Report to:	Executive Cabinet Member - Deputy Leader's Portfolio		
Date:	30 June 2014		
Report of:	Wendy Meredith, Director of Public Health	Report No:	
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Report Title:	**Commissioning Intentions for Improving the Health and Wellbeing of People with Complex Lifestyles**		

Non-Confidential	This report does not contain information which warrants its consideration in the absence of the press or members of the public
Purpose:	The purpose of this report is to describe the proposed approach and model for testing out a new service specifically to address the needs of those patients identified as having 'complex lifestyles' using the nationally applied GP practice list risk stratification tool.
Recommendations:	It is recommended that the Executive Cabinet Member note the key aims and objectives of this project. It is further recommended that the Executive Cabinet Member agrees to delegate authority to the Director of Public Health to award the contract to the successful organisation and to ensure the delivery of this project is robustly monitored.

(for use on Exec Rep)
Signed:

Leader / Executive Member	Monitoring Officer
Date:	

1. Introduction

1.1 Bolton Council, with partners from across the health sector, is looking to commission the delivery of a new programme aimed at addressing the needs of people with complex lifestyles. The purpose of this report is to describe the proposed approach and test model which will focus on those patients identified as having 'complex lifestyles' through the use of the nationally applied GP practice list risk stratification tool. The report also seeks approval for delegated authority for the Director of Public Health to approve the contract award to the successful contractor and to oversee the delivery and robust monitoring of this test programme.

1.2 There is not one single provider currently responsible for co-ordinating and helping people navigate services that meet the needs of the complex lifestyles patient group. New thinking is required to inform a different approach to addressing these issues which will result in reduced complex dependency and increased confidence to self-care. In the first instance this approach would need to be tested out with a relatively small number of the cohort to ensure that lessons learned are translated into future practice that is effective.

1.3 The test programme is intended to help stakeholders understand whether the approach and ethos is successful in improving outcomes for these specific patients and whether the approach has good potential to inform future models of service provision.

2. Background

2.1 Health and Social Care Integration, as a key strand of Public Service Reform, is high on the national and local agenda. It is recognised that by integrating services duplication will be reduced and scarce resources maximised. Individuals with complex lifestyles (and needs) have been identified as a key cohort for intervention nationally. This is because whilst they are relatively few in number they currently place a huge burden on a wide range of public sector services. Typically these individuals are "revolving door" patients who may not fit the criteria for existing service provision.

2.2 In particular, a high percentage of health care expenditure is associated with people with complex health and social care requirements. As these individuals further develop multiple needs, delivery of care becomes disproportionately complex and difficult for the health and social care system to manage. Such patients are often extremely vulnerable. Rapid deterioration in function is common in this cohort, putting them at high risk of unplanned hospital admissions, long term institutionalisation and crisis intervention.

2.3 In addition, service use is often further complicated by poverty and inequality as people experiencing deprivation may have low confidence in the effectiveness of services. People with complex lifestyles usually have poor engagement with community provision and high presentations to inappropriate services such as A&E.

2.4 Evidence has shown, however, that intensive, ongoing and individualised case management can improve quality of life and outcomes for these patients, thereby dramatically reducing emergency admissions and enabling patients who are admitted to hospital to return home more quickly.

3. Complex Needs Profile

3.1 In Bolton, the national risk stratification tool has been applied across all Bolton GP practices as part of the Health & Social Care Integration agenda. Consequently this tool has identified a relatively small cohort of patients (circa 450) as having complex needs and/or complex lifestyles. This cohort is known to be at the highest level of need and is likely to require a range of different interventions. (Further detail of the profile of the complex needs cohort is attached as Appendix 1).

3.2 For the purposes of this test programme the complex needs cohort has been further segmented and will focus on only those individuals defined as having complex lifestyles. The precise number of people fitting this definition across the borough will need to be established as the programme progresses.

4. The Proposed Model & Approach

4.1 The proposed model will specifically focus and target those complex needs patients with complex lifestyles. Specifically those with problems associated with substance misuse, mental health and social deprivation who do not currently, consistently engage with existing service provision. The model aims to mirror learning from a number of interventions and approaches currently being rolled out and/or previously delivered in Bolton such as Family First, the Alcohol High Impact Team and the Multi Agency Partnership for Safeguarding Adults.

4.2 The key features of the model include;

- A person-centred, home based, visit and conversation to listen to and thoroughly understand needs, challenges and barriers.
- Individual action planning specific to expressed and perceived need.
- Brief interventions to support, motivate and sustain behaviour change.
- Facilitation to help individuals navigate appropriate services, information sources and resources.
- Advocacy to ensure the delivery of active support, information or advice to encourage self-care and self-management plus reduced dependency.
- Direct liaison with other services, organisations and teams known to individuals with complex lifestyles.
- Intensive support to facilitate individuals in navigating systems of appropriate provision.
- Negotiation of systems for rapid referral and access across agreed agencies if appropriate.
- Establishment of appropriate data sharing arrangements.
- Development of joint approaches to care planning around each individual as required.
- Joint development of responses to patients in crisis.

4.3 The objectives of the programme are to:

- Increase access and appropriate uptake of and engagement with appropriate services
- Reduce use of inappropriate service provision

- Build confidence in existing services
- Increase understanding of available services that are appropriate to individual need
- Identify and work to resolve barriers to service access
- Lead or contribute to multi-agency collaborative action planning around individuals' specific needs
- Reduce avoidable presentations to services, particularly for crisis interventions
- Reduce avoidable admissions to hospital
- Reduce multiple presentations to services
- Reduce risk of suicide and self-harm
- Reduce risk of harm to others
- Reduce escalation of risk
- Build self-management/self-help skills to impart future resilience
- Reduce dependency

5. Timescales & Resources

5.1 The test period will run from 7th July 2014 until 31st March 2015 and will be split into two phases.

5.2 Phase 1:

- Will run early July 2014 until November 2014 with an interim review during December 2014.
- The provider will initially work with risk stratified patients identified from one or two GP practices (approximately 20 patients).

5.3 Phase 2:

- Will run from December 2014 to March 2015.
- The provider will move forward to work with a further cohort of risk stratified patients. These patients will be identified from a further small number of GP practices, ideally with a different demographic profile, during the test period (approximately a further 20 patients).
- The provider may be required to continue to provide some level of support to those patients from phase one as appropriate.

5.4 A maximum value of £50,000, identified by the Joint Transformation Group as part of the monies earmarked for Health & Social Care Integration, will be made available to the provider for the delivery of this contract and in line with EU procurement regulations. This investment will be used to recruit suitability skilled and experienced assertive case workers with the ability to coordinate a health and social care plan for each individual patient and ensure care plan delivery.

5.5 The support workers will carry a rolling caseload not expected to exceed 30 patients at any one time and will be expected to liaise proactively with a range of existing service providers. Close attention will need to be paid to working with clients who may already be open, or known, to local service providers.

6. Evaluation

6.1 The test model of delivery and approach will be subject to continuous evaluation which will be as close to real time monitoring as possible. This is necessary in order to quantify the impact on existing service provision.

6.2 All real time data will collated be used to review and further refine and the test model of delivery.

6.3 Public Health Intelligence Specialists will carry out the ongoing evaluation and support the collection of historical data in order that there is objectivity included in the evaluation from the outset.

6.4 Understanding what success looks like from service users' and carers' perspectives will be central to the evaluation. Both qualitative and quantitative methods will be required to elicit this feedback.

6.5 A multi-agency project steering group is in the process of being established to closely monitor progress and maintain oversight of the programme.

7. Timeline

7.1 On 19, June 2014 the Council invited five contractors to submit a quotation via The CHEST for the delivery of this contract.

7.2 The following organisations have been invited to provide a quote;

- Urban Outreach Bolton
- Greater Manchester West Mental Health NHS Foundation Trust
- Arch Initiatives
- Lifeline Project Ltd
- BAND

7.3 All submissions will be received by 12noon on Tuesday, 1 July 2014 via The CHEST.

7.4 The successful organisation will be expected to begin work on the project from 7, July 2014.

8. Recommendations

8.1 It is recommended that the Executive Cabinet Member note the aims and objectives of this project.

8.2 It is further recommended that the Executive Cabinet Member agrees to delegate authority to the Director of Public Health to award the contract to the successful organisation and to ensure the delivery of this project is robustly monitored.

Appendix 1

Complex Needs Cohort Profile

Patients classified as having multiple and/or complex needs include;

- Alcohol misuse
- Drugs misuse
- Mental ill health (including self-harm and suicide)
- Medically unexplained symptoms
- Learning disabilities
- Personality disorder
- Offending or risk of offending
- Poor/unstable accommodation or homelessness
- Worklessness
- Socioeconomic deprivation

It is also recognised that the primary presenting condition for this patient group, may not be the true underlying cause for presentation, especially those with repeated presentations.

The complex lifestyles test programme will only work with those individuals with substance misuse, mental health and social deprivation who do not currently consistently engage with existing service provision.