Luton’s plans for improving the health and wellbeing of its residents by making most effective use of the Better Care Fund to drive whole system change and deliver person-centred, efficient and effective care and health services.
**Introduction from the Chair of Luton Health and Wellbeing board and the Chair of Luton Clinical Commissioning Group**

In Luton in 2019 an ambulance crew on an emergency call-out to a 90 year old lady who has slipped in her home will learn she is Mrs Dorothy Brown, she is allergic to penicillin, is having treatment for high blood pressure and mild dementia, her GP is Dr Tariq Khan and her home care is organised by Amy Clarke, a member of the home care team. They can do this because their hand-held devices give them access to a personal electronic plan that shares vital information between Council social services care-workers and NHS health professionals in Luton. They can even phone Mrs Brown’s daughter to let her know what’s going on.

As a result, after making certain there is no immediate medical requirement to go to A&E, the ambulance crew satisfy themselves that Mrs Brown can safely stay in her own home. One phone call to her GP starts the ball rolling for a care worker familiar to Mrs Brown to come to her home and make her comfortable. Mrs Brown’s daughter meets the ambulance crew at the house. She is understandably worried about her mum, but is reassured that she can stay at home because she knows the GP is coordinating both the medical side of things and the home help.

Mrs Brown’s GP calls later and arranges intravenous hydration to be delivered in the comfort of her own bed by Nila Shah from our ‘hospital in the community’ nursing team. Her mild dementia is also recognised and an assessment in the community can be completed sharing the records with her care worker. Amy Clarke ensures home help is in place to look after Mrs Brown’s immediate needs and while that is being done she realises that a dressing needs changing and so does this. Knowing that Mrs Brown slipped on the floor in her kitchen, Amy also arranges for the falls service to fit special non-slip flooring and to have a chat with Mrs Brown about her slippers. She is also able to keep Mrs Brown’s daughter informed about what’s happening as her mum has given consent for her to share information about her care. By the way it doesn’t matter that this happened on a Saturday because we deliver the same level of care as if it were a Tuesday.

Today (2014), it’s highly likely that Mrs Brown would be ‘blue-lighted’ to hospital where she may spend a number of days or even longer, is at risk of contracting an infection and may become anxious or confused about what has happened to her. All because she has forgotten to drink enough, has become dehydrated and has fainted. We know this isn’t good enough, it’s not right for Mrs Brown, it’s poor health care and it’s unaffordable.

By getting the NHS and the Council working better together we are determined to make our vision of better health and social care a reality over the next five years. This is a game changing opportunity and our plan is therefore bold and ambitious in the steps we intend taking in the first two years. The fictional example given above is about an older resident, though our ambition applies equally to residents of all ages with all health and care needs.

Cllr Hazel Simmons, Leader of the Council  
Dr Nina Pearson, Chair of Luton NHS Clinical Commissioning Group
Purpose of this document

Luton is on a transformational journey, in which local people are increasingly influential and essential in the way commissioners and providers of health and care services design and deliver person-centred, holistic and seamless services. These services will be individually tailored, maximise independence and self-care and lead to long term sustainable improvements in health outcomes.

The first part of the transformation journey is forming a strong coalition around a clear vision, which is the collective whole system delivery of health and social care in 2019. This document sets out a vital component of the practical side of that vision; creating a pooled budget to integrate and transform services on behalf of the residents of Luton.

This document therefore provides locally owned, outcome focused, sustainable plans, developed and co-signed in partnership with the wider health and social care economy that address the challenges identified in NHS England’s Call to Action.

Date agreed at Health and Well-Being Board: 31 March 2014

Date submitted: 4 April 2014

Minimum required value of BCF pooled budget:

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>£657,000</td>
</tr>
<tr>
<td>2015/16</td>
<td>£13,021,000</td>
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</tbody>
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Total agreed value of pooled budget: 2014/15 £3,477,830 (including recurrent S.256 money)

2015/16 £13,021,000
Background and 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”.

This document is the two-year plan covering 2014/15 and 2015/16 that is required by the creation of the Better Care Fund (BCF).

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.

NHS England has set out A Call to Action to the public, patients, staff, and politicians to help the NHS meet current quality challenges, future demand and tackle the funding gap through honest and realistic debate, covering rising demand, new technology and patient expectation.

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.

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 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.
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.

**Key facts and figures**

- The population of Luton is projected to rise from 204,750 in 2010 to 220,350 in 2030, a rise of eight per cent.
- The number of older people (65+) is projected to rise from 28,050 in 2010 to 35,550 in 2030, a rise of 27 per cent.
- The number of people who are 85 years and older is set to grow by 55% from 2,350 in 2010 to 3,650 in 2030.
- The number of people living with dementia is also expected to rise significantly. The JSNA predicts a 9% increase in prevalence from 2010 to 2014 and a 29% increase to 2020.
- The pre-school and working age populations will be more stable.
- The Pakistani and Bangladeshi populations are projected to rise by approximately one third between 2010 and 2030.

Luton is a densely populated urban authority, divided into 19 wards, with more similarities to some London boroughs than to the surrounding towns and cities in its region. The official estimate of the population of Luton in 2011 was 203,600. Research undertaken by the Council suggests that this is an underestimate and a figure of 205,200 is more realistic. The Council assessment of the composition of the Luton population draws upon administrative data such as the GP register and Child Benefit records.

With an area of 4,336 hectares, the official population figure translates into a population density of 47.0 persons per hectare or 47.3 persons per hectare respectively using the Council estimate. Both of these figures are greater than many London Boroughs.

According to the 2011 Census, the age structure of Luton’s population differs from that of the population as a whole. Luton has a younger population than that of England and the eastern region. The under 15 age group account for 22% of the Luton population compared with 18% regionally and nationally. The 15-64 age group account for 67% of the Luton population compared with 66% nationally and 65% in the eastern region. The “Over 65” age group represents 12% of the Luton population compared with 16% nationally and 18% regionally.

The town is ethnically diverse, with over half (55.4%) of the population being of black and minority ethnic (BME) origin, with significant Pakistani, Bangladeshi, Indian and African Caribbean communities.

Luton is ranked as the 69th (out of 326) most deprived local authority. In 2007 Luton was ranked as the 87th most deprived local authority and in 2004 as the 101st. This indicates that Luton is becoming relatively more deprived in comparison to the other local
authorities of England. Luton has nine output areas in the top 10% most deprived areas in the country. Two of these are in Biscot, Dallow and Northwell wards and one each in Farley, High Town and South wards.

Using the NHS England ‘any town’ typology, Luton is typical of an urban area with one feature of a suburban archetype, which is a higher than average prevalence of long term conditions in the population. Our plan, therefore, is designed to meet the needs of our diverse population, mindful of particular requirements of residents with Pakistani and Bangladeshi heritage and mindful of the higher than average prevalence of long term conditions and growing numbers of over 85 year olds.

**Our shared vision and plans**

In 2019 Luton residents will benefit from integrated health and care that has four elements: prevention that helps people to keep themselves well, a person centred approach enabled by 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.

Luton will model the new ways to identify what works, what needs changing and how any barriers can be overcome. Our plan is that money will be saved by reducing the number of hospital beds and these savings will be used to fund the expanded home and community based services.

**Luton’s new Wellness Service**

One of the first parts of our new integrated approach is the opening of Luton’s Wellness service in April 2014. This new service brings together a number of services previously run by different providers in the NHS (stop smoking service run by CCS, health trainers run by CCS, the child weight management service run by the Weight Management Centre, slimming on referral run by Slimming World and Weight Watchers, exercise on referral run by Active Luton and the community food programme run by SEPT).

The service will run as a ‘one stop shop’, and is intended to help shift activity away from medical services provided in the NHS and particularly to relieve pressures on GP practices. This approach fits with the vision set out in the diagram below, which shows how we will move away from a service model that relies on specialist services with a focus on reactive intervention to early intervention supported through universal services supported by multi-agency working.
Our intention is to create 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. Professional accountability for the overall coordination of care for each individual will be held by a GP and a personal electronic plan will enable resident information to be shared across the whole system as necessary, including the ambulance service. Additionally, home care services will play an increasingly important role within the multi-disciplinary teams and will be trained to provide a broader range of services than on offer currently. This will enable them to support clinical care and to provide assistance in some areas such as pressure care, changing dressings and hydration. A clearer and simpler system should help all professionals to signpost people towards ‘healthier’ services, strengthening the early intervention and self-management model that is an important part of our shared vision.

**Service provider engagement**

Service providers in Luton, (Luton and Dunstable university hospital foundation trust, Cambridgeshire Community Services NHS trust South Essex Partnership university NHS foundation trust, Luton borough council and Luton’s voluntary and community sector) are all actively represented on the board of the Better Together programme (Luton’s health and social care integration programme). Through this forum and elsewhere all organisations have actively contributed to the creation of the BCF plan, which is a collaborative piece of work that is therefore owned and agreed across the whole local system.
Additionally, providers have contributed to the development of the programme through project groups and active engagement in developing new integrated ways of working. The Better Together programme forms the backbone of the BCF plan.

A voluntary sector briefing on 5 December 2013 additionally engaged groups providing a broad range of health and social care support to Luton residents and gave them the chance to feedback on BCF plan proposals. Further VCS workshops are planned and VCS groups are represented in work stream reference groups.

On 13 December 2013 a ‘leadership summit’ of commissioners and providers enabled the most senior managers of the health and social care sector in Luton to map out their collective priority for integration over the next two to five years, specifically focussing on the requirements of the BCF. The ‘whole system’ leadership agreed a collective vision for the health and social care economy in Luton in 2019, which is centred on four elements: prevention that helps people to keep themselves well, a person centred approach enabled by 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.

A second leadership summit was held on 24 March which explored in more depth the impact on the acute sector and the steps the system would collectively take to put in place the new model of multidisciplinary teams and collaborative working that will keep people out of hospital and support them through appropriate social care and healthcare in their home or another non-acute location.

These summits reflect research published by the Kings Fund and feedback from Pioneer sites that strong collaborative leadership of the ‘whole system’ is critical to the success of the integration plans.

The Council and the CCG have jointly engaged in a system leadership programme involving GPs and senior management from all NHS providers with the intention of improving overall officer leadership support to the Health and Wellbeing board. Initially this will look at a priority from the existing joint health and wellbeing strategy, which concerns variation in GP practice services across the town. A board development session is planned.

At a more detailed level, we have run a number of workshops with providers to develop our proposed joint models of integrated health and social care. Together with SEPT, CCS, the Luton and Dunstable hospital and the East of England ambulance service, the CCG and the Council have agreed a project for frail and elderly residents that will introduce a coordinated approach to care and health focusing on those most at risk of avoidable hospitalisation when treatment or care at home would be a better alternative.
The commissioning partners for the Luton health and social care system (Luton CCG, Luton Borough Council and NHS England South Midlands and Hertfordshire Area Team) have set up a joint programme of re-commissioning of mental health and community health services, and the procurement process is well underway, with final selection of provider or providers due in July 2014. The objective of the re-commissioning programme is to secure high quality, safe, clinically effective services for people in Luton, to meet current and future health and wellbeing needs, and provide good patient experience. These must also demonstrate value for money and ensure resources are deployed in the best way to meet local needs. Most importantly, services will be integrated, both within the portfolio being re-commissioned and with acute hospital services, primary care, the voluntary and community sector and Council services.

The approach we are taking, through a procurement process informed by market engagement in 2013, is to seek responses from providers, through a competitive dialogue procurement process, on how they would deliver against our required outcomes and demonstrate innovative solutions to drive improvement. These outcomes are set out in our ‘Better Together’ health and social care integration programme with much greater emphasis on supporting people to receive care in community settings and within their own homes, with more specialist care, for example in hospital, only when clinically necessary. We are also seeking much more focus on early intervention, in mental and physical health, to ensure people experiencing early signs of ill health are identified and supported with ‘right time first time’ care. This is particularly pertinent to the diverse population we serve in Luton and the very different cultural approaches to the take up, or not, of health and social care interventions.

The re-procurement programme is already demonstrating, through dialogue with bidding organisations that much more integrated models of care, different workforce roles and ways of working are available to be implemented in Luton, and provide parity between mental health and physical health. The commissioners are not intending to reduce overall funding for mental health services but are looking for innovation and to drive out duplication through integration, which will deliver better patient outcomes from the funding available.

Patient, service user and public 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.

Patient involvement means more than simply engaging people in a discussion about services. Involvement means having the patient voice heard at every level of the service, even when that voice is a whisper. The 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. [A promise to learn– a commitment to act: Improving the Safety of Patients in England National Advisory Group on the Safety of Patients in England, August 2013]

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

1. Community involvement should be at the heart of how partners improve services, set priorities and use resources.

2. 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.

3. Methods for involvement should be regularly reviewed to ensure they are cost effective, and meet the preferences and needs of all citizens.

4. Citizens should receive clear and prompt feedback on how their involvement has helped to shape services, places and communities.

5. Partners should work in a joined up way to avoid duplication.

6. Involvement should be the basis on which partners increase satisfaction, build trust and confidence in their organisations. [Community Involvement Strategy. LBC, 2010]

Luton CCG has identified two aims which demonstrate how patient and community engagement supports delivery of organisational and operational priorities. They are to:

1. Develop a culture of patient and community engagement within the CCG that actively seeks to ensure that the views of local people, patients and the public, inform all commissioning activities including the planning, design, delivery and monitoring of health services in Luton. The patient voice is at the centre of everything we do.
2. Seek out and support those who are marginalised in the community, as individuals or groups, to have a voice at every level of CCG decision making

[Developing communications’, patient and community engagement, our strategy for 2013-2016, Luton CCG]

As a result, the Council and the CCG engage residents through a number of forums, in different ways and for different purposes. The CCG has lay representation on its board and is working with Healthwatch and patient representatives drawn from GP practice patient groups in a ‘Big Conversation’ to support recommissioning community health and mental health services.

Similarly, the Council drew on the experience of residents when, through its task and finish group on hospital discharge, it considered how unnecessary hospital stays could be prevented. This resident input has been carried forward into the Better Together programme and our plans for integrating health and social care services.

Specifically for this Better Care plan, the CCG has written to all GP patient reps and the Council has consulted the general public and its own customer reference group via the Council’s consultation portal. This is styled as ‘pre-consultation’ as further consultation and involvement of residents will happen during the lifetime of Better Together.

Additionally, residents, employees and voluntary sector groups are all invited to become involved in the Better Together programme via the Better Together web page.

Both the Council and the CCG encourage the use of residents’ stories that give a service user perspective and enable us to model systems, procedures and commissioning plans on things that patients and their families say are needed. Further work to gather service user, their carers and residents experiences will be undertaken.

Every year the Council runs a ‘Takeover Day’, which gives young people a chance to air their views to decision makers and professionals about a range of topics. This year, for the first time, it was jointly sponsored by the CCG & LBC.

In the development of its commissioning intentions the CCG engaged with patients, the public, key providers, voluntary groups and employees in order to shape our plans. The following channels were used:

- **CCG Launch Event**
- **Protected Learning Time sessions with member practices**
- **Local Citizens Survey (with Luton Borough Council)**
- **Members forum**
- **CCG Public Survey**
- **Deliberative event with Healthwatch and**
Voluntary Organisations

General Practice Peer Groups
Health and Wellbeing Board Meetings
Exec to Exec meetings with providers
Luton Health and Social Care Review Group
Local Area Board Meetings
LCCG Patient Reference Group

A number of important themes emerged from the engagement programme:
- Improving GP Access
- Shorter waiting times
- Better patient information
- Improved hospital discharge processes
- Develop improved collaboration with the voluntary sector
- Improving communication between services
- Better understanding the needs of the public
- Improved support for carers

The joint health and wellbeing strategy was fully consulted upon through a public and stakeholder consultation which took place between June 14 and August 17 2012. A total of 202 people took part in the consultation and 96% of respondents agreed with the outcome goals. These outcome goals will continue to be the backbone of the refreshed joint health and wellbeing strategy as it is converted into the five-year strategy to 2019.

A major programme for community engagement and involvement is underway led by a project group with key partners and experts to guide and advise the Council and the CCG. This is a three stage process that has begun by informing people and getting their first thoughts on the proposals. Stage 2 will go further, to capture residents thoughts on what currently works well, what doesn’t work well and what services they would like to see integrated in the future. In stage 3 the feedback from stages 1 and 2 will be shared and specific proposals fully consulted on.

The Better Together webpage on the consultation portal is informing Luton residents about the Better Care Fund and explaining what LBC and LCCG are planning. Further promotion is also being undertaken informing residents about the Better Care Fund designed to enable informed views and capture any suggestions and ideas for integrating health and social care. To that end, a short questionnaire has been developed and over 2,000 have been:
- sent to service users and frontline staff, carers and family members
- sent out to children centres and day centres for adults
sent to patients review groups linked to Luton GP practices
sent to patients who have visited the hospital in the past three months.
distributed via the VCS, eg Age Concern
promoted by partner organisations on their website ie: Autism Bedfordshire, Parent Carer Forum, Parent Partnership, FUN, CHUMS
promoted by Better Together board partners on their websites
made available on the CCG and Luton and Dunstable hospital website.

Over 150 residents have given us their views about what works well and what works less well in Luton and what benefit they would like to see from health and social care integration.

Additionally, resident engagement is happening through patient experience groups in SEPT, CCS and NHS England area team and an analysis of existing service user data, including complaints and compliments is taking place.

Finally, we work closely with Luton Healthwatch and are mindful of Healthwatch England’s desire to put the voice of the public at the heart of health and care. In its Annual Report, published in October 2013, it proposed a new approach built around eight consumer rights. Number six is “the right to be listened to”:

“I have the right to have my concerns and views listened to and acted upon. I have the right to be supported in taking action if I am not satisfied with the service I have received.” [Healthwatch England, The way forward, 2103]

The Chair of Luton Healthwatch is a member of the board of Better Together and the Council has signed a joint working proposal with Healthwatch for it to take a ‘critical friend’ role in respect of the Better Together programme.

**What are our commissioning priorities?**

Using the information from the JSNA, the Health and Wellbeing board has identified three key areas where we need to ensure we focus our resources:

- Every child and young person has a healthy start in life
(not covered in this plan as the BCF pooled budget is just for adult services – see the Children and Young Persons Trust Board three-year plan which, like the BCF plan, is an integral part of the joint health and wellbeing strategy).

- Reduced health inequalities within Luton
- Healthier and more independent adults and older people

These will be influenced by a wide range of factors and joined up effort by the council, NHS, other public services, the voluntary and community sector and other providers. They will be critical in making an impact on the key areas identified in this strategy.

In order to reduce health inequalities, we will:
1. Develop a model of integrated healthy lifestyle services.
2. Prioritise the prevention and early detection of cardio-vascular disease (CVD) cancer and respiratory disease with increased intensity in areas of greatest need and specific focus on addressing the key risk factors of smoking, alcohol and obesity.
3. Strengthen integrated working across the wider determinants of health with a particular focus on improving housing conditions, supporting more people into employment and ensuring a healthy environment.
4. Strengthen community development by building on the strengths of a community (asset based approach) to increase social capital and empower individuals and communities to have greater control over their health and wellbeing.
5. Develop models of working to promote positive mental wellbeing.
6. Strengthen services to reduce the impact of domestic abuse.

In order to ensure Healthier and more independent adults and older people we will:
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.
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.
3. Drive forward the integration of health and social care services to improve health outcomes and seamless support to the individual by:
   a. Agreeing outcomes that span both health, and social care
   b. Developing and implementing care pathways across health and social care so that patients experience a seamless and personalised care package
   c. Develop common systems and 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
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.
5. Implement an Improving Access to Psychological Therapies (IAPT) service to increase support for people with mental health services.
6. Develop a comprehensive range of prevention and early intervention services which maintain wellness.
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.

The CCG’ commissioning strategy 2012 – 2015 sets out ten strategic priorities it believes will have the biggest impact:

1. Ensuring a Healthy Start in Life for Children and Young People
2. Primary and Secondary Prevention of Disease
3. Empowering People to Live Independently
4. Active Management of Long Term Conditions
5. Improving Medicines Management
6. Managing Planned Care and the Quality of Referrals
7. Improving Urgent Care
8. Improving the Management of People with Mental Health Needs
9. The Integration of Health and Social Care
10. Delivering High Quality, Safe and Value for Money Services

How will we make the strategy work?

In order to move away from viewing services in the silos of LBC Adults, LBC Children’s, Health and Public Health, four ‘Service bundle’ areas have been developed and validated with board members and stakeholders across LBC and LCCG. These are:
1. Prevention (keeping people well) - Universal or preventative services keeping people well
2. Early intervention - Targeted services for those who may be at risk in the future
3. Help at home - Services for adults who need support in the community and children on the edge of care
4. Specialist and acute - Services for children in care and for adults and children who cannot be supported in the community, including acute the sector.
The strategy governing this plan is based on a ‘wellness’ approach which brings services together and intervenes at the earliest opportunity to keep people well and free from illness and disability for as long as possible.

Wellness services aim to change the relationship between users and health services by empowering individuals to maintain and improve their own health. They aim to prevent ill health by intervening at an early stage and so reduce the need for more costly medical interventions. This will affect the way both the public and service providers approach health and will require a major change in the way services are perceived and delivered.

**Financial challenges**

Both the Council and the CCG face tight resource allocation

- Adult social care has £56m net budget
- Demographic pressures of £11.5m to 2017/18
- Savings target of £22m to 2017/18
- £6m efficiencies being worked on
- £2m health transfer assumption
- £14m to be found through prevention, demand management, eligibility criteria and integration
- CCG budget 2013/14 approximately £218.4m
- Budget ‘flat’ and demography assumed at 1.0%
- Inflation and small investment provided for, subject to FRP process
- QIPP savings targets of £13.6m for 2013/14, est.£5m for 2014/15
- Over 53.5% spent on acute hospitals for 2103/14
- CCG forecasting a £5.3m deficit for 2013/14 and recovery plan put in place
- 3.0% of budgets earmarked for BCF in 2015/16

Luton’s Better Care Fund allocation for 2014/15 is £657,000. For 2015/16, the allocation is £11,998,000 revenue funding, plus £439,000 social care capital grant and £584,000 disabled facilities grant.

This plan uses the NHS methodology from the ‘any town’ methodology pack, published in January 2014. The financial model contains a six-year (from 2013/14 to 2018/19) baseline scenario representing the financial and activity position of the representative ‘any town’ health system under the “do nothing” scenario, i.e. assuming that no intervention occurs.
For the baseline and for the intervention scenario, the outputs of the model include:

- The health system expenditure, related funding gap and the relative variation due to the interventions.
- The level of demand for each activity and the relative variation due to the interventions.

All outputs are disaggregated by setting of care, population subgroup and, for secondary and mental health, point of delivery.

**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 JSNA, which will be updated, and the joint health and wellbeing strategy will continue to set out the overall needs of people in Luton and the priorities for action to meet those needs. The joint health and wellbeing strategy is being updated and extended to 2019 in order to fit with the local health economy five-year strategic plan that is in development now. Both plans are due to be considered by the Health and Wellbeing board on 2 June 2014.

This Better Care Fund plan and the Better Together programme are both 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 persuasive vision to describe what integrated care will achieve
- Pool resources to enable commissioners and integrated teams to use resources flexibly
- Innovate in the use of commissioning, contracting and payment mechanisms and the use of the independent sector
- Engaging with primary and secondary care
- Primary and secondary care link to ensure smooth transition from hospital to home
- Care is coordinated by local level multi-disciplinary teams who deal with manageable caseloads
- 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
- Supporting capacity in integrated locality teams to ensure patients are discharged to alternative supports.
- Well-developed, integrated services for older people
- Integrating primary and social care has been shown to reduce admissions, and integration of primary and secondary care for disease management of patients with certain conditions has been shown to reduce unplanned admissions
The recommendations align with the following planned changes that have been put forward in the Better Care Fund Plan for Luton.

- Our plan is that money will be saved by reducing the number of hospital beds and used to fund the expanded home and community based services
- Our intention is to create 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
- Professional accountability for the overall coordination of care for each individual will be held by a GP and a personal electronic plan will enable resident information to be shared across the whole system
- Home care services will play an increasingly important role within the multi-disciplinary teams and will be trained to provide a broader range of services than on offer currently
- A clearer and simpler system should help all professionals to signpost people towards “healthier” services, strengthening prevention, early intervention and self-management.

**Luton’s plan’s to address the challenges it faces**

Wherever possible, our collective intention in Luton is to strengthen and expand our efforts to keep people well or enable them to manage their own care needs or health condition. The Wellness service opening in April 2014 is an important part of a broad approach designed to promote and support this, whether through advice and support to follow a personal diet plan, or medication plan or falls prevention.

In order to avoid people unnecessarily spending time in hospital, the health and care system will be fundamentally re-orientated so that clinical expertise is available in the community and in the home so that people can get the support and treatment they need without going to hospital. This will mean that, for example, elderly care physicians based at the Luton and Dunstable hospital will have a case load outside the hospital building as part of a multidisciplinary team, that itself will be aligned to one of four GP clusters covering the town. These clusters will also be aligned to community health services (with a lead nurse for each cluster) and to adult social care services provided and commissioned by the Council, as part of meeting Care Bill requirements. Clinical intervention outside the hospital will enable the identification of those who need qualified nursing input and those who need social care. From the resident’s point of view this will be a seamless and holistic service and they will receive whatever input is required to keep them safe and as healthy as possible at home.

Luton will model the new ways of working in a ‘perfect community day’ that mirrors the Luton and Dunstable hospital’s ‘perfect day’ change programme. This will enable the NHS and the Council to identify what works, what needs changing and how any barriers
can be overcome. For example, setting aside under a local agreement the restrictive tariff payments to the hospital in favour of a pooling approach that allows money to follow the patient. Money will be saved by reducing the number of hospital beds and used to pay for the expanded home and community based services.

The ‘perfect community day’ will initially be for a cohort of frail elderly residents who are at risk of multiple unnecessary hospital stays. They will be identified through a combination of hospital records, ‘mede-analytics’ risk stratification data and GP knowledge. The idea will be to identify a group of residents which has a baseline of hospital days and associated costs and to measure the difference over the course of a month due to different ways of working. This will take in Council, health and VCS spending and will attempt to uncover the level of change needed to sustain the new whole system approach to helping people stay out of hospital.

The ‘perfect community day’ will see the creation of multi-disciplinary teams that will include social workers, registered nurses (e.g. community nurses and hospital at home nurses), hospital consultants and home help. Professional accountability for the overall coordination of care for each individual will be held by a GP and a personal electronic plan will enable resident information to be shared across the whole system as necessary, including the ambulance service. Additionally, home care support workers will play an increasingly important role within the multi-disciplinary teams and will be trained to provide a broader range of services than on offer currently. This will enable them to support clinical care and to provide assistance in some areas such as pressure care, changing dressings and hydration. A clearer and simpler system should help all professionals to signpost people towards ‘healthier’ services, strengthening the early intervention and self-management model that is an important part of our shared vision.

**Meeting the national conditions**

**Jointly signed off**

The CCG and the Council co-developed this plan and a single joint report went to the Health and Wellbeing board as well as to the CCG board and Council Executive.

**Protects social care**

The expected outcomes for vulnerable adults are set out in the health and wellbeing strategy and Luton will continue to plan, commission and deliver services that maintain its focus on these agreed priority areas. Central to this will be Luton’s continued delivery of services to adults with a broad range of physical and mental health and care needs from the time they need it and not as
a result of a crisis that may have required a hospital stay. In this way we will deliver our commitment to maximise independence and keep people out of hospital. Central to achieving this latter point will be the provision of high quality reablement services.

Funding will be allocated to maintain the current level of eligibility criteria and to provide timely assessment, care management and review and commissioned services to Luton residents who have substantial or critical needs; information and signposting will continue to be given to those who are not eligible for Fair Access to Care Services. We recognise that we may need to consider adjusting our spend in this area in order to maintain this level of service, deliver seven day working and increase assessments for those people captured by the requirements of the Social Care Bill.

We therefore propose to increase our investment in social care to deliver enhanced rehabilitation and reablement services and to ensure we have the right level of rapid response services in order to reduce hospital readmissions and maintain our current excellent performance on admissions to residential and nursing home care.

Within the Better Care Fund pooled budget approximately 75% of the money will be spent on protecting social care outcomes aligned to new ways of working. Social care services will play an increasingly important role in the overall health and social care economy as we will develop a better skilled and efficient joined up social care workforce to provide a key element of our holistic person-centred support outside hospital.

Prevention and wellbeing are increasingly important parts of the social care service in Luton and we aim to promote the wellbeing of residents by supporting services that meet the needs of people who are at risk of social isolation and deteriorating physical and mental health. Our wellbeing clubs provide a range of support to promote mental and physical wellbeing, such as advice on diet, healthy living, signposting to physical activities and cultural events, the provision of advice and information about a wide range of topics including how to manage long term conditions such as diabetes.

**Data sharing**

A project to enable client data sharing across the whole health and care system is underway. It has three elements:

1. IT system,
2. staff engagement and support and
3. information sharing protocols and procedures.

The purpose of the project is to enable all authorised persons working across all parts of the NHS and the Council (and perhaps other partners) in Luton to read and update a service user or patient plan. This electronic personal plan will enable professionals to share relevant information about the client and as a result coordinate and tailor their service. This in turn will support the vision of
person centred planning and delivery that is seamless and holistic, preventing unnecessary hospital stays, avoiding gaps and duplication in service and helping people to manage their own conditions and maximise their independence.

The information sharing protocol and procedures ‘sub-project’ will deliver a common set of rules and guidelines for actively sharing client information to enable better health or social care service delivery and a whole system approach to obtaining informed client consent to share information.

The staff engagement ‘sub-project’ will deliver a shared ethos about the permission to share personal information (as well as the importance of doing so) for the ‘higher purpose’ of improving the health and social care of our clients.

The IT ‘sub-project’ will deliver a standalone web-based service that can be accessed on mobile as well as static devices enabling authorised professional service providers to see and update the client electronic personal plan.

We are committed to using the NHS Number as primary identifier for correspondence and the project to enable this will be complete by April 2015.

We are committed to adopting systems that are based upon Open APIs and Open Standards and we are committed to ensuring that the appropriate IG Controls including those set out in Caldicott 2 will be in place.

**7 day working**

Seven day working is a central part of the service vision for the ‘frail elderly’ work stream in the Better Together programme.

Nationally, the NHS commissioning 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.

As a first stage, the review will focus on improving diagnostics and urgent and emergency care. It will include the consequences of the non-availability of clinical services across the seven day week and provide proposals for improvements to any shortcomings. Emergency care should not be used when patients would benefit from care in other settings.”

In Luton, the priority for 2014/15 and 2015/16 will be to extend services across the whole health and care system where that 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 delays undertaken in 2013 identified a number of areas where improved access outside ‘office hours’ would help us to deliver the outcomes set out in this plan. These include:

- A recommendation that services, particularly LBC Adult Social Care work with residential/ care homes to help and support them overcome barriers to receiving patients back at weekends and after 4.30 pm, as well as to prevent avoidable admissions in the first place

- Exploring the possibility of providing a jointly resourced social work service with Central Bedfordshire to cover weekend work

- Our integrated discharge team works across all seven days to ensure that CHC assessments involve carers and patients families supporting them to make early decisions on discharges, this team will need to partner effectively with mental health services as an integrated team to support patients with dementia return to their own homes as soon as possible, as safely as possible

- 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. Community nursing supports intermediate care so it is essential that these services remain as integrated teams supported by social care

The new community model of care across Luton will ensure providers work together to develop and define a single assessment process negating the need for multiple reviews by specific individuals.

**Accountable professional**

Creating multidisciplinary teams aligned to General Practices has been an aspiration of many GPs for a long time.

Our plan is to align services with GP practices – this will be around a cluster model and work is underway looking at the possible design of four clusters that will coordinate with community health care, mental health and social care services. GPs will be the default ‘accountable professional’ (learning a lesson from our primary care led integration pilot July 2012 to May 2013) and the integrated system will be supported by a web-based personal electronic health and care plan drawing together data from key sources without integrating the different systems.
GPs have been working together in peer groups to deliver the requirements of the Quality and Outcome framework (QOF) for general practice around avoidable unplanned admissions. The QOF requirements change from 1st April 2014, providing the ideal opportunity to create clusters of practices with aligned multidisciplinary teams to deliver integrated care closer to home for patients, their families and carers.

Community Geriatricians will join the clusters, when required, as part of the multidisciplinary team ‘wrapped around the person’ in order to facilitate effective delivery of a new model of care for frail elderly residents. Each cluster will have a clinical Chair, administrative and business support and nurse and specialist support for the management of more complex patients. Such clusters will provide the opportunity for sharing of good practice and clinical expertise, localised workforce development, innovation and collaborative working whilst taking the administrative burden of the clustering away from practices. It is anticipated that the first meeting of each group will take place in May 2014.

All over-75 year olds will have a named accountable GP as part of the new GP contract from April 2014 and we will use the £5 per head initiative set out in Everyone Counts to support general practitioners to put in place clinically led patient care plans that are personalised, holistic and co-developed with the patient, their family or carer. Our contract specifications with providers will support clinical leadership for care planning and, where appropriate, we will use CQUINs to incentivise performance over the next two years.

Community nurses will deliver the majority of this care and support, it will be essential that a range of partner organisations including the wellness service, Active Luton and those in the voluntary and community sector, work with the cluster teams to identify support to reable elderly people through exercise and social engagement such as clubs and social events keeping them as part of the community and motivated to self-care where possible.

Developing community champions within the clusters will support the voluntary and community sector to work within the clusters with the overall aim of having social rehabilitation and reablement as opposed to the over-75s feeling ‘sicker’ as a result of the care planning.

**Impact on acute hospitals**

The Better Together programme envisages that greater effectiveness of prevention and early intervention will reduce unnecessary stays in hospital beds (either by preventing admissions or by enabling quicker discharge when the patient is ready to go). Additionally, the new model of integrated care, marrying social care or housing solutions with clinical care, will go further and enable
some people who would currently require hospital treatment to be cared for in a home setting. This will be enabled by a different model of delivery of care for elderly people by the hospital so that more is done in the community and less is done in the hospital.

The Luton and Dunstable hospital, Luton CCG and Luton Council are signed-up to the idea of closing at least 60 elderly care beds and moving medical expertise currently only available in the hospital into the community. This will require new ways of working from existing medical and care staff and a broader range of skills for some individuals. The need for a flexible, motivated and appropriately trained workforce is therefore a risk (see risk section), because those patients no longer in the hospital will need flexible, efficient and safe care at home or in another community setting.

Hospital staff working with colleagues from across the system will put a greater emphasis on rapid interventions to reduce avoidable admissions and will constantly monitor performance and adjust activity as necessary.

Evidence from change programmes elsewhere suggest that it takes a minimum of two years to fully make the changes we envisage and therefore planning for the BCF will be an iterative process, which is likely to still be on-going in 2015/16; additional costs will be incurred before savings can be taken.

The hospital envisages a step change shift to become a ‘hyper acute’ hospital in the future as clinical expertise increasingly becomes available in the community as an integral part of multi-disciplinary, GP cluster-based teams. Its broad vision also incorporates being a ‘women’s and children’s hospital’, an ‘elective centre’ and an academic teaching unit. All three clinical care service visions include the hospital being an integrated partner for healthcare outside the hospital.

The current re-commissioning programme of community health and mental health services places importance on considering the holistic needs of patients that takes into account mental health and physical health needs with equal weighting. As a result patient health and care plans will consider the broad health and wellbeing needs of an individual that support their recovery or management of their condition.

The roll-out of the new community based model of working will begin with a focus on frail and elderly residents following the timeline below:
Performance

Performance will continued to be monitored as a normal part of the work of all parts of the health and care economy in Luton. The five metrics set out below are intended to give a ‘litmus test’ indication of how well integration is doing in delivering change to the key proposition in the plan; that keeping people out of hospital and caring for them at home, planning around their needs will help people to recover more quickly and stay better for longer.

The Adult Social Care Outcomes Framework (ASCOF) is a national set of criteria that enable performance to be benchmarked against other areas, as well as helping to understand trends and highlight risks. Luton performs well above the national and comparator group average for permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population (ASCOF 2A, part 2) and our ambition is therefore to maintain this excellent performance. The target of 1% improvement will ensure we keep consistent performance although due to demographic change (increase of older people coming into the service) we anticipate a small increase in the actual number of people entering residential and nursing care over the next few years. Additionally we are mindful of extra pressure in this area that may flow from changes as a result of the Care Bill.
Our performance helping older people to stay at home after discharge from hospital into reablement / rehabilitation services (ASCOF 2B, part 1) is slightly below average and for that reason we are setting a stretching target of a 5% annual improvement. This increase will bring Luton into line with the 2012/13 national average of 81.5%. We are also looking to make a 10% annual improvement in ASCOF 2C part 1, delayed transfers of care in order to take us back towards national and comparator averages.

Luton needs to do better at avoiding unnecessary emergency admissions to hospital and we therefore plan to reduce these by 5% annually. We also want to improve customer satisfaction and increase the number of people feeling supported to manage their condition. The latter two measures are critical components of the BCF plan for a ‘big and bold’ change in the drivers and outcomes for the whole service.

Data will be available on a monthly basis showing all hospital admissions analysed by age category (exact age is known), so all patients over 75 can easily be separately monitored. We will also monitor the type of admission, whether it is ‘emergency’ or ‘planned care’ along with the diagnosis code.

Further analysis will show which GP the patient is registered with and therefore we will be able to coordinate the future provision of health in the community. Analysis of the monthly reported data will therefore demonstrate whether the transformational changes made in Luton have resulted in any change to the hospital admissions activity levels. If the monitoring did not show reductions in the levels of activity in the over 75 cohort alternative healthcare solutions would need to be developed and agreed between all the parties involved. The same monitoring can be applied to any age group to check what changes in activity levels have resulted from changes in the clinical pathways.

The best and most important judges of our integrated service improvements are the users of the services, their families and carers. The next two measures show the importance we will collectively give to hearing the views of residents and to ensuring that we take their experience seriously and use it as an indicator against which we will measure our success.

<table>
<thead>
<tr>
<th>Metrics</th>
<th>Baseline</th>
<th>Performance underpinning April 2015 payment</th>
<th>Performance underpinning October 2015 payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent admissions of older people (aged)</td>
<td>432.7</td>
<td>N/A</td>
<td>424.1</td>
</tr>
</tbody>
</table>
### Key Risks

Details of the most important risks and plans to mitigate them, including risks associated with the impact on NHS service providers.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>65 and over to residential and nursing care homes, per 100,000 population</td>
<td>106</td>
<td>24,500</td>
<td>107</td>
<td>25,197</td>
</tr>
<tr>
<td>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into regalement / rehabilitation services</td>
<td>73.9</td>
<td>N/A</td>
<td>81.5</td>
<td>N/A</td>
</tr>
<tr>
<td>Metric Value</td>
<td>120</td>
<td>165</td>
<td>118</td>
<td>145</td>
</tr>
<tr>
<td>Numerator</td>
<td>Denominator</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Delayed transfers of care from hospital per 100,000 population (average per month)</td>
<td>215.1</td>
<td>204,889</td>
<td>207.6</td>
<td>213,457</td>
</tr>
<tr>
<td>Metric Value</td>
<td>441</td>
<td></td>
<td>207.6</td>
<td>450</td>
</tr>
<tr>
<td>Avoidable emergency admissions per 100,000 population (average per month)</td>
<td>199.4</td>
<td>206,976</td>
<td>170.6</td>
<td>213,457</td>
</tr>
<tr>
<td>Metric Value</td>
<td>413</td>
<td></td>
<td>364</td>
<td>214,992</td>
</tr>
<tr>
<td>Patient / service user experience.</td>
<td>60%</td>
<td>(April 2012 - March 2013)</td>
<td>N/A</td>
<td>(March 2015)</td>
</tr>
<tr>
<td>Overall satisfaction of people who use service with their care and support (dependent on the detail of the national metric when developed)</td>
<td>62.7</td>
<td>N/A</td>
<td>63.3</td>
<td>N/A</td>
</tr>
<tr>
<td>Metric Value</td>
<td>Numerator</td>
<td>Denominator</td>
<td>(March 2013)</td>
<td>(March 2014)</td>
</tr>
<tr>
<td>Local measure</td>
<td>Percentage of people feeling supported to manage their condition</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Risk</td>
<td>Risk rating</td>
<td>Mitigating Actions</td>
<td></td>
<td></td>
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<td>----------------------------------------------------------------------</td>
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<tr>
<td>The CCG and the Council are unable to agree a plan that meets the national standards.</td>
<td>Low</td>
<td>Close working between officers, clinicians and board members with an iterative approach to developing plans.</td>
<td></td>
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<tr>
<td>The CCG and the Council disagree about how the Better Care Fund pooled budget should be spent.</td>
<td>Low</td>
<td>A budget for the two years has been agreed and a review of the S.75 agreement is planned for mid-2014/2015.</td>
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<tr>
<td>The plan is not supported by the Health and Wellbeing Board.</td>
<td>Low</td>
<td>The Health and Wellbeing board has considered integration including the BCF (formerly ITF) at four meetings in August 2013, October 2013, January 2014 and on 31 March 2014 when the final BCF plan was agreed for sign-off. Additionally there have been opportunities for Councillors and other board members to feed in views at other times.</td>
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<tr>
<td>Luton is not successful in meeting performance targets and cannot therefore readily access the payment by results part of the BCF.</td>
<td>Low</td>
<td>Targets will be nationally competitive and locally achievable. Existing management of performance to ensure achievement will continue. Money not now linked to performance in this plan</td>
<td></td>
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<tr>
<td>Most of the BCF money is from CCGs’ budgets covering existing services. This money in 2015/16 will have to be stretched further to cover existing health and social care services, demographic and needs growth pressures.</td>
<td>Medium</td>
<td>Growth in CCG allocation will help and close cooperation between the Council and the CCG has identified possibilities for joint savings and efficiencies.</td>
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<tr>
<td>Failure to achieve whole system culture change</td>
<td>Medium</td>
<td>A strong collective vision and commitment to collaborative working has been established by the system leadership. Employee engagement activity is planned as is a combination of system communication, coordinated by the Better Together programme and workplace seminars involving key staff.</td>
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</tr>
<tr>
<td>Savings from services that are diverted to integration work reduce the quality or capacity (or both) of services, putting vulnerable people in Luton at risk.</td>
<td>Medium</td>
<td>Integration plans must meet national tests and have board level supported business cases.</td>
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<tr>
<td>The current re-commissioning programme for mental health and community health services in Luton hampers provider engagement on the development of a shared view of the future shape of services and fails to deliver the integrated approach we are looking for.</td>
<td>Medium</td>
<td>Providers’ leaders engaged in planning and leadership meetings to shape the future of integrated services in Luton. The competitive dialogue process is bringing out innovative and realistic proposals for integration that could be applied in Luton.</td>
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</tr>
<tr>
<td>Issue</td>
<td>Priority</td>
<td>Description</td>
<td></td>
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<tr>
<td>Unable to get buy in from GPs to the new ways of working</td>
<td>Medium</td>
<td>GP leadership from the CCG and close working with NHS England area team will engage GPs in a constructive dialogue that promotes and supports the creation of GP clusters and the GP practice coordination responsibility. A GP engagement session is planned.</td>
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<tr>
<td>All parts of the ‘whole system’ are not able to share patient/service user information</td>
<td>Medium</td>
<td>A programme to ensure information sharing takes place is underway led by a CCG director with participation from all system organisations, driven by the Better Together board. This covers developing the shared ICT solution, engaging with employees (culture change to encourage and permit sharing), and information governance protocols and procedures.</td>
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<tr>
<td>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.</td>
<td>High</td>
<td>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. Performance will be closely monitored by the CCG and the Health and Wellbeing board.</td>
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<tr>
<td>We will not have the right whole system workforce (mix of skills location and practice).</td>
<td>High</td>
<td>We will develop a total workforce strategy with help from Health Education East of England, Skills For Care, Skills For Health and the University of Bedfordshire. A scoping meeting has been set for 9 April and a whole system project group led by the director of housing and community living from Luton Council will begin work in April 2014.</td>
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<tr>
<td>Luton residents, including patients, service users and carers, are insufficiently engaged in the planning process and the final plan fails to reflect community priorities</td>
<td>High</td>
<td>Consultation is already underway and a community engagement programme is being developed in conjunction with Luton Healthwatch (see resident engagement plan).</td>
<td></td>
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</tbody>
</table>