Item No: 18

Meeting Date: **Wednesday 27th September 2023**

Glasgow City Integration Joint Board

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The Complex Needs Service Annual Review

Purpose of Report:	This report provides an update on the progress of the development and implementation of the Complex Needs Service (CNS) in Glasgow City Health & Social Care Partnership (HSCP).

Background/Engagement:	The Complex Needs Service was established in March 2022 and has significantly changed the landscape of provision for vulnerable adults with complex needs in Glasgow City. The introduction of the Complex Needs Service involved extensive consultation and engagement with those affected by the change from a Homeless Health Service to a Complex Needs Service model. This engagement process included all associated services including Alcohol Drug Recovery Services, Community Mental Health Teams, Third Sector partners, Human Resource personnel, people with lived experience and trade unions. This paper also outlines the key governance process that oversaw the development and implementation of the service. The final iteration of the Complex Needs Service including the proposed staffing structure and changes to budget were considered via the Chief Officer, Chief Finance Officer then subsequently considered via the HSCP Senior Management Team.

Governance Route:	The matters contained within this paper have been previously considered by the following group(s) as part of its development. HSCP Senior Management Team ☒

	Council Corporate Management Team ☐ Health Board Corporate Management Team ☐ Council Committee ☐ Update requested by IJB ☐ Other ☐

Recommendations:	The Integration Joint Board is asked to: a) Note the contents of this report; and b) Provide continued support for the ongoing development of the Complex Needs Service within Glasgow City.

Relevance to Integration Joint Board Strategic Plan:

The delivery of an effective services to people with complex case histories is critical to the delivery of the Integration Joint Board Strategic Plan 2023-26. Particularly Partnership Priority 1 – Prevention, Early Intervention and Wellbeing, Priority 3 – Supporting People in their Communities and Priority 4 – Strengthening Communities to Reduce Harm

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome(s):	The delivery of an effective and efficient services to people with complex case histories contributes to a range of National Health & Wellbeing Outcome, including: 1, 2, 3, 5, 7 and 9.
Personnel:	None
Carers:	None
Provider Organisations:	None
Equalities:	A draft EQIA has been completed and will be published in accordance with HSCP guidance when approved.
Fairer Scotland Compliance:	None
Financial:	None
Legal:	None
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None
Risk Implications:	None

Implications for Glasgow City Council:	Continued development of the Complex Needs Service has the capacity to continue to improve outcomes for service users with complex case histories. The service aims to engage with a hard to reach population, retain them in service, reduce harm and the requirement for high cost services as they stabilise their lifestyles within community settings.

Implications for NHS Greater Glasgow & Clyde:	Continued development of the Complex Needs Service has the capacity to continue to improve outcomes for service users with complex case histories, improving health and reducing harm caused by multiple adversity including drug related harm. It is envisaged that this approach will see the reduction in service users using high cost services and acute NHS services as they stabilise their lifestyles within community settings.

Direction Required to Council, Health Board or Both	
Direction to:	
1. No Direction Required	☒
2. Glasgow City Council	☐
3. NHS Greater Glasgow & Clyde	☐
4. Glasgow City Council and NHS Greater Glasgow & Clyde	☐

1. Purpose

1.1. This report provides an update on the progress of the development and implementation of the Complex Needs Service (CNS) in Glasgow City Health & Social Care Partnership (HSCP). The service was formally launched in March 2022 following an extensive period of review and consultation led jointly with Human Resource personnel and included trade unions and those with lived experience, thus this paper provides a timely opportunity to reflect on the first full year of delivery and impact.

2. Background

2.1. Prior to 2020, the Homeless Health Services (HHS) based within Hunter Street, operated a single point of access model for a homeless population including rough sleepers and those living in emergency & supported accommodation. Hunter Street was responsible for all referrals for individuals requiring health services who were homeless in Glasgow, regardless of circumstances, level of need or location of homeless accommodation. The service provided a range of medical, health and social care interventions delivered by a range of speciality teams co-located within the Hunter Street base. Cross working between the teams was challenging given they all held separate caseloads, with no standardised criteria or referral processes. Resulting in a complicated model which presented opportunities to consider an improved model offering a seamless approach in relation to client centred care and experience drawing upon contemporary practice and the voice of lived experience.

2.2. A strategic review commenced in 2019 demonstrating the need for a more efficient, effective and financially viable model however this was paused temporarily due to the onset of the Covid pandemic. As with many other services, the impact of the pandemic required the HHS to dramatically change its mode of delivery:

- An assertive outreach model was established in response to an increase in homeless people residing in hotels in the city, moving away from the clinic-based approach and significantly reducing the footfall through Hunter Street.
- A RAG (Red, Amber, Green) rating was applied to manage the risk and complexity of this vulnerable client group ensuring appropriate assessment and response was in place in relation to the level of risk and vulnerability for each individual client.
- The team worked alongside statutory and third sector agencies to rapidly develop and deliver the city centre strategy ensuring all vulnerable, homeless individuals were supported in accommodation and had significant resources available to respond to the range of dynamic, challenging and complex needs. Face to face outreach contact was increased and became the default mode of care management.
- Approximately 300 mobile phones were distributed to service users, ensuring access and support were maintained.
- Covid vaccination clinics were established with approximately 1100 administered to the most vulnerable service users across 50 homelessness sites and supported accommodation provision.
- Opportunistic Blood Borne Virus (BBV) testing was provided alongside Covid vaccinations in partnership with the Sandyford Sexual Health Outreach Team. The team provided daily outreach to existing service users accommodated in the city centre hotels. In addition to this, support was provided to previously unknown vulnerable and complex clients who became more identifiable and accessible due to the assertive outreach and multi-agency approaches put in place.
- Physical health and wound care clinics were extended and offered at the Hunter Street base and across all the homelessness accommodations. Training and support was provided to hotel staff who were then required to deliver services to a population that were often experiencing multiple adversity including re occurring homelessness episodes. The re-purposing of hotels during Covid changed the landscape of homelessness in the city with hotel staff developing new skills to compliment hotel guests complexity of needs. The learning throughout the Covid period identified that the approaches adopted were much more responsive and successful in terms of identifying, responding to and meeting the needs of some of the most vulnerable individuals within Glasgow City.
- The single team approach and collaborative, multi-agency working achieved positive and sustainable outcomes with increased engagement, treatment compliance and a significant decrease in risk.

2.3. The extended review process recommended a move towards a complex needs model outlining a staffing skill mix across Health and Social Care. The complex

needs model aims to provide a specialist and high tariff service for individuals presenting with multiple and complex health & social care needs who are unable to engage with mainstream services. As such, the CNS replaced the historical HHS model, including criteria, which now focuses on level of complexity and risk rather than homelessness status alone. In turn, this now ensures that individuals who can access mainstream locality services are not prevented from doing so simply because of their homelessness status.

3. Implementation

3.1. The new model which operates on an assertive outreach approach officially launched in March 2022 with referrals being received from a wide range of services and agencies such as Acute Services, Primary Care, Community Justice, Alcohol & Drug Recovery Services (ADRS), Enhanced Drug Treatment Service, Adult Social Work, Adult Support & Protection, Learning Disability and Homeless & Housing Services, including Registered Social Landlords.

3.2. The formal launch followed a significant programme of engagement including stakeholder events which informed the model and the implementation plan and sought to move forward collectively in recognition of the importance of joint working across the Glasgow City landscape. The views of those with lived experience have been invited and represented throughout the scoping and development processes. The Glasgow Homelessness Involvement and Feedback Team (GHIFT) contributed to stakeholder events and discussions and the Scottish Government Lived Experience Policy Officer sits as a regular member of the Complex Needs Operational Oversight Group.

3.3. In acknowledgement of the complexity of the interface with Community Mental Health Teams (CMHTs) across Glasgow City it was agreed that a pathway between CNS and CMHTs and would be jointly developed and implemented at a later stage. This work is effectively now concluded with full ratification by November 2023.

3.4. As a consequence of the review and service realignment work, the decision was made to transfer the routine provision of General Practitioners (GP) services for the general homelessness population to mainstream community GP services following an extended period of review and consultation process. The previous GP service (1.3 whole time equivalent (WTE)) did not have access to other disciplines and did not benefit from the recent expansion of community services under the Primary Care Improvement Plan. Of those patients known to the GPs the vast majority were registered with community GP practices. All outstanding cases were reviewed and risk assessed in line with the NICE (National Institute for Health and Care Excellence) guidance on commissioning health and social care services for homeless people and those with multiple deprivation. This process was overseen by the appointed Clinical Director who reviewed cases that were identified as more complex in advance of being transferred to mainstream GP practices. In total the service reviewed 166 patients who were open to the GP service within the CNS. Approximately 20% of cases no longer required support in accessing a GP and the remainder were reviewed using the RAG process. Plans are currently under way to review how seamless this process has been for service users and any learning will be considered via the CNS operational group. The CNS will maintain an urgent

care and bridging service with the focus now on ensuring the CNS continues to offer support to those registered with a community GP. It is recognised that some GP provision remains within the CNS and plans are underway to consider how this will augment the inter-disciplinary review meetings in an advisory capacity.

3.5. Homelessness Health Visiting provision within the Hunter Street Service was also subject to review and the 4.5 WTE posts were realigned to Children and Families Services in keeping with mainstream modelling and in recognition of families residing within communities

4. Service Profile

4.1. The CNS provides a citywide single point of access to a vulnerable, transient, and high-risk population. The service provides a range of medical, physical and mental health and social care interventions for individuals with multiple and complex health and social care needs. The previously separate teams have been amalgamated into a single intra-disciplinary team (IDT). The IDT applies a single referral process and holds a caseload with regular IDT reviews and comprehensive assessments of individual cases.

4.2. The service has a budget allocation of £2.3 million. The team comprises 39.9 WTE staff made up of a Service Manager, Team Leaders, Advanced Nurse Practitioners, Adult Nurses, Mental Health Nurses, Clinical Psychologist, Occupational Therapists, Health Care Assistants, Social Care Workers and Business Support.

4.3. All individuals who are open to the CNS have significant histories of trauma and poor engagement with mainstream services, often with devastating impact on the individual themselves. A trauma informed approach with the building of relationships is fundamental in establishing trust and ongoing engagement with the team.

4.4. Service users will present with multi-faceted issues straddling a broad range including mental health, addictions, physical health, psychological issues, learning disabilities, risk, challenging behaviours, neurodevelopmental issues, homelessness and broader social issues. Whilst many service users will require case management and wrap around support from many members of the team, there are distinct components of the service which are focused on specific groups or presenting issues.

4.5. The Woman's Service continues to be hugely beneficial, allowing women to share their experiences and challenges in a dedicated safe space and feel a sense of security, which in turn improves engagement. The service provides blood borne virus (BBV) support, sexual health and medic review within this space and this allows women to drop in over and above the extensive outreach approach.

4.6. The Young Person's Service was previously established to respond to a highly complex and vulnerable population of age 16–26 years. Historically, this cohort had a poor history of engagement and compliance with many known across Criminal Justice Services and/or Alcohol & Drug Recovery Services. In addition

to the extensive outreach provision a weekly service is offered within the city centre Simon Community. Like the Women's Service, this focused approach has been very successful and allows young people open to CNS the space to drop in and speak with staff and address other issues such as benefits advice, sexual health or BBV and medic input.

4.7. From the period March 2022 to end July 2023 the service has received 418 referrals with a current caseload of 171. Referrals are made from a wide range of sources across the health and social care landscape. This includes statutory internal partners such as Adult Support & Protection, Alcohol and Drugs Recovery Service, Enhanced Drug Treatment Service, Homelessness Casework Teams, Asylum & Refugee Support Services and Mental Health Liaison, multi-agency partners such as Police Custody, Prisons and Accommodation Providers along with Third Sector partners such as Aspire, Simon Community & Turning Point Scotland.

5. Service Pathways

5.1. Individuals' cases are often discussed in an informal manner between their current team and the CNS. This allows for consideration of all the presenting challenges and agreement that referral to CNS would be appropriate. This supports a person-centred approach rather than adherence to a fixed inflexible criteria-led process. Following receipt of referrals a comprehensive assessment is completed with the service user. This then enables the IDT to support the service user to the right service at the right time based on all of their needs. If the CNS is deemed to be the right option, the service user is allocated and provided with a holistic care management approach. To date, the service has obtained engagement with every individual accepted to the caseload. The significant benefits of a fully integrated and specialised team who rapidly respond to the presenting needs of our most vulnerable demonstrates an approach which meets the needs of the service user.

5.2. As an interim service with the aim of supporting service users back to mainstream community services, the CNS operates a planned transitional transfer process that has proven to be supportive both to the service user and the locality service.

6. Impact

6.1. The development of a performance matrix and dashboard is underway. This will facilitate the visibility of a collective qualitative and quantitative data set which will allow the service to monitor and report progress, outcomes and impact, benchmarking the service against year-on-year performance and other services locally and nationally.

6.2. The performance framework will reinforce early indicative evidence of the positive impact the CNS model and approach is demonstrating. Since May 2022 through to August 2023; compliance with opioid substitution treatment (OST) is high and there are currently no reported drug deaths within the CNS caseload. Patients have engaged with the service and there are high levels of outreach appointments achieved, 216 covid vaccinations and 188 flu

vaccinations have been administered to date. Complexity ratings demonstrate downward trend as interventions progress.

6.3. Service user feedback is sought from every person who is being discharged from the service. This consistently demonstrates high levels of satisfaction and positive individual experience. Examples of service user statements:

- *“Treated me like a human being”*
- “*Complex Needs Service has helped to get me to the right services. They helped me get the best mental health support and the correct medication. They also helped me with different applications such as DWP, ADP, PIP”.*
- *“Complex needs also helped me to move to the best place regarding my health and support for young people”* .

7. Key Developments

7.1. Whilst the service is still very much in its infancy in relative terms it has demonstrated a dynamic approach to the broader needs of service users and other services across the HSCP landscape. A number of key developments have progressed within the first year in response to the emerging need as the service progresses.

7.2. **Advanced Nurse Practitioner role**: Advanced Nurse Practitioner (ANP) Team provides a citywide service across homeless accommodations in relation to physical health. Specialist fixed wound care clinics are provided across several homeless accommodations and there is currently a pilot of a clinic within the Simon Community Hub. The aim of this pilot is to identify demand and address any barriers that may exist for service users requiring physical health care and treatment. In addition, wound care is provided on site within Hunter Street and to multiple outreach locations when need is identified. This is not solely for individuals open to the Complex Needs caseload and is citywide. The team have now commenced a specialist Out-Patient Antibiotic Treatment (OPAT) service accepting referrals from ADRS, Primary Care and Hospitals. The ANP service has supported patients with health inequalities to receive a high standard of care using an outreach approach. It is known that this client group will not seek help until they have become acutely unwell, resulting in regular A+E attendances. Early intervention and the introduction of the OPAT service aims to improve outcomes, reduce secondary care pressures and save bed days in hospital.

7.3. **Clinical Psychology role**: The CNS employs one WTE Principal Clinical Psychologist. This role is multi-faceted with a focus on the provision of consultation and training to the CNS staff team to achieve wider scope of psychologically informed care than could be achieved should the single Psychologist hold a large caseload. The Psychologist contributes directly not only to the CNS team but provides input to external services to support collaborative working around the people all services involved endeavour to support. Key elements of this role include providing consultation within the weekly inter disciplinary (referrals and allocations and triage meeting) and multi-disciplinary (patient review) meetings, the provision of trauma informed and responsive care throughout all aspects of service including the development of psychological formulations for each individual patient.

(Formulations are a working hypothesis of a person's past and recent experiences in relation to their current difficulties. They seek to understand the factors maintaining a person's difficulties and the strengths they hold which can support their recovery). Additionally, the Clinical Psychologist facilitates a monthly reflective group for CNS staff and where relevant, other practitioners, where they are provided with a safe place to consider their patient facing work.

7.4. **Shorter term interventions**: The CNS has worked closely with the wide range of partner services and referrers to review and assess the appropriateness of the CNS for individual service users. In this period, before the service user has been formally accepted or not, it has been recognised that the team can often address some initial issues that can have an impact on their ability to be maintained within a mainstream service and may indeed be best placed then continuing with that service rather than being transferred to CNS. Examples include registering the patient with a GP, review by ANP to address physical health issues, wound management or harm reduction (commencing on opioid substitution treatment (OST)).

7.5. **Consultancy service / expertise**: The CNS is well placed to provide expert opinion to other services and agencies as required. For example, the service also provides a review of complex cases for services across Glasgow City Health & Social Care Partnership and currently supports the Bed and Breakfast Taskforce as they work to identify and respond to complex needs of residents and seek sustainable accommodation solutions.

7.6. **Strategic development**: The CNS has significant experience in understanding and responding to some of the most complex and vulnerable clients across Glasgow City. As services have evolved from the collective teams previously based at Hunter Street to the integrated approaches by the now established CNS, they are well positioned to inform local developments and national strategy. Examples include the Scottish Government Mental Health Division- Time, Space, Compassion (Recommendations for Improvements in Suicidal Crisis, Scottish Government 2021), Health Improvement Scotland, Scottish Government Homelessness Division and working with local partners namely Police Scotland and Third Sector organisations to strengthen responses such as early intervention, risk management, harm reduction and focus on long term accommodation solutions.

8. Governance

8.1. The CNS Operational implementation Group is chaired by the Head of Homelessness Service and Complex Needs for Glasgow HSCP and has a wide ranging membership including senior leadership form Alcohol, Drugs Recovery Services, Community Mental Health Teams, Service User engagement and Third Sector. The group was established well in advance of the commencement date of March 2022 and retains a core function for overseeing all operational developments and challenges ensuring multi-agency participation.

8.2. The CNS is also overseen by a Strategic Oversight group chaired by the Assistant Chief Officer for Public Protection and Complex Needs and has a membership including Clinical Director, Assistant Chief Officer Adult Services/

Chief Social Work Officer, Depute Associate Medical Director, CNS Service Manager and Head of Homelessness and Complex Needs. The group has strategic oversight responsibility for ensuring clinical and practice governance reporting arrangements are in place. More recently, the group approved the methodology for undertaking a comprehensive evaluation of the service reviewing the outcomes of 100 cases. This review will provide the necessary benchmarking to ensure the CNS are operating within the threshold of complexity as envisaged and will include a comparison with mainstream Alcohol Drug Recovery Services.

9. Summary and Looking Ahead

9.1. The establishment of the Glasgow City Complex Needs Service has achieved a person centred, trauma informed and high tariff provision which works in partnership with statutory, commissioned and third sector agencies to best meet the needs of some of the most complex and vulnerable people across the city. The Single point of access with a one stop shop and assertive outreach model ensures that services respond to the needs of the service user rather than the service user responding to the needs of the service.
The service is dynamic and has a strong ethos of continuous improvement with governance driven through both an Operational and Strategic Oversight Group. Key areas of focus looking ahead include: an in-depth audit of CNS cases to review a range of factors including impact on individuals and identify strengths and areas for improvement in the service, development of robust performance monitoring and reporting to demonstrate quantitative and qualitative outcomes and further develop engagement with all stakeholders and partners with consideration of a CNS network.

10. Recommendations

10.1. The Integration Joint Board is asked to:

a) Note the contents of the report; and
b) Provide continued support for the ongoing development of the Complex Needs Service within Glasgow City.