Appendix 5

The Doncaster Complex Lives Alliance Briefing and Case Studies

An Integrated Care approach to supporting rough sleepers with complex health and support needs

1. The rationale for the approach – the scale and nature of our challenge

Like many towns and cities in the UK, Doncaster has seen rising challenges related to homelessness and rough sleeping. This has been mostly centred on Doncaster City Centre and has been connected with growing public, business and public service concerns about the increasing levels of homelessness and rough sleeping. This includes concerns about poor physical and mental health, the use of synthetic cannabinoids (AKA Spice), begging and anti-social behaviour.

To provide a sense of the scale and dynamics involved:

- During the winter of 2017/18 including the so called 'Beast from the East' cold spell we were dealing with a cohort of over 30 rough sleepers in very challenging conditions. A very small number (5) could not be persuaded to take up offers of accommodation and support and chose to stay out all winter.

- During the exceptionally warm weather in the summer of 2018, rough sleeper numbers spiked to around 67. This led to some unwanted media attention about Doncaster as a particularly challenged area for rough sleeping and use of Spice, though reports were positive about our multi-agency response, featured here.

- This situation began to place unplanned and complex demands on a range of services, including the NHS where we identified concerns for demand at A&E, hospital discharge and lack of connection to primary care services.

- We recognised a specific prevention related challenge connected to the fact that Doncaster has four HM Prisons within its boundary. This left us particularly susceptible to prisoners being released with no fixed abode (NFA) or without adequate wrap around housing, health and care planning.

- A deep dive we conducted into the impact on public services of a relatively small cohort of 57 people with complex needs indicated a conservative estimated annual cost to the public purse of £1m. When scaled to the estimated total cohort of 4,200 people experiencing multiple disadvantage in Doncaster[1] this totalled almost £50m p.a. of mostly reactive costs to the system.

[1] https://lankellychase.org.uk/resources/publications/hard-edges/

2. The design of a new cross public service operating model – locally driven, informed by lived experience

In autumn of 2016, CDC and the Team Doncaster Strategic Partnership identified the issue as a priority for the development of a new, whole system operating model, reflecting the complexity of the challenge and the need for an integrated response across all public services and working with community, voluntary and faith sectors.

Between November 2016 and May 2017, a wide range of partners were engaged in a participatory design process to create the basis of a new delivery model. This was underpinned by ethnographic surveys of people with lived experience of the reality of being locked, often long term, into a cycle of rough sleeping, addiction, offending behaviour, poor physical and mental health and vulnerability - often underpinned by childhood trauma.

The case studies, alongside the deep engagement with local stakeholders ensured a bottom up design process, which looked across the whole system for issues and solutions. This is also established a core commitment to ensuring a user centred approach to the design and development of the model, which is still a key feature.

3. The Complex Lives Alliance delivery model - a 'whole system' Accountable Care Partnership approach in action

The product of this bottom-up design work was a system specification to guide the build and mobilisation of a new approach - the Doncaster Complex Lives Alliance. This model is now fully mobilised and operational, playing a crucial role in supporting some of the most disadvantaged and vulnerable people in Doncaster.

The model incorporates in practice services from Doncaster Council, RDaSH (NHS Community Foundation Trust), DBTH (Doncaster and Bassetlaw Teaching Hospital NHS
Foundation Trust), Primary Care Doncaster, St Leger Homes (Doncaster's Arms-length
Housing Management Company) other Supported Housing Providers, Community Rehabilitation Company, NACRO, National Probation Service, South Yorkshire Police, DWP, and also works with other community and voluntary sector partners.

The whole system model comprises a set of key operational and enabling features which provide a new integrated system for agencies to work within. These are the 'moving parts' of the model that together represent the whole system approach required to meet the scale and nature of the challenge. The key moving parts are illustrated in this extract from the system specification:-

OPERATIONAL FEATURES	SUPPORT/ENABLING FEATURES
Complex Lives Team - case management capactiy	Case Management model - process and ICT system
Complex Lives Asset Menu - support services	Outcome Framework and Performance Management
Doncaster Housing Plus Pathway - accommodation options	Developmental Evaluation and Learning model
Doncaster Changing Lives Fund - to remove barriers	Alliance Governance - to support collaboration
Prevention & Demand Management	Joint Commissioning (Social Care, CCG, Public Health)

4. The Complex Lives Team

At the heart of the Complex Lives Alliance is the Complex Lives team. This is a team of dedicated front line case workers, providing capacity to identify, engage, triage, and provide a strong accommodation and support plan for people living complex lives - focused on recovery, resettlement, empowerment and inclusion. These are people with a combination of mutually reinforcing challenges including homelessness, drug and alcohol misuse, offending behaviour, mental ill health, poor physical health, including sex workers.

People in these situations have often experienced childhood trauma, family breakdown, domestic abuse and other major life changing events. Therefore, the complex lives team will be the consistent point of contact for people and be their champion in co-defining their assets, needs and outcomes. The team works flexibly and provides personalised responses to individual strengths and needs – a strongly asset based approach. The number and sustainability of these posts depend on the funding secured from a variety of different funding streams

5. The Criteria

- **Currently Homeless or at risk of becoming Homeless** – Are they currently rough sleeping, sofa surfing or in temporary accommodation. The individual may be on notice, risk of eviction or leaving an institution (prison/hospital)
- **Are support needs being met by other agencies?** – Risk of duplicating work or other agencies pulling out of support when it is clearly needed
- **Is the individual subject to social exclusion? -** Social exclusion is the process in which individuals are blocked from (or denied full access to) various rights, opportunities and resources that are normally available to members of a different group, and which are fundamental to social integration. (e.g., housing, employment, healthcare, civic engagement, democratic participation, and due process)
- **Is the individual facing multiple disadvantage?** – People facing multiple disadvantage are those with a combination of problems including homelessness, substance misuse, contact with the criminal justice system and mental health.

6. The 'One Person One Plan' Approach

The Complex Lives Alliance allows for robust individual case management that allows multiple agencies to be part of one support plan. The approach is designed to support the individual to achieve better outcomes whilst working with a number of different agencies.

Wrap around support is an intensive, individualised case management process for those with multiple and complex needs

This approach allows a team of professionals to create, implement and action a plan of support. This support comes from the Complex Lives Alliance which includes a commitment from a number of agencies.

The agencies should aim to put the person at the centre of the plan and wrap the support specific to the individual around them.

7.PSPO – Supporting the Vulnerable

The PSPO has been a tool that has been used in partnership with Complex Lives team, to deliver care and support to some of the most vulnerable people in Doncaster. It gives a framework to ensure that individuals are directed to the support that they need whist visiting the City Centre. Whilst the PSPO prohibits certain behaviours within the City Centre, it is recognised that some of these behaviours can be secondary to an illness, an addiction, or personal circumstances.

Rather than been used as a tool to criminalise people, it is used to direct people to access the support services they need. To ensure that the response to this is holistic, individual cases are discussed in multi-agency forums to continue the one person, one plan approach.

Case Example – Person A

Identified support need/Vulnerabilities

Person A has had periods of rough sleeping for several years. During this time they have had very little stable accommodation. They were diagnosed with Asperger's but have never tried to understand the condition or seek help with learning how to live with it.

The individual had a substance misuse problem for over 20 years, it started with cannabis and is now spice, heroin and cocaine. Even when on a methadone prescription they did not fully engaged with Aspire (Drug & Alcohol services).

The individual has been offending since their late teens, has had several custodial sentences but has reverted back to substances and rough sleeping after an initial change of behaviours on release.

They are a regular beggar in the City Centre and they have said they do not need to change their behaviour due to making so much money they can afford their habit.

Overview of starting Circumstances

Person A has poor engagement with all services as they say they are losing money whilst not in their begging location. The individual would boast about how much they make in a day and is well known in the City Centre.

The introduction of the PSPO assisted with stopping some of their begging activity. A dispersal would mean they would have to leave the area for 24 hours or face a Fixed Penalty Notice (FPN) and potential arrest.

Due to the individual begging daily and not always being dispersed by enforcement officer there was concerns that they would not change their behaviour. There was enough evidence for the police to issue them with a Community Protection Notice warning letter for their begging behaviour. Due to their behaviour not changing they were issued with the full Community protection notice.

The City Centre Team, Neighbourhood Response Team and South Yorkshire Police officers and support officers were all made aware of the conditions but there was still an inconsistency of reporting.

The individual was encouraged to engage with Complex Lives, probation (When under supervision), Aspire, housing options, wound care, their GP and DWP. However, they continued to not attend appointments and only present in crisis. Even when the individual presented, they never followed through with actions. If staff located them in the City Centre the individual didn't want to engage due to them not earning money whilst staff were with him.

After a few weeks of the behaviour being disrupted and not being able to stay at a location for longer than 30 minutes, the individual started to attend the Changing Lives Centre to see their support worker more often than they had done. The individual agreed to a housing referral which resulted in them being housed in supported accommodation. After they were accommodated, they no longer begged during the day as it was no longer worth it and didn't want to put their tenancy in jeopardy.

Outcomes:
Person A attended Changing Lives after being dispersed to complain about the staff who dispersed them, but this gave Complex Lives Team and other team members the chance to engage with them. The lack of begging meant they struggled to afford their substance misuse habit, this forced them to discuss their substance misuse concerns with workers and agencies.

Case Example – Person B

Overview of starting circumstances:

- Physical Health - Refusal of Correct Treatment
- Housing –Rough Sleeping/Street Homeless
- Ability to maintain/sustain a tenancy
- Risks to others – Staff/Neighbours
- Isolated from Main Stream Services
- Substance and Alcohol Misuse
- Mental Wellbeing/Low Mood
- Challenging/Aggressive Behaviour
- Associations/Relationships
- Chaotic/Risk Taking Behaviour
- Hep C Positive
- Managing Finances
- Offending

Overview of actions taken:

- Managed under SNARM since April 2022. Meetings held within 25 days of the last due to being scored a level 3 risk and escalated to be brought forwards if changes in risk.
- Daily Welfare checks from Outreach Teams, City Centre Engagement Officers, Neighbourhood Response Team, Street Scene and Complex Lives Staff.

- Daily offers of support with housing and physical health needs. Including offers to call an ambulance, transportation to the hospital to access wound care provisions and encouragement to engage with registered GP for access to regular prescription of dressings.
- Access to clinic room in Changing Lives agreed for support in dressing their wounds regularly.
- Regular access to shower facilities at Wharf House available.
- Daily access to drug treatment from nominated pharmacy. Daily prompts to ensure they collect.
- Twice Monthly Key Work sessions at Aspire. Quarterly Prescribing appointments.
- Placed on monthly holdbacks with Aspire to encourage their attendance at appointments.
- Provided with harm minimisation advice, clean works and prompted to access needle exchange.
- Multi-Agency sharing of information and risks.
- Partnership working with CCEOs and SYP around recent CPN7 due to multiple breaches of PSPO which has been issued. This includes a positive requirement to encourage engagement with Complex Lives.
- Offers of support around finances, budgeting and keeping free from financial exploitation – Includes support to open own bank account, make new claim for UC and applying for PIP.
- Ongoing procurement work with Housing Providers to procure suitable accommodation through Housing First Project.
- Support to complete new homelessness assessment with St Leger Homes – Looking at Interim offers of accommodation and access to E.Bed/Supported Living.
- Ongoing encouragement from Hep C Trust to engage with treatment.

Outcomes:

- Since the issue of the CPN7 Person B seems more inclined to reach out for support and willing to speak with support staff. However, at present this is being seen more as a disguised compliance because the individual hasn't completed any agreed actions.
- They do continue to breach their CPN7 and reports/statements are regularly raised with SYP for fact gathering to see if theindividual can be escalated to a Criminal Behaviour Order. At present the judge does not deem offending and breaches as high enough to be criminalised.
- Good lines of communication have been established through CCEOs, SYP and NRT with regular updates being received. All partners are attending SNARM reviews and deliver the same line of support as agreed in this forum.
- Continued implementation of SNARM and actions agreed from all agencies.
- Ongoing approaches from multiple agencies to offer support to Person B and encourage accessing physical health treatment.
- Ongoing support to engage Person B with Housing Options and continue to support via The Housing First Pathway to try and get them accommodation.