APPENDIX A

OUR PRIORITY OUTCOME 3: HEALTHIER AND MORE INDEPENDENT ADULTS AND OLDER PEOPLE
This priority sets out our intention not only to extend life, but also to improve the quality of life (i.e. "adding years to life and life to years"). A focus on people with long term conditions (i.e. chronic health conditions such as diabetes or heart disease) and how they can be better supported to live independently will be a key aspect of this priority action.
WHAT WE KNOW
• There are estimated to be over 37,000 people currently living in Luton with some form of long term condition. • The two main causes of death between 2008 and 2010 in Luton were circulatory diseases (including heart disease and stroke) and cancer making up 31% and 27% of all deaths in Luton respectively. • Black and Minority Ethnic (BME) groups, representing 40.6% of Luton's population, are up to six times more likely to develop Type 2 diabetes than the White European population (having diabetes increases the risk of developing other cardiovascular disease). • Projections indicate that type 2 diabetes will increase in prevalence by more than 70% by 2050, with increases of 30% for stroke and 20% for heart disease over the same period. • There is considerable variation between General Practices in Luton in terms of access and also in overall health outcomes that patients achieve. This means that people with long term conditions may be managed more effectively in some practices than others, resulting in fewer avoidable hospital admissions and complications. • There are an estimated 6,200 people in Luton with heart disease, Chronic Obstructive Pulmonary Disease (COPD) or diabetes who have not been diagnosed and are not having their condition managed by their GP. • At least one in four people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time.

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OUR COMMISSIONING PRIORITIES	Update	Work for next period
3.1 Put in place 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.	• CCG key work programme • Healthwatch survey (yet to be considered by the board)	• Action plan developed from Healthwatch survey
3.2 Ensure GPs take 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.	• Key part of Better Together Programme and Better Care Fund • Frail Elderly work programme in progress	• Clear work programme developed with key deliverables and timescales
3.3 Drive forward the integration of health and social care services to improve health outcomes and seamless support to the individual by: • Agreeing outcomes that span both health, and social care • Developing and implementing care pathways across health and social care so that patients experience a seamless and personalised care package • Develop common systems and	• Better Together Programme developed with person centred approach • Information governance workstream • Information Technology workstream developed with key partners • Continuing Health care staff from CCG co-located with Adult Social Care staff	• Clear work programme developed with key deliverables and timescales • Clarity on information sharing • Clear progress on NHS number usage in Council systems • Prepare bid for DoH Technology Fund • Workforce plan developed • Mental Health Group work

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processes across partner organisations, including the pooling of budgets where appropriate, and the co-location of health and social care teams as part of the integrated care team approach.	• Mental Health Senior Officer Group in place across Luton & Bedfordshire	programme developed and the Mental Health Crisis Concordat prepared and agreed
3.4 Drive the development and delivery of tailored educational, training, communications and technological programmes and resources to empower everyone with a long term condition with the support they need to live a healthy and active life independently in their own homes for as long as possible.	• Telecare and Telehealth offer developed • Significant progress to offer personalised care and direct payments	• Develop personalised health budgets • Mapping and gap analysis of crisis support
3.5 Implement an Improving Access to Psychological Therapies (IAPT) service to increase support for people with mental health services.	• IAPT contract let and being offered through GPs	• Evaluation of programme and expansion of the self referral model
3.6 Develop a comprehensive range of prevention and early intervention services which maintain wellness.	• Wellness service contract let. • Information database developed and tested through Healthwatch	• Develop links into wellness service for key target groups such as carers • Develop the information

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		database. Formally launch. • Increase data available by adding Disabled go detailed information to enable people with mobility issue to gain greater insight into activities. •
3.7 Complementary to the prevention initiatives, promoting independence will also be achieved by targeting housing-related support services with the same aim of enabling people to live without the need for acute and eligible services.	• Review of the floating housing support service • Sheltered Housing review completed. • Dementia Friendly Communities launched with significant progress with a number of organisations signed up. Partnership across all sectors. • Project manager for loneliness project appointed	• Develop services in sheltered accommodation, Extra Care and Well being clubs. • Accommodation review (hostels and other supported accommodation) • Development of further community services through voluntary sector • Develop further initiatives in link social care and housing services • Continued development dementia friendly services. Conference planned for July to target carers help. • Loneliness project progress
OTHER	• Care Act- Royal assent 14th May • Learning Disability – Winterbourne plan on target • Mental Health and Community	• Guidance and policies due to be released end of May by DoH for Care Act • Continued progress on

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	Services procurement in progress	Winterbourne • Further progress on procurement