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
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	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

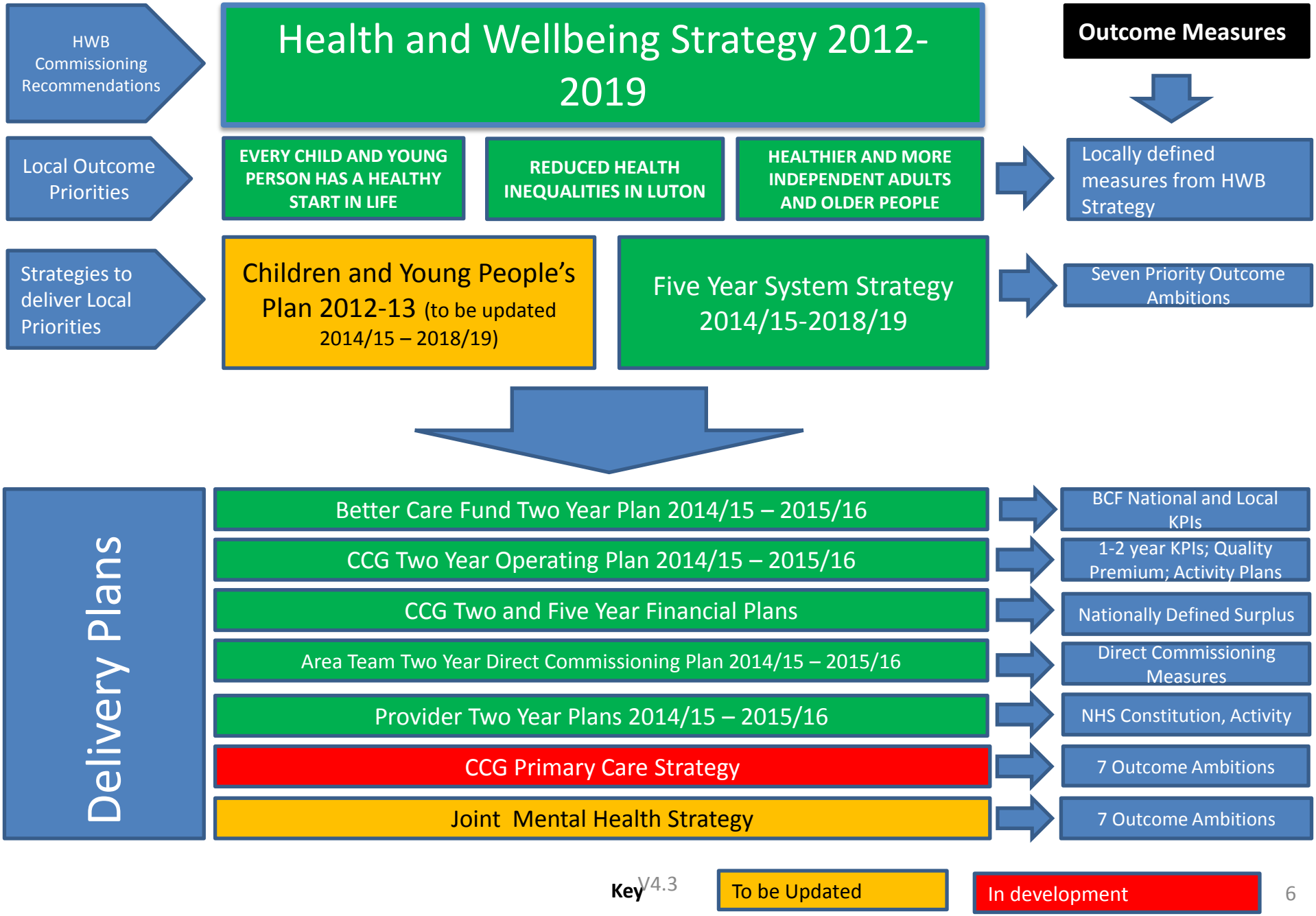
The Children and Young People's Plan articulates how Goal 1 and elements of Goal 2 are being addressed. The System Five Year Strategy with its focus on adults will articulate plans to address Goal 3 and elements of Goal 2.

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.

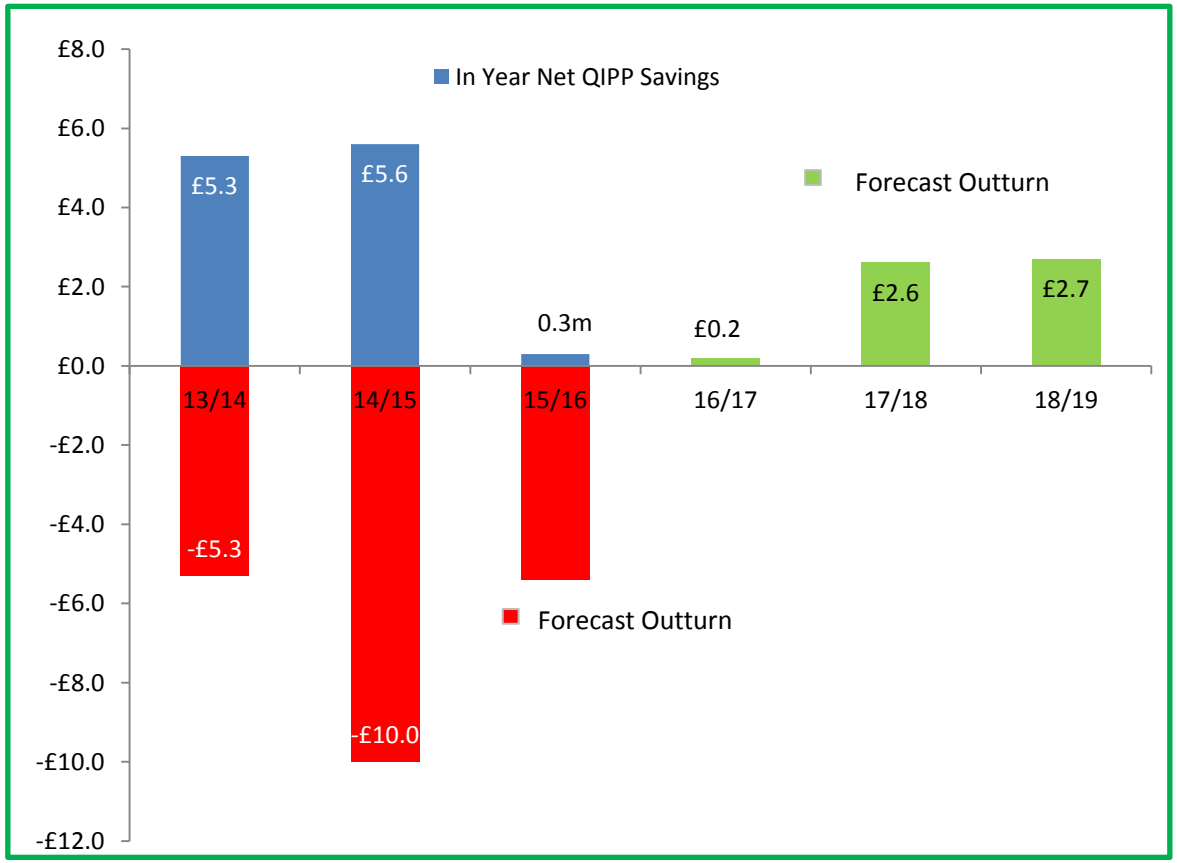
The underfunding is the main reason for the CCGs financial deficit incurred in 2013/14. Whilst the underfunding gap is being addressed to a certain degree, we need to plan for further overspend in 2014/15.

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-luton2.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

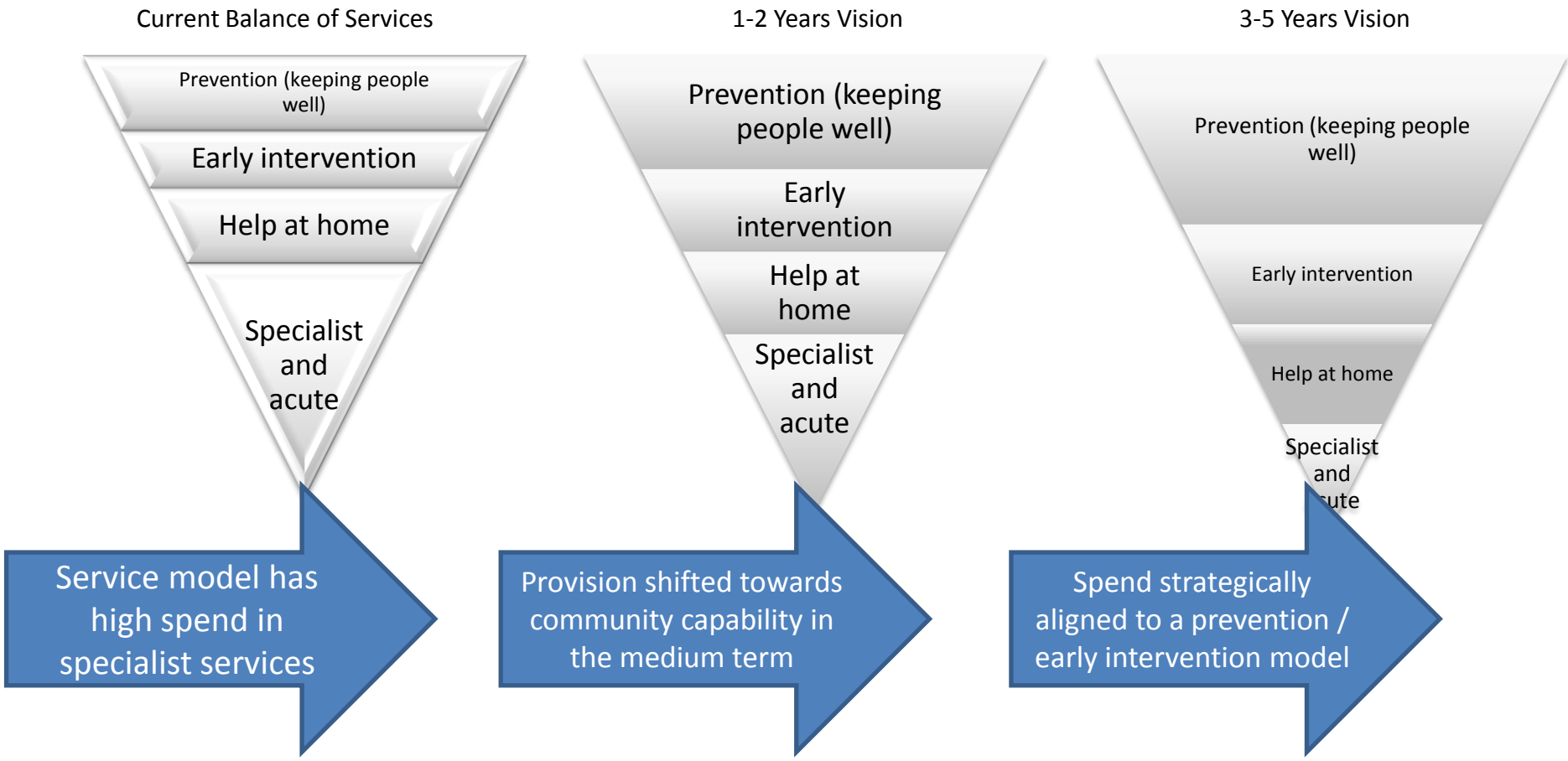
The system is driving the delivery of non complex elective care out of the hospital to deliver more care nearer to the home via primary and community care

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

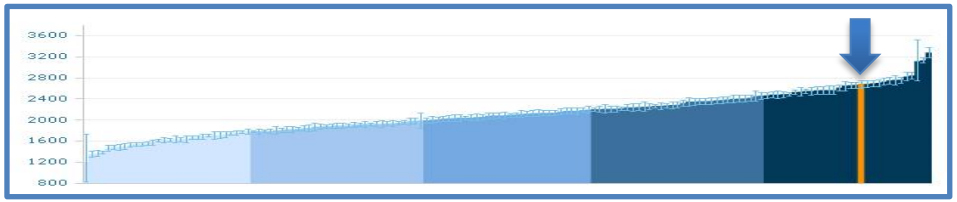
Process to Develop Outcome Ambitions

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

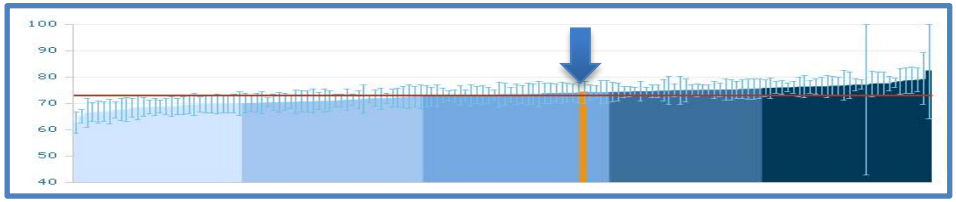
Potential Years of Life Lost

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



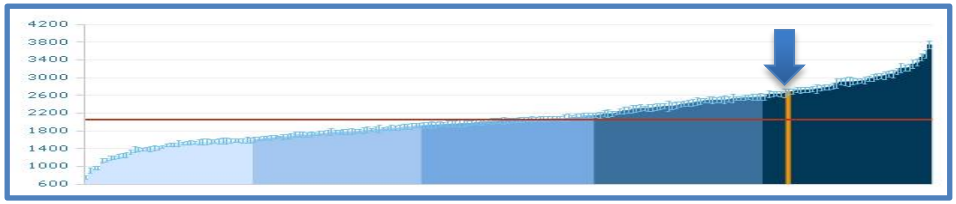
Quality of Life for people with LTCs

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



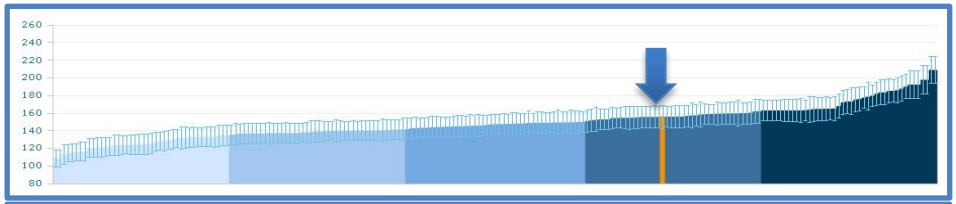
Avoidable Hospital Admissions

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



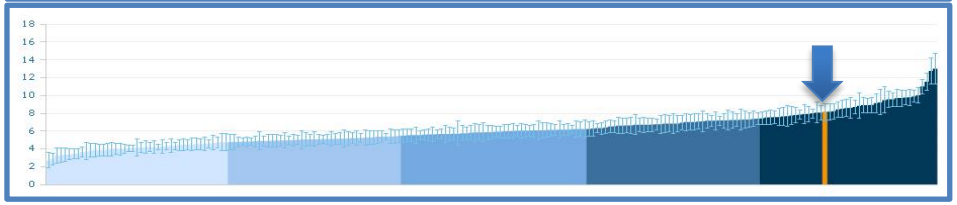
Patient experience in hospital

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



Patient experience out of hospital

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

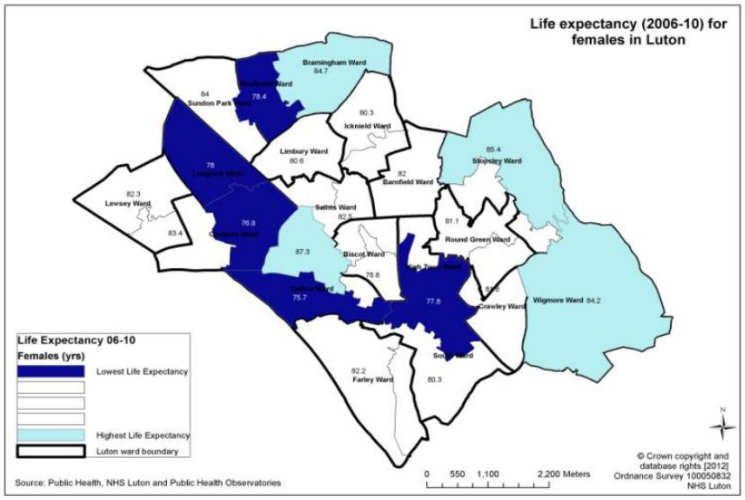


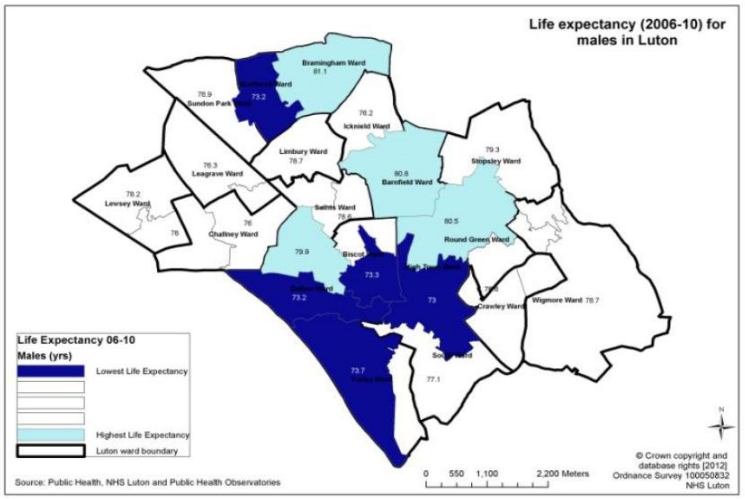
Health Inequalities in Luton

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

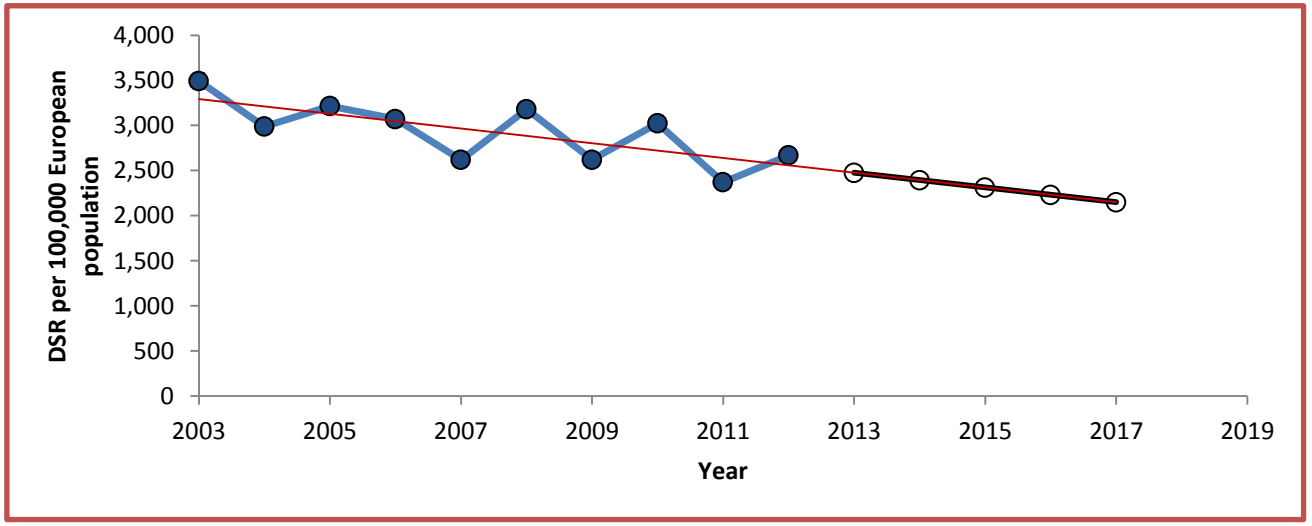
Seven Outcome Ambitions: 5 Years

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

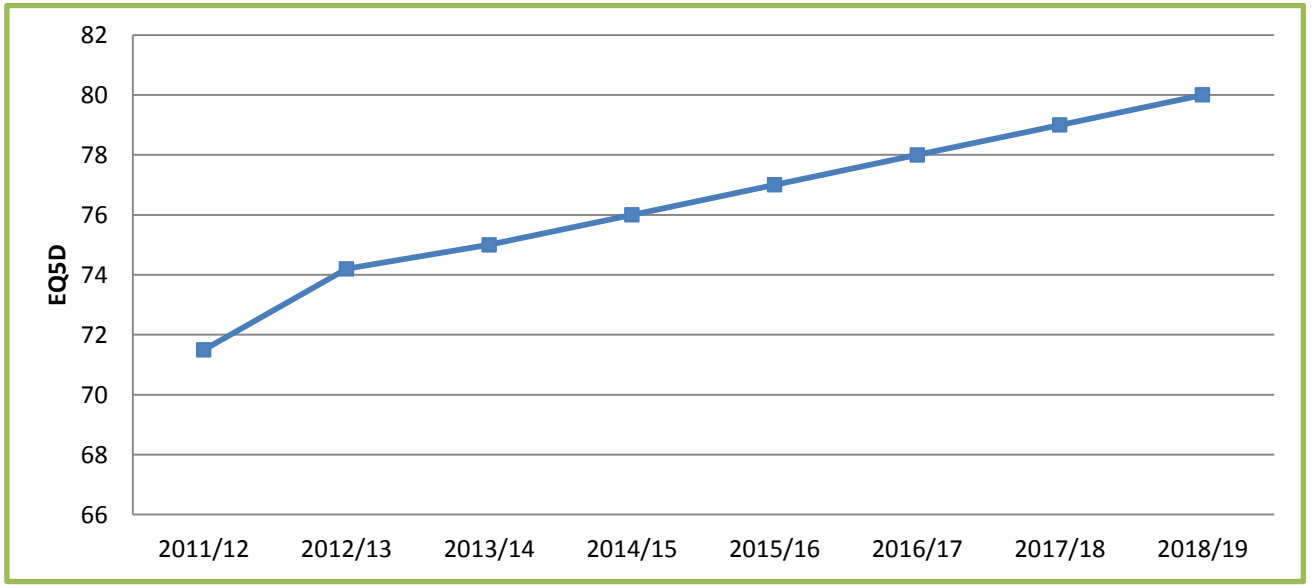
1 Securing additional years of life

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

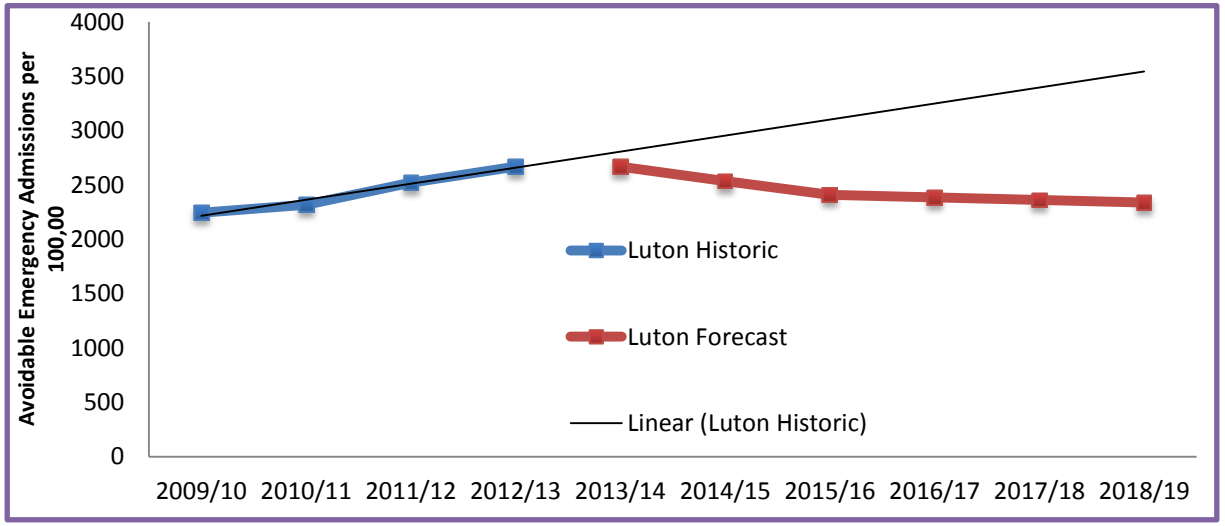
Indicator: Weighted EQ-5D values for all responses from people identified as having a long term condition – GP Patient Survey



Ambitions 3 and 5: Five Years

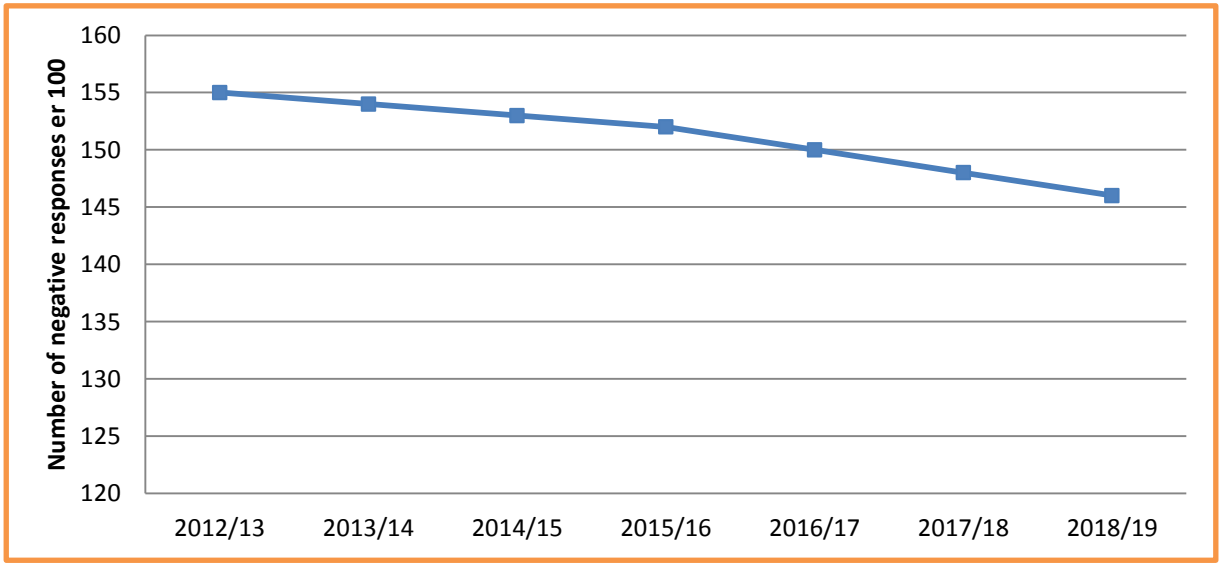
3 Reducing the amount of time spent avoidably in hospital

Indicator: Composite Indicator – Avoidable Admissions



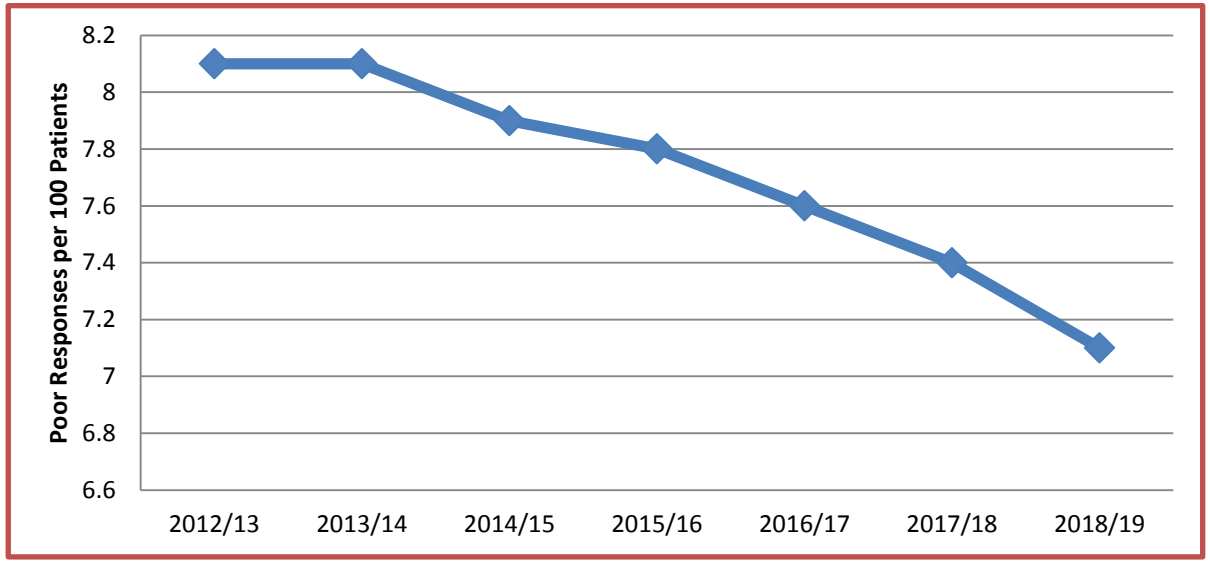
5 Positive experience of hospital care

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

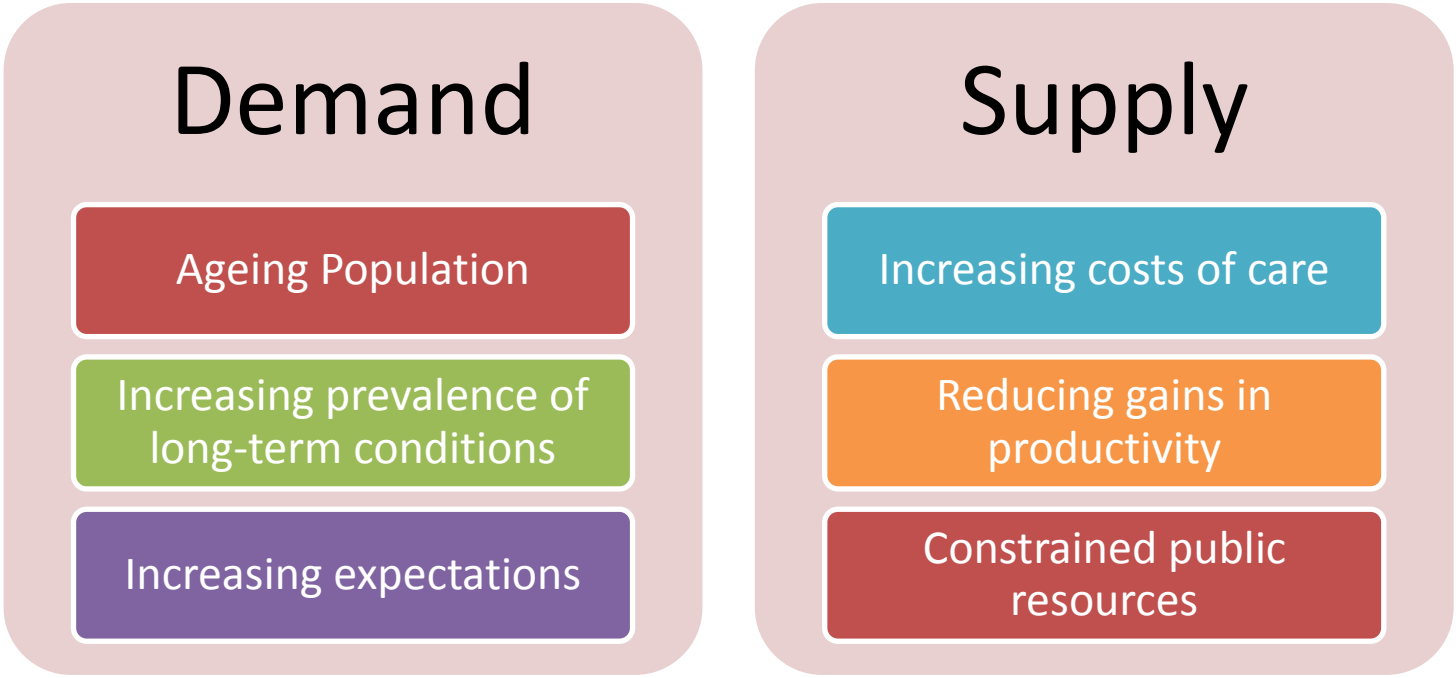
Five Year Ambition	1. Securing additional years of life	2. Health related QoL for people with LTCs	3. Reducing the amount of time spent avoidably in hospital	4. Increasing the proportion of older people living independently	5. Positive experience of hospital care	6. Positive experience of out of hospital 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

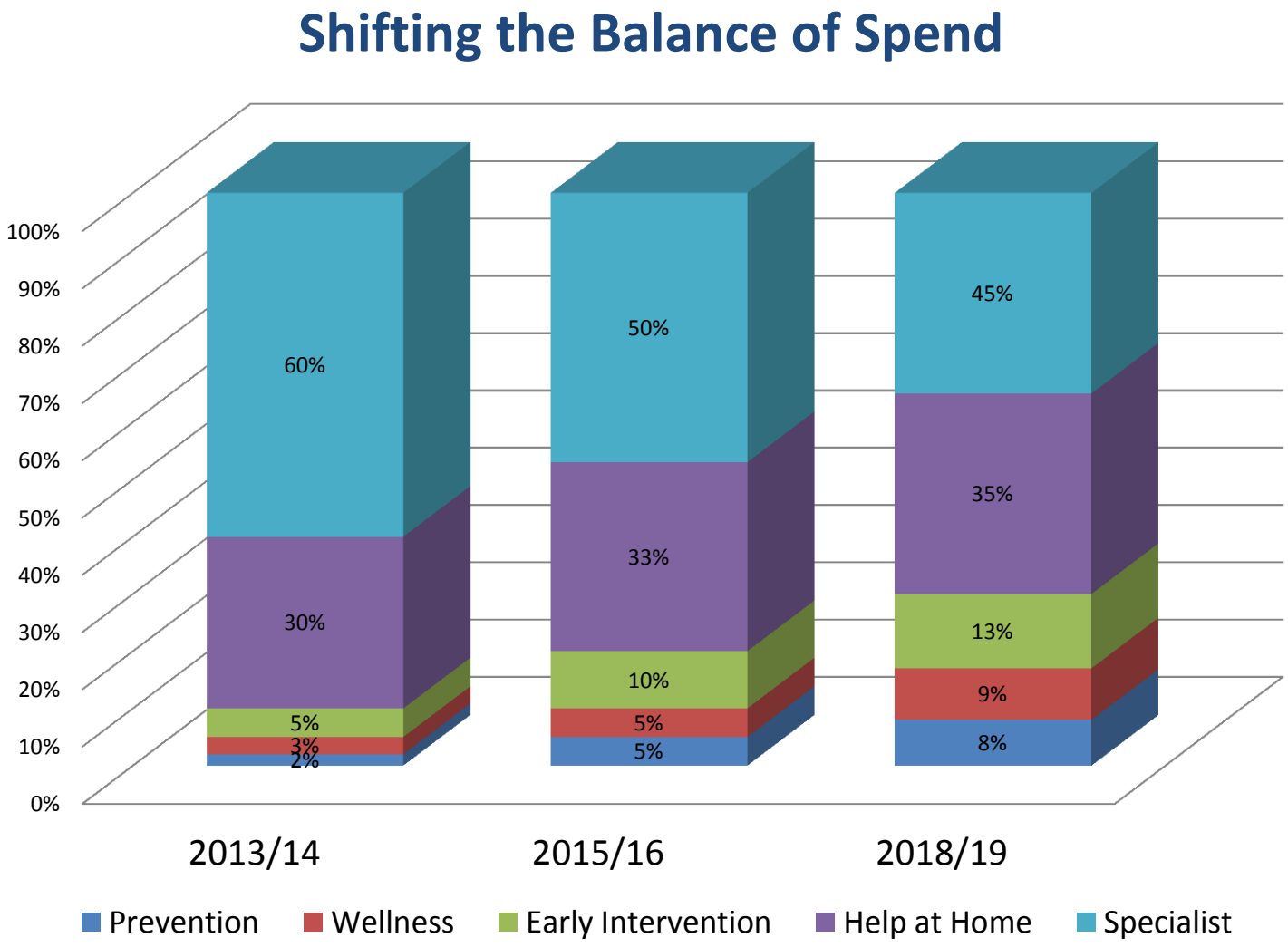


NHS England's "A Call for Action[1]" describes the future trends which threaten the sustainability of a high quality NHS. It is the potential impact of these trends summarised in the diagram above that means that while a new approach is urgently needed, we must take a longer-term view when developing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

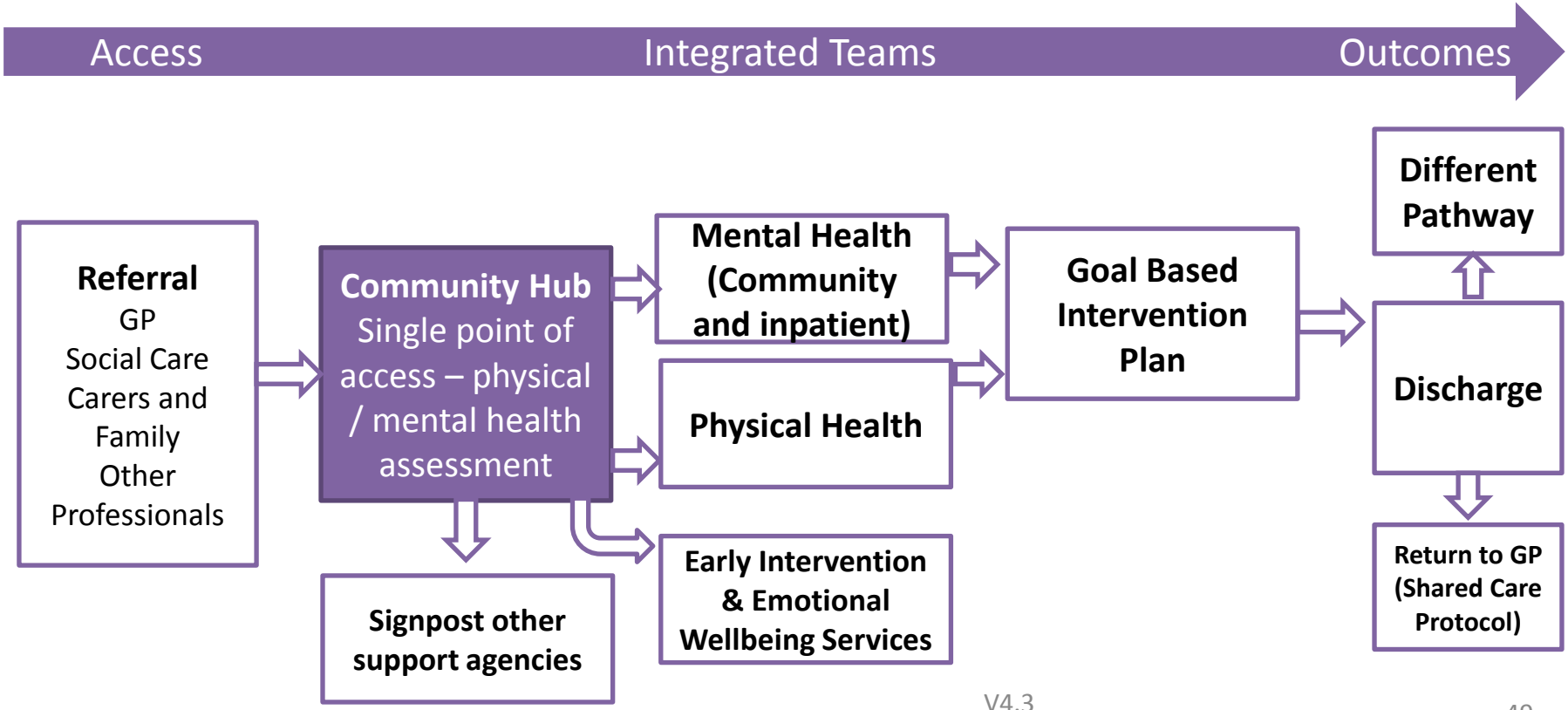
Community Services are commissioned through two organisations; South Essex Partnership University NHS Foundation Trust (SEPT) and Cambridgeshire Community Services (CCS). The significant majority of the Community services are provided within the CCS Portfolio, with a range of therapies, including those 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

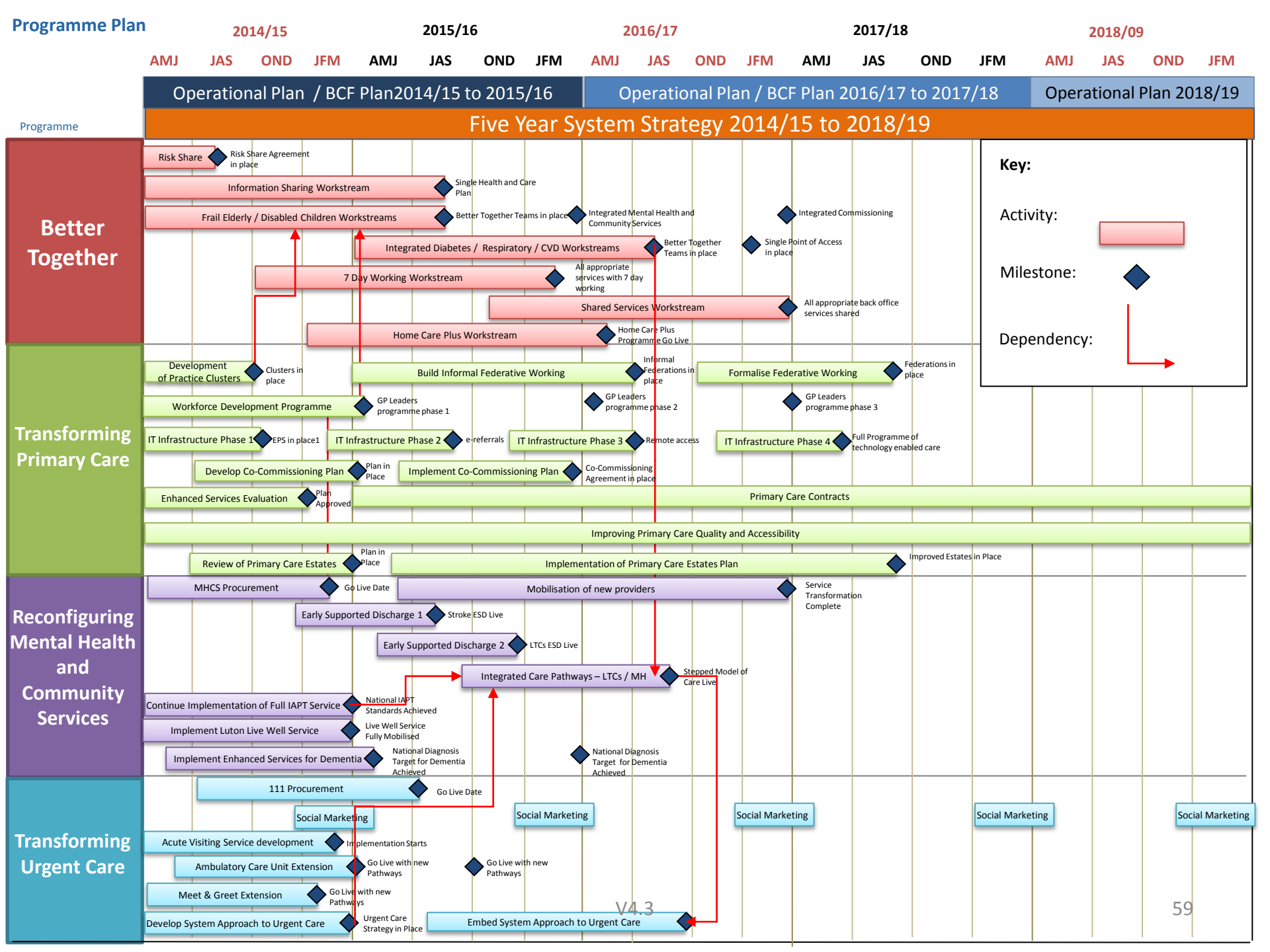
Reconfiguring Mental Health and Community Services

- 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

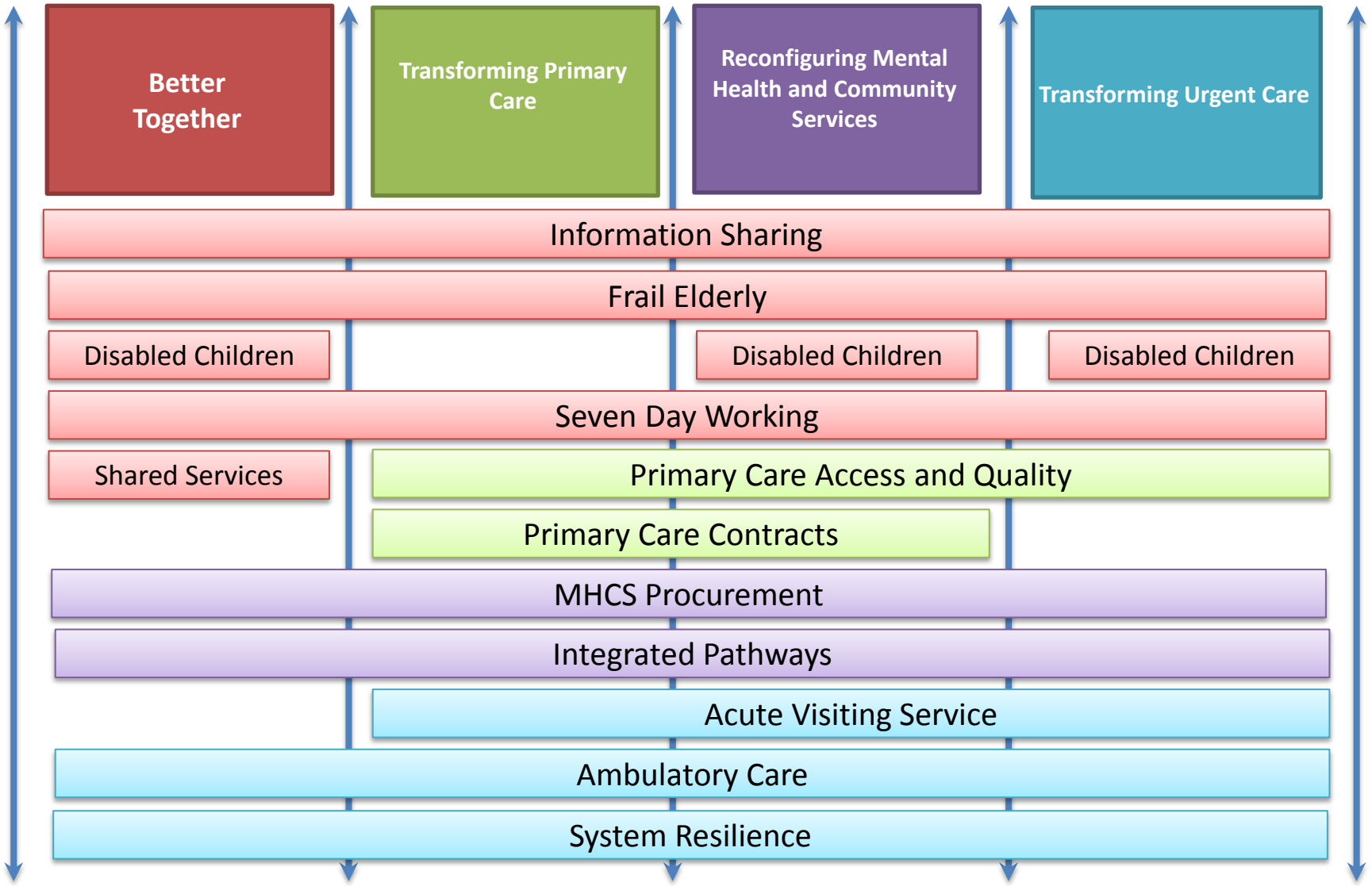
Transforming Urgent Care

- 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.

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"

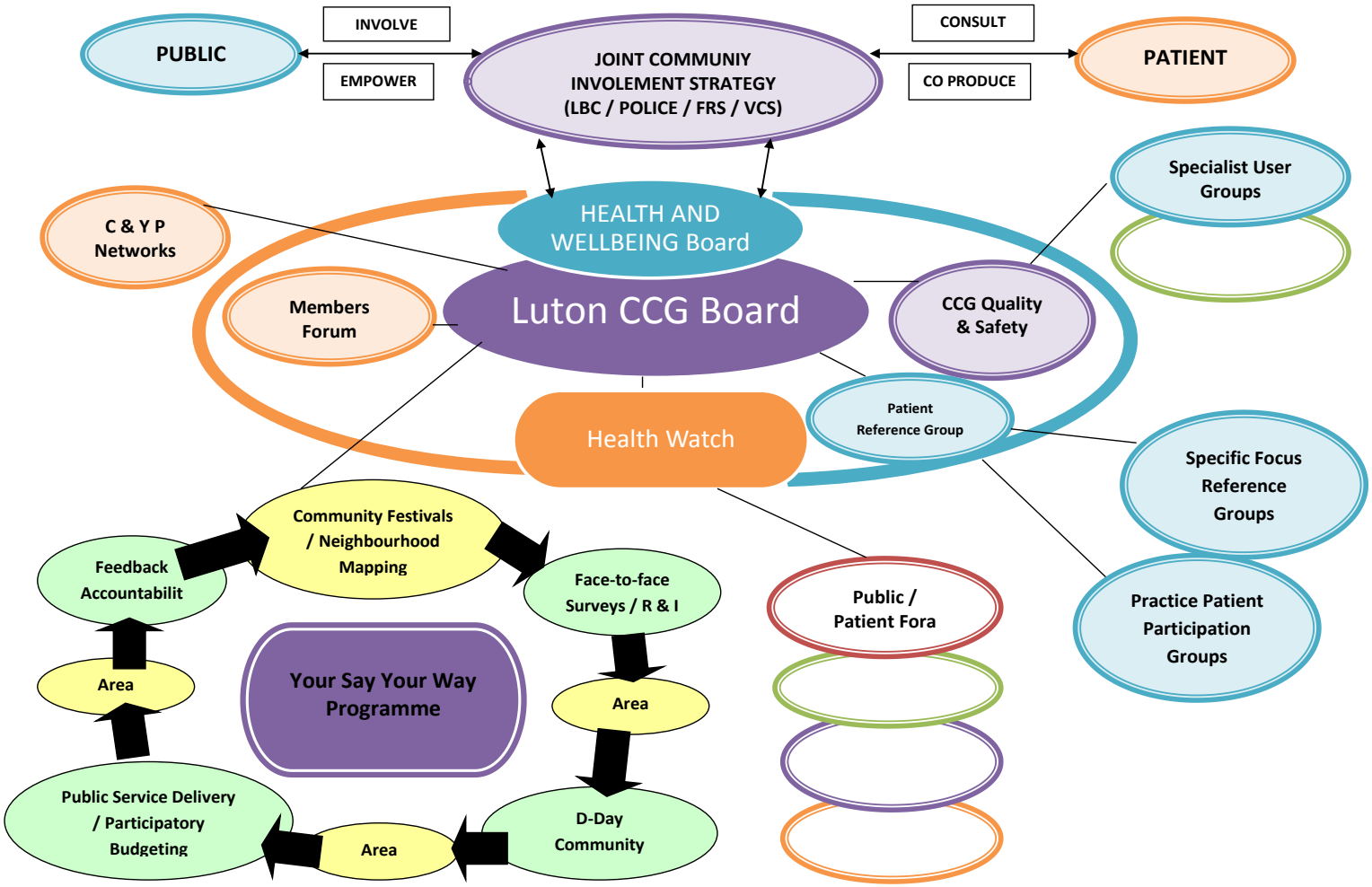
LBC and LCCG are active members of the "your say, your way" programme which enables a robust feedback cycle between community concerns and system response to those concerns.

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

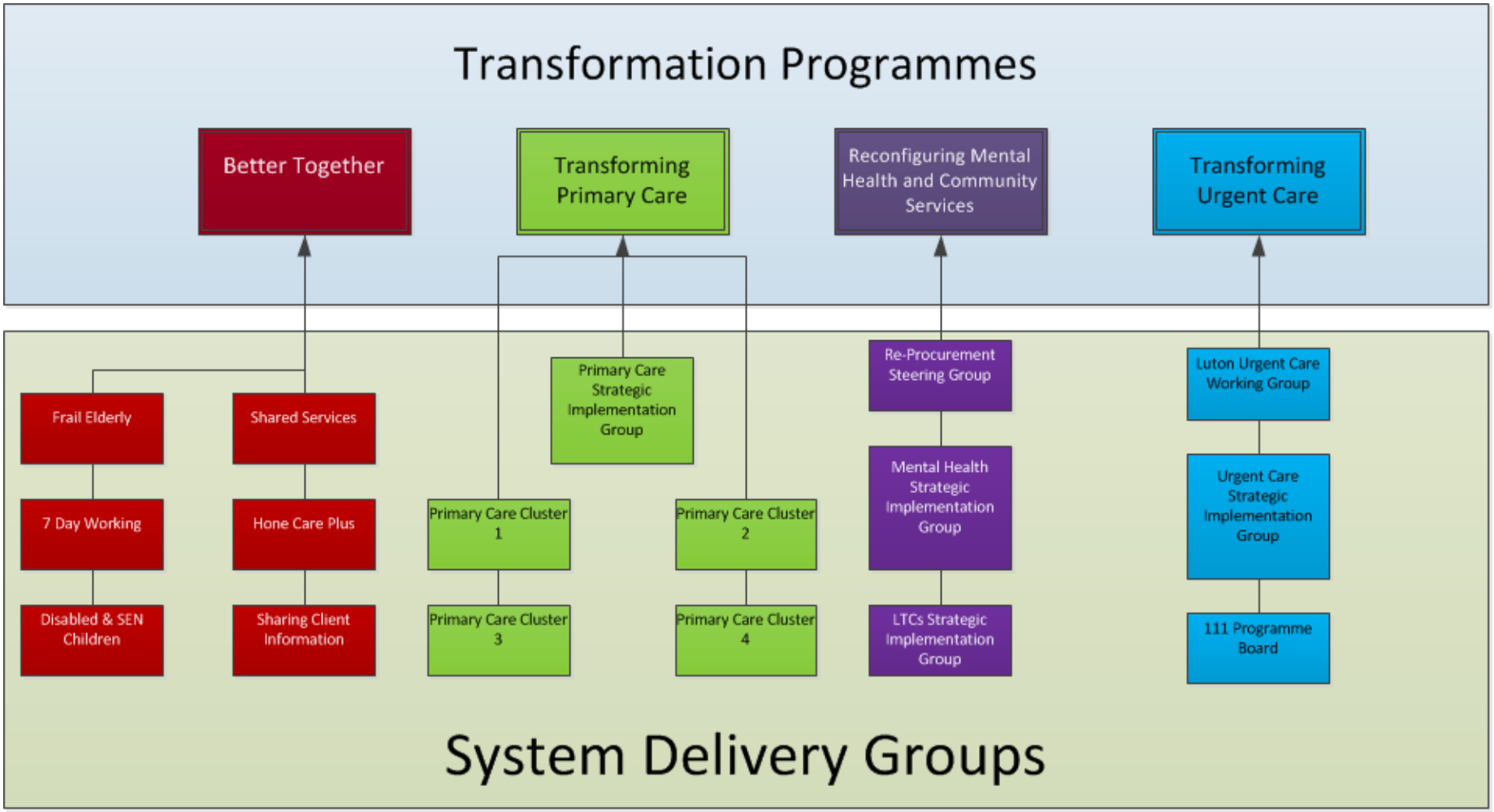
Introduction

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.

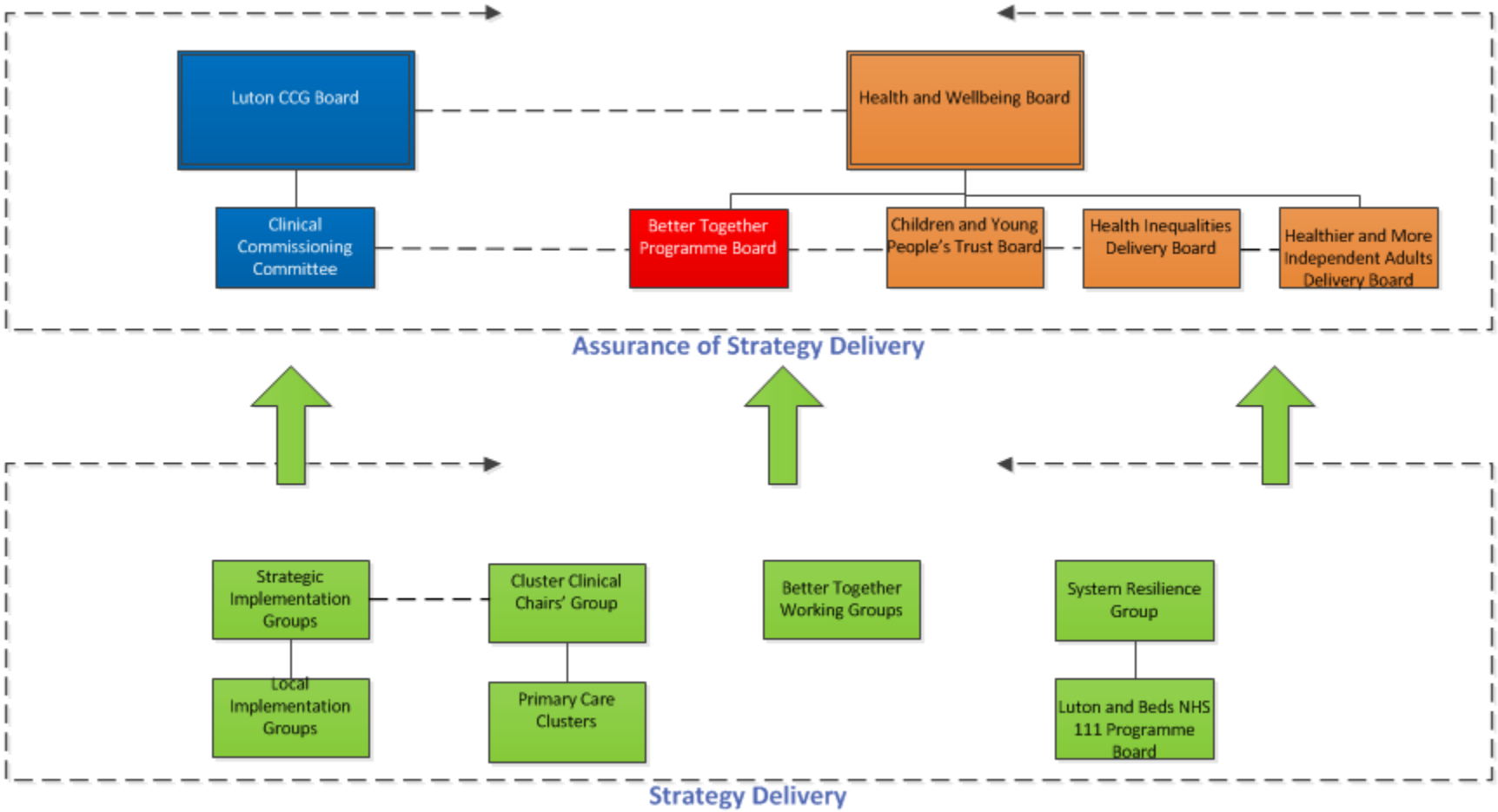
Fortunately the Luton System has pre-existing Governance Structures in place to ensure that the Strategy is delivered on time and within budget.

- 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