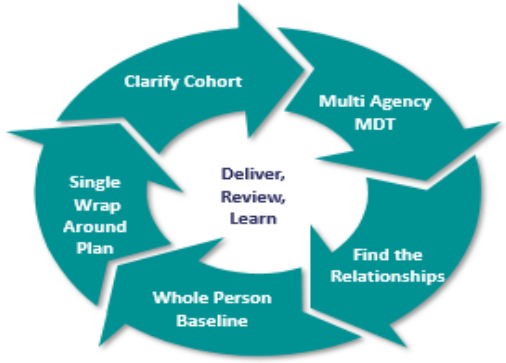
A detailed route map and SMART action plan has been created to guide and monitor progress of the whole system approach.

Figure 3: Key elements of the whole system approach

As part of Phase 1, the Steering Group developed a mobilisation brief to deliver on the short-term challenge of securing accommodation and solid wrap around plans for a cohort of 60 people, within B&Bs and hotels because of the Covid 19 pandemic. Work commenced to build the picture of the cohort i.e., beginning with NIHE clients who met the chronic homelessness[1] definition. Phase 1 was the starting point of the dual approach in terms of understanding both the people (potential cohort) and the system (services with responsibility and/or commissioned to support the cohort). Relationship building commenced amongst core agencies, which involved engaging statutory partners and those commissioned to provide direct services to the cohort.

[1] *Chronic homelessness is defined as "a group of individuals with very pronounced and complex support needs who find it difficult to exit from homelessness". Chronic homelessness often manifests itself as rough sleeping or other street activity, and clients experiencing this type of homelessness find it difficult to sustain a tenancy due to their extreme vulnerability – NIHE Homeless Strategy.*

Figure 4: Phase 1 Delivery



As part of the phase 2 prototyping work, robust governance structures and operational processes were put in place, through the establishment of a multi-agency, multi-disciplinary team, which has been the centre piece of this phase. The team meet on a weekly basis to consider and work through nominations and case reviews from the shared cohort list, building trusting relationships between each other and with the clients involved. A crucial magical ingredient of the whole system approach has been the shared commitment from all partners to work flexibly and creatively to support people in the Complex Lives cohort to stabilise and make positive progress. Work was also commissioned to ensure the user voice was central to the design and development of the Complex Lives model, including the development of user insights through ethnographic studies. Appendix 1 also features an anonymised case study example of someone who has been through the MDT process. Investment mapping was completed and areas for potential joint commissioning identified. The development process has been supported by a senior management level Steering Group which meets monthly.

A number of operational issues and learnings have emerged from the prototyping phase that require further (financial and system change) support and development, prior to the wider roll out and fuller implementation of the model (as per the Doncaster approach). Some of the key areas that need addressed include: strengthening joint case management operations; system enablers such as an agreed information sharing protocol, providing stability to the core support service providers agreeing two-year contracts (at a minimum), as well as enhancing those services to be able to offer key working and wrap around support at a larger scale.

3. The Results/ Impact

The Complex Lives whole system approach is developing to plan. The prototyping of the approach generated initial short-term impacts with highly vulnerable people, showing the benefits of a joined up and systematic approach. The phased approach taken has provided valuable insights into improvements and developments that can take the integrated approach further and ensure it is sustainable and secure.

Beyond that, the work has generated higher level strategic questions and transferable opportunities for integration that can serve a wider purpose in supporting partners in Belfast to respond to complex, shared and seemingly intractable issues. Relationships at all levels continue to flourish and community planning partners certainly feel that the Complex Lives work is one of the exemplar initiatives that has progressed under the auspices of Community Planning in Belfast – practically focusing on collaborative gain and impact.

This work has certainly made the case for deep reform in how we both plan and deliver services as a collective rather than as individual organisations – particularly when we are all working to same or similar goals and objectives. This will be a central consideration for partners as the next steps of the Complex lives whole system model are developed.

4. Contact Information

For more details on the representation of each of the groups please see Appendix 2. For further information about this intervention and approach, please contact:

Belfast City Council

Kelly Gilliland: GillilandK@belfastcity.gov.uk

Kevin Heaney: HeaneyK@belfastcity.gov.uk

Appendix 1: Case Study Example

Plan on a Page

/11/21 **Date of Next Review:** 12/01/22 (7 reviews held to date)

Case ID: XXXXX **Name:** Joe Bloggs **DOB:** XX/XX/XXXX
Notified by: PSNI & BHSCT-DOT
Lawful basis of information sharing: Client consent

Synopsis/Initial Triage

Homeless since 16 years old (now 25) long term rough sleeping.
Ongoing IV drug use – not open to services currently – very difficult to engage.
Extern (outreach) have been engaging with Joe Bloggs more recently and they have agreed to avail of a DASP bed – should be available from this coming Monday 22nd Nov).
Probation to provide more information next week.
Has engaged with health services to have wounds dressed.
PSNI – known to police.

08/12/21 Update

Extern – DASP bed in OC – now staying full nights (for the most part) however still causing issues in City Centre (particularly for SNOs & PSNI re moving on). PSNI – in contact daytime and late at night. Small steps with Joe Bloggs.
DOT – has been discharged from SPT – DOT did see him briefly (stated he was going to go cold turkey) got feeling he was overwhelmed and under 'p' from partner and peers who are a big pull/draw back to city centre, use, rough sleeping, etc.
BHSCT Inc Health – Joe Bloggs attends periodically and remains open – also provide a clinic in OC.

15/12/21 Update

Extern – Joe Bloggs has moved into the Ormeau Centre and is using this facility almost every night. He is no longer in a relationship with ** and appears to be prioritising his own needs. Extern staff are also encouraging Joe Bloggs to engage with DOT.
BCC/SNO's – mentioned noticeable progress with Joe Bloggs.

05/01/22 Update

DOT – their engagement with Joe Bloggs has been really positive and have managed to refer them onto SPT (which will take approx. 6 weeks) and he appears to still be staying nearly every night in the OC.
Extern – Joe Bloggs did have a bit of a downturn over the Christmas period – he discovered a fatal OD but he has remained in the hostel. PSNI – had only one incident recorded regarding Joe Bloggs being the victim of an assault in the Welcome Centre.

Initial Objectives

Plan needs to be established to create stability for Joe Bloggs once he enters the DASP facilities.

to continue to develop relationship with Joe Bloggs so that she hopefully become a trusted contact.

Identify ways that Joe Bloggs may lose the DASP bed and try and prevent these things happening ahead of time (e.g. dealing, stealing and possession of drugs).

Key Worker and Named Partner Contacts

Extern – Key worker: Carla
BHSCT DOT – Katy

Action	Partner	Contact
Ormeau Centre/Extern staff to encourage Joe Bloggs to continue to use bed, not to go out during night, and continue to support him to engage with DOT and SPT.	Extern	Buff/Michelle /Hostel Staff
Review on 12/01/22	MDT	Chair

Appendix 2: Complex Lives Group Representation

Senior Leadership Group (SLG): BCC (Chair), BHSCT, NIHE, PSNI, NIAS, EA, Translink, PHA, PBNI, BDACT and DOJ re: prisons.

Complex Lives Steering Group: BCC (Chair), BHSCT, NIHE, PSNI, PBNI, PHA, BDACT, BHDU and Homeless Connect.

Multi-Disciplinary Team (MDT): BCC (facilitation), NIHE, PBNI, PSNI, BHSCT, Extern, Welcome Organisation, Simon Community and DePaul.