
A Healthier Luton

Version 12.1 refreshed April 12th 2013
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1. Introduction to A Healthier Luton

This document summarises the Luton Clinical Commissioning Group (LCCG) Strategy for 2012-13 to 2014-15. **LCCG has developed a vision for a healthier Luton:**

> “Working in partnership to develop and deliver a high quality and cost effective NHS to the people of Luton, empowering them to lead healthy and independent lives”

LCCG has worked closely with the Health and Wellbeing Board in developing three **outcome goals** for a healthier Luton based on the local health needs expressed in the Joint Strategic Needs Assessment 2011 (JSNA). These are:

1. **EVERY CHILD AND YOUNG PERSON HAS A HEALTHY START IN LIFE**
2. **REDUCED HEALTH INEQUALITIES IN LUTON**
3. **HEALTHIER AND MORE INDEPENDENT ADULTS AND OLDER PEOPLE**

This document describes Ten Strategic Priorities which are designed to deliver the above three outcome goals and create a healthier Luton. These should not be viewed in isolation and many are interdependent on others (urgent care and long term conditions for example). The concept of Quality, Innovation, Productivity and Prevention (QIPP) is fully embedded into our strategy, each strategic priority and all projects and programmes.

Dr Nina Pearson:

Chair, Luton Clinical Commissioning Group

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Luton CCG

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04/11/2013
2. How our Strategy was Developed

2.1 Overview of Inputs to A Healthier Luton
“A Healthier Luton” was informed by a number of strands of work, policies and plans which included the Bedfordshire and Luton PCT Cluster Integrated Plan, which was jointly led by the CCG; the draft Joint Health and Wellbeing Strategy 2012-2017, the National Operating framework for the NHS 2012/13; Midlands and East Strategic Health Authority Ambitions; the views of our member practices and the outputs of a number of Luton CCG Board development sessions held between October 2011 and March 2012. This is illustrated by the diagram below.

This current version of the plan was refreshed in April 2013 to take account of national and local developments since the publication of the original strategy in October 2012.

2.2 Practice Inputs to A Healthier Luton
Our member practices were invited to help us shape our plans via practice engagement meetings and a systematic clinically led practice visit programme covering all practices, which took place between June and August 2012. The following are examples of priorities which have been incorporated into our plans following practice inputs:

<table>
<thead>
<tr>
<th>Investing in Primary Care</th>
<th>Integrated Information Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Capacity to deal with long term conditions</td>
<td>Local Service Solutions (e.g. Minor Surgery)</td>
</tr>
<tr>
<td>Accurate signposting through 111</td>
<td>Reducing medicines wastage</td>
</tr>
<tr>
<td>Procedures of Low Clinical Value</td>
<td>GP awareness of local services</td>
</tr>
<tr>
<td>Young People’s Health</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Public Education</td>
<td>Improving patient involvement</td>
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</tbody>
</table>

2.3 JSNA and Joint Health and Wellbeing Strategy
Luton CCG with the Luton Health and Wellbeing Board has reviewed the Luton Joint Strategic Needs Assessment (JSNA) and developed three overarching priority outcomes for Luton based on recommendations made in the JSNA:
These outcome goals are central to both the Joint Health and Wellbeing Strategy and “A Healthier Luton” and have been fully consulted upon through a public and stakeholder consultation on the Health and Wellbeing Strategy which took place between June 14th and August 17th 2012. A total of 202 people took part in the consultation and 96% of respondents agreed with the above outcome goals.

3. Our Strategic Priorities

In order to deliver our outcomes we have developed ten strategic priorities which we believe 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

We describe these strategic priorities in more detail over the next ten pages, in terms of why each is important to Luton, our vision, our key projects and what we have achieved so far. Our priorities are not listed by importance; each of them carries equal weight in the delivery of A Healthier Luton.
Strategic Priority One: Ensuring a healthy start in life for children and young people

Why is this important in Luton?

- 28.4% (approximately 14,650) Luton children live in poverty.
- Luton’s Infant Mortality rate for 2008-10 is the seventh highest nationally at 7.5 infant deaths per 1,000 live births, significantly higher than the England and Wales average of 4.5.
- The proportion of Low Birth Weight babies born in Luton is significantly higher than the national average (9.5% compared to 7.3% of all live births) 2010.
- Smoking at time of delivery (pregnancy) is around 15% (2011).
- Obesity in Year 6 children in Luton (21.9%) is significantly higher than the England average (19.00 %).
- The proportion of Luton’s five-year-olds with tooth decay, missing and filled teeth is 44% compared with the England average of 31%.
- The prevalence of mental health disorders in Luton’s children and young people is estimated to be 25% higher than the national average.

What is our vision?

We will ensure that children and young people have the best care and opportunities early in life to enable them to become healthy adults. Evidence indicates that health in later life is strongly influenced by childhood experiences and by focusing attention at this stage of life should not only improve the child’s health but also that of the whole family.

What are the key Programmes?

<table>
<thead>
<tr>
<th>Project / Programme</th>
<th>Monitored By</th>
<th>Measures of Success</th>
<th>Clinical Leads</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthening services for early intervention</td>
<td>Children and young people’s trust board</td>
<td>Infant Mortality&lt;br&gt;Children in poverty&lt;br&gt;Child development&lt;br&gt;Excess weight in 4-5 and 10-11 year olds</td>
<td>Dr Monica Alabi</td>
</tr>
<tr>
<td>Services for families with complex needs (including Parenting Programme)</td>
<td>Children and Young People Strategic Implementation Group</td>
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<tr>
<td>Services for children and young people with disabilities</td>
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</tr>
<tr>
<td>Paediatric urgent care (including Urgent Care Pathways, Rapid Response and Step Up Step Down)</td>
<td>Children and Young People Strategic Implementation Group</td>
<td>Reduced admissions&lt;br&gt;Reduced length of stay</td>
<td>Dr Monica Alabi</td>
</tr>
<tr>
<td>Access to remote technology (including telehealth)</td>
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<tr>
<td>Expansion of IAPT for children and Young People</td>
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What progress are we making?

✓ A whole system redesign of urgent care for children and young people has been implemented, improving the quality of care and reducing the number of unnecessary admissions to hospital.
✓ Begun to implement “Rapid Response” Urgent Care programme
✓ A whole system parent education programme has commenced (Luton STEPP) based on national best practice and is aligned to the healthy child programme.
✓ Introduced telehealth for nephrotic syndrome.
**Strategic Priority Two: Primary and Secondary Prevention of Disease**

**Why is this Important in Luton?**
- Around 25.2% of adults in Luton smoke, 25.9% of the adult population and 21.9% of our Year 6 children are obese.
- 15% of people in Luton are estimated to be drinking alcohol over recommended limits.
- There are estimated to be over 37,000 people currently living in Luton with some form of long term condition, though an estimated 6,200 people in Luton with heart disease, COPD or diabetes have not been diagnosed and are not having their condition managed by their GP.
- Over 50,000 people in Luton will suffer from a mental illness at some time in their lives.
- People with long term conditions, including mental illness, are the most frequent users of health care services, accounting for 50% of all GP appointments and 70% of all inpatient bed days in England.

**What is our vision?**
We will take a proactive approach to preventing health problems before they occur by driving the development of a “wellness” approach which brings services together and intervenes at the earliest opportunity in order to improve quality of life and prolong life. We will take systematic approach to detecting the early stages of disease (including heart disease and cancer) and intervene before full symptoms develop in order to prolong life, address health inequalities and improve health outcomes for our population.

**What are the key programmes?**

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</tr>
</thead>
<tbody>
<tr>
<td>NHS Health checks Programme (led by Public Health)</td>
<td>Prevention Group (Reports to Health Inequalities Board)</td>
<td>Number of healthchecks offered and delivered</td>
<td>Dr Shahid Rahman</td>
</tr>
<tr>
<td>Practice Based Disease Registers</td>
<td></td>
<td>Recorded v expected prevalence for diabetes and COPD</td>
<td>Dr Sahadev Swain</td>
</tr>
<tr>
<td>Early Detection of Cancer</td>
<td></td>
<td>Proportion of patients diagnosed at stages 1-2</td>
<td>Dr Nikki Davies</td>
</tr>
<tr>
<td>Making Every Contact Count</td>
<td></td>
<td>Staff trained in MECC</td>
<td>Dr Sahadev Swain</td>
</tr>
<tr>
<td>Delivery of public health service agreements through general practice</td>
<td></td>
<td>Smoking quitter targets; Chlamydia screening</td>
<td>Dr Sahadev Swain</td>
</tr>
<tr>
<td>Health Checks for people with Learning Disabilities</td>
<td>LD Partnership Board</td>
<td>Proportion of people on GP registers known to social care receiving a check</td>
<td>Dr Leena Thomas</td>
</tr>
</tbody>
</table>

**What progress are we making?**
- Smoking prevalence is falling year on year and is now estimated at around 22% for the general population of Luton.
- A new strategy group was set up in Q4 of 2011/12 to oversee the implementation of the healthy weight strategy and annual action plan.
- Health checks are being delivered to patients in Luton mainly through GP Practices. An external provider was commissioned to ensure target reached in 2012/13.
- In depth work commenced to “find the missing thousands” from the disease registers.
**Strategic Priority Three: Empowering People to live independently**

**Why is this important in Luton?**
- There are estimated to be over 37,000 people currently living in Luton with some form of long term condition. This is almost a fifth of our population.
- 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.
- 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.
- Respiratory disease is the third largest cause of death in Luton accounting for 14.9% of all deaths in 2007-09 of which COPD accounts for one third.
- Over 50,000 people in Luton will suffer from a mental illness at some time in their lives.
- People with long term conditions, including mental illness, are the most frequent users of health care services, accounting for 50% of all GP appointments and 70% of all inpatient bed days in England.

**What is our vision?**
Self management can improve health outcomes, patient experience and reduce unplanned hospital admissions. Our vision is to work collaboratively with patients and their carers to empower them with the skills, knowledge and resources to give them the confidence to care for themselves and their condition effectively and confidently. In so doing that they are able to maintain independence for as long as possible.

**What are the key Programmes?**

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</thead>
<tbody>
<tr>
<td>Telehealth and assisted technology linked to LBC telecare services</td>
<td>Long Term Conditions Strategic Implementation Group</td>
<td>Reductions in unplanned admissions to hospital; Reduced attendance at A&amp;E; Patient experience surveys</td>
<td>Dr Nasrin Razzaq; Dr Paul Singer; Dr Talib Abubacker</td>
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<tr>
<td>Self – help and patient education</td>
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<td>Personalised Health Plans</td>
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<tr>
<td>Meet and Greet Programme</td>
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<tr>
<td>Counselling Service for older people</td>
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<tr>
<td>Integrated Falls Prevention service</td>
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<tr>
<td>Enhancing LBC Reablement Team</td>
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</table>

**What progress are we making?**
- A self-help and education programme and maintenance programmes following community rehabilitation have been established.
- We have implemented a falls prevention programme.
- A counselling service for older people has been implemented with links to discharge processes and Community Matrons.
- The “meet and greet” service supports a minimum of 20 people a day. It provides support and assistance to people over 65, preventing deterioration, preventing admission or re admission and helping them live independently.
**Strategic Priority Four: Active management of long term conditions**

**Why is this important in Luton?**
- Due to high levels of ethnicity, the prevalence rates of heart disease, stroke and diabetes are higher than the national average
- The gap in life expectancy for males is mainly due to coronary heart disease (CHD) and stroke. For females the main diseases contributing to the gap are CHD, respiratory disease and cancer
- There are estimated to be over 37,000 people currently living in Luton with some form of long term condition.
- Over 50,000 people in Luton will suffer from a mental illness at some time in their lives
- Admission to hospital is costly but often preventable; a significant proportion of all acute hospital activity is related to long term conditions.

**What is our vision?**
We will provide a whole system and seamless approach to deliver health and social care with integrated enablement and recovery services. Our services will be patient centred, of a high clinical standard and promoting high levels of mental wellbeing, independence and self-care wherever possible. We will provide optimum levels of support in terms of patient experience, quality and service efficiency.

**What are the key Programmes?**

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</tr>
</thead>
<tbody>
<tr>
<td>Implement the use of risk stratification in primary care</td>
<td>Long Term Conditions Strategic</td>
<td>Reductions in unplanned admissions to hospital; Reduced</td>
<td>Dr Nasrin Razzaq</td>
</tr>
<tr>
<td>End of Life Care Pathway Review and Redesign</td>
<td>Implementation Group</td>
<td>attendance at A&amp;E; Patient experience surveys</td>
<td>Dr Paul Singer</td>
</tr>
<tr>
<td>The implementation of new models of care for diabetes and</td>
<td></td>
<td></td>
<td>Dr Peter Ward</td>
</tr>
<tr>
<td>COPD – community integrated teams</td>
<td></td>
<td></td>
<td>Dr Talib Abubacker</td>
</tr>
<tr>
<td>Falls prevention programme</td>
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<td></td>
<td>Dr Kuldip Sule</td>
</tr>
<tr>
<td>Telehealth and Telecare programme</td>
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<td></td>
<td>Dr Abdul Ebrahim</td>
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</table>

**What progress are we making?**
- We are designing a process for risk stratification which will be incorporated into the medeanalytics application. This will allow the proactive management of patients at high risk of admission to hospital.
- The Primary Care led Chronic Disease management hub has been designed for implementation during 2013/14
- Models of care for diabetes and COPD have been re-designed with four levels of care (GP Core Services; GP Enhanced Services; Intermediate Care and Specialist Care) – community integrated teams
- An initial Telecare/Telehealth programme has been developed and implemented. The CCG is expanding the programme to offer support to more people and link with LBC to integrate telehealth and telecare.
Strategic Priority Five: Improving Medicines Management

Why is this important in Luton?

- **Safety**: Medication errors occur in up to 11% of prescriptions, mainly due to errors in dosage (Sanders and Esmail, 2003). Medication errors are a top reason for hospital readmissions.
- **Safety**: Medication errors occur in 12% of Luton patients according to a recent study where 1 in 550 prescription items was associated with a severe error (Avery et al 2012). Based upon this study there are possibly 472 severe errors in Luton in any one year.
- **Efficacy**: Non-adherence to medicine is a major issue and between one-third and one-half and of medication prescribed for long term conditions are not taken as recommended.
- **Efficacy**: Medicine waste is estimated at between £2- £4 per head of population. Of this it is estimated that 50% is likely to cost effectively preventable. Luton CCG has between £200K to £400K avoidable waste.
- **Budget Pressure**: Prescribing costs account for around 10% of the primary care budget in Luton. the introduction of new expensive drugs, an ageing population resulting in increased numbers of patients with long-term conditions and dementia will all contribute to increasing pressures on prescribing costs.

What is our vision?

To provide our population with excellent medicines management that provides patients with safe, clinically effective, and acceptable medicines that additionally are cost effective and affordable. To enable this vision we will enable close links to practices through the “Towards Excellence” programme and will utilise new technology which demonstrates added value for patients. Improved communications will be established with primary and secondary care stakeholders and with patients to address complex issues such as non-adherence to medicines and reduce wastage.

What are the key Programmes?

<table>
<thead>
<tr>
<th>Project / Programme</th>
<th>Monitored By</th>
<th>Measures of Success</th>
<th>Clinical Leads</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory medicines</td>
<td>CCG Prescribing Committee</td>
<td>Reduction in number of Hospital related admissions</td>
<td>Dr Sahadev Swain</td>
</tr>
<tr>
<td>Reducing Medicines Waste</td>
<td></td>
<td>Reduction in medicine waste collected from nursing homes</td>
<td>Dr Ian Hill-Smith</td>
</tr>
<tr>
<td>Improving the pharmacological management of dementia</td>
<td></td>
<td>Reduced inappropriate medication</td>
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<tr>
<td>Cost effective acute and community prescribing</td>
<td></td>
<td>Financial efficiency</td>
<td></td>
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<tr>
<td>Reducing harm caused by inappropriate medicines</td>
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<td>Reduction in emergency admissions</td>
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</table>

What progress are we making?

- The effective management of medicines was a major contributor to the Luton QIPP challenge in 2012/13 through a number of key projects such as cost effective prescribing, respiratory medicines and reducing waste. Savings of over £1m were generated during the year.
- Successful switching to more cost effective diabetes testing strips
- Commenced implementation of Eclipse Live to drive reductions in inappropriate prescribing
- Commenced implementation of Blue Teq to drive cost effective utilisation of high cost drugs
Strategic Priority Six: Managing planned care and the quality of referrals

Why is this important in Luton?

- In 2011/12 GPs in Luton made almost 36,000 referrals to hospitals for elective care each year. Early data suggests that there has been a sharp increase in referrals in April, May and June compared to the same period last year.
- Referral rates to a particular specialty within a single area vary by as much as 10 fold between GPs within Luton.
- There are also patients who need a referral but fail to receive one. For example, lack of or late referral is thought to be a key driver of poor survival rates for cancer (Department of Health 2011b).
- The quality of referral letters in Luton varies from practice to practice and from GP to GP and the absence of key information can prevent the referral reaching the right destination.
- GPs, patients and specialists do not always share a common understanding of why referrals being made – for example, whether it is primarily for diagnosis, investigation, treatment or reassurance (Grace and Armstrong 1986, Broomfield et al 2001, Molloy and O’Hare 2003).

What is our vision?

We will drive excellence in primary care, improving the quality and efficiency of care across Luton, reducing unwarranted clinical variation in general practice using peer comparison and support and ensure that patients are treated in the right place by the right service at the right time.

What are the key Programmes?

<table>
<thead>
<tr>
<th>Project / Programme</th>
<th>Monitored By</th>
<th>Measures of Success</th>
<th>Clinical Lead(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Towards excellence in primary care</td>
<td>Primary and Planned Care Strategic</td>
<td>GP Access / Satisfaction Reduced inappropriate referrals</td>
<td>Dr Nasrin Razzaq Jeannie Szumski</td>
</tr>
<tr>
<td></td>
<td>Implementation Group</td>
<td>Reduction in non-elective admissions</td>
<td></td>
</tr>
<tr>
<td>Primary Care Investment Scheme</td>
<td>Value for Money Strategic Implementation</td>
<td>Patient Satisfaction Access to services</td>
<td>Dr Nasrin Razzaq</td>
</tr>
<tr>
<td></td>
<td>Group</td>
<td>Quality and safety outcomes</td>
<td></td>
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<tr>
<td>Out of Hospital Care – increasing community availability</td>
<td>Primary and Planned Care Strategic</td>
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<td>Group</td>
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What progress are we making?

✓ In November 2011 Luton CCG took over the existing NHS Luton “Primary Care Legacy Challenge.” The CCG has radically refocused the programme through the development of a systematic project plan. The programme has been rebranded as “Towards Excellence in Primary Care” to better communicate the programme aims. This programme is designed to drive improved quality and safety in primary care.
✓ A new Primary Care led Community Palpitations has been implemented.
✓ An initial Primary Care Investment Scheme was rolled out in the second half of 2012/13 which will be re-launched in 2013/14 to enable practices to deliver more high quality services and drive better management of those at risk of being admitted to hospital.
Strategic Priority Seven: Improving urgent care

Why is this important in Luton?
- The people of Luton have told us they find the system for urgent and unplanned care is confusing and subsequently we respond to their need wherever and whenever they enter the system. As a result people often respond by attending the A&E department at the L&D as they know they will usually be seen within four hours.
- Despite new unscheduled care services over the past few years, such as an urgent care centre co-located at the L&D and a Town Centre Walk-in facility, pressure on the local A&E department has continued to grow. We therefore regard it as a critical need to continue to reconfigure services in order to reduce this pressure and ensure that all attendances at A&E are appropriate.
- There is high variation between practices on patient attendance of urgent care. The highest is 280 attendances per 1,000 patients down to 162 per 1,000.

What is our vision?
Our approach to urgent care is to view all services as joined up an integrated system delivering high quality, consistent, affordable provision of urgent care to members of the public who perceive that they have an urgent care problem. We will target services specifically to meet the needs of the local population and will commission them from a patient pathway perspective. Services will be accessible, delivered near to people’s homes. Our approach to urgent care has close links to our work on the management of long term conditions.

What are the key Programmes?

<table>
<thead>
<tr>
<th>Project / Programme</th>
<th>Monitored By</th>
<th>Measures of Success</th>
<th>Clinical Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximising community support</td>
<td>Urgent Care Strategic</td>
<td>Reduced inappropriate emergency admissions; Reduced re-admissions; Patient satisfaction; Reduced A&amp;E attendance; Reduce ambulance call out</td>
<td>Dr Nina Pearson</td>
</tr>
<tr>
<td>(Single Point of Access, Navigator Nurse, Care Home Matrons, Crisis Response)</td>
<td>Implementation Group</td>
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<tr>
<td>111 non-emergency service</td>
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<tr>
<td>Ensure delivery of ECIST recommendations</td>
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<td>Urgent Care Comms Strategy</td>
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<td>Urgent GP Clinic</td>
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</table>

What progress are we making?
✓ The CCG has halted the month on month increase in people attending A&E since July 2012
✓ The Urgent GP clinic has continued to increase activity with minor illnesses to ease pressure on A&E
✓ Completed pilot navigator nurse service at L&D to avert avoidable admissions. This is now being continued as a key service
✓ A new “Hospital at Home” service pilot has commenced in April 2013 to assess the effectiveness of home care in facilitating earlier discharge and improving patient experience
✓ The community services admission avoidance programme has averted over 3,000 admissions in 2012/13
**Strategic Priority Eight: Improving the management of people with mental health needs**

**Why is this important in Luton?**
- At least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time.
- Mental ill health is Britain’s biggest social problem. A recent WHO study concluded that the impact of depression on a person’s functioning was 50 percent more serious than angina, asthma, diabetes and arthritis.
- Approximately 1,700 patients are likely to have dementia in Luton, however only a third of these patients have been diagnosed.
- Income deprivation, unemployment, poor health and poor housing are all associated with increased risk of mental illness. Luton is ranked as the 69th most deprived of 326 local authority areas, just outside the bottom 20% in England.
- Analysis of service use by ethnic group suggests that ‘non white’ groups are accessing services in lower numbers than expected.

**What is our vision?**
We will improve the mental wellbeing of our population by enabling the entire health and social care system to promote mental health. We will provide greater support to people with common mental health problems such as depression and anxiety, and ensure that community services are easily accessible to all who need them.

**What are the key Programmes?**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Promotion of mental wellbeing</td>
<td>Mental Health and Learning Strategic Implementation Group</td>
<td>Increasing the number of people on primary care disease registers</td>
<td>Dr Anthea Robinson</td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies (IAPT)</td>
<td></td>
<td>% of people who have depression/anxiety referred for psychological therapies;</td>
<td>Dr Christiane Harris</td>
</tr>
<tr>
<td>Liaison Psychiatry</td>
<td></td>
<td>Improved quality of life for people with dementia</td>
<td></td>
</tr>
<tr>
<td>Suicide Prevention</td>
<td></td>
<td>Reduction in the number suicides</td>
<td></td>
</tr>
<tr>
<td>Implementation of Joint Dementia Strategy</td>
<td>Dementia Steering Group</td>
<td>Improved quality of life for people with dementia</td>
<td></td>
</tr>
</tbody>
</table>

**What progress are we making?**
- Luton has begun to implement a stepped model of care for mental health care and as part of this we have introduced a range of self help support and also a talking therapies programme service.
- We have implemented Talking Therapy for older people at home as part of reablement.
- Consultant telephone advice line introduced for GPs.
- The procurement programme for expansion of IAPT has commenced.
- The Primary Care link workers programme has commenced.
Strategic Priority Nine: The integration of health and social care

Why is this important in Luton?
- The typical user of health services is elderly, frail, possibly vulnerable and suffering from one or more debilitating long term conditions and who needs coordinated packages of care to allow them to lead fulfilling lives.
- This cohort of patients represents 29% of the total population but 50% of all GP appointments, 65% of outpatients’ appointments and 70% of all inpatient bed days (DH)
- Additionally 51% of people receiving social services, 75% of adults in residential care and 91% of people in nursing care are over the age of 65 years (NHS Information Centre)
- The number of older people (65+) in Luton is expected to rise from 28,000 in 2010 to 35,550 in 2030, an increase of 27%. The older people are, the more likely they are to have a long term condition.

What is our vision?
Following the development of a local model we will drive the following long term outcomes:
- NHS, Public Health and Local Authority priorities and agendas are aligned and underpinned by locally agreed outcomes than span both health and social care.
- All care pathways developed across health and social care, and patients will experience a seamless and personalised care package.
- The development of common systems and processes across partner organisations, along with a new structure for the management and co-location of multi-functional health and social care teams based around clusters of GP practices.

What are the key Programmes?

<table>
<thead>
<tr>
<th>Project / Programme</th>
<th>Monitored By</th>
<th>Measures of Success</th>
<th>Clinical Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care led Integration Pilot and roll out</td>
<td>Integration of Health and Social Care Strategic Implementation Group</td>
<td>Patient experience Proportion of older people who are still at home three months after discharge; Health related quality of life for people with long term conditions</td>
<td>Dr Peter Ward Dr Nasrin Razzaq</td>
</tr>
<tr>
<td>Integrated Management Information Systems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated Hospital Discharge</td>
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<td></td>
<td></td>
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<tr>
<td>Integrated Reablement Strategy</td>
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<td></td>
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</tbody>
</table>

What progress are we making?
- The CCG is working with the LBC Overview and Scrutiny Committee to drive improvements in the hospital discharge processes and reduction of excess bed days
- Commenced Primary Care Led Integration Pilot in November 2012, this is being extended to June 2013
- Implementation of integrated discharge and rehabilitation teams
- Agreed whole system pathways into rehabilitation and intermediate care beds
- Commenced programme for integration of information systems
Strategic Priority Ten: Delivering high quality, safe and value for money services

Why is this important in Luton?
- For many years the least affluent communities in Luton have experienced longstanding variability in the quality and accessibility of local primary care services
- We have experienced increasing and serious concerns with regard to safeguarding and care standards which has resulted in the closure of one nursing home and temporary closure of a community unit
- Mental health provision was awarded to SEPT in 2009. Previous patient satisfaction ratings were poor and these have not significantly improved
- Patient and public involvement in the design and delivery of health services has not been optimal
- Luton CCG faces an efficiency savings target of over £10m over the next three years in order to improve the quality and safety of services and remain in financial balance

What is our vision?
We will work in partnership with patients, the public and other key organisations to develop and deliver a high quality, safe and cost effective NHS to the people of Luton, empowering them to lead healthy and independent lives.

What are the key Programmes?

<table>
<thead>
<tr>
<th>Project / Programme</th>
<th>Monitored By</th>
<th>Measures of Success</th>
<th>Clinical Lead (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality and safety assurance – Shared with Bedfordshire CCG</td>
<td>CCG Board Patient Quality and Safety Committee</td>
<td>Implementation of Safeguarding Vulnerable children and adults policies Healthcare acquired infections; Mixed sex accommodation; Patient experience surveys; Reduction in the incidence of pressure ulcers;</td>
<td>Anne Murray</td>
</tr>
<tr>
<td>Patient and public involvement strategy</td>
<td>CCG Board</td>
<td>Patient experience surveys</td>
<td>Shahzad Choudhry (Lay Member)</td>
</tr>
<tr>
<td>Contract management</td>
<td>Finance and Performance Committee</td>
<td>CCG financial balance; Delivery of QIPP plan</td>
<td>Dr Monica Alabi</td>
</tr>
</tbody>
</table>

What progress are we making?
- The development of an enhanced quality and safety Directorate with robust processes for quality and safety monitoring
- We have begun to implement a patient and public involvement strategy which includes the establishment of a Patient Reference Group and implementation of an equality delivery system
- The number of instances of mixed sex accommodation has declined dramatically during 2012/13
- The incidence of C.difficile infections has further reduced during 2012/13
4. Delivery of A Healthier Luton

4.1 Strategic Implementation Groups
Luton CCG has established seven Strategic Implementation Groups (SIG) to implement our strategic priorities. The SIGs are the strategy delivery hubs of the CCG, each is chaired by a clinician and is attended by all key individuals involved in delivering projects which support the delivery of our strategic priorities. Each SIG reports directly to the Clinical Commissioning Committee via a designated Clinical Director with clear individual accountability for the successful implementation of each strategic priority, the financial and operational performance and for patient experience, quality and safety.

<table>
<thead>
<tr>
<th>Strategic Implementation Group</th>
<th>Healthier Luton Strategic Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Young People SIG</td>
<td>1. Ensuring a healthy start in life for children and young people</td>
</tr>
<tr>
<td>Prevention Group</td>
<td>2. Primary and secondary prevention of disease</td>
</tr>
<tr>
<td>Long Term Conditions SIG</td>
<td>3. Empowering people to live independently</td>
</tr>
<tr>
<td></td>
<td>4. Active management of long term conditions</td>
</tr>
<tr>
<td>Prescribing Committee</td>
<td>5. Improving medicines management</td>
</tr>
<tr>
<td>Planned Care and Primary Care SIG</td>
<td>6. Managing planned care and the quality of referrals</td>
</tr>
<tr>
<td>Urgent Care SIG</td>
<td>7. Improving urgent care</td>
</tr>
<tr>
<td>Mental Health SIG</td>
<td>8. Improving the management of people with mental health needs</td>
</tr>
<tr>
<td>All Strategic Implementation Groups</td>
<td>9. The Integration of Health and Social Care</td>
</tr>
<tr>
<td></td>
<td>10. Delivering high quality, safe and value for money services</td>
</tr>
</tbody>
</table>

The SIGs report progress on a monthly basis with detailed commentary on:

- Progress against milestones
- Delivery of KPIs
- Financial Outcomes

The outputs of this report are reviewed at varying levels of complexity in a number of settings. The key forums are Executive Committee, Finance and Performance Committee and CCG Board. This enables the Board to gain full assurance of strategy delivery and full understanding of any mitigating actions in place. The roles of the various groups in assuring delivery is described below.

4.2 The Role of the Executive Committee
The Executive Committee is made up of the CCG Chair, Assistant Clinical Chair and members of senior Management. The Executive Committee meets weekly and devotes one meeting per month carry out a highly detailed review of the implementation of the strategy, identifying barriers and formulating solutions to overcome those barriers.

4.3 The Role of the Clinical Commissioning Committee
The Clinical Commissioning Committee (CCC) is “engine room” of the CCG and will make its key clinical commissioning decisions and ensure the delivery of A Healthier Luton. The committee comprises senior CCG clinical leadership, together with key CCG management and local allied health professionals. Each month the CCC holds Clinical Directors to account for delivery of the strategy and implementation of solutions put in place to overcome any key barriers.
4.4 The Role of the Finance and Performance Committee
The Finance and Performance Committee (FPC) is chaired by a lay member and composed of Clinical and Management Directors. The role of this committee is to understand which elements of strategy delivery are failing and to gain assurance that mitigating actions are in place.

4.5 The Role of the CCG Board
The Board receives an exception and mitigating actions report generated by the FPC. Additionally the CCG Board is responsible for reviewing overall performance at each monthly Board meeting via a report summarising performance against key national indicators together with activity against other national and regional indicators including safety and patient experience as identified in the NHS National Outcomes Framework and the CCGs Operational Plan. The Board reviews performance against quality in the 5 national domains and assures itself that actions are being taken to address any areas of underperformance. The five domains are:

- Domain 1: Preventing People from Dying Prematurely
- Domain 2: Enhancing Quality of Life for People with Long Term Conditions
- Domain 3: Helping People to Recover from Episodes of Ill Health or Following Injury
- Domain 4: Ensuring that People have a Positive Experience of Care
- Domain 5: Treating and Caring for People in a Safe Environment and protecting them from Avoidable Harm

4.6 Safeguarding Children and Vulnerable Adults
In delivering A Healthier Luton we will ensure that we fully embed the safeguarding of children and vulnerable adults across the health system, ensuring that all staff have a full understanding of local safeguarding policies and processes.

4.7 System Engagement
Engagement with cluster system health and social care partners, patients, the public and our staff, was a core component of the Bedfordshire and Luton Cluster Integrated Plan and this was achieved through a series of workshops and collaborative events.

4.7.1 Engagement through the SIGs
Luton CCG will continue to engage and involve the system through our Strategic Implementation Groups, the membership of which will include providers, partners and patient representatives. This will enable a collaborative approach to the delivery of our strategy, the sharing of future patient activity and an understanding of provider implications of all service developments based upon the triangulation of activity, financial savings and workforce.

4.7.2 Provider engagement through Exec to Exec meetings
Additionally the CCG has implemented quarterly Exec to Exec meetings with the key providers L&D, SEPT and Cambridgeshire Community Services to ensure mutual understanding of key issues, input into strategic developments and overcoming potential barriers to system progress.

4.7.3 Patient and Public Engagement
The Francis report published in February 2013 calls for a major change in culture whereby we place patients at the centre of all we do and ensure that the organisation focuses on gathering intelligence ensuring that listening to patients and the public is a major priority.

We will ensure that PPE is embedded within the culture, strategic planning and day to day work of LCCG at all levels. In order to do this we will ensure that we:
Put processes in place to collect, analyse and utilise the views of patients and the public to inform decision making, shape services and improve health outcomes

Capture the views of patients expressed in the consulting room to inform our strategy and our decision making

Empower and encourage patients to become more engaged in decisions about their own health, promoting shared decision making and choice

Support GPs and other clinicians to engage effectively with their patients and communities

Drive meaningful engagement with seldom heard or harder to reach groups which will, at times, require additional efforts and resources

The CCG has implemented a Patient Reference Group (PRG) with membership across a number of Luton practices. The PRG will help the CCG by providing a channel for the patients’ voice in the following areas:

- Our decisions about treatment and care
- Our decisions about service delivery e.g. planning and design of services
- The evaluation of services
- The delivery of genuine choice for patients

The CCG will also work closely with Luton Borough Council to drive public engagement through the five Area Boards to enable clinical leader engagement with the public and local councillors. The Area Boards have been put in place to respond to local needs such as health, crime and the environment and the CCG will utilise this existing framework to ensure that local communities are listened to and that services are tailored to meet the needs of local communities.

4.7.4 Practice Engagement

The engagement and involvement of our practices is critical to the delivery of A Healthier Luton. The CCG has developed a Practice Engagement Programme and we will work with the LCCG Board to implement it. This includes an LCCG branded engagement pack, working with selected practices to understand communication and engagement preferences and delivering communications training to GP and practice nurse Board members.

4.8 Quality and Safety

Luton CCG is committed to the on-going improvement in the quality and safety of the services we commission and this principle is firmly embedded in our delivery structure with quality and safety representation key to maintaining major focus through the individual SIGs.

4.8.1 Quality Monitoring

The quality monitoring process in relation to all our large provider contracts includes a quarterly face to face review. This review is based on intelligence provided from the provider in this case the Hospital in relation to the CQC outcomes framework. There is a detailed review of incidents, complaints and intelligence in relation to patient experience that we may get from external bodies including Healthwatch or GP practices. The other important source of intelligence in relation to provider quality and patient experience are the safeguarding alerts and investigations. Luton CCG is completely aware of the statutory requirement in relation to Children’s safeguarding and is an active partner on the Local safeguarding Board. The same principles in relation to partnership working and awareness raising and education are adopted for adult safeguarding.

4.8.2 Quality and Safety Committee

LCCG has established a Patient Safety and Quality Committee (PSQC) as a sub-Committee of the BCCG and LCCG Governing Bodies. The Committee will provide the LCCG Governing Body with assurance
that appropriate processes are in place to demonstrate effective delivery of the organisation’s priorities and objectives in the context of patient safety, clinical effectiveness and patient experience.

The Committee will:

- Agree and ensure that KPIs relating to patient safety and clinical quality are included in all provider contracts (e.g. acute, community, mental Health, OOH and 111) and monitored continuously via provider quality review meetings and site visits so any early warnings regarding possible deteriorating services is identified and acted upon.
- Review and analyse all quality data and information about providers to ensure recognition of early warning signs e.g. Integrated Performance and Quality Dashboards, Quality profiles and other data/intelligence about providers.
- Review and consider relevant published reports or data in relation commissioned providers e.g. NRLS, CQC, NHSLA and agree corrective action and reporting for any concerns identified.
- Review all information and data including Serious Incidents, Never Events, complaints trends and Serious Case Reviews, ensuring that corrective and preventative action is taken and that lessons learned are widely disseminated.
- Ensure providers have processes in place to report incidents to the NRLS, CQC and Monitor in a timely manner. Identify and report incidents to the NRLS in relation to Primary care and Independent contractors.
- Identify areas of potential risk for inclusion in the CCG Risk Register and Board Assurance Framework and ensure that action is taken to mitigate or eliminate such Risks.
- Review Safety Alerts and consider implications to commissioned services and ensure providers implement actions within timeframes.
- Ensure that Commissioning, Quality and Innovation (CQUIN) proposals are appropriate, challenging and lead to significant improvement in quality of services.
- Ensure, via reports from the Patient Experience that priority is given to improving the patient experience in line with local, regional and national priorities and measurements.
- Will ensure that patient experience and engagement intelligence is reported and utilised to inform and influence the design of services.
5. Luton CCG Delivery Structure

5.1 High Delivery Structure
6. Summary of A Healthier Luton

The chart below summarises our high level strategy for improving the health of people in Luton, our vision, our outcome goals articulated in the Joint Health and Wellbeing Strategy, with Key Performance Indicators in place to measure our progress and our ten strategic priorities which will drive the achievement of our outcome goals.