LUTON BOROUGH COUNCIL

COMMITTEE REF:

HSCRG/09/14

SCRUTINY HEALTH AND SOCIAL CARE REVIEW GROUP

Date : **THURSDAY, 11 SEPTEMBER 2014**

Time : **18:00**

Place : **COMMITTEE ROOM 3**
TOWN HALL, LUTON, LU1 2BQ

Members : **Foord (Chair)** **Knight**
Campbell **T. Malik**
J. Davies **Moles**
Gale **Zia**

Co-Opted Member: **Mr Norris Bullock (Healthwatch Luton)**

Quorum: **3 Elected Members**

Contact Officer: [Eunice Lewis] (01582 547149)

EMERGENCY EVACUATION PROCEDURE

Committee Rooms 1, 2, 4 & Council Chamber:

Turn left, follow the green emergency exit signs to the main town hall entrance and proceed to the assembly point at St George's Square.

Committee Room 3:

Proceed straight ahead through the double doors, follow the green emergency exit signs to the main Town Hall entrance and proceed to the assembly point at St George's Square.

AGENDA

Agenda Item	*Subject*	*Page No.*
1	**APOLOGIES FOR ABSENCE**	
2	**MINUTES** 31st July 2014	
	31st July 2014	4 - 13
3	**DISCLOSURES OF INTEREST**	
	Members are reminded that they must disclose both the existence and nature of any disclosable pecuniary interest and any personal interest that they have in any matter to be considered at the meeting unless the interest is a sensitive interest in which event they need not disclose the nature of the interest. A member with a disclosable pecuniary interest must not further participate in any discussion of, vote on, or take any executive steps in relation to the item of business. A member with a personal interest, which a member of the public with knowledge of the relevant facts would reasonably regard as so significant that it is likely to prejudice the member's judgment of the public interest, must similarly not participate in any discussion of, vote on, or take any executive steps in relation to the item of business. Disclosable pecuniary interests and Personal Interests are defined in the Council's Code of Conduct for Members and Co-opted members.	
4	**URGENT BUSINESS** The Chair to report on any business which is considered to be urgent and which should be discussed at the meeting in accordance with Section 100B(4)(b) of the Local Government Act 1972 and to determine when, during the meeting, any such business should be discussed.	
5	**REFERENCES FROM COMMITTEES AND OTHER BODIES**	
6	**CHAIR'S UPDATE** Chair to report on issues since the last meeting.	
7	**East of Anglia Ambulance Service Report** Report by the East of Anglia Ambulance Service	14 - 16
8	**Luton and Dunstable Hospital Update - Presentation** Report of the Chief Executive - Luton and Dunstable Hospital	17 - 17

9	**Five Year System Strategy LCCG** Report by Carol Hill - Luton Clinical Commissioning Group (LCCG)	18 - 96
10	**Commissioned Work on Genetics - Engagement with the Pakistani Community** Report of the Director of Public Health	97 - 104
11	**The Link Between the Family Poverty Strategy and infant mortality** Report of the Director of Public Health	105 - 112
12	**CDOP Audit of Gender Imbalance Findings - Presentation** Report of the Director of Public Health	113 - 113
13	**HSCRG - Report of Work Programme** Report of the Head of Policy and Performance	114 - 128
14	**LOCAL GOVERNMENT ACT 1972, PART VA** To consider whether to pass a resolution under Regulation 21(1)(b) of the Local Authorities (Executive Arrangements) (Access to Information) (England) Regulations 2000 to exclude the public from the meeting during consideration of the item(s) listed below as it is likely, that if members of the public were present during the transaction of the item(s), exempt information within the meaning of the Paragraph(s) of Part 1 of Schedule 12A to the Local Government Act 1972 indicated next to the item, would be disclosed to them.	

AGENDA ITEM
2

MINUTES OF THE HEALTH AND SOCIAL CARE REVIEW GROUP

THURSDAY 31ST JULY 2014 AT 6.00 PM – COMMITTEE ROOM 3

PRESENT: Councillor Foord (Chair), Councillors, Campbell, J. Davies, D. Moles, Bailey (Substitute for Gale), and T. Malik.

CO-OPTED MEMBER
Mr. Norris Bullock
Mrs. Farrah Gilani – Healthwatch Luton

SUPPORT OFFICERS / ADVISORS:

Tracey Brennan	- Joint Commissioning Manager (LBC)
Maud O'Leary	- Head of Adult Social Care (LBC)
Ian Hilsden	- (LBC)
Jon Cox	- (LBC)
Mike McMahon	- Head of Community Living (LBC)
Gerry Taylor	- Director of Public Health (LBC)
Carol Hill	- CCG - Luton
Nicky Poulain	- Director of Commissioning and Integration (CCG)
Eunice Lewis	- Democracy and Scrutiny Officer (LBC)
Chris Morris	- (LBC)
Diane Walsh	- (LBC)
Kay Kokabi	- Healthwatch Luton

		ACTION
36	**APOLOGIES FOR ABSENCE (REF: 1)**	
	Resolved: Apologies for absence from the meeting were received on behalf of Councillors Gale, Knight and Zia.	
37	**MINUTES (REF: 2.1)**	
	Resolved: That the minutes of the meeting held on 18th June 2014 be taken as read, approved as a correct record and the Chair be authorised to sign them.	
38	**CHAIR'S UPDATE (REF: 6)**	
	The Chair acknowledged and welcomed Mrs. Farrah Galani (co-opted member from Healthwatch) and Mrs. Nicky Poulain, CCG Director of Commissioning and Integration. **Update on Repeat Prescribing through Pharmacies - CCG** Carol Hill from Luton CCG, gave a brief progress update on repeat prescribing issues raised at previous meeting of the HSCRG. She advised that the CCG were taking steps to review the prescribing process through a phased way, with a working group which includes Luton Healthwatch and other stakeholders. Members were further advised as follows: • Need to initially identify categories of patients affected • A whole system review through planning groups and stakeholders before roll out of the programme across the town • Need to identify the impact of the change on service users to ensure a robust new system inclusive of the voice of the patient • Planned detailed progress to be reported to the HSCRG in three months' time.	

		ACTION
	Resolved: (i) That the update from the CCG on repeat prescribing and the Chair's update be noted. (ii) That Carol Hill, CCG be requested to submit a Progress Report on the Review of Repeat Prescribing through Pharmacies to a future meeting of the Committee in three months' time.	
39	**LEARNING DISABILITY – JOINT COMMISSIONING STRATEGY 2014 – 2017/DELIVERY PLAN (REF: 7)**	
	Tracy Brennan Joint Commissioning Manager submitted a report on the Learning Disabilities Joint Commissioning Strategy and Delivery Plan advising of timescales of the delivery plan developed to meet the objectives and the vision of the Strategy. The Strategy had received sign off from the Learning Disability Partnership following a 3 months consultation period. In response, to Members questions/ comments, Tracey Brennan provided further information on the key actions of the Delivery Plan as follows: • GP Services signed up additional health services to carry out more health checks for people with learning disabilities. In 2012/13, 244 health checks were completed by GP's, 208 of those were carried out in the last quarter. Up to five GP practices failed to sign up for health check in 2012/13. • In 2013/14, 342 health checks were successfully completed and only 2 surgeries did not take part. • The Service receives specific funding stream from LLAL monitored by the Service to ensure a significant number of carers are engaged in the process. Members were further informed of the "getting a new life" project carried out by the Service. This project offered service users the opportunity to choose the service that best suits their circumstances in terms of access to support services and independent living and relocation. In answer to a question about the proposals for change regarding the Day Centre at Bramingham, the Joint Commissioning Manager advised that the service building at Brammingham will close down. The proposals were approved at the Council's Executive meeting last night. **Resolved:** (i) That the report on the Learning Disabilities Joint Commissioning Strategy 2014/17 and Delivery Plan be noted. (ii) That the Joint Commissioning Manager be requested to submit a further progress on the Learning Disability Joint Commissioning Strategy and Delivery Plan at a future meeting of the Committee on 8th January 2015.	

40	**PROGRESS REPORT ON THE IMPLEMENTATION OF THE LUTON CARER'S STRATEGY – CARING FOR CARERS (REF: 8)**	

Chris Morris, Purchasing and Quality Assurance Manager reported on the progress of the implementation of the Luton Carer's Strategy – Caring for Carers.

Members were informed that the Strategy received clearance and sign off by the Health and Wellbeing Board in January 2014. He advised that one area of challenge for the Service was to identify good quality care providers in Luton not commissioned to work with the CCG but who are equally good and could potentially add value to the provision of care in Luton. The need to identify unknown hidden carers highlighted.

He explained that the review of the Strategy would continue till September with a number of additions to the action plan. He further explained that the Care Act June 2014 has significant implications for the future direction of the Strategy and the services for carers. The Act puts carers on a much more even footing, by strengthening and recognising a clear path and direction of support for carers to access and receive more services. He advised of the need to understand and recognise where the gaps were within the service in order to continue to incorporate actions into the Strategy.

Following questions and comments by Members, Chris Morris further advised;

- Support for young carers sit within the Children Services and a Young Carer support programme has been commissioned.
- The assessment requirement is quite clear in regards to carer assessments; there are a variety of services based on eligibility, such as home care, respite, short breaks, residential and direct payments funding to purchase a place in residential home, etc. From the stats there are lots of carers who do not wish to be classed as carers. They consider themselves as family members rather than carers and this is acknowledged by the Service.
- Need to ensure preventative measure for carers to prevent crisis, this area would be explored further by the service. There was real opportunity to remodel the service to engage with people and understand the outcomes for the individuals and not the organisation.
- The care staffs carries out a number of carer's assessment in relations to mental health.
- Every GP surgery has a carer assessment support staff and referrals are received from several organisations.
- The criteria for supporting carers remain the same and those entitled to support will continue to receive support; there was also progress with schools and GP's.

	• The Service has an obligation to provide care for all carers; the challenge for the service is how to reach a substantial number of hidden carers that the Service was unable to engage with. It was hoped that these will come through in terms of the action plan being developed and the Carers Strategy. Carol Hill explained that the CCG have a priority around carers; there is awareness that longer assessment period was required. The need to prioritise and be more sensitive to appointments was also highlighted. A Member stated that the Jelly Fish programme by the CCG informs people about services and there is need to encourage this. **Resolved:** (i) That the progress update on the Implementation of Luton's Carer's Strategy be noted; (ii) That a further progress on the Implementation of Luton's Carer's Strategy be submitted to a future meeting of the Committee on 8th January 2014.	

41	**JNSA AND PNA PROGRESS UPDATE (REF: 9)**	
	Jon Cox provided Members with a brief progress summary on the work to refresh the Joint Strategic Needs Assessment (JSNA) and the Pharmaceutical Needs Assessment (PNA). The report sought commends from Members on the two pieces of work. He advised of the timeline for the completion of the JSNA for 2014 and 2015 and stated that the Service was presently in the process of trying to agree a set of priorities and to take a systematic approach in setting these priorities. It was expected that the JSNA would receive final sign off from the Health and Wellbeing Board by January 2015. In regards to the PNA, he advised that it was a statutory requirement of the Health and Wellbeing Board to carry out assessment to look at the adequacy of the pharmaceutical services and its effectiveness. Each HWB must publish a PNA by 1st April 2015 covering a 3 year period and maintain the document issuing supplementary statements regarding need for pharmaceutical services as required. He further advised that a PNA document must include some of the following: • A statement of the pharmaceutical services provided necessary to meet the needs required across the town. • How the assessment has been carried out • Services have secured improvements to pharmaceutical service in the area, etc. A Member stated that there was a shortage of Pharmacies in Luton as a whole. Pharmacies were not evenly spread across the town but some areas were more affected than others. In response, Jon Cox advised that the Service will have input into new Pharmacies being set up depending on the population need in the area. There were strict rules and guidance around control of dispensaries in terms of instant sufficiency in the area. The Service would like to see development of a range of services delivered in the area, including pharmaceutical services. It was expected that the PNA document would be finalised in February and final sign off by the HWB in March 2015. **Resolved:** (i) That the progress report on JSNA and PNA be noted by the Committee; and that a further progress be reported back to the Committee after March 2015. (ii) That a further progress on the JSNA be submitted at the HSCRG in January for comments prior to sign off by the HWB in January 2015; (iii) That a further progress on the PNA be submitted to a future meeting of the HSCRG in March 2015 for comments prior to signing off by the HWB in	

	March 2015.	
42	**COMMUNITY TRANSPORT UPDATE (REF: 10)**	
	Mike McMahon, the Head of Community Living, reported on the progress and position of the Community Transport Service. He advised that the South Beds Dial-a-Ride (SBDAR) has been replaced by a Community Transport service whereby Age Concern Luton would be coordinating the new transport service. He highlighted some of the key areas of the services and proposals as follows; • The proposals from Age Concern Luton, included the following elements; expansion of the existing network of volunteer drivers,; development of partnership with other community transport providers and more extended range of options for service users; • The new service was to receive a donation of 11K from LLAL. • There was currently on-going dialogue with Age Concern Luton in terms of implementation, but with an aim that the new servicewillbe up and running within the next two months. • In the meantime, the interim service which has been in place since last August and provided by the PTU will continue to operate until the new service in in place.; • . All Volunteers will be CRB checked and will have needs assessment by Age Concern for every client. . The outcome of a market testing with regards to charges revealed that service users would be willing to pay up to £6.00 per journey. The aspect of insurance and injury for service users will be covered by Age Concern Luton being the main coordinator of the new service. In regards to a question about the details of the scheme and proposals Members were informed that such details are contained in the document between LLAL and Age Concern. In terms of volunteers, Age Concern will make provision to reimburse volunteers to ensure services rendered were not completely free of charge as expenses will be covered. **Resolved:** That the report on Community Transport Update be noted and that a further progress be reported and submitted to a future meeting of the Committee on 8th January 2015.	
44	**HOME CARE SERVICES (REF:11)**	

Ian Hillsden, Contracts Manager Adult Social Care, submitted the report on Home Care services advising Members on the effectiveness of the Strategic Partnership and the quality of the service provided. He highlighted some of the areas of improvement evidenced from the reviews carried out. He explained that there was room for further improvement around reliability in terms of the timing of calls and communication with families particularly when carers are running late and in responding to complaints.

He further advised Members that the feedback received from the reviews carried out between 2013 and 2014 demonstrated that individuals and their families were satisfied with some areas of the service, with further improvement required in other areas as follows:

- Carers were seen as being very professional in their approach and also offered choices to service users;
- Regular and consistent care and support received by service users and their families;
- Service users felt well informed, etc.
- Need to have a robust contingency plan in place to respond to calls and improved communication;
- Evidence suggests four main causes of delay; greater demand at certain times; ineffective deployment of carers/planning and fluctuating needs of the individuals.

Members queried some of the figures quoted in the report especially the Prime Care survey figures regarding rating of performance for care provision and the Aura calls ratings.

The Contracts Manager explained that Aura rating tells us when care was provided and the duration in minutes. This forms the basis on which the Partners are paid (actual care delivered and not planned care). Non Aura callas are those where the carers did sign in and sign out and these are reviewed as part of the Service Review.

A Member commented on the issue of low wages for carers. In response, the Contracts Manger explained that a recent examination of this concluded that allowing for travel time the majority of carers were paid above the minimum wage and only small minority (carers using the bus) were at risk of falling below the threshold. Excluding travel time all were paid above the national minimum wage. There is no evidence of carers not being paid or any complaints received to that effect.

He further informed Members that the Service had had significant improvement in terms of carer's travel time, working with Strategic Partners to get the travelling arrangements right and to ensure equity in terms of pay. He advised that he will be happy to look into individual cases.

The Representative from Healthwatch stated that they would be happy to speak to any Member with concerns about individual cases at an early stage.

	Resolved: That the report on the progress made with Home Care Services be noted and that a further progress is submitted to a future meeting of this Committee.	
45	**CARE BILL (ACT) JUNE 2014 – UPDATE OF IMPACT ON COMMUNITY (REF:12)**	
	Maud O'Leary Head of Community Living gave a presentation on the new Care Act published June 2014. Members were informed of the key changes to the Act under three headings as follows: Change 1 • Modernises • Clarifies • Provides for the development of national eligibility criteria Change 2 • Treats carers as equal • Reforms how care and support is funded • Supports the aim to rebalance the focus of care and support on promoting wellbeing and preventing or delaying needs Change 3 • Provides new guarantees and reassurance to people needing care • Promotes freedom and flexibility needed by local authorities and care professional to integrate with other local services, innovate and achieve better results for people Members were informed that more changes were expected within the next few weeks with ongoing consultations and 12 different fact sheets expected. A link to the fact sheet will be sent to Members. Members were further informed of further key changes of the Care Act 2014 as follows: • Introduction of deferred payment scheme – Already operated by Luton • Huge cost of assessment process • Much better forum for information and advice • Prevent needs for care and support • Promote integration of care with health and other • Work with Housing to provide housing assessment • Comply with the safeguarding framework Members received further information on key implementation dates and that a Project Board has now been set up in response to the Care Act and implementation.	

	• Before April 2015 Awareness raising • Statutory guidance/regulations just released and consulted on until October 2014 • Universal Deferred payment April 2015 • New Charging framework – single overarching charging system April 2015 • New Legal Framework in place April 2015 • Assessment Regulations in force April 2015 • National Minimum eligibility threshold April 2015 • Financial support – some changes April 2015 The Head of Service advised of an on-going project regarding action plans to ensure more effective way of working and to further develop joint working links with people and organisations, including Luton local Healthwatch. In terms of reaching out to people without internet access, it was hoped that the on-going better together programme would address some of these issues with the involvement of GP services. A progress report is expected within the next three months. **Resolved:** That the report on progress be submitted at a future meeting of the Committee in three months' time.	
46	**WORK PROGRAMME AND DATES OF FUTURE MEETINGS (REF:13)**	
	The Democracy and Scrutiny Officer submitted the work programme with proposed items for future meetings. She requested Members to consider that items proposed for the meeting in October be moved to the November. This would ensure that the October meeting was fully dedicated to the Coroners item and implementations of recommendations as previously requested by Members. **Resolved:** (i) That the Democracy and Scrutiny Team Leader be delegated the responsibility to update the committee's work programme as discussed, following consultation with the Chair. (ii) That the items listed for the October meeting be moved to November meeting to ensure that the October meeting was completely dedicated to hear the report on the Coroner's item.	
	(Note: The meeting ended at 8.30 pm)	

LUTON BOROUGH COUNCIL

SCRUTINY: HEALTH AND SOCIAL CARE REVIEW GROUP	AGENDA ITEM 7

DATE OF MEETING: 11th SEPTEMBER 2014

REPORT OF: CHIEF EXECUTIVE–EAST OF ANGLIA AMBULANCE SERVICE

REPORT AUTHOR: **SIMON KING AND CHRIS HARTLEY**

SUBJECT: East of Anglia Ambulance Service Strategic Plan: Update & Implications for Luton

PURPOSE

To give an update of the East of Anglia Ambulance Service and its current activities in Luton.

RECOMMENDATION

The Health and Social Care Review Group is requested to note the progress update and comment on any implication for Luton.

REPORT - BACKGROUND

In January, Anthony Marsh (Chief Executive of West Midlands Ambulance Service) became Chief Executive of the East of England Ambulance Service NHS Trust. Mr Marsh is one of the most experienced ambulance Chief Executives in the country and had also carried out an independent review of the Trust last summer.

Mr Marsh set six priorities for the Trust on becoming Chief Executive. These are:

1. Recruit 400 student paramedics in 2014/15
2. Upskill emergency care assistants (ECA) to emergency medical technicians (EMT) and EMTs to paramedics
3. Maximise clinical staff on frontline vehicles
4. Reduce response cars and increase ambulances
5. Accelerate fleet and equipment replacement programme
6. Reinvest corporate spend in frontline delivery

Significant progress has been made against these priorities, which is helping the Trust to turn a corner. Progress includes:

- We had nearly 4,000 applications to become student paramedics (for 400 original places)

- To date 367 conditional offers have been made for the student paramedic programme. At the moment, 64 of those are on their initial course, 32 are completing their driver training and 61 are already out on the road from July.
- More than 30 offers of contracts have been made to qualified and graduate paramedics
- Around 200 existing student paramedics will qualify and register as paramedics in 2015
- We have trained more than 20 emergency care assistants to emergency medical technical level, with more courses to follow as part of a rolling programme
- Similarly, 20 emergency medical technicians have started their course to progress to paramedics
- Our emergency operations centres (EOCs) have welcomed 21 new call handlers and 11 dispatchers to their teams
- This year 147 new emergency ambulances have been delivered to replace old ones and increase the fleet size. Another 120 new emergency ambulances have also been ordered, with the first five due to be on the road in September. All 120 will be operational by March next year, with seven of these earmarked for Bedfordshire and Hertfordshire. By March, no ambulance or RRV will be older than five years.
- Around £8m of savings have been found internally and will be reinvested in frontline services by ending a number of interim contracts, reducing management costs and streamlining back-office services.
- We're not only updating our fleet but our equipment too; 160 of the latest generation 12-lead ECG and defibrillators are being delivered and being rolled out onto ambulances.

Transforming the Trust is going to take time, but we are making positive steps that are improving the service. Our aim is to make the East of England Ambulance Service one of the best ambulance services in the country. Employing the best staff who are able to provide our patients with the best care is our top priority - and this remains at the heart of everything we do.

The ambulance service in Luton

The Trust has restructured its operations team to better support staff and drive improvements in the service provided locally. We now have a new management team in Bedfordshire and Luton. This is led by Dave Fountain, locality director for Bedfordshire and Hertfordshire. Dave is responsible for the 999 service in both counties and sits on the Trust Board, giving Bedfordshire, Luton and Hertfordshire communities a direct link to the top of the organisation.

Simon King is the Senior Locality Manager and he is responsible for managing the 999 service in Luton and South Bedfordshire. Simon has appointed a team of local officers to manage and co-ordinate the day to day running of the service.

Recruiting more frontline staff is a priority both across the region and in Luton. By the end of March, 29 new student paramedics will have started in Luton, with five of these starting this month. In addition we have six graduate paramedics starting in Luton in November and have already recruited one qualified paramedic and one qualified emergency medical technician in Luton.

A new emergency ambulance is operational in Leighton Buzzard. This will help better meet patient demand in Leighton Buzzard and mean ambulances from Luton will spend less time in Leighton Buzzard and more time in Luton.

The local team have been working with staff to design new rotas. These rotas, once approved, will better support staff and provide better day and night cover for Luton across the week and weekend. These have received positive feedback from staff and implementation is expected for November 2014.

As part of the fleet replacement programme, Luton now has a modern ambulance fleet. The oldest emergency ambulance is three years old, meaning our staff have the best possible

vehicles to treat patients, patients get a better service and experience and the Trust has a more reliable fleet.

The local management team is working hard to better support staff. As part of this we have set up a buddy scheme for new starters. This has been designed by a local member of staff to support new starters and help them integrate into their new working environment. We are also creating dedicated clinical development lines on our main ambulance rota to provide structured support from our very experienced paramedics. We have been working hard to support staff in returning from sickness absence and have reduced sickness rates to under 4% currently.

SCRUTINY: HEALTH AND SOCIAL CARE REVIEW GROUP (HSCRG)	AGENDA ITEM 8

DATE OF MEETING:	**11th September 2014**
REPORT OF:	Chief Executive – Luton and Dunstable Hospital
REPORT AUTHOR:	**Pauline Philip and Sarah Wiles**
SUBJECT:	**Luton and Dunstable Hospital - Update** **PRESENTATION**

LUTON BOROUGH COUNCIL

SCRUTINY: HEALTH AND SOCIAL CARE REVIEW GROUP	AGENDA ITEM 9

DATE OF MEETING: SEPTEMBER 11TH 2014

REPORT OF: LUTON CLINICAL COMMISSIONING GROUP

REPORT AUTHOR: **CAROL HILL / ROD WHILE** **TEL : 01582 532043**

SUBJECT: Five Year Health System Strategy

PURPOSE

To enable the Health and Social Care Review Group to review the Health and Social Care Five Year System Strategy 2014/15 to 2018/19

RECOMMENDATION

The Health and Social Care Review Group is requested to note the Five Year Strategy.

REPORT

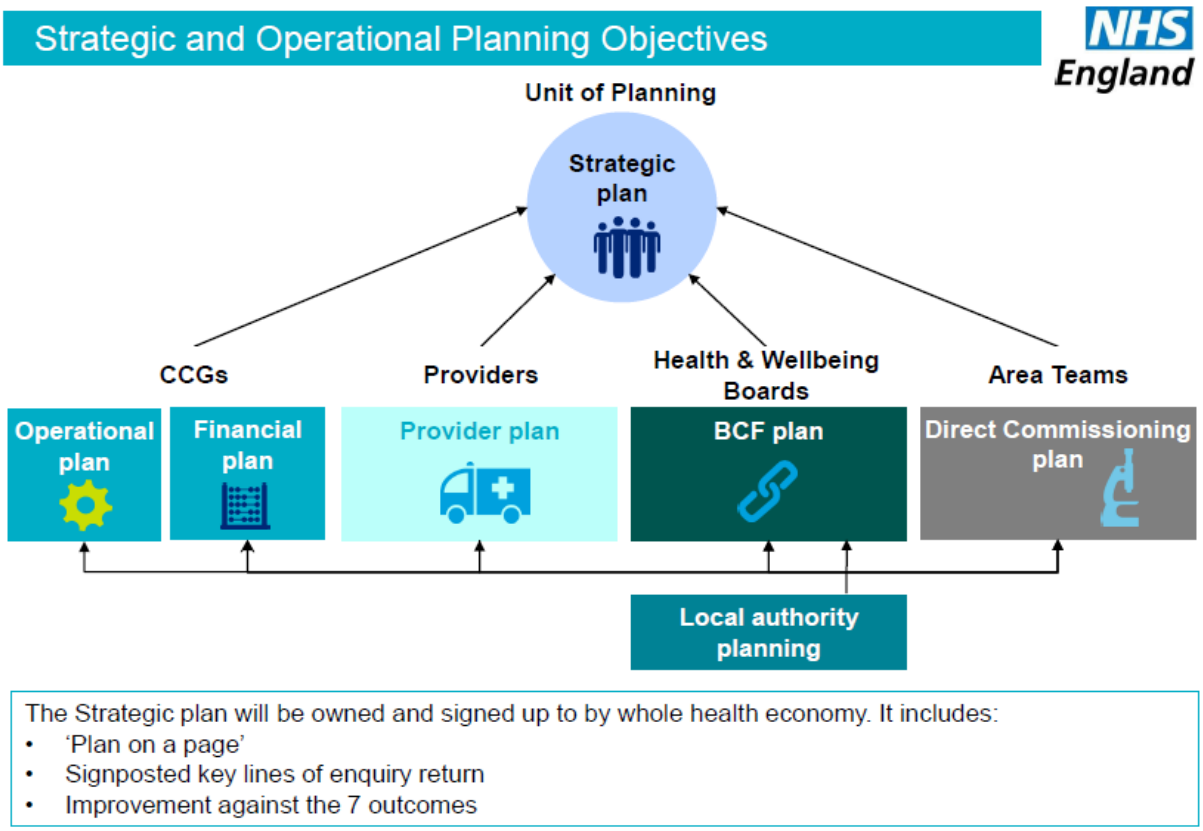
1. **Background**

National planning guidance published by NHS England in December 2013 mandated the development of a system owned FIVE YEAR STRATEGY which was to be agreed as part of a "Planning Unit". The Luton planning unit is the CCG, LBC, CCS, L&D, Health and Wellbeing Board and NHS England Area Team.

Guidance also mandated the development of a CCG Operational Plan to support the delivery of the first two years of the strategy and a financial plan.

Parallel to the above NHS England Area teams asked to develop two year Direct Commissioning Plans which includes plans for Primary Care Commissioning and certain other health services and Providers to develop two year and Five Year plans. Also part of the guidance was the need for Health and Wellbeing Boards to lead the development of a "Better Care Fund" (BCF) plan to explain how budgets pooled from Health and Social Care will be used in 2014/15 and 2015/16.

Given the complexity of planning requirements it may be helpful to refer to the diagram below which provides an overview of plans developed as a result of the guidance.



The Strategic plan will be owned and signed up to by whole health economy. It includes:

- 'Plan on a page'
- Signposted key lines of enquiry return
- Improvement against the 7 outcomes

Key Planning Requirements

The system was asked to define a "system vision" and to define a number of outcome ambitions and trajectories for 2014/15 to 2018/19.

Outcome Ambitions

a. Potential Years of Life Lost (PYLL) from conditions considered amenable to healthcare
b. Health Related Quality of Life for people with LTCs
c. Reducing unnecessary hospital admissions
d. Increasing the proportion of older people living independently at home following discharge (there is no indicator available at present)
e. Increasing the number of people having a positive experience of hospital care
f. Increasing the number of people with mental and physical health conditions having a positive experience outside of hospital (GP/OOHs)
g. Making significant progress towards eliminating avoidable deaths in hospitals caused by problems in care (there is no indicator at present)

A key objective of the National Assurance Process was to ensure that all plans were aligned and complementary.

2. Plan Development and Approval

The Five Year Strategy was developed collaboratively by the CCG alongside system partners and system buy in was obtained at a number of events dating back to the development of a system vision by leaders of the main system organisations in December 2013.

The table below details the Committees that have reviewed and approved previous versions of the Strategy.

Version	Reviewed By
0.3	CCG Executive 13th March 2014
1.0	CCG Board March 25th 2014
1.0	Health and Wellbeing Board March 31st 2014
2.0	Submitted to NHS England April 4th 2014
2.0	CCG Members Forum May 14th 2014
2.2	Healthier Luton Partnership May 19th 2014
2.2	Health and Wellbeing Board June 2nd 2014
4.1	Chair of Health and Wellbeing Board June 17th 2014
4.1	CCG Board June 24th 2014

National deadlines required submission of the Strategy to NHS England in June 2014.

3. Further Development

The NHS England Area Team have requested a further submission of the plan at the end of September 2014 to incorporate the following:

- Next iteration provide greater detail of the stakeholder (including providers) ownership and sign off of the Strategy
- Enhance the finance plan so it makes clearer how the plans have been costed, key milestones over years 1-5 and associated risks and mitigation.
- Provide greater detail of primary care work streams, including co-commissioning.
- Describe how the Better Care Fund work is more aligned than plan currently describes
- Provide examples of how stakeholder feedback has driven content of the plan
- Clarify how governance works, in particular at Chief Executive level and how organisations
  hold each other to account. Include systems in development to ensure close monitoring
  of delivery.
- Outline how you will manage the acute contract differently as is a key strand to meeting
  Financial challenge.
- Reached point of being able to sign a strong contract with local acute provider. Wellbeing
  of the plan is dependent on the acute contract delivering.
- Filled key gaps in team to ensure have permanent capacity and capability

APPENDIX:

1. Five Year System Strategy 2014/15 – 2018/19

Appendix 1

Luton Health and Social Care System Five Year Strategy

2014-15 to 2018-19

Version 4.3 June 24th 2014

Contents

Version History

Version	Reviewed By
0.3	CCG Executive 13th March 2014
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2.0	Submitted to NHS England April 4th 2014
2.0	CCG Members Forum May 14th 2014
2.2	Healthier Luton Partnership May 19th 2014
2.2	Health and Wellbeing Board June 2nd 2014
4.1	Approved by Chair of Health and Wellbeing Board June 18th 2014
4.1	Sent to CCG Board on June 17th in advance of Board meeting on June 24th 2014
4.2	Submitted to NHS England Area Team on June 20th

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 five year strategy to deliver a Healthier Luton through a sustainable health and social care system in June 2014.

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 based on the local JSNA[1] 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

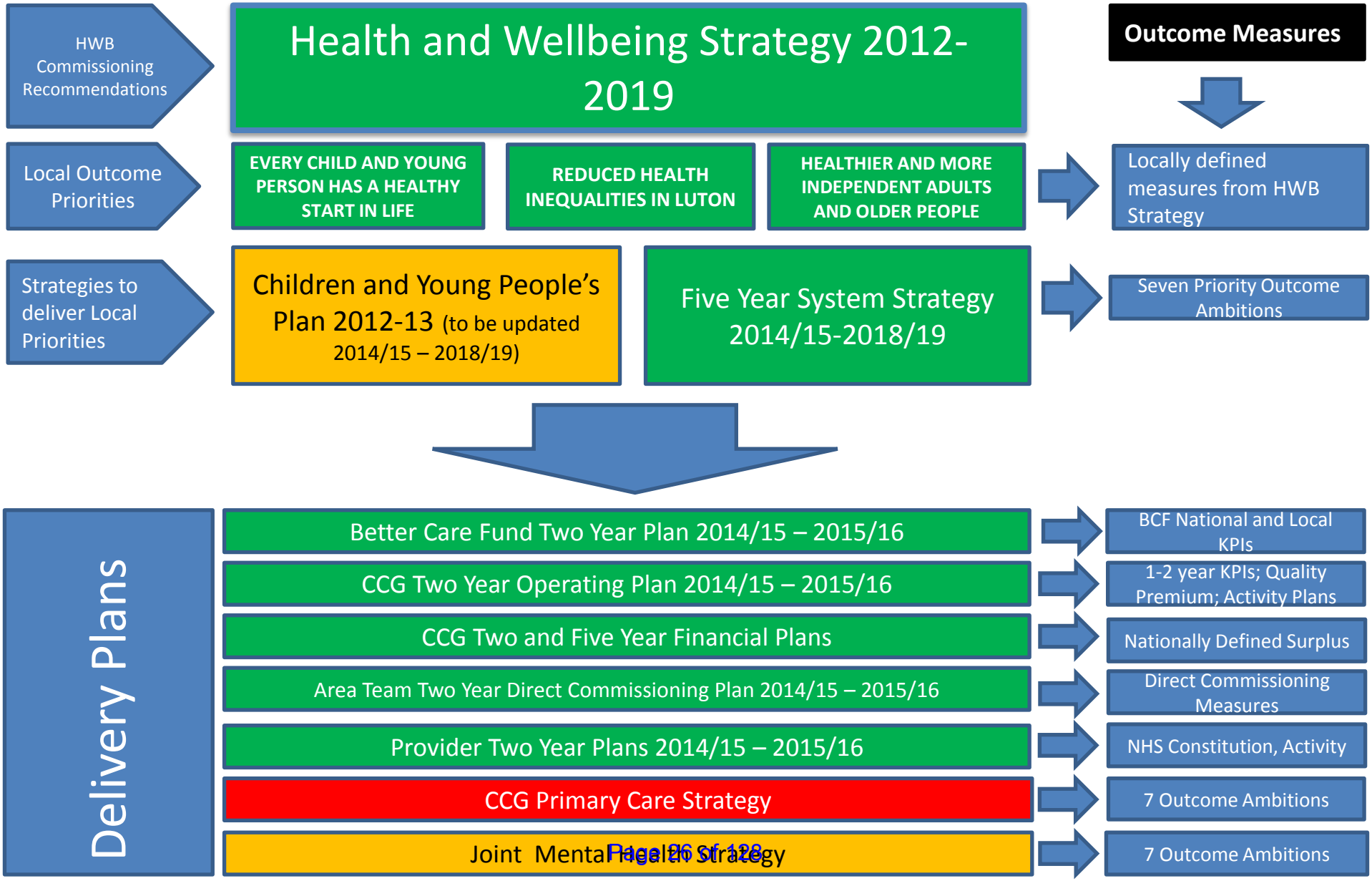
The Children and Young People's Plan articulates how Goal 1 and elements of Goal 2 are being addressed. The System Five Year Strategy with its focus on adults will articulate plans to address Goal 3 and elements of Goal 2.

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

1 JSNA 2011 and JSNA Core Dataset
http://www.luton.gov.uk/Community_and_living/Luton%20observatory%20census%20statistics%20and%20mapping/Pages/Joint%20Strategic%20Needs%20Assessment%20-%20JSNA.aspx

The Relationship Between the Health and Wellbeing Strategy and other System Plans



Local Need

Luton's Population and Health Profile at a glance[1]

- 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

[1]Based on JSNA 2011 and JSNA Core Dataset
http://www.luton.gov.uk/Community_and_living/Luton%20observatory%20census%20statistics%20and%20mapping/Pages/Joint%20Strategic%20Needs%20Assessment%20-%20JSNA.aspx

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

Financial Context 1

The Luton System faces a significant financial challenge over the next five years. Historic underfunding , the demands of an ageing population , high levels of deprivation and serious health inequalities mean that we have to work in a different way to make sure that every penny spent goes as far as possible.

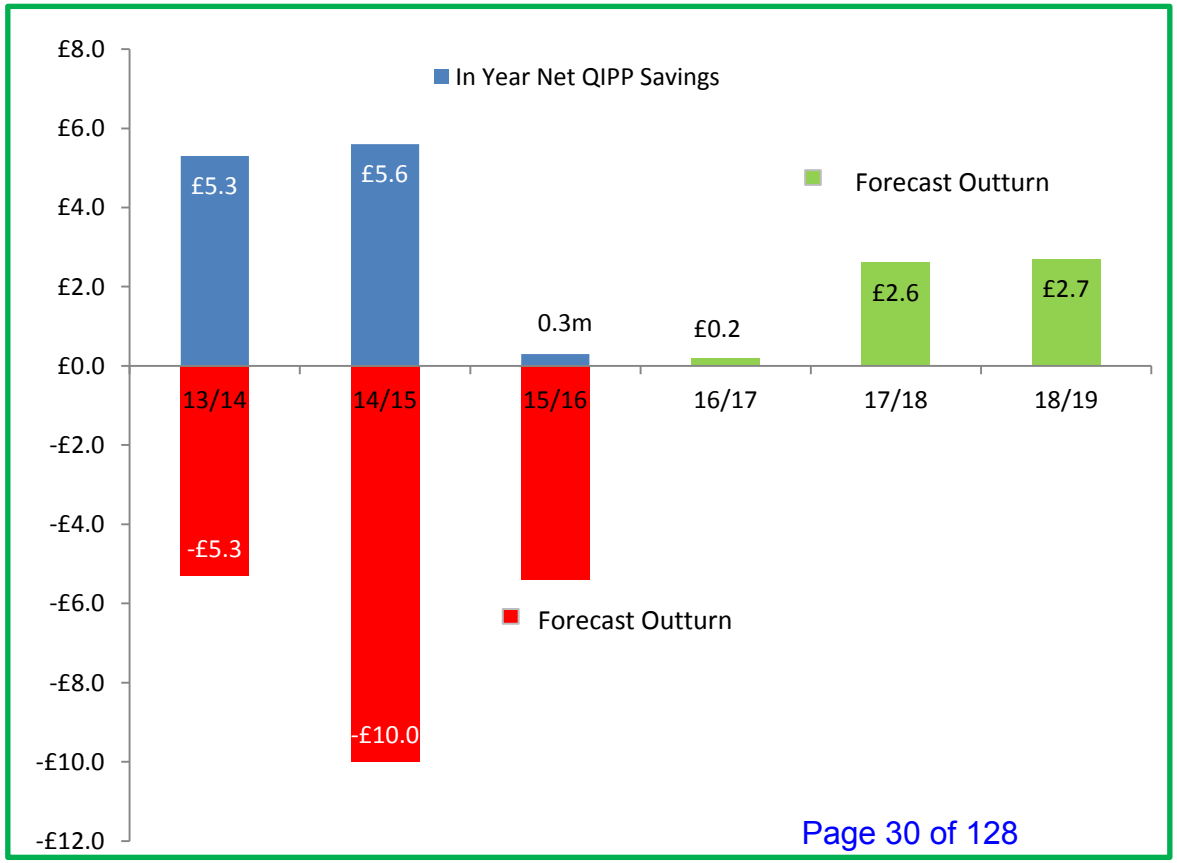
The underfunding is the main reason for the CCGs financial deficit incurred in 2013/14. Whilst the underfunding gap is being addressed to a certain degree, we need to plan for further overspend in 2014/15.

Luton Borough Council also faces a tight resource allocation and Adult social care has a £56m net budget in 2014/15 with demographic pressures of £11.5m to 2017/18 and a savings target of £22m.

Given our financial position and the potential gap we face over the next five years, we know that as a system we need to work closer together so that we can help each other to create high quality, value for money services that are tailored to the needs of individual patients and their carers. We also need to deliver services in a different way. We know that we have relied too much on hospitals to deliver care to our patients. Our local hospital is good at what it does but over reliance on this does not make the best use of limited funding. Consequently we need to ensure that General Practice works closely with community nurses, hospital specialists, social workers and other professionals to effectively wrap services around the patient so that they can stay in their homes for as long as possible.

Financial Context 2

In Year Outturn & Net QIPP Savings £m



The chart on the left shows how a CCG surplus is achieved by 2016/17 onwards through the effective delivery of our strategy

Local Opportunities

In addition to the JSNA. we have utilised a variety of resources to understand both the challenges and potential opportunities facing us as a system. These resources include the Outcomes and Benchmarking Support Pack[1], Commissioning for Value Insight Pack[2] and the "Anytown" model[3] developed by NHS England.

For example the table below is based on our review of the Commissioning for Value Insight Pack which identifies opportunities for both quality and financial improvements based on a comparison of local performance with similar areas in England.

Commissioning for Value Insight Pack	Quality Opportunity	Value Opportunity
Cardiovascular Disease	✓	✓
Endocrine / Metabolic Disorders	✓	
Genitourinary	✓	✓
Respiratory	✓	✓
Cancer	✓	✓
Gastrointestinal		✓

Opportunities identified in the Anytown Suburban Module
Case management and coordinated care
Palliative Care – Consultant – led community services
24-hour asthma services for children and young people
Mental Health Service user network
Reducing elective caesarian sections
Electronic palliative care coordination systems (EPaCCS)
Hyper Acute Stroke provision
GP Tele-consultation

1 http://www.england.nhs.uk/wp-content/uploads/2014/02/LApack_E06000032-luton.pdf
2 http://www.england.nhs.uk/wp-content/uploads/2013/11/cfv-slough2.pdf
3 http://www.england.nhs.uk/wp-content/uploads/2014/01/at-suburban-rep.pptx

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 focus on **PREVENTION** that helps people to keep themselves well; a shared **PERSONAL PLAN** for patients and service users; **BETTER USE OF SHARED EVIDENCE AND DATA**; **A MULTI-DISCIPLINARY, MULTI-PROFESSIONAL TEAM APPROACH** to service delivery built on Four 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

How will the system be different in 2019? Summary

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

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.

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

How will the system be different in 2019? Key Elements

Prevention

- Balance towards early intervention and prevention
- People understand how to keep well and do it
- Realistic understanding and taking ownership of peoples barriers to health issues

Personal Plan

- Assessment for complex needs within good time
- Key Coordinator worker
- Fewer professionals- better sharing info
- Single assessment and plan across organisations
- Existence of a personal plan- person feels able to change/develop/reassess their plan.
- People feeling in control and confident of "their" plan supported by professionals
- A key contact – someone to trust/get to know. Someone to help and support the plan to be delivered
- New roles- carers initiative across health, social care, voluntary sector etc

Multi-Disciplinary Team

- **New Roles- Carers, Social Care, Voluntary Sector etc**
- **Community based care services- Health, Social, Voluntary all together.**
- **Single point of contact for patients**
- **Health/well being/social prescription- all equally important**
- **Services aren't hidden away or discreet**
- **Mental health services integrated within every service**
- **Early customer access to 'knowledge'**
- **Points of Access- Hospital, Shopping Centre, Police Station, Town Centre**
- **Care and support is no longer buildings based**
- **People can access universal services**
- **Caring community**

Using the Evidence Well

- **System is better at predicting crisis and has put appropriate timely services around them**
- **Appropriate interflow between providers; information/physical experience**
- **Use data to deliver and organise services in different communities**
- **IT systems aligned**

2. System Vision

Our system vision embraces the six characteristics of a high quality and sustainable system[1]

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 deliver through the most appropriate routes

A Step Change in the Productivity of Elective Care

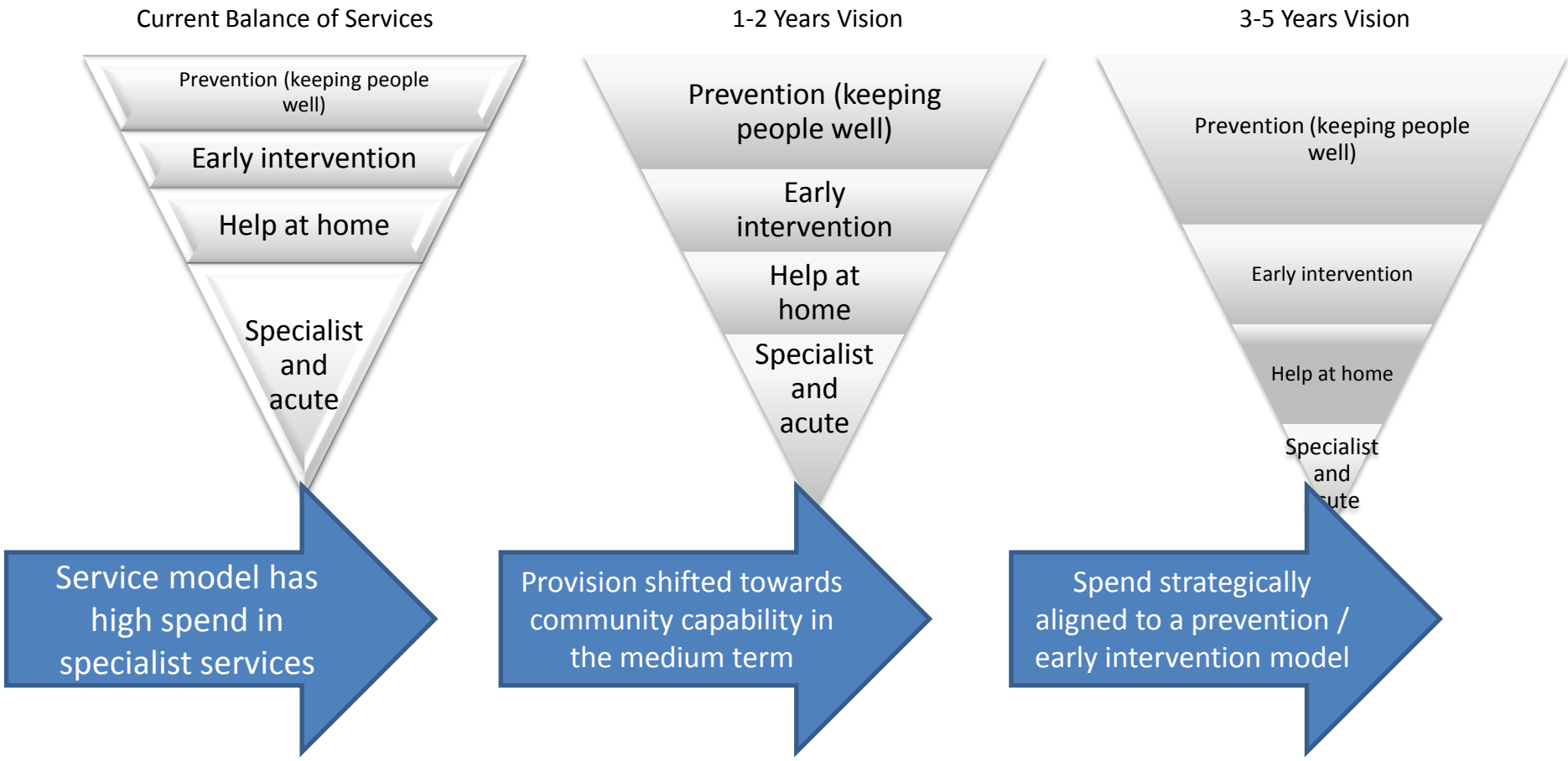
The system is driving the delivery of non complex elective care out of the hospital to deliver more care nearer to the home via primary and community care

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

Vision for services – progress through Better Together Programme[1]



1 See also Better Care Fund Plan
http://www.luton.gov.uk/Health_and_social_care/Lists/LutonDocuments/PDF/Better%20Care%20Fund%20plan.pdf

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

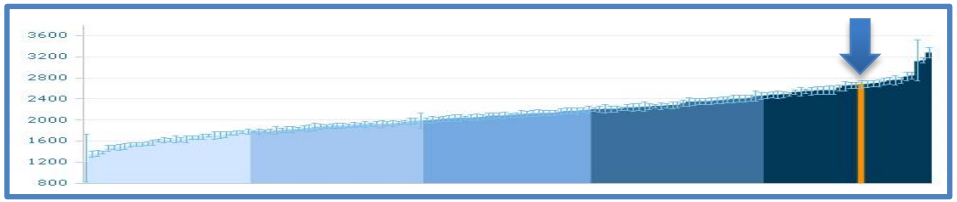
Process to Develop Outcome Ambitions

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.

Benchmarking Outcomes

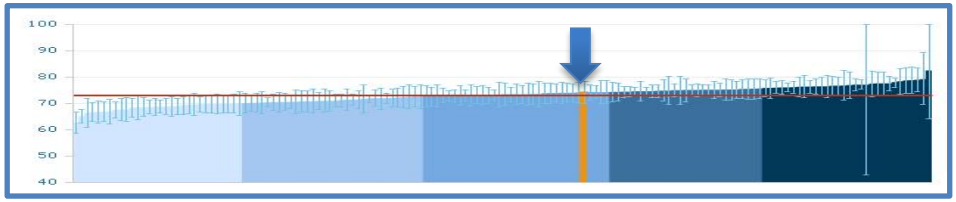
Potential Years of Life Lost

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



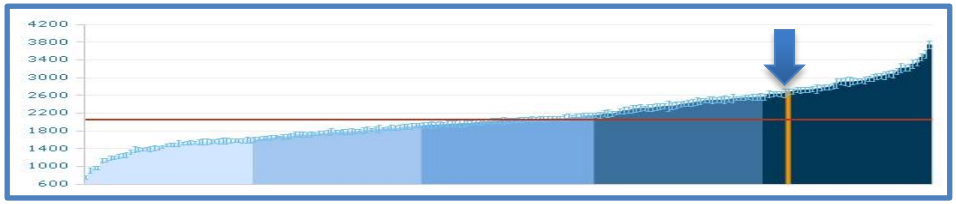
Quality of Life for people with LTCs

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



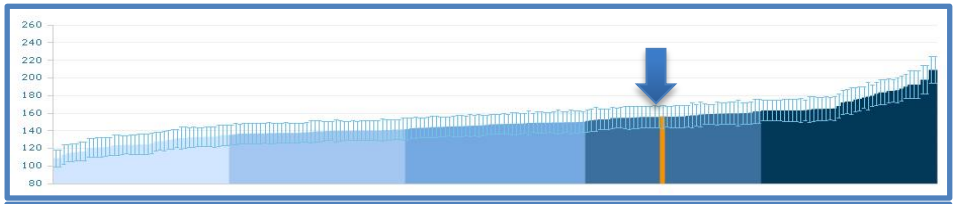
Avoidable Hospital Admissions

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



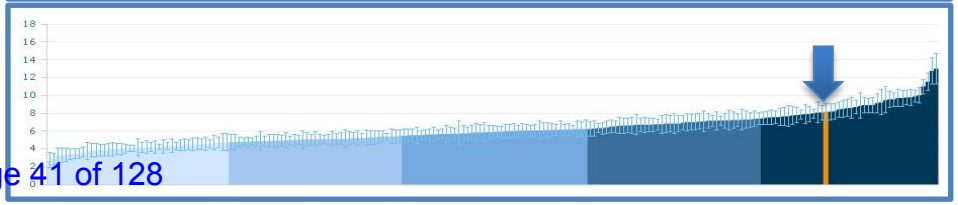
Patient experience in hospital

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



Patient experience out of hospital

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

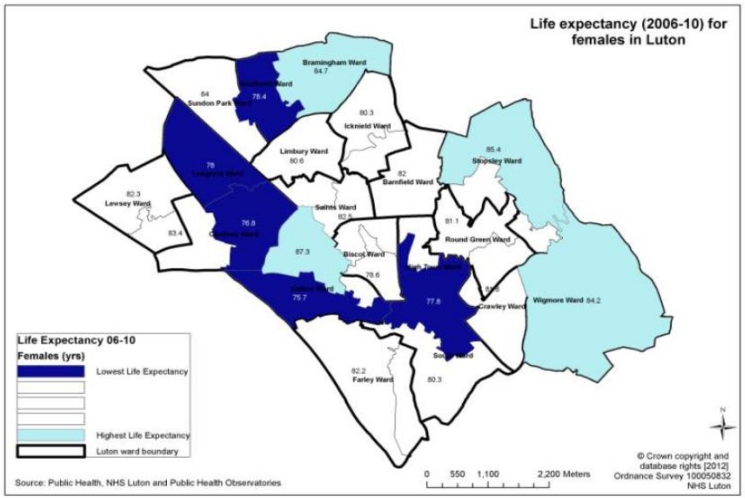


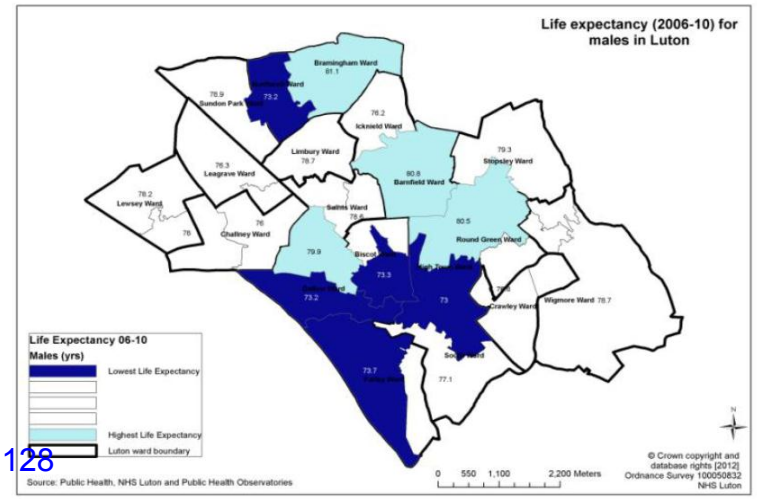
Health Inequalities in Luton

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).





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

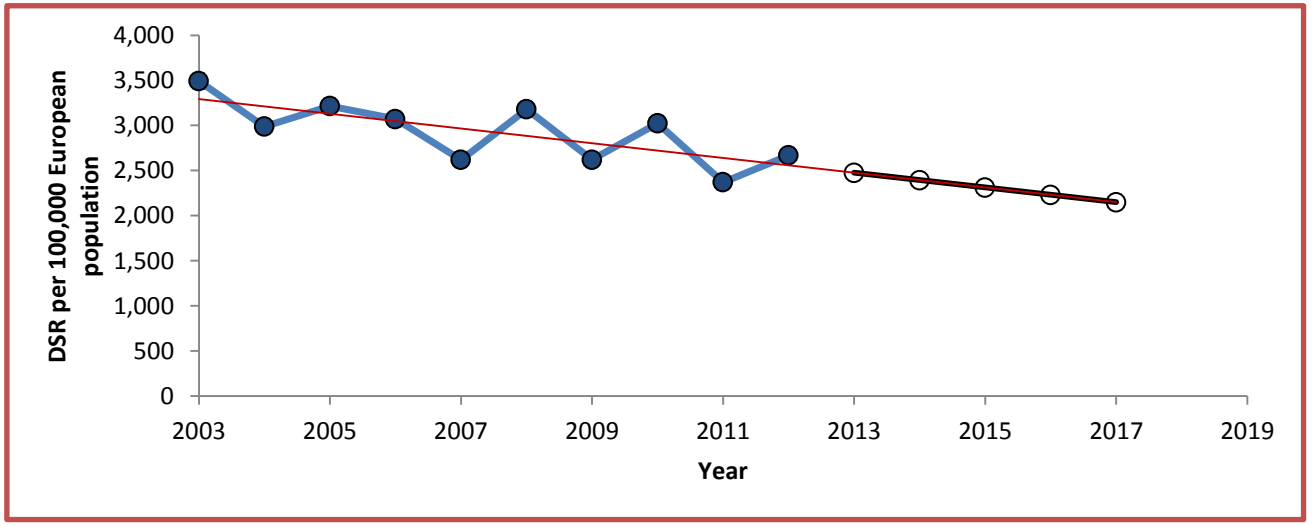
Seven Outcome Ambitions: 5 Years

1 Securing additional years of life	• Improve by 19% from baseline • 2669 (2012) to 2194 in 2018/19
2 Health Related QOL for people with LTCs	• Improve by 6% from baseline • 74.1 (2012/13) to 80 in 2018/19
3 Reducing the amount of time spent avoidably in hospital	• Improve by 12.5% from baseline • 2668 (2012/13) to 2336 in 2018/19
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

Ambitions 1 and 2: Five Years

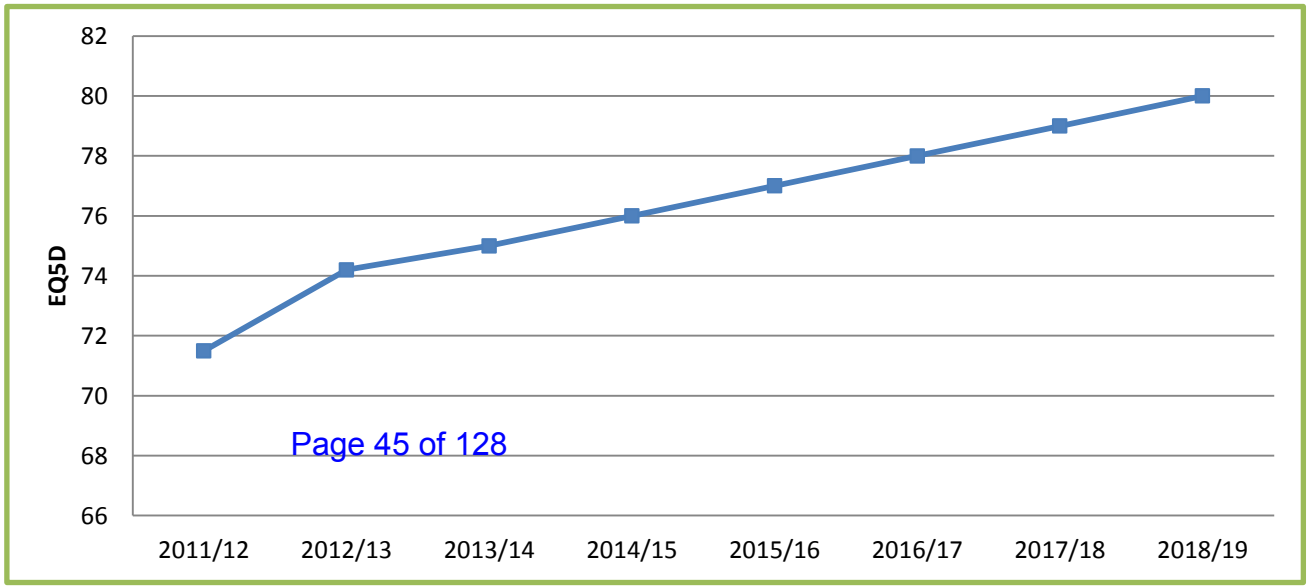
1 Securing additional years of life

Indicator: Potential Years of Life Lost (PYLL – Rate per 100,000 from causes considered amenable to healthcare (adults and children)



2 Health Related QOL for people with LTCs

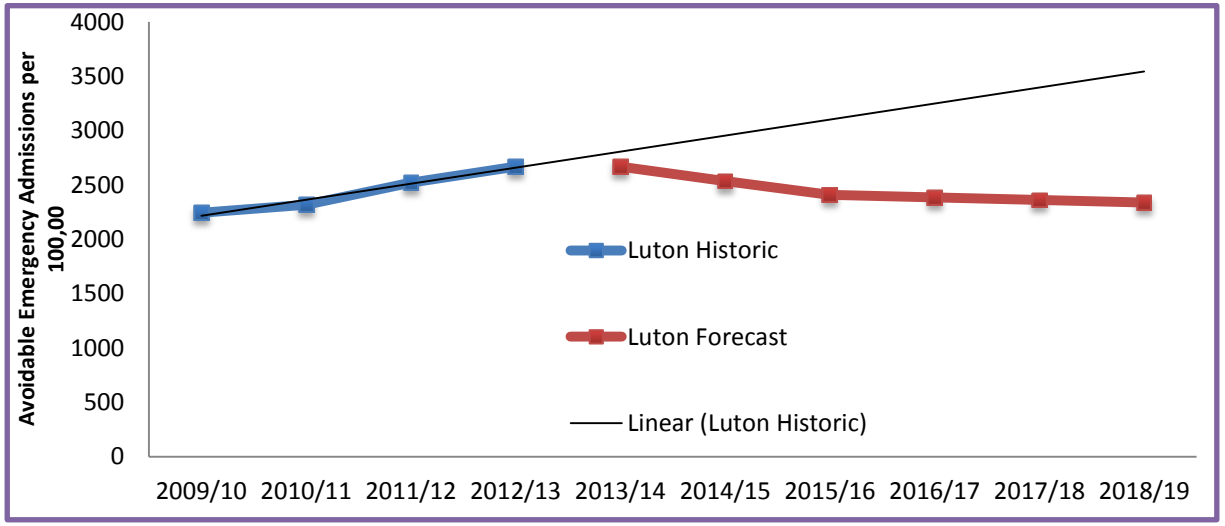
Indicator: Weighted EQ-5D values for all responses from people identified as having a long term condition – GP Patient Survey



Ambitions 3 and 5: Five Years

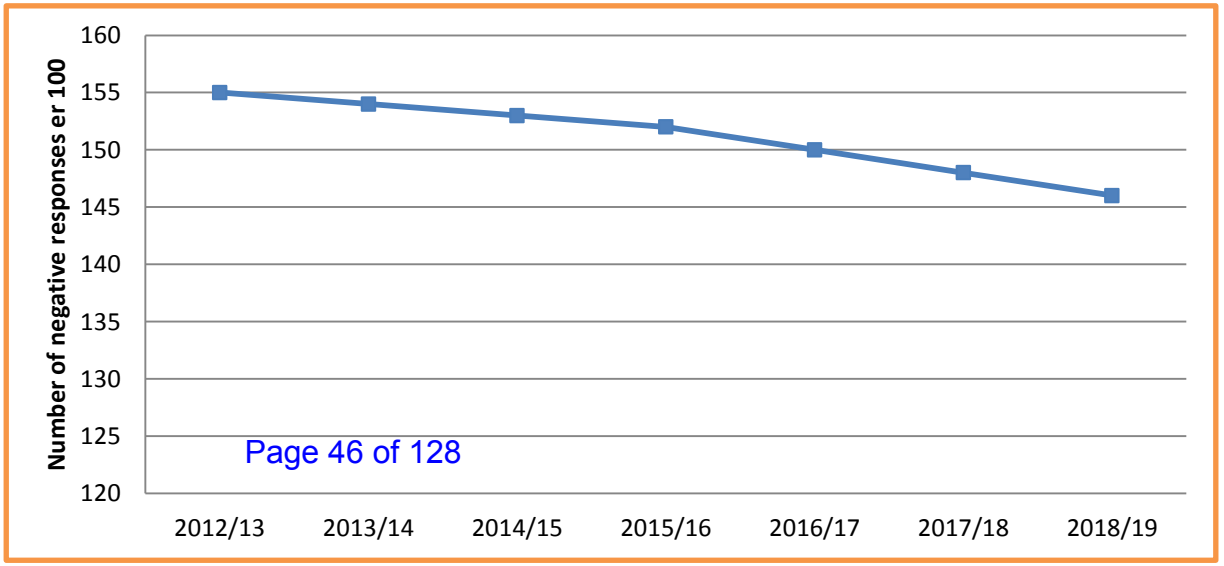
3 Reducing the amount of time spent avoidably in hospital

Indicator: Composite Indicator – Avoidable Admissions



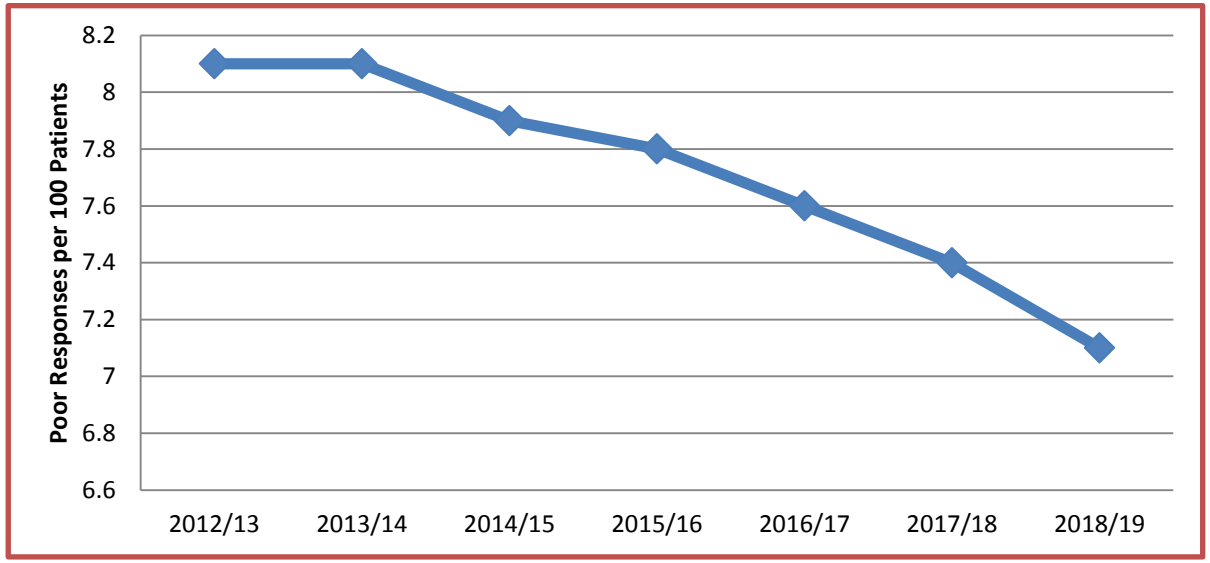
5 Positive experience of hospital care

Indicator: Number of negative responses per 100,000 – hospital inpatient survey



Ambition 6: Five Years

6 Positive experience of out of hospital care
Indicator: Poor responses per 100 patients – GP Patient Survey



Drivers of Delivery of Seven Outcome Ambitions

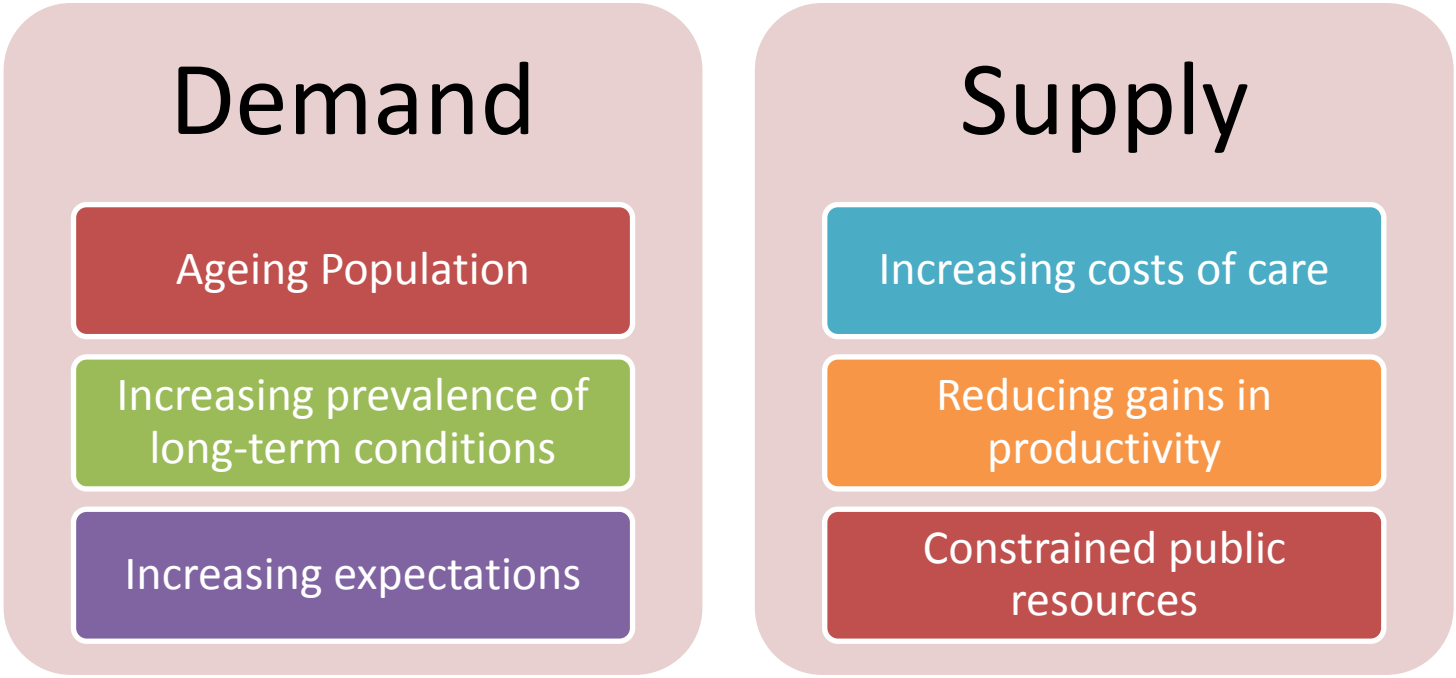
Five Year Ambition	1. Securing additional years of life	2. Health related QoL for people with LTCs	3. Reducing the amount of time spent avoidably in hospital	4. Increasing the proportion of older people living independently	5. Positive experience of hospital care	6. Positive experience of out of hospital care	7. Eliminating avoidable deaths in hospital
Five Year Improvement	19% ↑	6% ↑	12.5% ↓	TBC	6% ↑	10% ↑	TBC
Projects and programmes driving improvement	Prevention Early Intervention Early detection of cancer Live Well Luton Integrated Pathways Vaccination and Immunisation IAPT	Early Intervention Integrated Pathways 7 day working Homecare Plus Transforming Primary Care Projects IAPT	Early Intervention Integrated Pathways 7 day working Homecare Plus Transforming Primary Care Projects Transforming Urgent Care Projects	Early Intervention Integrated Pathways 7 day working Homecare Plus Transforming Primary Care Projects Transforming Urgent Care Projects	Integrated Pathways CQUIN Quality Monitoring L&D Trans - formation Programme Improved Discharged Process	Workforce Development Programme Primary Care IT Infrastructure Co-Commiss -- - ioning Primary Care Estates Enhanced Services	Prevention Early Intervention SI Processes Complaints Processes Quality Monitoring

Additional (Local) Outcome Ambitions: 5 Years

Reduction in Infant Mortality Rate (per 1,000 live births)	• Baseline 7.2 (2009-11) • Reduce to 5.0 by 2017-18
Increased life expectancy at birth and narrowed inequality gap with England - Males	• Baseline 77.9 (2009-11) • Increase to 80.3 by 2017-18
Increased life expectancy at birth and narrowed inequality gap with England - Females	• 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	• 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	• Baseline 6.4 (2006-10) • Reduce to 5.6 by 2017-18
Disability Free Life Expectancy (DFLE) - Males	• Baseline 9.1 (2011-12) • Increase to 10.0 by 2017-18
Disability Free Life Expectancy (DFLE) - Females	• Baseline 9.9 (2011-12) • Increase to 10.9 by 2017-18

4. Sustainability

The Sustainability Challenge

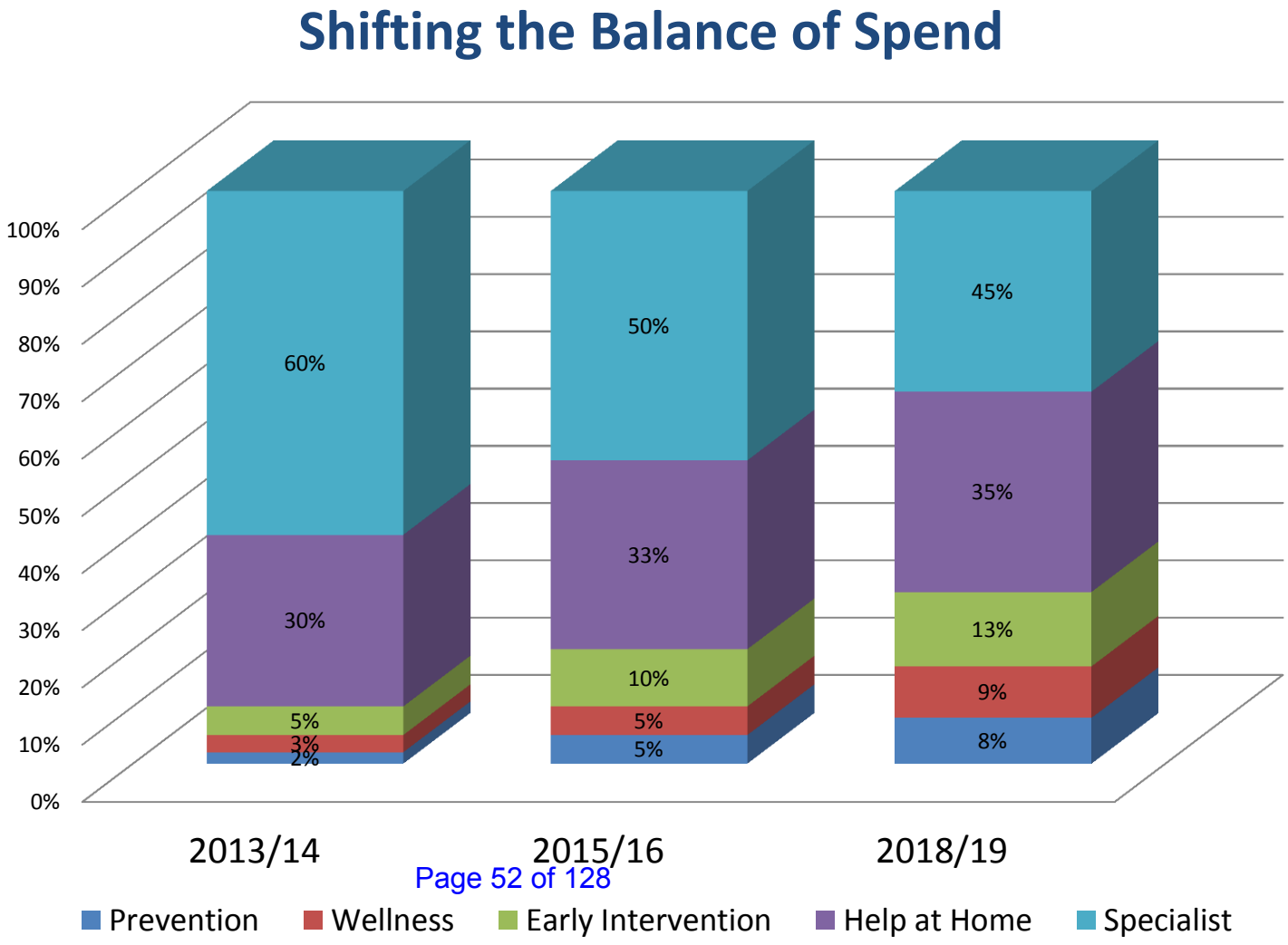


NHS England's "A Call for Action[1]" describes the future trends which threaten the sustainability of a high quality NHS. It is the potential impact of these trends summarised in the diagram above that means that while a new approach is urgently needed, we must take a longer-term view when developing 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

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



How the System will meet the sustainability challenge

On pages 9 and 10 we outlined the financial challenge facing the Health and Social Care System in Luton. Our financial position should not be understated, the CCG finished 2013/14 with a financial over spend of £5.3m and we currently plan in our FRP (Financial Recovery Plan) to deliver a further overspend 2014/15 and a lower level of overspend in 2015/16, but then delivering surpluses from 2016/17.

As we have already discussed, we need to deliver services in a different way to ensure that supply is able to meet demand. This strategy describes four key improvement interventions (see section 5) which represent our system focus for the next five years in delivering the necessary transformation to ensure financial sustainability. An example of how efficiencies will be delivered is shown by the modelling example on page

Transformation Fund
Due to the CCGs predicted deficit until 2015/16 , there are limited funds available to drive transformation for the first two years of this plan.

It is anticipated that the Transformation Fund will be available as follows *(provisional)*

2014/15: £0.3m
2015/16: £0.4m
2016/17: £2.5m
2017/18: £2.6m
2018/19: £2.7m

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

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.

Better Together[1]

Introduction

The government spending review in June 2013 created "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities".

At a national level, the Health and Social Care Act 2012 puts a responsibility on Health and Wellbeing boards to promote integration and the government is committed to introduce a national minimum eligibility threshold for care and support in England by April 2015.

There is a considerable body of evidence that supports the idea that holistic health and care services organised around a person (patient, service user or carer) leads to better health outcomes and has the potential to cost less. Luton Council's prospectus says: "We know that achieving good health outcomes comes from more than having good health services and that housing, education, work, diet, lifestyle and social activities make a big and sometimes decisive difference to health inequalities."

This view is supported in the public health white paper 2010 and Marmot report "Fair Society, Healthy Lives", also 2010.

Integration in Luton

Integration in Luton is being driven through the Better Together programme, which brings together the NHS, comprising Luton CCG, Luton and Dunstable university hospital foundation trust, Cambridgeshire Community Services NHS trust (CCS) and South Essex Partnership university NHS foundation trust (*SEPT*), with Luton borough council (LBC or the Council), Luton's voluntary and community sector (VCS) and Luton residents represented by Healthwatch.

At a local level, integration is identified in the joint health and wellbeing strategy as one of the key factors in improving health and reducing health inequalities. Additionally the JSNA sets out the health and care pressures and needs in Luton, identifying areas where integration is likely to be most urgently needed, such as care for people with dementia or older people unnecessarily staying in hospital and residents with long term conditions.

1 See also Better Care Fund Plan
http://www.luton.gov.uk/Health_and_social_care/Lists/LutonDocuments/PDF/Better%20Care%20Fund%20plan.pdf

Better Together

The proposition at the heart of this programme is that services designed and delivered around the person enable them and their family to stay independent for longer and that this not only improves their immediate and longer term health outlook, it also costs the public purse less money because it delays or avoids the need for expensive residential or hospital in-patient care.

Evidence Base

Our collective vision for integrated health and social care in Luton includes making better use of shared evidence and data. 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.

The Better Together programme is informed by a review of evidence, looking at work undertaken by the Kings Fund to review literature on studies of a number of health and social care integration projects in this country and abroad. The review of the evidence base indicates the following as good practice recommendations for developing and implementing the Better Care Fund in Luton

- Establish a shared leadership between the organisations
- Develop a shared narrative and vision
- Pool resources
- Innovate in the use of commissioning, contracting and payment mechanisms and the use of the independent sector
- Engaging with primary and secondary care to ensure smooth transition from hospital to home
- Single point of access, single assessment and sharing clinical records
- Supporting individuals to change behaviours such as smoking, for example, through advice during a consultation
- Well-developed, integrated services for older people Integrating primary and social care has been shown to reduce admissions,

Better Together – Defining the key programmes

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

Better Together – Key Measures of Success[1]

Major Milestones

2014/15
- Frail elderly plan delivered through 4 Clusters
- Disabled children plan in place
- Information sharing plan in place
- Risk share agreement with system in place

2015/16
- Better Together Teams in Place
- 7 Day Working in Place
- Integrated workstreams for LTCs
- Integrated Mental Health / Community Services

2016/17
- Homecare plus programme implemented
- Better Together Teams in place for LTCs
- Single Point of Access in Place
- Integrated Commissioning in place

2017/18
- Formal sharing of back office functions

2018/19
- Evaluation and consolidation

Key Performance Indicators

Patient Experience
- Improved patient and carer experience
- Deaths in place of choice
- Reduced EOLC patients dying in hospital
- Patients feeling able to manage their condition
- Elderly patients living independently at home after discharge

Clinical Outcomes
- Improved diagnosis – disease registers
- Reduced incidence of late diagnosis
- Reduced MRSA / C Diff / Never events
- Reduced child and adult obesity
- Increased child immunisations

Demand Management
- Reduced avoidable emergency admissions
- Reduced permanent admissions to care homes
- Reduced delayed transfers of care

[1]Further detail on specific KPIs can be found in the BCF Plan http://www.luton.gov.uk/Health_and_social_care/Lists/LutonDocuments/PDF/Better%20Care%20Fund%20plan.pdf

Better Together – Modelling Activity Changes - Example

We have extensively modelled the impact of the Frail Elderly workstream, with activity reductions based on those aged > 60

All activity has been categorised into Primary Care Clusters based upon GO LIVE dates of Aug 1st 2014 (Cluster 1); Oct 1st 2014 (Cluster 2); Dec 1st 2014 (Cluster 3); Mar 1st 2015 (Cluster 4)

There are 3 components to activity: Emergency Admissions (EA); A&E Attendances and Outpatient appointments (first and follow ups)

EAs have been reviewed at HRG level to identify those areas where admissions can be avoided through the Frail Elderly work. These are calculated at the marginal rate which is 30% of the full PbR tariff

For EAs we assume for Clusters 1, 2 and 3 a 20% reduction will take place in the first year from the go live dates. We assume a 25% reduction for Cluster 4. For each subsequent month we then assume an additional 2% reduction with a celing of 32% on the total cohort of EAs

EAs have been reviewed to evaluate how many were admitted via A&E. Where this is the case A&E attendances have been reflected in activity reductions

We have assumed a 10% reduction in outpatient appointments (first and follow ups) across all treatment function codes

Better Together – Key Risks[1]

Risk	Risk Rating	Mitigating Actions	Residual Risk
Alternatives to admitting and keeping people in hospital as a way of preventing unnecessary hospital stays may not be in place in time or at sufficient capacity to enable closure of two hospital wards.	High	Existing work to speed up discharge will continue and step-up and step-down capacity will be kept under close scrutiny, along with the development of greater home care service flexibility to ensure there are a number of routes available to avoid the need for unnecessary hospital stays. MCTs in the community will enable more proactive care and early intervention	Medium
We will not have the right whole system workforce (mix of skills location and practice).	High	Develop a total workforce strategy with help from Health Education East of England, Skills For Care, Skills For Health and the University of Bedfordshire. Scoping meeting set for 9 April and whole system project group led by director of housing and community living from Luton Council.	Medium
Luton residents, including patients, service users and carers, are insufficiently engaged in the planning process and the final plan fails to reflect community priorities	High	Consultation is already underway and a community engagement programme is being developed in conjunction with Luton Healthwatch.	Medium

[1]Further detail on risks can be found in the BCF Plan http://www.luton.gov.uk/Health_and_social_care/Lists/LutonDocuments/PDF/Better%20Care%20Fund%20plan.pdf

Transforming Primary Care

Introduction

Primary Care has critical role to play in the delivery of a high quality sustainable health and social care system. Due to historical unacceptable variations in the outcomes and accessibility of primary care in Luton together with the need to ensure that primary care as a whole is able to drive a decreased reliance on the hospital, we have identified the need to transform Primary Care as an essential building block of future success.

Whilst there are excellent examples of good Primary Care in Luton, we know that there is considerable variation in access to care and in health outcomes across Luton. Using the Primary Care Web Tool[1] we know that a number of practices are outliers for a number of indicators such as diagnosis and outcomes of Long Term Conditions, flu vaccinations and emergency admissions to hospital.

The need to improve overall quality and to reduce variation was a clear recommendation in the 2011 JSNA and the Health and Wellbeing Strategy.

Our vision for Primary Care is that we develop an offering that is comprehensive, person-centered, population oriented, coordinated, accessible, safe and high quality

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

A key enabler of transforming primary care is our plan to formalise the establishment of 4 Practice Groups (oe "Clusters" covering populations of 40,000 to 65,000. Each group will be chaired by a GP and supported by a co-ordinator with CCG approved governance arrangements in place to drive innovation, value for money, improved outcomes by enabling:

- Practices to work together to bid for and provide services at scale
- The sharing of premises and back office functions to allow system wide efficiencies
- Increased local workforce development opportunities
- Development of shared ICT and implementation of new technologies

Further details can be found in the CCG Operational Plan 2014/15 – 2015/16[1]

1 https://www.lutonccg.nhs.uk/page/downloadFile.php?id=12566

Transforming Primary Care – Key Measures of Success

Major Milestones

2014/15
- Primary Care Clusters in place
- IT Infrastructure Phase 1
- Enhanced Services Plan

2015/16
- GP Leaders Programme Phase 1 Complete
- IT Infrastructure Phase 2
- Enhanced Services Plan Delivery

2016/17
- Informal Federations in place
- GP Leaders Programme Phase 2 Complete
- IT Infrastructure Phase 3

2017/18
- Formal Federations in place
- GP Leaders Programme Phase 3 Complete
- IT Infrastructure Phase 4
- Improved Estates in place

2018/19
- Evaluation and consolidation

Key Performance Indicators

Patient Experience
- Ease of Access
- Overall Satisfaction with service
- Deaths in place of choice
- Patients feeling able to manage their condition
- Increased use of NHS number

Clinical Outcomes
- Reduced outliers on key primary care outcomes
- Number on disease / EOLC registers reflecting prevalence
- Increased smoking quitter rates
- Increased child immunisations

Demand Management
- Reduced avoidable emergency admissions
- Achievement of acute activity plan

Transforming Primary Care – Key Risks

Risk	Risk Rating	Mitigating Actions	Residual Risk
Practices are unwilling to work together leading to a failure to provide Primary Care at Scale	High	Recruitment of influential Cluster Chairs Members forum as a lever for change Utilise national and regional thought leaders to drive change	Medium
Fragmentation of Commissioning (CCG / NHSE / Prop Co etc) leading to an uncoordinated approach to Primary Care Transformation	High	Development of a collaborative strategy to deliver a transformation of primary care across Herts / South Midlands	Medium
Failure to attract high calibre workforce to Luton Practices leading to failure to achieve key objectives	High	Develop a total workforce strategy with help from Health Education East of England, Skills For Care, Skills For Health and the University of Bedfordshire. Implementation of Primary Care Leadership Programme in conjunction with University Beds and HE EoE	Medium High

Reconfiguring Mental Health and Community Services

Introduction
We are reconfiguring mental health and community services to support the drive towards integration and therefore this programme has close links with the Better Together Programme. In 2013/14 the CCG identified an opportunity to re-commission community health and mental health services simultaneously as current contracts were coming to an end, as well as identify future providers who will embrace the integration model being developed through the Better Together programme

National Context – Mental Health
The profile of mental health has rightly moved up the national agenda over the past five years. Our overall strategy for mental health is closely aligned to the following key publications:

- *No Health Without Mental Health – DH 2011*
- *Talking Therapies, a Four Year Plan of Action – DH 2011*
- *Closing the Gap : Priorities for Essential Change in Mental Health – DH 2014*

Locally we support the National goal of achieving **parity between mental and physical health** and the need to overcome the significant health inequalities for those with mental ill-health. That is why we have aligned transformation of mental health with the transformation of other services and in particular Community Services

Mental Health in Luton
Based on the Luton Community Mental Health Profile 2013[1] there are certain characteristics of the local population that suggest that strategic focus on mental health will address currently unmet needs of our communities. Luton has a worse than England Average:

- Percentage of 16-18 year olds not in employment, education or training
- Rate of violent crime per 1,000 of the population
- Percentage of the population living in the 20% most deprived areas in England
- Rate of statutory homeless households
- Number of first time entrants to the youth justice system
- Percentage of adults participating in physical activity

[1]http://www.nepho.org.uk/cmhp/index.php?pdf=E06000032

Reconfiguring Mental Health and Community Services

Local Need – Mental Health

A Mental Health Needs Assessment[1] published in 2012 made the following recommendations:

- Commission services on the basis of need
- Improve use of data to monitor and evaluate services
- Ensure community services are accessible to all
- Increase routes of access into services
- Increase depression case finding
- Focus on physical health of those with mental health issues
- Develop a mental health promotion strategy
- Develop a care pathway
- Understand community mental wellbeing

Beyond Procurement

Our procurement strategy is to procure new providers through competitive dialogue . This means that we will work with potential providers, as experts in service provision, to map out future service configuration in line with our overarching goal to wrap services holistically around the needs of people. For this reason we cannot accurately define future service configuration though an example of how services might look is depicted on the next page

Community Services Context and Goal

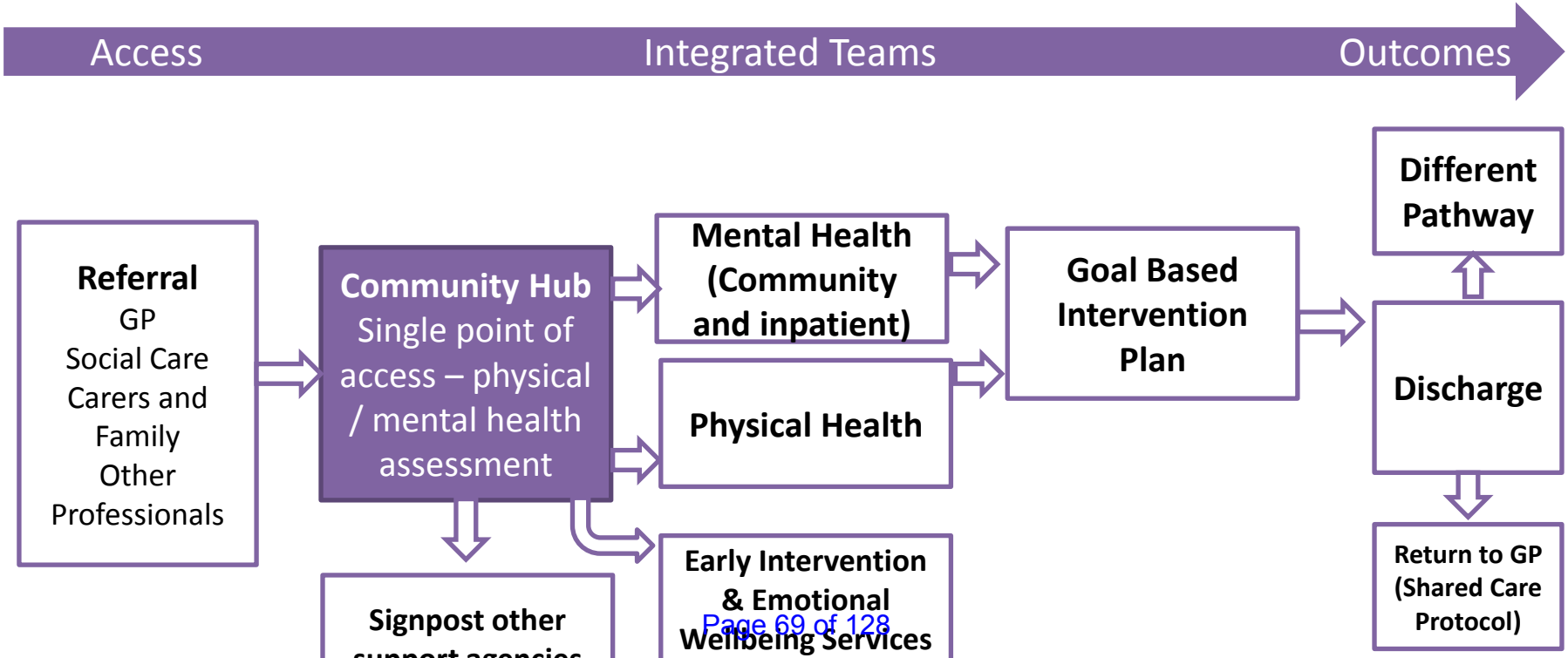
Community Services are commissioned through two organisations; South Essex Partnership University NHS Foundation Trust (SEPT) and Cambridgeshire Community Services (CCS). The significant majority of the Community services are provided within the CCS Portfolio, with a range of therapies, including those for children, provided by the SEPT contract. The SEPT Contract provides for Luton some services which are also provided to Bedfordshire and are therefore part of a county wide service.

Our goal for community services is to make sure that services work more effectively and with better alignment to Primary and social care services and with considerably reduced system barriers that will support the seamless delivery of holistic services that are characterised by earlier prevention and planned care for our most vulnerable populations.

[1] Luton Adult Mental Health Needs Assessment: 2012

Reconfiguring Mental Health and Community Services

The diagram below represents a potential final integrated care Pathway , dependent on the outcomes of the competitive dialogue with potential providers



Reconfiguring Mental Health and Community Services

The System has identified the following key workstreams to drive forward this programme of transformation

Prevention and 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

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

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

Reconfiguring Mental Health and Community Services

Major Milestones

2014/15
- Completion of procurement of Mental Health and Community Services and transition
- Implementation of full IAPT Service
- Implementation of Luton Live Well Service

2015/16
- Stroke Early Supported Discharge
- Complete implementation of enhanced dementia services

2016/17
- Service Transformation complete
- Early supported discharge for LTCs
- Integrated Care Pathways in place for LTCs / Mental Health

2017/18
- Review of service implementation and ensure system alignment

2018/19
- Evaluation and consolidation

Key Performance Indicators

Patient Experience
- Patient experience measures of individual services
- Friends and family test
- Use of NHS Number in Communications

Clinical Outcomes
- Dementia Diagnosis
- IAPT treatment and recovery rates
- Reduced gap in mortality for people with MH diagnoses
- Increased smoking quitter rates
- Reduced child and adult obesity
- Health related quality of life

Demand Management
- Reduced avoidable emergency admissions
- MH bed days per weighted population

Reconfiguring Mental Health and Community Services – Key Risks

Risk	Risk Rating	Mitigating Actions	Residual Risk
The re-procurement process may introduce risks associated with uncertainty and change which impacts on the quality of current service provision and transition to new providers	High	High Quality Communication and engagement. To include identification of needs and role of wide range of stakeholders. Additional Comms and Engagement Support to achieve "on message" consistent communication to stakeholders.	Medium
Due to the potential procurement of a number of providers there is a risk of fragmentation of service delivery	High	Ensure robust contractual performance measures are in place to ensure providers deliver services that are integrated and “wrapped” around the patient	Medium
The available financial envelope may be insufficient to enable services to deliver the desired outcomes	High	The competitive dialogue approach to procurement will allow for challenging but realistic service specifications.	Low

Transforming Urgent Care - Context

Context

Pressures on A&E have been managed effectively by the system over the past 18 months, with the 4 hour wait target being achieved month on month. However Luton has seen unacceptable increases in avoidable emergency admissions since 2007/08 when compared to the England average

Emergency admissions for acute conditions that should not usually require admission [1]

The effective management of the flow of patients through the health system is at the heart of reducing unnecessary emergency admissions and managing those patients who are admitted.

- Primary, community and social care can reduce admissions through improving management of long-term conditions;
- Ambulance services can reduce conveyance rates to accident and emergency (A&E) departments, for example by conveying patients to a wider range of care destinations;
- Hospitals can reduce emergency admissions by ensuring prompt initial senior clinical assessment, prompt access to diagnostics and specialist medical opinion; and
- Once admitted, hospitals working with community and social care services can ensure that patients stay no longer than is necessary and are discharged promptly.

[1] Levels of Ambition Tool http://ccgtools.england.nhs.uk/loa/flash/atlas.html

Transforming Urgent Care - Aims

Overarching Goal for Urgent Care
To respond to urgent care needs of people of Luton through the provision of the most appropriate care in a timely and cost effective way.

Aims

1. To promote self-management of care need
2. To give patients speedy access to care services
3. To provide care nearer to patients' home
4. To support the role of the GP as coordinator of patient care
5. To reduce hospital attendance and admission, ensure speedy discharge
6. To support the delivery of national and local standards of care
7. To improve cost-effectiveness of services
8. To make good use of data to inform decisions
9. To ensure integration of services through partnership working
10. To adopt good practice, encourage innovation and ensure sustainability

Delivered Through

- 111
- Managing Winter Pressures
- Hospital at Home
- Acute GP Visiting Service
- Ambulatory Care
- Mobile Care Service
- Clinical Navigation
- Meet & Greet Discharge
- Social Marketing

[1] Levels of Ambition Tool http://ccgtools.england.nhs.uk/loa/flash/atlas.html

Transforming Urgent Care – Key Work Streams

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 – Mobile Care Service. 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

Winter Pressures. to provide additional services to meet the additional pressures that occur in the local health system during the winter months, with a focus in sustained patient care and achievement of A&E waiting time and other standards

5. Improvement Interventions

Transforming Urgent Care

Major Milestones

2014/15
- Implementation of Acute Visiting Service
- Extension of Meet and Greet Service
- 111 Procurement commences
- Urgent Care Strategy in Place

2015/16
- Substantive Provider of 111 in place
- Social marketing during winter months
- Ambulatory Care Unit Extension

2016/17
- Further Ambulatory Care Pathways
- Social marketing during winter months

2017/18
- Social marketing during winter months

2018/19
- Social marketing during winter months
- Evaluation and consolidation

Key Performance Indicators

Patient Experience
- Patient experience measures of individual services
- Friends and family test
- Four hour waits for A&E services
- Ambulance response and handover times

Clinical Outcomes
- Survival from major trauma
- Improved recovery from stroke
- Improved recovery from fragility fractures
- Emergency admissions within 30 days discharge

Demand Management
- Reduction in A&E attendances
- Reduced avoidable emergency admissions

Transforming Urgent Care – Key Risks

Risk	Risk Rating	Mitigating Actions	Residual Risk
A&E demand continues to rise resulting in the ambition for reducing avoidable admissions is not met	High	The are numerous initiatives designed to reduce A&E demand. Should this fail to deliver the required outcome the System Resilience Group will ensure a system wide approach to drive a consistent message to the community	Medium
Fragmentation of services due to the involvement of a large number of providers and commissioners involved	High	System Resilience Group to ensure that desired outcomes are shared across all system partners	Low
There is a risk that the necessary data is not readily available to facilitate the effective monitoring of urgent care services	High	Reconfiguration of Business Intelligence function to drive improved internal customer focus. System Resilience Group to overcome barriers and blockages to data provision	Low

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; reducing unnecessary admissions to hospital; reducing demand on A&E; improving experience of out of hospital care

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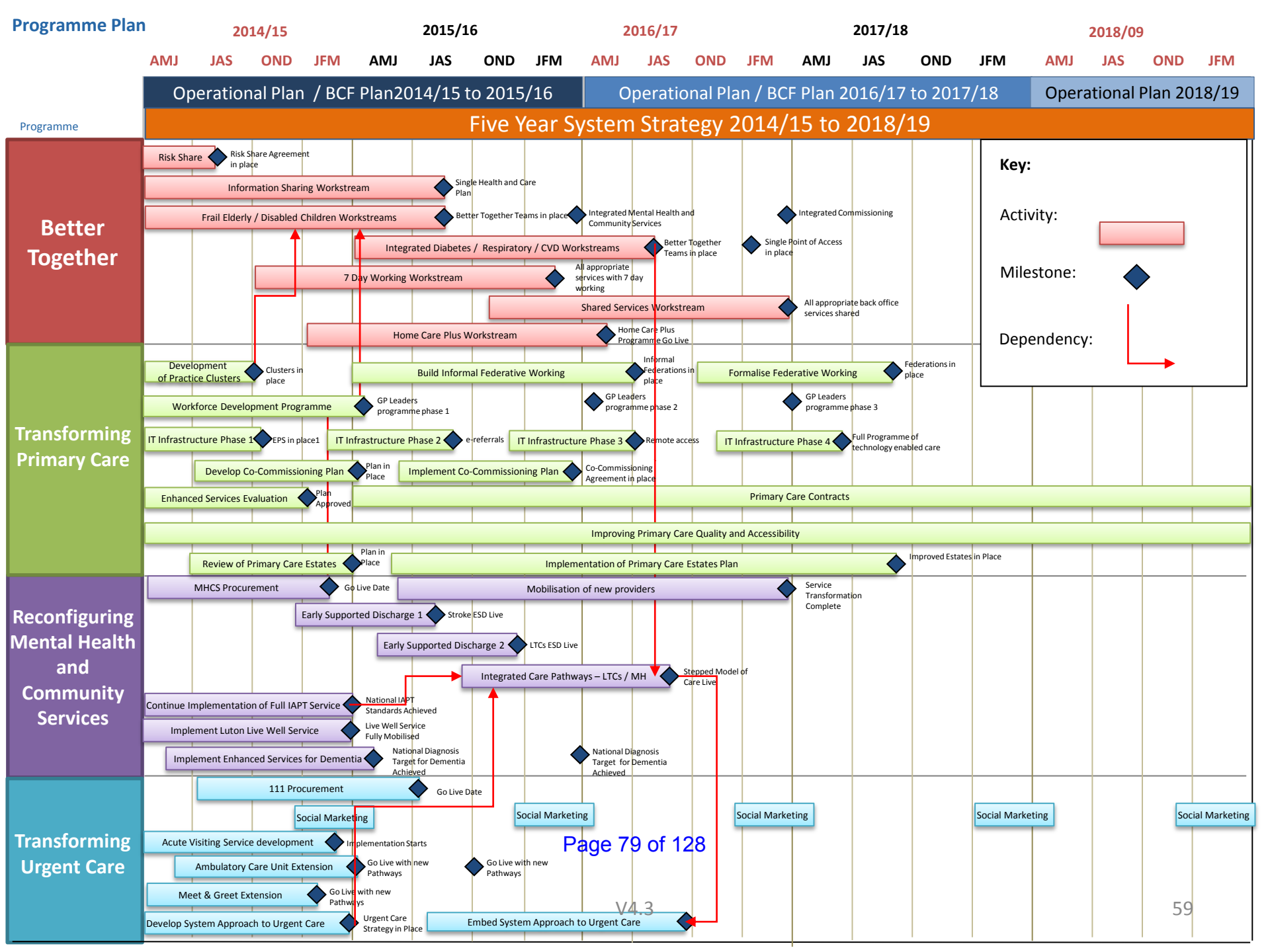
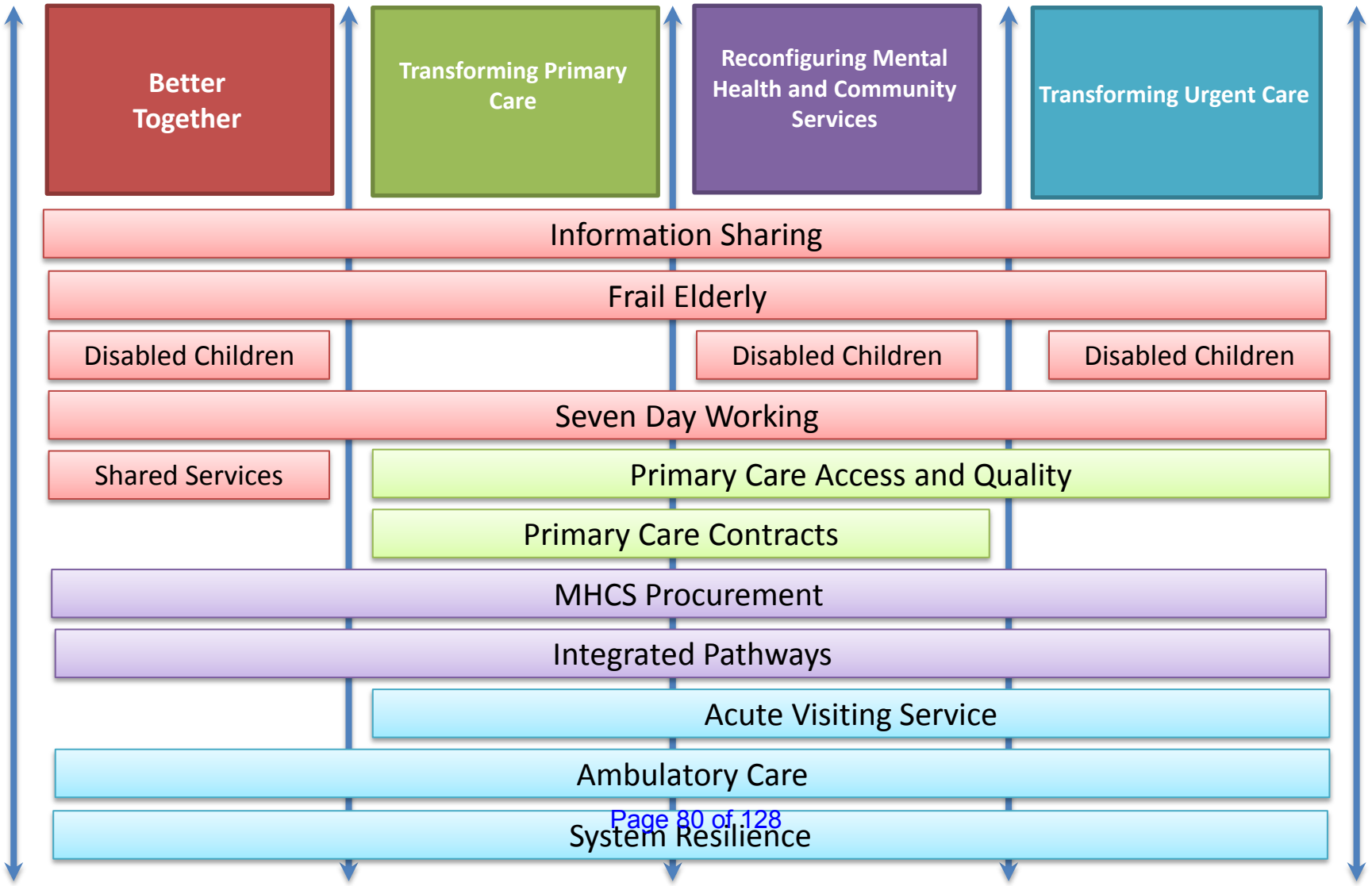
Programme Plan



Interdependencies



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.

An important principle of public engagement is to put in place a feedback loop to inform the public what we have done as a result of their inputs. We will ensure that this principle is fully incorporated into our approach.

We will also be honest with people to enable them to understand that not everything can be addressed quickly within current constraints

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]

Citizen Engagement "Your Say, Your Way"

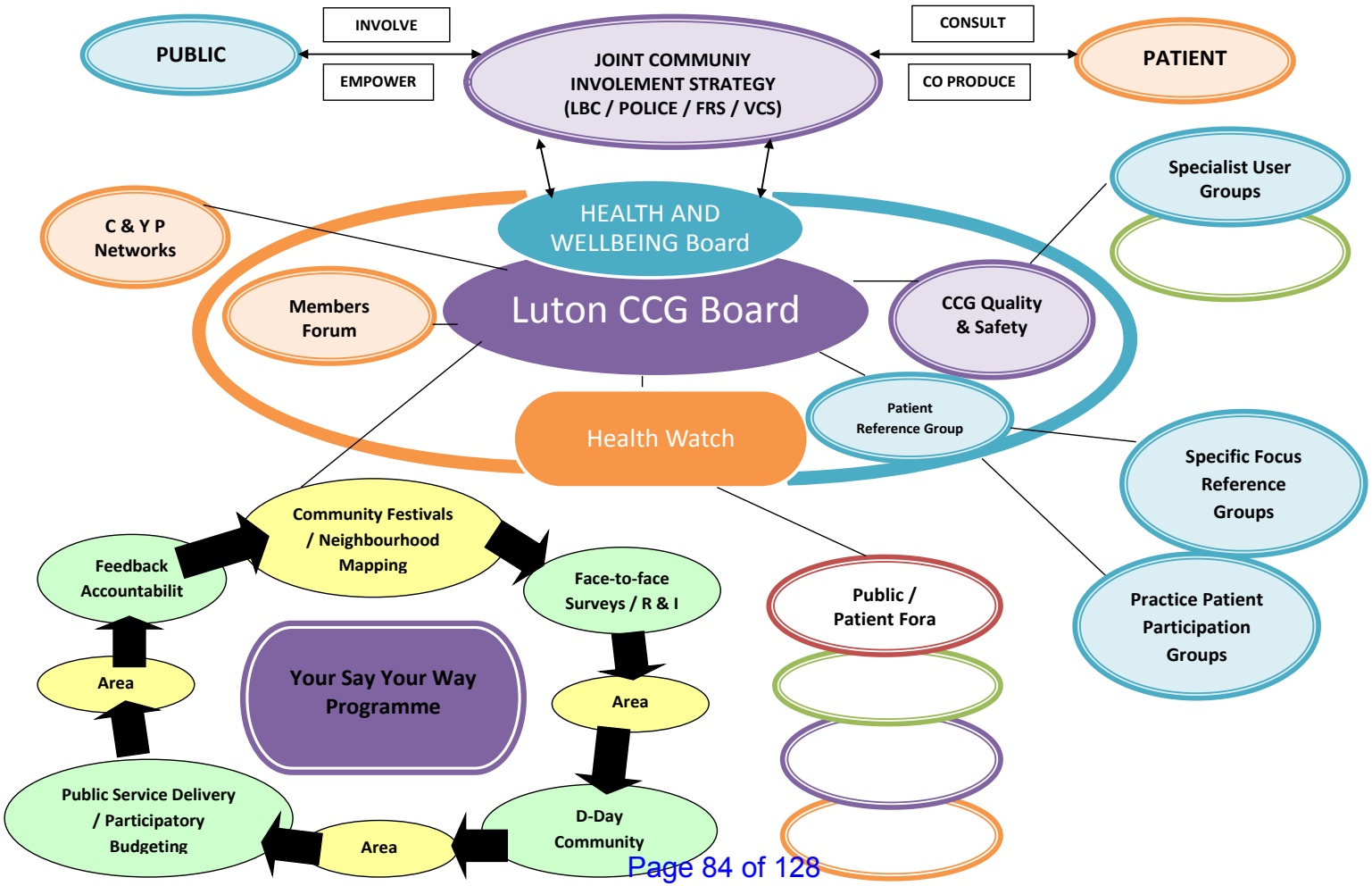
LBC and LCCG are active members of the "your say, your way" programme which enables a robust feedback cycle between community concerns and system response to those concerns.

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.

Luton Engagement Map



Clinical Engagement

General Practice
Clinical Commissioning places GPs and other Clinicians at the heart of commissioning. The CCG has a well developed programme of on-going communication channels for practice engagement such as practice visits, the Members Forum, Practice Managers Group and Protected Learning Time. As a result almost 40% of our local GPs are actively involved in leadership roles in the CCG.

Wider Clinical Engagement
The development of this strategy has also been strongly informed by the views of clinicians working outside of the GP Community. A programme of clinical engagement has been delivered via the following routes

- ✓ Luton and Dunstable Hospital "Grand Round"
- ✓ Clinical Engagement Suppers
- ✓ Board to Board meetings with key providers
- ✓ CCG Clinical Commissioning Committee – which includes members from Community Pharmacy, Optometry and Dentistry
- ✓ Integrated Diabetes Local Implementation Group
- ✓ Respiratory Local Implementation Group

The system is currently also putting in place a formalised Clinicians Forum comprising members from L&D Hospital and Luton, Bedfordshire and Hertfordshire CCGs.
Further engagement has taken place with the Strategic Clinical Networks , the University of Bedfordshire and Health Education East of England in the development of our plan

Engagement Objectives

1. Further develop a patient and community engagement model for Luton which is underpinned by a transparent and inclusive governance infrastructure which will ensure that patients, the public and partners are actively engaged with and feel they can influence commissioning decisions to improve local health and social care services

2. Ensure that every Luton General Practice has an active Patient Participation Group in place which is able to ensure a feedback loop is in place to drive improved commissioning decision-making

3. Provide all staff with the tools and knowledge to ensure that patient and community engagement is at the heart of commissioning and service provision

4. Drive behavioural changes in the general public to ensure that they understand the need to act in order to a) Maintain a healthy lifestyle b) Understand the importance of early intervention c) Access the right services to meet their needs when they are ill

5. Ensure full system-wide clinical engagement to ensure decision making is clinically-led and as effective as possible.

6. Ensure that “early-warning” systems are in place so that issues regarding quality and safety of services can be addressed immediately

7. Developing the Workforce

Workforce Transformation

The Luton System is developing 5 year workforce plan for Luton with key partners across the health and social care system including Heath Education East of England, Skills for Care, Skills for Health and the University of Bedfordshire. This takes into account the current difficulties in recruiting into Adult Community Nursing and Specialist Services.

In order to provide higher acuity care for adults older people and those with long term conditions , the community nursing and social care workforce will need to be enhanced both in terms of numbers and skills.

Forecasted workforce requirements are an integral part of the procurement process for Community health services and the Better Together integration programme for Luton

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. A scheme is being developed by the CCG to recruit GPs into Luton, working with the GP Tutor, Health Education England and University of Bedfordshire. The scheme will take 2 GPs per year for a three year programme, with sessions in practices, the CCG and the University.

Seven Day Working

Nationally, NHS England board has committed the NHS to "move towards routine services being available seven days a week. This is essential to offer a much more patient-focused service and also offers the opportunity to improve clinical outcomes and reduce costs.

Our priority for the first two years of this strategy will be to extend services across the health and social care system where this will enable admission prevention, reduce the risk of emergency re-admission, speed up hospital discharge and ensure everyone can leave within 24 hours of being "ready to go"

A review of hospital discharge processes undertaken in 2013 identified a number of areas where improved access out of office hours would help us to deliver improved outcomes. These include:

- Adult social care services to work with residential / care homes to overcome barriers to receiving patients back at weekends and after 4.30pm
- Exploring the provision of a jointly resourced social work service with Central Bedfordshire to cover weekend work
- Integrated discharge team to work seven days to ensure that CHC assessments involve carers and families , supporting them to make early decisions on discharges
- Community nursing covers seven day working, the intermediate care services supported by social care will move to a similar pattern to support rapid assessment and early supported discharge for stroke patients back into the community and into rehabilitation services.

8. Governance

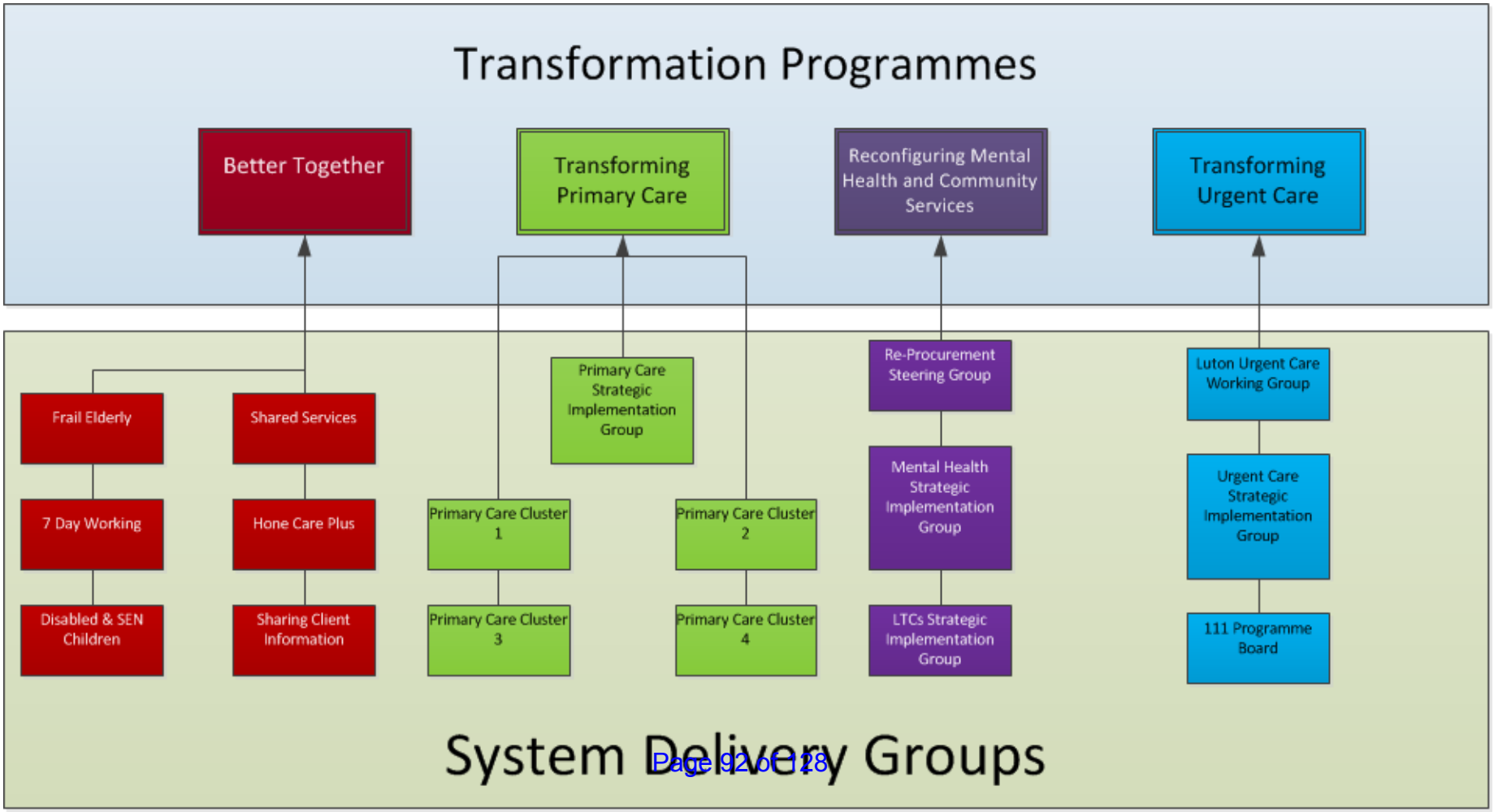
Introduction

The challenges and ambitions we have set for ourselves for the next Five Years can only be delivered through a robust system of Programme Governance through which those responsible for delivery of key elements of our strategy are called to account by System Leadership.

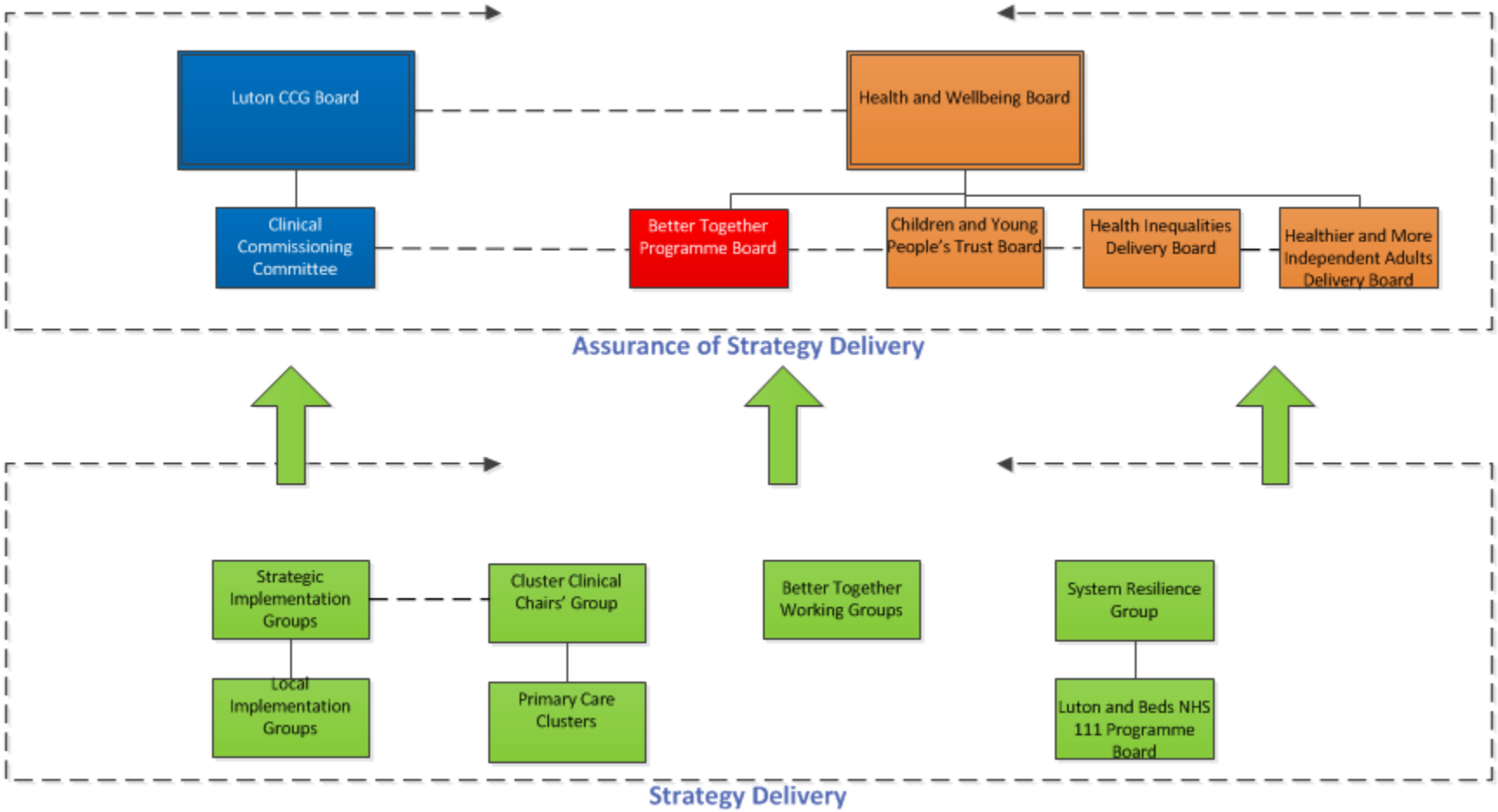
Fortunately the Luton System has pre-existing Governance Structures in place to ensure that the Strategy is delivered on time and within budget.

- The **Health and Wellbeing Board** is the "Owner" of the Strategy .
- The **Better Together System Transformation Programme Board** with membership comprised of system leaders across all partners is the Programme Delivery Board and will assure the delivery of the Strategy through reporting from the **Strategy Delivery Groups.**
- These delivery groups include the Better Together Working Groups, the CCG's Strategic Implementation Groups, the Practice Clusters and the Urgent Care Working Group
- The **Clinical Commissioning Committee** has clinical decision making responsibilities and will drive the development of business cases for service change . The Committee will also hold the Strategic Implementation Groups and Cluster Clinical Chairs Committee to account on delivery of key elements of the Strategy

Five Year Strategy Delivery Vehicles



Programme Governance Structure



Our Strategy is delivered through a wide variety of collaborative delivery groups, some of which are listed above. Progress is primarily assured through reporting to the Better Together Programme Board as this group has senior system leaders as its membership. Additionally formal reporting lines from the delivery groups to the CCC and Health and Wellbeing Board Delivery Boards will continue

9. Risk

Managing the Risks Associated with Strategy Delivery

The key risks for each of the transformational programmes are articulated earlier in this document. There are a number of wider system risks, of which the key ones are listed below

Risk	Risk Rating	Mitigating Actions	Residual Risk
There is a risk of the plan failing to deliver due to lack of system ownership of the outcome goals	High	Ensure robust programme governance is in place and that the strategy is owned by the Health and Wellbeing Board and delivery is systematically managed by the Better Together Programme Board, holding individuals and organisations to account for their part of delivery	Medium
Lack of capacity and resources to effectively deliver key objectives	High	Continue to lobby for equitable funding for Luton. Establish a system wide resource pool to call upon when gaps are identified	Medium
There is a risk that the desired shift of resources out of hospital does not take place at the pace required to deliver the financial plan	High	Put in place a risk share scheme across LCCG / LBC / L&D to ensure that the problem is a shared problem	Medium

10. 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%

System Objective Two

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

System Objective Three

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

System Objective Four

To stop the increase in unnecessary hospital admissions

System Objective Five

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

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

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

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

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.

Overseen through the following governance arrangements

- Health and Wellbeing Board and Better Together Programme Board 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

SCRUTINY: HEALTH AND SOCIAL CARE REVIEW GROUP	AGENDA ITEM **10**

DATE OF MEETING: 11th September 2014

REPORT OF: Director of Public Health

REPORT AUTHOR: Kelly O'Neill - Assistant Director of Public Health

TEL : 01582 548439

SUBJECT: Engagement with Luton Pakistani/ Kashmiri community: To inform Infant Mortality Genetic work programme

(Recommendation by the Scrutiny Task & Finish Group – UPDATE):

PURPOSE:

The Infant Mortality task and finish group requested that the engagement consultation commissioned by public health from the University of Bedfordshire to inform the infant mortality genetics programme be presented to the Health and Social Care Review Group.

This paper presents the executive summary report.

The full report is being prepared for wider distribution and will be available in November 2014 at which time an action plan based on the findings will have been completed.

RECOMMENDATION:

The Health and Social Care Review Group are asked to note the contents of the report and agree an annual update of progress against the recommendations.

EXECUTIVE SUMMARY AND RECOMMENDATIONS

ENGAGING THE PAKISTANI/ KASHMIRI COMMUNITY IN LUTON WITH A CONVERSATION ON CONSANGUINEOUS (COUSIN) MARRIAGES

BACKGROUND

Luton Borough Council commissioned the Institute for Health Research (IHR), University of Bedfordshire to carry out an engagement exercise to discuss and explore, with the Pakistani/ Kashmiri community in Luton, their views on the cultural practice of consanguinity (cousin marriage), understanding of associated risk of genetic conditions, and awareness of universal and specialist health services that are available to inform parents and families of risk for informed decision making.

Consanguineous marriage refers to the social practice of marriage between second cousins (and closer) and comes from the genetic classification of consanguinity or 'blood relation' (Bittles, 2001). In common parlance, consanguineous marriages are frequently referred to as cousin marriages.

AIMS OF THE RESEARCH

The aim of this engagement exercise was to discuss and explore Pakistani/ Kashmiri views on cousin marriage, understanding of associated risk of genetic conditions, and awareness of universal and specialist health services that are available to inform parents and families of risk for informed decision making.

This aim was met by achieving the following objectives:

- Explore community perceptions of the cultural practice of cousin marriage;
- Gauge the level of participants' understanding of hereditary (genetic) conditions and the associated risk;
- Consider participants' awareness of universal and specialist services available for genetic screening and counselling available to inform parents and families of genetic risk;
- Identify any perceived barriers and enablers towards increasing the uptake and access to universal/specialist genetic health services in Luton;
- Make recommendations for improving health outcomes based on the views identified by participants engaging in the exercise from the communities stated.

ENGAGEMENT EXERCISE DESIGN

A qualitative approach was used to meet the engagement exercise aim and objectives. Eight single-sex focus groups were carried out with members of the Pakistani/ Kashmiri community living in Luton (x2 17-25yr olds: male n= 8, female

n=9; x2 26-35yr olds: male n=6, female=7; x2 36-55r olds: male n=8, female n=10; x2 55+yr olds male=x11, female n=7). A total of 66 people took part in the exercise and focus groups comprised of a mix of participants who were in cousin marriages and those that were not.

The focus group discussions highlighted age and gender differences in Pakistani/ Kashmiri views on cousin marriage, understanding of risk, awareness of universal/specialist genetic health services delivered, and views on how these services could be improved.

ENGAGEMENT FINDINGS

PREVALENCE AND PERCEPTIONS OF COUSIN MARRAIGES

- Participants explained cousin marriages as unions between first or second cousins. Some participants extended the definition to include members of the *biraderi* (extended familial/kin network).

- Other ethnic groups were seen to practice cousin marriages but participants explained that cousin marriage was a more visible practice among Pakistani/Kashmiri settlers in Luton because of the size of the population. Cousin marriages were seen as a central element of Pakistani/Kashmiri culture and legitimised by religion in the form of Islam.

- There was some confusion over the Islamic injunctions about cousin marriages.

- Cousin marriages were usually arranged by parents/senior relatives and some participants emphasised that in some cases they were forced marriages.

- Cousin marriages were favoured for being a source of social/emotional support and provided economic/financial benefits; whilst the disadvantages centred on the breakdown of cousin marriages on family relationships and children born with abnormalities and/or disabilities.

- Overall, participants regardless of age and gender felt that non Pakistani/ Kashmiris stigmatised the practice of cousin marriages because there was a stereotype that they were arranged/forced marriages rather than love marriages. Also, participants felt that there was negative media coverage representing cousin marriages as the cause of disabilities amongst the Pakistani/Kashmiri community because cousin marriage was a primarily Muslim practice.

- Cousin marriages were least favoured by younger participants but some were willing to consider marrying cousins if they were born and brought up in the UK rather than cousins from Pakistan.

- All participants regardless of age and gender said that the prevalence of cousin marriages was high in Luton but was declining over time. The decline in cousin marriages was attributed to changing preferences for cousin

marriages which were based on being influenced by living, and being educated in the West and immigration legislation. Specifically a Western upbringing was leading to a desire to choose own marriage partners/have love marriages which was a result of increased social mixing. There was increased awareness through education about genetic risks associated with cousin marriages leading to more informed marriage choices and immigration restrictions limiting trans-national marriages

GENETIC RISK AND CONSANGUINOUS MARRAIGES

- All participants regardless of age or gender had some awareness of the genetic risk associated with cousin marriages.

- Information about the genetic risk associated with cousin marriage for older participants came from personal and family experiences and healthcare service providers. Younger participants also obtained information from family, friends, schools, colleges, universities, the news and websites.

- The explanations of genetic risk associated with cousin marriages focussed on descriptions of birth abnormalities and/or disabilities rather than stillbirths or infant deaths. Participants gave examples of thalassemia, deafness, asthma, eczema diabetes and learning disabilities like Down's syndrome as hereditary conditions.

- Overall, all participants regardless of age and gender felt the prevalence of abnormalities and/ or disabilities, stillbirths and infant death was low within the Pakistani/ Kashmiri community in Luton.

- Younger participants were more inclined to accept the statistics relating to genetic risk associated with cousin marriages but, like all other participants questioned the science, giving examples of family members who were not in cousin marriages and non-consanguineous ethnic groups having children with abnormalities and/or disabilities.

- Reasons for perceived low rates of stillbirths and infant deaths were presented as good healthcare provision and family support.

- The causes of stillbirths and infant abnormalities and/or disabilities and child deaths were to the age of the mother, poor lifestyle, types of physical activity during pregnancy and medication rather than the genetic risk associated with cousin marriages. Extra-marital relations and cultural explanations were also offered as the reason behind adverse child health outcomes.

- For all participants regardless of age and gender there was a tendency to attribute stillbirths, infant deaths and abnormalities and/or disabilities to being 'Gods will', the 'Qadr of Allah' (Allah's decree) and pre-destiny.

BARRIERS TO ACCESSING UNIVERSAL/SEPECIALIST SERVICES

- Although women had more knowledge of universal and specialist services available than men, the overall awareness was low. Women were more knowledgeable about universal service than specialist services and gave examples of universal screening as part of maternity care.

- Women regardless of age explained that when screening identified potential abnormalities and/or disabilities, they were unable to terminate the pregnancy for religious reasons and relied on the 'Qadar of Allah' (Allah's decree) for a good birth outcome.

- Overall there was poor knowledge of specialist services. Participants that had some knowledge of specialist services explained that they had struggled to be referred to them by healthcare professions.

- GPs were not seen as a good source of information about genetic risk associated with cousin marriage and did not refer to specialist services.

- Good birth outcomes despite a poor prognosis presented doubt about healthcare professionals' ability to predict birth outcomes, the science of genetic risk associated with cousin marriages, and presented an additional example of the 'will of God' or 'Qadar of Allah' (Allah's decree) overriding scientific advice.

- Participants felt that healthcare service providers were also part of the general population and held negative views about cousin marriages but participants agreed that health professionals did maintain a level of professionalism in dealing with cousin couples.

- Improving access to universal and specialist service in Luton centred on improving awareness and understanding of the risks associated with cousin marriages and improving specialist genetic screening.

- Participants suggested that an awareness campaign that particularly focussed on and included marginalised members of the Pakistani/ Kashmiri community, women with poor English literacy and recent migrants from Pakistan should be implemented. Young people called for more information for parents on the risks associated with cousin marriages.

- Participants agreed that information should be delivered in community settings/centres, schools, colleges and Mosques in the form of seminars and workshops. Younger participants suggested Inspire FM, Zee TV and Asian newspapers as possible forums for discussing consanguinity and genetic risk.

- There was a clear consensus that information should be provided by experts from within the Pakistani/ Kashmiri community in Luton and by non-Pakistani/ Kashmiri healthcare service providers who were sensitive to the cultural practices and religious injunctions on cousin marriage.

- Specialist screening services were favoured by participants who noted that Pakistani/Kashmiri cousin couples may not terminate pregnancies but that these specialist screening services would allow cousin couples to make informed pregnancy choices. Some men were suspicious of genetic screening services and saw it as a way of controlling a growing Muslim population. All participants regardless of age and gender were in favour of genetic counselling services.

NEXT STEPS:

A task group has been established, with the first meeting in September 2014 to review the recommendations and take forward actions. The initial scope of the task group (pending discussion by the group and extended actions) are set out in response to each recommendation of the report.

Recommendation 1: To conduct a local 'know your genes' awareness campaign that is - culturally sensitive; is able to reach its intended audience; improves knowledge of the range of available services; reduces the stigma associated with cousin marriage and accessing services; and supports the Pakistani/Kashmiri community in Luton to make informed decisions regarding cousin marriage and pregnancy choices.

Response/ Plan: *Working together with the Flying Start programme and with the expertise of the regional genetics service public health will identify similar campaigns and the impact of the interventions to raise awareness and measure this on access to specialist services and reduction in child deaths and disability.*

Recommendation 2: To improve awareness of genetic risk associated with cousin marriages including information on different types of gene disorders, family single gene disorders, congenital anomalies, learning difficulties, physical disabilities and multifactorial conditions.

Response/ Plan: *In addition to community awareness, health and social care professionals will have access to local education and awareness training.*

Recommendation 3: To provide information on specialist services and pathways for referral to specialist services for the Pakistani/Kashmiri population in Luton.

Response/ Plan: *See response to recommendations 1 and 2. In addition the referral pathway and capacity of specialist services will be reviewed to ensure any increase in referral can be accommodated.*

Recommendation 4: To provide information on the prevalence of stillbirths, infant deaths and abnormalities and/or disabilities in the Pakistani/ Kashmiri and wider Luton community factoring in an explanation of the wider determinants of health.

Response/ Plan: *Public Health will continue to monitor and share all data relating to infant and child adverse birth and health outcomes ensuring that the impact of wider determinants and increased associated risk is factored into action plans for the council and partner health organisations.*

Recommendation 5: To provide information on the genetic risk associated with cousin marriages as part of universal services.

Response/ Plan: *The task group will look at the training and education programme of health and social care professionals working with families; primary care, maternity, health visitors, school nurses and children centres and identify current education programmes and additional education required to reflect local education requirements.*

Recommendation 6: To engage with the Pakistani/Kashmiri community involving local Imams/ mosques committees for internal debate on the Islamic injunctions related to cousin marriage.

Response/ Plan: *Initial discussions with some faith leaders have been undertaken by the University of Bedfordshire and public health independently. We will seek membership of a faith leader on the task group and engage with to facilitate and encourage active engagement of the faith community to support local campaigns and education programmes will be part of the work of the task group.*

Recommendation 7: To provide information on current legislation on forced marriage.

Response/ Plan: *Links will be made with organisations nationally and locally to ensure that awareness of legislation is promoted in communities in Luton.*

Recommendation 8: To carry out an audit of training provision for healthcare service providers to ensure that adequate cultural literacy is embedded into practice in a systematic fashion to make universal/specialist services more accessible to the Pakistani/Kashmiri community in Luton.

Response/ Plan: *Please refer to response to recommendation 5.*

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LUTON BOROUGH COUNCIL

SCRUTINY: HEALTH AND SOCIAL CARE REVIEW GROUP	AGENDA ITEM **11**

DATE OF MEETING: 11th September 2014

REPORT OF: Director of Public Health

REPORT AUTHOR: Kelly O'Neill - Assistant Director of Public Health

TEL : 01582 548439

SUBJECT: The Link between the Family Poverty Strategy and Infant Mortality.

PURPOSE:

The Infant Mortality task and finish group requested that the link between Luton Family Poverty Strategy and Infant Mortality be considered as a recommendation.

RECOMMENDATION:

The Review Group is asked to note the information and be assured that the council approach to poverty is being implemented in the programme of work to reduce infant mortality in Luton.

September 2014

Author: Kelly O'Neill, Public Health

There are many research studies that examine the impact of poverty and the variables that lead to poverty on infant mortality rates. Globally it is recognised that infant mortality rates increase relative to the wealth of the country with poorer countries and those with poor health care systems having the highest rates of deaths among children under the age of one year.

Within England, infant mortality is highest among more deprived areas and communities.

The Implementation Plan for Reducing Health Inequalities in Infant Mortality (DH 2007) states that 'the impact of the wider, social determinants of health is identified through the impact of poverty, housing and overcrowding. This sets the context where persistent inequalities blight people's lives, opportunities and health'.

Infant mortality: The number of deaths per 1000 live births under the age of 1 year of age.

The current infant Mortality rate for Luton is 5.4 deaths per 1000 live births (2010-12), reduced from 7.3 (2009-2011) compared to 4.6 for England. Using three-year pooled data is a tool to show a more accurate trend-line when looking at data which involves small numbers. This reduces the variability that arises with annual data of small samples.

The Wider Determinants of Infant Mortality

Infant mortality is affected by a number of health and social determinants. Nationally the focus previously has been on health care and lifestyle however there are a group of factors; socio-demographic and deprivation that have significant impact on child and family health that have in previously had less attention.

The Child and Maternity (chimat) profile is produced annually and compares geographical areas to each other and the national rate. The indicators set out in the profile are those used by DH as health variables that increase the risk of infant mortality. The ChiMat profile (2012) shows the infant mortality rate and other key wider determinants: deprivation, children living in poverty, IMD, child wellbeing index, overcrowded households and rates the local performance data against the national average.

The 2012 profile shows that the IMR in Luton is high, and towards the worse end of the scale in England. This position has improved and will be reflected in future profile updates. The use of these profiles is that the indicators presented are considered risk factors for higher rates of infant mortality. For overcrowded housing, BME population and children living in poverty Luton is also worse than the England average. These have all been identified as key evidence based interventions for tackling infant mortality as well as targeting those in routine and manual socio-economic groups.

This profile is presented as appendix 1.

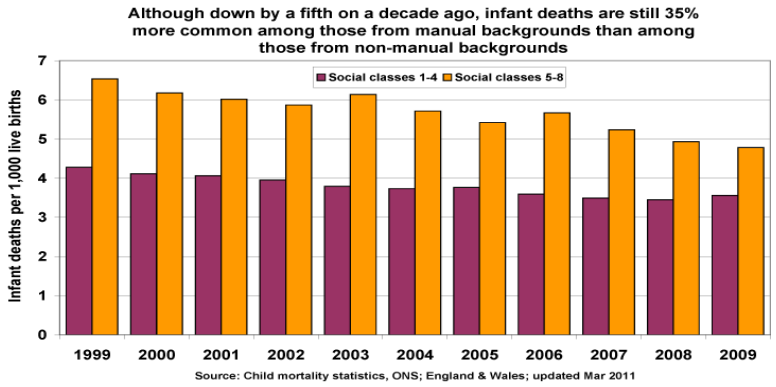
This paper identifies the link between the Luton Family Poverty Strategy 2011-2014 and Infant Mortality.

Deprivation, Disadvantage and Child Poverty:

The links between poverty and poor health outcomes for children are both profound and inextricable. Childhood poverty is a cause of ill health and the relationship

between poverty and health is complex as a number of associated risk factors will determine the outcome. The negative effects of childhood poverty on health may start as early as prenatal through exposure by the mother (smoking, stress, poor nutrition, obesity etc.). Children born to mothers living in poverty are at an increased risk of being born prematurely, having a lower birth weight and dying of sudden infant death syndrome (SIDS).

Although infant death rates among both those from manual backgrounds and those from non-manual backgrounds have fallen by around a fifth over the last decade, infant deaths are still 35% more common among those from manual backgrounds than among those from non-manual backgrounds.

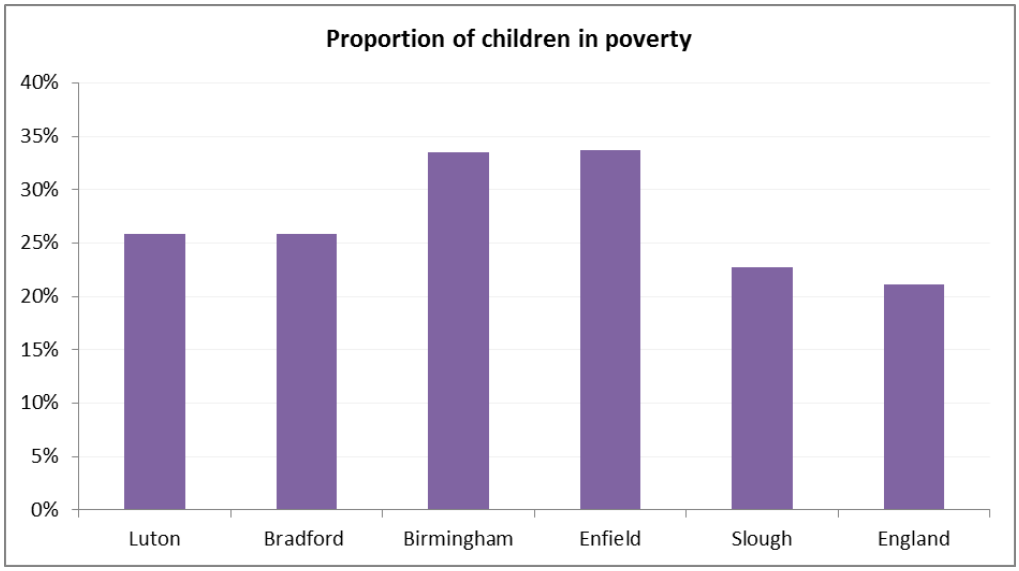


The Child Poverty Act 2010 set out a strategy to eradicated child poverty by 2020, the need to reduce socio-economic disadvantage, prevent poor children becoming poor adults through raising educational attainment.

Luton Family Poverty Strategy:

The Luton Family Poverty Strategy 2011-14 states that ‘Luton will be a town where family poverty is reduced and the impact of poverty on children and families is alleviated’.

The strategy recognised that child poverty cannot be seen or addressed in isolation outside the context of wider family poverty and using the information from the Child Poverty Needs Assessment, 2011 found that 1 in 4 children in Luton were living in poverty. The graph below shows child poverty levels in Luton compared to statistical neighbours.



There is a wealth of empirical evidence that families in poverty experience a cycle of generational deprivation; poverty in childhood has a profound negative impact on long term health, educational attainment, employment prospects, future income and a lifetime of general health and wellbeing. This is presented fully in the Annual Report of Luton's Director of Public Health on the wider determinants of health 2013/14.

The ambitions of the Strategy are essentially the drivers for how to reduce infant mortality at population level. Reducing deprivation, and disadvantage, improving aspirations, education, and thereby creating good employment opportunities with all agencies recognising the role they play to deliver this, in addition to building individuals, families and community resilience to create a healthier population.

Healthy populations have better maternity and child health outcomes. Mothers in higher socio-economic groups are more likely to have healthier lifestyles adopted as part of their childhood, maintain good health pre, during and post pregnancy, there are fewer affluent mothers with unhealthy lifestyle behaviours such as smoking, poor nutrition, obesity, alcohol or drug consumption which all impact on infant health and can lead to premature birth. Nationally, most infants who are going to die in the first year of life usually die in the first week or month after birth. This is true for Luton. These infants die as a result of extreme prematurity, being born too soon.

Families who are more deprived are more likely to have poor lifestyle factors. In addition there may also be extrinsic factors, such as poor housing, social isolation and mental ill-health, these indicators can be inter-related. Poor housing, can lead to an increase in child accidents in the home, multi-occupancy increases the risk of shared accommodation, lack of space and unsafe sleeping arrangements that can lead to Sudden Infant Death.

A further risk is poor family stability, domestic abuse and violence, poor relationships, safeguarding and child protection factors are also causes of infant mortality although this issue is not exclusive to poorer families.

Infant Mortality: Understanding the needs of Children and Families in Poverty:

There are well established links between poor intrinsic and extrinsic factors that can lead to increased risk of a child dying before its first birthday. Having a clear picture of the reasons why children die and taking action to address these risks is fundamental to reducing infant deaths.

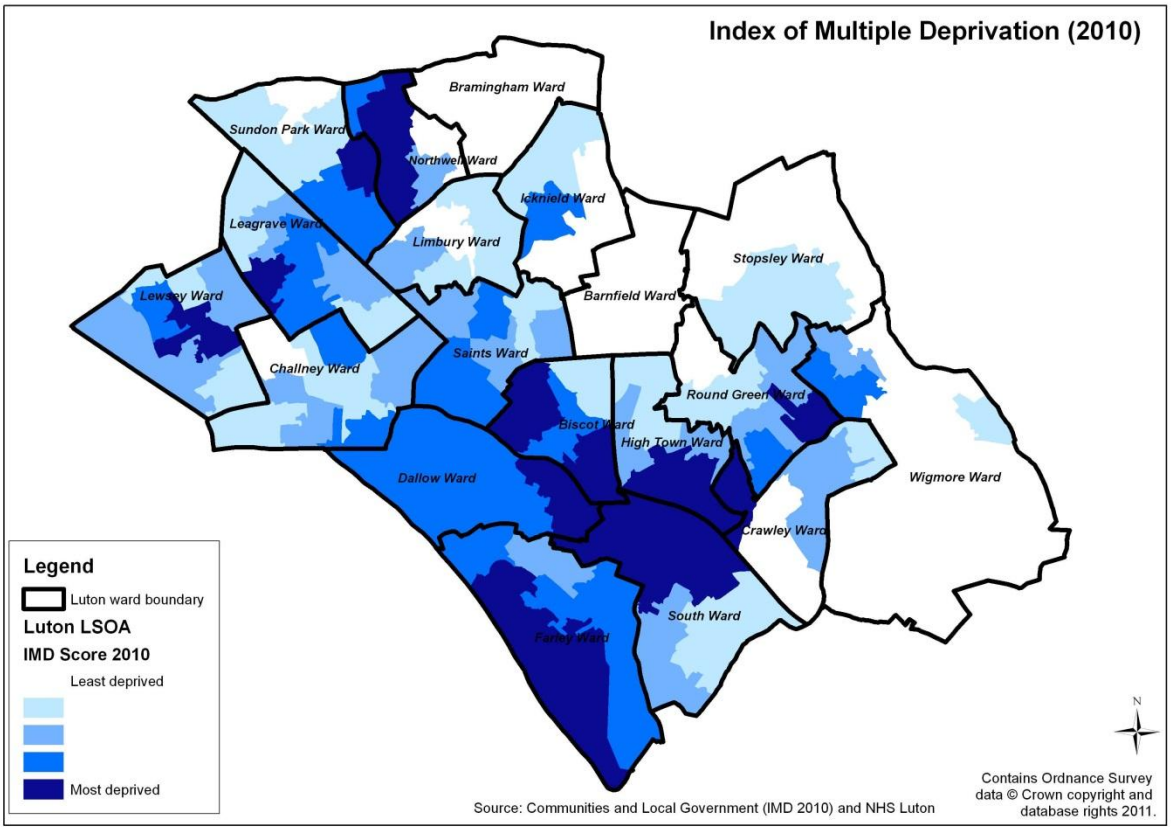
By analysing child death data, from death registration information and through the investigation by the child death panel in Luton and the Joint Strategic Needs Assessment we know that:

- More deprived wards of Luton have higher numbers of infant deaths, babies born with a low birth weight and rates of child disability. There is an issue in this data as approximately 20% of deaths are due to genetic disorders as a result of cousin marriage rather than poverty.
- There is lower life expectancy in the poorer areas of Luton
- 51% of mothers of infants who die in the first year have a modifiable factors considered to contribute to the death, smoking in pregnancy, excess maternal weight, lifestyle factors that are more prevalent in deprived families.

The Flying Start programme recognised the 5 most deprived wards in Luton needed to be targeted to improve healthy lifestyle within families as a means to improve the health of young children in Luton.

Index of Multiple Deprivation:

The index of multiple deprivation (IMD) shows the level of relative deprivation across small areas. The factors that contribute to the measure recognise that deprivation consists of a general lack of resources and opportunities and combines scores for income, employment, health, education, crime, access to services and the living environment. The darker areas on the map are the more deprived.



The wards in Luton with the highest rates of infant mortality (note that information is based on small numbers) using information collated from death registration (2008-2012):

Ward	Rate	Number of deaths 2008-12	Index of Deprivation
Challney	9.4	11	22.3
Lewsey	9.4	9	27.2
South	8.3	10	35.2
Northwell	8.3	6	38.1
Leagrave	7.6	8	27.6
Dallow	7.5	16	38.1
Farley	6.8	7	32.9
Hightown	6.3	5	29.6
Biscot	5.9	12	37.1

Recommendations of the Family Poverty Strategy that can and are being used to improve infant health and reduce infant mortality:

Infant mortality is highest among more deprived communities internationally, nationally and within local areas, including Luton. Therefore as a guiding principle, increasing wealth, aspiration, family resilience and improving housing should have significant improvement on population and family health and consequently on infant health and infant mortality.

As a local authority, working with NHS partners, schools, statutory and voluntary organisations as the family poverty strategy sets out, together we can best challenge the generational cycle of poverty. Key actions being taken by the council and partner organisations that support the work to reduce infant mortality are set out below although this is not an exhaustive list. It is important to emphasise that all work the council do that addresses wider determinants of health, reduces family poverty and increases child wellbeing contributes to reducing infant mortality and should be considered as part of the Family Poverty Strategy refresh:

- Recognition that the actions in the Family Poverty Strategy will help tackle infant mortality and ensuring that this is clearly linked to the IM action plan.
- Active engagement of all partner organisations to understand the impact their areas of responsibility and the services they provide contribute to increasing wellbeing and health and ensuring strategies and plans are linked so show wider impact.
- Working with housing and the children centres, public health are promoting interventions for warmer and safer homes through joint working with the Home Improvement Agency and Safe@Home scheme that reduces child accidents. The Housing strategy also addresses the impact of poor housing and deprivation on health.
- Education of health and social care professionals, emergency services, children centres to raise awareness among early year family facing services to increase parents' knowledge of Sudden Infant Deaths and the risk of co-sleeping.
- Working with Luton CCG, NHS England, L&D maternity Services and Cambridge Community Services, through contracted arrangements compliance with the Healthy Child Universal programme is improving and there is close monitoring of public health interventions to address poor health lifestyles especially among pregnant women and new mothers.
- Leading the teenage pregnancy agenda, public health are developing a programme to improve the health and aspiration of young people in secondary schools in Luton through better personal, social, health education programmes being delivered in addition to better support for teenage parents to improve parenting and life prospects for their future.

- Ensuring that data is being developed upon which decisions can be made that have an impact on health in Luton is an integral part of improving health, and the health of children who will be adults of the future.

Appendix 1: Infant mortality profile 2012 – produced by ChiMat

Indicator	Area	Number	Value	Eng. Avg.	England Worst	Current Performance	England Best
▼ Infant Mortality							
Infant mortality rate	Luton PCT	79	7.50	4.60	8.0		2.2
▼ Deprivation							
Children living in poverty	Luton PCT	13,063	31.30	22.44	66.5		10.2
Index of Multiple Deprivation	Luton PCT		25.78	23.72	45.3		8.8
Child Wellbeing Index	Luton PCT		194.48	168.68	358.8		69.4
▼ Socio-demographics							
Overcrowded households, %	Luton PCT	8,968	18.49	10.50	54.6		3.9
BME population, %	Luton PCT	77,700	41.15	16.35	68.4		3.6
▼ Teenage conceptions							
Teenage conception rate (age <18 years)	Luton PCT	388	35.00	38.1	64.9		20.2
Change in teenage conception rate, %	Luton PCT		-2.23	-5.21	-19.5		7.4
▼ Pregnancy and infancy							
Smoking in Pregnancy, %	Luton PCT	117	13.64	13.17	29.7		2.0
Breastfeeding Initiation, %	Luton PCT	579	67.48	73.74	42.5		95.7
Low birth weight (<2500g), %	Luton PCT	334	9.50	7.30	11.5		5.2
Antenatal assessement by 12 weeks, %	Luton PCT	969	79.10	84.20	34.6		100
▼ Immunisations							
Completed MMR (by age 2 years), %	Luton PCT	3,010	86.8	89.10	75.4		96.8
Completed Diphtheria, Tetanus, Polio, Pertussis,...	Luton PCT	3,304	95.2	96.00	87.3		98.9
Completed MenC immunisation (by age 2 years),...	Luton PCT	3,322	95.76	94.80	77.5		98.9
Completed Diphtheria, Tetanus, Polio, Pertussis,...	Luton PCT	3,209	91.95	94.20	82.5		98.2
Completed MenC immunisation course by 1st bir...	Luton PCT	3,178	91.06	93.40	81.0		98.0
Completed Pneumococcal conjugate vaccine (by...	Luton PCT	3,174	90.90	93.60	80.5		97.8

Significance compared with England average: worse ● better ● none ● could not be calculated ○

England Average | Regional Value ◆

Q0 to Q1 Q1 to Q3 Q3 to Q4

LUTON BOROUGH COUNCIL

SCRUTINY: HEALTH AND SOCIAL CARE REVIEW GROUP (HSCRG)	AGENDA ITEM 12

DATE OF MEETING:	**11th September 2014**
REPORT OF:	Director of Public Health
REPORT AUTHOR:	**Kelly O'Neill–Assistant Director of Public Health**
SUBJECT:	**CDOP - Audit of Gender Imbalance Findings - PRESENTATION**

SCRUTINY: HEALTH AND SOCIAL CARE REVIEW GROUP (HSCRG)	AGENDA ITEM 13

DATE OF MEETING:	11th September 2014		
REPORT OF:	Head of Policy and Performance		
REPORT AUTHOR:	Eunice Lewis	**Tel:**	01582 547149
SUBJECT:	HSCRG Work Programme		

PURPOSE

1. To enable HSCRG to plan and determine its work programme.

RECOMMENDATIONS

2. That HSCRG approves its work programme with or without any amendments, as appropriate;

3. That HSCRG determines whether to include for scrutiny on its work programme, any of the items from the Executive Forward Plan;

4. That HSCRG delegates responsibility for making necessary changes to the work programme between meetings, to the Democracy and Scrutiny Team Leader, after consultation with the Chair.

REPORT

5. The draft work programme with proposed items for future meetings is attached at **Appendix A.**

9. The Executive Forward Plan from 22nd September 2014 is attached at **Appendix B**.

10. Members are requested to review both documents and determine the items they wish to include on the programme, or suggest any other emerging matters not currently listed.

Scrutiny: Health and Social Care Review Group Work Programme - Municipal Year 2014/2015

This draft work programme is updated on a regular basis following each meeting of HSCRG and as required, in consultation with the Chair. Unallocated potential future items are listed at the end of this document.

Meeting Date: 11th September 2014	**Time:** 6.00 pm	**Committee Room:**
Reminder out:	**Report in:**	**Despatch:**
Democracy & Scrutiny Officer: Bert Siong		

Agenda item	Report Author and format
Chair's Update (Standing item)	Cllr. Foord Oral Report
East of England Ambulance Service Strategic Plan: Update & Implications for Luton	Simon King/ Locality Director Written Report
'Luton & Dunstable Hospital - The Future': Update	Pauline Philip/ Sarah Wiles (L&D Hospital) Written Report? Presentation (TBC)
5 year Health Systems Strategy	Carol Hill, Luton CCG (and partners) Written Report
Public Health commissioned work on Genetics	Gerry Taylor/ Kelly O'Neill Written Report
Links between the Family Poverty Strategy, and Infant Mortality	Gerry Taylor/ Kelly O'Neill Written Report
The audit of Gender Imbalance Findings	Gerry Taylor/ Kelly O'Neill Written Report
Work programme and Future meetings /Including Current Executive Forward Plan (Standing item)	Democracy and Scrutiny Officer Written Report

Date	C/Room	Comments
8th October 2014	3	
18th November 2014	2	
8th January 2015	3	
2nd March 2015	3	
1st April 2015	3	

Scrutiny: Health and Social Care Review Group
Work Programme - Municipal Year 2014/2015

Meeting Date: 8th October 2014	**Time:** 6.00 pm	**Committee Room:**
Reminder out:	**Report in:**	**Despatch:**
Democracy & Scrutiny Officer: Bert Siong/ Eunice Lewis-Okeowo		

Agenda item	Report Author and format
Chair's Update (Standing item)	Cllr. Foord Oral Report
Coroner's Policy and Practice - Update on the implementation of HSCRG's recommendations	Tony Ireland Written Report
Work programme and Future meetings /Including Current Executive Forward Plan (Standing item)	Democracy and Scrutiny Officer Written Report

Date	C/Room	Comments
18th November 2014	2	
8th January 2015	3	
2nd March 2015	3	
1st April 2015	3	

LUTON BOROUGH COUNCIL

Scrutiny: Health and Social Care Review Group
Work Programme - Municipal Year 2014/2015

Meeting Date: 18th November 2014	**Time:** 6.00 pm	**Committee Room:**
Reminder out:	**Report in:**	**Despatch:**
Democracy & Scrutiny Officer: Bert Siong/ Eunice Lewis-Okeowo		

Agenda item	Report Author and format
Chair's Update (Standing item)	Cllr. Foord Oral Report
Progress report on Safeguarding Adults in Luton	Prof. Michael Preston - Chair, Adult Safeguarding Board/ Patricia Jennings Written Report
(LSCB Annual Report) Safeguarding Children in Luton – Annual Report (moved from 11th Sept at request of C. Barrett)	Prof. Michael Preston-Shoot/ Catherine Barrett Written Report
Continuing Healthcare Assessments: Implications of increases in demand on resources (tbc)	Carol Hill to inform of new author (Written Report)
Reducing Loneliness and Social Isolation in Luton - Update	Joe Biskupski Written Report
Older People's Day Services: Update	Kim Radford Written Report
Luton CCG Financial Recovery Plan and Implications for Services in Luton	Carol Hill (Luton CCG) Written Report
Luton CCG Commissioning Intentions 2015/16	Carol Hill, Luton CCG Written Report
Work programme and Future meetings /Including Current Executive Forward Plan (Standing item)	Democracy and Scrutiny Officer Written Report

Date	C/Room	Comments
8th January 2015	3	
2nd March 2015	3	
1st April 2015	3	

LUTON BOROUGH COUNCIL

Scrutiny: Health and Social Care Review Group
Work Programme - Municipal Year 2014/2015

Meeting Date: 8th January 2015	**Time:** 6.00 pm	**Committee Room:**
Reminder out:	**Report in:**	**Despatch:**
Democracy & Scrutiny Officer: Bert Siong/ Eunice Lewis-Okeowo		

Agenda item	Report Author and format
Chair's Update (Standing item)	Cllr. Foord Oral Report
Home Care Service	Written Report Ian Hilsden
Review of the Managed Repeat Prescription Process –	Carol Hill, Luton CCG Written Report
CARE (ACT) JUNE 2014 - PROGRESS -UPDATE OF IMPACT ON COMMUNITY	Maud O'Leary
PROGRESS REPORT ON THE IMPLEMENTATION OF THE LUTON CARER'S STRATEGY – CARING FOR CARERS	Chris Morris
Work programme and Future meetings /Including Current Executive Forward Plan (Standing item)	Democracy and Scrutiny Officer Written Report

Date	C/Room	Comments
2nd March 2015	3	
1st April 2015	3	

LUTON BOROUGH COUNCIL

Scrutiny: Health and Social Care Review Group
Work Programme - Municipal Year 2014/2015

Meeting Date: 2nd March 2015	**Time:** 6.00 pm	**Committee Room:**
Reminder out:	**Report in:**	**Despatch:**
Democracy & Scrutiny Officer: Bert Siong/ Eunice Lewis-Okeowo		

Agenda item	Report Author and format
Chair's Update (Standing item)	Cllr. Foord Oral Report
Progress on Final Priorities – JSNA and PNA (Bert this won't be ready now) – check minutes 31st July	Information only report/or Written report
Work programme and Future meetings /Including Current Executive Forward Plan (Standing item) **Date** / **C/Room** / **Comments** 1st April 2015	Democracy and Scrutiny Officer Written Report

Scrutiny: Health and Social Care Review Group
Work Programme - Municipal Year 2014/2015

Meeting Date: 1st April 2015	**Time:** 6.00 pm	**Committee Room:**
Reminder out:	**Report in:**	**Despatch:**
Democracy & Scrutiny Officer: Bert Siong/ Eunice Lewis-Okeowo		

Agenda item	Report Author and format
Chair's Update (Standing item)	Cllr. Foord Oral Report
Integrated Commissioning	Carol Hill, Luton CCG and Pam Garraway, HCL Written Report
Community Transport: Update	M. McMahon / K. Toye/ M. Davie Written Report
Work programme and Future meetings /Including Current Executive Forward Plan (Standing item) **Date** / **C/Room** / **Comments**	Democracy and Scrutiny Officer Written Report

List of Potential Future items for the work programme – Dates to be confirmed

- Incidence of multiple admissions to hospitals for age group 55 – 59
- CQC Inspection of GP and out of hours Services: Briefing on new arrangement
- Regional Stroke Services Re-Design Consultation;
- Parks Strategy – What is in place
- Luton CCG Financial Recovery Plan and Implications for Services in Luton;

LUTON BOROUGH COUNCIL

FORWARD PLAN OF **KEY DECISIONS** FROM 22ND SEPTEMBER 2014

EXECUTIVE MEMBERSHIP: Councillors Akbar, Ashraf, N. Ayub, Hussain, A. Khan, K. Malik, Shaw, Simmons, Taylor and Timoney.

Commencing from Monday 22nd September 2014 the Council plans to make key decisions on the issues set out below. Key decisions relate to those which are likely:

- ◊ to result in the local authority incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates; or
- ◊ to be significant in terms of its effects on communities living or working in an area comprising two or more wards or electoral divisions in the area of the Borough.

The Forward Plan lists the business undertaken by or on behalf of the Executive and will be published 28 days prior to each Executive meeting. Those items identified for decision more than 28 days in advance may change in forthcoming Plans. There may also be occasions where a key decision is deferred to a later meeting. Each new Plan supersedes the previous Plan. Any questions regarding individual issues should be addressed to the contact specified in the Plan.
The agendas and Forward Plans for meetings of the Executive will be published as follows:

Forward Plan Published	Publication of Agenda	Executive Meeting Date	Forward Plan Published	Publication of Agenda	Executive Meeting Date
28th July 2014	14th August 2014	26th August 2014	12th December 2014	w\c 22nd December 2014	12th January 2015
22nd August 2014	11th September 2014	22nd September 2014	9th January 2015	29th January 2015	9th February 2015
19th September 2014	9th October 2014	20th October 2014	6th February 2015	26th February 2015	9th March 2015
17th October 2014	6th November 2014	17th November 2014	9th March 2015	25th March 2015	7th April 2015
14th November 2014	4th December 2014	15th December 2014	27th March 2015	16th April 2015	27th April 2015

Link to published Executive Agendas, Reports and Decisions: http://democracy.luton.gov.uk/cmis5public/Documents/PublicDocuments.aspx

Note:

From time to time there will be a necessity to consider issues which will result in key decisions being taken which are not included in the Forward Plan, e.g. items of an extreme urgency, consultation papers issued by Government. Executive meetings are open to the public except to the extent that the public are excluded under paragraph 4(2) of The Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012. (4(2)(a) Confidential information. 4(2)(b) Exempt Information. 4(2)(c) lawful power to exclude person to maintain orderly conduct of the meeting.))

This is a Formal Notice under the Local Authorities (Executive Arrangements)(Meetings and Access to Information)(England) Regulations 2012 that part of the Executive meeting listed in this Forward Plan will be held in private because the agenda and reports for the meeting will contain exempt information under Part 1 of Schedule 12A to the Local Government Act 1972 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it.

The last page of this document sets out the definitions of Exempt Information under Paragraphs of Part 1 of Schedule 12A of the Local Government Act 1972.

Any correspondence to be addressed to: The Head of Policy and Performance, Luton Borough Council, Town Hall, Luton, LU1 2BQ unless otherwise stated.

LUTON BOROUGH COUNCIL
FORWARD PLAN OF KEY DECISIONS AND KEY ISSUES

Title	Key decisions and key issues	Decision maker	Date of decision	Documents submitted for consideration	Exclusion of public required	Contacts/ Lead Executive Member(s)
Treasury Management decisions on borrowing and investments to optimise the Council's financial position	To borrow and invest, and to restructure borrowings where appropriate, in order to optimise the Council's financial position while minimising risk and ensuring that all actions are in accord with the Council's treasury management policy and strategy.	Head of Corporate Finance	Ongoing with dates dependent on financial market conditions	Record of decisions	N/A	Dave Kempson (01582) 546087 Councillor Ashraf
Youth Justice Strategic Plan for Luton 2014/15	To agree the Plan for Luton for 2014/15	Executive	22nd September 2014	Report	No	Hilary Griffiths/Anita Briddon (01582) 547502 Councillors N. Ayub and Akbar
Variation in Arrangements for Funding Mental Health	To ensure management of the contract with the future mental health provider in an integrated way by the Council and CCG	Executive	22nd September 2014	Report	No	Maud O'Leary (01582) 547503 Councillor A. Khan/Councillor Hussain
*NEW - Budget Principles	To set the budget principles for preparing the 2015/16 budget	Executive	22nd September 2014	Report	No	Dave Kempson (01582) 546087 Councillor Ashraf
*NEW – Scheme of Delegation to Officers (Executive Functions)	To approve revisions to the scheme of delegation to officers (Executive Functions)	Executive	22nd September 2014	Report	No	John Newman (01582) 546385 Councillor Simmons
*NEW – Provision of Kerb sett Memorial at the Vale Cemetery	To consider the use of full memorial kerb setts at the Vale Cemetery	Executive	22nd September 2014	Report	No	Alex Contantinides/Barry Timms (01582) 547282/546702

KEY: * denotes new item; Date in brackets denotes the date the item appeared in the previous published version of the Plan

LUTON BOROUGH COUNCIL
FORWARD PLAN OF KEY DECISIONS AND KEY ISSUES

Title	Key decisions and key issues	Decision maker	Date of decision	Documents submitted for consideration	Exclusion of public required	Contacts/ Lead Executive Member(s)
						Councillor Khan
*NEW – Proposed Memorial in Stockwood Park	To consider the implications of a memorial plot within Stockwood Park	Executive	22nd September 2014	Report	No	Alex Contantinides/Barry Timms (01582) 547282/546702 Councillor Khan
*NEW – Capital Funding for Replacement of Telephony System	To approve the business case for release of capital funding included in the Council's 2014-19 capital programme	Executive	22nd September 2014	Report	No	William Clapp (01582) 547392 Councillor Ashraf
Smokefree Policy	To request implementation of the Policy in January 2015	Executive	20th October 2014 (22nd September 2014)	Report	No	Olena Sawal (01582) 548433 Councillor A. Khan
Anti-Social Behaviour Crime & Policing Act 2014	To seek approval to amend the Scheme of Delegation to Officers (Executive Functions) to authorise the relevant Heads of Service to exercise the Council's powers in relation to the Anti-Social Behaviour Crime & Policing Act 2014 (when enacted), in so far as those powers are the responsibility of the Executive.	Executive	20th October 2014 (22nd September 2014)	Report	No	Sarah Hall (01582) 547283 Councillor N. Ayub
Statutory Proposals for the Amalgamation of St Joseph's Infant and Junior Schools	To approve the amalgamation proposals	Executive	20th October 2014	Report	No	Debbie Craig (01582) 548015 Councillor Akbar

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LUTON BOROUGH COUNCIL
FORWARD PLAN OF KEY DECISIONS AND KEY ISSUES

Title	Key decisions and key issues	Decision maker	Date of decision	Documents submitted for consideration	Exclusion of public required	Contacts/ Lead Executive Member(s)
Treasury Management Activity to date 2014/15.	To report the outturn on Treasury Management for the financial year 2014/15.	Executive	20th October 2014	Report	No	Barry Crick (01582) 546117 Councillor Ashraf
Transfer of New Horizons to a Charitable Organisation	To provide feedback and recommendations based on the findings of consultation and the outcome of the investigation to identify a suitable provider.	Executive	20th October 2014	Report	No	Tracey Brennan (01582) 547886 Councillor Hussain
Community Offer Review	To consider options appraisal and agree Organisational Change Assessment and consultation proposals.	Executive	17th November 2014 (30th July 2014)	Report	No	Jayne Robinson (01582) 547952 Councillor K. Malik
Strategic Review of the Commissioning and Provision of Passenger Transport	To advise Executive of the review.	Executive	17th November 2014	Report	No	Jacqueline Groom (01582) 547314 Councillor Taylor
Hockwell Ring Day Centre	To consider the results of the consultation on the proposed relocation of Hockwell Ring Day Centre	Executive	17th November 2014	Report	No	Kim Radford (01582) 547706 Councillor Hussain
Treasury Management Mid-Year Report – 2014/15	To receive a mid-year update on treasury management activity for the half year ended 30th September 2014	Executive	17th November 2014	Report	No	Barry Crick (01582) 546117 Councillor Ashraf

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LUTON BOROUGH COUNCIL
FORWARD PLAN OF KEY DECISIONS AND KEY ISSUES

Title	Key decisions and key issues	Decision maker	Date of decision	Documents submitted for consideration	Exclusion of public required	Contacts/ Lead Executive Member(s)
*NEW - LLAL Partnership Fund 2015/16 – Shareholder review of recommendations	To consider the recommendations for donations for 2015/16 proposed to be made by Theme Leads to LLAL	Executive	17th November 2014	Report	Yes	Mark Turner (01582) 522458 Councillor Simmons
*NEW – Scale of Fees & Charges for 2015	To approve the Council's Scale of Fees and Charges to apply from 1st January 2015.	Executive	17th November 2014	Report	No	Tim Lee (01582) 546094 Councillor Ashraf
Luton Local Plan for Consultation (REVISED)	To report the summary of representations to the draft Luton Local Plan consultation and schedule of proposed responses and to update the timetable to Pre-submission consultation in the light of progress on cross boundary planning under the 'duty to co-operate'.	Executive	15th December 2014 (20th October 2014)	Report	No	Chris Pagdin/Kevin Owen (01582) 546329/7087 Councillor Timoney
Housing Strategy 2014-2018	To seek Executive approval to the publication of the amended Local Housing Strategy for Luton.	Executive	12th January 2015 (10th March 2014)	Report	No	Alan Thompson (01582) 546232 Councillor Shaw
Treasury Management Activity	To report the treasury management activity to date to the Executive	Executive	12th January 2015	Report	No	Barry Crick (01582) 546117 Councillor Ashraf
Community Offer Review	To consider the results of consultation and approve the proposals.	Executive	12th January 2015 (20th October 2014)	Report	No	Jayne Robinson (01582) 547952 Councillor K. Malik

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LUTON BOROUGH COUNCIL
FORWARD PLAN OF KEY DECISIONS AND KEY ISSUES

Title	Key decisions and key issues	Decision maker	Date of decision	Documents submitted for consideration	Exclusion of public required	Contacts/ Lead Executive Member(s)
Treasury Management and Annual Investment Strategy 2015/16	To approve the treasury management strategy and recommend to Council approval of the annual investment strategy for 2015/16.	Executive	9th February 2015	Report	No	Barry Crick (01582) 546117 Councillor Ashraf
			9th March 2015			
Treasury Management Activity	To report the treasury management activity to date to the Executive	Executive	7th April 2015	Report	No	Barry Crick (01582) 546117 Councillor Ashraf
			27th April 2015			

KEY: * denotes new item; Date in brackets denotes the date the item appeared in the previous published version of the Plan

EXEMPT INFORMATION
SUMMARY OF THOSE MATTERS WHICH BY VIRTUE OF PART 1 OF SCHEDULE 12A OF THE LOCAL GOVERNMENT ACT 1972 MAY BE DISCUSSED IN PRIVATE

Paragraph No.	
1.	Information relating to any individual.
2.	Information which is likely to reveal the identity of an individual.
3.	Information relating to the financial or business affairs of any particular person (including the authority holding that information).
4.	Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour related matter arising between the authority or a Minister of the Crown and employees of, or office holders under, the authority.
5.	Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings.
6.	Information which reveals that the authority proposes: (a) to give under any enactment a notice under or by virtue of which requirements are imposed on a person; or (b) to make an order or direction under any enactment.
7.	Information relating to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime.

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