Changing the system for people experiencing severe and multiple disadvantage

Improving local governance and the wider system of support

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What is Severe Multiple Disadvantage (SMD)?

- There is no universally agreed definition of severe and multiple disadvantage
- It is often defined as the combined experience of Homelessness, Substance Use, Mental Health Issues, contact with the Criminal Justice System, and/or Domestic Abuse
- However, this ‘traditional’ conception of multiple disadvantage is likely over simplistic and far too narrow

Multi-disciplinary teams and integration of Health and Social Care

- Multidisciplinary teams (MDTs) are central to achieving the vision of Integrated Care Systems (ICSs) - they are a structured forum in which practitioners from across health and social care can come together around the needs of individuals and communities (Social Care Institute for Excellence, 2018)
- MDTs include a range of professionals from different agencies and disciplines, including social care, health and mental health, education, criminal justice, and the community
- MDTs have been recommended in the NICE guidelines to support the integration and quality of care and support

→**MDTs as an opportunity to overcome the complexity of the system and facilitate engagement for people with Severe and Multiple Disadvantage**

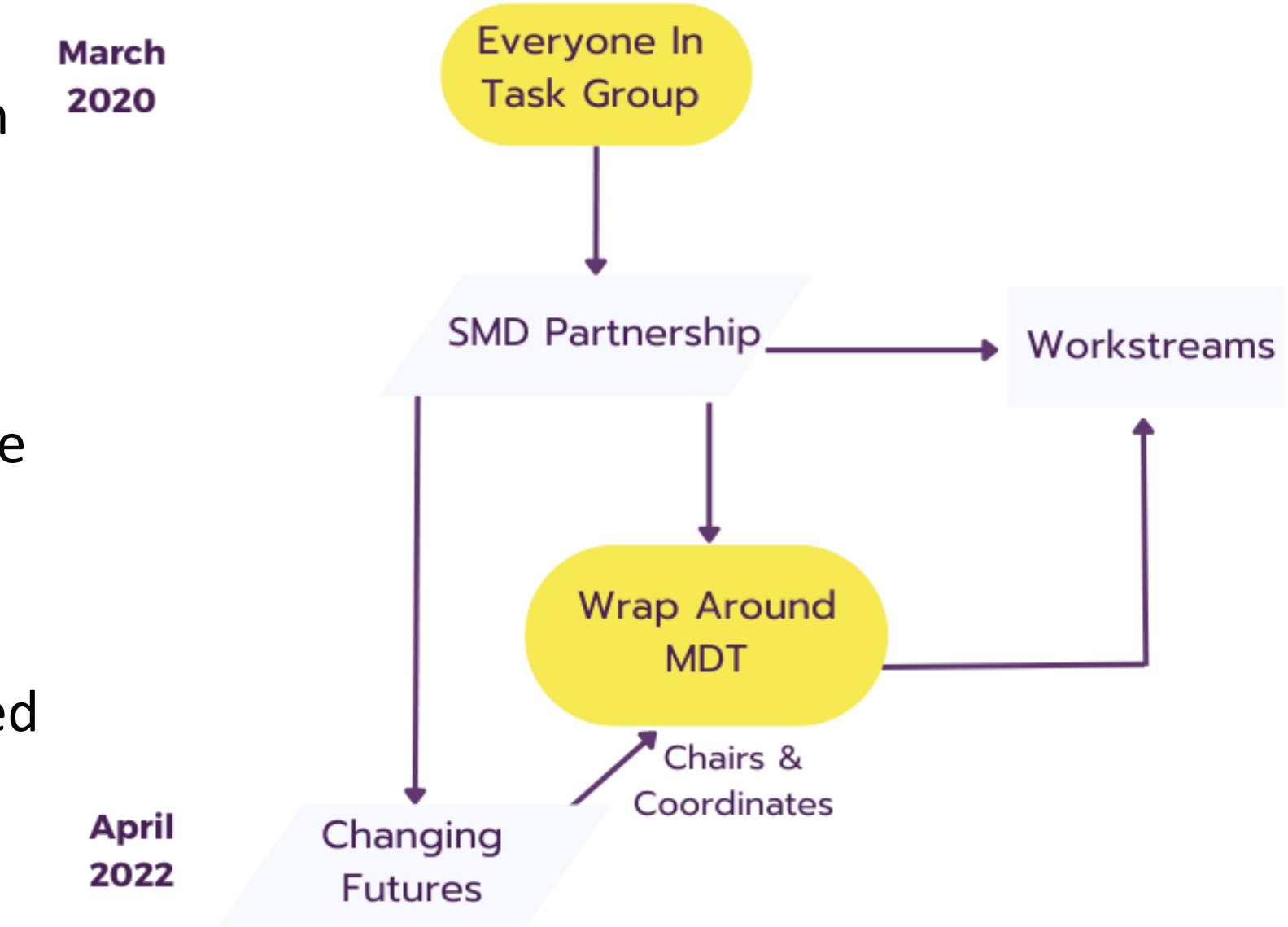
The Nottingham City Wrap Around (WA) MDT

- A multi-agency forum to support people with a high level of unmet need who would benefit from a multi-agency approach. Consists of a fortnightly meeting which discusses a person's individual circumstances to provide integrated, person-centred and interdisciplinary response
- Developed from 'Everyone In' Initiatives
  - Weekly crisis meetings with different (mostly voluntary) organisations in Nottingham
  - Development of the SMD partnership and the WAMDT to continue the work of "Everyone In"

"People that would never would have accessed housing that got into housing through the hotels, or people that hadn't seen a GP in years that were getting medication. […] we've achieved some great outcomes, why should we stop that kind of working?" (S1)

- Using the learning from Fulfilling Lives, the WAMDT became an integral part of the Changing Futures Nottingham programme

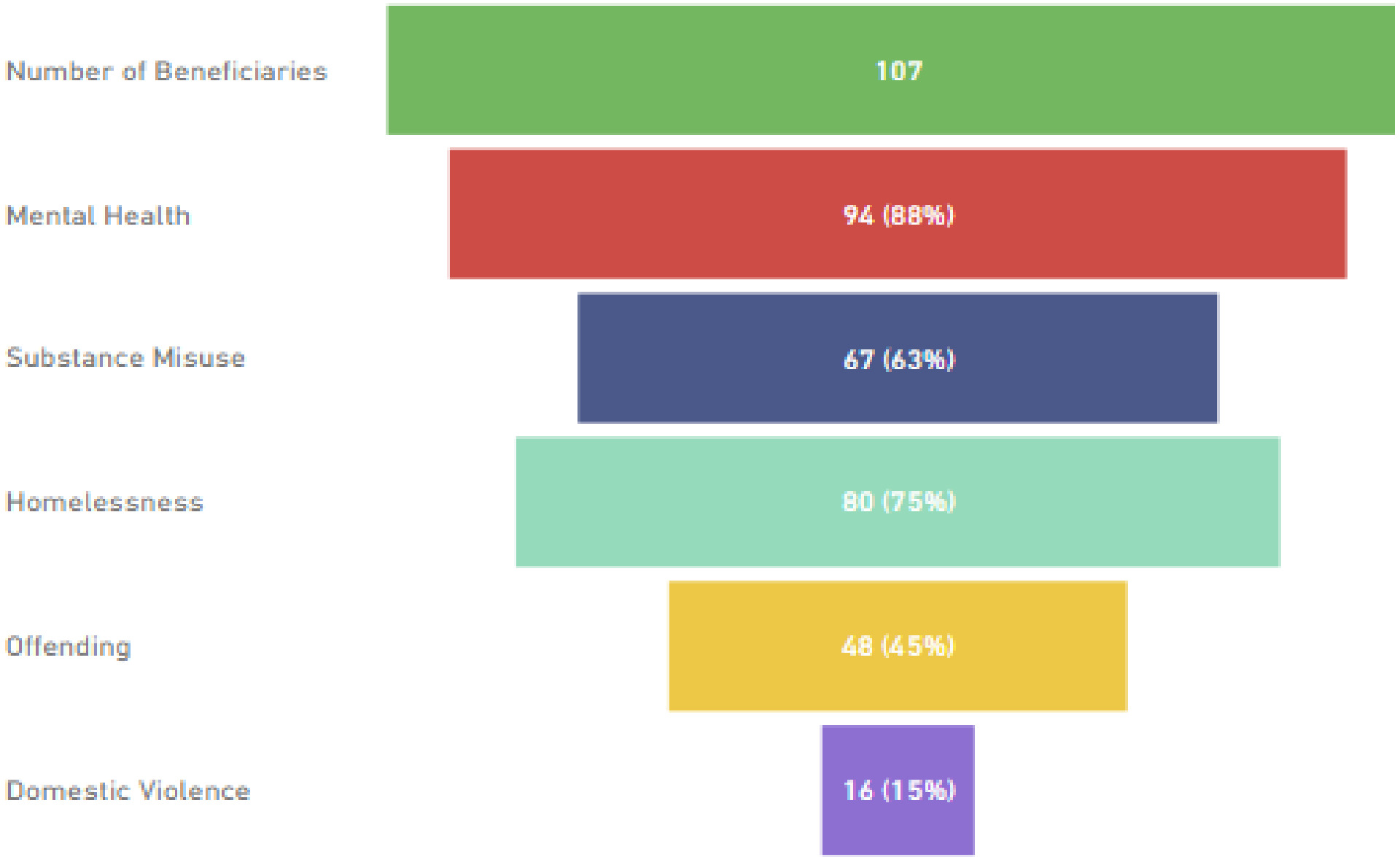
- The WAMDT became one of the six work strands of the Integrated Care Partnership



The Nottingham City Wrap Around MDT Today

- Run by two Changing Futures staff and a specialist navigator from the Rough Sleeper Drug and Alcohol Team
- The initial group responsible for implementing the Everyone In Scheme in Nottingham City grew and expanded to become the Nottingham City SMD Partnership
- Over 100 referrals made into the WAMDT since January 2021; 51 have been discussed; 6 pending. People referred are predominantly (entrenched) rough sleepers, vulnerably housed or have high unmet meets
- More people with a health or social care need; these are often problems not "*picked up on the kind of traditional understanding of severe multiple disadvantage" (S1).*
- Core participants from voluntary and statutory services

Area of Disadvantage



Providing evidence through an internal evaluation of the Wrap Around Multi-Disciplinary Team

A multi-agency partnership forum at Changing Futures Nottingham

Evaluation Methods

- 8 semi-structured interviews with WAMDT participants
- 3 group discussions, one with WAMDT team; one with senior staff from the Integrated Care Board and Framework Housing Association who had been involved with setting up the WAMDT
- WAMDT attendance records and three case studies compiled by WAMDT coordinator from case file records and care plans to highlight the outcomes from a beneficiary perspective

Impact of the WAMDT on service delivery

Bringing services together

- *“before we had the WAMDT, we'd have lots of individual MDT's around service users. So, we might have one within mental health care services and invite the GP and invite social care, but you don't always get all the agencies, you don't always get lots of voluntary sector people being involved in those discussions. So that's a big thing in terms of having the right people around the table” (P5)*

Learning and Communication

- *“It's not just the four or five patients that are discussed every week. It's the network that develops from that and hopefully the learning that can come from that.” (P1)*

Creating a network and connections

- Having a *“face and the name rather than just a generic e-mail” (S1)*
- *“the little questions that take like a week to get an answer to when you're making phone calls and sending emails someone can literally just type in a name and give it you within 5 minutes. I think that's a massive benefit to having the people in the same room.” (P5)*

Identifying risks, sharing advice, and information

- *“It’s about pulling together knowledge and then people saying that's a very good idea. That's a very good idea…. [but] have you thought about this?” (P5)*

Encouraging services to work more person-centred…

- *“the WAMDT is trying to offer more thoughtful response about ‘Will the person want it? What's their perspective?’ And that leads to, you know, better outcomes” (P8)*

…Creative

- *“getting some slightly different ideas about a case that felt quite stuck” (P5)*

…Trauma-informed and flexible

- *“Let's just kind of take it a little bit slower and take some time to build this relationship with this person’ who doesn't want to talk […]. Then he'll just leave or not wanna talk to you or whatever, so let's look at some techniques and how we can engage somebody. So that's the way more sort of slowly … thinking about the person and how they respond to see if we can break down some of those barriers for him in terms of and what he can do” (P3)*

Improving the system for people who use services: Reducing barriers to service access

Thresholds and eligibility

- Rigid interpretation of SMD and high thresholds often means that *“there's a huge raft of people just under that who also need service input that might miss out” (P1)*

→ Reassessing “priority need” and “intentional homelessness”, establishing local connections

Facilitating Engagement

- *“When they have referrals from anyone, they don't have to go through GP, they'll then come out and see people around the back of Tesco or wherever they are, they'll work very closely with the substance misuse services, GP's, voluntary sector hostels, etc, etc. So, when somebody's brought in by any service to the MDT, then we're able to think […] how we might work that person differently rather than being on waiting lists and being sent in opt in letters” (P2)*

Creating more sustainable solutions and looking beyond someone's decision to disengage

- Acknowledging that people's journeys is not 'linear': *"actually they're seeing the benefits of the support and they are starting to engage with services a lot better" (P6)*

Addressing systematic barriers

- Engaging people with services who have been excluded or 'hidden' from services or face difficulties navigating them due to their multiple competing needs; e.g. provision of cooking facilities for people in temporary accommodation or GP access

"There's a number of practices that the homeless health team could just register people without them turning up at a service which is massive." (P3)

Case Study I

*His **mum had extensive mental health issues and his dad was a traveller and from a young age, he was involved in quite a violent scene and a lot of his needs were neglected**. And he's got **pro morbids and physical and mental health difficulties and has been in and out of the prison system**.*

*He **can feel very paranoid about engaging with services as they are,** and I think that's what of a lot of people with SMD struggle with, because there's a definite like power imbalance. And so, for example, the local crisis team is based at [hospital] and that is where **his mum has been sectioned in the past and so he feels that that's a constant threat if he's ever asked to go and meet anyone there and it's very overwhelming for him.***

*So **being able to negotiate with teams and meet people where they are** has definitely helped, and gathering that information from the WAMDT and specifically within the MDT, we've managed to **ensure his mental health conditions are better understood by housing, so they can be more flexible and addressing what he needs**. They've been able to make sure to [...] get him **in temporary accommodation in quieter areas** and that those plans have been **more effectively gathered and passed onto places like social care** who can then have most of the things they need and they don't have to go to him and start from scratch again.*

Case Study II

*David has been **homeless for many years**, sometimes sofa surfing with friends and family, other times rough sleeping in his car. He has been caught up in a **cycle of offending** leading to prison sentences. He struggles to engage with services due to trust issues and feeling let down by professionals. He has been **diagnosed with Post Traumatic Stress Disorder, Personality Disorder, anti-social and paranoid traits and anxiety**. He has been known to **neglect his personal care needs and** has a **deep-seated anxiety of being in medical settings** to the point that not getting treatment for significant health issues seemed to be less scary than having to face his fear of being in a medical environment. This has led to minor illness progressing into infection.*

*Considering the intensity of distress that this caused David, **the MDT acted on his behalf and asked the GP practice if they could offer flexibility by allowing him to wait in his car instead of the reception**. This was agreed to by the staff. Another idea was to ask David if he felt comfortable **taking a photo on his phone of his ulcer and sending it to the Homeless Health Team so they could have a look at his condition.** It was also acknowledged that the photo could be sent straight to the GP practice by a male worker. The conclusion was that **a male GP went out to see David where he was rough sleeping in his car and completed a screening assessment. The GP was then able to prescribe some cream for the ulcer and give him a referral letter to be seen at the Spinal Clinic for his back pain which causes him mobility issues and incontinence.***

*Another barrier was housing. To complete a Housing Aid assessment the tenancy history has to be provided; as David experiences memory problems it was difficult for him to recall the information needed. Core participants from the **WAMDT worked together by collecting and sharing information with Housing Aid** but there continued to be a barrier with no decision being made about whether they found David homeless or not.*

Impact on Partnership Formations

- **Increased cooperation** among agencies and different partnership forums in the city
- Importance of **establishing links with key statutory services** in the city
  - Embedded posts in housing, social care, mental health, primary care and probation helped to increase communication and impact in statutory services to work out more effective solutions to decisions made by statutory services
  - Links to other partnership forums prevents duplicated efforts - more efficient support
- Inclusion of the **WAMDT and SMD as one of the strands in the Nottingham Integrated Care Board**

  → Strategic priority and opens resources from key stakeholders, such as Nottingham City Council and Nottinghamshire County Council
- **Facilitating System Change**
  - Partners' commitment to partnership working and SMD
  - Development of new initiatives and solutions to address challenges faced by individuals with complex needs

  → Ensuring that **SMD and a wrap-around response remains on the commissioning agenda** is imperative to sustain ongoing commitment and support.

How can we sustain a multi-disciplinary response?

Usefulness of the WAMDT

- WAMDT participants recognised the tangible benefits that emerged from this collaborative effort
- *”People will turn up while it is they're getting something out of there” (S5)*

Sense of joint ownership

- Services share a “*a very joint message that everybody just keeps going with and that I think has helped the MDT as well as that wider work*” *(S4)*
- *“You don't need to convince someone to try and help you because they're there because they’re supposed to be and being a part of this sort of multi-agency response” (S2)*

WAMDT’s integration into key strategies and commissioning processes

- To show commitment to the WAMDT and ensure participation, some services have made the WAMDT part of their remit to attend the meetings

Commitment of its team members and core participants.

- *“Things like access to oral healthcare has been a huge thing and a huge challenge for this kind of cohort, so it makes sense for the voluntary sector services to be linked in with people that can provide dental care and things like that. And I think it's only via these that multi-agency form that has some oversight from a healthcare body where those things can get done. I have no intention of it stopping if possible. […] It's the people who are involved …. and who are driving it” (S1)*

Recommendations and Learning

1. **Collaborative working:** Bringing together different services across sectors to gain a better understanding of each other's roles and responsibilities
2. **Diversity** within multi-agency teams and participants; including specialist services for e.g., women, different ethnic minority groups and people with disabilities
3. **Incorporating learning and feedback** from different agencies to render services more accessible for people experiencing multiple disadvantage
4. **Awareness raising and reflective practice:** Sharing good practice and highlight systemic and operational barriers and blockages
5. Creating a **strategic plan to respond to SMD**, which involves people in senior and commissioning positions to create a supportive infrastructure. While MDTs often benefit from the drive of a few individuals, having people in strategic positions involved helps to overcome blockages in services and reduces systematic barriers.
6. **Persistence:** Acknowledge the importance of gradual, but often small changes, in overcoming rigid and siloed practices.

What's next?

Working on blockages and barriers impeding implementation of good practice

- Eg. legislation (no recourse to public funds) hindering effective solutions/strains financially feasible options
- Recording instances of systemic barriers to identify reoccurring issues for people experiencing disadvantage in Nottingham City and how they may be resolved in the future

→ Exploring opportunities to escalate cases to those at senior or strategic level when necessary

Involving more people in decision-making positions, advocating for a system-wide approach

- *"a constant ongoing conversation and reminder of how are we embedding all of these ideas into the culture of the services that we're all running because it's great to have a handful of staff doing it […] but we want entire teams, entire services to be running in a way that don't exclude people, that are trauma- informed, psychologically-informed, that are doing all of this good stuff, it needs to be across the board as opposed to little pockets of good practice." P5*

Improving WAMDT attendance for core participants

- WAMDT as part of the remit for core participants
- Background work ensures that meetings are focussed and efficient

Increasing diversity and representation of agencies

Increasing capacity of WAMDT

- Safeguarding and Consent

Raising awareness of benefits of WAMDT and encouraging partnership working: disseminating good practice and learning

Weblinks and further information

- Changing Futures Nottingham: www.changingfuturesnottingham.co.uk
- WAMDT: www.changingfuturesnottingham.co.uk/nottingham-city-wrap-around-mdt/
- Summary of the evaluation report and complete evaluation report will be published soon: www.changingfuturesnottingham.co.uk/learning/
- *Previous report:* Mukuka, H., Hazzouri B., Everitt G. (2022): Wrap-Around Internal Evaluation Report www.changingfuturesnottingham.co.uk/uploadedfiles/documents/74-1657730453-mdt_evaluation.pdf
- **If you have questions contact Carolin** (carolin.hess@ntu.ac.uk) or **Jeremy** (jeremy.garner@frameworkha.org)