Luton Better Together
Integrated Team

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People of Luton: At the heart of Better Together

• 203,600 in 2015
• Ethnically ‘super diverse community’ with 1/3 population of BME origin and large South East Asian community – ‘plural community’
• Increase in people from EU countries particularly Poland
• Proportion of 65+ years was 12% in 2012, and will be 16% in 2037
Local drivers for change:

• Growing population with growing numbers of older people
• Increasing numbers of people attending A&E
• Increasing deprivation score (69th most deprived)
• Housing shortage issues impacting on health
• Experience in successful models of integrated working and colocation delivery
• Strong commitment across organisations to an integrated model
• Health inequalities
Better Together Board

BCF Programme Implementation Group

Enabler 1 – Enhancing Joint Commissioning

Enabler 2 – Workforce Skills

Enabler 3 – Improving Technology for Joint Working/Improving information sharing

Enabler 4 – Integrated personalised commissioning

Scheme 1 – Proactive and Integrated Primary Care Services

Scheme 2a – Implementing the Better Care Integrated Team
  2b – Rapid Response
  2c – Mental Health

Scheme 3 – Improving 7 day a week working

Scheme 4 – Reablement

Scheme 5 – Therapy Services

Scheme 6 – Reducing children’s emergency admissions

Scheme 7 – Social Prescription

Together for a healthier Luton
Luton Landscape: Supporting the integration journey

- Positive stable senior management relationships
- One high performing acute trust
- One unitary local authority
- One CCG
- 30 GP practices
- Vibrant VCS
- Newly procured CHS, MHS and intermediate care providers:
  - ELFT (commenced April 1st)
  - Virgin (commenced April 1st)
  - HPFT (to commence June/July)
Commissioning approach

Luton Borough Council & Luton Clinical Commissioning Group

Coordinating Provider(s)

- HPFT
- LBC - Social Care
- East London Foundation Trust
- GPs
- Acute Trust

MDT Co-ordinators, District Nurses, Community Matrons and Social Workers aligned to each of the 4 GP Clusters
Better Together: Model of Care Practice Level

- GP
- Community Matron
- MDT co-ordinator
- Other aligned staff
- Practice staff
- Mental health
- District Nurse
- Social Worker

Patients and carers
Planned Outcomes

• Reduction in avoidable hospital admissions 3.5% in 15/16 (822 people)
• Reduction in NHS delayed transfers of care
• Improved and coordinated experience of patients and carers
• Reduction in already low admissions to residential homes
• Maintain and support social care services
• Reductions in hospital stays
• Improved working experience for staff
• Joined up IT systems
Key Considerations

• GP Leadership ability
• Cultural change
• Managing conflicting system drivers
• Achieving value proposition for all stakeholders
• Models of consent
• Selecting cohort
• Financial drivers and demonstrating outcomes
Challenges:

- Limited financial resources across CCG (8m overspend in 14/15) and huge social care saving targets
- Changes in the political landscape
- New providers commencing in Luton
- Changing population and new trends
- Workforce retention- all professionals
Next Steps:

• Finalize roll out of integrated teams
• Complete fully induction and development of new MDT coordinator role
• Strengthen GP buy in and leadership
• Finalize detail of lead provider arrangements
• Consolidate longer term programme arrangements
• Integrated planned and unplanned response