

Luton Health and Social Care System Five Year Strategy



2014-15 to 2018-19

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1. Context of Plan

National Context

National Planning Guidance requires that individual units of planning develop a five year system strategy 2014/15 to 2018/19 with key deliverables for the first two of those years articulated via:

- ✓ A CCG Operating Plan
- ✓ A CCG Financial Plan
- ✓ A Better Care Fund Plan
- ✓ Individual Provider Plans
- ✓ An NHS England Area Team Direct Commissioning Plan

This Five year strategy represents the Luton Health and Social Care Systems approach to delivering improved outcomes for local people via a sustainable, joined up , collaborative system.

The need for a cohesive system planning programme is essential to meet the sustainability issues posed by the imbalance between rising demand and supply pressures and our unit of planning (Luton CCG, Luton Borough Council, Luton and Dunstable Hospital, Cambridgeshire Community Services, South Essex Partnership Trust and the Luton Health and Wellbeing Board) will publish its draft five year strategy to deliver a Healthier Luton through a sustainable health and social care system in early April 2014.

1. Context of Plan

Local Planning Context

The diagram on the *next page* shows how local plans fit together to support the Luton Health and Wellbeing Strategy.

The Health and Wellbeing Strategy makes a number of commissioning recommendations based on a in depth analysis of local needs and highlights three major outcome goals:

**Health and Wellbeing
Goal 1. EVERY CHILD AND
YOUNG PERSON HAS A
HEALTHY START IN LIFE**

**Health and Wellbeing
Goal 2. REDUCED
HEALTH INEQUALITIES IN
LUTON**

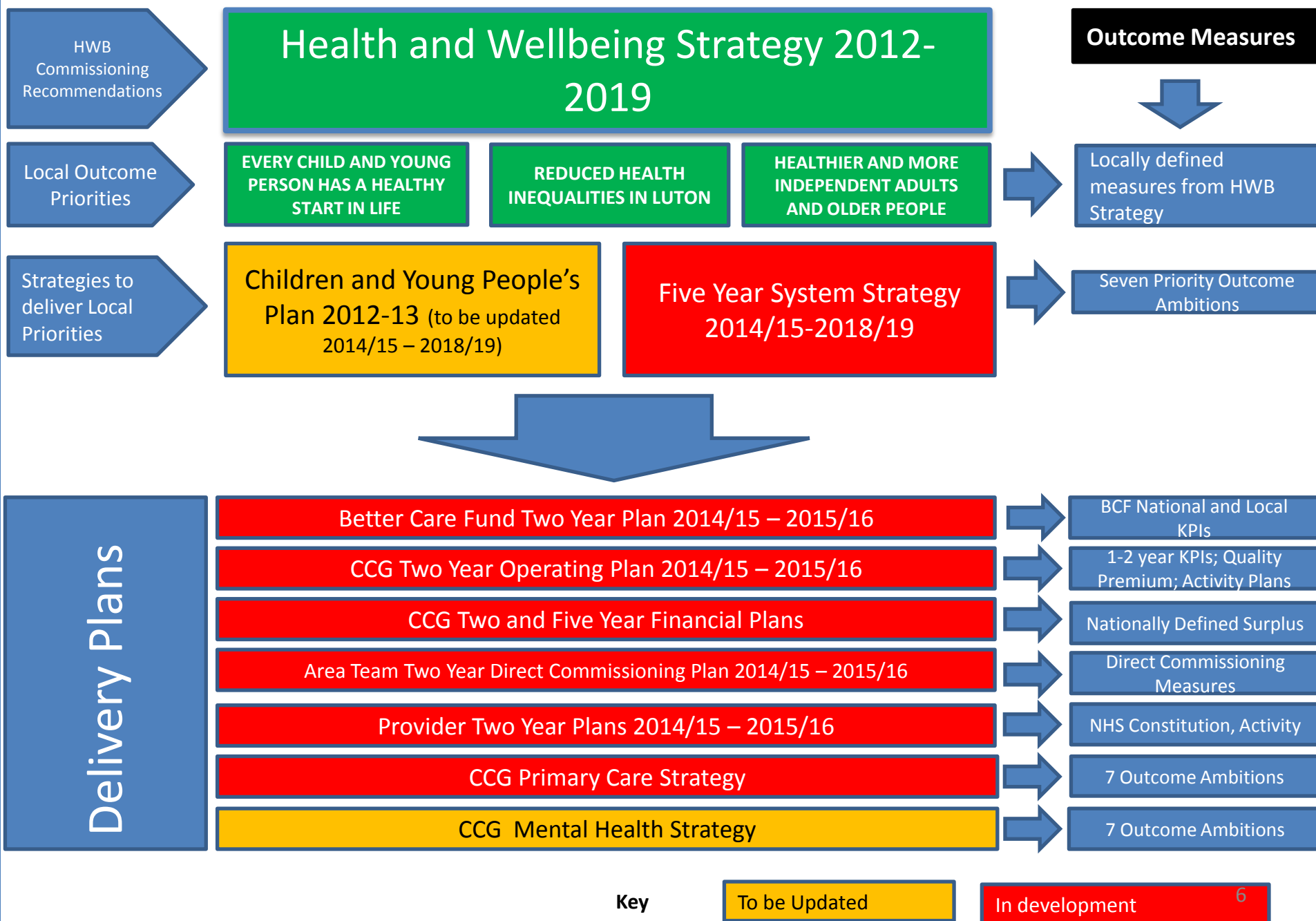
**Health and Wellbeing
Goal 3. HEALTHIER AND
MORE INDEPENDENT
ADULTS AND OLDER
PEOPLE**

The Children and Young People's Plan articulates how Goal 1 and elements of Goal 2 are being addressed. The System Five Year Strategy with its focus on adults will articulate plans to address Goal 3 and elements of Goal 2.

This Five Year System Strategy has been developed by the **Luton Unit of Planning** which is made up of the following partners:

Luton Health and Wellbeing Board
Luton CCG
Luton Borough Council
Luton and Dunstable Hospital Foundation
Trust
NHS England Area Team (South Midlands
and Hertfordshire)
South Essex Partnership Trust
Cambridgeshire Community Services

The Relationship Between the Health and Wellbeing Strategy and Current Plans in development



Local Need

Luton's Population and Health Profile at a glance

- Population 204,000
- BME equals 55% of the population and 66% of school children
- High levels of deprivation – 12,000 children live in poverty. Life expectancy lower than England average
- Life expectancy gap for most deprived areas is 8.9 years for men, 6.4 years for women
- 23.2% of Year 6 children are obese, worse than the England average. Breast feeding and smoking in pregnancy worse than England. Teenage pregnancy and alcohol specific hospital stays among the under 18s are better than the England average.
- Infant mortality is above the England average
- Low rates of adult physical activity and high levels of adult obesity
- CVD mortality worse than England
- Dementia in over 65's to increase by 10% between 2012 and 2016

Local Views

The Luton system has undertaken an extensive programme of patient and public engagement in order to seek inputs to improving the health of the local population. This has included:

- Patient Reference Groups / Practice Patient Participation Groups
- Deliberative events
- Citizen surveys
- CCG Public launch event
- Is A&E for me? Marketing campaign
- Social media
- Neighbourhood Governance Programme
- “The Big Conversation” engagement programme related to the reconfiguration of mental health and community services

There are a number of themes that have emerged repeatedly:

1. Communication needs to be improved directly with patients/carers and between organisations that are having interactions with patients/carers.
2. Better access to primary care – GPs
3. Quicker referrals onto hospitals/other specialists
4. Accessing all the communities that live in Luton and adapting services to the needs of those communities; both in terms of ethnicity and communities of health.

The key themes have informed the planning and delivery of our major transformational programmes

2. System Vision

Development of a System Vision

As part of Luton's Better Together Integration programme, system leaders contributed to the development of a system vision by participating in a Leadership Summit which took place on December 13th 2013. The purpose of the Leadership Summit was for health and care organisations in Luton to share priorities over the next 2-5 years and to consider how we can collectively lead the whole care and health sector to meet integration challenges over the same period.

The group was tasked with articulating what the Health and Social Care System will look like in 2019 and the outcomes of those deliberations are summarised in this section.

Leaders from the following organisations were represented at the Summit: Luton and Dunstable Hospital, Luton Borough Council, East of England Ambulance Services Trust and Luton CCG.

Our System Vision and Principles



In 2019 Luton residents will benefit from integrated health and care that has four elements: a person centred approach enabled by a shared **PERSONAL PLAN** for patients and service users; **PREVENTION** that helps people to keep themselves well; **BETTER USE OF SHARED EVIDENCE AND DATA**; **A MULTI-DISCIPLINARY, MULTI-PROFESSIONAL TEAM APPROACH** to service delivery built on three GP clusters in the town. We will work in partnership with patients, their carers, providers and other partners to deliver a high quality and cost effective health and social care system to the people of Luton, empowering them to lead healthy and independent lives.



Principles

- Integration and collaboration
- Service Innovation
- Services around the patient
- Safeguarding the vulnerable
- Early intervention
- Value for money
- Citizen engagement
- Quality and Safety

2. System Vision

How will the system be different in 2019? Summary



A Personal Plan

- An e-plan that is personalised and can be shared across the system
- Care co-ordinated by the GP



One Multidisciplinary Team

- Multi-disciplinary teams that will include social workers, district nurses, hospital at home nurses, hospital consultants and home help
- Planning around the person will take account of both physical and mental health needs and mental health professionals will be an integral part of the multi-disciplinary team.



A focus on Prevention

- Delivering a wellness programme rather than a focus on treating illness
- Early intervention driving improved outcomes and reduced need for specialist intervention



Using the Evidence Well

- Accurately predicting risk of a crisis and putting in place appropriate services to prevent hospital admission
- Putting the right services in place appropriate to the evidence

2. System Vision

How will the system be different in 2019? Key Elements

| Personal Plan | One Multidisciplinary Team | Prevention | Using the evidence well |
|--|---|---|---|
| Assessment for complex needs within good time | New Roles- Carers, Social Care, Voluntary Sector etc | Balance towards early intervention and prevention | System is better at predicting crisis and has put appropriate timely services around them |
| Key Coordinator worker | Community based care services- Health, Social, Voluntary all together. Single point of contact for patients | People understand how to keep well and do it | Appropriate interflow between providers; information/physical experience |
| Fewer professionals- better sharing info | Health/well being/social prescription- all equally important | Realistic understanding and taking ownership of peoples barriers to health issues | Use data to deliver and organise services in different communities |
| Single assessment and plan across organisations | Services aren't hidden away or discreet | | IT systems aligned |
| Existence of a personal plan- person feels able to change/develop/reassess their plan. | Mental health services integrated within every service | | |
| People feeling in control and confident of "their" plan supported by professionals | Early customer access to 'knowledge' | | |
| A key contact – someone to trust/get to know. Someone to help and support the plan to be delivered | Points of Access- Hospital, Shopping Centre, Police Station, Town Centre | | |
| New roles- carers initiative across health, social care, voluntary sector etc | Care and support is no longer buildings based | | |
| | People can access universal services | | |
| | Caring community | | |

2. System Vision

Our system vision embraces the six characteristics of a high quality and sustainable system¹

Patient and Citizen Involvement

The system is signed up to the Luton Community Involvement Strategy which is fully embedded in the Health and Wellbeing Strategy and this Five Year Strategy.

Wider Primary Care provided at scale

The need for high quality consistent primary care is a key commissioning recommendation in the Health and Wellbeing Strategy. The CCG is currently developing a specific strategy for primary care in partnership with the Area Team with a focus on increasing the range of services available, driving a reduction in variation, improving access, driving clinical leadership, workforce development and training, commissioning of enhanced services, estates, informatics and IT

A modern model of integrated care

The Luton system has commenced delivery of its “Better Together” Programme to drive the delivery of joined up care based around personal needs to create a shift towards prevention, early intervention and treatment at home with reduced reliance on specialist care.

Access to the Highest Quality Urgent Care

An urgent care system working group has been in place for a significant period of time in Luton driving a collaborative approach to ensuring that unscheduled care is delivered through the most appropriate routes

A Step Change in the Productivity of Elective Care

The system is driving the delivery of non complex elective care out of the hospital to deliver more care nearer to the home via primary and community care

Specialised services concentrated in centres of excellence

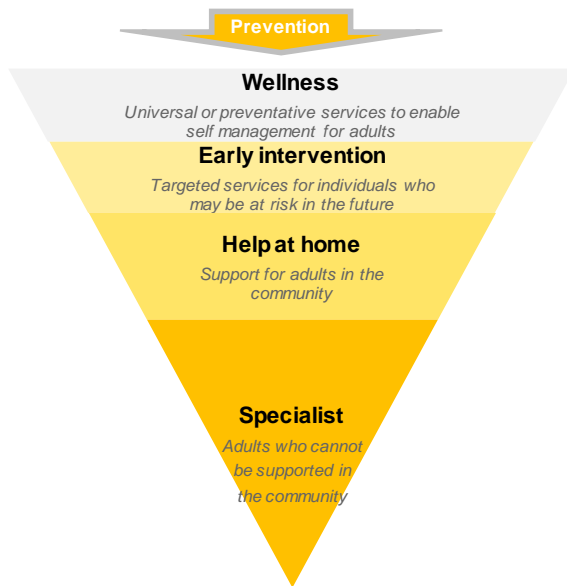
Whilst driving non-complex care away from the acute trust we will enable the repatriation of specialist interventions such as acute stroke and percutaneous coronary intervention (PCI Angiography)

1. Planning Guidance <http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf>⁴

2. System Vision

Vision for services – progress through Better Together Programme

Current balance of services



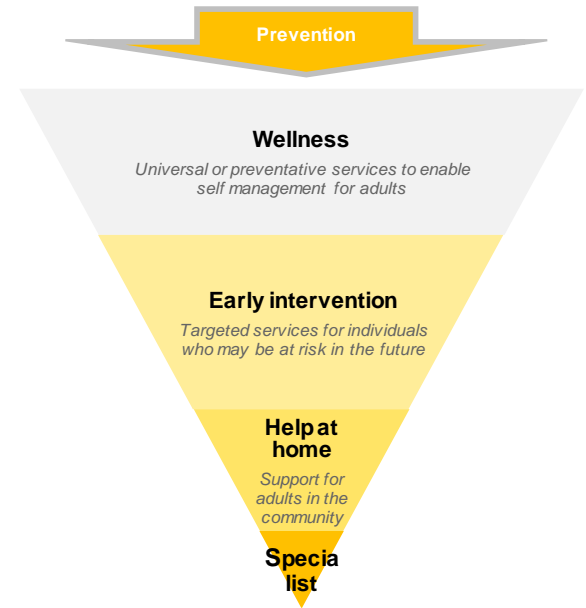
Service model has high spend in specialist services e.g acute and high cost residential settings

1 to 2 years vision



Provision shifted towards community capability in medium term

3 to 5 years vision



Spend strategically aligned to a early intervention and preventative model

3. Improving Quality and Outcomes

3. Improving Quality and Outcomes

Improving Quality and Outcomes

Introduction

National Planning Guidance requires CCGs to submit trajectories to support the seven outcome ambitions (see System Five Year Strategy):

- ✓ Securing additional years of life or people with treatable mental and physical health conditions
- ✓ Improving the quality of life of people with Long Term Conditions
- ✓ Reduce the amount of time spent avoidably in hospital
- ✓ Increasing the proportion of older people living independently at home following discharge from hospital
- ✓ Increasing the proportion of people with a positive experience of hospital care
- ✓ Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital
- ✓ Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

Process to Develop Outcome Ambitions

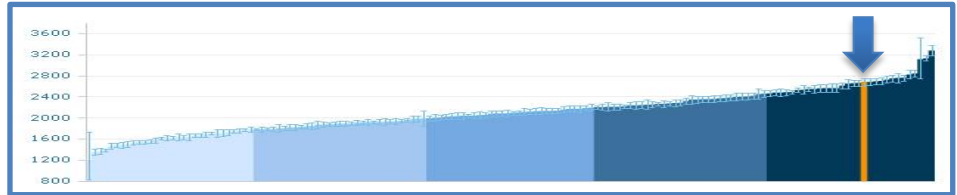
The initial proposals articulated in this document were developed by CCG Clinical Directors and Public Health utilising benchmarking data and in particular the performance of Luton in comparison to the national average and similar populations of Redbridge, Hillingdon, Wolverhampton and Birmingham East and North. The Levels of Ambition Tool enables benchmarking for the above outcomes and demonstrates that Luton outcomes are below the national average for many outcomes but is broadly performing in line with other populations with a similar make up to Luton.

3. Improving Quality and Outcomes

Benchmarking Outcomes

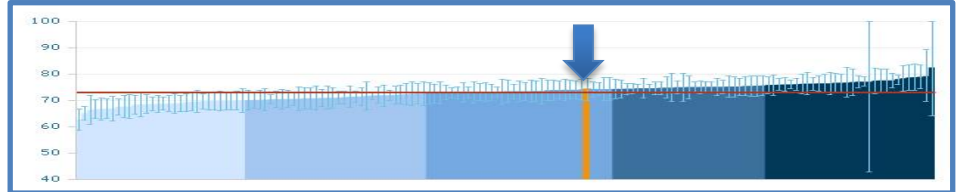
Potential Years of Life Lost

Luton Current Position: Baseline 2012 – 2669
Luton – Bottom Quintile



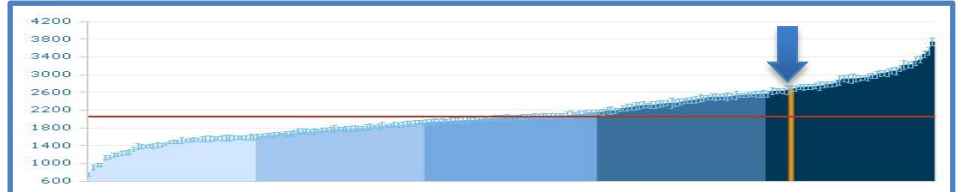
Quality of Life for people with LTCs

Luton Current Position: Baseline 2012/13 – 74.1
Luton – Middle Quintile slightly better than England



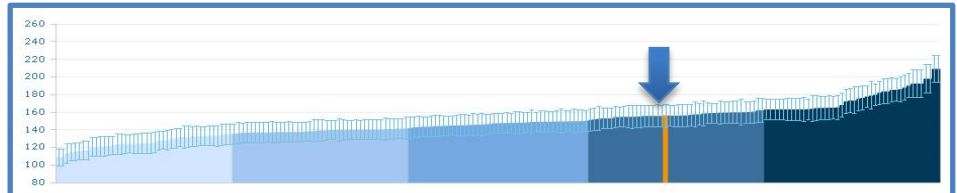
Avoidable Hospital Admissions

Luton Current Position: Baseline 2012/13 – 2668
Luton – Bottom Quintile



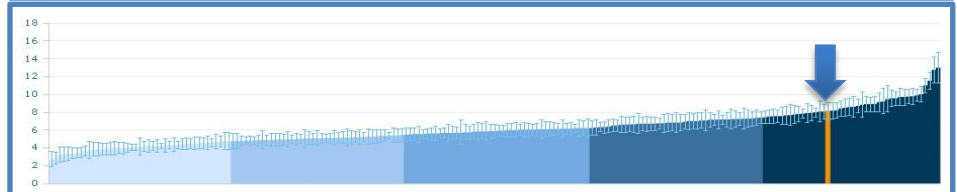
Patient experience in hospital

Luton Current Position: Baseline 2012 – 155
Luton – Quintile 4



Patient experience out of hospital

Luton Current Position: Baseline 2012 – 8.1
Luton – Bottom Quintile

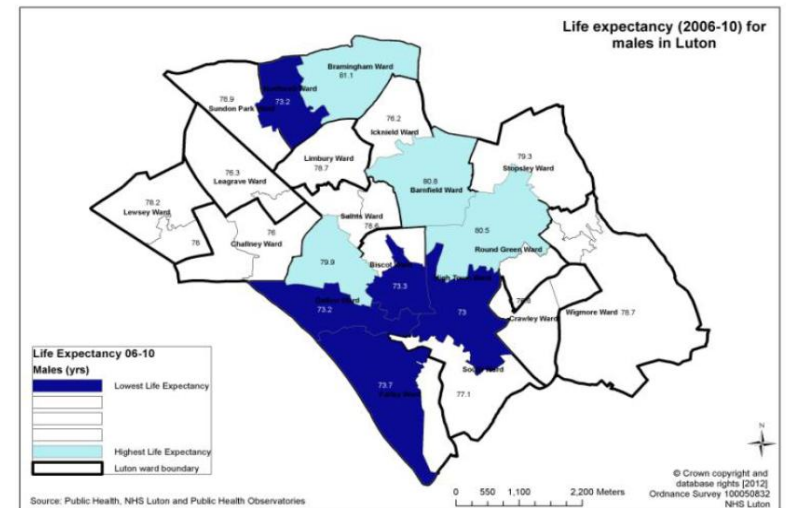
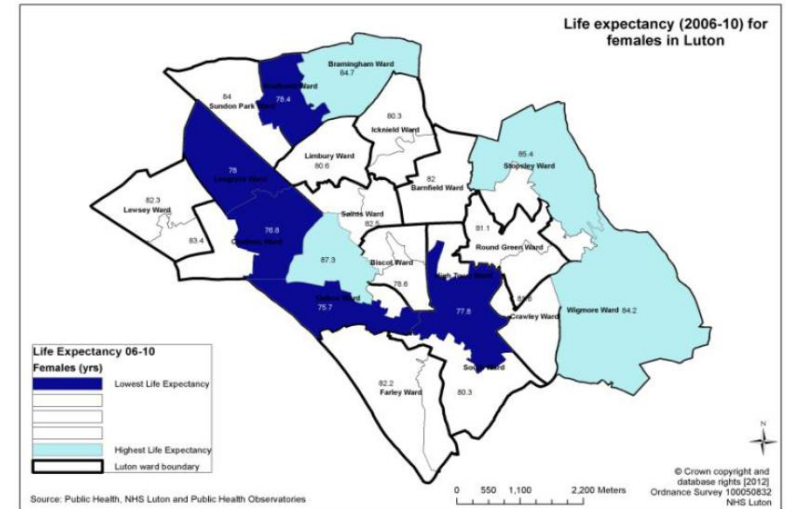


Health Inequalities in Luton

Research into the health of local people published in the Joint Strategic Needs Assessment (JSNA), in 2011, clearly identifies the key health challenges and highlights the inequalities in life expectancy which exist in Luton.

Although life expectancy in Luton has shown a steady increase since 1999, average life expectancy for both males (now 77.9 years) and females (at 81.9 years) remains below the national averages which are 79.2 years and 83.0 years respectively.

However significantly more worrying, these statistics mask the very serious inequalities that exist between areas within Luton with an 8.9 years life expectancy gap for males and 6.4 years for females between the most and least deprived areas of the town (see maps opposite).



3. Improving Quality and Outcomes

Driving a Reduction in Health Inequalities

As discussed earlier in this document , the Luton Health and Wellbeing Strategy articulates 3 major priority outcomes goals: **1. EVERY CHILD AND YOUNG PERSON HAS A HEALTHY START IN LIFE, 2. REDUCED HEALTH INEQUALITIES IN LUTON** and **3.HEALTHIER AND MORE INDEPENDENT ADULTS AND OLDER PEOPLE**. The Children and young people's plan has been put in place to address Goal 1 and part of Goal 2. This Strategy addresses Goal 3 and part of Goal 2 and therefore implementation of this Five Year Strategy has a major role to play in driving a reduction in health inequalities through the following recommendations from the Health and Wellbeing Strategy

- Systematic programmes to reduce the variability of General Practice in Luton to ensure that all members of the Luton population are able to easily access high quality and safe primary care.
- A risk based approach to identify all patients on their lists with long term conditions who are at increased risk of exacerbation or admission and take proactive steps to ensure these patients are supported to minimise unnecessary admissions to hospital or complications.
- integration of health and social care services to improve health outcomes and seamless support to the individual
- Integrated wellness service

3. Improving Quality and Outcomes

Seven Outcome Ambitions: 5 Years

1 Securing additional years of life

- Improve by 19% from baseline
- 2669 (2012) to x 2194

2 Health Related QOL for people with LTCs

- Improve by 6% from baseline
- 74.1 (2012/13) to 80 2018/19

3 Reducing the amount of time spent avoidably in hospital

- Hold at current position of 2668

4 Increasing the proportion of older people living independently at home following discharge

- There is no indicator currently available

5 Positive experience of hospital care

- Improve by 6% from baseline
- Poor responses 155 2012/13 to 146 2018/19

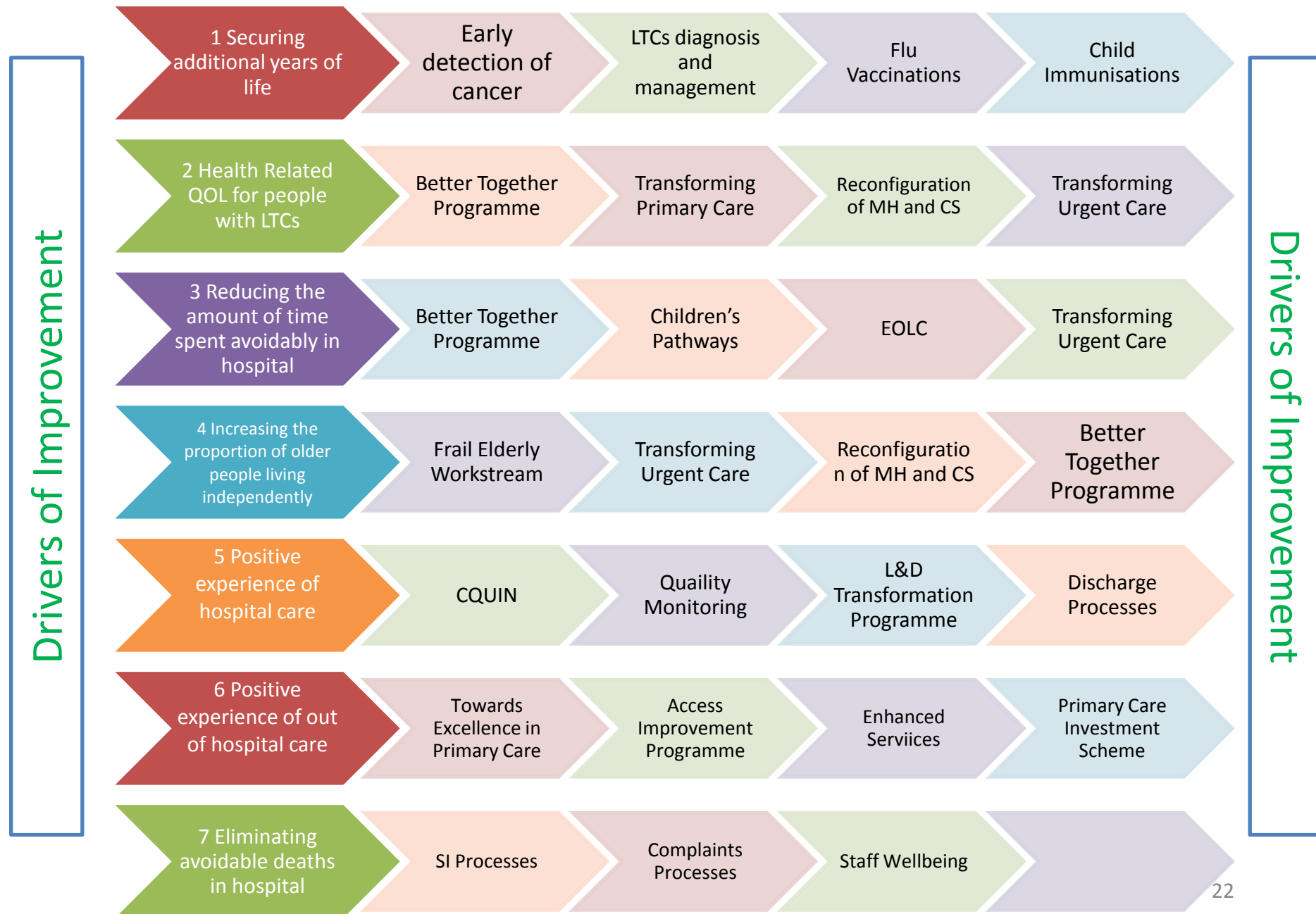
6 Positive experience of out of hospital care

- Improve by 10% from baseline
- Poor responses 8.1 2012/13 to 7.1 2018/19

7 Eliminating avoidable deaths in hospital

- There is no indicator currently available

3. Improving Quality and Outcomes



3. Improving Quality and Outcomes

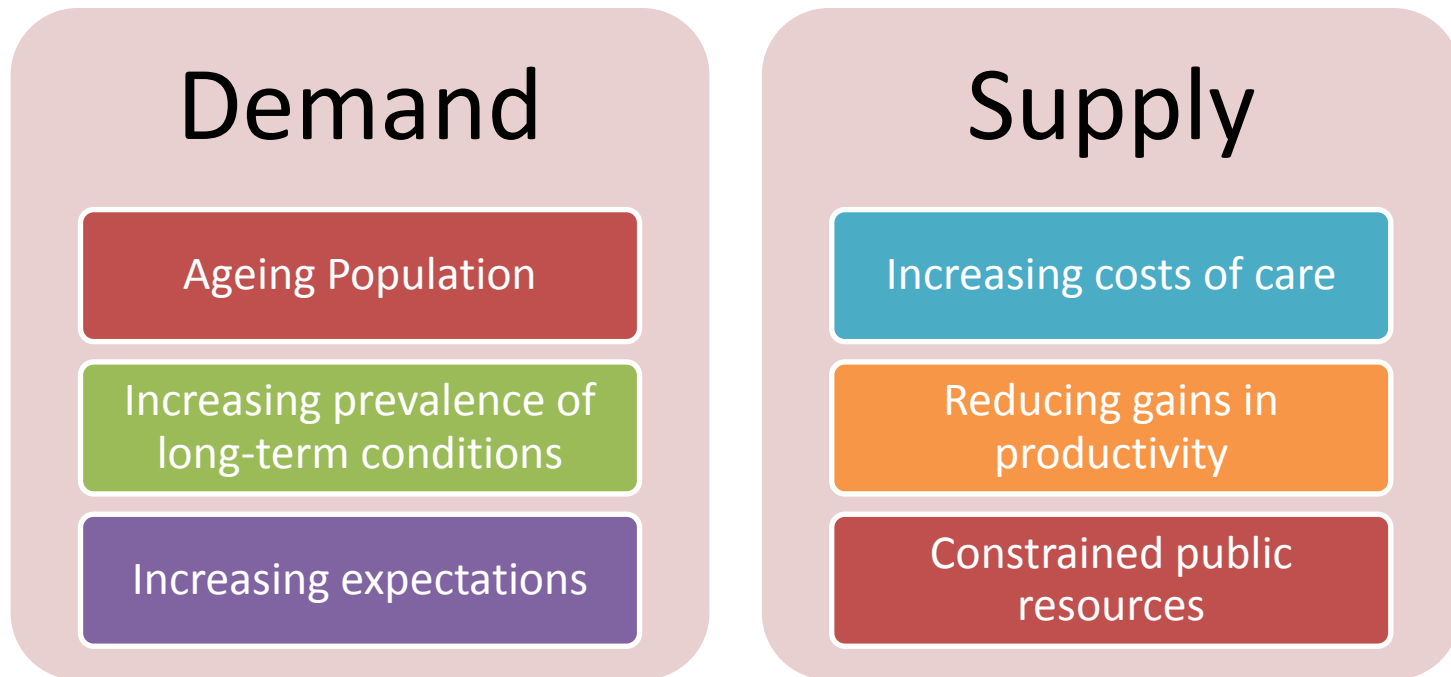
Additional (Local) Outcome Ambitions: 5 Years

| | |
|---|---|
| Reduction in Infant Mortality Rate (per 1,000 live births) | <ul style="list-style-type: none">• Baseline 7.2 (2009-11)• Reduce to 5.0 by 2017-18 |
| Increased life expectancy at birth and narrowed inequality gap with England - Males | <ul style="list-style-type: none">• Baseline 77.9 (2009-11)• Increase to 80.3 by 2017-18 |
| Increased life expectancy at birth and narrowed inequality gap with England - Females | <ul style="list-style-type: none">• Baseline 81.9 (2009-11)• Increase to 82.7 by 2017-18 |
| Life Expectancy gap between the most and least deprived areas in Luton - Males | <ul style="list-style-type: none">• Baseline 8.9 (2006-10)• Reduce to 7.9 by 2017-18 |
| Life Expectancy gap between the most and least deprived areas in Luton - Females | <ul style="list-style-type: none">• Baseline 6.4 (2006-10)• Reduce to 5.6 by 2017-18 |
| Disability Free Life Expectancy (DFLE) - Males | <ul style="list-style-type: none">• Baseline 9.1 (2011-12)• Increase to 10.0 by 2017-18 |
| Disability Free Life Expectancy (DFLE) - Females | <ul style="list-style-type: none">• Baseline 9.9 (2011-12)• Increase to 10.9 by 2017-18 |

Note : Needs to be updated to reflect 18/19 target

4. Sustainability

The Sustainability Challenge



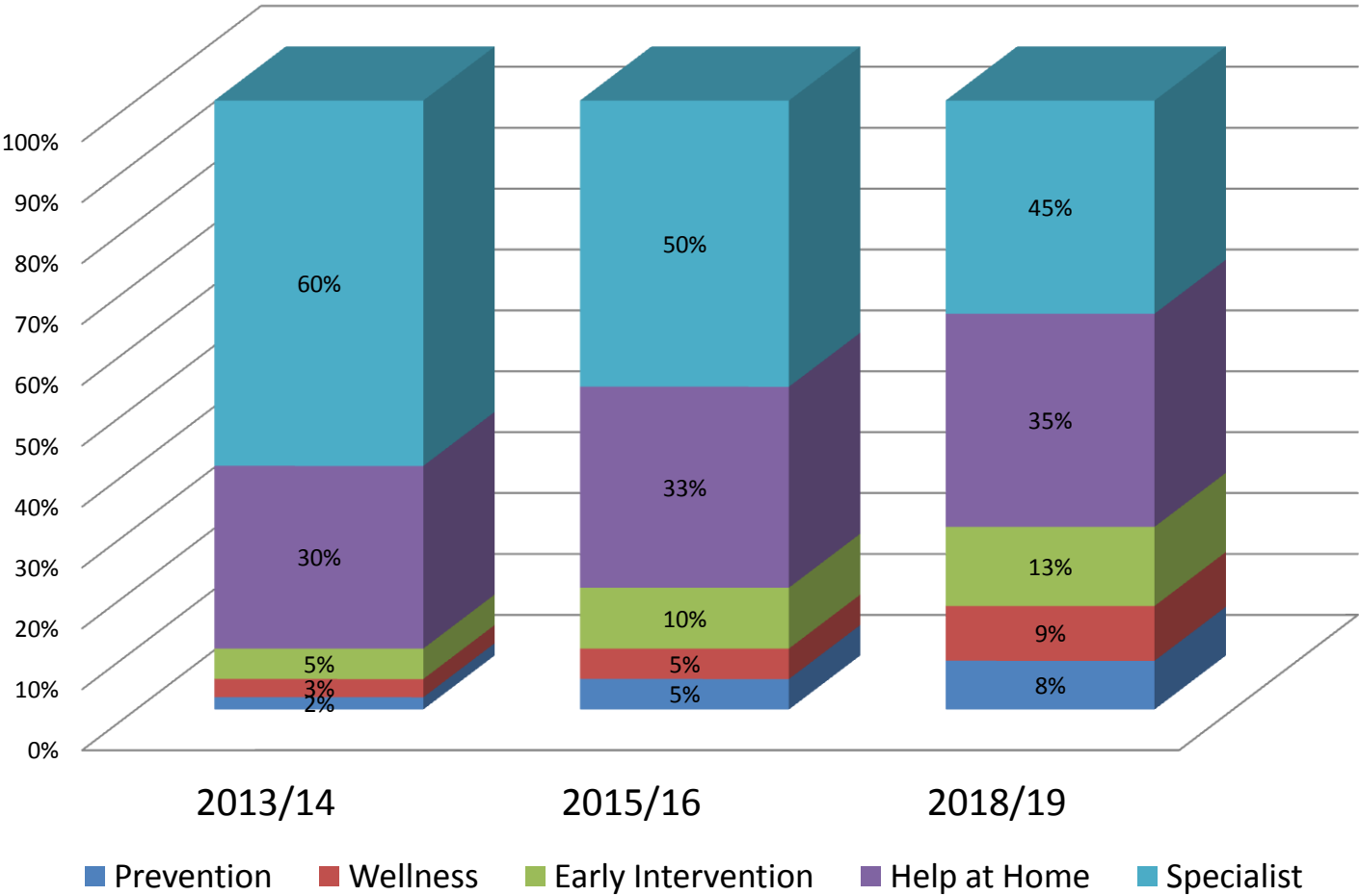
NHS England's "A Call for Action¹" describes the future trends which threaten the sustainability of a high quality NHS. It is the potential impact of these trends summarised in the diagram above that means that while a new approach is urgently needed, we must take a longer-term view when developing it. The Luton system understands that in order to overcome the impact of these trends, we need to shift the balance of health and social care spend away from specialist care and towards prevention, wellness, early intervention and care at home so that specialist care is reserved for more complex interventions for the more severely ill.

¹ <http://www.nhs.uk/NHSEngland/thenhs/about/Documents/nhs-belongs-to-the-people-call-to-action.pdf>

Meeting the sustainability challenge

Shifting the Balance of Spend

This graph is a stylised representation of the relative shift in the balance of spend, primarily driven by the Better Together Programme



Goals for sustainability

- All organisations within the health economy report a financial surplus in 18/19
- Delivery of the system outcome ambitions
- No provider under enhanced regulatory scrutiny due to performance concerns
- With the expected change in resource profile

5. Improvement Interventions

5. Improvement Interventions

Summary of Key Interventions



Better Together – Integration of Health and Social Care

- Building personalised services around the needs of patients
- Switching the focus towards prevention and early intervention



Transforming Primary Care

- Driving a transformation in the capacity and capability of primary care to deliver a broader range of high quality and safe services in the community.



Reconfiguring Mental Health and Community Services

- Redesign of community and mental health services to drive improved health outcomes, system integration and financial sustainability



Transforming Urgent Care

- Redesign of unscheduled care provision to ensure the right level of care delivered appropriate to the needs of the patient.

5. Improvement Interventions



Better Together

Frail Elderly. Personal e-plans, shared across the system delivering seven days a week service coordinated around the needs of the patient

Disabled Children. Holistic assessment of educational, social care and health needs met through the delivery of a single plan

Information Sharing. A single e-plan accessible via mobile devices to provide access to critical information by all involved in the delivery of care

Shared Services. A collective approach to procurement and back office functions

Organisational Change. Delivering the shift from individual organisation vision and purpose to a collective vision and purpose

Seven Day Working. For health and care services preventing unnecessary hospital stays and maximising service user and patients' independence

Homecare Plus. Implementation of multi-tasking Homecare Plus workers to keep people safe at home and maximise independence

5. Improvement Interventions



Transforming Primary Care

Towards Excellence. Clinically led practice development programme driving reductions in performance variation in clinical quality, safety and financial performance across practices

Primary Care Access Improvement. Focused CCG-led support programme driving improvements in practices in the bottom decile based on the GP Patient Survey

Primary Care Investment Scheme. Driving the achievement of local priorities, making funds available to deliver high quality primary care at scale

•Workforce Development. The CCG is implementing its Organisational Development Plan which includes the development of primary care clinicians and attracting primary care leadership talent to the area

5. Improvement Interventions



Reconfiguring Mental Health and Community Services

Integration and Collaboration. Driving system collaboration and an approach embedded in the principle “the needs of patients are more important than the needs of the organisation”

Workforce. Attracting the right talent to Luton and establishing a world class workforce which places patients at the heart of all we do

New Pathways of Care and Innovation. Driving innovative services build around patients with GPs as the central point within an integrated model

Early Intervention. Delivering a cost-effective impact “downstream”, helping people to recover more quickly from illness and maximising independence for those with long term conditions

Value for Money. Effective use of resources across the health, social care and other public services in Luton

Patient Engagement and Experience. Using service user and carer feedback to develop effective services for vulnerable adults in the past ensuring equity of service and a seamless care experience.

5. Improvement Interventions



Transforming Urgent Care

111. Driving improved signposting to the right services to meet the individual needs, reducing pressure on A&E attendances and short stay admissions.

Hospital at Home. Supporting early discharge through a Hospital-at-Home nursing team under the direction of the consultant.

Acute Home Visiting Service. Supporting General Practice by undertaking home visits to patients early in the day, addressing care needs in the home.

Ambulatory Care. Patients attending A&E who are mobile are streamed early to a dedicated service which can provide speedy resolution of care needs, and discharge patient, with follow-up as required.

Ambulance Response – Care at Home. Ambulance paramedics supporting people at home where appropriate

Clinical Navigation. Clinical Navigator Nurse Team providing holistic direction to patients being discharged from A&E and EAU to ensure that appropriate follow up care is in place

Intervention Outcomes



Better Together

- Shift of spend towards prevention, early intervention, and care closer to the home.
- Securing additional years of life; increasing QoL for LTCs; Reducing unnecessary hospitalisation; independent living



Transforming Primary Care

- Delivery of range of low complexity “acute” services in the community; Reduced variation in primary care outcomes; enhanced patient experience; reduced unnecessary admissions to hospital



Reconfiguring Mental Health and Community Services

- Integration of mental health and community services; Securing additional years of life, QoL for people with LTCs, reduced unnecessary admissions, improved post-discharge outcomes, improved patient experience



Transforming Urgent Care

- Supporting the integration of health and social care; reduced unnecessary admissions to hospital; reduced demand on A&E; improving experience of out of hospital care.

6. Citizen and System Engagement

Citizen Engagement

The heart of integrated health and social care is person centred planning and this plan draws on a wide range of national and local evidence and experience to set its principles around resident engagement and the importance of listening and responding to the real life stories that tell local residents' experiences.

Our goal is not for patients and carers to be the passive recipients of increased engagement, but rather to achieve a pervasive culture that welcomes authentic patient

partnership – in their own care and in the processes of designing and delivering care. This should include participation in decision-making, goal-setting, care design, quality improvement, and the measuring and monitoring of patient safety.

Patients and their carers should be involved in specific actions to improve the safety of the healthcare system and help the NHS to move from asking, "What's the matter?" to, "What matters to you?" This will require the system to learn and practice partnering with patients, and to help patients acquire the skills to do so

In order to ensure that Luton residents' views are taken into account, LBC has developed six principles for public consultation:

- Community involvement should be at the heart of how partners improve services, set priorities and use resources.
- There should be a range of opportunities for involvement that are well publicised, link to local democracy and in which all citizens are encouraged to participate.
- Methods for involvement should be regularly reviewed to ensure they are cost effective, and meet the preferences and needs of all citizens
- Citizens should receive clear and prompt feedback on how their involvement has helped to shape services, places and communities.
- Partners should work in a joined up way to avoid duplication.
- Involvement should be the basis on which partners increase satisfaction, build trust and confidence in their organisations.

[Community Involvement Strategy. LBC, 2010]

6. Citizen and System Engagement

“Your Say, Your Way”

LBC and LCCG are active members of the “your say, your way” programme which enables a robust feedback cycle between community concerns and system response to those concerns.

The programme delivers a range of community involvement, development and grant funding opportunities which are adapted to identify the priorities for and meet the needs of each neighbourhood, including:

- Community festivals
- Neighbourhood mapping/Community surveys (R&I)
- Local neighbourhood networks
- Area Board partnership work programmes and reporting arrangements
- Participatory budgeting/ community project support
- Volunteer development and community learning opportunities
- Community planning decision days

These platforms provide unique opportunities for reaching large numbers of local people for the purposes of public information and health promotion, community empowerment, consultation, accountability and direct local involvement. Diversity profiling of community involvement in the programme consistently shows significant increases and improvements in community involvement matching the diversity of local populations – in other words, the programme makes a major contribution to social inclusion reaching communities that much conventional public engagement does not.. Although the programme now provides coverage across the Borough, it continues to maintain a focus on neighbourhoods and LSOAs with relatively higher levels of deprivation and health inequalities.

Engagement Strategy

To be completed

7. Governance

Proposed System Governance for Strategy Development and Delivery

Healthier Luton Partnership

The System has put in place “the Healthier Luton Partnership” group to discuss and agree strategic issues across the following partners:

- Luton CCG
- Bedfordshire CCG
- Luton Borough Council
- Luton and Dunstable Hospital
- Cambridgeshire Community Services
- SEPT

Meetings are chaired by the Luton CCG Chief Officer and are attended by leaders of the composite organisations. This plan and strategy has been written and approved by this forum.

Future Governance Arrangements

System Governance arrangements are currently under discussion and it is likely that the responsibility for plan delivery will sit with Better Together Programme Board which will report to the Health and Wellbeing Board.

Plan on a Page

In 2019 Luton residents will benefit from integrated health and care that has four elements: a person centred approach enabled by a shared personal plan for patients and service users; prevention that helps people to keep themselves well; better use of shared evidence and data; a multi-disciplinary, multi-professional team approach to service delivery built on three GP clusters in the town. We will work in partnership with patients, their carers, providers and other partners to deliver a high quality and cost effective health and social care system to the people of Luton, empowering them to lead healthy and independent lives.

System Objective One

To reduce potential years of life lost by 19%

Delivered through Better Together Programme

Whole system integration programme

- driving the effective use of **shared evidence** and data -shifting the balance towards wellness (**prevention** and early intervention)
- delivering **personal plans** to build the right services around the needs of individuals
- creating a **multi-disciplinary team** to deliver personalised care

System Objective Two

Increasing the proportion of older people living independently at home following discharge

Delivered through the Reconfiguration of Mental Health and Community Services:

Redesign of community and mental health services to drive improved health outcomes, system integration and financial sustainability

System Objective Three

To improve the quality of life people with LTCs by 6%

Delivered through the Transformation of Urgent Care

Redesign of unscheduled care provision to ensure the right level of care delivered appropriate to the needs of the patient.

- NHS 111
- Hospital at home
- Acute visiting service
- Clinical Navigation
- Ambulatory Care

System Objective Four

To stop the increase in unnecessary hospital admissions

Delivered through The Transformation of Primary Care : Driving a transformation in the capacity and capability of primary care to deliver a broader range of high quality and safe services in the community.

System Objective Five

To increase patient experience of care outside of hospital by 10%

Overseen through the following governance arrangements

- Health and Wellbeing Board and Healthier Luton Partnership overseeing implementation of the improvement interventions
- Individual organisations leading on specific projects

Measured using the following success criteria

- All organisations within the health economy report a financial surplus in 18/19
- Delivery of the system objectives
- No provider under enhanced regulatory scrutiny due to performance concerns
- With the expected change in resource profile

Our System Principles

- Integration and collaboration
- Service Innovation
- Services around the patient
- Safeguarding the vulnerable
- Early intervention
- Value for money
- Citizen engagement
- Quality and Safety