Multiple and Complex Needs Initiative: Programme Evaluation Report

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EXECUTIVE SUMMARY

Introduction

1 The Multiple and Complex Needs (MCN) initiative was launched by the then Scottish Executive in April 2006. The MCN initiative was a series of 14 pilot projects aimed at exploring different approaches to improving service provision for individuals with multiple and complex needs. The programme initially ran for a two year period (April 2006-March 2008) and was later extended to run for another nine months (until December 2008). A total budget of £4.8 million was made available through the Closing the Opportunity Gap fund.

2 The overall aim of the programme evaluation was to draw lessons around what does and does not work in improving service access, the service experience and outcomes for clients with multiple and complex needs.

The 14 MCN projects

3 The selection of the 14 MCN projects was an organic process with few strict selection criteria. This meant that the projects were diverse in their target groups, size, rationale and project set-up. The 14 MCN projects were:

- African Health Project (Waverley Care);
- Improving Primary Health Care Services for People with MCN (NHS Borders);
- Inequalities Sensitive Practice Initiative (Greater Glasgow and Clyde Health Board);
- LGBT (Lesbian, Gay, Bisexual and Transgender) young people with MCN (LGBT Youth Scotland);
- Male Carers Initiative (VSA Carers Centre);
- Partnerships for Access to Health Project (Lothian NHS Board, in partnership with NHS Highland);
- Plan2Change (Lothian NHS Board);
- Positively Sorted (Aberdeen Foyer);
- Project Empower (Glasgow West Community Health Partnership);
- RCA Trust project (RCA Trust, formerly Renfrew Council on Alcohol);
- Routes out of Prison (Wise Group);
- Securing Care for Ethnic Elders in Scotland (SCEES);
- Supporting BME Families of Deaf Children (National Deaf Children’s Society);
- Tayside Domestic Abuse and Substance Misuse (Dundee City Council).

4 For the purpose of this evaluation, ‘multiple and complex needs’ was defined as any combination of at least one intense service need (such as for example, severe mental health problems) and at least two complicating factors (such as for example, a first language other than English or caring responsibilities). Most of the 14 pilot projects looked at multiple and complex needs in the context of a particular target group (for example, male carers or ex-offenders). Individuals in these target
groups did not automatically have multiple and complex needs, but in most cases a large proportion of their clients were individuals with multiple and complex needs.

5 Different MCN projects focused on different service gaps as follows:

- There simply was no or insufficient provision;
- The service is available but clients were not accessing the service;
- Some needs were not identified; or,
- There was scope for making service provision more attuned to needs.

6 In some cases, there was a fairly clear understanding of the service gap; in other cases, the starting point was an assumed service gap and the MCN pilot offered an opportunity to research and test assumptions. By and large, the service gaps MCN projects first identified proved to be correct, even when initially based on anecdotal feedback or perceptions rather than hard evidence.

7 Projects approached these service gaps in a number of different ways. At the most basic level, projects fell into two broad categories: direct service delivery to clients or change management projects.

**Service gap: improving access**

8 Eight of the 14 MCN projects aimed to address access challenges. For most of these projects there was some evidence that client access to service provision improved. The evidence of improved access was strongest for projects that:

- Had a clear focus on a well-evidenced and highly specific access challenge;
- Offered provision that addressed a service need that was seen as a priority for the target group; and,
- Undertook proactive outreach into the target community, providing continued support to the individual client until the point of access.

9 MCN evidence confirms that no one size fits all and the nature of outreach activities must necessarily be different for different target groups and in different service settings, as follows:

- Working with selected statutory service providers may be more effective where the target group is known to these particular services. Developing and nurturing relationships with other service providers is a slow process: other providers need to understand the service and feel confident about its value before they will start referring clients. Co-location and senior management buy-in can support this process.
- Wider outreach in the community, using more innovative and indirect channels may be necessary in the case of more ‘hidden’ target groups, such as the victims of domestic abuse, HIV-positive individuals or sensory impaired individuals with alcohol addiction problems.
• Recruiting staff from the target group or introducing dedicated activities for the target group can facilitate access. However, this can only ever be a partial step: at the very least, clients still need to find out that peer support workers are available or that the dedicated activities are taking place.

• Introducing a client advocate role can significantly improve client access. This role tends to be additional to existing provision, but caseloads can be high and the provision is not necessarily full-time: clients dip in and out of support. The additionality of the resource is arguably less important than the flexibility which enables staff to focus on the client’s own agenda.

Service gap: improving needs assessment

10 Five of the 14 projects aimed to improve the needs assessment process. All five projects showed positive feedback to the training sessions they organised to achieve this, but evidence of actual changes in staff attitudes or service change was scarcer. The evidence of service change was strongest for projects that:

• Embedded the training in a wider process of working with and alongside staff;
• Provided staff the time to discuss the issues with their peers which encouraged engagement in the issues and may have gone some way to overcome concerns of (yet) another top-down edict on service standards;
• Made the training practical and included sessions on how to raise sensitive questions with clients; and,
• Included an input from the target group.

11 The MCN projects suggest that merely including an issue in a checklist or questionnaire is not sufficient – it can be reduced to a mere tick-box exercise. The nature of staff engagement and training is important: it is not enough to just tell staff to include an additional question; staff need to understand its relevance and they need to feel they would be able to justify to the client why it is being asked. Peer time to discuss service practice may well have value in allowing staff to discuss what they do away from the pressure of delivery.

12 Staff also need to feel confident and competent about asking sensitive questions. Useful arguments to boost their confidence are that they already possess the skills to ask difficult questions and they do not need to become experts but simply need to refer and support clients onto appropriate services; evidence that clients do not mind being asked sensitive questions as long as it is done in a respectful and non-judgmental way, can also help.

Service gap: improving needs assessment

13 Seven of the 14 MCN projects had a particular focus on improving quality of the service provision itself – as opposed to improving access to the service or assessing client needs. The two client service delivery projects in this group provided evidence of improved client outcomes and client service experiences. What these two projects have in common is peer support. The service redesign
projects that could point to the strongest evidence of service change had the following in common, they:

- embedded their training and workshops in a wider process of working alongside and with frontline staff;
- had a strong operational focus, suggesting and exploring highly specific and practical service changes; and,
- had a clear focus on introducing the voice of the client.

14 The MCN programme evaluation suggests that peer support provision can significantly improve the clients’ service experience and can also result in better client outcomes, in particular increased client empowerment. One-to-one peer support is particularly powerful when the peer support worker shares similar lived experiences with the clients, such as mental health issues, a prison record or a disability.

15 There is value in consulting clients as these exercises may result in new and sometimes unexpected insights. Change managers can use the consultation evidence to support and strengthen their case. However, consultations alone may not be sufficient in changing (frontline) staff awareness. Direct interaction between clients and staff, through informal discussion events or more formal training sessions with individuals from the client group acting as trainers or witnesses, can be more powerful.

Service gap: improving needs assessment

16 Influencing staff appeared to work significantly better when there was:

- Sufficient face-to-face time between staff and the change manager: this often means a slow and time-intensive staff engagement process – even if at one point creating a sense of urgency became necessary. The process also tended to benefit from direct interaction between frontline staff and the client group or between frontline staff from different organisations.

- A dedicated staff resource to support the learning process: many of the MCN change managers had loose job descriptions and were able to operate independently. Even so, supportive line management structures were necessary: change management is a long and challenging process with inevitable set-backs and even the most enthusiastic change manager risks becoming disillusioned without collegial or line management support.

- Direct alignment with organisational priorities: introducing change works better if the organisation has already identified that there is a problem and/or is already trying to address the issue.

- A champion for the change within the organisation: this is a different role to the change manager role. Getting senior staff involved can be facilitated by aligning the change offer with existing organisational priorities or by offering support to help the organisation fulfil any existing (legal) obligations or minimise risk.
A positive staff engagement process, working alongside staff and offering them support rather than criticising them for failing the target group and creating some space for staff to discuss these issues together. Frontline staff often realised that they were failing their clients and were happy to get extra support – it all depends on how this offer of support is presented to staff. In some cases it may be more effective to de-emphasise the change process.

Conclusions and recommendations

17 The Scottish Government invested £4.8 million in testing what ‘works’ and what does not in improving service provision for people with multiple and complex needs. If this investment is to pay off, lessons from the programme need to be learnt and shared. This report holds findings and lessons for different service sectors. This includes health given an important health component in the MCN programme and criminal justice because of the significant investment in the MCN project which targeted ex-offenders (Routes out of Prison). That being said, a whole range of agencies encounter clients with MCN characteristics and therefore providers, managers and commissioners of service provision at all levels, including community planning partnerships, can draw lessons from this report. Ultimately, the MCN programme is about inequalities generally and about how public services can respond.

18 Much MCN learning provides further evidence and case study examples confirming principles of service improvement that are familiar from elsewhere. This includes for example the importance of proactive outreach to engage harder to reach clients, partnership working and a flexible, client-centred approach. None of this is new – these insights and principles have been championed for some time now. However, practical application of these principles has often proved elusive. The added value of the MCN programme is that it has enabled stakeholders to explore in more detail the challenges to implementation, as well as a number of possible practical solutions to these challenges.

What provokes MCN as an issue in an organisation?

19 The majority of projects were ‘external’ to the service that they were seeking to change and in most cases, had some association to the MCN group they were seeking to support. An involvement with the MCN client group in question provided many organisations with the evidence for (i) the extent of the problem and (ii) how best to respond to address this issue.

20 Pilot projects which were ‘internal’ to the service provider were a minority of MCN projects. In these settings, MCN was provoked through a combination of policy drivers and the presence of a champion: services (at frontline or management level) often know the problem with delivery; change is first triggered when a champion is prepared to act on this knowledge.
Lessons for service managers

21 Service managers were the key players in the MCN service improvement agenda. Key tasks for this group are:

- To identify where their service is currently deficient in relation to MCN clients. This includes a review of who is currently not accessing provision and why (as specified in figure 1 below).

Figure 1 – Checklist for service managers: client engagement

- To identify the scope and nature of possible changes to service delivery, including both possible light-touch adjustments to improve communication and interaction with individuals and the introduction of specialist provision where provision is currently lacking or ineffective (following the checklist suggested in figure 2 below).
To establish the necessary evidence base to facilitate this process of identifying deficiencies and possible solutions – including the introduction of a mechanism for talking to individuals from key MCN groups to get their views on all aspects of the service.

To create the space to allow changes to service delivery to come about – this will include investment in staff development, reviewing overall staff resources and individual staff workloads, sourcing or shifting resources and, in most cases, the introduction of a change manager role to take the agenda forward.

**The role of the Scottish Government**

The role of the Scottish Government will essentially be one of enabling and facilitating service managers to implement the MCN service improvement agenda. This can include:

- Developing the evidence base, together with local partners;
- Working with each of the major service providers (including the NHS, Scottish Prison Service (SPS) and others) to develop MCN Service Improvement Action Plans; and,
- Facilitating a dialogue between different (local) service commissioners and (national) service providers to secure potential economies of scale.

**Financing the MCN service improvement agenda**

Financing the MCN service improvement agenda will be challenging. There are no easy answers here but the MCN programme can again provide some guidance. In particular, it is important to note that:

- Redesign of existing provision should not be seen as cost-free alternative to introducing specialist support provision: creating space to allow changes
to service delivery to come about requires funding for staff development and freeing up staff time to invest in provision; and,

- Funding the MCN improvement agenda is ultimately a matter of organisational priority. A limited number of MCN pilots showed that, if service providers recognise the value of the proposed changes or the new support offer, they will shift or find resources for a continuation.
CHAPTER ONE  INTRODUCTION

Background and policy context of the Multiple and Complex Needs (MCN) Initiative

1.1 The Multiple and Complex Needs (MCN) initiative was launched by the then Scottish Executive in April 2006. The MCN initiative was a series of 14 pilot projects aimed at exploring different approaches to improving service provision for individuals with multiple and complex needs. The programme initially ran for a two year period (April 2006-March 2008) and was later extended to run for another nine months (until December 2008). A total budget of £4.8 million was made available through the Closing the Opportunity Gap fund.

1.2 The MCN initiative links into several major Scottish Government policy frameworks that have been launched recently relating to service delivery for people with multiple and complex needs, including:

- ‘Achieving our Potential’: A framework for tackling poverty and income inequality in Scotland launched by the Scottish Government in November 2008 setting out the approach of the Scottish Government and the Convention of Scottish Local Authorities (COSLA) to fight poverty. The framework outlines the key actions such as the strengthening of income maximisation work, launching a campaign to raise awareness of statutory workers’ rights and supporting people who find it hardest to get into jobs or use public services. The framework also sets out how the Government will strive to improve the life chances of people in Scotland and target the causes of poverty by providing greater access to jobs, improved early years provision, enhancement of skills and educational achievement, regeneration of our communities, better health and public services and approaches to remove the barriers that stand in the way of individuals realising their full potential. The framework also calls for the UK government to transfer responsibility for personal taxation and benefits to Scotland and simplify the tax credits scheme.

- ‘Equally Well’: The June 2008 report of the Ministerial Task Force on Health Inequalities signals a commitment for changing organisational culture to underpin real progress in reducing health inequalities. The document proposes adopting a number of key principles, including the notion of engaging those most at risk of poor health in services and in decisions relevant to their health, and delivering health and other services that are both universal and appropriately prioritised to meet the needs of those most at risk of poor health. A number of Equally Well test sites have been launched to further explore ways to develop service delivery adopting an outcome focused approach, and concentrating on client pathways to evidence successful outcomes where services are leading change with support given centrally.

- ‘Better Health, Better Care Action Plan’: In December 2007 the action plan set out the Government's programme to deliver a healthier Scotland. At the centre of the action plan sits a commitment to develop the NHS into
a ‘mutual’ organisation, where patients see themselves not only as users of NHS services, but also as part-owners and partners in care. The action plan stresses the importance of giving patients a clearer voice. In this context, a public consultation on the introduction of a Patient Rights Bill ran between September 2008 and January 2009.

• ‘Early Years Framework’: The framework published in December 2008 lays out local and national government’s joint commitment to give all children in Scotland the best start in life and break the cycle of poverty, inequality and poor outcomes in and through early years.

• ‘Changing Lives’: The social care implementation plan (February 2006) has taken a fundamental look at all aspects of social work, recognising the need for transformational change where social work needs to change to match expectations for high quality, accessible, responsible and personalised service. It aims to build capacity for sustainable change, focusing on performance improvement, service development, workforce development, practice governance and leadership and management. It also highlights the need to develop partnerships to design services around the needs of people and positioning social work alongside the work of their partners in different sectors.

• ‘Scotland’s Choice’: The report published July 2008 presented the findings of the work of the Scottish Prison Commission, convened in 2007 to examine Scotland’s use of prison in the 21st century. Key themes of the report, including the importance of swift justice, more restricted use of imprisonment and a stronger focus on community payback schemes have been taken up in the December 2008 Scottish Government report on ‘Protecting Scotland’s Communities, Fair, Fast and Flexible Justice’ and in the proposed Criminal Justice and Licensing (Scotland) Bill. The December 2008 report also underlines the importance the Scottish Government attaches to reducing re-offending: every change is to be judged by the simple benchmark of whether it will reduce re-offending and make communities safer.

1.3 There are a number of generic service provision principles underpinning these policy frameworks:

• All documents highlight the need for partnership working and have been developed jointly by central and local government, demonstrating the commitment to collaborative working and supporting local change and development, articulated by Single Outcome Agreements.

• The focus has shifted away from providing services to people as passive recipients to capacity building and empowerment of individuals, families

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1 Single Outcome Agreements are agreements between the Scottish Government and each local authority in Scotland, setting out how they will work towards improving national outcomes for people in a way that reflects local circumstances and priorities. For more information, see www.scotland.gov.uk/Topics/Government/local-government/SOA.
and communities, where they are given a stronger role in the way services are designed and delivered.

- Another overarching element is the commitment to invest in prevention and early intervention to reduce levels of poverty, intergenerational inequality and poor health in Scotland – commitments to rooting out inequality and promoting equality are central part of these policy documents.

- The policy documents all recognise the complexity of issues and the need to link frameworks so that they support each other and set out specific actions needed to meet shared long-term outcomes and aspirations.

- The role of the third sector in connecting with individuals and communities and bringing experience of practical and multiple and complex need issues to the design of public services has also been recognised in these documents.

1.4 Findings from the MCN programme will have a specific role in supporting these frameworks by feeding lessons about organisational change, sharing good practice processes and innovative steps with the potential to build up over time to have significant impacts on wider public sector reform.

1.5 Where the findings of the MCN programme suggest that there may be value in introducing new roles or providing additional funding – be it for setting up new services or supporting a service redesign process – this will need to be carefully assessed against the current economic climate.

Evaluation objectives and research methodology

1.6 The overall aim of the programme level evaluation of the MCN initiative was to draw out generic lessons about what works (and what does not work) in helping individuals with multiple and complex needs access services (‘getting in’), have a better service experience (‘getting through’) and achieve better service outcomes (‘getting on’). Project level evaluations, done in-house or commissioned separately, ran alongside this Scottish Government funded programme level evaluation. An overview of project level evaluations can be found in Annex A. This document does not assess the 14 pilot projects on their relative merit – it focuses instead on what the 14 pilot projects can tell us about improving service delivery for clients with multiple and complex needs.

1.7 The evaluation ran from August 2006 until March 2009. The main elements of the research methodology were:

- A review of key documents for all 14 projects, including the reports of research undertaken by the projects, monitoring data and feedback forms and the project level evaluations that were available. Annex A presents an overview of the MCN project documents reviewed, including the project evaluations.
Three rounds of fieldwork with the MCN projects: a first round of interviews with project managers took place in October-November 2006; a second round of interviews with project managers, project staff and project partners took place in March-April 2008; the final round of interviews with project managers, project staff and project partners took place between December 2008 and February 2009.

Participation during MCN workshops and activities organised by the Scottish Government or by individual projects, such as the September 2006 workshop launching the MCN initiative. Cambridge Policy Consultants (CPC) also organised six MCN workshops and action learning sessions (held between June 2007 and August 2008) covering the following themes:

- Introducing the evaluation
- Interaction between frontline staff and clients
- Joining-up service delivery
- Transfer of lessons from MCN pilots
- Change management processes, and
- Discussion of the interim evaluation report.

Interviews with 12 senior Scottish Government officials on mainstreaming and service redesign for individuals with multiple and complex needs.

1.8 Given the diversity of the rationale and set-up of projects and their approach to evaluation, the nature and availability of evidence varied between projects. In a limited number of cases there was comprehensive monitoring data and clear quantitative evidence; in most instances this was lacking and learning and findings had to be based on the projects’ own research and evaluation activities, the views of project managers, frontline staff and project partners and qualitative evidence of client outcomes (including client stories).

1.9 There was also the wider issue of what ‘success’ looks like for MCN client groups: given the complexity of client needs, the often chaotic lifestyles of clients and the limited time available for some of the interventions, it would have been unrealistic to expect evidence of (hard) client outcomes on any large scale for many of the projects. More detail about the research methodology is included in Annex B.

Structure of the report

1.10 This report is structured as follows:

- Chapter 2 presents an introduction of the 14 pilot projects, including their key characteristics, an assessment of the multiple and complex needs of their client groups, which service gaps they are addressing and how they approached closing this service gap.

- Chapter 3, 4, and 5 discuss the generic lessons that can be drawn around what ‘works’ in improving service delivery for individuals with multiple and complex needs. Each of the chapters focuses on a different service gap: chapter 3 looks at lessons around access barriers (‘getting in’); chapter 4
presents the findings relating to developing a more comprehensive needs assessments and chapter 5 looks at lessons around improving the client service experience or client outcomes (‘getting through’).

- Chapter 6 draws a number of overall lessons on mainstreaming – what MCN projects can teach service providers about initiating and managing service or organisational change.

- Chapter 7 concludes and presents a number of recommendations.

**Who is this report for?**

1.11 This report holds findings and lessons for different service sectors. This includes health given an important health component in the MCN programme, and criminal justice because of the significant investment in the MCN project which targeted ex-offenders (Routes out of Prison). That being said, a whole range of agencies encounter clients with MCN characteristics and therefore providers, managers and commissioners of service provision at all levels, including community planning partnerships, can draw learning from this report. Ultimately, the MCN programme is about inequalities generally and about how public services can respond.
CHAPTER TWO THE 14 MCN PILOT PROJECTS

Background to the 14 MCN projects

2.1 The selection of the 14 MCN projects was an organic process with few strict selection criteria. The Scottish Government Social Inclusion Division asked a number of other Scottish Government teams to suggest project ideas which led to a variety of methods for identifying potential projects. For example, the Scottish Government’s mental health team placed an open call for proposals which resulted in about 90 mental health related project proposals being submitted. Other Scottish Government teams used a more targeted approach, directly contacting organisations whom they knew were active in service provision to clients with multiple and complex needs. Different Scottish Government teams were more or less involved, which explains why some service sectors were more or less present in the MCN initiative. In particular, there was a strong health perspective in the MCN initiative; equal opportunities similarly featured prominently. The organic selection process also explains the diversity in target groups, size and budget\(^2\), rationale and project set-up across the 14 MCN projects.

2.2 Initially, the Scottish Government’s aim was that the 14 MCN projects would explore service improvement at all stages of service delivery: how clients are getting into services, getting through the service provision and getting on from the support. There was particular interest in the ‘getting on’ stage and in how clients with multiple and complex needs could build their self-confidence and be empowered to go onto positive destinations and onto other services. In practice, there was a strong focus across the MCN Initiative on the earlier stages of engagement, in particular ‘getting in’.

2.3 The focus on the getting in stage was partially the result of time constraints: the earlier stages of engagement were a natural first step for many projects and moving onto later stages was not always possible. There was also a more fundamental issue at stake: in many settings, supporting clients may be less of a challenge than getting clients to access provision in the first place; once clients are accessing provision, the client support pathway can be relatively straightforward.

Overview of the 14 projects

2.4 Table 2.1 below presents a brief summary of the project rationale, main project activities and MCN clients for each of the 14 pilot projects. The table focuses on activities; outputs and outcomes of particular activities are discussed in subsequent chapters. A more detailed description of the 14 pilot projects can be found in the project evaluations (Annex A).

\(^2\) MCN budgets range from about £20,000 to £1 million.
Table 2.1: Overview of MCN pilot projects

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<tr>
<td>African Health Project (Waverley Care)</td>
<td>Africans have the highest numbers of new HIV (Human Immunodeficiency Virus)-infections in Scotland, but a number of barriers prevent Africans from coming forward for HIV-testing and support – for example, HIV positive Africans have physical health needs (HIV/AIDS) and many have mental health problems, are homeless (not necessarily rough sleeping but living in unsuitable accommodation) and unemployed. Therefore, the African Health Project tried to encourage HIV-testing through outreach work and employed two (African) support workers to support HIV-infected Africans.</td>
</tr>
<tr>
<td>Improving Primary Health Care Services for People with MCN (National Health Service Borders) – hereafter NHS Borders Project</td>
<td>The project aimed to facilitate access to healthcare and improve the service experience for (1) migrant workers, (2) homeless people, (3) travellers and (4) people with learning disabilities. Project activities included training frontline staff, developing information materials and communication tools and making available staff time for dedicated support to homeless people and travellers. Project activities were based on, for example, the knowledge that many homeless people experience mental health issues, substance abuse and physical health problems and, people with learning disabilities face at least one intense service need and many have low skills and are unemployed.</td>
</tr>
<tr>
<td>Inequalities Sensitive Practice Initiative (ISPI) (Greater Glasgow and Clyde Health Board)</td>
<td>The project aimed to encourage staff to adopt an ‘inequalities sensitive’ practice – this means adopting a more holistic approach to healthcare provision, considering the multiple and complex issues that can impact on an individual’s health (including for example poverty or domestic abuse). The starting point for the project was existing good practice in four departments (maternity, children, mental health and addiction). Project staff worked with and alongside staff in these four departments to build a detailed picture of the good practice delivery and of what enables or prevents good practice from flourishing – thus facilitating a transfer of good practice to other areas in the departments. For example, in addiction services or in children services, the Parents and Children Together (PACT) teams work with families whose needs straddle health and social care provision.</td>
</tr>
<tr>
<td>LGBT (Lesbian, Gay, Bisexual and Transgender) young people with MCN (hereafter LGBT Project) (LGBT Youth Scotland)</td>
<td>The project aimed to develop a clearer evidence base on young LGBT people’s use and experience of service provision (through research). This was because identifying as LGBT can often lead to experiencing homelessness, mental health issues, discrimination and substance abuse. Project staff also worked with service providers (through interactive training modules) to help them deliver more LGBT friendly service provision.</td>
</tr>
<tr>
<td>Male Carers Initiative (VSA Carers Centre)</td>
<td>Male carers are less likely to access existing carers support services than female carers do therefore can often experience social isolation or poverty associated with having to give up work. The project worked with male carers to better understand male carer support needs and to better address these needs. The project also worked with commissioners of carer support to encourage them to include a gender-perspective in their strategies.</td>
</tr>
<tr>
<td>Partnerships for Access to Health Project (PATH) (Lothian NHS Board, in partnership with NHS Highland)</td>
<td>The project supported three CHPs (Community Health Partnership) to improve their service delivery for MCN groups: Edinburgh CHP focused on improving health provision for prisoners (before and after release) and their families in one of Edinburgh’s most disadvantaged communities; East Lothian CHP focused on encouraging community psychiatric nurses (CPNs) to refer clients at risk of homelessness to the Council’s homelessness prevention team; Mid-Highland CHP project aimed to improve the quality of single shared assessment for people</td>
</tr>
<tr>
<td>Project Name</td>
<td>Organisation</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Plan2Change (Lothian NHS Board)</td>
<td></td>
</tr>
<tr>
<td>Positively Sorted (Aberdeen Foyer)</td>
<td></td>
</tr>
<tr>
<td>Project Empower (Glasgow West CHP)</td>
<td></td>
</tr>
<tr>
<td>RCA Trust project (RCA Trust, formerly Renfrew Council on Alcohol)</td>
<td></td>
</tr>
<tr>
<td>Routes out of Prison (RooP) (Wise Group)</td>
<td></td>
</tr>
<tr>
<td>Securing Care for Ethnic Elders in Scotland (SCEES) (Policy Research Institute on Ageing and National Resource Centre on Ethnic Minority Health)</td>
<td></td>
</tr>
<tr>
<td>Supporting BME Families of Deaf Children (National Deaf Children’s Society, NDCS) – hereafter NDCS project</td>
<td></td>
</tr>
<tr>
<td>Tayside Domestic Abuse and Substance Misuse (Dundee City Council) – hereafter Tayside Project</td>
<td></td>
</tr>
</tbody>
</table>
Target groups – defining MCN

2.5 Most of the 14 pilot projects looked at multiple and complex needs in the context of a particular target group (male carers, ex-offenders, deaf Asian children). The diversity and specificity of the MCN projects’ target groups raised questions around whether and how the evaluation would be able to draw generic lessons around what ‘works’ in improving service delivery for individuals with multiple and complex needs, such as:

- To what extent can the client groups of the 14 MCN projects be considered to be MCN clients – in other words, how are we to interpret and define ‘multiple and complex needs’; and,

- To what extent can findings from a particular target group be generalised to the wider MCN population?

2.6 The phrase ‘multiple and complex needs’ is widely used but rarely defined: it is often assumed that multiple and complex needs are something you recognise when you see it and do not need to be defined. The evaluation took as its starting point the definition by Rankin and Regan\(^3\) which refers to ‘breadth’ and ‘depth’ or the number and intensity of need. We further developed these concepts into a service-based definition – primarily because the evaluation was seeking to understand service delivery and how service delivery can be changed. The evaluation thus distinguished between ‘intensive service needs’ (depth of need) and ‘complicating factors’ (breadth). The definition of MCN used in this evaluation is presented in box 2.1 below.

### Box 2.1: Definition of MCN

For the purpose of this evaluation, MCN are defined as any combination of:

**DEPTH** – at least 1 intense service need:
- Homelessness;
- Severe long-term illness or (physical or learning) disability;
- Severe mental health problems; and,
- Low basic skills, in particular literacy and numeracy;

and

**BREADTH** – at least 2 complicating factors (or other intense service needs):
- Substance abuse;
- Criminal record;
- Caring responsibilities (including lone parenthood);
- (History of) economic inactivity;
- First language other than English.

2.7 Applying the definition to the 14 MCN projects (see table 2.1) shows that:

- The majority of projects (9) had large proportions of MCN clients (up to 100%);

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• Four projects focused on individuals with a particular ethnic identity (BME), sexual orientation (LGBT) or gender (men). Being in a particular identity group does not automatically mean individuals have multiple and complex needs but it may complicate service delivery or be more likely to lead to disadvantage;

• The remaining project (ISPI) was not focusing on one specific client group but targeted particular healthcare departments or units that were likely to service individuals with multiple and complex needs, such as for example addictions services.

2.8 Most of MCN projects had a (partial) health focus – severe health needs (mental health, disability or illness) was the intense service need quoted most often. Substance abuse was the complicating factor featuring most prominently. A first language other than English similarly appeared frequently because of the BME focus of a number of projects.

Identifying the service gaps

2.9 Although most projects aimed to offer a better all-round service experience for their client groups, the basic rationale behind the project set-up of the 14 MCN pilot projects focused on well-defined and fairly specific service gaps or combination of service gaps. In some cases projects had a clear understanding of the service gap and its cause(s), based on existing evidence or their organisation’s past experience; in other instances, projects started from an assumed service gap or assumed cause(s) of this service gap and tested the validity of their assumptions through the MCN pilot project.

2.10 A number of service gaps could be distinguished:

• There simply was no or insufficient provision targeting a particular need or client group;

• The service was available but clients were not accessing the service;

• Clients were accessing the service but some needs remained unidentified because of an incomplete needs assessment for example, the absence of holistic person centred assessment which encompasses medical and social circumstances;

• Finally, in some cases client needs were being identified and addressed but there was still scope for improving the clients’ service experience or improving client outcomes by making service provision better attuned to clients’ particular concerns or needs.

2.11 Table 2.2 below presents an overview of the service gaps the 14 MCN pilot projects focused on. More detail about the projects’ reasons for their assumptions about service gaps and their evidence about service gaps can be found in Annex C.
<table>
<thead>
<tr>
<th>Project</th>
<th>Service gap</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No or insufficient provision</strong></td>
<td></td>
</tr>
<tr>
<td>RCA Trust</td>
<td>There is insufficient alcohol counselling for people with sensory impairment: few if any staff know BSL.</td>
</tr>
<tr>
<td>Plan2Change</td>
<td>There is little provision for people whose mental health needs are serious but not sufficiently serious for referral to secondary services.</td>
</tr>
<tr>
<td><strong>Clients not accessing provision</strong></td>
<td></td>
</tr>
<tr>
<td>NDCS project</td>
<td>BME families are less likely to access Audiology/NDCS support.</td>
</tr>
<tr>
<td>Project Empower</td>
<td>BME clients are less likely to access home care support.</td>
</tr>
<tr>
<td>SCEES</td>
<td>BME clients are less likely to access palliative care.</td>
</tr>
<tr>
<td>African Health Project</td>
<td>African people are less likely to test for HIV.</td>
</tr>
<tr>
<td>Male Carers Initiative</td>
<td>Male carers are less likely than female carers to access carer support services.</td>
</tr>
<tr>
<td>NHS Borders project</td>
<td>Migrant workers are more likely to go to accident and emergency (A&amp;E) instead of registering with a GP (General Practitioner).</td>
</tr>
<tr>
<td></td>
<td>Travellers are unlikely to register with GPs.</td>
</tr>
<tr>
<td></td>
<td>Homeless people are likely not to access healthcare provision.</td>
</tr>
<tr>
<td>Tayside project</td>
<td>Women with substance abuse issues are often not accommodated in shelters.</td>
</tr>
<tr>
<td>PATH</td>
<td>Ex-offenders may not be able to register with a GP to access methadone prescriptions.</td>
</tr>
<tr>
<td><strong>Incomplete needs assessment</strong></td>
<td></td>
</tr>
<tr>
<td>Tayside project</td>
<td>Domestic abuse is not routinely raised as an issue by substance misuse services.</td>
</tr>
<tr>
<td>PATH</td>
<td>People at risk of homelessness are not always identified by healthcare services (East Lothian CHP).</td>
</tr>
<tr>
<td></td>
<td>Some staff use the Single Shared Assessment but others do not (Mid-Highland CHP).</td>
</tr>
<tr>
<td>ISPI</td>
<td>Abuse, domestic abuse, employability, poverty, etc. are not raised as issues by healthcare staff.</td>
</tr>
<tr>
<td>LGBT project</td>
<td>Staff may not feel comfortable asking about sexual orientation.</td>
</tr>
<tr>
<td>African Health Project</td>
<td>GPs may not feel comfortable suggesting HIV testing to Africans.</td>
</tr>
<tr>
<td><strong>Inappropriate provision</strong></td>
<td></td>
</tr>
<tr>
<td>LGBT project</td>
<td>Service provision may not be sufficiently sensitive to LGBT needs.</td>
</tr>
<tr>
<td>Positively Sorted</td>
<td>Homelessness services are not sufficiently focused on helping homeless people escape from their negative outlook on the world and their belief that they cannot control or change their situation.</td>
</tr>
<tr>
<td>PATH</td>
<td>Healthcare services are not sufficiently sensitive to the specific needs of female prisoners, prisoners’ families and non-clinical needs (Edinburgh CHP).</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>Healthcare services are not sufficiently sensitive to the needs of people with learning disabilities, in particular in</td>
</tr>
</tbody>
</table>
their communication.

ISPI Healthcare services are not sufficiently ‘inequality’ sensitive – they do not take sufficiently into account the multiple and complex issues (such as domestic abuse and poverty) that can impact on an individual’s health.

RooP Service provision may not be sufficiently sensitive to the needs of ex-offenders.

2.12 A number of projects moved away from the service gaps they initially identified. For example, PATH in Edinburgh CHP did not do much work with GP surgeries on registration of ex-offenders, but focused instead on raising other partners’ awareness of the health needs of ex-offenders and their families. Plan2Change initially struggled to get GPs to refer clients to their project and increased its scope beyond individuals with serious mental health needs which were however not serious enough to warrant secondary service intervention.

2.13 Reasons for the service gap may be varied and may be situated at the level of the client or the service. For example, clients may not be accessing a service because they:

- Are not aware of the service;
- Believe the service is not for them;
- Decide not to access the service because of the stigma attached to accessing a particular service; or,
- Because there are (perceived or real) practical access barriers such as transport or language barriers or problems with opening hours.

2.14 These reasons are discussed in more detail in Chapter 3.

2.15 Similarly, staff may not ask relevant questions for a number of different reasons, as follows:

- Staff may lack the confidence to ask a question;
- They may not realise the relevance of particular actions for a particular target group;
- They may lack basic knowledge about their clients’ background;
- Staff may have become desensitised to particular client needs;
- Staff may be prejudiced against a particular target group – distinguishing consciously or unconsciously between ‘deserving’ and ‘undeserving’ clients;
- Organisational/structural barriers, in particular time pressures but also the role of organisational culture in addressing or promoting certain values.

2.16 Chapter 4 explores barriers to comprehensive needs assessment in more detail.

2.17 The January 2007 MCN literature review⁴, undertaken as part of the MCN initiative, provides a wider discussion about service gaps identified in the literature. For example, the review includes a detailed overview of organisational barriers such

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as criteria governing service use, targets, waiting lists, repeat assessments and inappropriate referrals.

**Approach to improving service delivery for the client groups**

2.18 Projects approached these service gaps in a number of different ways, as has already been described in table 2.1. At the most basic level, projects fall into two broad categories (see table 2.3 below):

- A number of MCN projects decided to recruit *client support workers* or make available frontline staff time for delivery of dedicated support services directly to the client group. Project activities included the provision of one-to-one support, organisation of events or activities for the client group and advocacy and signposting support – seven of the fourteen MCN projects were classified as (predominantly) direct client delivery projects.

- A number of projects recruited *change managers* to work with frontline staff, middle managers or senior staff to change their knowledge, skills, attitudes or behaviour or work towards wider organisational change and thus *indirectly* improve service delivery for the client group. Project activities included the development and distribution of good practice descriptions (e.g. DVDs as a result of engagement with frontline staff and managers), toolkits and information materials and the organisation of training and awareness-raising sessions – the remaining seven projects were (predominantly) service redesign or change management projects.

<table>
<thead>
<tr>
<th>Table 2.3: Basic approach to improving service delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct support to clients</td>
</tr>
<tr>
<td>- African Health Project</td>
</tr>
<tr>
<td>- Male Carers Project</td>
</tr>
<tr>
<td>- NDCS Project</td>
</tr>
<tr>
<td>- NHS Border Project <em>(homeless, travellers)</em></td>
</tr>
<tr>
<td>- Plan2Change</td>
</tr>
<tr>
<td>- RCA Trust Project</td>
</tr>
<tr>
<td>- RooP</td>
</tr>
<tr>
<td>Service redesign/ change management</td>
</tr>
<tr>
<td>- ISPI</td>
</tr>
<tr>
<td>- LGBT Project</td>
</tr>
<tr>
<td>- NHS Borders Project <em>(migrant workers, learning disabilities)</em></td>
</tr>
<tr>
<td>- PATH</td>
</tr>
<tr>
<td>- Positively Sorted</td>
</tr>
<tr>
<td>- Project Empower</td>
</tr>
<tr>
<td>- SCEES</td>
</tr>
<tr>
<td>- Tayside Project</td>
</tr>
</tbody>
</table>

2.19 It is important to note that all ‘client support’ projects included a ‘service redesign’ element: the project managers of these projects tried to encourage other service providers to take on board lessons from their pilots. In some projects, such as for example the Male Carers initiative, the service redesign element was quite significant. Conversely, a number of the ‘service redesign’ projects included a (small) ‘client service’ delivery element. For example, the Tayside project encouraged a number of drugs service providers to pilot women-only spaces;
SCEES and Project Empower project staff offered advocacy and signposting services for the target group.

**Direct client support provision**

2.20 Six of the seven direct client support projects were based on the principle of peer support: the client support was being provided by project staff or volunteers who came from a similar ethnic background, had the same gender or had lived through similar experiences as the client group. These six projects are presented in box 2.2 below. The only exception to the peer support approach was the NHS Borders project which made available dedicated community nursing or health visiting time to provide a support service for homeless people and travellers.

**Box 2.2: Peer support in the 6 MCN direct client delivery projects**

<table>
<thead>
<tr>
<th>Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>The African Health Project employed three African outreach and support workers;</td>
</tr>
<tr>
<td>The NDCS Project employed one BME support worker;</td>
</tr>
<tr>
<td>Plan2Change recruited individuals with a mental health history to help individuals overcome mental health barriers;</td>
</tr>
<tr>
<td>RooP support staff spent time in prison themselves;</td>
</tr>
<tr>
<td>The Male Carers Initiative employed a male support worker;</td>
</tr>
<tr>
<td>The RCA Trust trained volunteers with a sensory impairment to provide alcohol abuse counselling services to individuals with a sensory impairment.</td>
</tr>
</tbody>
</table>

2.21 In most cases, the MCN client delivery operated alongside, rather than instead of, existing services: the (peer) support worker offered all-round advocacy and signposting services rather than specialist service provision. The only exceptions were the RooP employment coaches, the RCA Trust alcohol counsellors and the Plan2Change mental health peer support workers – although staff in the latter two projects also engaged in advocacy and signposting.

**Service redesign/change management projects**

2.22 The approach followed by service redesign or change management projects tended to combine some or all of the following elements, several of which have already been highlighted in table 2.1:

- An element of research often based around client surveys or client consultation – this research was then used as direct evidence to support the case for service redesign. In a number of projects the case for service redesign was further strengthened by establishing a direct dialogue between the client group and staff.

- The development of toolkits, communication tools and/or training for frontline staff – training was an important feature in several service redesign/change management projects; communication tools in the NHS Borders project, which developed a number of easy-read documents to improve communication with people with learning disabilities, and ISPI developed DVDs to help develop staff communication skills for example, to ask sensitive questions on domestic abuse.
• More informal staff engagement methods – where project staff operated alongside frontline staff to rethink and revise service delivery to the client group – similarly important for most of the service redesign projects.

2.23 Five of the 8 service redesign/change management projects were managed by statutory providers; the three remaining projects were managed by voluntary sector organisations or (in one case) a research institute. The challenges faced by statutory and third sector service providers will be discussed in more detail in subsequent chapters, in particular Chapter 6 (Mainstreaming). Box 2.3 provides examples of service redesign and change management methods used.

**Box 2.3: Examples of service redesign methods used**

<table>
<thead>
<tr>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The LGBT project undertook a survey of LGBT young people and of service providers to better understand the challenges faced when delivering services to LGBT young people;</td>
</tr>
<tr>
<td>- The NHS Border project undertook research with healthcare staff to better understand staff attitudes and behaviour towards individuals with multiple and complex needs;</td>
</tr>
<tr>
<td>- The Tayside project undertook research with users and providers of domestic abuse and substance misuse services to better understand the current service provision available to women who face domestic abuse and substance misuse;</td>
</tr>
<tr>
<td>- SCEES undertook research with BME women to better understand their service experience and expectations;</td>
</tr>
<tr>
<td>- PATH undertook two literature reviews, one aimed at identifying what service users with multiple and complex needs want from service providers and a second aimed at identifying good practice in service provision to people with multiple and complex needs;</td>
</tr>
<tr>
<td>- ISPI undertook research with users of maternity services to understand the client experience and identify good practice in delivery. ISPI also used an action research approach with practitioners and managers;</td>
</tr>
<tr>
<td>- The Male Carers initiative undertook research with male carers to identify and better understand the support needs of this group. The project also undertook a survey of GPs and carer support workers to help understand the barriers to referral.</td>
</tr>
</tbody>
</table>

**Direct dialogue between clients and staff**

- SCEES facilitated a discussion between palliative care providers and Chinese/Asian communities – for example identifying a need for adjusting visiting hours (to reflect the fact that many Chinese/Asian communities work in the catering sector) and a dislike for use of the word ‘hospice’;
- The NDCS project invited professionals to attend BME parents’ coffee mornings, where they initially made a presentation of the services available which was followed by informal question and answer sessions.

**Training of frontline staff**

- The NHS Borders project organised frontline staff training on travellers, homeless people, learning disabled people and migrant workers; the project also organised dedicated GP training on the specific needs of learning disabled people;
- The LGBT project organised 14 interactive training sessions, focusing on small practical changes service providers can undertake to make their services more sensitive to LGBT needs; the training also looked at asking questions about sexual orientation;
- The Tayside project organised a series of training sessions about the interaction between substance abuse and domestic abuse; the training included role-play scenarios showing how to raise domestic abuse issues with clients;
- ISPI organised a series of interactive training workshops on gender and gender-based violence, poverty, unemployment and LGBT issues for mental health, addiction, children’s services and maternity staff;
- As a result of the ISPI working groups and engagement with practitioners a number of workforce development tools have been developed for use by the whole organisation including a DVD, pathways, practice descriptors and practitioner stories;
- The African Health Project organised training for GPs on referring African patients to HIV testing.

**Analysis and review of existing training modules and support provision**

- Project Empower staff sat through the existing Home Carers Induction Training – cultural
awareness training is included in the induction but the review showed that this element of the training is difficult to apply in practice; it was suggested that it would be better to have examples from home carers who have actually worked with BME clients. It was also suggested that the induction would include something on nutrition in ethnic meals. Staff also reviewed existing translations – introducing 'plain English' principles to other languages (translators often use highly complicated words and phrases);
- ISPI developed an Equality Impact Assessment tool for use in commissioning and assessing training modules.

Chapter conclusion

2.24 The selection of the 14 MCN projects was an organic process with few strict selection criteria. This meant that the projects were diverse in their target groups, size, rationale and project set-up.

2.25 The evaluation defines multiple and complex needs as any combination of at least one intense service need (such as for example severe mental health problems) and at least two complicating factors (such as for example a first language other than English or caring responsibilities). Most of the 14 pilot projects looked at multiple and complex needs in the context of a particular target group (for example male carers or ex-offenders). Individuals in these target groups did not automatically have multiple and complex needs, but in most cases a large proportion of their clients were individuals with multiple and complex needs.

2.26 Different MCN projects focused on different service gaps as follows:

- There simply was no or insufficient provision;
- The service is available but clients were not accessing the service;
- Some needs were not identified;
- There was scope for making service provision more attuned to needs.

2.27 In some cases, there was a fairly clear understanding of the service gap; in other cases, the starting point was an assumed service gap and the MCN pilot offered an opportunity to research and test assumptions.

2.28 Projects approached these service gaps in a number of different ways. At the most basic level, projects fall into two broad categories: direct service delivery to clients or change management projects.
CHAPTER THREE  SERVICE GAP: IMPROVING ACCESS

Assessing the project rationale and outcomes

3.1  This chapter looks at the service gap of access difficulties. Seven of the fourteen MCN projects had a particular focus on engaging with clients who were not accessing services. In some cases, there was fairly clear evidence that individuals were not coming forward, in others, projects started with a perception that certain groups were missing out and used the MCN project (partially) to test the validity of this perception. Most of the projects introduced new staff roles to undertake outreach and facilitate the access process. The NHS Borders project (migrant workers) was an exception: the project developed and distributed a leaflet explaining, in a number of different languages, how and why patients should register with a GP practice.

3.2  Table 3.1 below presents an overview of the findings for these seven projects, discussing whether access difficulties were actually (part of) the issue and whether the access difficulties have been solved. It is important to note that the table below does not evaluate the projects on their overall achievements; it rather uses a very fine lens to look at one aspect of each project only: what if any evidence can this project offer that access has improved? This evidence will then be used in the second part of this chapter (Lessons Learnt) to explore what ‘works’ in addressing access barriers.

Table 3.1: Were access difficulties the issue?  Were they solved?

<table>
<thead>
<tr>
<th>Project</th>
<th>Baseline</th>
<th>Improved access?</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Health</td>
<td>Epidemiological evidence that Africans in the UK are diagnosed much later with HIV than other groups. There was also evidence suggesting that the increase in HIV-diagnoses in Scotland is the (partial) result of HIV-infections among Africans.</td>
<td>The Greater Glasgow and Clyde Health Board confirms that there has been an increase in people coming forward for HIV-testing; no exact figures were available. Direct attribution is difficult, but the Health Board believes this increase has come about as a result of the African Health Project and the wider work by HIV Scotland and the Greater Glasgow Action Plan.</td>
<td>No hard data, but partner feedback that take-up of HIV testing has increased. The Greater Glasgow Health Board will provide funding for the support worker’s role to continue.</td>
</tr>
<tr>
<td></td>
<td>Male Carers Initiative</td>
<td>NDCS Project</td>
<td>NHS Borders Project (homeless people)</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Only 10% of male carers seek support whereas men represent 40% of carers; of the people who come to the VSA Carers Centre, an estimated 90% are women. There are an estimated 20,000 male carers in the Grampian area, of whom 1,500 are under 18.</td>
<td>The project has succeeded in engaging a number of male carers in VSA Carers Centre activities – for example 13 male carers participated in 3 dinners; 37 and 50 carers (men and women) participated in a coach trip and Christmas event respectively. There was no exact data about the current percentage split between men and women accessing the VSA Carers Centre. Secondary research found that over 50% of male carers just want information – suggesting that the issue is as much one of different support needs as of access.</td>
<td>Anecdotal evidence of improving clients’ access to service provision.</td>
<td></td>
</tr>
<tr>
<td>NDCS had only 1 BME member on a total membership of 1,900 (Scotland-wide). There were also reported difficulties and no-shows for Audiology appointments among BME families of deaf children.</td>
<td>NDCS has succeeded in engaging with 58 BME families with deaf children – which the project estimates represents 90% of all BME families with deaf children in the Glasgow area. Of these families, at least 38 have become NDCS members. Audiology confirmed that there had been an increase in the take-up of Audiology appointments among BME groups; exact figures on improved take-up were not available.</td>
<td>Hard evidence of increase in NDCS membership among BME families. No hard data of increased take-up of Audiology support, but partner feedback that this is the case. NDCS has decided to continue funding the support worker’s post from their core budget.</td>
<td></td>
</tr>
<tr>
<td>A perception that homeless people might not be accessing the healthcare provision they need. There are an estimated 3,300 homeless people in the Scottish Borders.</td>
<td>There was evidence of homeless people registering with NHS dentists, GPs or being referred to other services as a result of their participation in the project: of the 52 homeless people contacted, 30 were assisted to register with an NHS dentist, 12 were advised/assisted to register with a GP surgery and 9 were referred to other services. There was anecdotal evidence of homeless people also accessing primary healthcare and other service provision following referral or registration but no exact data were available for this. There was anecdotal evidence of homeless people receiving direct healthcare support from the project worker (including a blood pressure or Chlamydia test).</td>
<td>Anecdotal evidence of improving clients’ access to service provision.</td>
<td></td>
</tr>
<tr>
<td>NHS Borders project (travellers)</td>
<td>A perception that travellers might not be accessing the healthcare they need. The June 2004 count suggests that there are about 120 travellers in the area.</td>
<td>There was some evidence that travellers were assisted to register and access primary healthcare as a result of the project: of the 15 traveller families who were contacted, 3 (children) were registered with a GP. There was similarly evidence of travellers receiving direct healthcare support from the project worker (including for example vaccinations). Only women and children engaged with the project. Client feedback suggested that travellers were already familiar with health visitors and community nurses. Client feedback also suggested that travellers registered with GP surgeries elsewhere and simply wait until they go back ‘home’ for accessing non-emergency care. The overall perception was that, without the project, travellers would still have accessed healthcare, but at a later stage – for example children would have been vaccinated a few months later.</td>
<td>Anecdotal evidence of improving clients’ access to service provision.</td>
</tr>
<tr>
<td>NHS Borders (migrant workers)</td>
<td>A perception that migrant workers may not be registering with GPs but show up at A&amp;E instead. The project did a snapshot of migrant worker use of A&amp;E but the snapshot data were not available.</td>
<td>Evidence that registration with GPs has increased could not be captured because the current IT system records ethnicity (‘other white’) rather than nationality. There was no evidence that incorrect use of A&amp;E by migrant workers has reduced (the snapshot exercise was not repeated). There was anecdotal feedback that healthcare provision (other than emergency care) or GP registration was not a priority for migrant workers.</td>
<td>Very little supporting evidence. There was no direct project engagement with migrant workers – this made evidence-gathering more difficult.</td>
</tr>
<tr>
<td>Project Empower</td>
<td>BME clients represent 1% of the overall group receiving home care (99 out of 8,000 users), but represent more than 4% of the population in the Greater Glasgow and Clyde Health Board area. Research identified 3 main access barriers for Chinese and South Asian people: awareness of services (only 20% (19) of Chinese respondents were aware of home care service), language barriers and transport issues.</td>
<td>There was anecdotal evidence of BME clients learning about the availability of home care and accessing home care as a result of the project. The project also supported a number of people in accessing benefits (including 3 attendance allowance applications and 3 disability allowance), requesting a community care assessment (6 people) or accessing help with transport (including 3 blue badge applications, 2 concessionary travel applications and a number of Dial-a-Ride applications). Seven bi-lingual (Chinese or South Asian) home care workers were recruited. Exact data about the current percentage of BME users of home care was not available.</td>
<td>Anecdotal evidence of improving clients’ access to service provision.</td>
</tr>
<tr>
<td><strong>RCA Trust</strong></td>
<td>Individuals with sensory impairment, in particular those who have BSL as their first language, are not well engaged with services including RCA Trust. The hypothesis was that the lack of counselling services in BSL prevented clients from accessing. There was no exact data on the number or percentage of clients with sensory impairment accessing counselling services.</td>
<td>The first phase of the project consisted of training and preparing individuals with sensory impairment to act as volunteer counsellors, so the timescale for direct client engagement was limited. To date, 18 individuals with sensory impairment have been supported by the RCA Trust project. There was anecdotal evidence that the project was bringing in people who were not normally assisted by mainstream or voluntary sector providers. The project has received referrals from as far afield as Manchester, suggesting need. Additionally, a small number of specialist professionals, including professionals working in mental health, have identified the RCA project as offering a unique counselling service for some of their clients.</td>
<td>No hard data, but indications of improving access: the referral to the RCA Trust project from as far as Manchester suggests that the value of the RCA Trust approach is recognised.</td>
</tr>
<tr>
<td><strong>SCEES</strong></td>
<td>Low uptake of palliative care services among BME groups. There was no exact data available about BME uptake of palliative care.</td>
<td>Sixty-four Chinese and South Asian individuals participated in 5 palliative care listening events. Between 63% and 93% had no idea what palliative care was prior to the listening events, but all had after; around 80% of participants wished to be contacted by palliative care services to receive further information. There was no exact data available about current levels of BME uptake of palliative care.</td>
<td>Anecdotal evidence of improving clients’ access to service provision.</td>
</tr>
</tbody>
</table>

**What does this evidence suggest?**

3.3 Most of these seven projects can point to some evidence that clients’ access to services has improved. The evidence of improved access is stronger in some cases, including for example the African Health project, the NDCS project and the RCA Trust project. For these projects, the evidence goes beyond anecdotes and also includes hard data and external stakeholder feedback of improved access.

3.4 Key characteristics of projects where the evidence of improved access was stronger included:

- A clear focus on a well-evidenced and highly specific access challenges;
- Provision that addressed a service need that was seen as a priority for the target group; and,
- Proactive outreach into the target community, providing continued support to the individual client until the point of access.
3.5 Most of the seven projects share some of these characteristics. However, for projects where the evidence of improved access is weaker, their focus was not quite as specific, their evidence base not quite as well-developed or their outreach not quite as intensive and sustained. For example, the three project workers in the Male Carers project, Project Empower and SCEES were responsible not only for outreach to their target groups, but also spent significant amounts of their time providing one-to-one support, organising events, managing research and working with staff and management in partner organisations. As a result, their outreach could never be quite as intensive or sustained as for example the African Health project, which had a full-time staff resource dedicated to outreach.

3.6 Importantly, it is not as clear that the support offer of projects for which the evidence base is weaker corresponded quite as clearly to what clients saw as their priority needs. The African Health and NDCS projects were arguably the two projects (in this group of seven) that started most clearly from their clients’ own agenda, addressing issues as and when they arose, be it housing, immigration or education. The project offer of other projects remained more closely linked to the organisation’s own service sectors or existing support offer. For example, non-emergency healthcare is not necessarily a priority for homeless people, travellers or migrant workers and this was identified as a continued challenge for the NHS Borders project’s outreach activities.

Lessons learnt

3.7 On the basis of the available monitoring data, project evaluation reports, client stories and interviews with project staff, a number of lessons can be drawn around improving client engagement with service provision.

*Proactive and creative outreach in the target community*

3.8 Successful client engagement tends to imply *proactive* outreach methods – rather than simply distributing leaflets or putting up posters and waiting for clients to arrive. Projects tried raising awareness of the availability of services and the importance of accessing provision through community intermediaries or non-traditional methods such as going to hairdressers or through community radio stations. Raising awareness of provision indirectly took place where stigma may hinder client engagement: the target group was invited to awareness-raising events or support groups which were not labelled as such. Alternatively, projects were bringing service delivery directly to the target group, in some cases literally knocking on clients’ doors to present provision or accompanying other service providers, who already had some existing contact with key client groups, on their rounds. A number of examples demonstrating the importance of proactive outreach in the target community are presented in the box 3.1 below.
Box 3.1: Examples demonstrating the importance of proactive outreach in the target community

- Project Empower worked with the Chinese Healthy Living Centre and other local organisations to organise an information event for Chinese and South Asian Communities in Glasgow to raise awareness of the home care services provided and on how to access these services. They ran a health information programme on community radio Awaz (in Urdu), combining this with a writing competition.

- The African Health Project worked through churches, country associations and hairdressers to reach out to the African community. They tried raising awareness of the importance of HIV testing indirectly, during events which were not initially presented as HIV-related (otherwise Africans would not have participated). Project support workers were based at or showed up at HIV clinics at set times to present the Waverley Care support offer to African patients in person. Alternative approaches (where clinic staff referred patients to Waverley Care or even gave African patients the telephone number of the African support worker) proved less effective, because the face-to-face contact was missing.

- The Male Carers initiative similarly worked indirectly, inviting male carers to a ‘quiz’ rather than a support group or information session on caring.

- The NDCS project worker accompanied Teachers of the Deaf to visits with BME families with a deaf child, enabling her to introduce the NDCS support offer. Previous approaches (asking statutory providers to hand out NDCS leaflets to BME families) had proved ineffective. The project also provided information indirectly through regular coffee mornings for BME parents where parents could share experiences and where service providers were invited to give presentation on services available.

- The NHS Borders homelessness nurse used a number of outreach mechanisms, including client engagement in homelessness shelters and accompanying other service providers on their visits – for example, asking homeless people whether she can sit in during their discussion with the Council’s homelessness support workers or accompanying the looked after children nurse on her visits to care homes to make sure that she was a familiar face for these children – who often run the risk of becoming homeless at the age of 16.

- The NHS Borders travellers support worker knocked on doors in a caravan park, using a hand-held record for travellers as pretext for engagement. She visited the site weekly to deal with any healthcare issues arising. One of the families was instrumental in helping her gain access to the other families.

- The RCA Trust similarly found that a particular deaf person was instrumental in helping them gain access in the tightly-knit community of deaf people.

- A possible counterfactual can be found in the work of the NHS Borders project: the project tried to encourage GP registration among migrant workers by developing an information leaflet in a number of different languages (including Polish, Urdu and Russian) explaining the principles of GP registration and distributing it to a range of community venues and among large local employers – without any additional proactive community outreach. There was no hard evidence about the impact of the leaflet on GP registration levels, but at least one partner felt that the leaflet had not (yet) achieved the desired effect.

- RooP life coaches similarly brought the service to the target group, engaging with prisoners in the prison setting, a few weeks prior to their release.
Carefully developing and nurturing relationships with other service providers

3.9 Success in securing referrals from other providers typically means hard and sustained efforts to develop and nurture relationships with other services. This tends to be a slow process. Securing referrals from mainstream agencies appeared to work significantly better after service providers developed a better understanding of the service offer and its value – for the client group or for their own organisation. Co-location on the same premises can facilitate this process. Buy-in at senior management level can act as an important trigger for co-operation, but can only do so much.

3.10 Any (perceived) legal or practical constraints can be resolved fairly easily once services recognise the support offer’s value: for example, statutory services providing MCN projects with copies of appointment letters or information about the days and time when clients will show up at their premises. Data protection legislation in itself did not appear to act as a barrier to client engagement: for example, clients tended to be happy for their information to be shared with other services (1) when they were asked for their consent by someone they trusted and (2) when it was explained why and with whom the information would be shared. Where necessary, accessible data protection consent forms were being used in this respect. Box 3.2 below lists some MCN examples demonstrating the process of securing referrals.

Box 3.2: Examples demonstrating the process of securing referrals

- The NDCS BME support worker worked with staff in Audiology to encourage referrals to NDCS; the introduction of a simple data protection consent form meant that Audiology now forwards client details to NDCS whereas previously they had just presented an NDCS leaflet to clients meaning clients had to take the initiative to contact NDCS. At least as important was that Audiology reported better attendance of BME families at their own meetings – seeing a direct organisational benefit from engagement with NDCS.

- Senior management buy-in from the Council’s Homelessness Team for the NHS Borders homelessness nurse facilitated the referral pathway: when referrals were slow to materialise, managers instructed each team member to go through their caseloads and refer five homeless people each. That being said, senior support has not resolved all issues: one team member still did not refer anybody; others considered the referral of five individuals a one-off rather than the start of an ongoing process. Co-location of the homelessness nurse on the premises of the Homelessness team meant that she had access to the Homelessness team’s records and could identify potential referrals directly. Good personal relations developed because of the co-location and also enabled the homelessness nurse to accompany team members on their visits or sit-in during interviews, thus opening up a direct engagement channel with clients.

- The Plan2Change peer support project had hoped to source clients through a local GP practice. When this failed to produce a flow of clients the recruitment net was extended to other GP practices, secondary care institutions, Community Psychiatric Nurses (CPNs) and community-based projects. The project evaluation identified a number of barriers to the GP referral route, including time constraints, lack of faith in the quality of the intervention and worry that if things went wrong they would be held responsible, a reluctance to refer to non-health services and lack of faith that the project would be there in the long-term. As the project developed, GP surgeries began referring as they developed more understanding of the service due to relationships the project built-up with CPNs.

- Senior Scottish Prison Service buy-in for the RooP project was crucial in getting Scottish Prison Service (SPS) staff to accept former prisoners back into the prison as peer support life coaches.

- HIV clinic staff commented that they were happy to proactively refer African clients to the Waverley Care support service because they received positive feedback about the support offer.
from their patients; in Edinburgh, a long tradition of working with Waverley Care supported co-operation. The African support workers were based on the premises of the HIV clinic (Glasgow) or were informed when African patients will present (Edinburgh). In both Glasgow and Edinburgh, Waverley Care support staff attended the HIV clinic staff meetings. Co-location (Glasgow) facilitated the development of strong relations.

Reflective delivery - recruiting staff from the target group may facilitate access

3.11 There was some qualitative evidence to suggest that the presence of staff from the target group facilitated access. The presence of staff from the target group was not, however, in itself sufficient to get clients to come forward for service provision: potential clients still needed to be referred or told by someone else that the peer support was available. By and large, the impact of the presence of staff from the target group on access to services was less well evidenced than the impact of this presence on individuals’ service experience (see Chapter 5). Box 3.3 below gives two MCN examples demonstrating that recruitment from the target group can facilitate access.

Box 3.3: Example of recruitment from the target group facilitating access
- One parent of a deaf child commented that he only responded positively to the NDCS letter because he noted that the letter was signed by someone whose name suggested she was from a similar ethnic background. NDCS still would not have reached this BME family without the help of the Audiology Department (who asked the family whether they could share their contact details with NDCS) and without their own active outreach (presenting its support offer in the letter).
- Several of the clients supported by Project Empower suggested they accessed project support because the project worker was able to speak to them in their mother tongue (Chinese Mandarin or Urdu).

Dedicated activities for the target group may facilitate access

3.12 A limited number of projects experimented with dedicated activities for the target group, including women-only spaces, dedicated male carer events or separate coffee mornings for BME parents with a deaf child. As with the recruitment of staff from the target group, there was fairly clear evidence about the impact of these dedicated activities on the clients’ service experience; there was less evidence about the extent to which these activities improved access. Box 3.4 below presents a number of MCN examples demonstrating that dedicated activities for the target group may facilitate access.
Box 3.4: Examples of dedicated activities for the target group

- The Tayside project succeeded in encouraging 4 substance misuse services to pilot women-only spaces. The women-only spaces ran over a period of several weeks or months (depending on the pilot). About 15 women engaged with the Tayside women-only spaces. There was anecdotal client feedback that the women-only space had facilitated access, for example for women whose controlling partner would never previously have let them attend a substance abuse service on their own. Other women had not been aware of the women-only element of the provision prior to accessing it. Getting substance misuse services to trial the women-only spaces in the first place was considered a particularly significant achievement.

- The NDCS Project set up BSL classes for BME parents with a deaf child. The purpose was to build capacity among their client group to better communicate with their children. Some clients, however, needed further support with the English language before being able to learn BSL, thus the project also set up ESOL (English for Speakers of Other Languages) classes for these parents.

Introducing staff with client advocate roles can significantly improve access

3.13 There was consistent and clear evidence that introducing staff with an advocacy and signposting role can significantly improve clients’ chance of accessing service provision. Importantly, MCN advocates often succeeded in delivering client empowerment impacts – mainly in terms of helping clients identify and articulate their needs and making them aware of services that were available and of their entitlements and rights to support provision. Box 3.5 below presents a few MCN examples that demonstrate the value of client advocates.

Box 3.5: Examples demonstrating the importance of advocacy support

- The NHS Borders Homelessness Outreach Worker succeeded in securing a ground floor three-bedroom apartment for a mother and three children. This had previously been refused because of rules that there should be a separate bedroom for the parent(s) and each of the children. The Outreach Worker successfully argued that one of the children was disabled and (1) needed a ground floor apartment and (2) would sleep in the mother's bedroom anyway even in a four-bedroom flat.

- The RCA Trust project quoted an example of the project intervening on behalf of a deaf client who had enjoyed a less than satisfactory experience with police and legal services in the pilot area: police had treated the client as if he had learning disabilities rather than a sensory impairment. The project was able to raise awareness of this individual’s communication needs and secure his rights for communication support (i.e. BSL interpreter) with criminal justice services.

- The NDCS project helped a number of BME families with deaf children consider and communicate their preferred choice for their child’s education (specialist or otherwise) as well as their choice of whether or not to follow the focus on speech development favoured by Teachers of the Deaf or, access BSL classes and start signing with their child. One client commented: “Before I met you, I didn't have any information on deafness or anything. Now I can sit at home and get all the information by just calling you. It is not just information about deafness, but you have helped with my housing problems, benefits. I am very happy with the service”.

- Project Empower supported a Chinese female suffering from cancer, heart condition and diabetes, who had twice applied for the Disability Living Allowance (DLA) but both times the application was declined. The client felt the assessor was hostile and judged her by appearance – she was told she did not look ill enough. The unsuccessful application on the DLA stopped her from getting any other help. Project Empower staff helped the client get the DLA application approved. On top of that, the project also helped her to get a Concessionary Bus Pass, a Blue Badge and Home Care Services with a Bilingual Home Carer which was a relief for the client both emotionally and financially.

- The African Health Project provided support to an asylum-seeker from the Ivory Coast whose farms were destroyed during the civil war and who paid to be taken to Europe, was abandoned
at Heathrow in 2001 and dispersed to Glasgow in the same year. His asylum application was rejected in 2006 and he was made homeless. In the same year he tested HIV positive. The project has helped the client find an immigration lawyer, sort out his housing, get NASS (National Asylum Support Service) vouchers and apply for additional financial support.

- RooP life coaches support ex-offenders in accessing a range of services. For example, one client commented: “What [my Life Coach] has been really great at is helping me with the social work. Basically with the charge that I have, I have found it really hard to get the social work to listen to me as they think that I am a bad b****** and that is that so [he] has been great to be able to say to them that no I am not a bad b****** and actually I am really good with my kid. He has been great at backing me up.” Another client said: “Aye, he has got me talking to people better, get through the council and that, I used to not to deal with them, I just lose the head and walk away and tell them to keep it, but now I do not, I will think about it a wee bit now and I will phone him and see if he can contact them for me.”

3.14 Current policy stresses practice development and service redesign (within existing budgets) over developing additional provision. This is for example the case in Equally Well. In most cases in MCN projects, however, the advocacy and signposting role operated alongside rather than instead of existing provision, which meant there were direct resource implications. In this context, it is interesting to note that despite the all-round nature of the support offer, caseloads tended to be fairly high and the advocacy role was not necessarily full-time: clients dipped in and out of support as needs fluctuated.

3.15 A number of projects tried limiting the resource implications of introducing the advocacy role by working with volunteers. Outcomes of these attempts were mixed. It appeared that volunteers can play a crucial role in terms of offering emotional support and making clients realise that they are not alone in their predicament. However, volunteers were less likely to have developed sufficient in-depth knowledge of the wider service support network or the skills or inclination to act as advocates to help clients access provision. Box 3.6 below presents a number of examples of MCN projects that introduced volunteers in the support provision.

Box 3.6: Role of volunteering in providing support to MCN clients

- NDCS recruited 7 volunteers — they initially believed that the MCN support worker would undertake the initial needs assessment and that the advocacy support role would then be taken over by the volunteers. They came to realise that only some volunteers were able and willing to provide the type of support families needed (e.g. some may only wish to help out with transport from time to time). Even the volunteers who were interested in taking on a support role were more likely to accompany the MCN support worker during house visits than to take over the support for the family. The signposting role (finding out what services are available for individuals and helping them access these services) was not taken on by any of the volunteers.

- Waverley Care trained a number of HIV-infected Africans to act as champions in their communities and raise awareness. Volunteers were less involved in providing one-to-one support.

- Project Empower noted an interest from 11 BME individuals (including 3 carers and 3 disabled persons) to act as volunteers, offering support to other disabled people and their carers. One of the volunteers who herself suffered from a long-term illness, supported a terminally ill client during the last weeks of her life: “A few months ago, the project worker and I visited an old lady who had terminal illness. I made contact with another volunteer and visited her twice before she passed away. Inevitably, I could not help the old lady to recover, but I felt good and meaningful that I was able to give her love and care in her final stage of her life. Seeing other people become happy because of what I had contributed, it made me feel happy as well.”
3.16 What makes the advocacy and signposting role particularly successful is its flexibility: MCN advocates were able to let the client set the agenda and address needs as and when they came up – as opposed to focusing on a particular need or barrier. This did however result in clients developing high expectations from their support workers. This meant advocates had to go through steep learning curves to find out where to go for advice while also developing clear expectation management strategies: they needed to go the ‘extra mile’ while at same time explaining the limits of the organisations. Going this extra mile was important: clients needed to know that they were trying to help them and doing some of the initial legwork rather than just trying to get them out of the door by referring them on. Referring clients on and ‘letting them go’ can be a challenge for the support staff themselves. The MCN examples in box 3.7 below demonstrate the importance of going the extra mile.

Box 3.7: Importance of going the extra mile

- The African Health Project reported that clients would ‘test’ the project worker once (for example ringing late at night to test whether she would respond) but once the project worker had passed this initial test, clients were quite comfortable with being told that now was not a good time.
- This was confirmed in the ISPI maternity setting client survey: women did not necessarily feel the need to use the direct telephone facility much, but the knowledge that it was available was seen as supportive: “I suffered from a lot of postnatal depression so she says anytime just to phone her … phoned her once but knowing that she was there was great”
- Research with LGBT young people confirmed that they did not mind when LGBT support services referred them to other services as long as they did not feel they were just being pushed through the door: as long as the support worker gave the initial support and clients felt the support worker cared, they did not mind being referred on.

Chapter conclusion

Assessing the project rationale and outcomes

3.17 Eight of the 14 MCN projects aimed to address access challenges. For most of these projects there was some evidence that client access to service provision improved. The evidence of improved access was strongest for projects that:

- Had a clear focus on a well-evidenced and highly specific access challenge;
- Offered provision that addressed a service need that was seen as a priority for the target group; and,
- Undertook proactive outreach into the target community, providing continued support to the individual client until the point of access.

Lessons learnt

3.18 No one size fits all and the nature of outreach activities must necessarily be different for different target groups and in different service settings, for example:

- Working with selected statutory service providers may be more effective where the target group is known to these particular services, such as deaf children, registered homeless people or prisoners. The evidence suggests that developing and nurturing relationships with other service providers
was a slow process: other providers needed to understand the service being provided and feel confident about its value – for the client group or for their own organisation – before they would start referring clients on. Co-location and senior management buy-in can support this process.

- Wider outreach in the community, using more innovative and indirect channels may be necessary in the case of more ‘hidden’ target groups, such as the victims of domestic abuse, HIV-positive individuals or sensory impaired individuals with alcohol addiction problems.

- Recruiting staff from the target group or introducing dedicated activities for the target group can facilitate access. However, this can only ever be a partial step: the evidence suggests at the very least, clients still needed to find out that peer support workers were available or that the dedicated activities were taking place. Proactive outreach in the MCN target community was very important: clients were unlikely to respond just to leaflets or posters.

- The evidence shows that introducing a client advocate role can significantly improve client access, including in situations where clients had previously tried and failed to access provision. This role tended to be additional to existing provision, but caseloads could be high and the provision was not necessarily full-time: clients dipped in and out of support. The additionality of the resource was arguably less important than the flexibility which enabled staff to focus on the client’s own agenda.
CHAPTER FOUR SERVICE GAP: IMPROVING NEEDS ASSESSMENT

Assessing the project rationale and outcomes

4.1 Five of the MCN projects looked in some detail at how the needs assessment of individuals with multiple and complex needs could be improved in order to better address their needs. Mostly, these projects tried introducing one or a limited number of additional issues that sit outside the primary focus of organisations, for example introducing questions around debt or domestic abuse in the needs assessment of addiction services or introducing homelessness as an issue among CPNs. In other words, MCN projects tried to move away from a service-centred needs assessment towards a person-centred assessment. This shift was more pronounced in some pilots than in others: for example, the introduction of domestic abuse as an issue in addiction services in Tayside was explicitly linked to the close relation between domestic abuse and addiction services’ primary focus, substance abuse; the African Health Project stayed within a single service area (health), trying to encourage GPs to overcome their reluctance to refer Africans for HIV testing.

4.2 All five projects aimed to improve the needs assessment through training and/or by working alongside frontline staff to raise their awareness on particular issues or build their confidence to ask sensitive questions. One (Tayside project) also developed additional tools, including posters of domestic abuse being put up in drugs services indicating that it is okay to raise these issues or posters explaining that it is the agency’s policy to ask everyone about domestic abuse, asking people not to feel targeted by this question. ISPI had a significant training component but also built-up a detailed picture of existing good practice in undertaking needs assessment (‘sensitive enquiry’) and of what encourages and undermines sensitive enquiry at all organisational levels.

4.3 Table 4.1 below reviews to what extent an incomplete needs assessment was indeed an issue in the context of these five projects and whether or not the MCN approach succeeded in improving needs assessment. *It is important to note that the table below does not evaluate the projects on their overall achievements; it rather uses a very fine lens to look at one question only: what if any evidence can each project offer that needs assessment has improved?* This evidence will then be used in the second part of this chapter (Lessons Learnt) to explore what ‘works’ in improving the needs assessment process.
<table>
<thead>
<tr>
<th><strong>Project</strong></th>
<th><strong>Baseline</strong></th>
<th><strong>Improved needs assessment?</strong></th>
<th><strong>Evidence</strong></th>
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<tbody>
<tr>
<td><strong>African Health Project</strong></td>
<td>GPs may be less likely to refer Africans for HIV testing because they fear insulting patients. There is recorded (by clinics) evidence of Africans being sent for a whole array of tests by GPs (despite presenting with symptoms that are a clear trigger for an HIV test).</td>
<td>GPs reacted positively to training by an African trainer about how to ask questions on HIV. However, there was no exact data on whether African patients are now more likely to be referred for HIV testing.</td>
<td>Mostly evidence of staff reacting positively to the training they received.</td>
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<tr>
<td><strong>LGBT project</strong></td>
<td>Service providers may feel uncomfortable asking clients about their sexual orientation. They may also think that sexual orientation is a non-issue for their service: they may sense that a client is gay but may think that this has no implications for their practice.</td>
<td>Staff reacted positively to survey questions and LGBT training which included information on how LGBT relates to service provision and on how to ask people about their sexual orientation. Feedback from participants suggested that, as a result of training, reviews of young people’s equalities monitoring forms were undertaken by several organisations.</td>
<td>Survey of training participants revealed examples of actual changes in staff behaviour and service processes.</td>
</tr>
<tr>
<td><strong>ISPI (Mental Health Services)</strong></td>
<td>Starting position was very much that primary care mental health staff did not see a role for themselves outside the therapeutic intervention (focus on depression and anxiety). Staff were unhappy with the introduction of the domestic abuse question when the single shared assessment was introduced. Staff were also not asking clients about their employment status or sexual orientation.</td>
<td>Clients are now being asked about their employment status and about their sexual orientation in the South West PCMH (Primary Care Mental Health) team, whereas previously that was not the case. Staff commented very positively about the gender based violence training they received which included asking clients about domestic abuse. There was no evidence whether clients are being asked about domestic abuse issues. Staff from other PCMH teams showed a keen interest to get involved with ISPI.</td>
<td>Anecdotal evidence of actual changes in staff behaviour and service processes.</td>
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<td><strong>ISPI (Addiction Services)</strong></td>
<td>Addiction services staff can be flexible in terms of how much time they spend per client which allows for a fairly comprehensive needs assessment. Clients tend to be forthcoming with their life stories and staff working in addictions tend to be good at identifying issues. However, some issues are more difficult to surface because of the stigma attached to it (debt, prostitution, domestic abuse) and a degree of apathy: staff get confronted with poverty constantly so they become desensitised. Questions about debt, prostitution and domestic abuse may be included in the questionnaires but they risk being reduced to tick-box exercises. The challenge is to resurface these issues.</td>
<td>Community Addiction Teams (CATS) in Glasgow included a question on debt in their needs assessment. However, to what extent and how the issue was being raised during assessments was unclear. Employability is now included in the CATS baseline assessment process.</td>
<td>Evidence of service change (inclusion of question in needs assessment).</td>
</tr>
<tr>
<td>ISPI (Maternity Services)</td>
<td>One of the challenges for ISPI in the maternity setting is that midwives often lack the confidence to challenge their clients. For example, in case of a child protection issue, they will refer to social services but they will not challenge women. The ISPI maternity setting client survey revealed that only 48% of women <em>recalled</em> being asked about domestic violence, although this question has been on the needs assessment forms for eight years.</td>
<td>Maternity staff received training on gender and gender-based violence and other issues relating to inequalities. The training was evaluated positively, but there was no evidence about a change in the needs assessment. Strengthening of the quality and consistency of enquiry is underway.</td>
<td>Mostly evidence of staff reacting positively to the training they received.</td>
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<tr>
<td>ISPI (Children’s Services)</td>
<td>Parents and Children Together (PACT) teams worked with clients whose needs cut across social services and health – as such they were already aware that clients face a range of different issues. Staff may however not feel comfortable or see a role for themselves in talking to clients about unemployment, poverty or domestic abuse. The training needs survey carried out by the project suggested that staff thought that about 80% of their clients had domestic abuse issues but only about half of staff had received domestic abuse training. The survey also showed that 80% or more of staff felt very or quite confident responding to gender-based violence issues or poverty issues.</td>
<td>Children’s services staff now also record employment status, refer individuals to local support services and record these referrals. Staff received training on gender and gender-based violence and other issues relating to inequalities. The training was evaluated positively, but there was no evidence about a change in the needs assessment. There was however evidence of increased awareness of the links between poverty and gender-based violence and children’s services. Staff also valued having time to re-assess their roles. A DVD was produced with Children’s services staff which models sensitive enquiry into gender-based violence issues, this will be used for mainstream workforce development.</td>
<td>Evidence of service change (inclusion of question in needs assessment).</td>
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<tr>
<td>PATH (Mid Highland – Single Shared Assessment)</td>
<td>NHS and social services use the same assessment framework (the Single Shared Assessment or SSA). In theory all SSAs should be available on the electronic social services database ‘Carefirst’, but NHS staff and social services have different IT systems which has meant that healthcare staff complete SSAs on paper and forward them to social services for entering onto the Carefirst database. Moreover, NHS staff do not have access to Carefirst.</td>
<td>Notebooks were bought for NHS staff to enable them to do their SSAs electronically, but there was no evidence (yet) that the assessment itself has improved. SSA training was still being planned at the time of the final evaluation. The project was also planning to buy Carefirst licenses for relevant NHS staff so they can access and load up their SSAs directly onto the database.</td>
<td>Very little supporting evidence.</td>
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<td>PATH (East Lothian – People at risk of homelessness)</td>
<td>The Council’s Homelessness Prevention team of 3 team members were at their maximum caseload of 30 clients each. They depend on other services helping them identifying people at risk of homelessness. Health visitors have been fairly proactive in referring individuals to the Prevention team, but they had not previously received any referrals from CPNs.</td>
<td>In December 2008 CPNs were asked to apply a simple homelessness risk assessment tool (tick-box checklist) to all clients in their caseload. The project received 201 responses from CPNs and 31 clients were identified through the homelessness risk assessment tool as suitable for follow-up. These individuals would not have been identified otherwise. Of these, 2 consented to being contacted by the Homelessness Prevention team for support. At the time of the final evaluation fieldwork, the homelessness risk assessment tool had not yet been validated: in other words, it was not yet clear whether the tool indeed identified individuals at risk of homelessness. The project was planning to validate the tool by following up with the 31 identified clients in six months time to check their housing status.</td>
<td>Output data: number of CPNs willing to trial the homelessness risk assessment tool.</td>
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<tr>
<td>Tayside project</td>
<td>One of the starting points for the project was that substance misuse services did not routinely ask female clients about domestic abuse – as confirmed by the research undertaken by the project. Drugs services may have a lot of experience with ‘controlling’ partners of drugs users, but felt at a loss when domestic abuse, in particular physical violence, was disclosed and the clients did not want to follow-up on their suggestion to go to specialist domestic abuse support organisations.</td>
<td>Two (out of 50 drugs services) started routine screening; one of them already had a question in their assessment on risk, but it was easy to let it slip past so they changed the question. One of these services is the only open access service in Dundee, which means they have a huge potential client reach. Staff reported increased awareness about domestic abuse and increased confidence in raising the issue and knowing how to react. Overall 34 staff were trained; feedback forms scored the training very high in terms of usefulness for their work. There were four disclosures of domestic abuse in the women-only spaces trialled by the project.</td>
<td>Anecdotal evidence of actual changes in staff behaviour and service processes.</td>
</tr>
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</table>
What does this evidence suggest?

4.4 All five projects can point to positive verbal or written feedback about the training sessions that they organised. Evidence of actual changes in service provision and/or staff attitudes was limited, arguably at least partially because this type of evidence can be harder to collect as such changes require considerable time (i.e. longer than one/two years) to evidence. Most projects can, however, point to some evidence of service change, including for example the LGBT and Tayside projects and ISPI (mental health, addictions and children services settings): for these projects, there was anecdotal evidence that frontline staff were including revised or additional questions in their needs assessment or client monitoring.

4.5 Key characteristics of projects that offered the strongest evidence of service change include:

- Their training offer was embedded in a wider process of working with and alongside frontline staff. For example, in the case of ISPI and the Tayside project, this involved a series of formal and informal workshops, events and discussions with staff and managers; in the case of the LGBT project, participation of service providers in the project’s initial research phase raised interest and prepared the ground for the actual training sessions.

- In many cases, simply getting together with their colleagues provided staff with an opportunity to reflect on what they do – re-affirming what they do well and identifying what else could be done to improve services for clients, as one ISPI group member said: “You think your practice is good. But having the time to get together with others and talk about your practice and ISPI has helped me see how I could do things differently” [Community Additions Services Practice Report, p15].

- The training focused on the daily realities of service delivery and included sessions on how to ask clients sensitive questions, in the case of the Tayside project using role-play to act out different situations frontline staff may come across.

- The service redesign process included direct inputs from the target group to get the message across – either in an organised and structure format such as including an LGBT testimonial during a training session or ad hoc and informally: for example, in the ISPI mental health setting the phrasing of the sexual orientation monitoring questions was changed following patient feedback.

4.6 There is an impression that for projects where the evidence base is weaker, the training offer was not as closely embedded in a wider process of working with frontline staff, was not quite as operational or did not quite include a clear direct input from clients. For example, the African Health Project’s training sessions for GPs were essentially stand-alone sessions. Some of the ISPI training sessions on domestic abuse (outside the mental health setting) did not include an explicit discussion of how to ask the sensitive question of whether people are at risk of domestic abuse.
Lessons learnt

Clients do not mind being asked sensitive questions

4.7 MCN projects confirmed that clients do not mind being asked sensitive questions as long as the question is formulated in a respectful and non-judgmental manner. There is a risk of frontline staff getting too hung up about not saying the wrong thing or offending people – it is no so much about what you say or do but about they way of saying/doing this. The MCN examples in box 4.1 below demonstrates this point.

Box 4.1: Examples showing that clients do not object to sensitive questions

- The LGBT research with service providers suggested that concerns about upsetting clients by monitoring LGBT identity is not necessarily founded: a housing officer reported that she went ahead with an equal opportunities monitoring exercise despite concerns from colleagues and found that only a handful of respondents objected to the LGBT question.
- The ISPI Primary Care Mental Health team similarly introduced sexual orientation monitoring and found that patients only had difficulty with the terminology used: they did not mind being asked about their sexual orientation, but felt more familiar with ‘gay or straight’ than with ‘heterosexual or homosexual’.
- The ISPI maternity setting client survey suggested that women were positively disposed to midwives enquiring actively about their wider life circumstances. One woman commented: “I think it is important [to be actively asked about wider issues]. If they hadn’t asked me [about domestic abuse] then I might not have said anything”.

Two additional arguments can go quite far in developing staff’s confidence

4.8 Showing staff that clients do not mind being asked sensitive questions is an important first step. Two additional arguments can be quite effective in boosting staff’s confidence to ask sensitive questions, as follows:

- Staff may not realise they already have the skills and can transfer these skills: “difficult clients are difficult clients” – if you can ask individuals intimate questions such as where they inject their drugs, you have the skills needed to ask clients about domestic abuse issues.
- Staff are not expected to be experts: they only have to ask the question and then signpost clients to the right support. One project worked with ‘crib sheets’ to facilitate this process. These crib sheets are simple laminated A4-documents which on one side explain eligibility criteria for referral and on the other side the questions that need to be asked.

Staff can be encouraged to ask additional questions if they see their relevance

4.9 Services can be encouraged to ask additional questions if they see the point of asking the question: if they see the link with their own service and the relevance for the client: frontline staff feel they would need to be able to explain to clients why they are asking the question. The MCN examples in box 4.2 below illustrate this point.
**Box 4.2: Examples that demonstrating relevance is important**

- ISPI across all practice settings engaged frontline staff in workshops and meetings in discussions why, from a professional health service delivery perspective, questions on financial needs, employability and gender-based violence were important and good practice.

- In the mental health setting (ISPI), staff were carefully coached beforehand ensuring that that they were able to explain to patients why they were being asked about their sexual orientation or employment status.

- In the Tayside project, evidence about the incidence of substance abuse among women who were the victim of domestic abuse and information about links between substance misuse and domestic abuse were important – for example, pointing out that the abusive partner might also be the woman's main source of supply.

- ISPI staff feedback forms stressed that the evidence-based approach during the training session (for example data on the prevalence of domestic abuse) had been crucial in facilitating this transfer of learning.

- Feedback from LGBT training participants suggested that the training highlighted the relevance of LGBT issues in their own work. One participant commented: "It made me aware that I didn’t have to be embarrassed about the issues. Before I thought if a young person wanted to talk to me then they would and if they didn’t choose to tell me then okay – now we’re thinking, well maybe it should be on the forms and maybe we should be helping young people with this because it’s really difficult for them to talk about it".

**Winning hearts and minds**

4.10 Unsurprisingly, securing participation in training sessions can be challenging. The MCN projects also showed that training alone may not be sufficient to change behaviour. Moreover, the nature of the training is important: presenting staff with evidence about the relevance of the issue for their service matters, but this needs to be combined with practical information on how to raise a particular issue. Box 4.3 below uses a number of MCN examples to demonstrate this point.

**Box 4.3: Pitching the training at the right level and going beyond training**

- Tayside substance misuse services who confirmed that their staff had changed their attitudes and behaviour believed that this was because of a combination of the training they received and the women-only spaces piloted by the project. The training developed their understanding and confidence, but the women-only spaces made it real. Partners doubted whether the same, sustainable effect would have been achieved with training alone.

- Feedback forms show that ISPI training sessions on domestic abuse were evaluated very positively by participants. Several participants commented that they felt that the training was relevant for their day-to-day practice. A limited number of ISPI participants explicitly asked for (even) more practice-oriented training and on how to raise the issue of domestic abuse with service users.

- The importance of relating the training to day-to-day practice is confirmed in the Tayside project: participants commented that they had appreciated the training precisely because of its focus on practice and raising the issue of domestic abuse.

- The NHS Borders project provided training for GPs and other service providers on providing services for migrant workers and people with learning disabilities. To make them realise the need for communication support tools, a couple of interesting techniques were used. GPs were challenged to fold an origami figure with just the description of what needed to be done, without the pictures; they succeeded but with difficulty. This demonstrated how people with learning disabilities may well be able to follow a text without pictures, but only with much difficulty. Similarly, training participants were told to complete a form in a different language; support to complete to form was given by one of the instructors – in Portuguese. Training participants commented that this exercise made them better understand what it must be like to arrive in the UK without much (or any) knowledge of English.
**Providing the right organisational context**

4.11 Staff can be encouraged to ask additional questions, but they need to be given space and time to discuss and explore the importance of a more holistic needs assessment. MCN projects created opportunities for training and discussion; in the absence of MCN change managers, line managers and senior management will need to facilitate a similar process. This issue will be discussed in more detail in Chapter 6 (Mainstreaming).

**Chapter conclusion**

**Assessing the project rationale and outcomes**

4.12 Five of the 14 projects aimed to improve the needs assessment process. All five projects can point to positive feedback to the training sessions they organised to achieve this, but evidence of actual changes in staff attitudes or service change was scarcer. The evidence of service change is strongest for projects that:

- Embedded the training in a wider process of working with and alongside staff;
- Provided staff the time to discuss the issues with their peers which encouraged engagement in the issues and may have gone some way to overcoming concerns of (yet) another top-down edict on service standards;
- Made the training practical and included sessions on how to raise sensitive questions with clients; and,
- Included an input from the target group.

**Lessons learnt**

4.13 Merely including an issue in a checklist or questionnaire is not sufficient – it can be reduced to a mere tick-box exercise. The nature of the staff engagement and training is important: it is not enough to just tell staff to include an additional question; staff need to understand its relevance and they need to feel that they would be able to justify to the client why it is being asked. Peer time to discuss service practice may well have value in allowing staff to discuss what they do away from the pressure of delivery. This is different from case conferencing and should encourage staff to reflect on what they do.

4.14 Staff also need to feel confident and competent about asking sensitive questions. Useful arguments to boost their confidence are that they already possess the skills to ask difficult questions and that they do not need to become experts but simply need to refer and support clients onto appropriate services; evidence that clients do not mind being asked sensitive questions as long as it is done in a respectful and non-judgmental way, can also help.
CHAPTER FIVE  SERVICE GAP: IMPROVING PROVISION

Assessing the project rationale and outcomes

5.1 Seven of the fourteen MCN projects had a particular focus on improving the quality of service provision itself – as opposed to improving access to the service or assessing client needs. Box 5.1 below presents an overview for these seven projects, presenting findings on whether there was indeed an issue with the existing service provision and whether this issue has been solved. It is important to note that the table below does not evaluate the projects on their overall achievements; it rather uses a very fine lens to look at one question only: what if any evidence can each project offer that client outcomes or the service experience has improved? This evidence will then be used in the second part of this chapter (Lessons Learnt) to explore what ‘works’ in improving the quality of service provision.

Table 5.1: Was there an issue with service provision? Was this solved?

<table>
<thead>
<tr>
<th>Project</th>
<th>Baseline</th>
<th>Improved service provision?</th>
<th>Evidence</th>
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<tr>
<td>ISPI (Maternity services)</td>
<td>A survey of maternity services users identified a number of good practice elements – in particular community care services (the Women’s Reproductive Health Services centres in Greater Glasgow and the community midwives in Clyde) with higher staff/client ratios and seamless links with other services. There was also negative feedback, mainly from service provision in the post-natal wards which are busy and task-oriented. Examples included the absence of translation support for a BME woman; the perception from a female drug user that she was being treated differently because of her addiction; and a nurse just closing the curtain on a woman who was crying because she feared that her child would be taken into care the next day.</td>
<td>There was a better evidence base of what services should look like as a result of ISPI but there was no evidence (yet) that this has led to changes in staff behaviour or service provision. All ISPI practice areas recognised the need to collate data on service improvement to support the change process, especially with service managers but this presents substantial challenges in the health service with client confidentiality issues.</td>
<td>There was no evidence (yet) of changes in the service itself, in the clients’ service experience or client outcomes.</td>
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<td>NHS Borders (people with learning disabilities)</td>
<td>The starting point was that healthcare services are not sufficiently sensitive to the needs of people with learning disabilities. Feedback from people with learning disabilities (registered during the initial client consultation phase) indeed suggests that their service experience can be improved: staff may talk about the client to their carers rather than to the client or may not give them enough time to think about their response. There are an estimated 640 people with learning disabilities in the Borders.</td>
<td>About 180 easy-read hand-held health records have been distributed to people with learning disabilities. Feedback from carers has been mixed: some felt completing the health record had been empowering for the client; others objected to yet another example of form-filling. Anecdotal evidence from a limited number of GPs suggested that clients were not bringing the health record into the service with them. The GP toolkit received positive feedback from clients and their carers but did not appear to be used by GPs (yet). There was positive feedback (from GPs) on the training sessions on dealing with patients with learning difficulties, but there was no evidence whether or not this has led to changes in practice. Of 63 women with learning disabilities invited for breast screening with an easy-read letter, 39 showed up and 32 completed the screening. There was no data to benchmark these outcomes against. Client feedback about easy-read letters was positive.</td>
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<td>PATH (Edinburgh CHP)</td>
<td>Healthcare services approach ex-offenders largely from a clinically defined needs basis; however, prisoners’ and their families’ accounts of what affects their health largely ignore clinical issues and focus instead on social determinants of health. The particular healthcare needs of female prisoners are not sufficiently understood. For example, up to 90% of women in prison have been abused sexually or physically; up to 98% have substance abuse problems. Families of prisoners are an ‘invisible’ group in the NHS.</td>
<td>Partners reported a heightened awareness of the particular needs of female prisoners and their families and of the need to approach prisoner health from a more holistic perspective.</td>
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<td>Plan2Change</td>
<td>Plan2Change’s initial project rationale centred on the lack of provision for clients with serious mental health issues that were however not considered sufficiently serious to warrant a referral to secondary provision. However, difficulties to encourage GPs to engage with the project meant that different referral routes had to be found. The project actually got referrals from secondary provision (and CPNs). The project rationale became no longer one of service provision that is lacking but whether or not the Plan2Change peer support provision can lead to a better service experience or better client outcomes than existing provision. Plan2Change’s 4 peer support workers engaged with 44 clients and secured 11 employment outcomes (to date). Of the 23 clients who were no longer supported, 12 did not need other service support, 9 were signposted to other services and 2 did not wish to continue the service. There were no benchmarks available to assess these outcomes against. However, there was anecdotal evidence that the project achieved outcomes where previously there had been no progress: “Ever since I have started meeting [my Peer Support Worker] I have started going on a bus and before I never set foot outside of the house for two years, before I met [her]”; “I have been in mental health services for a long time and now I have started to look forward to achieving some of my goals”. Client feedback also suggested a positive client service experience.</td>
<td>Anecdotal evidence of improved client outcomes and a positive client experience.</td>
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<tr>
<td>Positively Sorted</td>
<td>A recent study revealed that young homeless people showed a significantly greater incidence of anxiety and depression than the general population. Progress to independence is often hampered by lack of confidence, self-esteem and hope; which may be maintained by an individual’s cognitive processes. This thinking may perpetuate pessimism, helplessness and general poor wellbeing. Pessimism in homeless clients (and those who support them) can impact on service provision in that services become full or ‘stuck’ or that individuals do not break out of the ‘revolving door’ of support services. A limited number of staff were trained in optimism skills, but it was unclear to what extent this has led to changes in staff behaviour or service provision due to delays in implementation.</td>
<td>There was no evidence (yet) of changes in the service itself, in the clients’ service experience or client outcomes.</td>
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<td>RooP</td>
<td>The starting point for the project was re-offending rates - 50% of prisoners return to custody within two years. The two principal factors influencing whether an ex-offender will return to custody are the effectiveness of their re-engagement with family and community and whether or not they gain employment. About 10,000 prisoners per year fall in the project eligibility criteria Scotland-wide (release from a sentence of up to four years). The average cost per prisoner place in 2006/07 was £30,989 (SPS, 2008). Early analysis suggested that re-offending is substantially less than the rates for control groups, but this was based on small numbers (RooP project evaluation, 2009). Fifty-eight per cent of the eligible group engaged with the project while in prison (just less than 3,000 prisoners) and between August 2006 and October 2008, 295 clients accessed training or employment – 20% of those with at least one community engagement secured a job outcome, compared to a Jobcentre Plus/SPS benchmark of 7%. It is unclear whether these two percentages can be directly compared. There was evidence on the effectiveness of the employment consultant role with employment outcomes increasing from 4.5 per month to 20/25 per month following the introduction of the employment consultants operating alongside the life coaches. Client feedback suggested a positive client experience.</td>
<td>Early evidence of improved client outcomes, but based on small numbers though benchmark figures were available. Anecdotal evidence suggested a positive client experience.</td>
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What does this evidence suggest?

5.2 Summarising the evidence base for this chapter is particularly difficult, given the range of service delivery challenges and approaches addressed in this chapter. Strong evidence of improved client outcomes and an improved client experience was only available for a limited number of projects, including for example RooP and Plan2Change. Both are peer support projects: project staff have lived through the same experiences as their client, a prison sentence and mental health problems respectively.

5.3 Other projects did not have a direct line of engagement with clients and thus cannot offer evidence of client outcomes. They were however able to offer evidence of changes in staff attitudes or of (planned) service change. Evidence of this type of change was stronger in some projects, including for example the LGBT project and the PATH (Edinburgh CHP) project. Key characteristics of projects offering stronger evidence was because they:

- Offered a series of workshops or training sessions that were embedded in a wider process of working with and alongside frontline staff and started from frontline staff’s needs, perspectives and priorities;
- Had a strong operational focus, suggesting and exploring highly specific, practical and sometimes fairly light-touch service changes (such as simply introducing fruit in the canteen of a prison’s visitor’s centre or putting up LGBT posters) and, in the case of the PATH project, actively sourcing funding when a suggested service change required additional monies;
- Had a clear focus on including a direct input from service users.

5.4 Most projects in this chapter share some of these characteristics but the impression for projects which the evidence of change was weaker is that they did not focus quite as much on frontline staff’s needs, perspectives and priorities, did not include as strong a focus on specific and practical change opportunities or did not introduce as strong a client voice/input. For example, the NHS Borders project (learning disabilities) worked closely with people with learning disabilities when developing easy-read materials, but did not initially invest as heavily in working with and alongside GPs and other frontline healthcare staff to explore the challenges of using the easy-read materials.

Lessons learnt

Peer support provision can significantly improve the clients’ service experience

5.5 Peer support provision was a feature of all but four of the MCN projects and there was evidence to suggest that peer support provision can significantly improve the clients’ service experience. Peer support can also result in better client outcomes, often in terms of increased client empowerment: through interaction with their peers, clients realised that they are not the only ones facing a particular predicament and break through the paralysing sense of isolation they may feel.
Where these peers have managed to overcome barriers, they can act as role models: clients recognised that they too can overcome barriers.

5.6 The beneficial impact of peer support operates through three distinct routes:

- One-to-one peer support to clients by peer support worker;
- Peer support by a group of other service users in similar situations; and,
- Interaction between the peer support worker and other staff, facilitating organisational change.

One-to-One peer support

5.7 Client stories seemed to suggest that one-to-one peer support is particularly powerful where the peer support worker shares similar lived experiences with the clients and faces or faced the same severe barriers the client is currently struggling with, such as mental health issues, a prison record, a disability. Peer support workers from the same ethnic background as the client also received positive client feedback, but the shared ethnicity did not appear to have the same empowering effect: clients were clear that the shared ethnicity facilitated the interaction because there were fewer language or cultural barriers, but positive client feedback in BME support projects more often tended to stress the personality of the support worker and the flexible and tailored support offered (starting from individual needs), rather than the shared ethnicity per se.

5.8 A blend of provision – peer support workers operating alongside non-peer support staff – may be needed as some clients do not want to get support from peer support workers: some prisoners for example chose for a complete break with their past and wished to have nothing to do with the prison or other ex-offenders. Some African clients were initially reluctant to accept a peer support worker from their own community because the African community is small and they feared their HIV status would soon be common knowledge. The MCN examples in box 5.1 below demonstrate the empowering impact of one-to-one peer support.

Box 5.1: Examples of the empowering impact of one-to-one peer support

- RooP life coaches reported how they could get through to some prisoners more easily because they could talk to them on the basis of a shared experience. Life coaches acted as role models to their clients being clear proof that rehabilitation and recovery are possible. One commented that: "[My Life Coach] is very easy to speak to and maybe that is about the fact that he has been there and done that and it is not that he has been violent or anything like that but it is just that he has been through things, you know. He understands more than most people, like say you asking me or that". Another said: "I think that him being an ex-offender is a big help as the stories that he tells you, compared to what he done what I did is like nothing, so keeps me away from the trouble."

- Client feedback from Plan2Change confirmed that the peer support element of the project helped clients overcome their sense of isolation and could offer them hope for the future:
  - "I really like how the peer support worker shares his life story, which gives me confidence that there is light at the end of the tunnel."
  - "She (the peer support worker) just said that this organisation was run by people like myself who struggle and that made me actually feel a little better because it meant I wasn't alone with how I am feeling and stuff."
  - "I think the main strength to me has been the similarities he has gone through in his life. He was further down the road of depression than I was and he has a
greater understanding of where I possibly was heading.”

- “Working with him is fine, it’s a pleasure. He is good to talk to and good for emotional support as well, he’s a good role model, a bit of an inspiration to folk I think as well.”

- Client feedback about the NDCS project’s BME support worker showed that some of the clients believed that having someone from a BME background was important because cultural similarities made it easier for the families to relate to her. Other positive feedback stressed the worker’s genuine willingness to try sorting out any issues they might raise – without referring to her ethnicity. NDCS staff commented about the empowering impacts of BME parents of deaf children meeting the (deaf) director of NDCS Scotland.

- Clients accessing the African Health Project service stated that it helped having staff who knew what it is like in Africa as they didn’t have to keep explaining things to them and it felt much safer.

**Peer support groups**

5.9 Peer support groups can provide a valuable place for capacity building and empowerment where clients are able to meet others in similar situations and share their experiences. The social element of groups is particularly important: the groups provide a ‘safe place’ to meet and learn how to cope with or improve their situation and overcome any barriers they may have. Clients credited the MCN peer support groups with reducing their sense of isolation and depression and strengthening their social capital, but also valued the group as a place to gain information about services for them. The MCN examples in box 5.2 below illustrate the empowering impact of peer support groups.

**Box 5.2: Examples of the empowering impact of peer support groups**

- Clients participating in the NDCS project referred to the empowering impact of meeting other parents in the same situation as themselves in coffee mornings: “A lot of parents are afraid and embarrassed of a deaf child, they don’t want people to know … It was like a barrier, now I look at the situation from another angle – I want to provide my daughter with the normal life she deserves”. The fact that the group included only those speaking English as their second language was also highlighted as important: “I value the coffee mornings and feel they should remain the way they are; open to BME families. I think we have the deafness in common, but also the fact that we all don’t have English as our first language and the cultural similarities. So we feel more comfortable and don’t feel silly to ask stupid questions and don’t feel awkward. I don’t mind mixing with other families at our NDCS outings, but the coffee mornings should be just for BME families.”

- Feedback from NDCS project partners was also positive; one partner suggested that there is a definite feel of empowerment among the target group, parents have started to speak out and are not afraid to demand their rights, such as their right for an interpreter.

- Client feedback from the African Health Project tended to stress the importance of getting to know other HIV-positive (African) people. One client commented that, before his engagement with the project, he thought that he was the only African man with HIV in Glasgow and that it had been heartening to meet others who are staying well.

- Clients participating in the Tayside project’s women-only spaces similarly spoke about the sessions reducing their sense of isolation and enabling them to make friends.

- Three male carers who participated in three separate ‘fish supper’ events organised by the Male Carers initiative, wrote to the project to convey how much they appreciated the opportunity to get out of the house, enjoy lively discussions and for a change have a meal cooked for them. Men, and in particular older carers, had expressed the need to discuss anything but their carer role.
Impact of peer support element on staff

5.10 Interaction between the peer support project worker and other staff can initiate and facilitate organisational change, bringing benefits and change to the host organisation and partner organisations, as the peer support worker raises awareness on cultural and other equality issues. Peer support workers can be specifically successful in bringing in a client perspective to the service and suggesting alternative and improved ways to client engagement and general interaction. The peer support worker can thus take on a role as champion, and not only change attitudes and behaviour of staff but influence the host organisation’s overall processes and procedures. Box 5.3 presents a number of MCN examples of how peer support can bring about organisational change.

Box 5.3: Examples of peer support and organisational change

- The direct interaction of RooP life coaches (former inmates) with SPS staff meant that SPS staff had to learn to see ex-offenders on an equal footing with themselves. Towards the end of 2008, ex-offender life coaches were routinely allowed access to prisoner residential areas to talk to offenders directly about RooP, unthinkable even twelve months earlier.

- An initial delay in sorting out a desk for the African support worker in the HIV clinic (in the African Health Project) meant that the support worker was based in the Waverley Care premises for the first few months – resulting in opportunities to learn about African culture for other Waverley Care staff.

- NDCS as an organisation became more aware of the BME issues and developed their policy accordingly – they introduced four new BME family officers across the country, so the provision for BME clients increased. The project also increased awareness of specialist mainstream services already available to their client groups: for example, prior to the project the Audiology department was not aware of the NHS free translation service.

- Newly recruited BME home carers (in Project Empower) were shadowing existing home carers resulting in two-way learning outcomes. The host organisation to Project Empower, West Glasgow CHP, forged links with BME voluntary sector organisations, and set up a BME Support Network for Disabilities and Carers. The network agencies came together to respond to the Glasgow City Council’s draft Carers Strategy.

Enable MCN clients to participate in service (re)design

5.11 The MCN initiative shows that there is value in undertaking client consultation exercises, as they can bring to light new insights and introduce the clients’ voice – which is often absent in service redesign processes: “the system is obsessed with vulnerable women, but no one has ever bothered listening to their voice”\textsuperscript{5}. Client consultations also enabled change champions to point to a clear evidence base for the need for service redesign. Nevertheless, encouraging organisations to act on (unexpected) findings of client surveys can be a challenge. Complementing client consultation exercises with a more direct and interactive dialogue between clients and (frontline) staff can be particularly powerful in raising awareness and encouraging change. This can take the form of informal discussion events or more formal training sessions, where representatives from the client group offer their testimony or even act as trainers. The MCN examples in box 5.4 below illustrate the importance of including individuals with multiple and complex needs in the service (re)design process.

\textsuperscript{5} Quote from Health Board staff in one of the MCN projects managed by the NHS.
Box 5.4: Examples demonstrating the importance of including MCN clients in service (re)design

- Project Empower conducted focus groups with Chinese and South Asian older people with a long-term illness. This led to new insights for example about the translated information provided by Health Scotland: the use of overly complicated text in some translated materials suggested that ‘plain English’ principles also need to be applied to translated texts; the focus groups also highlighted literacy problems among the client group (both English and their first language), suggesting that audio or visual materials might be a more appropriate method of communication.

- SCEES Palliative Care events helped practitioners to understand BME communities and how to deliver the service for them. The events as a model were effective and at least some service providers intend to use this approach in the future. Forth Valley ran a work group in a national event (Five Years On Scottish National showcase on race equality and health, 200 delegates) on their experience of the palliative care listening events and got several organisations approaching them for more detail as they wanted to do something similar (one local authority and a few health boards).

- The LGBT survey showed that LGBT young people tended to be generally quite happy with service provision; there was a gap between perception of services (individuals who did not use particular services perceived these as ‘not for them’) and the actual service experience which was quite positive: as long as staff were respectful and non-judgmental there was not much that LGBT individuals expected from services. The LGBT project followed the initial survey with more formal training sessions – which included direct testimonies from LGBT individuals. Participant feedback suggested that the inclusion of an LGB or T young person talking to the group directly and answering their questions would have made the issues seem more real and urgent: “it becomes a bit diluted, doesn’t it, when it’s someone representing young people’s voices rather than having the young people doing it themselves.”

- Similar comments were made by GPs participating in training delivered by the African Health Project and by the Borders project: GPs appreciated the fact that the training was delivered by an African individual and by individuals with learning disabilities respectively.

- The PATH focus groups with prisoners showed that healthcare tended to be fairly low on their list of priorities; not being able to find a job following their release was their main concern.

Chapter conclusion

Assessing the project rationale and outcomes

5.12 Seven of the 14 MCN projects had a particular focus on improving quality of the service provision itself – as opposed to improving access to the service or assessing client needs. Summarising the evidence base for these seven projects was particularly difficult given the range of issues involved and approaches used. The two direct client service delivery projects can both point to evidence of improved client outcomes and client service experiences. What these two projects had in common was peer support. The service redesign projects that can point to the strongest evidence of service change had the following in common, they:

- embedded their training and workshops in a wider process of working alongside and with frontline staff;
- had a strong operational focus, suggesting and exploring highly specific and practical service changes; and,
- had a clear focus on introducing the voice of the client.
Lessons learnt

5.13 Peer support provision can significantly improve the clients’ service experience and can also result in better client outcomes, in particular increased client empowerment. This happens both when clients receive one-to-one support from a peer support worker or in the context of peer support groups. One-to-one peer support is particularly powerful when the peer support worker shares similar lived experiences with the clients, such as mental health issues, a prison record or a disability. Where the peer support workers have managed to overcome barriers, they can act as role models. The presence of peer support workers can initiate and facilitate organisational change: the direct interaction between peer support workers and other staff offers useful indirect and informal learning opportunities for staff.

5.14 There is value in consulting clients as these exercises may result in new and sometimes unexpected insights. Change managers can use the consultation evidence to support and strengthen their case. However, consultations alone may not be sufficient in changing (frontline) staff awareness. Direct interaction between clients and staff, through informal discussion events or more formal training sessions with individuals from the client group acting as trainers or witnesses, can be more powerful.
CHAPTER SIX  MAINSTREAMING

Assessing the project rationale and outcomes

6.1 The principal objective of the MCN Programme was to explore different approaches to improving mainstream service provision for individuals with multiple and complex needs and most of the MCN projects indeed impacted on mainstream service delivery. The previous chapters have already presented a number of examples of changes in service delivery. A number of additional examples can be found below in box 6.1.

Box 6.1: Examples of impacts on organisational culture or practice

- As a result of an internal learning curve about BME needs, NDCS began offering non-residential support weekends – since the residential aspect was considered a barrier for some BME clients. NDCS project partners have learnt to appreciate that there can be differences in the quality of interpretation and translation and are slowly building a pool of reliable interpreters. As a result of interaction between the BME support worker and the Audiology Department, Audiology now also offers regular hearing tests to children who do not wear a hearing aid (recognising BME parents’ concerns that their daughter may not be able to get married if she wears the aid). After the experience of the BME project, the Sensory Support team now hopes to adopt a similar approach to supporting visually impaired individuals, to provide an equivalent service, and at the time of reporting, were in talks with Visibility Scotland.

- As a result of LGBT Youth Scotland’s interaction with a BME Youth Service (as part of the LGBT research with service providers) LGBT Youth Scotland began exploring an additional research project looking at stigma and barriers for BME LGBT young people – this is not an example of an impact of LGBT Youth Scotland’s advocacy work on other providers but demonstrates that learning and impacts are a two-way process.

- Frontline staff from HIV clinics reported a steep learning curve on African-sensitive provision as a result of the direct interaction with Waverley Care’s African outreach worker and support staff.

- The Dundee project presented a number of significant changes to service delivery as a direct result of its advocacy work including the introduction of a question on domestic abuse in the needs assessment forms of a number of substance misuse support services. The project also increased confidence among substance misuse support workers to raise the issue of domestic abuse with their clients. Changes on domestic abuse support services were reported to be less pronounced.

- The Scottish Prison Service now allows former inmates back into prison as professional support workers on an equal footing with prison staff. This has been a challenge for SPS staff but has achieved a level of real change in terms of how SPS staff regard ex-offenders. Senior management support for the project was crucial in this respect.

- As a result of their involvement with Project Empower, staff in the Social Services Department of Glasgow City Council were reported to be more aware of BME issues – the Department is now also undertaking more comprehensive monitoring of language, ethnicity and religion. Dial-a-Bus materials have been translated into minority languages. As a result of the involvement in Project Empower, Health Scotland included additional checks to improve the quality of their translation material.

- As a result of information received in Palliative Care events, hospices learned that GPs do not necessarily inform patients about services available in hospices - it was found better to channel information through primary care nurses. After the experience of SCEES Palliative Listening event with Chinese clients, Forth Valley Palliative Support team planned to organise a similar event with South Asian clients.

- ISPI has been successful in achieving commitment from the Board’s Directors group to take forward an outcomes focussed approach to developing ISP. This will involve utilising new health improvement or service delivery monies for the purposes of workforce and organisational development.
**Lessons from MCN approaches**

**Sufficient face-to-face time**

6.2 What successful MCN change management approaches had in common was that they followed slow and time-intensive staff engagement processes with little opportunity for short cuts. In most instances, these approaches involved direct interaction between frontline staff and the client group or frontline staff from different organisations.

6.3 Evidence from projects covering large geographical areas suggested that significant progress was only achieved where enough face-to-face time was put in. This was, for example, the case in the Tayside project where changes to substance misuse support service provision initially were most pronounced in the Dundee area. The same was true in the context of the Male Carers project. Likewise, progress appeared more pronounced where frontline staff teams were smaller (allowing direct interaction with all staff): NDCS reported more progress in getting a more BME-sensitive Audiology support service in Edinburgh and Waverly Care reported a better relationship with the HIV clinics in Glasgow for this reason.

6.4 That being said, at one level, creating a sense of urgency may be necessary. Change management takes time, but time pressure (such as the approaching end of the MCN funding) may well be necessary in certain circumstances to encourage partners to take action.

**Need for a change manager and senior management support**

6.5 MCN evidence confirms the need for funding for change facilitation processes and roles. Substance misuse agencies were adamant that they would not have taken up the domestic abuse cause without the constant chasing, telephone calls and meetings with the project staff. NHS Borders partners mentioned that one of the lessons coming out of the project was the need for a change management lead – they were currently looking at work on carers and had included a budget for a project manager which they would not have done without the experience of the MCN project – “you need a [name of project manager]”. Elsewhere partners asked: “How do we clone [name of project manager]?”

6.6 Where the change management role came on top of existing responsibilities, as was the case in Mid-Highland CHP, progress was slower. Appointing existing staff into a change management role only seemed to work when cover was provided to backfill the post. That being said, effective change managers were aware that one of their responsibilities was to develop a clear exit strategy and make their support role redundant. For example, one change manager pretended towards the later stages of a project that she could not stay for the whole meeting of the group she had set-up. This was a white lie, intended to prepare the group for managing without her after the end of the project.

6.7 What is striking was that many of the MCN project managers working on affecting change had very loose job descriptions and flexibility as to how to go about
their jobs – developing relationships, building networks and slowly planting seeds. Recruiting the right person for the job (with a strong focus on people and networking skills) appeared to be more important than getting the job description right.

6.8 At the same time, even proactive change managers used to operating independently and on their own initiative, need line management support. Some of the most enthusiastic MCN change managers sounded fairly disillusioned during the final round of fieldwork, commenting that the change management job could be lonely or they were starting to lose their patience with partners not willing to engage. This was less likely to happen where the change management role was embedded in a team structure or with clear line management support.

6.9 Different MCN project managers were operating under different line management structures: many were employed by a voluntary sector organisation and were attempting to change staff attitudes and behaviours in statutory services from the outside; others were trying to change processes from within.

6.10 Change managers stressed the advantage of direct (line management) links with the organisations they were trying to influence, but also saw benefits in operating (and being seen to operate) relatively independently: one change manager with a long NHS employment record commented that she had continued to think outside the NHS organisational box throughout her career. This combination of being inside the service, and simultaneously observing it from the outside, was seen as beneficial. Box 6.2 below discusses the management structures in a number of MCN projects.

**Box 6.2: Importance of organisational links of the change manager**

- The Tayside project manager combined the best of both worlds: she was employed by the Council but reported to the Tayside MCN Management Group (partnership). This meant she straddled the border of statutory and voluntary services.
- The project manager for Project Empower was line managed by the Health Improvement and Inequalities Manager within the Glasgow West CHP, although the project was set up by the National Resource Centre for Ethnic Minority Health.
- The location of the ISPI team within a corporate function gave the initiative corporate leadership and facilitated the opportunity for sharing learning across the organisation.

6.11 It is important to have a champion to further the change agenda. This is a different role to that of the project manager – the champion is someone within the organisation who is willing to support the suggested changes, for example, by spreading information, allowing staff time to attend sessions or encouraging staff to take part in training. For example, in the context of the PATH Project, the support of the head of the Edinburgh CHP for the MCN project was quoted as crucial.

**Alignment with organisational priorities**

6.12 MCN learning seems to confirm the crucial importance of timing and alignment with organisational priorities: introducing change appeared to work much better if the organisation had already identified that there was an issue and/or was trying to address the issue. The MCN examples in box 6.3 below illustrate this point.
Box 6.3: Importance of alignment with organisational priorities

- The NHS will be taking over healthcare in prisons (currently managed by the SPS) in two years time so is thinking ahead about what is needed. This meant that the PATH Project’s Prison Leavers project (Edinburgh CHP) tended to receive a positive reception. In the two other participating CHP areas no issue leapt out in the same way and as a result progress was slower.

- The Greater Glasgow Health Board launched ISPI just a few months after setting up a Corporate Inequalities Team. In the maternity setting, the change management lead built on the system’s clear focus on vulnerable women to launch the change process.

- The Greater Glasgow Health Board realised that HIV infection rates among Africans were increasing and was in the process of developing a strategy to address this issue. The Waverley Care project came exactly at the right time – partners were initially mainly interested in the outreach work (trying to get Africans to come forward for testing). Over time they came to appreciate the role of the advocacy support work.

- A recent audit by the Welfare Commission told NHS Borders that primary care and learning difficulties units were not working together closely enough. This acted as an additional trigger for the MCN work on improving communication between GP surgeries and patients with learning difficulties. Similarly, NHS Borders (and the local authority) had previously identified barriers to accessing healthcare for a number of ‘mobile’ groups (homeless people, migrant workers, early entrants and gypsy/travellers). Partners commented that MCN funding allowed them to put-in some resources to addressing issues they had previously identified.

- NHS Grampian received funding to assist with the implementation of the Carers Information Strategy which allowed them to create a Carer Awareness Post. This facilitated the process of building relationships for the Male Carers project; they were able to input in the strategy design process. Similarly, the project developed very close links with Aberdeenshire Council who have a Carers Strategy and Action Plan. Links were less well developed with Aberdeen City Council who were considering cuts in support for carers because of budgetary difficulties.

- The LGBT Youth Scotland training sessions on LGBT for service providers proved very popular and service providers were quite interested in advice and support on dealing with LGBT, partially because they were anticipating the introduction of the Single Equality Bill6.

- The Tayside project noted increased interest in the domestic abuse agenda among substance misuse services following the announcement that routine screening of domestic abuse issues would become standard policy.

- NDCS started its BME outreach project from a realisation that NDCS was only reaching white middle class individuals. This meant that the project was fully embedded in the organisation and towards the final phase of the project, the organisation started exploring how to incorporate the BME support within the overall NDCS support offer. Similarly, project partners commented that they had previously been aware of the need for a BME perspective in their work with families of deaf children but that resource issues had meant they had never been able to take this forward.

- Access to Work, a provider of employment support services, was reported to have tried for years for a way into the NHS to encourage referrals from healthcare providers. Only when ISPI introduced training around employability and the links between health and employment (introduced employability as an organisational priority from within) could progress be made.

- SCEES Palliative Care Listening events attracted wide professional interest due to parallel development of the National Strategy for Palliative Care and newly emerging Managed Clinical Networks.

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6 The Single Equality Bill is being introduced to simplify the current equality legal framework, offering a single piece of legislation to replace the Sex Discrimination Act (1975), Race Relations Act (1976), Disability Discrimination Act (1995) and other legislation covering discrimination on grounds of religion or belief, sexual orientation and age. The Bill was published by the Government in April 2009 following its first reading in the House of Commons.
Working alongside staff, starting from their perspectives and needs

6.13 Reactions of frontline staff to change can vary. The overall impression from the research is that staff will respond positively to offers of help when people are working alongside them and build on what they are already doing well – rather than criticising them. MCN project staff commented that organisations or frontline staff tended to realise that they are failing their clients and that they need all the extra support they can get – given caseloads and time pressures. It all depends on how this offer of support is presented to staff.

6.14 In the context of ISPI, the first session of training around poverty awareness proved less successful: stakeholders felt that one reason for this was that the training provider took a confrontational approach starting from what was currently missing in statutory provision. The approach was subsequently changed. ISPI training was felt to be effective when staff were offered a safe environment to discuss their own attitudes and value systems – staff would challenge each other on statements such as ‘some people you are never going to get into employment’, leading to shifts in attitudes and views. Similarly, it was considered important not to present ‘caricatures’ of behaviour as frontline staff were highly unlikely to recognise their own behaviour in these caricatures; subtlety is what is needed. In many large service providers, there is a need to balance the traditional top-down nature of service re-organisation and re-design with a bottom-up process seeking the views and reflections of frontline staff.

6.15 In this context, some believed that it was more effective to de-emphasise the change process – identifying the different small steps needed to achieve a final objective and trying to introduce these small changes almost unnoticeably. In one ISPI setting, the lead officer was told by a line manager that her team would collaborate as long as they would not have to make any service change; the ISPI lead proceeded on these terms and succeeded in making a number of important service changes (such as introducing data collection around sexual orientation and employment status) which were however not labelled as such. Making sure that the process is fun for staff also helped – one project pointed out that they made sure always to serve a warm lunch before meetings. This relates back to a need for a slow and time-intensive staff engagement process working alongside staff, rather than imposing change on staff.

6.16 There were examples of frontline staff responding rather defensively to the client advocate role of MCN staff – for example, community nurses offering support in homeless shelters did not understand why the NHS homeless outreach worker came to these shelters; healthcare staff in prisons initially did not necessarily see any need for a liaison officer helping the transition between healthcare in prison and following release. Overcoming these attitudes was not however considered to be a major obstacle – people skills and one-to-one contact (co-location or in one case just sharing mobile phone numbers to ensure a direct line of contact) cleared up most of the confusion.

6.17 Engaging GPs in the change agenda is different to engaging other frontline service providers (i) because GPs are independent contractors as opposed to NHS employees and (ii) because of the nature of the contact between patient and GP, in
particular the short contact time. Several MCN projects attempted to engage GPs in the change agenda, for example encouraging GPs to refer patients on for support, to attend training, adjust their communication style, transfer medical notes to another GP or accept former prisoners on the registry. This often proved challenging but a number of projects designed innovative engagement strategies and a couple could count on a GP ‘champion’. Box 6.4 below discusses the different approaches used by MCN projects to engage with GP surgeries.

**Box 6.4: Engagement with GP surgeries**

- The Plan2Change project undertook direct outreach to GP surgeries to explain the peer support (mental health recovery planning) available and encourage onward referrals. These attempts had mixed success – the very short appointment times meant that some GPs were willing only to present a brochure of the new service rather than discuss it or actively recommend it. However, over time, as GPs started to become more familiar with the Plan2Change support offer, they started referring clients.

- NHS Borders involved two GPs in the development of a toolkit for patients with learning difficulties – the GPs were however only involved in the design of the actual toolkit; there was no discussion on how use in GP surgeries could be encouraged. When GPs appeared fairly reluctant to use the support tool, the project tried introducing the tool indirectly, handing it out to carers of individuals with learning disabilities. The idea was that carers would take it to the GP and ask them to use it.

- The Male Carers initiative conceived a strategy of trying to identify GPs who have caring responsibilities themselves, but had not yet been able to test this strategy at the time of the final evaluation fieldwork. The project felt that GPs with caring responsibilities might be a possible route in.

- The NHS Homelessness outreach worker attempted direct outreach to GPs to facilitate the transfer of medical notes for a homeless woman – the normal route which involves GPs transferring notes to a central service first which then forwards the notes to the new GP is time-consuming. The outreach worker was trying to speed up the process to allow the woman’s new GP to assess her mental health status as this would allow the Council to put her in a higher priority group for housing. The Council is under a statutory obligation to process the housing file within 28 days – without the GP statement it is not possible to change the priority status and the GP could not pronounce on her mental health without the medical notes. No progress was made in this respect. It was felt that Government guidance allowing direct transfer of notes would be necessary given data protection issues.

- NHS Borders experimented with compulsory training for GPs on communication with learning difficulties. Compulsory training could be introduced through the Learning Difficulties Enhanced Services option – all GP surgeries in Borders opted in for this Enhanced Service and are expected, in return for additional payment, to comply with a number of activities aimed at improving provision for patients with learning difficulties. The training experience was quite difficult with negative attitudes from (some) GPs who did not see any need for the training and commented that they had never experienced any challenging behaviour which they would not have been able to deal with. However, the feedback forms were remarkably positive – GPs were particularly positive about the fact that the training was done by individuals with learning difficulties themselves.

- Greater Glasgow Health Board offered non-compulsory training for GPs on raising HIV testing with African patients – encouraging attendance by referring to the Government’s focus on an enhanced role for GPs in HIV testing. Feedback about the training was positive. About 15 GPs showed up (out of a total of 600 GPs in the Greater Glasgow area).

- Project Empower contacted a GP after one South Asian client came to see the project and told them that her GP, although also South Asian, only spoke to her in English, telling her that she had to practice the language. The surgery’s response to project Empower was that the patient spoke English fine. The client herself however insisted that her English language skills might be fine at the social level but that she still preferred to discuss health matters in her native language (Urdu). In other words, there was a reluctance to see that client needs should be set by the client herself, not by others. It is unclear whether the patient was ultimately addressed in Urdu or not.
Strategic and senior management support the change agenda

6.18 There are a number of ways in which the almost organic bottom-up process of staff engagement can be supported at a strategic level. MCN evidence seems to confirm the need to use levers at all levels in the organisation. Projects which focused their efforts mainly at a more strategic level noted that commitments at strategic level do not necessarily result in changes at frontline delivery level; on the other hand projects which engaged mainly with frontline staff achieved positive results on the ground but struggled to reach out beyond the enthusiastic individuals who came forward because they were keen to make a difference as expressed by a project staff member:

“You are either preaching to the converted or banging your head against a brick wall” (MCN project staff).

6.19 Other than trying to align the change offer with existing organisational priorities, MCN project staff pointed to a number of arguments used in trying to get senior level staff involved, as follows:

- Referring to the organisation’s obligation under the legislative framework (for example equal opportunities) and offering support to help the organisation fulfil their obligations – “I simply had to be persistent and challenge agencies by their obligation to the equality and diversity agenda” (MCN project manager).

- Similar to the previous point, referring to possible risks to the organisation – for example the severity of mental health issues for some LGBT individuals and the risk of suicides, late HIV testing among Africans leading to deaths which might have been avoided. Referring to GPs’ reluctance to change, one MCN partner felt that a ‘fatal incident inquiry’ (following the death of a patient with learning difficulties) would be the only thing that would change GPs’ attitudes.

- Taking as the starting point that organisations want to offer a good service to their clients – who are my clients and what does this mean for access to and experience of my service?

6.20 Once senior management is on board, there are a number of additional strategic support tools to further the change process. In most cases, MCN stakeholders commented on the need for using these support tools; in a couple of instances, MCN projects actively experimented in this field. For example:

- Staff recruitment/induction – staff attitudes and behaviour were almost inevitably mentioned as key to the quality of (MCN) clients’ service experience. In a number of cases, in particular in a voluntary sector context, MCN project managers commented on having invested heavily in the MCN staff recruitment process not only looking at qualifications and past experience but also assessing attitudes and personality and in a number of instances explicitly targeting individuals from a particular ethnic background.
• **Supportive line management structures** – stakeholders commented that recruiting the right staff is not enough: many individuals decide to apply for a position because they have the right attitudes and personality: they care about other people and want to help them. The task for management is not to undermine these attitudes and the soft skills staff initially bring to the job – talking all the time about service redesign can easily be interpreted as an indication that staff are not doing their job properly. It would be better to compliment frontline staff on the excellent work they are doing and recognise the structural constraints (in particular time pressure on frontline staff) that prevent progress.

• **Use peer group time to support staff development** – simply having some time to reflect on service practice with colleagues should be considered as one route to encouraging service improvement.

• **Systems of appraisal and accountability** – MCN stakeholders raised the fact that appraisal procedures may need to be revised to encourage changes.

• **Risk management** (including support/training on risk management for frontline staff) – a willingness at strategic level to take risks was identified as a prerequisite for organisational change. However, stakeholders felt that risk management support for frontline staff was perhaps even more important. For example, addictions services were reported not to be good at discharging clients – discharges tend to happen by default (individuals just stop showing up) rather than in a well-organised, planned manner. This is partially because frontline staff were worried about the risk of discharging an individual – whenever there is an incident involving a drug addict, people’s first question is always whether or not this individual was being supported by addiction services.

• **Monitoring, analysis and evaluation** – MCN stakeholders reported massive amounts of data being collected but not necessarily much being done with this data. For example, data shows clearly the differential in access to addiction services between men and women (3 to 1 ratio) but this is not acted upon. In other situations, data is not being collected and performance management is not aligned with measuring progress in supporting MCN clients.

**Chapter conclusion**

6.21 An important principal objective of the MCN Programme was to explore different approaches to improving mainstream service provision for individuals with multiple and complex needs. Most of the MCN projects impacted on mainstream service delivery.

6.22 Influencing staff appeared to work significantly better when there was:
• Sufficient face-to-face time between staff and the change manager: this often meant a slow and time-intensive staff engagement process – at one point creating a sense of urgency may become necessary. The process also tended to benefit from direct interaction between frontline staff and the client group or between frontline staff from different organisations.

• A dedicated staff resource to support the learning process: many of the MCN change managers had loose job descriptions and were able to operate independently. Even so, supportive line management structures are necessary: change management is a long and challenging process with inevitable set-backs and even the most enthusiastic change manager risks becoming disillusioned without collegial or line management support. There are advantages to direct (line management) links with the organisations change managers are trying to influence. At the same time, change managers benefit from operating and being seen to operate relatively independently.

• Direct alignment with organisational priorities: introducing change works better if the organisation has already identified that there is an issue and/or is already trying to address the issue.

• A champion for the change within the organisation: this is a different role to the change manager role. MCN evidence suggests the need to use levers at all levels in the organisation and investing in engagement with frontline staff, line managers and the strategic level. Getting senior staff involved can be facilitated by aligning the change offer with existing organisational priorities or by offering support to help the organisation fulfil any existing (legal) obligations or minimise risk. Once senior management was on board, additional strategic support tools to further the change process included for example, the staff recruitment and induction process and monitoring, analysis and evaluation.

• A positive staff engagement process, working alongside staff and offering them support rather than criticising them for failing the target group and creating some space for staff to discuss these issues together away. Frontline staff often realised that they were failing their clients and were happy to get extra support – it all depended on how this offer of support was presented to staff. In some cases it may be more effective to de-emphasise the change process.
CHAPTER SEVEN CONCLUSIONS

Summary findings

Introduction

7.1 The Scottish Government’s MCN initiative set out to explore different approaches to improving service provision for individuals with multiple and complex needs – the overall aim of the programme evaluation was to draw lessons around what does and does not work in improving service access, the service experience and outcomes for clients with multiple and complex needs.

7.2 The process of selecting the 14 MCN demonstration projects led to significant diversity in target groups, size, rationale and project set-up across the 14 MCN projects. This has presented a particular challenge to the programme evaluation and the nature of evidence available to the evaluation team. Only half of the MCN projects had an element of direct client engagement; the others were change management or service redesign projects which focused their attention on staff – the latter group could not provide evidence of changes in client outcomes; they could however point to changes in staff awareness or behaviour.

7.3 Much MCN learning provides further evidence and case study examples confirming principles of service improvement familiar from elsewhere. This includes for example the importance of proactive outreach to engage harder to reach clients, partnership working and a flexible, client-centred approach. None of this is new – these insights and principles have been championed for some time now. However, practical application of these principles has often proved elusive. The added value of the MCN programme is that it has enabled stakeholders to explore in more detail the challenges to implementation, as well as a number of possible practical solutions to these challenges.

What provokes MCN as an issue within services?

7.4 The 14 MCN projects tended to focus on well-defined and fairly specific service gaps, as follows:

- No or limited provision targeting a particular need or client group;
- No or low take-up of the available service;
- Clients were accessing the service but some needs remained unidentified; or,
- More needed to be done to drive at the root causes of MCN by making service provision better attuned to clients’ particular concerns or needs.

7.5 Evidence on the nature and extent of the service gap varied. In some cases projects had a clear understanding of the service gap and the cause(s) for the gap, based on existing evidence or their organisation’s past experience. In other instances, projects started from an assumed service gap or assumed cause(s) of this service gap and tested the validity of their assumptions through the MCN pilot project. By and large, the service gaps MCN projects first identified proved to be correct, even when initially based on anecdotal feedback or perceptions rather than
hard evidence. Some projects changed their focus but this was not because of a fundamental shift in their understanding of the service gap.

7.6 The majority of projects were ‘external’ to the service that they were seeking to change and in most cases, had some association to the MCN group they were seeking to support. An involvement with the MCN client group in question provided many organisations with the evidence for (i) the extent of the issue and (ii) how best to respond to address this issue.

7.7 Pilot projects which were ‘internal’ to the service provider were a minority of MCN projects. In these settings, MCN was provoked through a combination of policy drivers and the presence of a champion: services (at frontline or management level) often knew that there was a problem with delivery; change was first triggered when a champion was prepared to act on this knowledge.

Getting in – engaging with clients

7.8 The key findings from MCN projects on engaging MCN clients are very familiar: no one size fits all and the nature of outreach activities must necessarily be different for different target groups and in different service settings. Many MCN clients were in contact with some (other) service providers. However, potential inward referrals from other providers only came about if:

- These other providers felt comfortable raising additional issues with their clients – for example, housing staff feeling comfortable raising mental health issues or employability with their clients; and,
- They understood and trusted other providers’ service offer sufficiently to recommend it to their clients.

7.9 Moreover, relying on referrals or recommendations from other service providers did not work if there was any (perceived) stigma attached to accessing the service or if the service was perceived as ‘not for us’. More proactive outreach methods are then required. MCN projects did this through proactive outreach to the target community, for example operating from another provider’s premises (a prison, a HIV clinic).

7.10 The above has direct implications for human resource policy: MCN staff were given the space and time to (i) build their knowledge and awareness of wider MCN needs, (ii) establish direct relationships with contacts in other organisations and (iii) where relevant, engage in advocacy or community outreach.

7.11 Although the outreach element (to other providers and the target group) was important, engagement was not wholly external to the service setting. Services also had to accept a degree of change and stretch out to reach MCN clients. MCN projects did this through:

- Reflective delivery with an active policy of recruiting staff from backgrounds similar to the spectrum of clients;
• Dedicated support for the client group introduced through changes in staff induction and Continual Professional Development training or for example through women-only or BME-only provision; and,
• Client advocacy roles within the service. This role tended to be additional to existing provision, but caseloads could be high and the provision was not necessarily full-time: clients dipped in and out of support.

7.12 The key characteristics of MCN projects where the evidence of improved access was stronger are that they:

• Had a clear focus on a well-evidenced and highly specific access challenge;
• Offered provision that addressed a service need that was seen as a priority for the target group; and,
• Undertook proactive outreach into the target community, providing continued support to the individual client until the point of access.

7.13 The MCN research findings present service managers who are interested in improving their service’s client engagement pathway with a checklist (see figure 7.1):

• Do services actually know who they are reaching and not reaching? Are their monitoring systems and needs assessments sufficiently robust and comprehensive to assess the reach of their provision? Are data available about the presence of the target group(s) in the geographical area of the service provision to assess the extent of any gaps?

• Does the service know why some groups are not accessing the service? Have services asked target groups why they are not coming forward?

• Which factors should guide service managers in the prioritisation process? This prioritisation process is important if funds and/or resources are to be found to support the process of improving the client engagement pathway. Do we have enough evidence to convince service managers that service improvements are worthwhile – when set against other service targets, other client groups and other objectives?
Figure 7.1 – Checklist for service managers: client engagement

Who are we not reaching?
EVIDENCE BASE? (monitoring data, needs assessment)

Is this a problem (for our service)?
Should it be a priority for our service?

What are possible access barriers?
EVIDENCE BASE? (research/dialogue with client group)

What can we do to remove barriers?

Getting in – identifying needs

7.14 Improving needs assessment by pursuing difficult issues with clients was a challenge. This took time and often involved additional resources to implement, capture the evidence and keep the signposting knowledge base up-to-date. Staff needed support and encouragement to feel confident in asking questions outwith their existing service role. A number of MCN projects established that sensitive questions troubled providers more than clients – in an appropriate context, clients typically felt that services enquiring across a broader range of issues were more supportive of their circumstances. MCN projects confirmed that staff can be supported to take a more holistic perspective to their needs assessments, but merely including a new issue in the checklist or questionnaire was not sufficient: staff needed to see the relevance and feel confident about asking sensitive questions.

7.15 Those projects which were more successful in introducing changes in their client engagement and needs assessment process, were those that:

- Embedded their awareness-raising sessions and training in a wider process of working with and alongside staff;
- Provided staff the time to discuss the issues with their peers – this encouraged engagement in the issues and may have gone some way to overcoming concerns of (yet) another top-down edict on service standards;
- Made the training practical and included sessions on how to raise sensitive questions with clients; and,
- Included an input from the client target group in the training or wider process.
Getting through and getting on – supporting and empowering clients

7.16 MCN examples throughout the evaluation report have shown how much can be achieved through fairly small steps, by simply enabling staff to step back from their day-to-day practice and by thinking outside the box. However, the experience of some MCN projects – such as RooP – suggested that in some cases there was a need for substantial service enhancement as opposed to light touches and small steps. Figure 7.2 presents the two pathways that are available to service managers who are interested in making their provision more sensitive to the needs of MCN clients:

- Are there any light-touch improvements services can make?
- Are there instances where light-touch improvements alone are not sufficient and the introduction of specialist provision, advocacy support or peer support would be beneficial?

Figure 7.2 – Checklist for service managers: adjusting provision

7.17 The MCN programme shows that undertaking client consultation exercises can significantly facilitate this process for service managers: clients can bring to light new insights and introduce the clients’ voice – which is often absent in service redesign processes and is very powerful in overcoming any resistance to the need for service change. This can be useful both in identifying and implementing examples of light-touch changes to the service provision and in wider service redesign.

7.18 A key challenge is knowing when to make light-touch improvements to existing provision and when to opt for the introduction of specialist provision. The MCN initiative provides some guidance in this respect. The MCN pilots seem to suggest that relatively light-touch improvements to existing provision are most effective where communication barriers or culturally determined patterns of behaviour or human interaction are at stake. This does include for example, offering translation support to people whose first language is not English and, using the term
‘partner’ instead of ‘girlfriend’ to accommodate people with different sexual orientations or, talking to the person with the learning disability rather than to his or her carer. Staff awareness raising sessions, in particular when delivered by people from the target group, appeared to be especially effective for these types of service adjustments.

7.19 There are arguments for introducing specialist support provision if:

- There is a clear gap in provision – for example, the RCA Trust project offered a service (alcohol counselling in BSL) that was not available previously.

- A pilot project shows that introducing specialist provision achieves more or better client outcomes than existing provision – for example, there were some early indications that the peer support provision offered by RooP and Plan2Change may lead to better client outcomes. More generally, the MCN initiative offers consistent evidence of the value of peer support provision in improving the service experience and empowering clients, in particular where peers have had similar lived experiences to the client, such as mental health issues or a criminal record.

- A pilot project shows that introducing specialist provision is more cost-effective.

7.20 Evidencing better client outcomes can be tricky. In some instances it should be possible to compare and contrast provision: for example, over time, it should be possible to compare recidivism between RooP-supported ex-offenders and others. In other cases, the improvements may relate to soft indicators such as a better service experience or a sense of empowerment – which cannot be quantified but can be assessed through qualitative research and/or anecdotal client feedback or client surveys.

7.21 If specialist provision is being introduced, a separate question is how to best deliver this support, in-house or commissioned externally. For example, if a service wants to introduce advocacy support, it can shift existing resources to free-up staff time to offer this support, recruit new staff or commission another organisation to act as advocates. For example, the Greater Glasgow and Clyde Health Board saw value in the advocacy support offered through the African Health Project and decided to offer funding to continue the peer support worker’s post. It considered recruiting the African Health Project worker as NHS staff and commissioning Waverley Care to continue delivery. At the time of the final evaluation fieldwork, it was unclear which the preferred option was.

7.22 Economies of scale and comparative advantages (in effectiveness and cost-effectiveness of delivery) may be guiding principles in choosing between different options. Economies of scale play where the target group is relatively small in any particular geographical area, such as deaf Asian children or deaf people with alcohol misuse problems. Effectiveness of delivery may again be difficult to assess, as it can include hard or soft indicators.
Mainstreaming lessons

7.23 An important aspect of the MCN service improvement agenda is facilitating and managing the process of change, in particular the way that frontline staff and their supervisors and managers operate. MCN evidence suggests that influencing staff appeared to work significantly better when there was:

- A dedicated staff resource to support the learning process (the 'change manager'), ideally able to operate and be seen to operate independently but with direct links with the organisation they are trying to influence and strong line management support.

- Sufficient face-to-face time between staff and the change manager, finding the right balance between allowing sufficient time for the staff engagement process and at one point creating a sense of urgency. The process also tended to benefit from direct interaction between frontline staff and the client group or between frontline staff from different organisations.

- Direct alignment with organisational priorities: introducing change worked better if the organisation had already identified that there was an issue and/or was already trying to address the issue.

- A champion for the change within the organisation – getting senior staff involved can be facilitated by aligning the change offer with existing organisational priorities or by offering support to help the organisation fulfil any existing (legal) obligations or minimise risk.

- A positive staff engagement process, working alongside staff and offering them support rather than criticising them for failing the target group and creating some space for staff to discuss these issues together.

7.24 The last point is particularly important. The MCN programme suggests that the service improvement agenda needs increased attention for the ‘staff empowerment’ process. MCN projects have shown what can be achieved when ownership and decision-making are returned to the frontline level and staff are given flexibility (away from performance targets) to follow their clients’ agenda and invest time in developing and nurturing partnership links.

Recommendations

Introduction

7.25 The Scottish Government invested £4.8 million in testing what ‘works’ and what does not in improving service provision for people with multiple and complex needs. If this investment is to pay off, lessons from the programme need to be learnt and shared. A clear dissemination strategy needs to be developed, drawing out the lessons for different service sectors, in particular health given the important health component in the MCN programme, and criminal justice – because of the significant investment in the RooP project. That being said, the conclusions and recommendations apply widely: a whole range of agencies encounter clients with
MCN characteristics and the dissemination strategy should make the MCN findings accessible to a wide audience, including local community planning partnerships. The dissemination strategy also needs to differentiate between key stakeholders and what their role in the MCN agenda can be.

7.26 This final section sets out a preliminary route map for the dissemination strategy, identifying key MCN messages for different stakeholders.

**Service managers**

7.27 Service managers are the key players in the MCN service improvement agenda. Key tasks for this group are:

- To identify where their service is currently deficient in relation to MCN clients. This includes a review of who is currently not accessing provision and why (as specified in figure 7.1 above);

- To identify the scope and nature of possible changes to service delivery, including both possible light-touch adjustments to improve communication and interaction with individuals and the introduction of specialist provision where provision is currently lacking or ineffective (following the checklist suggested in figure 7.2 above);

- To establish the necessary evidence base to facilitate this process of identifying deficiencies and possible solutions – including the introduction of a mechanism for talking to individuals from key MCN groups to get their views on all aspects of the service;

- To create the space to allow changes to service delivery to come about – this will include:
  - Investment in staff development to raise their awareness of MCN client issues and increase their confidence in raising sensitive questions – this may or may not involve formal training sessions; it may well be more important to create time for staff to meet each other and discuss practice and scope for improvements;
  - Reviewing overall staff resources and individual staff workloads to create opportunities for more active outreach towards the target community or for building direct links with external partner organisations;
  - Sourcing or shifting resources to fund the specialist support provision that is being proposed;
  - Finally, the MCN evidence suggests that the MCN service improvement agenda will in most cases require the introduction of a change manager role to take the agenda forward.
Role of the Scottish Government

7.28 The role of the Scottish Government will essentially be one of enabling and facilitating service managers to implement the MCN service improvement agenda. This can include:

- Developing the evidence base – a number of MCN projects indicated that it was difficult to collect data, evidence and benchmarks relating to their client groups. The Scottish Government, together with local partners, can decide to invest in developing the evidence base, for example on the national and local presence of different MCN target group(s) and benchmarks of effective and cost-effective delivery, and encouraging learning and sharing of good practice between services.

- Working with each of the major service providers (including the NHS, SPS and others) to develop MCN Service Improvement Action Plans – which would identify deficiencies in MCN delivery, practical suggestions for improving delivery and information on how to implement, resource and enable the service improvement agenda, including the change management process. The Action Plans would build on the understanding generated by the evaluation, other research studies and where relevant direct consultation with the MCN target group(s). What is needed are action plans (as opposed to strategy documents) with specific actions, a timescale and information on who will undertake these actions, and how they will be funded.

- Facilitating a dialogue between different (local) service commissioners and (national) service providers to secure potential economies of scale.

7.29 In the health sector, the Scottish Government is currently exploring the possibility of introducing independent advocacy and patient rights officers, similar to the English Patient Advocacy and Liaison Service (PALS). The advocacy support offered by several of the MCN projects is different to the suggested scheme in that the MCN advocates:

- Tended to be peer support workers;
- Focused their attention on one specific target group, as opposed to being universally available to all users; and,
- Focused their attention in particular on individuals with multiple and complex needs.

7.30 Despite these differences, the proposed Scottish patient advocacy scheme may be able to draw on the MCN findings.

7.31 The success of the MCN advocate role stemmed from its flexibility and the fact that advocates were able to take the client’s agenda as their starting point, addressing issues and needs as and when they arose. The suggested patient advocacy scheme may understandably wish to focus on healthcare provision. Still, it may be worthwhile to avoid too rigid role boundaries and allow sufficient time and line management support for the patient advocates to (i) present a flexible support
offer to patients and (ii) invest in establishing a wider network of named contacts in organisations outside the health sector who can provide additional support to the patient.

7.32 Secondly, MCN advocates invested heavily in proactive outreach to their client groups, in particular in the early phases of the project life cycle, before word-of-mouth had started operating. It is not sufficient to put in place an advocacy support service; potential users must still be made aware that the service exists and make the decision to use the service. In an MCN context, this often meant that the engagement process had to be made as simple and direct as possible: advocacy support workers had to be at the right place at the right time to be able to introduce themselves face-to-face to potential clients. A universal service such as the suggested Scottish patient advocacy scheme may not require quite the same investment in client engagement. Still, the key message about the importance of awareness-raising and facilitating the engagement process still stands: for the suggested patient advocacy scheme to be truly universal it should also reach patients with multiple and complex needs.

Financing the MCN service improvement agenda

7.33 The current economic climate means that financing the MCN service improvement agenda – the introduction of advocacy support roles or change management roles, a reduction in staff workloads or investment in staff development – will be challenging. There are no easy answers here but the MCN programme can again provide some guidance. In particular, it is important to note that:

- Redesign of existing provision should not be seen as cost-free alternative to introducing specialist support provision: creating space to allow changes to service delivery to come about requires funding for staff development and freeing up staff time to invest in provision. It does, however, stress the importance of *evidencing* proactive outreach, more intensive provision or building relationships with other providers;

- Funding the MCN improvement agenda is ultimately a matter of organisational priority. The MCN pilots showed that, if service providers recognised the value of the proposed changes or the new support offer, they would often be able to shift or find resources for a continuation. For example, NDCS decided to continue to fund the BME support worker from its core budget; the Greater Glasgow and Clyde Health Board decided to take over funding for the African support worker from the African Health Project; NHS Borders was considering a continuation of the homelessness outreach nurse from its core budget. This is not to underestimate the challenge of resource constraints: it is difficult to generalise on the basis of a limited number of MCN pilots which were successful in generating funding for a continuation of staff posts or support the value of provision.
ANNEX A RESEARCH UNDERTAKEN BY MCN PROJECTS

The following research and evaluation reports were made available to the evaluation team by the MCN projects:

_African Health Project_
- African Health Project Evaluation Report
- African Health Project Monitoring Report
- GP Training Sessions Evaluation
- African Health Project Final Project Evaluation Report (It’s Good to Go for a Test)
- MCN Client Monitoring Data
- MCN Client Stories

_Improving Primary Healthcare Services for People with MCN_
- Baseline Research on Improving Primary Healthcare Services for People with MCN
- Improving Primary Healthcare Services for People with MCN Year One Progress Report
- Improving Primary Healthcare Services Final Project Evaluation Report
- client stories

_Inequalities Sensitive Practice Initiative (ISPI)_
- Six-monthly report Maternity Setting
- Addictions Task Group. LGBT Workshop. Summary of Evaluations
- Community Addiction Teams Event. Poverty and Gender Training. Summary of Evaluation
• Poverty training session for SW PACT & Pathways teams. Summary of evaluations
• PACT Teams – Gender and Gender-based violence. Summary of evaluations
• PACT Teams – Gender and Gender-based violence. Session 2. Summary of evaluations
• PACT Teams – Poverty workshop. Summary of evaluations
• PACT. Training Needs Assessment. Results
• Report. PACT Team Leader Workshop
• Inequalities Sensitive Practice Initiative Evaluation Report

**LGBT Young People with MCH**
• Exploring LGBT Young People’s Use of Services. Research Report
• Report analysing LGBT Training participants experiences
• End of Year Report

**Male Carers Project**
• Survey of Male Carers
• Male Carers Final Evaluation Report
• Client feedback

**Partnerships for Access to Health**
• What do people with multiple and complex needs want from services? Literature Review Findings from the PATH Project Vol 1
• What can service providers do to improve access to services for people with multiple and complex needs? What works and why? Summary of Literature Review Findings PATH Project, May 2008
• Rapid Appraisal of the 3 PATH CHP areas
• A Report of the Edinburgh CHP Prison Leavers Project
• PATH Project Plan for Identifying People at risk of Homelessness
• PATH Mid-Highland CHP Project
• PATH East Lothian Project, Homelessness Risk Assessment (December 2008)

**Plan2Change**
• Documentation on Agreed Process for Referrals to the Project
• Monitoring Data on Client Baseline Characteristics
• Monitoring Data on Equal Opportunities
• Monitoring Data on Client Numbers Over Time
• Draft Evaluation Report (2008), Scottish Development Centre for Mental Health
• Evaluation Final Report (October 2008), Scottish Development Centre for Mental Health
• 10 client stories
**Positively Sorted**
- Draft Training Pack Moving on with Optimism – Developing Hope Resilience and Personal Well-Being through Cognitive Awareness and Change

**Project Empower**
- Project Empower End of Year One Progress Report
- 18th Feb 2008 Information Event on Home Care Service, Community Care Assessment, Carers Assessment
- The South Asian Home Carers Recruitment Day 13 November 2007
- The Chinese Home Carers Recruitment Day 14 November 2007
- Home Care Induction Training Report
- First Aid Training Report (June 2008)
- Basic Computer Skills Training Report (July 2008)
- Volunteer Recruitment Information Day
- Health Scotland Translated Information Consultation Report (June 2008)
- Stress Management Training Report (May 2008)
- British Red Cross Chinese Community Consultation Report (August 2008)
- State Benefit Information Event Report (March 2008)
- Project Empower Final Evaluation Report
- A Collection of Stories from the Chinese Community Affected by Disabilities in Scotland
- 12 MCN Client Stories

**Routes out of Prison**
- Social Return on Investment Study (Eddy Adams Consultants and Smart Consultancy)
- Monitoring Data on Levels of Engagement
- Monitoring Information on Client Characteristics
- Monitoring Information on Equal Opportunities
- Interim Evaluation Report 2 (May 2007)
- Business Plan for Big Lottery Fund Application
- Interim Evaluation Report 4 (March 2008)
- RooP Data Integrity: An Interim Report (October 2008), Criminal Justice Social Work Development Centre for Scotland
- Engaging Clients Interim Report (September 2008), Criminal Justice Social Work Development Centre for Scotland
- RooP Steering Group Meeting (September 2008)
- RooP Steering Group Meeting (December 2008)
Securing Care for Ethnic Elders in Scotland
- Active Ageing – Chinese and South Asian Champions Training Report
- Personal Health Diary and Self Assessment Tool feedback questionnaire analysis
- Palliative Listening Events Report
- SCEES Co-ordinator meeting records

Sensing Change (RCA)
- Evaluation of Alcohol Counselling Training Course for Sensory Impaired Counsellors
- Final Evaluation of Sensing Change: Key Findings
- 3 volunteer stories

Supporting Black Minority Ethnic Families of Deaf Children
- Supporting Black Minority Ethnic Families of Deaf Children Final Evaluation Report
- 8 MCN Client Stories
- Monitoring data on client characteristics, outings and events’ attendees

Tayside Domestic Abuse and Substance Misuse
- The Tayside Domestic Abuse and Substance Misuse Project: Final Research Report
- Tayside Domestic Abuse Training Consortium. Domestic Abuse Awareness Training. Evaluation
- Final evaluation report
ANNEX B METHODOLOGY

The programme evaluation research methodology for each MCN project is presented below:

**African Health Project:**
- Face-to-face interview with the project manager
- Face-to-face interview with two project officers
- Focus group with 5 project stakeholders
- Review of monitoring information
- Analysis of client stories
- Review of the final project evaluation report

**Improving Primary Health Care Services for People with MCN:**
- Face-to-face interview with the project officer
- Face-to-face interview with Homelessness Support Worker
- Focus group with Learning Difficulties staff (3 individuals)
- Focus group with 3 project partners (steering group members)
- Review of the final project evaluation report

**Inequalities Sensitive Practice Initiative (ISPI):**
- Telephone interview with the project manager
- Face-to-face interviews with the four setting leads
- Face-to-face interview with the Learning and Development Officer
- Review of the maternity setting client survey
- Review of other project materials
- Review of the final project evaluation report

**LGBT Young People with MCN:**
- Face-to-face and telephone interview with the project officer
- Telephone interviews with training participants
- Review of training participant survey report

**Male Carers Initiative:**
- Face-to-face interviews with the project manager and the project officer
- Interviews with project stakeholders
- Review of project materials and advisory group member feedback
- Review of the final project evaluation report

**Partnerships for Access to Health (PATH):**
- Face-to-face interview with the project officer and the research officer
- Face-to-face and telephone interviews with CHP leads
- Telephone interview with the project manager
- Telephone interviews with project partners
- Review of 2 literature reviews undertaken by project
- Review of other project materials
- Review of the final project evaluation report

**Plan2Change – Craigmillar Pilot Peer Support Project:**
- Face-to-face interviews with the project manager and peer support workers
- Review of project materials
- Review of evaluation reports
- Review of client stories

**Positively Sorted:**
- Face-to-face interview with current project manager
- Face-to-face interview with former project manager

**Project Empower:**
- Face to face and telephone interviews with the project manager and project officers
- Face to face and telephone interviews with project stakeholders and partners
- Face to face interviews with project clients and one volunteer
- Participation in the Project Empower Seminar
- Review of project materials
- Review of the final project evaluation report

**RCA Trust project:**
- Face-to-face interviews with project manager, project staff and Steering Group Chair
- Focus group with project volunteers
- Review of project materials
- Review of volunteer feedback
- Final Evaluation of Sensing Change: Key Findings (Ann Rosengard Associates 2009)

**Routes out of Prison**
- Face-to-face interviews with project manager and Wise Group Director
- Focus group with project staff
- Review of project materials
- Review of draft evaluation findings
- Review of evaluation reports

**Securing Care for Ethnic Elders in Scotland:**
- Telephone interview with project manager
- Face to face and telephone interviews with project partners
• Review of project materials

**Supporting BME families of deaf children:**
• Face-to-face interviews with the project manager and the project officer
• Face to face and telephone interviews with project stakeholders and partners
• Face to face interviews with clients and volunteers
• Review of client stories
• Review of the project evaluation report

**Tayside Domestic Abuse and Substance Misuse:**
• Face-to-face interview with project manager
• Telephone interview with development worker
• Focus group with 4 project partners (steering group members)
• Review of research report
• Review of other project materials