# HEALTH & CARE PARTNERSHIP

**FORMERLY THE HEALTH AND WELLBEING BOARD**

**When:** **Wednesday, 22 February 2023 at 14:00**

**Where:** **Civic, 1 Saxon Gate East, Milton Keyens, MK9 3EKJ and on Youtube**

**Enquiries**

Please contact Andrew Clayton on 01908 252046 or andrew.clayton@milton-keynes.gov.uk

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**Agenda**

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## Agenda

**1. Welcome, Introductions and Apologies**

**2a Minutes (Pages 5 - 10)**

To approve, and the Chair to sign as a correct record, the Minutes of the meeting of the Partnership held on 12 October 2022.

**2b Actions Arising (Pages 11 - 12)**

To consider the Health and Care Partnership Tracker 2022/23 and information regarding actions agreed at previous meetings.

**3. Disclosures of Interest**

Councillors to declare any disclosable pecuniary interests, other registerable interests, or non-registerable interests (including other pecuniary interests) they may have in the business to be transacted, and officers to declare any interests they may have in any contract to be considered.

**4. Public Health Update**

To consider, Items 4a to 4c

**4a Stop Smoking Service Update (Pages 13 - 18)**

**4b Director of Public Health Report (Pages 19 - 20)**

**4c Director of Public Health Report Annex 1 (Pages 21 - 42)**

**5. Integrated Care Partnership (ICP) and Board (ICB) Update (Pages 43 - 52)**

To consider, Item 5

**6. Update on the Progress of the MK Deal (Pages 53 - 60)**

To consider, Item 6

**7. Locality/Neighbourhood Working in Milton Keynes (Pages 61 - 76)**

To consider, Item 7

**8. Date of Next Meeting**

To note, the next meeting of the Health and Care Partnership is scheduled for Wednesday 7 June 2023 at 2.00pm

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Minutes of the meeting of the HEALTH and CARE PARTNERSHIP held on WEDNESDAY 12 OCTOBER at 2.00 pm

**Present**: Councillors Marland (Chair), R Bradburn, E Darlington and D Hopkins, M Bracey (Chief Executive, Milton Keynes City Council), V Collins (Director - Adult Services, Milton Keynes City Council), M Heath (Director – Children's Services, Milton Keynes City Council), Dr R Makarem (Chair of BLMK ICB) (Vice-Chair), F Cox (Chief Executive, BLMK ICB), J Hannon (Diggory Divisional Director of Operations, CNWL NHS Foundation Trust), J Harrison (Chief Executive, Milton Keynes University Hospital NHS Foundation Trust), V Head (Director of Public Health, Milton Keynes City Council), Dr N Alam (Representative of Primary Care Networks), C Bell (Deputy Chief Fire Officer, Bucks Fire and Rescue Service), M Taffetani (Chief Executive, Healthwatch Milton Keynes), Supt M Tarbit (LPA Commander, Thames Valley Police), P Wilkinson (Chief Executive, Willen Hospice), J Held (Independent Scrutineer, MK Together)

**Officers:** M Carr (Deputy Director Public Health, Milton Keynes City Council), D Stout (Development Director, Milton Keynes Health & Care Partnership) and A Clayton (Overview and Scrutiny Officer), Milton Keynes City Council

**Observers**: R Green (Head of MK Improvement Action Team, BLMK ICB), M Wogan (Chief of System Assurance and Corporate Services, BLMK ICB)

**Apologies**: None

**HCP08 MINUTES AND ACTIONS ARISING**

The Partnership considered the Minutes of the Health and Care Partnership's meeting held on 1 June 2022 and noted that all actions from the meeting had been completed or were in the process of being completed, with those outstanding being recorded on the Forward Plan.

RESOLVED -

1. That the Minutes of the meeting of the Health and Care Partnership held on 1 June 2022 be approved and signed by the Chair as a correct record.

2. The actions arising from the previous meeting held on 1 June 2022 were noted. All other actions were completed or in the process of being completed and noted accordingly on the Forward Plan.

**HCP09 DISCLOSURES OF INTEREST**

None.

**HCP10 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)**

The Partnership received two reports; a) a progress update on the JSNA and b) Milton Keynes Place Profile 2022.

The Director of Public Health presented the report and drew the Partnership's attention to several key points of progress this year:

- Musculoskeletal Health Needs Assessments had been completed, undertaken collaboratively by the MKCC Public Health Intelligence Team and the ICB. This would drive commissioning going forward.
- Work on the Children and Young People Inequalities and Vulnerabilities chapter of the JSNA is underway, with completion planned by December 2022.
- The chapter on Long Term Conditions and Ageing Well was being scoped.
- The Place Profile for Milton Keynes had been developed.

The Partnership heard that the objective was to make the data for the ICB region available on a web based platform, with place-specific dashboards providing key demographic, socio-economic and health indicators. Efficiencies would be achieved through the adoption of the same platform across all councils in the region. Over time it was anticipated that the data would provide an increasingly granular view, allowing for more efficient deployment of public health resources. Disparities in health outcomes amongst different socio-economic groups within the City were made manifest by the data and provided opportunities for appropriate intervention.

The Partnership welcomed the progress made thus far and discussed ways in which the data could be deployed to improve health outcomes. Working collaboratively across the region provided for both a better overview and opportunities for pooling and thereby reducing resources. It was recognised that the JSNA formed the evidential basis on which future commissioning decisions would be made by the ICB in consultation with MKCC, and that, resources being finite, priority should be given to public health initiatives with a strong evidential basis that optimised positive health outcomes for the residents of Milton Keynes.

RESOLVED -

That the reports be noted.

**HCP11 FEEDBACK FROM THE BLMK INTEGRATED CARE PARTNERSHIP (ICP)**

The Partnership received an oral report from the Chief Executive, BLMK ICB, who identified the following salient points:

- The Integrated Care Partnership for BLMK had now met twice and the focus of discussions to date had been the strategy for the living well priority for children. The ICP was required to formulate clear priorities, whilst taking into account the views and opinions of diverse groups including childcare professionals and members of the general public. The ICP was required by Government to produce the strategy by Christmas this year.
- Whilst the strategy timetable involved working to a deadline, it was more important for the ICP to consider matters in the round in order to arrive at a longer term view.
- The ICP would be meeting next in November 2022.

RESOLVED -

That the oral report be noted.

**HCP12 UPDATE ON THE PROGRESS OF THE MK DEAL**

The Partnership received an update report on the progress of the MK Deal. The Report was presented by the Chief Executive of Milton Keynes City Council, who provided some background information:

Underneath the Partnership a Joint Leadership Team (JLT) had been formed, comprising representatives from CNWL NHSFT, PCN and MKCC. The JLT met fortnightly to consider in detail how the improvement priorities for Milton Keynes, as decided by the Partnership, might best be met through the working relationship with the BLMK ICB and to bring this together under the MK Deal. The MK Deal is the formal agreement between the Partnership and the BLMK ICB that sets out the arrangements and responsibilities that will operate between the parties to deliver these improvement priorities.

The MK Deal had been agreed with the ICB on 30 September 2022 and an officer had been appointed by BLMK ICB to lead a team on the implementation of the deal in Milton Keynes. One of the key priorities of the implementation was to simplify arrangements and to strengthen the focus on evidence-based solutions, i.e. to focus on key initiatives that were proven to be working well and to cease those initiatives for which the evidence was not strong.

Overall, matters were progressing well. The relationships between the various partners were operating efficiently and the team was

now ready to move forward and put the agreement and plans into action.

The Partnership considered the report and made the following observations:

- That prevention is better than cure, i.e. that the solutions to advancing some of the priorities lay in early interventions, better health education, and the development of strong collaboration with all parties involved in the process, including the voluntary sector, pharmacies and statutory bodies.
- That regarding the hospital discharge policy the plans under consideration would not significantly impact the problems being experienced during this winter season, but the intention was to make improvements in time to alleviate problems during the next.
- That the integrated approach to healthcare offered the potential to improve outcomes across the City. It was hoped that the collaboration required to achieve the four priority areas set this year would strengthen the partnership across the sectors and help build a strong foundation for working together in the future.

RESOLVED –

1. That the MK Deal, as set out in the report, was agreed and a letter sent to the ICB confirming this.
2. That the work on hospital discharge and obesity should start first with a report back to the Partnership at its next meeting on 22 February 2023.
3. That development work on the other two priorities should continue, with a view that the Partnership will agree when these will start at its next meeting on 22 February 2023.
4. That where additional approvals were required to meet the objectives in the MK Deal that these be agreed and actioned by the JLT in consultation with the Chair and Vice-Chair of the Partnership.

**HCP13 MILTON KEYNES BETTER CARE FUND (BCF) PLAN SEPT 2022**

The Partnership received a report from the Director of Adult Services, who explained that the statutory return was completed and submitted recently and that this report comprised the narrative part of that return.

That the approach and focus of the plan this year was essentially a repetition of the previous year's plan and that no significant changes

had been proposed. The overall spend under the plan was circa. £26 million and had been agreed by all parties, including a range of performance indicators to provide for measurement of success and accountability.

The Partnership considered the report and made the following observations:

- There was a considerable focus on initiatives pertaining to hospital discharge, one of the priorities of the MK Deal. For example, the BCF included funding for a social care team based in the hospital. The use of the BCF provided a model in many ways for the future operation of the MK Deal, involving cooperation between many providers of healthcare in the City.
- That the BCF provided for many services that had become core, essential services. As it was not a fixed fund, but additional monies that were agreed on an annual basis, the Partnership expressed concerned about the reliability of these funds in the future, particularly in the context of possible cutbacks in public sector funding.

RESOLVED -

That the report be noted.

**HCP14 INFORMATION ITEM – UPDATE FROM SAFEGUARDING PARTNERSHIP**

RESOLVED –

That the report be noted.

**HCP15 DATE OF NEXT MEETING**

It was noted that the next meeting of the Health and Care Partnership would be held on Wednesday 22 February 2023 at 2.00 pm.

THE CHAIR CLOSED THE MEETING AT 3.22 PM

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# DECISION TRACKER 2022/23 - HEALTH AND CARE PARTNERSHIP

## OUTSTANDING ACTION POINTS

**COLOUR CODE**:

| | |
|---|---|
| (R) RED: | NO OR LIMITED PROGRESS |
| (A) AMBER: | PROGRESS PENDING FURTHER ACTION |
| (G) GREEN: | SIGNIFICANT PROGRESS MADE |
| (C) COMPLETED: | NO FURTHER ACTION |

Referrals to Council

Referrals to Cabinet

**Presented to Health and Care Partnership**: **22/02/2023**



Item 2b

## HEALTH AND CARE PARTNERSHIP

| Date of Meeting | Minute | Subject and Decision | Action Taken/Lead Officer | Action Since Last Review (01/06/22) | Current Indicator |
|---|---|---|---|---|---|
| **08/09/2021** | **HWB12** | **Mental Health Service Developments** | | | |
| | | That officers from the Police, CNWL and Milton Keynes Council work together to identify preventative measures that could reduce the number of mental health crises that escalate to the point that they require police intervention (Section 136). | Sarah Nickson<br>Head of Mental Health and Complex Needs | CNWL, TVP and MKCC (AMHP Lead) meet on a weekly basis to review all s136 and discuss any issues that may arise from each individual detained and also discuss whether s136 was an appropriate legal framework. This joined up approach has seen a reduction in those detained under s136. Monitoring is ongoing. | **GREEN** |
| **23/02/2022** | **HWB21(a)** | **Health and Wellbeing Strategy - Priorities for 2022/23** | | | |
| | | That an audit of late diagnosis of HIV be undertaken to explore missed opportunities for testing and earlier diagnosis. | This is currently being scoped with NHSE/I colleagues who commission HIV care and hold the patient notes and public health are liaising with CCG/ICS colleagues to assist with this project. | The necessary Information Governance protocols have been agreed with MKUHT who are commissioned (by NHSE) to provide HIV Care and Treatment and 30 late diagnosis patients have been identified for review. This is due to commence shortly. | **GREEN** |

Item 4a

MK Together | Health and Care Partnership

# STOP SMOKING AND TOBACCO CONTROL SERVICE UPDATE

**Author:** Vicky Head (Director of Public Health, Milton Keynes City Council)

Ruth Dean (Public Health Principal – Stop Smoking and Tobacco Control, Bedford Borough, Central Bedfordshire and Milton Keynes Public Health Team)

**Purpose of Report:**

The purpose of this report is to: update the Partnership on smoking prevalence in MK and the key activities of the Stop Smoking Service and wider strategic partners; outline key challenges in reducing smoking prevalence and associated inequalities; and outline future planned work.

## 1. Recommendations

1.1 That the Partnership:

1) Notes the stagnation in smoking prevalence in Milton Keynes and the activities and achievements of the Stop Smoking Service and wider partners.

2) Considers opportunities available through the Partnership to address the challenges we face in continuing to reduce smoking prevalence, particularly in Primary Care and the Acute and Mental Health Trusts, and in meeting the more complex needs of smokers.

## 2. Introduction

2.1 The aim of the Stop Smoking Service (the Service) is to reduce both the smoking prevalence in the local population and the inequalities gap in smoking prevalence by increasing access to stop smoking support for vulnerable groups.

2.2 The Stop Smoking Service for Milton Keynes residents is managed by Central Bedfordshire Council as part of the shared public health service across Bedford Borough, Central Bedfordshire and Milton Keynes.

2.4 The purpose of this report is to: update the partnership on smoking prevalence in MK and the key activities of the Service and wider strategic partners; outline key challenges in reducing smoking prevalence and associated inequalities; and outline future planned work.

## 3. Background

3.1 Helping individual smokers to quit is a vital way to reduce smoking prevalence and remains a key priority for the Service.

3.2 Of equal importance to this are evidenced-based tobacco control measures which serve to de-normalise smoking and prevent residents from being exposed to second-hand smoke.

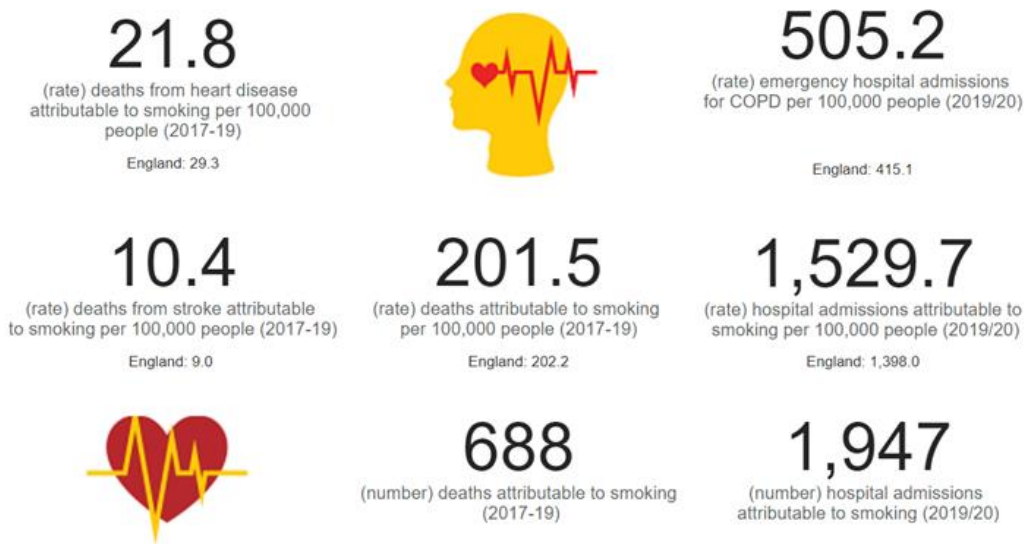
3.3 In 2021-2022, 597 Milton Keynes residents quit smoking following an intervention from the Stop Smoking Service. This number has decreased by 17% on the 2020-21 figures, where 698 residents had a successful quit outcome. This decrease can largely be attributed to a fall in overall capacity of the Stop Smoking Service due to the impact of the COVID-19 pandemic on Primary Care. This is expanded on further in Section 7 of this report.

## 4. Smoking prevalence in Milton Keynes

4.1 14.9% of Milton Keynes residents smoke, which is higher than the national average of 13% and its deprivation decile of 11.6%. At least half of these smokers will die prematurely if they do not give up smoking.

4.2 Every year nearly 2,000 Milton Keynes residents are admitted to hospital because of their smoking and 688 residents die of smoking-related illnesses. Further details of the burden of tobacco-related disease are shown in Figure 1.

**Figure 1: The burden of tobacco related disease in Milton Keynes.**




Infographic from UKHSA Tobacco Control Dashboard, referencing using indicators from the OHID Local Tobacco Control Profiles.

4.3 In Milton Keynes residents are:

- Significantly more likely to smoke if they work in a routine or manual labour role (25.2% prevalence) compared to those working in managerial and professional occupations (8.2% prevalence)
- Nearly three times more likely to smoke if they have a diagnosed long-term mental health condition (42.8% prevalence).

4.4 Smoking tobacco is the biggest contributing factor in the life expectancy gap between the poorest and the most affluent cohorts, and between those with and without long-term mental health issues.

# 5. Current work programmes of the Stop Smoking Service

## 5.1 Standard programme of support

5.1.1 The standard programme of support delivered by the Service to clients includes eight weeks of intensive behavioural support. It also includes an option of single nicotine replacement therapy, medication or, since 1 October 2022, an e-cigarette for the duration of the course.

5.1.2 There are extended treatment programmes for vulnerable groups, including pregnant smokers and those with a long term or mental health condition. Face-to-face support is also available for vulnerable groups and the Service runs regular clinics based at Milton Keynes Library and Water Eaton Health Centre.

## 5.2 Targeted place-based interventions

5.2.1 Over the last 12 months the Specialist Service has delivered targeted place-based interventions in response to particularly high smoking prevalence rates affecting residents of the Lakes Estate.

5.2.2 Work on the Lakes Estate has included:

- Running regular drop-ins and face-to-face support from the Spotlight Centre (local community centre).
- Attendance and talks at local events and the Community Larder.
- Engagement with the local secondary school, care home, GP Practice and pharmacy.
- Two new clinics being set up at Water Eaton Health Centre.

5.2.3 Evaluation of these interventions is ongoing. Initial findings show increased numbers of residents engaging with the programme, setting quit dates and successfully completing the programme as a direct result of this approach.

5.2.4 We will develop this model further to incorporate community-led interventions in future, including opportunities for peer support workers who have direct experience of using the Service. We are also working with Public Health Social Housing colleagues and the Milton Keynes Housing Team to expand our work to include areas such as Fullers Slade and Netherfield. We have also been linking with partners to support Community Cafés and Money Saving Events in targeted areas across Milton Keynes in February and March.

### 5.3 Introduction of e-cigarettes to support smokers to quit

5.3.1 As part of ongoing service development, from 1st October 2022 the Specialist Service has introduced e-cigarettes (popularly known as "vapes") as part of a universal offer to all adult smokers who access the Service, alongside medicinally licenced stop smoking products.

5.3.2 A 2021 Cochrane Review determined that e-cigarettes are more effective as an aid to quitting smoking than nicotine replacement therapy (NRT). The Review also concluded that more people remained abstinent from smoking for at least six months using e-cigarettes compared to those using NRT.

5.3.3 E-cigarette products are considered to pose a fraction of the risk of tobacco smoking (at least 95% less harmful), and the UK has some of the strictest regulation for e-cigarettes in the world. We only recommend e-cigarette usage for adult smokers as part of a quit attempt and only provide e-cigarettes to support residents quit smoking

5.3.4 We are closely evaluating the uptake and impact of this intervention for different cohorts of smokers in different localities.

## 6. Work led by strategic partners

6.1 The NHS Long Term Plan sets out a three-year pathway for Tobacco Dependence Treatment Programmes to be implemented in NHS inpatient care and maternity services by March 2024.

6.2 Milton Keynes Maternity Services have recruited a Stop Smoking Advisor to work directly with pregnant smokers as a wider part of their maternity care. The pathway is still being refined, but this Service should be in place by April 2023 in Year 3 of the programme. It is heavily supported by the Specialist Stop Smoking Service, who will assist with elements such as funding for the pharmacotherapy component, staff training, data collection and referral pathways for both Bedfordshire Hospitals Trust and Milton Keynes University Hospital.

6.3 The Acute and Mental Health elements of this pathway, led by Milton Keynes University Hospital (MKUH) and CNWL, have progressed more slowly due to challenges around capacity and funding. A Prevention Programme Manager has been recently recruited by BLMK ICB and is working with MKUH, CNWL and Public Health colleagues to move this forward. This area represents a key opportunity to embed smoking cessation in clinical pathways, significantly increasing engagement with stop smoking interventions across Milton Keynes.

# 7. Challenges

## 7.1 **COVID-19 pandemic**

7.1.1 The COVID-19 pandemic has had a significant impact on the Stop Smoking Service. Primary Care is a key component in the current Service through direct delivery as a commissioned provider and as a referral route into the Service.

7.1.2 The impact of the COVID-19 pandemic and ongoing pressures on Primary Care services means there is reduced capacity to deliver smoking cessation treatment or refer via GPs.

7.1.3 In 2021-22 42% of quits for the Stop Smoking Service in Milton Keynes were delivered by Primary Care, compared to 69% in the pre-pandemic period of 2019-20, creating an overall deficit in capacity to reach smokers across Milton Keynes and delivering reduced outcomes.

## 7.2 **Increasing complexity and changing support needs of smokers**

7.2.1 While the prevalence of smoking in England has fallen year on year since 2011, in Milton Keynes it has remained relatively unchanged since 2016. The needs of smokers are becoming increasingly complex, with greater levels of addiction and many experiencing multiple issues such as poor mental and physical health and economic pressures.

7.2.2 Currently fewer than 5% of smokers in Milton Keynes access support from the Stop Smoking Service and the way in which smokers want to quit is also changing. Evidence suggests they are becoming increasingly less likely to access traditional face-to-face services and more likely to engage with remote support. There is a risk however that digital service models create barriers for some people to access the service. Providing an accessible service for all that also recognises the needs of more vulnerable groups is an ongoing challenge.

# 8. Future planned work

8.1 New work is already being developed and implemented by the Specialist Stop Smoking Service as outlined above.

8.2 In addition we have had a research proposal accepted by PHIRST London. This is evaluating the impact of digital interventions in the Stop Smoking Service on health inequalities. This will enable us to better understand the needs of smokers living in the most deprived wards in Milton Keynes. It will also provide an evidence-base from which we can develop effective and targeted interventions to reduce persistently high prevalence rates in these groups.

8.3 We have recently recruited a Tobacco Control Practitioner to lead on co-ordination of evidence-based tobacco control programmes. They will focus on areas such as regulatory enforcement, smokefree public places, and targeted marketing and communications campaigns. This will be vital to our work

supporting the wider development of a culture which actively discourages smoking for our residents.

8.4 We are engaging with workplaces around the Healthy Workplace Standards. We will focus predominantly on organisations who have medium to large routine and manual workforces to support a change in culture which challenges and de-normalises smoking in Milton Keynes, and reduces the high smoking prevalence which disproportionately affects those in routine and manual occupations.

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## List of Annexes

None

## List of Background Papers

None

Item 4b

MK Together | Health and Care Partnership

# REPORT TITLE Director of Public Health Report 2022

**Author:** Vicky Head, Director of Public Health for Milton Keynes

Fatumo Abdillahi, Senior Health Protection and Public Health Specialist, Bedford Borough, Central Bedfordshire and Milton Keynes Public Health team

**Purpose of Report:**

To 1) share with the Partnership the statutory Director of Public Health Report 2022: Taking Local Action to Address Excess Weight in Milton Keynes, and 2) to seek endorsement of the ambitions noted in the report.

## 1. Recommendations

1.1 The Partnership is asked to endorse the ambitions noted in the report:

1) To create healthy, active places to learn, work, and play.
2) To work together to support more people to lose weight and keep it off.

## 2. Background and introduction

2.1 It is a statutory requirement of the Director of Public Health (DPH) to produce an annual report on the health of their population. The focus of the 2022 DPH report is excess weight.

2.2 Excess weight is a major cause of preventable disease and death in Milton Keynes. The increase in excess weight locally will have significant health and economic consequences.

2.3 The report describes the impact of excess weight on population health in Milton Keynes, outlines the main factors driving excess weight, and sets out effective actions that can be taken locally to reduce excess weight.

## 3. Taking local action together

3.1 Together, partner organisations and businesses in Milton Keynes play important roles in shaping our environment and keeping our population healthy. There is more we can do to prevent people developing excess weight and to support more people to lose weight.

3.2 The report outlines two key ambitions for Milton Keynes, and associated actions:

**Ambition 1: Work together to create healthy, active places to learn, work and play**

- Employers and service providers, including the City Council and the NHS, should make it easy to access healthy food, through the food services they procure and the businesses that sell food and drink on their premises.
- Organisations, including the City Council, should explore opportunities to limit the marketing, placement, advertising and sponsorship of unhealthy foods.
- The City Council continues, through its planning and transport responsibilities, to make it easier and safer for residents to walk, cycle and use public transport where it is appropriate to do so, and support greater access to green space.
- Employers should explore options to build movement into the working day and make active forms of travel easier, attractive, and more affordable.
- System partners should ensure there is support for voluntary and community organisations to increase access to healthy food and physical activity, with a focus on families most affected by increases in the cost of living.

**Ambition 2: Work together to support more people to lose weight and keep it off**

- The City Council and the NHS should work together to make it easy to access all publicly funded weight management services and explore innovative approaches to support increase physical activity and achieve a healthy weight
- The NHS should work to increase the number of patients successfully referred to the full range of locally available weight management services.
- Health and care services should work to increase the confidence of frontline professionals to raise the subject of excess weight and offer brief advice, including where to get support.
- Employers, as part of their approach to workplace wellbeing, should promote the availability and access to local weight management services.
- Throughout these actions extra effort should be made to improve access to weight management services for those at higher risk of excess weight, including people with learning disabilities, people with severe mental illness, those living in areas of higher deprivation and people from minority ethnic groups.

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## List of Annexes

Annex 1: Taking Local Action to Address Excess Weight in Milton Keynes: Director of Public Health Report 2022 (pdf).

Milton Keynes City Council

# Taking Local Action to Address Excess Weight in Milton Keynes

## Director of Public Health Report 2022

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# **Introduction** from Vicky Head

**Two out of three adults and two out of five 11-year olds living in Milton Keynes are overweight or obese.** Excess weight is a major cause of ill health and death locally and disproportionately affects some of our poorest communities. We know that:

- Excess weight increases the risk of developing chronic diseases including cardiovascular disease, type 2 diabetes, cancer, and osteoarthritis. It increases an individual's risk of hospitalisation and is associated with mental health problems such as anxiety and depression[1].
- Excess body fat is a factor in nearly a quarter of deaths among people aged over 45 and now contributes to more deaths in this age group than smoking. Moderate obesity reduces life expectancy by about three years and severe obesity can shorten a person's life by 10 years. This 10-year loss is equal to the effects of lifelong smoking[2].
- Obesity was a factor in over 4,200 hospital admissions in Milton Keynes in 2019/20[3]. Obesity-related admissions in the most deprived areas of England are 2.4 times greater than in the least deprived areas[4].
- The NHS spends around £6.5 billion a year (close to 4% of its 2022/23 budget) on treating the consequences of obesity. This is forecast to rise to £9.7 billion by 2050. The annual cost to society, including wider economic costs, is around £54 billion, roughly equal to 1-2% of GDP or the total annual funding allocated to schools in England[5].
- Excess weight carries significant economic costs for Milton Keynes, including lost working days and economic inactivity, increased benefits payments and costs associated with NHS treatment and care[6].

Tackling excess weight is not simply a matter of educating individuals to make healthier choices. The people who are most likely to become overweight or obese are those whose lives are shaped by work, school and social environments that promote overeating and inactivity. It is easy to feel overwhelmed by the scale and complexity of the challenge, but there are effective actions we can take locally. My report this year focuses on the important roles that partner organisations and businesses in Milton Keynes play in shaping our environment and keeping our population healthy. If we are serious about working preventatively to improve health in Milton Keynes, there is more we can do together to stop people developing excess weight and support more people to lose weight.

**Vicky Head**
Director of Public Health

(23)

# **Chapter 1:** The scale of the problem

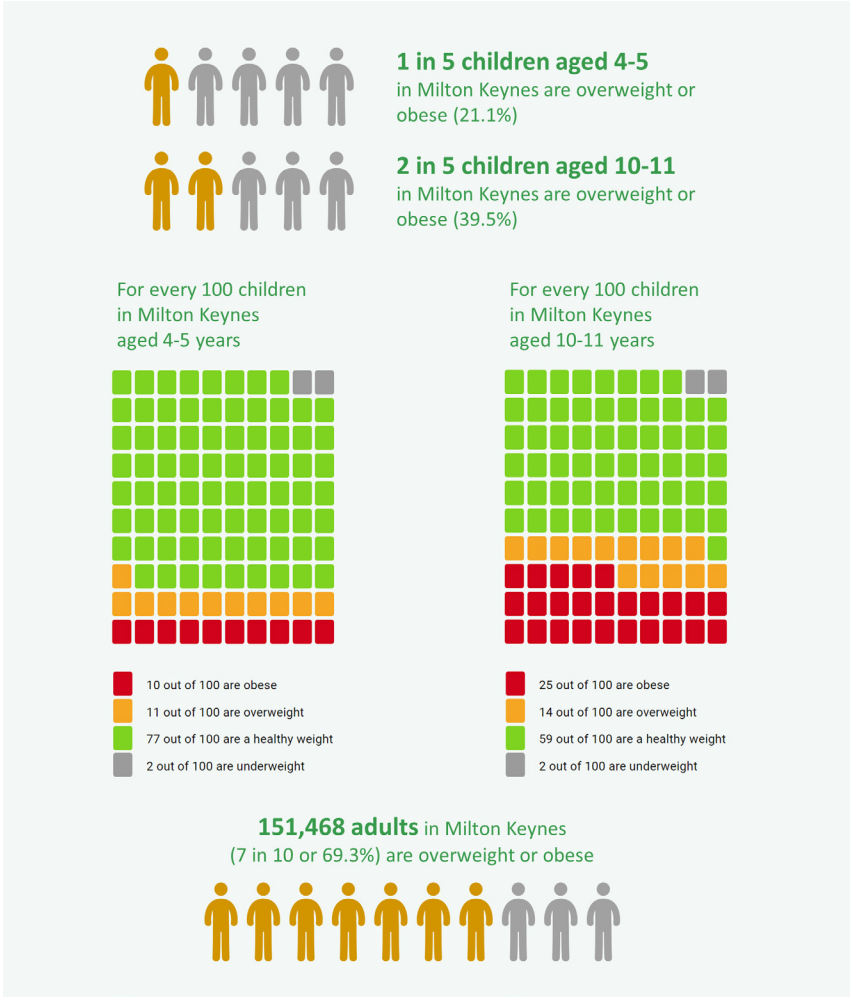
Obesity is a complex, chronic health condition with multiple causal factors impacting its development including genetics, psychological, environmental, and societal factors. Despite this, it is a commonly held belief that weight loss is solely an individual's responsibility. This can lead to weight stigma, the negative stereotyping of people based on body weight, which can cause considerable harm.

## Excess weight is even more common in Milton Keynes than the England average

In Milton Keynes over 150,000 people aged over 18 are overweight or living with obesity. This equates to over two thirds of adults (69%), which is significantly higher than the England average of 64%.

21% of children aged 4-5 years old are overweight or obese which is similar to the England average of 22% for this age group. By the time children in Milton Keynes reach 10-11 years old, almost double the proportion (39.5%) are overweight or obese, which is higher than the England figure of 38%.

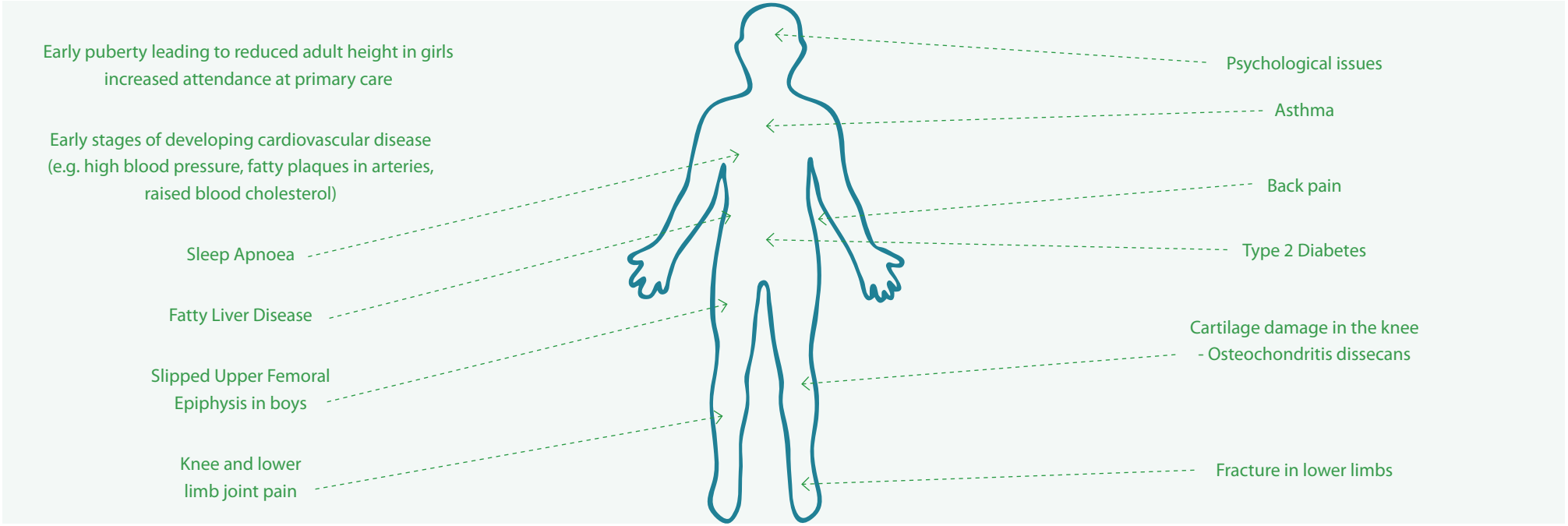
**Figure 1:** Prevalence of excess weight in Milton Keynes




**Source: Health Survey for England 2019 and National Child Measurement Programme 2021/22**

Levels of excess weight for both adults and children are increasing over time[7] and younger people are becoming obese at earlier ages and remaining obese in adulthood. Being overweight or obese in childhood has profound impacts on health and affects the quality of our children's lives, their education, and their life chances. Children who are obese or overweight are more likely to experience physical health issues[8], including type 2 diabetes, aasthma, musculoskeletal pain, and mental health problems, such as depression (Figure 2). If children born in 2022 continue eating current diets, the projected health implications of obesity as they age are stark. By the age of 65 years 75% of those children will be overweight or obese, 1 in 3 will have diabetes and 1 in 5 will have cardiovascular disease[9].

**Figure 2:** Health impacts of childhood obesity

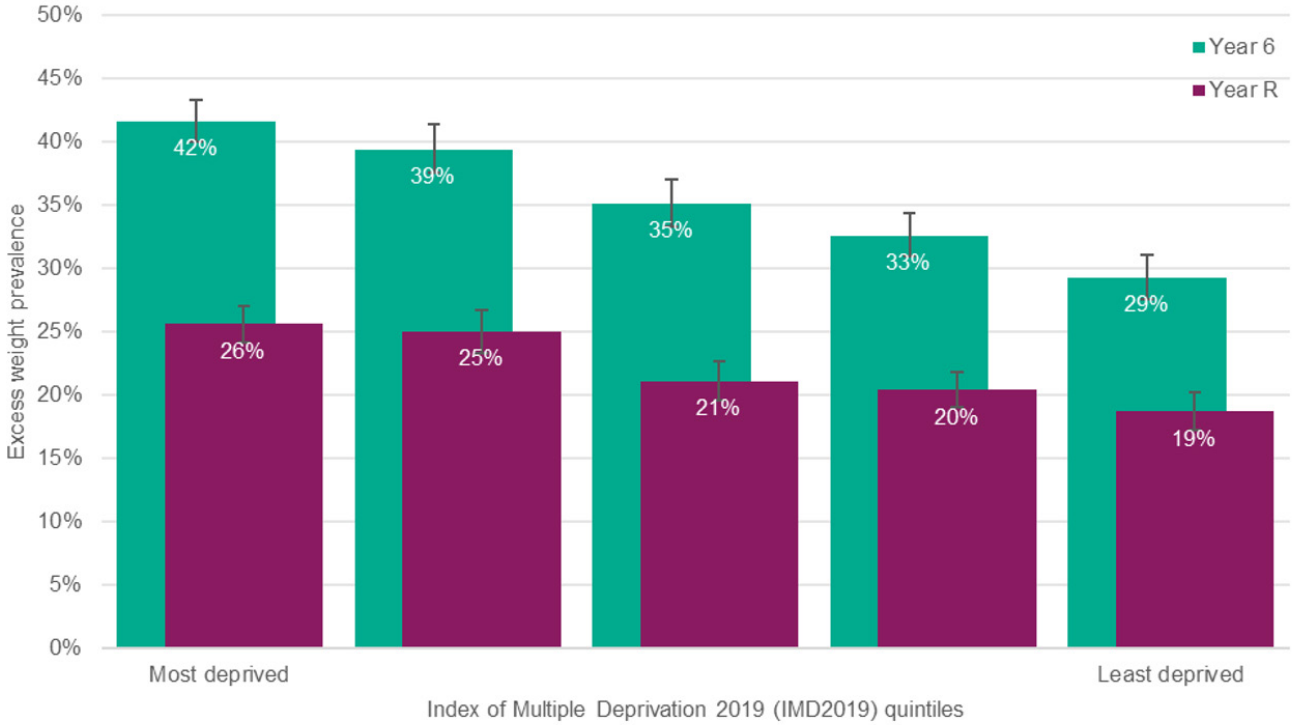



**Source: Time to Solve Childhood Obesity. An Independent Report by the Chief Medical Officer, 2019**

## Excess weight is an important driver of inequalities in health

Excess weight can affect anyone, but it more commonly affects people living in areas of deprivation, on low incomes, those living with disabilities and some black and minority ethnic groups[10]. These differences in excess weight translate to worse health outcomes for people as well as contributing to health inequalities. This pattern is apparent across areas of highest deprivation in Milton Keynes, where the latest data shows that just over a quarter of children (26%) residing in the most deprived wards are living with excess weight when they begin school (aged 4-5 years old), and this figure Increases to 42% by the time they are 10-11 years old. This figure is far less in the most affluent areas, where 29% of 10-11 year olds are living with excess weight. This inequalities gap is getting bigger over time.

**Figure 3:** Excess weight prevalence of primary school children by deprivation quintile in Milton Keynes (2016-19 & 2021-22)[11].




**Source:** National Childhood Measurement Programme 2021/2211
**Note:** 2019-20 years are not included due to Incomplete/missing data during the Covid-19 pandemic

(26)

# **Chapter 2:** The problem of scale: supporting individuals to lose weight

Free weight management programmes are available locally to support people living with excess weight. Evidence suggests they are effective for short-term weight loss and programmes can be targeted so that they help address health inequalities. Weight loss tends to be modest but even small weight reductions bring health benefits. These programmes are an important intervention to enable individuals to improve their health but on their own they will not solve the obesity problem at a population level.

## Local weight management services are not used as much as they could be

The full range of free local weight management services is listed in Appendix A. The three interventions available through the NHS or commissioned by the local authority are MoreLife, the NHS Digital Weight Management Programme and the NHS Diabetes Prevention Programme.

**MoreLife** provide weight management services for children and young people, adults, and pregnant or recently pregnant women in Milton Keynes, Central Bedfordshire, and Bedford Borough. In 2021/22, 3,653 residents were referred (including self-referrals) to the MoreLife programme across the three local authorities and 855 people completed the programme. In terms of capacity, this service had an additional 1,300 spaces that were unused. The online component of MoreLife has unlimited capacity.

The **NHS Digital Weight Management Programme** is available on referral for people with high BMI and diabetes or hypertension. Just 65 people were referred to the NHS Digital Weight Management programme across BLMK (Bedford Borough, Luton, Milton Keynes and Central Bedfordshire) between April and July 2022. Based on this an estimated 260 people will be referred over the course of 2022, which is just over 10% of the referral target for this service. Again, as an online service, in practice this service has unlimited capacity.

**The NHS Diabetes Prevention Programme** is available on referral for people at high risk of developing diabetes. The programme has capacity to support over 13,000 people across BLMK a year. Based on current activity, it's estimated that around 9,600 residents will be referred, leaving 3,700 places unused.

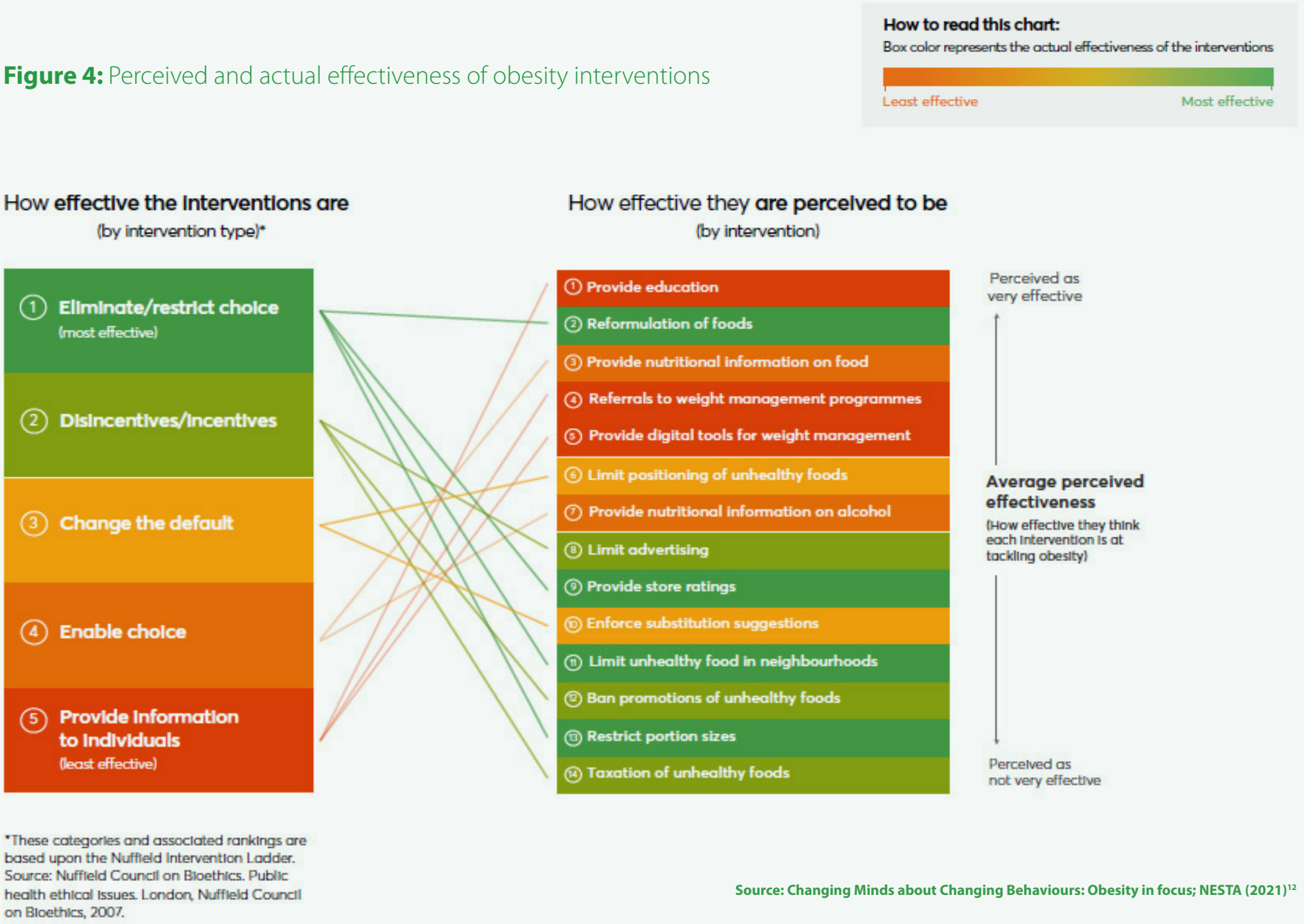
More people could be supported to lose weight through these services and making the most of the available support is an important challenge. More can be done to raise awareness of MoreLife so that residents can self-refer, but referral by clinicians to all three services is critical. It can be difficult to raise the subject of weight, but training can help frontline professionals feel confident to offer brief advice, including where to get support.

## Weight management services help individuals improve their health but will not solve the problem

While together these services could be supporting around 20,000 people from Milton Keynes, Central Bedfordshire, and Bedford Borough to lose weight every year, we know that over 150,000 Milton Keynes residents alone are living with excess weight. The scale of the obesity challenge means the impact of individual weight management services is limited. To have a greater impact at a population level, the most effective interventions are those which restrict less healthy food choices or provide incentives for healthy eating, such as through limits on portion sizes, reformulation of foods, restrictions on advertising or taxation. As well as promoting weight loss, these interventions are critical for preventing people – especially children – from gaining weight.

Research suggests there is a mismatch between what people think the most effective ways of addressing excess weight are, and what the evidence-base suggests is most effective (Figure 4). To have the biggest impact on excess weight, we need to shift the focus away from providing health education to individuals and focus instead on interventions that change people's default behaviours, incentivise healthier choices and even restrict or eliminate unhealthy choices.

**Figure 4:** Perceived and actual effectiveness of obesity interventions




*These categories and associated rankings are based upon the Nuffield Intervention Ladder. Source: Nuffield Council on Bioethics. Public health ethical issues. London, Nuffield Council on Bioethics, 2007.

Source: Changing Minds about Changing Behaviours: Obesity in focus; NESTA (2021)[12]

## Making progress locally:

### MoreLife Weight Management Service

- Free adult and child weight management services for eligible Milton Keynes residents to support weight loss either face to face or remotely.
- Support for women during pregnancy.
- Sessions run in a fun & friendly environment, covering a range of subjects including healthy eating, physical activity, and body image to help support sustainable, long term weight loss.

Over 900 Milton Keynes residents have been supported through the MoreLife programme since 2019; however, we need more people to take advantage of the support available.

This is particularly true for people who may be at higher risk of poorer health outcomes, for example, people with a learning disability or severe mental illness, those living in areas of higher deprivation and people from minority ethnic groups. It can be difficult to raise the issue in a way that doesn't stigmatise excess weight, but training is available to support staff to do this in a sensitive manner.



# Case Study

### MoreLife Weight Loss Programme

For years Clive's weight has impacted his mobility, quality of life, family life and his mental health and after speaking to his local GP he realised he needed to take action.

**"I've been offered encouragement and good advice, together with understanding. I have also managed to lose more weight than I expected to."**

**"I feel that I am confident, that I will move forward, and I will continue to make progress."**

Clive

# Chapter 3: We can create a healthier food environment

Many of the factors driving unhealthy weight gain are linked to the environment we live in. A variety of socio-economic factors – including income, housing, education, sale of unhealthy foods, and exposure to advertising – impact whether we can eat healthily and determine our risk of developing excess weight. Differences in the availability of affordable, healthy foods for example play a key role in driving health inequalities between people living in advantaged and disadvantaged circumstances.

## Our environment makes it difficult to make healthy choices

Food environments refer to the ways in which we are exposed to food on a daily basis. Healthy food and drink choices are often not affordable, convenient, or accessible to everyone (Figure 5). Fast and processed food companies influence food choices by monopolising advertising space, using their financial power to offer appealing food promotions, including buy one, get one free offers on high calorie and processed foods. Unhealthy options often dominate the checkouts, shops and workplaces and restaurants and takeaways overwhelm us with large portion sizes, far exceeding those recommended. The density of fast-food outlets has increased significantly, particularly in areas of high deprivation.

Advertising and sponsorship are used to place brands centre stage and help them shine brightly in the minds of young people, often using cartoon characters or famous people to make unhealthy food appear attractive and part of everyday life. The UK Government has set out plans to regulate some of these practices, like restricting unhealthy food advertising online and on TV. Whilst there is a need for national regulation, there are also opportunities to intervene locally and many areas are now developing policies to restrict unhealthy advertising in these spaces and on their public transport networks.

Nationally more than one quarter (27.1%) of adults and one fifth of children eat food from out-of-home food outlets at least once a week. These meals tend to be associated with higher energy intake, higher levels of fat, saturated fats, sugar, and salt, and lower levels of micronutrients[13]. Across Milton Keynes, just 57% of adults meet the recommended '5-a-day' on a 'usual day' which is similar to the national figure of 55%.

The City Council, NHS and other public sector organisations procure food services and lease premises that sell food. They could use their buying power more effectively to encourage the production and supply of healthy food options. There can be a disconnect between the verbal message given to people, for example in a diabetes clinic, and the visual message when they then walk into a hospital shop that offers a range of sugary drinks and treats. Several NHS Trusts have set clauses for the balance and types of food on sale in food shops on their premises.

## The cost of living and COVID-19 pandemic have impacted access to healthy food

The social and economic impacts of the pandemic and current financial crisis have been widespread. During the height of the COVID-19 pandemic many people faced challenges in accessing and maintaining a healthy diet and exercising. The pandemic influenced how people use their local environments and access food. More people are now working from home, and early evidence suggests that the pandemic has modified eating behaviours, with increased snack frequency and a preference for sweets and ultra-processed food rather than fruits, vegetables, and fresh food[14].

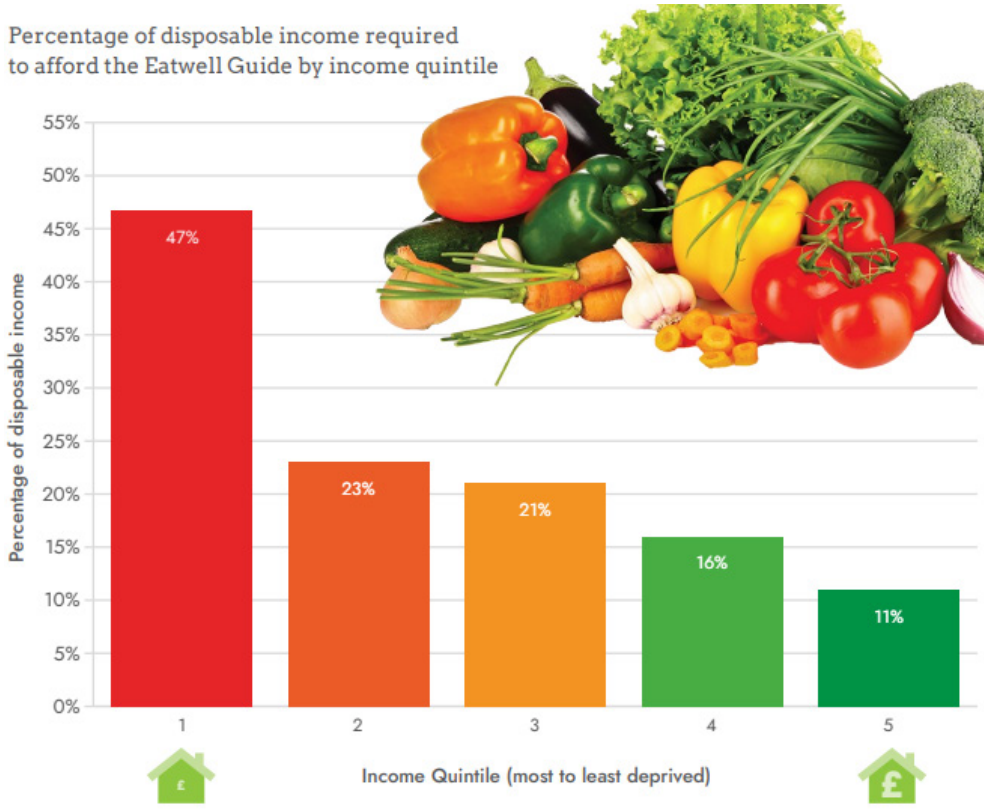
Affordability influences access to healthy foods and, for families on a lower income, a healthy diet may be unaffordable[15]. The poorest fifth of UK households would need to spend an estimated 47% of their disposable income on food to meet the cost of the Government's recommended healthy diet. This compares to just 11% for the richest fifth.[16] (Figure 5).

Those on lower incomes are more likely to be price-sensitive when shopping and therefore more influenced by their local food offer.

Along with the economic impact of the COVID-19 pandemic[17], the current cost of living crisis risks many being unable to afford essentials to maintain their health. This may cause increased stress and anxiety as families try to make ends meet. A recent ONS report highlighted that 15% of adults were worried their food would run out before they had money to buy more, and the proportion was higher among those with dependent children (25%), those who were Asian (or Asian British) (26%), "Other ethnic group" (46%) or living in the most deprived areas in England (29%)[18].

Local foodbanks are seeing a dramatic increase in demand. Milton Keynes foodbanks distributed 40% more emergency food parcels (or equivalent) this year than in 2021. Over 3,200 separate households have received crisis parcels and over 1,000 households received longer-term support via the 'Top-up Shop'. Of these households, well over half have never used a food bank before. On average, around 50 new clients contact a local foodbank every week.

**Figure 5:** Affordability of a healthy diet




Source: Food Foundation[19]

(31)

## Making progress locally:

### Supporting vulnerable families: Holiday Activity and Food (HAF) Programmes including Summer of Play

These programmes launched in 2021 and provide activities in the school holidays for children who qualify for free school meals. Children receive at least one hot meal a day that meets the requirements of the School Food Standards.

**Over 12 months, the programme has seen over 11,500 attendances across Milton Keynes.**

# Healthy Start Scheme: a healthy start to life

The Healthy Start Scheme is a national, means-tested scheme providing a pre-paid card to buy fruit and vegetables, vitamins and milk for low-income pregnant women, families with pre-school children and mothers under 18 years of age.

2,229 families in Milton Keynes were eligible to access the scheme[20] at the start of the pandemic. This figure increased by almost 18% the following year.

Current uptake of the scheme is 72%, which is similar to uptake nationally but could be higher. The Public Health team are working with partners to increase uptake.

# **Chapter 4:** We can build active places and neighbourhoods

Neighbourhoods are places where people live, work, and play and have a sense of belonging. Research shows that the environment in which we live is linked to our health throughout our lives. For example, the design of neighbourhoods can influence how much physical activity we undertake, how we travel and move, how we socialise and make local connections, and impacts on our mental and physical health and wellbeing.

Plan: MK, the Local Plan for Milton Keynes,[21] sets out the vision and framework for future development in Milton Keynes up to 2031. It addresses issues such as housing, the economy, infrastructure, the environment, adapting to climate change and securing good design. The plan also requires Health Impact Assessments to be submitted for certain new developments.

Milton Keynes is also developing a new Local Plan to set out the planning framework for the city until 2050. The City Council are working to embed health within this new plan, with a particular focus on how the plan can contribute to addressing physical inactivity, obesity, and inequalities. Plans for a Mass Rapid Transport scheme in Milton Keynes will also support people to live actively and help tackle excess weight.

Efforts to improve health outcomes through the planning process are also applied by taking account of access to services and facilities by walking and cycling, and by providing access to formal and informal community meeting spaces and sports facilities. The links between health, education, community and planning are highlighted in national planning policy which acknowledges the role that the planning system can play in improving health outcomes.

## Active travel increases regular activity

As a society we move less than we used to. Access to safe and attractive routes for walking and cycling is important in giving people the opportunity to be active regularly, which is necessary for good physical and mental health.

Milton Keynes has over 200 miles of shared-use paths, known as Redways, which facilitates access to safe routes for cycling. The City Council enables schemes to improve access to cycling including the Santander Cycles MK Hire Scheme. The scheme started in July 2016 and has over 500 bikes at 50 locations across the city for short-term use. Almost 130,00 journeys were made in the first three years of the scheme.

## Making progress locally:

### MK Deal

Tackling excess weight is an area of focus for the 'MK Deal' - an agreement between the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board (ICB) and the Milton Keynes Health and Care Partnerships (HCP) for local delegation of responsibility for certain health outcomes.

### Introducing innovative ways to be more active:

As part of the MK Deal, Milton Keynes City Council and Milton Keynes University Hospital are working in partnership to develop and deliver a research trial to promote and incentivise physical activity amongst residents with type 2 diabetes. The scheme will test how wearable devices can record participants' movement, and how a mobile app might be used to offer tailored prompts and hints to encourage residents to be physically active.

# MK Love Exploring

Space Walk

Love Exploring is a fun, free, multigenerational smartphone app that promotes walking and physical activity through its augmented reality games and guided trails. The app is family friendly, available in different locations across Milton Keynes and makes walking in Milton Keynes an adventure. It includes lots of child-friendly games to choose from including Dinosaurs, Mega Mini Beasts, and the Space Walk and encourages users to discover new places and interesting things. The app has guided trails around Milton Keynes such as mindfulness, to street art and tree identification.

## Green spaces bring physical and mental health benefits

Green spaces are valued for their physical and mental health benefits and for the part they play in creating successful, balanced, and sustainable communities. Milton Keynes has always planned early and strategically for green spaces. It was built as a New Town, a model of urban development that originated from the Garden City Movement from the early 1900s, which looked to combine the amenities of urban life with easy access to nature. Today, The Parks Trust manage 6,000 acres of green spaces in the city. As Milton Keynes grows, the trust takes on new parks and green spaces from developers, so that all new areas of the city benefit from the same quality of green space and Milton Keynes remains a great place to live, work and play.

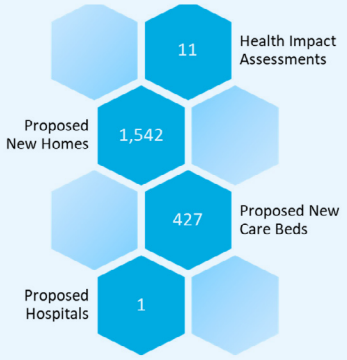
National surveys report that during the pandemic engagement with green space was important to people, but that access was not uniform across all communities. People living in areas of higher deprivation or from Black and minority ethnic groups generally have less access to adequate green space, including private gardens and public spaces. The green spaces they do access tend to be of lower quality, smaller size, and further from their homes compared to White British residents. This is referred to as "green deprivation" and the communities that experience it are more likely to have to travel longer distances for safe access to good quality green space[22].



# Making progress locally:

## Health Impact Assessments (HIAs) for new developments

Health Impact Assessments are a means to systematically consider the health and wellbeing impacts of proposed new developments. Since July 2021, all proposed care homes, hospitals, and residential developments of 50 or more homes in Milton Keynes require a HIA. This forces developers to systematically think about the health of residents. Eleven HIAs were reviewed in the first year, which together proposed over 1500 new homes and 427 care beds, with the potential to accommodate 5000 new and existing residents.




## Case Study

The City Council were consulted on the HIA for a planning application proposing the conversion and extension of an office block in Central Milton Keynes to provide 237 new flats.

The City Council identified insufficient children's play areas in the local area as a potential negative impact on children's physical and mental health and identified there was sufficient space in the development to provide an on-site play area. This resulted in the developer being required to provide for informal children's play in the courtyard as a condition of receiving planning permission for the development.

The play area will provide the children living in the flats access to outdoor play and mitigate the negative health impacts identified.

# **Chapter 5:** Taking local action together

Multiple factors contribute to excess weight and its consequences for the health and wellbeing of our residents. A growing body of evidence suggests that excess weight cannot be tackled by a single agency. Alongside national interventions by Government, it requires a collaborative approach across organisational boundaries, making it everybody's business. Together, partner organisations and businesses in Milton Keynes play important roles in shaping our environment and keeping our population healthy. There is more we can do to prevent people developing excess weight and to support more people to lose weight. The ambitions below set out actions that the City Council and partner organisations can take together to address the excess weight crisis and send a clear message to members, residents, and service providers that this is a priority.

**Figure 6:** Actions to tackle excess weight

# Ambitions for change

## Ambition 1

### Work together to create healthy, active places to learn, work and play

1. **Employers and service providers, including the City Council and the NHS, should make it easy to access healthy food, through the food services they procure and the businesses that sell food and drink on their premises.**

2. **Organisations, including the City Council, should explore opportunities to limit the marketing, placement, advertising, and sponsorship of unhealthy foods.**

3. **The City Council continues, through its planning and transport responsibilities, to make it easier and safer for residents to walk, cycle and use public transport where it is appropriate to do so, and support greater access to green spaces.**

4. **Employers should explore options to build movement into the working day and make active forms of travel easier, attractive, and more affordable.**

5. **System partners should ensure there is support for voluntary and community organisations to increase access to healthy food and physical activity, with a focus on families most affected by increases in the cost of living.**

(37)

# Ambition 2

## Work together to support more people to lose weight and keep it off

1. **The City Council and the NHS should work together to make it easy to access all publicly funded weight management services and explore innovative approaches to increase physical activity and promote healthy weight.**
2. **The NHS should work to increase the number of patients successfully referred to the full range of locally available weight management services.**
3. **Health and care services should work to increase the confidence of frontline professionals to raise the subject of excess weight and offer brief advice, including where to get support.**
4. **Employers, as part of their approach to workplace wellbeing, should promote the availability of local weight management services.**
5. **Throughout these actions extra effort should be made to improve access to weight management services for those at higher risk of excess weight, including people with learning disabilities, people with severe mental illness, those living in areas of higher deprivation and people from minority ethnic groups.**

# **Appendix A:** Local weight management services for adults

| Intervention | Area service is available | Brief Summary |
|---|---|---|
| **NHS Diabetes Prevention Programme** | BLMK | 9-12 months behavioural change programme to prevent diabetes in those at high risk. Group-based but one-to-one digital coaching also available. Click here for more information |
| **MoreLife (Tier 2 weight management service)** | Bedford Borough, Central Bedfordshire and Milton Keynes | Locally commissioned 12 week group behavioural and lifestyle interventions to reduce BMI. Programmes available for adults, pregnant women and families. Click here for more information |
| **NHS Digital Weight Management Programme** | BLMK | Nationally available 12-week digital behavioural and lifestyle intervention to reduce BMI. Click here for more information |
| **Specialist obesity services (also known as Tier 3 and 4 services)** | BLMK | Multidisciplinary services involving behavioural, medical and psychological services. Route to bariatric surgery if clinically indicated. Click here for more information |
| **NHS Low Calorie Diet Programme pilot Click here for more information** | BLMK | 12-month programme with 3 months of total diet replacement followed by further 9 months of behavioural support. |

# **Appendix B:** References


1. Public Health England. [online]. Guidance: Health matters: obesity and the food environment. 2017. Available from: Health matters: obesity and the food environment - GOV.UK (www.gov.uk)

2. Prospective Studies Collaboration. Body-mass index and cause-specific mortality in 900 000 adults: collaborative analyses of 57 prospective studies. Lancet. 2009; 373 (9669); 1083-1096. Available from: https://doi.org/10.1016/S0140-6736(09)60318-4

3. NHS Digital. Statistics on Obesity, Physical Activity and Diet 2021: Data tables. 2021. Available from: https://digital.nhs.uk/data-and-information/ publications/statistical/statistics-on-obesity-physical-activity-and-diet/england-2021/data-tables

4. NHS Digital. Ministry of Housing, Communities and Local Government. 2021

5. NESTA. The economics of obesity. [online]. Dec 2022. Available from: https://www.nesta.org.uk/blog/the-economics-of-obesity/

6. Public Health England, 2015. Making the case for tackling obesity – why invest? [online]. 2015. Available from: Factsheet (khub.net)

7. House of Commons Library. Obesity statistics. [online]. 2022. Available from: https://researchbriefings.files.parliament.uk/documents/SN03336/SN03336.pdf

8. Department of Health & Social Care, HM Government. 2018. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/718903/childhood-obesity-a-plan-for-action-chapter-2.pdf

9. The Food Foundation. The Broken Plate [online]. 2022. Available from: Home (foodfoundation.org.uk)

10. Office for Health Improvement & Disparities. Adult obesity: Applying All Our Health. 2022. Available from: https://www.gov.uk/government/publications/ adult-obesity-applying-all-our-health/adult-obesity-applying-all-our-health

11. NHS Digital. National Child Measurement Programme 2021/2022 School Year.

12. NESTA. Changing Minds about Changing Behaviours: Obesity in focus [online]. 2021. Available from: Changing Minds about Changing Behaviours: Obesity in focus | Nesta

13. Public Health England. Research & Analysis: Fast food outlets: density by local authority in England. 2018. Available from: https://www.gov.uk/government/publications/fast-food-outlets-density-by-local-authority-in-england

14. Public Health England. Guidance: Health matters: obesity and the food environment. 2017. Available from: https://www.gov.uk/government/publications/health-matters-obesity-and-the-food-environment/health-matters-obesity-and-the-food-environment--2

15. Gonzale-Monroy, C. et al. Eating Behaviour Changes during the COVID-19 Pandemic: A Systematic Review of Longitudinal Studies. Int J Environ Res Public Health. 2021.18(21):11130

16. The Food Foundation. The Broken Plate. [online]. 2019. Available from: https://foodfoundation.org.uk/publication/broken-plate-2019

17. Williamson, S et al. Deprivation and healthy food access, cost and availability: a cross-sectional study. Journal of Human Nutrition and Dietetics. 2017. 30 (6);791-799. Available from: https://doi.org/10.1111/jhn.12489

18. Office for National Statistics. The impact of winter pressures on different population groups in Great Britain: 22 November to 18 December 2022. 2022. Available from: The impact of winter pressures on different population groups in Great Britain - Office for National Statistics (ons.gov.uk)

19. Joseph Rowntree Foundation. Going under & without: JRF's cost of living tracker, winter 2022/23 [online]. 2022. Available from: Going under and without: JRF's cost of living tracker, winter 2022/23 | JRF

20. The Food Foundation. The Broken Plate [online]. 2022. Available from: Home (foodfoundation.org.uk)

21. Milton Keynes Council. Plan: MK: 2016 to 2031. 2019. Available from: Plan:MK | Milton Keynes City Council (milton-keynes.gov.uk)

22. New Economics Foundation. Escaping green deprivation. [online] 2021. Available from: https://neweconomics.org/2021/01/escaping-green-deprivation

## Finding out more

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Milton Keynes City
MK9 3EJ

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Item 5

Bedfordshire, Luton and Milton Keynes Integrated Care Board

| Report to the Milton Keynes Health and Care Partnership – 22 February 2023 |
|---|
| **Bedfordshire, Luton and Milton Keynes Health and Care Partnership and Integrated Care Board update** |

| **Vision:** "For everyone in our towns, villages and communities to live a longer, healthier life" | |
|---|---|
| Please state which strategic priority and / or enabler this report relates to | |
| **Strategic priorities** | |
| ☒ | **Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood. |
| ☒ | **Live Well:** People are supported to engage with and manage their health and wellbeing. |
| ☒ | **Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible. |
| ☒ | **Growth:** We work together to help build the economy and support sustainable growth. |
| ☒ | **Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population. |

| **Enablers** | | | |
|---|---|---|---|
| Data and Digital ☐ | Workforce ☐ | Ways of working ☐ | Estates ☐ |
| Communications ☐ | Finance ☐ | Operational and Clinical Excellence ☐ | Governance and Compliance ☒ |
| Other ☐(please advise): | | | |

| | |
|---|---|
| **Report Author** | Maria Wogan, Chief of System Assurance and Corporate Services and MK Link Director, Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB) |
| **Date to which the information this report is based on was accurate** | 6 February 2023 |
| **Senior Responsible Owner** | Felicity Cox, BLMK ICB CEO |

| **The following individuals were consulted and involved in the development of this report:** |
|---|

- BLMK Health and Care Partnership – 14 December 2022
- BLMK Integrated Care Board – 25 November 2022 and 27 January 2023

**This report has been presented to the following board/committee/group:**

This report summarises key items of business from the BLMK Integrated Care Board and BLMK Health and Care Partnership (a Joint Committee between the local authorities and the ICB) that are relevant to the MK Health and Care Partnership. The agenda and papers for these meetings are available by clicking the following links – here, here and here.

**Purpose of this report - what are members being asked to do?**

The MK Health and Care Partnership is part BLMK Integrated Care System (ICS) governance. It performs the functions of the MK Health and Wellbeing Board and the MK Place Based Partnership (as defined in the Health and Care Act 2022).

This report connects MK and BLMK governance by updating on work at BLMK level and highlighting specific issues that are likely to be of interest to or require decisions from the MK Health and Care Partnership.

This report also invites the MK Health and Care Partnership to request support from the ICB. Feedback from the MK Health and Care Partnership's meeting will be provided to the BLMK Health and Care Partnership and ICB Board.

**Recommendations:**

The MK Health and Care Partnership is asked to:

1. **Note** that the BLMK Health and Care Strategy has been agreed and published and that Milton Keynes City Council has a statutory duty to have regard to the integrated care strategy when exercising any of its functions, in relation to the Council's area (s116B Health and Care Act 2022)
2. **Note** that the Chair of the MK Health and Care Partnership will be reporting on the MK Health and Care Partnership's priorities as described in the MK Deal at the next meeting of the BLMK Health and Care Partnership on 7 March, and that these priorities will be included in the Operational Plan 23/24 and Five Year Joint Forward Plan for BLMK
3. **Note** the MoU agreed between the ICB and the VCSE to establish a strategic partnership.
4. **Note** the health impact analysis of the BLMK Green Plan.
5. **Note** the updates provided on the following matters and **agree any actions** that should be taken in relation to MK:
    a. Key items of business considered by the BLMK Health and Care Partnership and Integrated Care Board meetings between November 2022 and January 2023 as listed at Appendix A
    b. The digitisation of social care programme
    c. The planned procurement for Musculoskeletal (MSK) services for BLMK residents

d. Guidance on the role of Health and Wellbeing Boards published on 22 November 2022 that will be discussed at the next Health and Care Partnership meeting on 7 March 2022
e. The arrangements for the MK Health and Care Partnership commenting on the ICB's first annual report

6. **Nominate** a representative to join the ICB's Primary Care Assurance and Commissioning Committee**, or agree a process for doing this**
7. **Identify** any areas where support from the ICB is required to deliver the MK Health and Care Partnership's priorities for its population.

## 1. Brief background / introduction:

The report sets out three strategic areas of work for consideration by the MK Health and Care Partnership:

a. BLMK Health and Care Strategy and next steps in planning;
b. Developing a Strategic Partnership with the VCSE;
c. Health Impacts of the Green Plan;

and also provides updates on:

d. Areas of BLMK-wide work which are relevant to MK Health and Care Partnership's priorities
e. Governance matters relevant to the role of the Partnership

**A. BLMK Health and Care Strategy (found here) & Next Steps in Planning**

The BLMK Health and Care Strategy was agreed by the BLMK Health and Care Partnership in December 2022. It highlighted the difference in life expectancy and healthy outcomes in deprived areas compared to more affluent areas and how health and wellbeing can be affected by more than one inequality. The Partnership was particularly concerned about how the cost-of-living crisis would widen health inequalities and have a significant impact on the health of local people.

The strategy:

- reflects the 5 strategic priorities (Start Well, Live Well, Age Well, Growth and Tackling Inequalities)
- is committed to subsidiarity (to Place), with a focus on planning, decision-making and delivery as close to the resident as possible
- emphasises the need to further use our partnerships to support residents to live longer, healthier lives, and the central role of VCSE in achieving this; and,
- speaks to real examples that make a difference to local people

The Health and Care Act 2022 requires each of the 42 Health and Care Partnerships to produce a strategy and for the ICB and local authorities who are members of the Partnership to have 'regard to' the strategy in discharging their functions.

***BLMK (NHS) Operational Plan 2023-2024 and BLMK Five Year Joint Forward Plan 2023-2028***

The Health and Care Act requires the BLMK ICB to produce an Operational Plan (due end March 23) and a Five Year Joint Forward Plan (due end June 23).

The Operational Plan is for 2023/24 and requires ICBs to describe how the local NHS will deliver against mandated NHSE operating plan requirements, including agreement of the BLMK NHS system budget. This plan takes account of local priorities including those set out in the MK Deal and will be reported to the Board of the ICB on 24 March 2023.

ICBs and their partner trusts must involve relevant Health and Wellbeing Boards in pre-paring or revising the Joint Forward Plans (JFP). This includes sharing a draft with each relevant Health and Wellbeing Board (HWB) consulting as to whether the JFP takes proper account of each relevant local health and wellbeing strategy.

As JFPs will build on existing Joint Strategic Needs Assessments, Health and Wellbeing Strategies and NHS delivery plans, we do not currently anticipate their development will require full formal public consultation.

The Chair of the MK Health and Care Partnership, Cllr Peter Marland, has been invited to present MK's priorities to the BLMK Health and Care Partnership meeting on 7 March and this will contribute to the development of the JFP for BLMK. MK's priorities are as set out in the MK Deal. BLMK ICB will co-ordinate public engagement on the JFP prior to its anticipated sign off by the Board of the ICB on 30th June 2023.

**Recommendation to:**

**Note** that the BLMK Health and Care Strategy has been agreed and published and that Milton Keynes City Council has a statutory duty to have regard to the integrated care strategy when exercising any of its functions, in relation to the Council's area (s116B Health and Care Act 2022)

**Note** that the Chair of the MK Health and Care Partnership will be reporting on the MK Health and Care Partnership's priorities as described in the MK Deal at the next meeting of the BLMK Health and Care Partnership on 7 March, these priorities will be included in the Operational Plan 23/24 and Five Year Joint Forward Plan for BLMK

**B. Establishing a Strategic Partnership between the ICB and the VCSE (Memorandum of Understanding (MoU))**

A MoU between the ICB and the VCSE sector was approved at the ICB Board in November. To support the development of the strategic partnership with the VCSE, the ICB has invested in two part-time, fixed-term partnership roles hosted by MK Community Action who are working across BLMK. Next steps in this work include mapping of the investment in the VCSE / VCSE assets across BLMK, and joint work to improve ICB operational processes to enable greater VCSE involvement eg. procurement.

Milton Keynes Health and Care Partners are requested to support the mapping of local assets and the mapping of the amount spent with MK VCSE organisations.

The VCSE Strategy Group was involved in the development of the MoU and the Integrated Care Strategy and has informed how to engage the VCSE "at place". In Milton Keynes, the two VCSE members of the MK Health and Care Partnership, Clare Walton and Peta Wilkinson, are members of the BLMK VCSE Strategy Group.

In MK, VCSE organisations are forming part of the teams delivering the MK Deal priorities and this work will extend as additional priorities 'go live'. For example, Peta Wilkinson is a member of the Improving System Flow Steering Group as a representative of the VCSE Alliance and a wider stakeholder group has been established which includes Willen Hospice and Age Concern.

**Recommendation to note** the MoU agreed between the ICB and the VCSE to establish a strategic partnership.

**C. ICS Green Plan Health Impact Assessment**

The ICS developed a Green Plan in 2022, setting out high level commitments to be a net zero system by 2035, 5 years ahead of the national NHS ambitions for emissions it directly controls (2040) and in line with national ambitions for emissions it has influence over (2045).

The Health Impact Assessment analyses the impact of the ambitions in terms of carbon reduction and the full report is available here

The Board of the ICB agreed that the Green Plan should be more detailed, specific and ambitious, and further work will be done to improve the data and evidence available. The key areas identified as having a good evidence base for initial work are air pollution, extreme weather, active travel and nutrition. The ICB is seeking to work closely with local authority partners and other anchor institutions on these areas.

The MK deal obesity priority provides a good opportunity to address the green plan agenda. All four places in BLMK have identified obesity as a priority area so there is also the opportunity for system-wide initiatives and sharing learning.

**Recommendation to note** the findings of the health impact analysis of the BLMK Green Plan.

**D. BLMK ICS Update**

A summary of the main items of business considered at recent BLMK Health and Care Partnership and BLMK ICB meetings is attached as Appendix A.

The following programme updates are provided for information.

**Digitisation of Adult Social Care**

The Digitising Adult Social Care programme across Bedfordshire, Luton and Milton Keynes is providing a host of benefits to local residents and care homes.

**Acoustic Monitoring** alerts care home staff to investigate when the Wi-Fi connected device detects 'unusual' sounds and movements. The device can recognise sounds such as waking, crying out, calling for help, or being restless. National estimates tell us that this is likely to result in care home staff having 40% more time, falls will reduce by 55%, and there will be 20% fewer hospital admissions.

**Acoustic monitoring implementation in Milton Keynes is as follows:**

| Care Home Name with Acoustic Monitoring | Beds | Live |
|---|---|---|
| Veryan Place | 3 | |
| Tolcarne Avenue | 3 | |
| Burlington Hall | 53 | |
| Westbury Grange | 45 | On target for installation in Feb |

The **Whzan Blue Box** contains everything needed to enable staff to make regular health checks on their residents. Being able to see early signs of changes means they can alert clinical colleagues before a resident becomes so unwell they need hospital care. Measurements such as heart rate, blood oxygen levels, temperature and blood pressure can be taken with the kit.

Whzan Blue Box has been installed in 17 care facilities in Milton Keynes.

The manager of Burlington Hall, Milton Keynes said, "*Since being implemented in Burlington Hall Care Home, the Whzan Blue Box has been fundamental in helping us to monitor our residents' vital signs efficiently and with precision. The Whzan Box is used twice a week by our seniors on both Maple and Larch units to regularly monitor all the residents' vital signs quickly and easily."*

Another product that is improving care for local residents is the **Raizer Chair.** If someone falls but does not injure themselves, the **Raizer II** emergency chair can be assembled around them by a single member of staff to lift them quickly and safely – avoiding the need for an ambulance. In the three months since 77 chairs were introduced across 27 MK care homes (42 care homes are the target, 11 care homes have declined a Raizer Chair), there has been a reduction in ambulance call-outs of 24% and reduced hospital admissions of 65%, as well as staff time being saved so that they can spend more time caring for other residents. In addition, care home managers tell us that their residents feel safer and less anxious when they are using the Raizer Chair instead of the traditional hoist.

More information can be found here

**Musculoskeletal (MSK) Health Services – Forthcoming Procurement**

Due to expiry of the contracts with four MSK providers across BLMK (Connect Health and Ravenscroft in MK) on 31st March 2024, the ICB has been working with patients, providers and wider stakeholders to determine how services should transform to 1) improve the quality of life for people with MSK 2) improve productivity, removing fragmentation and duplication and 3) focus on prevention of MSK illness which is particularly impacted

by rates of Obesity, levels of physical activity and smoking and 4) release GP capacity by providing direct access to physiotherapy appointments.

An Integrated MSK and Pain Service Specification has been drafted based on best practice and is in the process of being finalised. Following ICB governance approval between February – March 2023, the intent is to commence a full procurement exercise between April – September 2023, followed by mobilisation of the new provider/s during October 2023 – March 2024 with official service commencement on April 2024. It is expected that any staff impacted by a change of provider would transfer to the new provider. Members of the public will also be invited to be part of the new provider/s mobilisation to ensure local needs are captured and implemented.

**Recommendation to note** the updates provided and **agree** any actions that should be taken in relation to MK.

## E. Governance Matters

The Health and Care Partnership is requested to consider the following governance matters:

### Request for Representation from the Milton Keynes Health and Care Partnership on the ICB's Primary Care Commissioning and Assurance Committee.

The ICB has responsibility commissioning primary medical services and to discharge that responsibility, the Board of the ICB has established a Primary Care Commissioning and Assurance Committee.

The Committee is chaired by a non-executive board member and the membership consists of ICB executives and representatives from primary care. The terms of reference also allow for non-voting attendees, including representatives from each of the health and wellbeing boards (HWBs) in the system.

We are inviting the Milton Keynes Health and Care Partnership to nominate an appropriate person to attend. There are approximately four meetings per year, currently via Microsoft Teams, and the responsibilities of the Committee range from approving practice mergers and commissioning newly designed enhanced services to making decisions relating to primary care estates and digital issues. From April 2023, the ICB and Committee will also take on responsibility for commissioning community pharmacy, optometry and dental services in BLMK.

**Recommendation to nominate** a representative to join the ICB's Primary Care Assurance and Commissioning Committee**, or agree a process for doing this.**

### Health and Wellbeing Board Guidance

In November 2022 the Department of Health and Social Care issued non-statutory guidance on the roles and duties of Health and Wellbeing Boards and clarifies their purpose within the new integrated care system architecture. A link to the guidance is given below:

Health and wellbeing boards – guidance - GOV.UK (www.gov.uk)

The BLMK Health and Care Partnership will be reviewing this guidance at its next meeting on 7 March 2023.

**ICB Annual Report**

ICBs are statutorily required to produce an Annual Report at the end of each year. (In this case the reporting period is July 2022 to end March 2023). As part of the production of that report an ICB must reflect on its contribution to the delivery of relevant local Health and Wellbeing Strategies. In doing so, the ICB must engage with each local Health and Wellbeing Board to seek feedback. The Health and Care Partnership is asked to note that the ICB will soon be writing to the Chair of the Partnership for comment. The Annual Report will be published later in 2023.

**Recommendation to note the:**

a. guidance on the role of Health and Wellbeing Boards; and,
b. arrangements for the MK Health and Care Partnership commenting on the ICB's first annual report.

## 2 Appendices

Appendix A – Summary of BLMK Health and Care Partnership and ICB Board business

**Appendix A – Summary of BLMK Health and Care Partnership and BLMK Integrated Care Board Business November 2022 - January 2023**

1. **Health and Care Partnership – 14 December** 2022 – Agenda items:

- **Health and Care Strategy** – JSNA noted and strategy agreed
- **Fuller Neighbourhoods** – briefing provided on the findings of a review undertaken by Dr Claire Fuller of integrated primary care, looking at what is working well, why it's working well and how we can accelerate the implementation of integrated primary care across systems.

Next Meeting - 7 March 2023, 5-8pm in Milton Keynes, venue TBC – Agenda items:

- Health and Care Strategy and Five year Joint Forward Plan
- Place delivery plans and Health and Wellbeing Board updates
- Delegation of Dentistry, Optometry & Community Pharmacy to the ICB Mental Health, Learning Disability and Autism collaborative
- Community engagement

2. **Board of the BLMK ICB – 25 November 2022 and 27 January 2023 – Agenda Items:**

- **Working with People & Communities Strategy -** approved
- **Memorandum of Understanding (MOU) with the Voluntary, Community & Social Enterprise (VCSE) Sector -** approved
- **Developing a BLMK Mental Health, Learning Disability & Autism Collaborative -** A proposal to develop a BLMK Mental Health, Learning Disability and Autism Provider Collaborative was supported. The vision, which we will seek to further develop with input from service users, patients and system partners, puts patient and service user voice and a focus on place at its heart, refocusing our efforts on addressing inequalities and unwarranted variation, and working at scale where it makes sense to do so.
- **Resident's story** – about the challenges and barriers faced by a transgender resident accessing health services. The story emphasised the importance of raising awareness and sensitivity training which is being supported by the ICB.
- **Luton Airport – Development Consent Order** – supported the proposed development of Luton Airport on the basis on the mitigating actions being taken and the economic benefits of the scheme and the positive impact this would have on BLMK residents.
- **People Strategy** - agreed
- **Inequalities** - update on delivery of the inequalities including how £3.5M had been invested in BLMK.
- **Green Plan Health Impact Assessment** – as described in the main report
- **Delegation of Pharmacy, Optometry, Dental (POD) Commissioning and Specialised Commissioning to the ICB** – progress report with the risks and opportunities associated with the transfer of commissioning responsibility to the ICB. POD is expected to be delegated from April 2023 and Specialised Commissioning from April 2024. A decision on the delegation of POD will be taken at the next Board meeting.
- An update on the **Community Diagnostics Centres** was given. Positive progress for the MK and Bedford sites with more work to do on the proposal for Luton.

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Item 6

# MK Deal Update

## The first three months

Author: Michael Bracey, Chair of the Joint Leadership Team (JLT)

Rebecca Green, Head of Milton Keynes Action Improvement Team

**Executive Summary**
To provide an update on progress within the first three months of the MK Deal and to seek support from the Partnership to move to the 'go live' stage for the children and young people's mental health priority from 1 April 2023.

**Recommendations:**

1. That the progress updates for the two MK Deal priorities that commenced on 1 December 2022 (Priority 1 Improving System Flow and Priority 2 Tackling Obesity) are noted.
2. That the proposal for the third priority, Children & Young People's Mental Health, is considered and a decision made on whether to 'go live' on 1 April 2023.
3. That the fourth priority, Complex Care, remains in the development phase with a proposal to be brought to the Partnership at its next meeting.
4. To note that further potential MK Deal priorities will be brought to the Partnership for consideration as they are developed by the Joint Leadership Team.

**The MK Deal**
The MK Deal is an agreement between the Milton Keynes Health and Care Partnership and the Bedfordshire, Luton and Milton Keynes Integrated Care Board which formalises the commitment of the main local NHS partners in MK and the City Council to work more closely together.

The objective of the 'deal' is to drive improvements in population health and improvements in the quality and efficiency of the health and care services provided to local people through the development of stronger local partnerships. The MK Deal aims to provide the foundation for both the local delivery of the strategic objectives of the BLMK integrated population health strategy and the opportunity for BLMK Integrated Care System to become a national leader in the establishment of inclusive and impactful place-based working.

The content of the MK 'deal' will iterate over time as the partnership matures, but initially focuses on the four priorities agreed by MKHCP at its meeting on 1 June 2022.

Following the last Health and Care Partnership meeting on 12 October 2022 where the MK Deal was agreed a letter was sent by the Leader of the Council to the Chair of the ICB confirming this. In her response the Chair of the ICB, Dr Rima Makarem expressed her gratitude to all of the partners in Milton Keynes "for engaging so constructively with our new ways of working as part of the BLMK Integrated Care System and in particular for the positive way in which you have progressed this work for the benefit of the residents of your City." The full letter is attached as Appendix 1.

On 1 December the MK Deal went live with its first two priorities of Tackling Obesity and Improving System Flow (hospital discharge). In addition, the further two priorities of Complex Care and Children & Young People's Mental Health moved into the pre-start phase to further develop a detailed proposal and start date.

## Priority 1 - Improving System Flow

The focus of Improving System Flow is 'urgent and emergency care services for older and/or frail and/or complex service users'.

Lead by the Medical Director of Milton Keynes University Hospital, Dr Ian Reckless, the ISF Steering Group was established in December and meets on a three weekly basis to provide strategic oversight. The Steering Group is multi-organisational with senior clinical and managerial members from across health and social care providing their time. All parties recognise that large scale transformation of Urgent and Emergency Care services, if it is to be successful and sustained, must take place at a local level with providers working together to reshape demand, and the delivery of care.

The Steering Group has started its development of a long term improvement plan to deliver integrated services between MKUH, CNWL and Milton Keynes City Council and our primary care partners focusing on:

1. Simplification of existing pathways for care
2. Greater workforce integration to drive efficiencies to address significant workforce shortages
3. Renewed focus on getting people home - Planning and delivery of the 'virtual ward' model in MK
4. Agreement of shared risk management and other clinical policies
5. Harnessing the full potential in primary care
6. Investment in facilities and equipment

A core project team made up of staff seconded from MKCC, MKUH, CNWL and the ICB is in place the ensure there is sufficient dedicated staff capacity to deliver the aims of Improving System Flow priority at pace. For all of the ISF themes this team is leading the assessment, planning, securing services and review process.

Supporting the ISF Steering Group with the ongoing operational management of urgent and emergency care services is an operational focus group which has a particularly key role during the busy winter period.

Challenges in urgent and emergency care were marked across England during December and January. National media covered extreme delays in ambulance handover, emergency department overcrowding and long waits for a bed following a decision to admit. In Milton Keynes, we have seen increased activity over the height of winter: December was impacted by a sharp peak in influenza cases leading to hospital admission and in some cases, death. January saw surges in admissions following the cold weather. However, we did manage to avoid extreme ambulance delays through focus on handover (we were celebrated as one of two 'how to do it' case studies by the Association of Ambulance Chief Executives) and at the height of our pressures, the number of patients who did not meet criteria to reside (i.e., could theoretically have had their needs met elsewhere) was stable and at times lower than the trend line. In other words, the hospital was under pressure with many additional patients but most of them did need to be there.

This relatively positive position, compared to the national picture, is due to a number of factors including good collaborative working between partners in MK, and our good fortune in having the physical facility of the Maple Centre open in time for winter.

Going forward, patient numbers remain high, and this reduces our ability to undertake planned procedures (surgical care). The lack of capacity (beds) in MK care homes is now very evident and is a concern going forward.

**Recommendation** – That progress is noted.

## Priority 2 - Tackling Obesity

The second of the initial four agreed MK Deal priorities. Tackling Obesity is focused on helping people lose weight and maintain a healthy weight through easily accessible weight management programmes, use of technology, pharmacological therapies and education/prevention work.

Within the MK Deal this priority is jointly lead on behalf of the Joint Leadership Team by the Primary Care Networks - GP leads Dr Salman Razi and Dr Tayo Kufeji – and the Director of Public Health Vicky Head.

The Tackling Obesity Steering Group has been established and its first meeting brought together a range of experts who were able to share, synthesise insights and discuss opportunities to supports residents to lose weight. Clinical leaders across the MK System in attendance including Dr James Bursell (Consultant Paediatrician), Dr Ian Reckless (Medical Director), Dr Fatima Alkali (GP), Beverly Shaw (Children Services Manager), Lea Fowler (Advanced Clinical Practitioner), Wendy Bryant (Healthy Lifestyle Midwife), Oliver Mytton and Laura Waller (Public Health Consultants) with support from the MK Action Improvement Team (Rebecca Green and Sandra Vanreyk).

The Steering Group discussion was productive with contributions from all system partners on the growing prevalence of overweight in both children and adults and short, medium, and long-term opportunities/proposals that could reduce and prevent more people from reaching an unhealthy weight.

Three themes to be taken forward by working groups on behalf of the steering group were agreed;

Theme 1: Increasing referrals into weight management services

Theme 2: Innovation & upscaling

Theme 3: Shaping the environment

Early successes have included the establishment of a research trial to promote and incentivise physical activity amongst residents with Type 2 diabetes, which affects more than 17,000 people across Milton Keynes. The scheme will test out how wearable devices can record participant movement, and how potentially, a mobile app could offer tailored prompts and hints to be physically active. Further incentives are being considered such as vouchers for meeting physical activity goals.

Type 2 diabetes can cause significant health problems and has a huge resource impact on the NHS and social care system. Regular physical activity is proven to be an important part of managing diabetes to help reduce complications and treatment costs. The Milton Keynes trial will help health and council partners around the UK determine whether adopting their own version of the scheme will help patients and reduce long term costs.

**Recommendation** – That progress is noted.

## Priority 3 - Children & Young People's Mental Health

**Background and progress to date:**

Good mental health in children and young people helps build resilience, develop healthy relationships and lays the foundation for better mental and physical health

and wellbeing throughout their whole lives. Early intervention is key for lifelong wellbeing: 75% of adult mental health issues are present by the age of 24.

We are aware that there is significant pressure on resources in this area and, as stated in the MK Deal paper agreed by the Partnership in October 2022, the ICB will remain responsible for the overall performance of the system. We are however committing to work together to ensure more effective use of resources.

A Steering Group reporting into JLT has been established to lead the CYPMH priority and has now met twice. The group includes members from CNWL, MKCC Children's Services and Public Health. Interviews have been carried out with a wider range of system partners.

This is a large area of need, and, through our preparatory work, we have developed four themes: closer working, getting help and advice, neurodevelopmental pathways and crisis response.

**1. Closer working between system partners**

This includes sharing data, prioritisation and exploring co-location of teams. By ensuring our teams understand each other's pathways we can also improve communication with children and their families. As we progress this work it will also help us to develop a more coherent system offer. We will also need to improve our collective understanding of thresholds for services and the advice and other support available for those who do not meet thresholds for services.

**2. Getting advice and getting help**

This involves building a more consistent, clear, and understandable MK-wide offer, with appropriate interventions for advice and early help that are accessible for groups at higher risk of poor mental health. We will improve our understanding of what provision is needed, and review how we can best meet this need with our collective resources.

We will develop the local 'getting help' offer in MK, to provide appropriate community-based support, including more face-to-face options. This will be supported by £125k of additional funding from the ICB. We will consider ways to maximise the reach of Mental Health Support Teams in schools across MK.

**3. Joining up training on Neurodevelopmental Pathways**

The ICB are leading a BLMK wide review of multi-agency neurodevelopmental pathways. In MK as a first step we will to join up multi-professional training for Autism Spectrum Conditions (ASC) and will work together to reduce the number of children waiting for an ASC diagnosis as well as reducing the number of referrals for assessment in the longer-term.

**4. A smoother crisis offer**

This includes setting up a time limited task and finish group across partners to improve our joint crisis response to children and young people. Making full use of the new mental health inpatient unit 'Evergreen' for children and young people. This centre will provide specialist, short-term care for children and young people with severe or complex mental health difficulties across BLMK ICS.

**Proposal**

It is proposed that the MKHCP takes on the following responsibilities in relation to children and young people's mental health take forward the themes identified above:

- Leading Health & Care Partnership-based work plans to improve outcomes for children and young people's mental health.
- Interfacing with the ICB Mental Health Transformation Programme to ensure join up for key deliverables and recovery plans.
- Ensuring that plans will address inequalities across MK.
- Providing assurance as required to NHSE
- Providing information and training across system partners
- identifying and deciding the services necessary to meet the needs of the population including design of new pathways, services, working with finance, contracting, primary care and quality colleagues to ensure this is done to provide high quality care at best value.

**Additional Considerations:**

The majority of children and young people will not require specialist secondary services. We will be measuring timely access for those who need it.

**Next steps**

By the end of April 2023 we will;

- Establish governance structures for each of the four CYP MH priority areas including leads and working groups for each
- Agree key deliverables and metrics for measuring progress
- Further define implementation methodologies and action plans for each priority area that will enable us to determine whether we are on track.

**Recommendation -** That the proposal for the third priority, Children & Young People's Mental Health, is considered and a decision made on whether to 'go live' on 1st April 2023.

## Priority 4 - Complex Care

The fourth priority Complex Care is focused on the improving the planning, assessment, commissioning, and case management for people who have the most complex needs. This priority is led by the Director of Adult Services Victoria Collins

Local discussions have taken place and we have agreed that our initial focus will be people with a learning disability and /or autism and/or physical complexities between the ages of fourteen and twenty-five years. The benefit of this focus is that we know that the management of learning disabilities is an existing priority for the ICB, and we also have evidence that a pro-active model of assessment, planning and case management for people between 14 and 25 years is likely to reap benefits in terms of reducing emergency placements that are often outside of Milton Keynes at a high cost.

A workshop bringing system partners together to develop this proposal in more detail to identify areas where outcomes and effectiveness can be improved for children and young people and get best use of system resources is being organised for April.

**Recommendation :** That the fourth priority, Complex Care, remains in the development phase with a proposal to be brought to the Partnership at its next meeting.

## Appendix 1; Letter from Dr Rima Makarem to Cllr Pete Marland

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

24th November 2022

3rd Floor
Arndale House
The Mall
Luton
LU1 2LJ

Email: rima.makarem@nhs.net

Councillor Pete Marland
Milton Keynes Council
1 Saxon Gate
Central Milton Keynes
MK9 3EJ

Sent Via Email: peter.marland@milton-keynes.gov.uk

Dear Pete

Thank you for your letter of 9 November, confirming the MK Health and Care Partnership's agreement to the MK Deal on 12 October 2022.

Thank you also for confirming the details of the two priority areas on avoiding unnecessary hospital stays/system flow and tackling obesity which both 'go live' on 1st December 2022. I note that the other two priority workstreams, children and young people's mental health and managing complex needs, are in the 'pre-start' development phase and will be discussed at the MK Health and Care Partnership meeting on 23 February 2023.

I would like to express my gratitude to you, Michael and all of the partners in MK for engaging so constructively with our new ways of working as part of the BLMK Integrated Care System and in particular for the positive way in which you have progressed this work for the benefit of the residents of your City. Your strong, collaborative and resident-focused leadership of this agenda has established a really positive sense of momentum for joining-up health and care services. I look forward to hearing about the positive impact of the 'MK Deal' at our future Board and Health and Care Partnership meetings.

Felicity, Maria and the team will continue to work with Michael and the other MK partners to agree a longer-term resource plan that will further support the achievement of your ambition for Milton Keynes and your residents.

I am greatly encouraged by your progress in Milton Keynes and am committed to supporting this work as our partnership strengthens.

Your sincerely

**Dr Rima Makarem**
**Chair, Bedfordshire, Luton and Milton Keynes Integrated Care Board**

Cc: Felicity Cox; Michael Bracey, Maria Wogan

*End of report*

Item 7

# Locality/Neighbourhood working in Milton Keynes

Author: Michael Bracey, Chair of the Joint Leadership Team (JLT)

**Executive summary**

To provide the Health and Care Partnership with an overview of the policy drivers for locality/neighbourhood working and to highlight some of the opportunities this offers us in Milton Keynes.

**Recommendations:**

1. To consider the issues set out in the paper
2. To agree to pilot locality/neighbourhood working in one or two areas of Milton Keynes
3. To ask the Joint Leadership Team to develop a more detailed proposal for the pilot, potentially as a fifth priority for the MK Deal, to the next meeting of the Health & Care Partnership

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## 1. Background

The BLMK Integrated Care Board agreed at its meeting on 22nd November 2022 that Place Boards are pivotal to the development of neighbourhood teams aligned to local communities.

This paper sets out for consideration of the Milton Keynes Health and Care Partnership:

- the policy background to the development of locality/neighbourhood working in health and care;
- the current locality/neighbourhood arrangements in Milton Keynes;
- the opportunities to pilot new approaches within Milton Keynes; and
- proposed next steps.

## 2. Policy background

### 2.1 An overview of neighbourhoods, places, and systems.

The King's Fund has summarised the role of neighbourhoods within the wider context of Integrated Care systems:

- **Neighbourhoods** (covering populations of around 30,000 to 50,000 people): where groups of GP practices work with NHS community services, social care and other providers to deliver more co-ordinated and proactive care, including through the formation of primary care networks (PCNs) and multi-agency neighbourhood teams
- **Places** (covering populations of around 250,000 to 500,000 people): where partnerships of health and care organisations in a town or district – including local government, NHS providers, voluntary, community and social enterprise (VCSE) organisations, social care providers and others – come together to join up the planning and delivery of services, redesign care pathways, engage with local communities and address health inequalities and the social and economic determinants of health. In many (but not all) cases, place footprints are based on local authority boundaries.
- **Systems** (covering populations of around 500,000 to 3 million people): where health and care partners come together at scale to set overall system strategy, manage resources and performance, plan specialist services, and drive strategic improvements in areas such as workforce planning, digital infrastructure and estates.

### 2.2 NHS Long Term Plan (2019) - Primary Care Networks

Primary care networks (PCNs) were established in 2019 as a key building block of the NHS long-term plan. Bringing general practices together to work at scale had been a policy priority for some years for a range of reasons, including improving the ability of practices to recruit and retain staff; to manage financial and estates pressures; to provide a wider range of services to patients and to more easily integrate with the wider health and care system.

NHS England set out significant ambitions for primary care networks, with the expectation that they would be a key vehicle for delivering many of the commitments in the long-term plan and providing a wider range of services to patients:

- Provision of a wider range of primary care services to patients, involving a wider set of staff roles than might be feasible in individual practices, for example, first contact physiotherapy, extended access and social prescribing.
- The footprint around which integrated community-based teams would develop, and community and mental health services will be expected to

configure their services around PCN boundaries. These teams would provide services to people with more complex needs, providing proactive and anticipatory care.

- Consideration of the wider health of their population, taking a proactive approach to managing population health and assessing the needs of their local population to identify people who would benefit from targeted, proactive support.
- Focus on service delivery, rather than on the planning and funding of services and are expected to be the building blocks around which integrated care systems are built.
- Ambition is that primary care networks will be the mechanism by which primary care representation is made stronger in integrated care systems, with the accountable clinical directors from each network being the link between general practice and the wider system.

The NHS Long Term plan also included a vision of the establishment of expanded neighbourhood teams which would comprise a range of staff such as GPs and SAS doctors, pharmacists, district nurses, community geriatricians, dementia workers and AHPs such as physiotherapists and podiatrists/ chiropodists, joined by social care and the voluntary sector. In many parts of the country, functions such as district nursing are already configured on network footprints, and this will now become the required norm.

**2.3 Fuller Stocktake (2022)**

Dr Claire Fuller produced a report in 2022, shortly before the formal establishment of Integrated Care Boards. It set out a new vision for integrating primary care, improving the access, experience and outcomes for our communities, which centres around three essential offers:

- streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it
- providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions
- helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention

At the heart of the new vision for integrating primary care is bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations. This is usually most powerful in neighbourhoods of 30-

50,000, where teams from across primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.

The report noted that the development of PCNs, established just prior to the pandemic, has already enabled many neighbourhoods to make progress in this direction. However, a lack of infrastructure and support has held them back from achieving more ambitious change.

Integrated neighbourhood 'teams of teams' need to evolve from Primary Care Networks (PCNs), and be rooted in a sense of shared ownership for improving the health and wellbeing of the population. They should promote a culture of collaboration and pride, create the time and space within these teams to problem solve together, and build relationships and trust between primary care and other system partners and communities.

This would require two significant cultural shifts: towards a more psychosocial model of care that takes a more holistic approach to supporting the health and wellbeing of a community; and realignment of the wider health and care system to a population-based approach – for example, aligning secondary care specialists to neighbourhood teams. The key ingredient to delivering this way of working is leadership – fostering an improvement culture and a safe environment for people to learn and experiment.

The report set out an expectation that systems should aim to have integrated teams up and running in neighbourhoods that are in the most deprived areas by April 2023. This would not only ensure that we can start to better support those communities who need it most, it would create the necessary pace and ambition to move to universal coverage throughout 2023 and by April 2024 at the latest.

The report recommended:

> "Integrated Care Systems should enable all PCNs to evolve into integrated neighbourhood teams, supporting better continuity and preventive healthcare as well as access, with a blended generalist and specialist workforce drawn from all sectors. Secondary care consultants – including, for example, geriatricians, respiratory consultants, paediatricians and psychiatrists – should be aligned to neighbourhood teams with commitments reflected in job plans, along with members of community and mental health teams. With teams collocated within neighbourhoods, to extend models of personalised care, embed enhanced health in care homes and develop a consistent set of diagnostic tests."

## 3. Locality/Neighbourhood working in Milton Keynes

There is currently a varied approach to locality/neighbourhood working in Milton Keynes:

- *GP practices* – there are 27 GP practices in Milton Keynes. Each has its own registered list of patients with a defined core practice area. Each practice has a Patient Participation Group.
- *Primary Care Networks* – there are seven PCNs within Milton Keynes covering registered populations of between 32,000 – 58,000 (see *Appendix One*). All the PCNs are contracted to provide Integrated Care Support Team (ICST) services (see *Appendix Two*) and to deliver enhanced care home support services.
- *Community Health Services* – most community health services are delivered on a whole Milton Keynes footprint. The eight district nursing teams are aligned to GP practices, but these are organised geographically rather than aligned to PCNs (see *Appendix Three*).
- *Mental Health Services* – most mental health services are delivered on a whole Milton Keynes footprint, although the consultant psychiatrists working within the Hub (community mental health team) are aligned to the PCNS. CNWL also employ mental health workers (AARS funded) and primary care plus staff who aligned to each PCN.
- *Milton Keynes University Hospital (MKUH) services* – currently MKUH services are not delivered on a locality/neighbourhood basis, apart from named geriatricians being aligned to PCN care home support services. There are opportunities to align a range of services to PCNs such as older people services and pharmacy
- *Adult Social Care Services* – social work services are delivered through specialist teams (e.g. working age adults, mental & complex needs) which cover the whole of Milton Keynes. Milton Keynes City Council (MKCC) does align an individual social work support worker to each PCN as part of the ICST service. Home Care services are provided on a geographical basis with a North and a South team. Other provider services such as reablement and day care are Milton Keynes wide services. Some external providers of adult social care (e.g. care home providers) commissioned by MKCC have a geographical footprint
- *Children & Family Services* – MKCC provides a range of universal services for children & families including support and activities for families from 17 Children and Family Centres across Milton Keynes. In addition, MKCC provides more targeted services including the Multi-Agency Safeguarding Hub (MASH) and four child support teams and child & family practice teams which operate across four geographical quadrants (see *Appendix Four)*
- *Schools* – there is school nursing support to all schools and there are mental health support teams providing input to 40% of schools in Milton Keynes. Schools also directly employ counsellors and support workers. There is a regular meeting

for secondary school heads across Milton Keynes, while primary school heads meet regularly supported by MKC in each quadrant.

- *Housing services* – MKC provides around 11,500 social housing properties which are managed through 15 neighbourhood officers which cover specific geographies within Milton Keynes. In addition, there are a number of Housing Associations in operation across the city (see *Appendix Five*)
- *Voluntary, community & social enterprise (VCSE) services* – VCSE services are organised on a variety of footprints including pan BLMK, cross Milton Keynes and more locally. VCSE organisations may provide direct services and/or represent the interests of particular communities. The MK Voluntary Sector Alliance operates as a network of networks.

**4. Opportunities to pilot new approaches within Milton Keynes**

Considering the current relatively limited scope of integrated locality/neighbourhood working in Milton Keynes, it clear that there are opportunities to develop the approach to promote innovation in the way that services are delivered including developing new ways to:

- Improve the coordination of services – not just health and social care but also wider services such as housing support, debt management, education
- Explore opportunities to co-locate services in shared premises
- Address inequalities in access to care from disadvantaged communities
- Increase the focus on prevention and early access to treatment and care
- Improve care in the community for frail older people and people with long term conditions to support independence and reduce the need for hospital care
- Develop more effective use of VCSE services at local level
- Strengthen the voice of local people in the planning and delivery of services

However, there are several barriers to locality/neighbourhood working which would need to be considered, including:

- Economies of scale – many services in Milton Keynes are not sufficiently large to split efficiently or effectively into localities/neighbourhoods
- Tension between localities/neighbourhoods defined by natural communities and where people live and those defined by PCNs which are based on GP lists.
- Cross boundary issues where GPs have people registered who live outside of Milton Keynes

It is also clear that there is potential for significant disruption of existing services if we tried to move in one go to a new universal approach across Milton Keynes. It is therefore proposed that in order to take forward work on developing locality/neighbourhood working in Milton Keynes we consider piloting a new approach in one or two localities/neighbourhoods where we could test the model

over an agreed period. This would enable us to evaluate the success of the approach prior to any decision to roll out across the whole of Milton Keynes.

In choosing a pilot we would need to consider a range of issues, including:

- Levels of need in the different localities/neighbourhoods – piloting the approach in areas of highest needs/levels of inequality would be desirable
- Level of alignment between PCN lists and natural communities
- Degree of 'buy-in' from local leadership
- Any resourcing support which would be needed to support the pilot

Further work would be required to work up the proposal in more detail for a pilot. If this approach is supported it is proposed that we bring back a more detailed proposal to the next Health & Care Partnership Board for agreement.

**5. Proposed next steps**

The Milton Keynes Health & Care Partnership Board is asked to:

- Consider the issues set out in this paper
- To agree to pilot locality/neighbourhood working in one or two areas of Milton Keynes
- Ask the Joint Leadership Team to develop a more detailed proposal for the pilot, perhaps as a fifth priority for the MK Deal, to the next meeting of the Health & Care Partnership

**Appendix One**

## Primary Care Networks in Milton Keynes

## Total registered population 328,790 (July 2022)

| |
|---|
| **Ascent PCN 32,620 patients** |
| Asplands Medical Centre (Woburn Sands/Woburn) |
| Fishermead Medical Centre (Fishermead) |
| Walnut Tree Health Centre (Walnut Tree) |
| **The Bridge PCN 46,149 patients** |
| Newport Pagnell Medical Centre |
| Kingfisher Surgery (Newport Pagnell) |
| Brooklands Health Centre (East MK EEA) |
| **Crown PCN 43,410 patients** |
| Cobbs Garden (Olney) |
| Red House Surgery (Bletchley) |
| Whaddon Medical Practice (Bletchley) |
| **East MK PCN 54,791 patients** |
| Ashfield Medical Centre (Netherfield) |
| CMK Medical Centre (Bradwell Common) |
| MK Village Practice |
| The Grove Surgery (Eaglestone) |
| **Nexus MK PCN 57,526 patients** |
| Neath Hill Health Centre |
| Oakridge Medical Centre |
| Purbeck Health Centre (Stantonbury) |
| Sovereign Medical Centre (Neath Hill) |
| Stonedean Practice (Stony Stratford) |
| Wolverton Health Centre |
| **South West PCN 48,499 patients** |
| Bedford St Surgery + Furzton branch (Bletchley) |
| Parkside Medical Centre (Bletchley) |
| Westcroft Medical Centre |
| Westfield Rd Surgery (Bletchley) |
| **Watling Street Network PCN 45,795 patients** |
| Hilltops Medical Centre (Great Holm) |
| Stony Medical Centre (Stony Stratford) |
| Watling Vale Medical Centre (Bletchley) |
| Whitehouse Health Centre (West MK WEA) |

**Appendix Two**

**Service specification for Integrated Community Service Team**

| | |
|---|---|
| **The stated objective at the outset** | • Provide the infrastructure to deliver case management to people over 65 and those living with frailty<br>• Release capacity for clinicians to focus on managing complex medical needs<br>• Improve quality of life and wellbeing for patients and carers<br>• Reduce dependency on GP visits & out of hours calls<br>• Reduce acute unplanned service use; 999 calls; A&E attendance; emergency admissions<br>• Proactively manage social care needs, reducing dependence on high cost packages of care<br>• Support delivery of the wider ambition for Primary Care Home |
| **Intended intervention** | MDT assessment resulting in appropriate support from Health and Social services:<br>• Personalised Care and Support Planning / strengths based assessment<br>• Health Coaching / Social Prescribing<br>• Support with self-care and education<br>• Specialist support for HISU<br>• Support with 'non eligible' social care needs<br>• Case Management to co-ordinate complex care packages and provide continuity of care<br>• Access to peer support groups<br>• Benefits advice<br>• Support and advice with Mental Health Diagnosis<br>• Medicines Management<br><br>Underpinned by:<br>• Core 'personalisation' skill set including motivational interviewing for all staff, with specialist areas of expertise<br>• Electronically enabled information sharing<br>• Regular MDT's<br>• Database of local people with lived experience<br>• Local directory of services and community links |
| **Intended benefits** | • Improve patient experience (brief case studies – consider video case studies as well as written)<br>• Reduce unplanned activity – A&E attendances |

| | |
|---|---|
| | • Reduce unplanned activity – A&E Admissions<br>• Deliver system wide savings<br>• Staff satisfaction, Recruitment and retention measure<br>• Activity data |
| **Target KPI's** | In line with the 2019/20 Frailty and EOL QIPP ambitions;<br>• A reduction of attendances at A&E<br>• No growth year on year on A&E attendances<br>• A reduction in admissions<br>• A reduction in hospital length of stay<br>• No growth year on year on A&E emergency admissions<br>• Reduction in GP appointments<br>• Reduction in ambulance calls<br>• Reduction in admissions to care homes<br>• gather feedback from staff at regular intervals<br>• Data – reduction in GP appointments/other health service in GP surgeries<br>• No unexpected staff resignations in the 12 months since the start of the pilot<br>• Referrals<br>• Contacts<br>• Length of intervention<br>• Caseload |

**Overview of the service**

The **PCN based ICST's** include the following key roles / functions:

Care Co-ordinator: (New role)

- Provide a single point of access for ICST within each PCN
- Support proactive case finding within Primary Care
- Co-ordinate access to the support from the most appropriate team member &
- Co-ordinate team activity, practice rotas
- Administration and data collection
- Work with the local community to identify / recruit local community groups, volunteers, activities to work with the PCN
- Build a local database of community assets

MKC Support Work: (New Role)

- Care Navigation for people;
- with more complex social care needs

- who have not had contact with Primary Care for longer than would have normally been expected.
- Provide education and advice within Primary Care regarding how Social Care works; teams; eligibility criteria etc.

Physical Health Nurse: (New Role)

- Support and education with LTC Management
- Care Navigation
- Health coaching

'Live Life MK' Social Prescribing Link Workers (Existing service, working more closely with ICST)

CPN – Primary Care Plus: (Existing service, expanded to have a presence in all clusters)

- The service works to support GPs in caring for patients with mental health problems by focusing on the individual's current needs and improving their knowledge and skills. PCP has been working with secondary mental health services to support stable patients with severe and enduring mental health problems return to Primary Care when they no longer require specialist support.

Each PCN will also have pre-existing roles & new Social Prescribing roles within GP Practices that are being aligned with the ICST and referral process to achieve a single point of access for clinicians.

The **ICST Hub** provides the following key functions:

- A single point of access for the frailty pathway and for referrals from MKUHFT to the ICST service. The team will be based in the Home 1st Rapids team. - Referrals can be made via the telephone or via SystmOne.
- The nurses work closely with the six PCN ICST's and are able to share information and tasks via the SystmOne Frailty Unit.
- Provide Active Case Management for the frail elderly as required - or allocate to the most appropriate professional / ICST member
- Facilitate peer support / access to peer support for the cohort
- Complete frailty assessments as required
- Provide proactive tracking of people with frailty via SystmOne so that the necessary services are alerted to changes in condition, this may be for example if someone is admitted to hospital. This supports timely sharing of key information and enhances co-ordination of care.

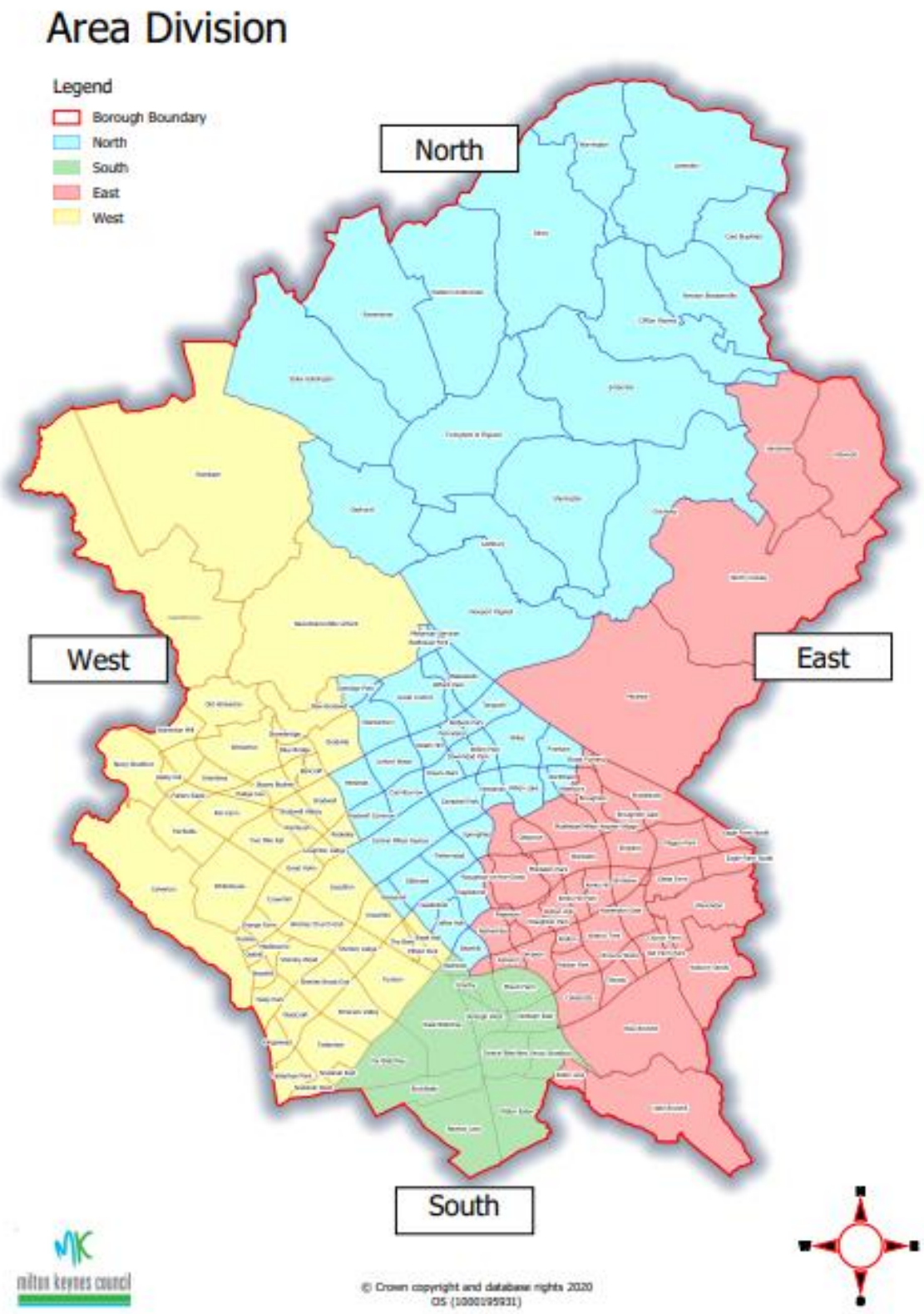
**Appendix Three**

**GP Practices: District Nurse Teams Alignment Milton Keynes**

| ***PCN*** | ***DN Teams Covering each Practice/PCN*** | | |
|---|---|---|---|
| ***Ascent*** | | | |
| Asplands Medical Centre | Not covered by CNWL | | |
| Fishermead Medical Centre | Ashfield | MKVP | |
| Walnut Tree Health Centre | Ashfield | | |
| | | | |
| ***The Bridge*** | | | |
| Newport Pagnell Medical Centre | Not covered by CNWL | | |
| Kingfisher Surgery | Not covered by CNWL | | |
| Brooklands Health Centre | MKVP | | |
| | | | |
| ***Crown*** | | | |
| Cobbs Garden Surgery | Sovereign | | |
| Red House Surgery | Red House | | |
| Whaddon Medical Centre | Parkside | Red House | |
| Water Eaton Health Centre | Red House | | |
| | | | |
| ***East:MK*** | | | |
| Ashfield Medical Centre | Ashfield | | |
| CMK Medical Centre | MKVP | Oakridge | |
| The Grove Surgery | Ashfield | | |
| Milton Keynes Village Practice | MKVP | | |
| | | | |
| ***Nexus*** | | | |
| Neath Hill Health Centre | Sovereign | | |
| Oakridge Park Medical Centre | Oakridge | | |
| Purbeck Health Centre | Oakridge | Sovereign | |
| Sovereign Medical Centre | Sovereign | | |
| Stonedean Practice | Stony Stratford | | |
| Wolverton Health Centre | Oakridge | Stony Stratford | |
| | | | |
| ***South West Network*** | | | |
| Bedford Street & Furzton Surgery | Parkside | Red House | Watling Vale |

| | | | |
|---|---|---|---|
| Parkside Medical Centre | Parkside | | |
| Westcroft Health Centre | Watling Vale | | |
| Westfield Road Surgery | Parkside | Red House | |
| | | | |
| ***Watling Street Network*** | | | |
| Hilltops Medical Centre | MKVP | Oakridge | Watling Vale |
| Stony Medical Centre | Stony Stratford | | |
| Watling Vale Medical Centre | Watling Vale | | |
| Whitehouse Surgery | Watling Vale | | |

**Appendix Four**



**Appendix Five**

**Milton Keynes Council – Housing patches**

| | | |
|---|---|---|
| Lakes 3 & 1 | Heelands Est | Bradville |
| Wolverton Est | Stantonbury Est | Newport Pagnell |
| Willen Est | Galley Hill Est | Westcroft |
| Willen Park Est | Pennyland Est | Stoke Goldington Est |
| Haversham Est | | Northcrawley Est |
| Springfield Est | Fishermead | Conniburrow |
| Oldbrook Est | Neathhill | Downs Barn |
| Counties | Olney Est | Hardmead Est |
| Rivers Est | Wavendon Est | Chichley Est |
| Astwood | | Woolstone Est |
| Weston Underwood | | Downhead Park Est |
| | | Crownhill |
| Eaglestone | Beanhill | Lakes 2 & 4 |
| Stony Stratford | Fenny Stratford | Greenleys |
| Stacey Bushes | Cent Bletchley | Little Brickhill Est |
| Granby | Trees | Bow Brickhill Est |
| Ravenstone Est | Filgrave Est | Castlethorpe Est |
| Lavendon Est | | Hanslope Est |
| | | Newton Blossomville |
| Bradwell | Coffee Hall Est | CMK |
| Hodge Lea | Peartree Bridge Est | Great Linford Est |
| Bradwell Common | Tinkers Bridge Est | Saints Est |
| Old Bradwell | Milton Keynes Village | Emberton Est |
| New Bradwell | Woburn Sands | Emerson Valley |
| | Simpson Est | Water Eaton Est |
| | Moulsoe Est | Windmill Hill Est |
| | Furzton 1 Est | |
| Netherfield | Fullers Slade | |
| Woughton | Castles | |
| Great Holm Est | Abbeys | |
| Shenley Church End Est | Two Mile Ash 1 Est | |
| Shenley Lodge Est | Loughton Est | |
| | Bolbeck Park | |

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