MK Together | Health and Care Partnership

HEALTH & CARE PARTNERSHIP

FORMERLY THE HEALTH AND WELLBEING BOARD

When: **Wednesday 8 November 2023 at 14:00**

Where: **Room 1.02, Civic, 1 Saxon Gate East, Milton Keynes, MK9 3EK This meeting will not be live streamed, but a recording of the meeting will be available on YouTube as soon as practical after the meeting.**

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

The Chair to welcome councillors, partners and other attendees to the meeting.

2(a) Minutes of the Previous Meeting **(Pages 5 - 14)**

To approve, and the Chair to sign as a correct record, the Minutes of the meeting of the Partnership held on Wednesday 20 September 2023.

2(b) Actions Arising **(Pages 15 - 16)**

To consider actions arising from 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. Integrated Care Board (ICB) Report **(Pages 17 - 20)**

The Partnership to receive an update report from the BLMK Integrated Care Board.

5. Moving to a more dynamic JSNA **(Pages 21 - 26)**

The Partnership to receive a report on the Milton Keynes Joint Strategic Needs Assessment and the BLMK Population Health Intelligence Unit from the Shared Public Health Service.

6. The Carnall Farrar review of the development of health and care integration in Milton Keynes **(Pages 27 - 44)**

The Partnership to receive a report on the Carnall Farrar review of the development of health and care integration in Milton Keynes, including Annex A (Separate Document) and Annex B (incorporated in main document), from Milton Keynes City Council.

7. Better Care Fund 2023-2025 Quarter 2 Report **(Pages 45 - 58)**

The Partnership is asked to note the Better Care Fund 2023-2025 Quarter 2 Report.

8. Revised MK Together Partnership Diagram **(Pages 59 - 60)**

The Partnership is asked to note the revised MK Together Partnership Diagram (October 2023).

9. Date of the Next Meeting

To note, the next meeting of the Health and Care Partnership is scheduled for 20 March 2023 at 2.00pm.

Together | Health and Care Partnership

Minutes of the meeting of the HEALTH AND CARE PARTNERSHIP held on Wednesday 20 September 2023 at 14:00

Present: Councillors Marland (Chair), R Bradburn, Darlington and D Hopkins, Dr R Makarem (Vice-Chair), M Bracey (Chief Executive, Milton Keynes City Council), F Cox (Chief Executive, BLMK ICB), V Collins (Director, Adult Services, Milton Keynes City Council), M Heath (Director of Children's Services, Milton Keynes City Council), V Head (Director of Public Health, Milton Keynes City Council), J Hannon (Diggory Divisional Director of Operations, CNWL NHSFT), Dr I Reckless (Medical Director, MKUH NHSFT), Dr N Alam (Representative of Primary Care Networks), M Taffetani (Chief Executive, Healthwatch Milton Keynes), Supt E Baillie (LPA Commander, Thames Valley Police) and P Wilkinson (VCSE Representative)

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

Officers: A Clayton (Overview and Scrutiny Officer, Milton Keynes City Council)

Apologies: J Harrison (Chief Executive, MKUH NHSFT) (I Reckless Deputising), J Thelwell (Bucks Fire & Rescue Service, Chief Executive) and M Begley (South Central Ambulance Service, Head of Operations)

HCP08/09 MINUTES AND ACTIONS ARISING

The Partnership considered the Minutes of the Health and Care Partnership's meeting held on 13 June 2023 and noted that all actions from the meeting had been completed or were in the process of being completed.

RESOLVED:

1. **That the Minutes of the meeting of the Health and Care Partnership held on 13 June 2023 be approved and signed by the Chair as a correct record.**

2. **The actions arising from the previous meeting held on 13 June 2023 were noted. All other actions were completed or in the process of being completed.**

HCP10 DISCLOSURES OF INTEREST

None.

HCP11 INTEGRATED CARE BOARD (ICB) REPORT

The Partnership received a report from the Chief Executive, BLMK ICB. Key areas of the report were highlighted:

- From February 2024, most "Specialised Commissioning" would be delegated to ICBs by NHSE. Specialised Commissioning related to the commissioning of high-volume specialised services, such as chemotherapy, radiotherapy and dialysis. Very few of these services were currently delivered within the region, with most being delivered through hospitals in London or Oxford. As the fastest growing ICB within the East of England, and one of the fastest growing nationally, there was a strong argument that more of these services should be delivered locally.
- The Denny Review on health inequalities was due to be published shortly, and had received the support of all four Healthwatch groups in the region. The ICB would consider the review and any recommendations in due course.
- The success of the Health Inequalities funding model put in place by the BLMK ICB had been recognised nationally, and other ICBs were looking to replicate the model.
- Financial pressures were being keenly felt by the ICB, councils and other partner organisations, all of whom were looking to make economies where they could. Collaboration would be key to ensuring that gaps in essential services did not result from savings, and partners would be working together to ensure that their services worked in tandem with each other.
- The ICB had recently held an employment seminar to consider the links between health and employment outcomes. It had highlighted the connections between unemployment and ill health, and the stresses and strains that could result from becoming "trapped" in unstimulating employment. The JLT was considering the findings of the seminar.
- The ICB was currently reviewing its governance and structures, and had published its revised organisational structure. This was a difficult period for many staff, as many of them had been placed on notice of change or redundancy. Partners had helped to inform the new structure, to ensure that it provided a suitable operating model for the future.

Members of the Partnership considered and discussed the presentation. Many areas of health and care locally were improving as a result of integration, such as the hospital discharge work, but one area that did not seem to be changing for the better was dentistry. The Partnership heard that dentistry had been delegated to the ICB on the 1 April this year, once the annual contracts had already been agreed, giving the ICB little room for manoeuvre. The specialised commissioning, covered earlier in the report, perhaps provided opportunities to improve access to complex dentistry locally, but otherwise no changes were anticipated soon.

Although work was being undertaken to improve data compatibility amongst the partners, it remained the case that partners were using incompatible computer data systems, e.g. across MKUH, MKCC and CNWL. Members queried when measures would be in place to make these disparate systems more compatible. The Partnership heard that progress was being made, but a fuller answer with details would be provided after the meeting, following consultation with technical colleagues.

The June Sentiment Benchmarking Report suggested that NHS Dentistry access rates in Milton Keynes were lower than in neighbouring areas, and members queried whether special measures were required to address this. It was noted that the ICB and Public Health would be considering this finding and possible actions that could be taken.

RESOLVED:

The Partnership noted the content of the report and annexes presented at Item 4 and agreed with the next steps outlined therein.

HCP12 THE BLETCHLEY PATHFINDER (NEIGHBOURHOOD WORKING)

The Partnership received a report from the Chief Executive of Milton Keynes City Council. Key areas of the report were highlighted:

- The key drivers of the Bletchley Pathfinder were the recommendations of the Fuller Report, and the priorities of local partners. In short, this meant providing proactive, personalised care and support to people through a multi-disciplinary approach, and to help people stay well for longer as part of a stronger focus on prevention of ill health. These objectives encompassed many areas of health and care, but an important thread running through it all, was the imperative to address health inequalities, to provide everybody with the same opportunities to lead a healthy and fulfilled life.

- A neighbourhood working pilot had first been discussed by the partnership in February 2023, and again in June when the JLT was asked to use Bletchley for the pilot and to carry out background work in preparation for a September 2023 start. Lots of work had now been undertaken by partners, including colleagues from Healthwatch MK, the NHS, Inspiring Futures Through Learning and MKCC.
- Initial findings had helped identify the immediate tasks and challenges. The first being how to develop personalised multi-agency responses, for which the proposal is to develop a "Team Bletchley" of professionals from those agencies and involving the voluntary sector, with a focus on delivering shared objectives. Secondly, there was a real need to understand and develop ways of working that would enable the various partners to properly engage, without duplication and conflict. There were differences of opinion and approaches to engagement, for example the relationship between schools and primary care was under-developed. Thirdly, there was a need to put together a standard conferencing model for addressing issues that required input from several partners, which could be a family-focussed issue for example, or could be something wider. At the moment there were several models employed by the different agencies and they were all very different.
- Initial plans include the development of a "Bletchley Health Coach" model, the development of local support and activity groups, building on work that has already taken place on the Lakes Estate, and the introduction of programmes supporting families to eat well. It was not proposed to construct "one size fits all" solutions; there were many groups and charities already carrying out good work in Bletchley and it was proposed that this work be built on and developed.
- The Governance model was presented in the papers, of which a key element was the Bletchley Pathfinder Delivery Board, which would need to be independently chaired. An indicative budget was also presented for consideration, with monies coming from ICB funds for health inequalities and place based co-ordination.

Members of the Partnership considered and discussed the presentation, which was welcomed. The Bletchley Pathfinder offered a real opportunity to make a meaningful difference to resident's lives, and members looked forward to learning more about the outcomes. The project team were urged to consider "tearing up the rule book" where unnecessary bureaucracy presented obstacles.

It was noted that reducing smoking rates and the prevalence of obesity were outliers in the town, and therefore high priorities, but that mental health was an important issue. Members heard that a separate collaboration involving CNWL and MKCC was working on mental health in the city and that this would overlap with the Bletchley Pathfinder. It was recognised that poor mental health impacted lifestyles in many ways and that it covered a spectrum of problems from long-standing mental illness through to short term, lower level issues.

Members related that the project had gained a great deal of attention in Bletchley and early surveys were showing that the Pathfinder was broadly welcomed. Partners in primary care were keen to involve GP surgeries in the project, and were able to offer a range of services to support it. GPs found that residents were very open to ideas such as the "Health Coach", as shown by the positive reception given to social prescribing. It was important that such initiatives were community-based and personal to the individuals being supported, not seen as "imposed from above".

The project was also broadly welcomed by VCSE organisations in Milton Keynes, who highlighted that it was important to identify target groups most in need of support.

Members heard that the Bletchley Pathfinder was principally a project designed to help residents to help themselves. The ambition was to devolve decision making to the community, to allow the community to decide how to deploy the available resources to improve the health and wellbeing of local people. The Pathfinder was not a range of new and additional services provided by others. It was anticipated that it would provoke a good deal of community level discussion and that it would take a while for the process to come together and become embedded, and before the benefits of the approach were realised.

RESOLVED:

1. **That the Partnership convey its thanks to the Joint Leadership Team for their work on the Bletchley Pathfinder.**

2. **That the Bletchley Pathfinder Proposal be agreed.**

3. **That the six proposed areas of work detailed therein be agreed.**

4. **That the BLMK ICB be requested to include the Bletchley Pathfinder within the MK Deal.**

5. **That the proposed governance arrangements be agreed.**

6. **That the indicative budget be agreed.**

7. That the broad approach to evaluation be agreed.

HCP13 HEALTH INEQUALITIES FUNDING

The Partnership received a report from the Director of Public Health. Key areas of the report were highlighted:

- The BLMK ICB made £2M of NHSE health inequalities funding available to places within the ICS, with each place receiving £500K. Use of the fund was not tightly prescribed, but should be used to support measures to help reduce health inequalities.
- It was recommended that around 70% of the fund be used to tackle inequalities as a part of the Bletchley Pathfinder, with activities such as lower cost access to fitness activities, school breakfast clubs, cooking classes and access to healthy food and a free bike loan scheme, with activities designed and delivered in collaboration with the voluntary and charity sector.
- The remaining 30% would be used to support work to reduce inequalities within the community and primary care across Milton Keynes.

Members of the Partnership considered and discussed the presentation. At the present time it was understood that the health inequalities funding would be a recurrent fund, i.e. a similar fund made available in future years for the same purpose, but this could not be guaranteed. Public Health were asked to consider prioritising regeneration areas of the city in respect of the 30% of remaining funds.

RESOLVED:

1. To approve the recommendation to deploy 70% of the available health inequalities funding on a large scale intervention as a part of the Bletchley Pathfinder work, with the remaining 30% to be used for community and primary care projects.

HCP14 SPOTLIGHT ON THE PROGRESS OF THE MK DEAL

a) Improving System Flow

The Partnership received a report from the Medical Director, MKUH NHSFT.

The key focus of this work was keeping people out of hospital that did not need to be there. The longer someone spends as a hospital patient, in a hospital bed, the worse it is for their health and the more difficult it can become for them to return to the community. In addition, Milton Keynes has a population whose average age is increasing, leading to an exponential increase in demand on hospital beds. These difficulties are made worse by a hospital system that is complicated and inefficient in parts, with significant duplication of work at various stages of the process. The system required simplification and streamlining; the team were on the right track and had made good progress in some significant areas, but it would take time to effect the levels of change desired.

MKUH had recently carried out some work with Healthwatch and residents, which confirmed that the current system left patients feeling helpless and unable to exert control throughout their hospital experience.

Recent developments and plans included a virtual ward, funded for 2 years. This allowed patients to be properly treated in their own homes, rather than being admitted to hospital, through the use of a range of technologies. Currently around 75 patients were being cared for using the MKUH virtual ward. An integrated discharge hub was also being set up, collaboratively between MKUH, MKCC and CNWL, to streamline and facilitate patient discharge. It was planned to have this up and running properly within the next two months. A Health and Care Academy was being developed to provide training for therapists and carers; it would help fill vacancies and provide a better career pathway for those professions.

The Partnership considered the report and presentation. In the context of the approaching winter, would these current initiatives be able to assist in what was likely to be a high demand period for the hospital? It was planned to have the discharge team in place by the end of November, along with an increased capacity for the virtual ward. By these measures it was hoped that some of the pressure would be taken off. It was also important to seek to prevent those problems that led to hospital admissions, e.g. falls in icy conditions, and partners were working with the voluntary sector to consider what could be done.

Partners discussed the growing role of technology in supporting patients to remain well and under supervision whilst remaining in their home. The Director of Adult Services explained that MKCC operates a support service which is significantly enhanced with the use of such technology. The MedTech area was a rapidly developing area and new solutions were coming on line regularly, this could be deployed quickly and would become an increasingly important part of health and care systems generally.

b) Tackling Obesity

The Partnership received a report from the Director of Public Health

This was about helping residents to lose weight, and shaping the environment in Milton Keynes to encourage activity and healthy eating.

There were three key themes, the first being to simplify and thereby increase referrals to the weight management service. It was now possible for patients to be referred from their GP and other partners, such as CNWL, and training was being provided to primary care staff to support this, e.g. how to refer and how to have the conversation with potential patients. A programme to support those with learning disabilities was also available.

The second theme was a research project based on innovation, using wearable tech to monitor and encourage users, alongside a financial incentive scheme, with a focus to encourage physical activity in those with T2 diabetes. This was a collaborative research project involving MKCC, MKUH, primary care partners and Loughborough University, and the trial would commence shortly.

The third theme was shaping the environment to change the cultural, social and other factors that lead to obesity and sedentary behaviour. This might include initiatives such as encouraging walking and cycling through employer schemes or by using financial incentives, reviewing food procurement by partners, along with commercial food arrangements on partner's premises, and developing policies to limit the exposure and promotion of unhealthy food to children.

The Partnership considered and discussed the issues. The breadth of the ambition was noted, i.e. from changing the food environment, to physical activity to weight loss programmes to wearable tech. It would be difficult to assess which elements of this were successful and which less successful. The meeting heard that some elements of the project, for example the trial being conducted with Loughborough University, would be subject to detailed monitoring. However, it was not possible to apply a detailed set of metrics across

all elements of the programme, and a holistic view would need to be taken where direct measurement was not feasible. Some elements were straightforward, e.g. counting the number of people on weight loss programmes and whether they are they losing weight, but it was difficult to monitor, say, the impact of policy changes to the food environment. In the current environment the money was simply not available to conduct detailed statistical analysis.

Primary Care partners reported that there was a high demand for weight loss services, which included requests for weight loss drugs and surgery, in addition to interest in weight loss programmes. With the rise in these alternatives, it was important to understand the success rate of such programmes and whether they represented best value for money.

The meeting heard that there was also an important role for MKCC to play in the planning sphere. For example, ensuring that schools had adequate playing fields and other facilities and that they were not sited next to fast food outlets.

c) Children and Young People Mental Health

The Partnership received a report from the Diggory Divisional Director of Operations, CNWL NHSFT, and the Director of Children's Services.

The overall aims of the initiative were to make mental health services more accessible to those that needed them and to have a more coherent understanding across partners and the wider community of what mental health support looked like, and what was needed at each stage. Considerations included ensuring that the limited resources were employed effectively, and that plans should address health inequalities.

Additional staff posts had been recruited to support these aims, including an additional Clinical Psychologist in CAMHS, and a joint-funded SEND partner in Children's Services. Collaborative working between CNWL, Children's Services and other partners was working well.

There was a rapidly growing demand for mental health support for children and young people, with a common perception amongst parents and some professionals that there was a large cohort of young people with undiagnosed mental health problems. In fact, these "problems" were often issues associated with youth and adolescence and were a normal part of growing up, for example issues around self-confidence or identity; the normal stresses and strains of teenage life. These were increasingly being unhelpfully conflated with mental health problems. This could have a

deleterious effect on the young person, by labelling them and making them falsely believe that they were mentally unwell. There needed to be better ways to respond and deliver support to young people to help them with these feelings, without giving large numbers of young people the impression they were suffering mental health problems. The "noise" created by this was actually hindering the ability of partners to identify and support those that genuinely need support.

RESOLVED:

1. That the Partnership thanks those involved in the preparation of these reports and the work delivered on behalf of the residents of Milton Keynes.

2. That the reports be noted.

3. That the planned activities outlined in the reports be noted.

HCP15 THE BETTER CARE FUND (BCF) 2023-2025

The Partnership received a report from the Director Adult Social Care.

The BCF Plan had been worked up and agreed collaboratively with key partners, and submitted to and approved by NHS England. The BCF has previously been an annual plan, but this year a two year plan had been prepared. The plan would inevitably be varied over the period as it moved into the second year, due to the likelihood of change in areas such as system flow, demand for dementia care, and the availability of technology.

RESOLVED:

1. That the Partnership express its thanks to the Better Care Fund team for the work carried out for the benefit of residents of Milton Keynes.

2. To approve the Milton Keynes Better Care Fund Plan 2023-2025.

HCP16 DATE OF NEXT MEETING

It was noted that the next meeting of the Health and Care Partnership would be held on Wednesday 8 November 2023 at 2.00 pm.

THE CHAIR CLOSED THE MEETING AT 16:00

MK Together | Health and Care Partnership

Item 2b

DECISION TRACKER 2023/24 - HEALTH AND CARE PARTNERSHIP

OUTSTANDING ACTION POINTS

COLOUR CODE:

RED: NO OR LIMITED PROGRESS

AMBER: PROGRESS PENDING FURTHER ACTION

GREEN: SIGNIFICANT PROGRESS MADE

BLACK: COMPLETED, NO FURTHER ACTION

Referrals to Council

Referrals to Cabinet

Presented to Health and Care Partnership: **8 NOVEMBER 2023**

HEALTH AND CARE PARTNERSHIP

Date of Meeting	Minute	Subject and Decision	Lead Officer	Action Since Last Review	Current Indicator
20 September 2023	**HCP12 2023**	**THE BLETCHLEY PATHFINDER (NEIGHBOURHOOD WORKING)**	**Chief Executive**	**The Bletchley Pathfinder Proposal is now included in the MK Deal** **The JLT is actioning the proposal as agreed by the Partnership and will bring periodic progress reports to future meetings**	GREEN

MK Together | Health and Care Partnership

Bedfordshire, Luton and Milton Keynes Integrated Care Board report

Author: Felicity Cox, Chief Executive, BLMK Integrated Care Board

Date: **8 November 2023**

Purpose of Report:

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 Milton Keynes City Council.

1. Recommendation

The Health and Care Partnership is asked to **note** the report.

2. Introduction

2.1 The following summarises items of interest that have been considered by the BLMK Health and Care Partnership and the Board of the ICB since the last meeting of the MK Health and Care Partnership.

3. Annual General Meeting (AGM)

The Annual General Meeting (AGM) of the Integrated Care Board took place on 29 September 2023. Chair Dr Rima Makarem, Chief Executive Felicity Cox and Deputy Chief Finance Officer Stephen Makin provided an overview of 2022/23, including the break-even financial position achieved by the ICB. Also presented were the Annual Reports for BLMK Clinical Commissioning Group for months 1-3 of 2022/23. Both Annual Reports can be found on the ICB's website.

4 Bedfordshire, Luton and Milton Keynes Integrated Care Board Meeting

4.1 The Board of the ICB met on 29 September 2023, the communications summary from the meeting is below.

4.2 Felicity Cox provided an overview of work underway to prepare for the planned industrial action from consultants and junior doctors week commencing 2 October 2023 and informed the Board that, following inspections, there was no reinforced autoclaved aerated concrete (RAAC) in BLMK's NHS estates. The Board celebrated the news that Head of the BLMK Cancer Network, Kathy Nelson, had been named Ground-breaking Researcher of the Year Award at the national BAME Health and Care Awards in London on 28 September 2023.

4.3 There was one question from the public about how the ICB plans to fund the East of England (South) Integrated Stroke Delivery Network. Chief Nursing Director, Sarah Stanley, outlined that the ICB is committed to the concept of Integrated Stroke Delivery Networks and is working with partner ICBs, and regional and national colleagues, to consider how these could best be supported in an affordable and sustainable way. She acknowledged the hard work of all local health and care staff who provide direct or indirect support to those affected by strokes.

4.4 The following items were discussed:

4.4.1 **Resident's story** – members watched a video from Catherine, a resident from Bedford who is deaf. She shared her powerful story in BSL. She explained the challenges that people who are deaf face when accessing health and care, including being able to make or change an appointment and engage with health and care professionals. The Board reflected on the need to think about and change how we communicate to ensure easy and fair access for everyone – a key part of the Denny Review of Health Inequalities.

4.4.2. **MK Deal – inclusion of the Bletchley Pathfinder** – The Board received an update from all four places including MK and was pleased to agree to include the Bletchley pathfinder as the fifth priority within the MK Deal.

4.4.3 **Health and Employment Outline Framework** – The Board heard how Places are taking forward the action plans arising from the ICB's Health and Employment Seminar in July. In MK this is due for discussion at the Joint Leadership Team in November/December. At a system-level a framework was agreed which will include work to maximise the support from Anchor Institutions, make full use of the Apprenticeship Levy and broaden volunteering opportunities. The Chief People Officer for the ICB outlined what the ICB will be working on to support residents in applying for work in the health and care system. The Chief People Officer also shared examples of recent work, such as a campaign to support residents without easy access to the internet to hear about job opportunities. It was confirmed that VCSE organisations would be central to supporting the development and implementation of new Health and Employment Framework for BLMK, an outline of which will come to the BLMK Health and Care Partnership meeting on 31 October.

4.4.4 **Mental Health, disabilities and autism** – The Board supported work to develop a new Mental Health, Disabilities and Autism collaborative in BLMK that would encourage more joined up working across the system, with focused work at place to deliver care closer to those who need it. The Board heard how a model for new ways of working was in development and asked for more information on how Primary Care Networks (PCNs) and GP surgeries

would fit into the model. The Board asked for more detailed work to be undertaken around the governance and membership as the collaborative emerges.

4.4.5 **Equality, Diversity and Inclusion** – the Chief People Officer for BLMK took the Board through six areas where focus is needed to help us retain our health and care workforce. Providing a living wage for staff and creating the right culture was the focus of the discussion, including ensuring that all people are empowered to 'speak up'. Partner organisations were invited to reflect on the culture of their organisations and endorse the action areas to support their people in thriving at work.

4.4.6 **Financial and operational reports** – members received formal updates from quality and performance, finance and governance, as well as an update on Section 75 agreements, which were agreed by the Board. The Chief Transformation Officer provided assurance on winter plans for urgent and emergency care and the Board approved the plan, in line with NHSE requirements and thanked partners in Bedfordshire and MK for their efforts in working together to maintain system flow. Board members asked that officers continue to work to a prevention agenda to support people in keeping well and encouraged neighbourhoods to lead the way on this work. The roll out of virtual wards was commended as among the best performing in the England. The Board added a strategic risk to its register to respond to the challenge of health literacy in our population as highlighted by the Denny Review.

5. Single Version of the Truth – Follow-up from Last MK HCP Meeting

5.1 At the last meeting, further detail on the plans to establish a single version of the truth was requested. ICS partners have worked together over the past few months to explore how we deliver a single version of the truth, in terms of shared view access to data. Through this work, the project has identified a preferred solution and a procurement approach to link our data, maximising our existing and planned investments through the use of a federated data view that will allow partners to safely share and access each other's data to deliver better outcomes for our residents in the future.

5.2 The ICB is taking the preferred approach to partner organisations' governance meetings before coming to the ICB Board in December to agree the system-wide approach. The current timeline is to have an operationally live platform available and bringing benefits to our residents by July 2025.

6. Future Meetings

6.1 BLMK Health and Care Partnership – 31 October 2023 at Luton Town Hall – a verbal update will be given at the meeting.

6.2 Joint ICB and Health and Care Partnership seminar – 24 November 2023 – on early years development and supporting children to be ready for school at MK Christian Centre, Oldbrook

6.3 Board of the ICB – 8 December 2023 at MK City Council Civic Offices

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List of Annexes
List of Background Papers
None

MK Together | Health and Care Partnership

Moving to a more dynamic JSNA – An update on the Milton Keynes Joint Strategic Needs Assessment and the BLMK Population Health Intelligence Unit

Author: Ian Brown, Chief Officer for Public Health at Bedford Borough Council

Date: 8 November 2023

Purpose of Report:

The report gives provides an overview of a new approach to maintaining a Joint Strategic Needs Assessment (JSNA) for Milton Keynes and seeks formal support from the Health and Care Partnership for this new way of working. The report also sets out progress towards establishing the Bedfordshire, Luton and Milton Keynes Population Health Intelligence Unit.

1. Recommendations

The Partnership is asked to:

1.1 Endorse the new, dynamic approach to the JSNA and note that going forward this will replace the previous arrangements.

1.2 Promote the new JSNA website as a useful resource for understanding local needs and supporting effective service planning.

1.2 Engage with the ongoing JSNA development process and provide feedback on the content and presentation of the JSNA.

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2. Joint Strategic Needs Assessment

2.1 The JSNA provides a local assessment of current and future health and social care needs. Health and Wellbeing Boards have a statutory responsibility to produce a JSNA and must have regard to the JSNA when preparing their Joint Local Health and Wellbeing Strategy[1]. The shared public health team for Milton Keynes, Bedford Borough and Central Bedfordshire lead the JSNA process on behalf of the MK HCP.

2.2 The Milton Keynes JSNA previously consisted of a series of static topic-based chapters that were difficult to maintain and not widely used. The aim of the new JSNA is to bring together existing public health intelligence products

[1] https://www.gov.uk/government/publications/jsnas-and-jhws-statutory-guidance

more clearly under the JSNA banner, alongside a series of new interactive data dashboards and in-depth chapters.

2.3 The new JSNA website replaces the previous JSNA process and is an important resource for those working within the Council, NHS and beyond who are planning and delivering services on behalf of and in partnership with local communities. It will also be a source of information for anyone in the wider community who is keen to understand the many factors that impact on the health and wellbeing of the people of Milton Keynes.

2.4 The JSNA takes a life course approach (from pre-conception to end of life). It should not be seen as a static document but as an evolving resource. New content will be added over time and content can be shaped to meet users' needs.

2.5 As well as previous Director of Public Health reports, the Pharmaceutical Needs Assessment, various topic-based needs assessments and population profiles, at launch the JSNA includes the following new resources:

Population and Place Data Dashboard – a PowerBI dashboard providing the latest data on the population of Milton Keynes including: age and sex, ethnicity, life expectancy, healthy life expectancy and population density.
Children & Young People Data Dashboard – a PDF dashboard, which will be upgraded to PowerBI by the end of 2023. It includes: the latest data on fertility, birth and infant mortality rates, smoking during pregnancy, birth weight, school attainment, childhood obesity and hospital admissions.
Children & Young People Detailed Analysis – the factors that impact on the health and wellbeing of children and young people, and the interventions to address them. Sections on healthy pregnancy, healthy birth and early years and school-aged years.

2.6 The following elements will be added by the end of 2023:

Ageing Well Data Dashboard – including the latest data on over 65 population demographics and projections; life expectancy; mortality; morbidity; and disability-adjusted life years.
Living and Working Well Dashboard – including the latest data on smoking; drug and alcohol use; sexual health; healthy weight; national screening programmes; and wider determinants, including employment and deprivation.

2.7 Over the next 12 months further content will be added on topics including an adult learning disabilities data dashboard and detailed analysis for Special

Educational Needs and Disabilities; vulnerabilities and inequalities for children and young people; living and working well; and ageing well.

2.8 To remain up-to-date and relevant the JSNA platform requires the on-going support and engagement of teams across the local authority, as well as BLMK ICB and other NHS partners, local Healthwatch and the community and voluntary sector. This can sometimes be a challenge due to competing priorities within the teams.

2.9 The Milton Keynes JSNA is overseen by a steering group that includes representatives from Milton Keynes City Council Public Health, Children's and Adult Social Care teams, as well as BLMK ICB and Healthwatch Milton Keynes. The development and maintenance of the JSNA is overseen by the Public Health Evidence and Intelligence team, which is part of the shared public health service across Bedford Borough, Central Bedfordshire and Milton Keynes City councils. The team can be contacted at: jsnafeedback@bedford.gov.uk

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3. BLMK Population Health Intelligence Unit

3.1 All Integrated Care Systems (ICS) have been asked by NHS England to establish a 'shared intelligence function' which is a "*system-wide, multi-disciplinary collaboration of intelligence professionals, with representation from analytical leaders and key teams across the whole ICS*[2]".

3.2 Building upon existing collaborative working between the local public health intelligence teams and the Integrated Care Board (ICB), BLMK ICS has invested in the development of the BLMK Population Health Intelligence Unit (PHIU), which is being hosted by the public health team at Bedford Borough Council.

3.3 The PHIU will harness existing analytical capacity and bring in new resources to create an integrated team that produces high quality local insights to inform decision making by ICS partners across BLMK.

[2] https://www.england.nhs.uk/long-read/building-an-ics-intelligence-function/

3.4 The five PHIU objectives are:

3.5 The PHIU will undertake a number of discrete projects each year to address strategic system-level questions, e.g. 'how will population growth and demographic change over the next 20 years affect demand for health and care services?', as well as providing routine analytical outputs, e.g. self-service dashboards, to provide operational and clinical insights for programmes of work at local authority 'place' and neighbourhood levels.

3.6 The PHIU will consist of a dedicated core team hosted by Bedford Borough Council, adding analytical specialisms that are currently in short supply across our system. This team will draw on the existing expertise of analyst colleagues from across the system.

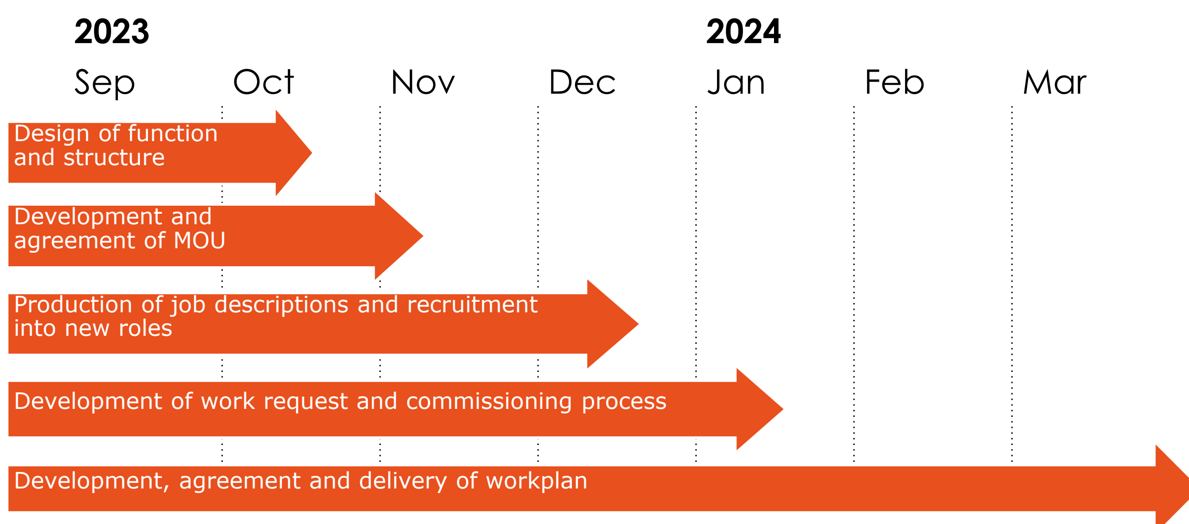
3.7 As well as working with the ICS digital programme to influence the digital and data strategies (including the development of a Strategic Data Platform), the PHIU will be responsible for improving data literacy among non-analysts and championing evidence-based decision making across the ICS.

3.8 While there is potential overlap between the JSNA and PHIU functions, the PHIU will be focussed providing new insights derived from linked health and local authority data, increasing analytical skills and capacity, and developing a data-driven culture. Relevant outputs from the PHIU will be hosted on the JSNA platform, and over time the PHIU will help to improve the quality of JSNAs and ensure that JSNAs inform decision-making in the NHS.

3.9 A Consultant in Public Health has been recruited to lead the PHIU and work is underway to recruit to the core PHIU posts. A work plan is being developed, and several projects are already completed or underway including:

BLMK Employment and Health Data Pack – a set of infographics that describe how employment and related health conditions vary across BLMK for specific population groups. This data pack was used to inform the discussions at an ICS seminar on 21 July 2023.
BLMK Early Years Data Pack – a set of infographics describing how early years outcomes vary across BLMK. This pack will be used to inform the discussions at an ICS seminar on 24 November 2023.
BLMK Population Health Modelling – estimating future demand for major health conditions and the potential for mitigation through preventative interventions in order to inform strategic decision making across the ICS. This work will be based on a set of new population projections that are adjusted for planned housing growth.
Fuller Neighbourhood Profiles – the PHIU is developing a series of neighbourhood profiles to support primary care and system partners to implement the recommendations of the Fuller Stocktake. The neighbourhood profiles will include information on local population demographics, health needs and community assets.

3.10 The PHIU implementation timeline is as follows:



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MK Together | Health and Care Partnership

Carnall Farrar review of the development of health and care integration in Milton Keynes

Author Michael Bracey, Chair of the Joint Leadership Team (JLT)
Rebecca Green, Head of Milton Keynes Action Improvement Team

Date 8 November 2023

Purpose of Report

To share the independent review of health and care integration in Milton Keynes and proposed some follow-on actions for the Health and Care Partnership to consider.

1. Recommendations

1.1 To note the full report at Annex A and consider the main recommendations included.

1.2 To ask the Integrated Care Board (ICB) to produce a framework by June 2024 which sets out how greater responsibility for resources and decision making will be made available to our place based partnership as is matures.

1.3 To organise a workshop in early 2024 with the aim of developing our medium term vision for each of our priorities, and health and social care more generally.

2. Introduction

2.1 Back in 2019/20 Carnall Farrar (CF) worked with health and care organisations in Milton Keynes and the ICB (BLMK CCG at that point) on the development of a Milton Keynes place-based operating model.

2.2 On behalf of BLMK ICB and the Joint Leadership Team, CF were invited to return in September 2023 to undertake an independent review of the development of health and care integration in Milton Keynes since their 2019/20 visit.

2.3 The CF review explores progress, highlights the enabling factors which have been critical to the success of the MK place-based partnership so far and makes recommendations for consideration by the ICB and all partners for the further development of the place based operating model. The full report is provided at Annex A.

2.4 The CF report will be taken to the ICB board meeting on 8 December 2023 for consideration along with any recommendations to the ICB Board from the Milton Keynes Health and Care Partnership.

3. Summary of report findings

3.1 The CF report makes the following recommendations:

1. Building on current progress to further drive and embed a population health management approach within Milton Keynes - This includes use of local data to segment local populations, targeted interventions to improve outcomes and address health inequalities and establishing a neighbourhood-based delivery model.

   Bletchley Pathfinder is highlighted as an opportunity to accelerate PHM, setting the direction for other neighbourhoods. The importance of ensuring engagement of a wider network of health and care partners such as primary care, VCSEs and residents is highlighted.

2. Agreement of future funding to support Place priorities - As the current transformation fund for the Milton Keynes Health and Care Partnership is non-recurrent the ICB and place-based partnership will need to work together to identify recurrent funding for place-based transformation work.

   Considering financial pressures, clear reporting and assurance structures are required to demonstrate impact of any investment. The place-based partnership should consider how to collaborate to achieve efficiencies for the system as well as drive transformation.

3. Aligning on the target operating model for Place-led functions – To date the MK Deal has intentionally focused on delivering transformation work rather than the operational responsibilities of the ICB and this is reflected in the ICB's latest target operating model.

   Place led functions, both existing and future ones, could evolve into leading commissioning of some services where wider operational responsibilities may be better organised and led locally.

   Additional specific responsibilities and the associated resources will need to be clearly defined through open dialogue between the ICB and the MK HCP and agreed by all partners.

4. Building resilience and flexibility within Place - The success and positive culture which has been established is rooted in the strong personalities and reputations of place-based leaders; a change management programme will help embed and codify the positive, collaborative culture that has been created to ensure the partnership can endure future changes in leadership. As the partnership matures, arrangements will require a structured and

regular review process to support flexibility and evolution of the priorities, whilst reviewing the continued effectiveness and oversight of place-based arrangements.

List of Annexes

Annex A – The development of health and care integration in Milton Keynes – report of findings (Separate Annex)
Annex B – Draft 2028 Workshop proposal (Below)

ANNEX B

For consideration by the Health and Care Partnership on 8 November 2023

DRAFT 2028 WORKSHOP PROPOSAL

The independent CF review into the development of health and care integration in Milton Keynes has highlighted the need for us to set out a clearer vision for the medium term development of place-led functions, in relation to both our agreed priorities any wider operational responsibilities which may be better organised and led locally.

As a result it is a proposed that we hold a workshop in January or February 2024 with the aim of developing an ambitious medium term vision for each of our priorities. In essence, what are we trying to achieve over the next four years.

As a reminder of our priorities:

- Improving system flow (hospital admissions and discharge)
- Tackling obesity
- Children and young people's mental health
- People with complex needs (not yet started)
- Neighbourhood working (Bletchley Pathfinder)

Outline of the proposed workshops:

- Half day session
- Invitation-only, likely to be around 50 participants

- Aiming for a mix of service leaders, practitioners, councillors, voluntary sector and Healthwatch
- Starting with an overview of progress to date
- Followed by group discussion, each focusing on a different priority (five groups)
- Groups asked to consider aspects such as prevention, access, workforce, integration and so on
- Groups facilitated by the responsible members of the Joint Leadership Team (JLT)
- Then time to think about other responsibilities that may be better place-led by 2028
- Plenary/feedback session at the end to bring together some of the main messages

The workshop will be written up and presented to the Health and Care Partnership on 20 March 2024 for a discussion and agreement of any actions.

The development of health and care integration in Milton Keynes

CONTROLLED DOCUMENT

1. Introduction

In 2022, Milton Keynes (MK) was given city status, an important breakthrough for securing its local identity and endeavour to build a place for its communities and businesses to thrive. As now one of the UK's most productive and largest economies, the city has a diverse and fast-growing population of nearly 300,000 people. A largely coterminous set of health and care public sector organisations are working as part of the community in MK, they are Milton Keynes City Council (the Unitary Local Authority), Milton Keynes University Hospital (the acute provider), Central and North West London NHS Foundation Trust (the community health and mental health provider) and seven established PCNs.

Supported by its coterminous geography and clear identity, the health and care organisations in MK have long expressed strong ambitions to deliver transformative change for their population and respond to growing demand whilst containing system costs; it has been well recognised that collaboration is critical to meeting these goals. However, progress to realising these ambitions has been slow with the absence of formal arrangements through which to coordinate the work.

The joint work required to manage the Covid-19 pandemic provided an accelerant and the advent of Integrated Care Systems (ICSs), and a shift towards more collaborative, place-focused arrangements set out in legislation and NHSE's vision for *'Thriving Places',* created a renewed opportunity for cementing place-based working. In response to this, MK health and care partners have been embedding and maturing their model for place-based working and have achieved significant progress. This includes developing, agreeing, and working on a set of shared local priorities – the MK Deal – and aligning on these with the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board (ICB).

This report sets out findings and learnings from an independent review of progress in the MK place-based partnership, since it set out to determine its operating model in 2019. Carnall Farrar (CF) were commissioned to undertake the independent review having worked previously with health and care organisations in MK and in the wider BLMK ICS in 2019/20 to support the development of proposals for place-based arrangements and plans for joint working. In 2019 relationships were strained and extensive engagement was required to align partners on a collaborative agenda. This review has explored progress since this initial work. It has involved a desktop review collating findings from CF's previous work in BLMK and comparing this with documentation describing current MK place-based arrangements; observation of a MK Joint Leadership Team (JLT) meeting to observe governance and current ways of working; and 1:1 interviews with key partners from across MK Place and the BLMK ICB to explore progress, enablers and opportunities for the future.

The report outlines the journey MK health and care organisations have been on over the past four years, critical factors which have enabled their success, and opportunities for further development.

2. Where are MK now?

Context

Early in Government's plans to formalise ICSs and Place arrangements, health and care organisations in MK were already demonstrating significant appetite for change. Partners in MK recognised they were in a good position to accelerate place-based working; sharing ambitions to go further, faster, in working together to meet rising demand and system pressures. They were well-positioned with a clear MK identity, well-performing providers, stable finances, and the opportunity to scale the early stages of integrated care already underway.

Despite perceived readiness for change in MK, initial progress towards establishing a formal place-based model was slowed by the pandemic and other competing factors. Although agreed on an ambition for place-based working in MK, partners were unsure how to realise that future through new arrangements as the strategic commissioning policy emerged nationally alongside concepts of lead providers and devolved

commissioning responsibilities. Whilst the pandemic accelerated informal collaboration and relationships, its legacy of operational issues impacted progress, in part driving organisations to focus on individual agendas. In addition, relationships with, and between providers within, the historical commissioner landscape of MK CCG and combined BLMK CCGs were sometimes disjointed and challenging; there was a lack of transparency and bilateral relationships between each provider and commissioners used competition as a mechanism for change inhibiting collaboration.

Over recent years the context has begun shifting; greater progress has been made and ways of working within MK Place have evolved and matured to advance the MK place-based partnership agenda. Health and care partners have collectively developed and allied behind a shared vision and direction for the Place, supported by an effective governance structure, stronger collaboration, and maturing working relationships. The formation of the single BLMK CCG in 2021 supported an effective environment for change in the initial stages; new arrangements motivated MK health and care partners to rapidly secure an MK Place identity within the BLMK system, as well as encouraging the CCG to think more about delegation to Place and individual providers, and a transition to 'strategic commissioning'.

Governance and oversight

A clear governance structure led by the Council Chief Executive oversees, coordinates, and makes decisions for Place in MK. These structures are widely recognised across Place leaders and the wider system:

- **The Health and Care Partnership (HCP)** exists as an evolution of the MK Health and Wellbeing Board (H&WB). It is chaired by the Leader of MK City Council and draws on a range of partners from health, care and wider public services including Buckinghamshire Fire and Rescue, BLMK ICB, Central and North West London (CNWL) NHS Foundation Trust, Healthwatch, MK University Hospital NHS Foundation Trust, MK Council, Primary Care Networks, the Thames Valley Police and VCSEs. Whilst continuing to meet the statutory duties for H&WBs, the group functions as the place-based partnership for MK; it holds overall accountability for delivery of the place-based strategy and any responsibilities delegated by the BLMK ICB, including decisions for deploying resources allocated by the ICB to best meet local population needs.

- **The Joint Leadership Team (JLT)** is accountable to and reports to the HCP and acts more as a day-to-day management team to oversee and drive delivery of agreed place-based priorities and support effective collaboration between MK health and care partners. This team is chaired by the Chief Executive of MK City Council and meets every 3 weeks to progress action on key strategic areas. Membership includes two representatives from each of the MK provider Trusts, MK City Council, primary care and BLMK ICB.

Discussions supported by these structures led to the creation of the first-ever "MK Deal" – a clear, place-based strategy for MK focused on a select number of shared health and care priorities.

The MK Deal

The MK Deal was launched in December 2022 through a formal agreement and partnership between BLMK ICB and MK HCP. It marked a clear commitment to closer working across health and care partners in MK, established a clear remit and resourcing for the running and improvement of the local health and care system, and has driven forward change through the development of local priorities.

The MK Deal started out with four clear priorities, each with their own programme lead, steering group, success measures and progress reporting**.** The JLT and ICB agreed to work together to deliver these, combining resource and sharing workstreams, with the BLMK ICB playing an enabling and supporting role. These priorities are described in *Figure 1*.

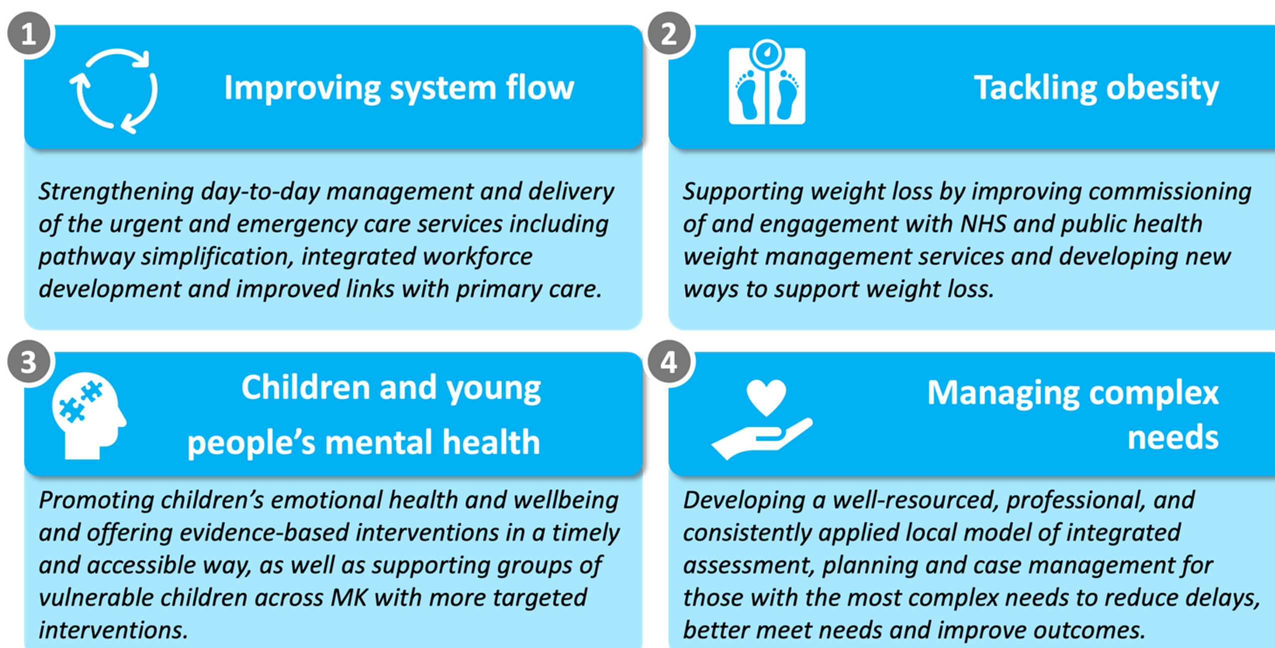

Figure 1: Four priority workstreams as part of the MK Deal, December 2022

Based on the Fuller stocktake findings, MK health and care partners are in the process of establishing a fifth priority on integrated locality (neighbourhood) working, with an initial focus on one neighbourhood referred to as the **'Bletchley Pathfinder'.** This would take a population health management approach, using insights from local population data and bringing together local partners and residents to deliver more proactive, personalised care at a neighbourhood level.

Progress across the MK Deal priorities to date has been variable, with some being further developed than others. This is in part driven by decisions to focus place-based transformation funding in particular areas and partly driven by variability of sufficient programme team resource to drive forward progress. Examples of the ongoing work within two of the most mature of the MK Deal priorities; Improving System Flow and Tackling Obesity; are provided in

Figure 2 and *Figure 3*.

Improving system flow - *Virtual wards initiative*

As part of the 'Improving system flow' priority, and in line with NHSE requirements to establish and expand virtual wards in 2022, MK health and care partners have designed a Virtual Ward composed of hub and spokes to look after patients in their own homes. An initial model for virtual wards has been developed and progressed into an agreed business case to secure significant financial investment.

A small task and finish group is responsible for leading on this work, reporting into the ICS steering group. Membership consists of subject matter experts from MKUH, CNWL and MK City Council, as well as wider advisory group membership from primary care, BLMK ICB and VCSEs. The group committed to both the development of the initial business case, and subsequent delivery of the agreed virtual wards model, ensuring continuity and commitment to delivery in line with the business case.

The business case proposes a hub and spoke model for virtual wards in MK:

- ***The virtual ward hubs** are intended to focus on more dependent patients with multiple comorbidities who often have clinical markers of frailty, and patients requiring the frequent input of specialist hospital consultants (e.g., cardiology or respiratory).*
- ***The virtual ward spokes** are intended to focus on patients with more specific healthcare needs, ordinarily relating to a single specific condition which can be managed by community care clinicians. These patients are less likely to have multiple clinical markers of frailty. Any medical input will be provided in conjunction with the patient's GP, or, where necessary through escalation to a virtual ward hub.*

Plans for virtual wards in MK Place will focus on a performance monitoring system that encourages the 'pulling' of patients into the virtual ward. The service aims to operate at close to capacity to help both mitigate and tolerate clinical risk, freeing up more physical hospital facilities. Outcomes of the scheme will be monitored by recording the extent to which patient needs are being met; the resources that are being deployed; and the acute hospital services that have been released.

Figure 2: Virtual wards initiative case study

Tackling Obesity - *Digital wearables project for diabetes patients*

As part of efforts to tackle obesity in MK, health and care partners are finalising plans to launch a digital incentive scheme across their diabetic population, with the intention of raising physical activity levels and assessing the impact of this on associated patient health outcomes.

The 'Tackling obesity' programme team in MK are due to launch a trial providing diabetic patients with:

1. *A digital wearable device to record physical activity;*
2. *Access to a phone application with personalised activity prescriptions, data and links to rewards;*
3. *Vouchers as rewards for achieving their physical activity goals.*

Health and care partners from MKUH, MK City Council, Primary Care, Loughborough University, Thames Valley Clinical Research Network and the BLMK ICB have been working in collaboration across sectors to deliver on this work, supported by a coterminous footprint with familiar stakeholders. Involvement of a research and development team from MKUH has provided clinicians the reassurance and confidence to engage, provided improved credibility to the work and strengthened the position to obtain the necessary data.

The trial will launch in September 2023 and will span 24 months with plans to recruit around 1000 participants via diabetic annual reviews. Half of patients will have immediate access to the interventions with the other half receiving interventions at 12 months. Patients will undergo regular follow-ups at their annual diabetes checks to collect data on clinical and patient outcomes such as HbA1c and quality of life. This is a unique and exciting opportunity for the population of MK and the trial will enable place-based teams to understand the cost effectiveness of the intervention for potential wider rollout.

Figure 3: Digital wearables project case study

How does this meet policy ambitions for place-based integration?

The place-based partnership approach adopted in MK embodies the aims set out in NHSE's *'Thriving Places'* guidance to make more effective use of combined local resources to drive local outcomes. *Figure 4* outlines how MK and ICB partners perceive its place-based arrangements to deliver against the responsibilities set out in this guidance. As place-based partnerships have no statutory functions, it is up to each individual Place to determine their specific responsibilities based on local requirements and priorities. The MK place-based partnership has intentionally focused its initial agenda on place-based strategy and service transformation rather than through delegation of statutory functions from the ICB with a more operational focus. Whilst there are intentions to widen the scope of the partnership in future, for example, through the adoption of more formal commissioning responsibilities, this table provides an assessment of current arrangements.

Key Significant existing maturity | Some evidence of maturity | Limited maturity

Proposed responsibilities for place-based partnerships, as set out in NHSE's 'Thriving Places' guidance	Maturity assessment of the MK place-based partnership (*with notes)*
Health and care strategy and planning at Place *Supporting development and delivery of strategy at place, in line with both local and system-wide priorities*	*Developed the 'MK Deal' outlining the strategy for Place with a set of focused priorities and corresponding programme steering groups to coordinate delivery of work*
Service delivery and transformation *Integrate and coordinate the delivery of health, social care and public health services around the needs of local population, and empower people who use the services*	*Current focus has been more on service transformation with evidence of collaboration on integrated service delivery e.g. empowering service users through digital wearables project.*
Connect support in the community *Work with a wide range of community partners to leverage and invest in community assets and support for improved wellbeing*	*Efforts to engage wider community partners are shown through existing priority work e.g. digital wearables project, which utilises annual diabetes health checks to identify and monitor patients. The Bletchley Pathfinder priority is likely to drive further community connections.*
Align management support *Collectively agree options to align and share resources*	*The HCP brings together health and care partners from across MK to collectively decide how to deploy resources allocated by the ICB to Place to best meet the needs of the MK population.*
Promote health and wellbeing *Work with local agencies and community partners to influence the wider determinants of health and wellbeing, and to support other local objectives such as economic development and environmental sustainability*	*There is a variety of work underway in MK to promote and improve wider population health and wellbeing. For example, the Tacking Obesity priority is conducting work to identify and implement actions to address the spectrum of health and wellbeing drivers related to obesity, including the wider determinants of health across MK such as advertising. Furthermore, the MK50 plan outlines ambitions for MK Place by 2050, with strong emphasis as a healthy city and working to reduce inequalities. Work through the Bletchley Pathfinder priority will support this goal by engaging wider system partners and looking to further explore and address the wider determinants of health.*
Service planning *Taking responsibility for elements of the commissioning cycle*	*The ICB has agreed to be led by the MK place-based partnership on the commissioning of services in scope of MK Deal priorities and there is a potential opportunity to mature this function in future (for example, delegation of formal commissioning responsibilities from the ICB to Place)*
Population health management *Drawing on population health insight to support care redesign locally and address health inequalities*	*The Tackling Obesity priority has demonstrated a data-driven approach to tackling obesity across the spectrum of population health, from the healthcare focused end of increasing access to and uptake of weight management services, through to embedding innovation (e.g. wearables) for upstream obesity management and prevention solutions, and shaping the wider environment and determinants of health across MK.* *Whilst this data-driven population health approach provides an effective building block for driving forward more targeted population health management (PHM), further work is required to adopt a PHM approach. This includes continuous use of data to segment and risk stratify local populations, development of targeted interventions to improve outcomes*

	for those segments address health inequalities and implementing a neighbourhood-based multi-disciplinary team delivery model. The emergent Bletchley Pathfinder priority is expected to drive a greater focus on PHM and meet current gaps in this approach.

Figure 4: Maturity assessment of MK place-based partnership arrangements against NHSE "Thriving Places" guidance

The Integration White Paper published in February 2022 has a significant focus on improving integration of health and care across all sectors within Place, as well as allowing significant opportunity for increased local decision-making. The paper highlights the importance of adopting a robust governance model, a dedicated leader who is accountable for delivery of the place-based strategy and leveraging the use of pooled budgets between NHS and local government, all of which are being demonstrated in MK. The paper also describes the intention for Places to develop additional local priorities based on national NHS objectives; the MK place-based partnership has reflected these in the MK Deal priorities where relevant and recognise their responsibility to support their delivery. BLMK ICB are looking to establish more robust mechanisms to report progress against these priorities to place-based forums and across the ICS.

Whilst progress against the national priorities continues to be monitored by the ICB, reporting of these national priorities into the HCP/JLT will need to be established with the hope to address this through the implementation of place-based teams from the ICB.

3. What have been the critical success factors?

A series of success factors have been critical to building the collaboration, including the shared vision for health and care and the effective governance in the MK place-based partnership. **The five enabling factors outlined below** have been fundamental to secure direction, alignment, and commitment across MK's health and care leadership - all essential components for high-performing leadership teams.[1]

1. Alignment around a shared direction and focused priorities

The clear, coterminous geographical and health and care provider footprint has supported MK to establish a clear identity as a 'Place'; with established organisational partnerships and delivery structures providing a significant foundation to build upon.

The MK Deal has clearly set the direction and focus for health and care partners in MK and has built a strong sense of shared ownership of, and commitment to, the MK Deal priorities. In part, this was enabled by the place-based partnership having the space and autonomy to develop this independently and bottom-up around local needs and shared strategic objectives. The process involved in developing the MK Deal, as much as the deal itself, has been critical to building collaborative approaches across health and care partners through shared problem-solving. It has helped to build stronger relationships and trust between leaders, breaking down historical barriers and shifting focus from internal facing to aligning around the new shared direction.

Being intentionally selective and limiting numbers of priorities has ensured discussions are more delivery focused and workloads are more manageable, supporting more effective delivery and greater impact. The shared and focused direction in the form of the MK Deal has allowed the JLT to dedicate energy and time to making tangible progress on a select number of priority areas.

The MK Deal priorities are clear, visible, and accessible meaning wider partners and the public outside of the formal governance understand what the priorities stand for and share a commitment to the same direction. This widespread awareness is supported by the engagement of local politicians and Healthwatch MK in the development of the priorities, creating local energy and momentum around driving change.

[1] DAC model, Center for Creative Leadership

"There is a real sense of shared ownership than previously. The priority work has helped to build local relationships and trust by solving problems together."

"We have benefitted from not trying to do everything and focusing on a small number of priority areas."

"I have been really impressed with the contributions from politicians and Healthwatch in MK – they have been strategic and supportive of the whole approach in MK, ensuring questions are constructive. Healthwatch representatives have shown understanding and shared ownership of the MK Deal work."

2. Resource dedicated to place-based priorities

Transformation funding provided by the ICB, and in turn ringfenced by the HCP for MK Deal priorities, has been critical to progress collaborative working on shared priorities. Having dedicated budget for these from the outset has enabled a focus on delivery and action through place-based discussions, by providing partners with the resource and authority to implement joint decisions.

Resource in the form of workforce has also been key to progressing place-led work. BLMK ICB has committed to providing a dedicated team for the MK Deal in the form of the MK Improvement Action Team. In addition, having ICB place-based representatives on the HCP and JLT has been vital to broker conversations and build understanding and relationships between place-based leaders and the ICB. Participation from the ICB has provided line of sight in both directions and facilitated greater transparency in communications by clearly translating the intentions of each, whilst effectively balancing the level of input required from the ICB with clear efforts to maintain the autonomy of Place.

Having people internally in MK Place who are aligned and focused on driving forward the MK Deal priorities has helped coordinate efforts to meet key milestones and timely programme delivery. Health and care organisations have shown commitment to the shared vision by dedicating a consistent set of senior representatives to form core governance structures and attend meetings in person. A key part of this is through the JLT which convenes senior representation from across Place on a regular basis to coordinate delivery of place-based priorities. JLT members also commit significant time and energy outside of JLT meetings to act as programme leads for the MK Deal priorities, as well as dedicating members of their own organisation's staff to act as part of the integrated programme steering groups. This shows shared ownership and support for the place-led agenda across organisational boundaries.

"MK has been provided money and the authority to work together in this space."

"ICB representatives within MK governance structures have acted as an effective translation service for the ICB, whilst ensuring the autonomy of Place is maintained to pursue their own agenda."

"Staff have been allowed dedicated time to work on the MK Deal priorities by their host organisations."

3. Strong leadership from the Council

The leadership shown by the Council for the MK Deal, HCP and JLT has been widely identified as critical. Both in acting as an honest broker in NHS-focused discussions and as an equal partner in discussions with the NHS. The involvement of the Council in this way has facilitated meaningful engagement across different sectors grounded in place-based needs, and helped build integration, relationships, and collaborative working into the governance of the MK place-based partnership. The Council's significant involvement has also created a firmer understanding of the roles of the NHS and the Council, that were historically blurred, developing a common language between the two.

In particular, the Chief Executive of MK City Council, a well-respected figure in MK, has been instrumental in supporting and brokering the MK Deal and providing strong leadership of its place-based governance structures. Often taking ownership for local health and care decisions in a unique and progressive way for a place-based system, many have reflected on the significant cultural change this has created across health and care partners in MK.

"Leadership from the council has been pretty fantastic - helping bring leaders across place together and manage engagement with wider partners effectively."

"The bravery of a couple of key individuals in the JLT has been particularly important and the JLT team has supported them to do this… leadership from the Council CEO in particular has been very significant."

4. Clear leadership, decision-making and governance arrangements

Place-based arrangements in MK are underpinned by an effective governance structure composed of two principal groups: the HCP and JLT. Together, these provide complementary forums for discussions to occur between place-based partners that enable effective decision-making, oversight, and delivery of health and care for the whole of MK. There is widespread clarity on the purpose, roles and responsibilities of the HCP and JLT; and each has its own Terms of Reference, membership and clear alignment of the role and decision-making authorities of each in relation to one another. The HCP meets every three months as the strategic overarching structure for place, taking overall responsibility for decisions on how to spend the transformation budget. The JLT meets every three weeks, functioning as the day-to-day leadership team progressing and operationalising the MK Deal and reporting into the HCP.

The JLT is considered a core feature of the MK place-based partnership's success, acting as a productive and action-focused forum to coordinate and oversee delivery of the place-based agenda, convening the Council, ICB and all NHS providers on a regular basis. Key features of the JLT include:

- **A focused and targeted membership** composed of core place-based health and care partners considered to have the greatest knowledge of MK Place and role in delivering its health and care priorities;
- **A balanced membership structure** which ensures all partners have an equal voice at the table by comprising two representatives from each of the NHS Trusts, the MK Council, primary care and ICB;
- **Consistency in membership** and thus meeting attendees has created continuity and familiarity with decision-making processes, as well as enabling senior leads to build relationships through regular interaction;
- **Seniority in membership** and dedication of senior people to attending these meetings means that those who are at the meeting and contributing can drive action;
- **Short and focused meeting agendas**, with only the most relevant information provided and discussed. This means time is spent on brainstorming and tackling difficult issues to generate clear actions and agenda items have a focus on MK Deal priorities which all partners in Place have bought into;
- **Face-to-face meetings**, essential for building lasting and trusted relationships;
- **A safe space** for healthy debate between partners where voices are respected, differences in opinion are discussed openly and shared actions can be agreed and taken forward.

In addition to these fora, each deal priority has its own integrated steering group with dedicated leads and representation from relevant health and care partners across MK. Some of whom sit on the JLT and with dedicated resource from across Place and providers. These steering groups have delegated responsibilities and decision-making powers to drive forward work on the MK Deal priorities.

The governance described has supported strong, collaborative, and more equitable relationships across provider organisations and commissioners. As a result, place-based working in MK has shifted from dispersed teams aligned to individual organisations to a joint management team meeting regularly and partnering on shared agendas. As a result, individuals across NHS and local government have a greater understanding for each other's roles and priorities.

"Face-to-face meetings of the JLT have been massively effective to build relationships and familiarity."

"JLT meetings involve senior people attending in person every 3 weeks for 1.2-2 hours – this commitment and focus from organisations and senior people is very powerful"

5. Cross-organisational and sector collaboration founded on closer partnerships

There is a positive culture founded on familiarity and relationships, alignment on shared priorities and willingness to collaborate and an equal and safe platform for the voices of different providers and leaders. This significant cultural shift in how partners communicate and perceive their relationships with one another has been critical to the transformation of MK's place-based arrangements. Where leaders were previously focused on specific organisational needs (leading to tensions and limited progress), now they communicate with one another as equals and leader-to-leader, understanding different perspectives and having more open discussions about the shared agenda. There is a mutual respect of one another and a continuity of relationships, as well as a recognition that partnership working is essential to achieve individual as well as collective success. Differences in opinions which naturally exist are managed respectfully between individuals through open, inclusive, and constructive debates to reach a shared agreement. Outside of governance structures, partners have clear lines of communication in place to regularly make themselves available to one another, with operational bilateral discussions often taking place.

> *"The JLT act as critical friends to one another and we always bring each other back around to the key priorities."*
>
> *"There is very positive attitude, culture and way of working together which is straight-talking and adult-adult, but also focused on getting stuff done and sorting stuff out in a pacey, no-nonsense manner."*

4. Opportunities for further progress

The place-based partnership in MK has built strong foundations through its place-based vision, priorities and partnership structures for health and care. This provides a progressive and exciting platform to go even further in setting out and delivering its intentions and priorities for Place.

Driving a population health management approach

Population health management (PHM) is critical to improving local population outcomes and reducing health inequalities. Effective PHM requires use of local data to segment and risk stratify local populations, development of targeted interventions to improve outcomes and address health inequalities, and establishment of a neighbourhood-based multi-disciplinary delivery model. As a key component of the ambitions set out in *'Thriving Places'*, the vision has always been for PHM to form a core responsibility of the MK place-based partnership.

MK's Tackling Obesity priority demonstrates an approach to improving population health through three strands of work: 1. Using insights from data to identify and improve patient access to weight management services; 2. Innovation, such as digital wearables; and 3. Shaping the wider environment and determinants of health. Whilst this work provides a strong foundation for effective PHM in MK, further work is required to adopt the PHM approach as described in *'Thriving Places'* and above.

The new Bletchley Pathfinder priority has the potential to significantly accelerate and bridge the gaps for population health management in MK by enhancing maturity and setting the direction for other neighbourhoods. It also provides an opportunity to better engage MK residents and the wider network of health and care providers such as primary care partners and VCSEs; all essential partners for delivering effective population health management. In line with the ambitions of the Fuller Stocktake to establish multi-disciplinary neighbourhood teams at a place-level, the MK place-based partnership will need to consider how best to engage and involve these voices in place-led decisions, and whether this requires new governance arrangements to do so. This will be supported by the provision of additional primary care roles and integrated neighbourhood manager roles dedicated to Place as part of the ICB's new resourcing structure.

"The place-based partnership in MK is not currently looking at population health in its entirety. As they mature, they should review local data to identify priorities that can make a real difference to local population outcomes. Bletchley pathfinder will be a good opportunity for this."

"There is a need to bring more voices from primary care, VCSEs and local residents around the table at place-level – at the moment representation is only from general practice."

Agreement of future funding to support Place priorities

The availability of a shared transformation fund for the MK HCP has been critical to securing collaboration and alignment across teams and enabling tangible progress on the shared priorities to date. However, there is no expectation for this funding to continue into future years. Absence of dedicated funding for MK to sustain existing initiatives and initiate further work risks collaboration becoming less action-focused and more reflection-based, compromising existing developments and limiting further evolution of the place-based partnership. To enable MK health and care partners to continue working collaboratively, and with autonomy to drive forward transformation at Place, the ICB and the MK HCP will need to co-develop a shared plan for funding ongoing transformation work; this should look to identify a recurrent budget, from existing ICB and Place resources, to allocate to place-led activities. Current financial pressures in the system underline the importance of mutual commitment to this work from all health and care partners, as well as establishing clear reporting and assurance structures to demonstrate impact of investment.

To date, discussions between health and care partners in MK have predominantly focused on how best to spend money on transformation initiatives, rather than considering shared ways to generate financial savings in MK Place. Whilst continued funding to support further transformation work is important, the MK place-based partnership, enabled by the ICB, should also consider ways to collaborate to save money for the system, as well as how best to contribute to ICB decision-making on the most effective use of core funds.

"We need a medium-term financial plan for MK Place as money will ultimately become the blocker to further progress once it runs out"

"So far, we have focused on spending interesting discretionary transformation funding. We have not yet been collaborating to save money or involve ourselves in the decision-making processes for core funds."

Aligning on the target operating model for Place-led functions

To date, MK HCP has intentionally focused on delivering transformation work rather than the operational responsibilities of the ICB. This is reflected in its responsibilities in the ICB's latest target operating model. However, future aspirations are for the MK partnership to transition to leading commissioning of some services associated with the MK Deal priorities. This involves defining how far it wants to take a greater role in commissioning; whether this continues to have a transformation-only focus or if responsibilities spread wider into leading other elements of commissioning, such as performance monitoring and assurance. The ICB needs to support MK HCP to align on the right balance and any associated resource requirements.

The level of resource required to support these future arrangements in Place needs to be affordable to the BLMK system, originate from both MK-based organisations and the ICB, and be proportionate to the level of responsibility taken on by the MK HCP. It is also important that the resource dedicated to the MK place-based partnership – distinct from resource provided by individual partners – can facilitate the necessary assurance required from each statutory organisation in terms of performance against the priority areas. For example, the leadership of commissioning functions means facilitating the assurance required of the ICB and the Council. With significant presence on the ICB from MK there is already a governance alignment that can be leveraged. Additional specific responsibilities and the associated resources will need to be clearly defined through open dialogue between the ICB and the MK HCP and agreed by all partners.

"The ICB restructure will better define resource for places in terms of having a funded core team able to support the MK deal priority programmes"

"If we were provided additional people to work within Place we would progress faster"

Building resilience and flexibility within Place

The leadership and relationships of the JLT and HCP lie at the core of their place-based success and positive culture. This is specifically rooted in the strong personalities and reputations of those leading the place-based agenda. Whilst extremely positive, it also highlights the need to sufficiently embed and codify the positive, collaborative culture that has been created by these individuals across all levels of Place to ensure the partnership can endure future changes in leadership and to support dissemination down to all levels of each organisation. An effective change management programme, supported by the ICB, could help to inform individuals below leadership levels of the changes occurring within MK place and how this impacts their ability to inform and impact health and care service transformation.

In addition to establishing a resilience in culture, the MK Deal priorities and associated governance will need to adapt to expand their scope, alter their direction, and strive for greater ambition as the MK place-based partnership matures, reflecting on and learning from previous priorities. A structured and regular review process will be essential to support flexibility and evolution of the priorities whilst ensuring the continued effectiveness and oversight of place-based arrangements. Selecting the right moment to commence this review cycle will be key to secure ongoing success.

"Would like to extend the scope of the deal into other areas at some point but choosing the right moment to do this will be important."

"If there is any risk in the model at the moment it's because it hinges on specific personalities so need to make sure the culture is embedded."

5. Conclusion

Health and care partners in MK have dedicated significant effort over the past few years to building an effective and pioneering approach to MK's place-based model of working, supported by BLMK ICB. There are clear governance structures in place to formalise the partnership and enable tangible progress, and relationships have evolved significantly with partners now working towards the same direction. Additionally, the place-based partnership in MK is already demonstrating an approach aligned to many elements set out in the NHSE's guidance for "Thriving Places", with plans to mature further in other areas.

Development of the MK Deal, the first of its kind in BLMK ICS, has been critical to transforming place-based relationships and aligning partners towards common goals, shifting the way in which organisations work together to transform health and care in MK. The progress made so far would not have been possible without dedicated resource to deliver on these agreed priorities, strong leadership from the council acting as honest-brokers to facilitate place-based discussions and a robust governance structure with forums such as the JLT dedicated to delivering this work. This is all underpinned by a cultural shift in the way in which partners are communicating and making themselves accessible to one another now they are agreed on a shared direction.

With these critical foundations in place, the MK place-based partnership should look for ways to develop further as they progress delivery of the MK Deal priorities. The partnership should view the Bletchley Pathfinder work as a leading opportunity to involve wider partners in place-based discussions and deliver more ambitious transformation at a neighbourhood level; using local insights to deliver population-specific initiatives and help reduce health inequalities for MK. To support continued delivery of MK Deal priorities, the partnership will need to work collaboratively with the ICB to identify continued funding, agree on a suitable place-based workforce to deliver the work, and communicate any commissioning responsibilities they will adopt as the place-based partnership matures. Core to strengthening place-based arrangements in MK, the Place and ICB should support a cross-organisational and sector change management programme to disseminate information and establish a results-driven culture, similar to the MK leadership team, across all levels of Place.

Although this review did not involve comprehensive benchmarking analysis of MK against other Places, the CEO of Carnall Farrar, Hannah Farrar, provided her views on how the MK place-based partnership is performing based on her extensive experience working with other Places across England:

"CF has worked with multiple Places at different stages of development across the country. There are examples of Places further developed than MK and these have informed some of the recommendations of this report. However, many Places are yet to have developed and implemented a model in the same way as MK, with the Council taking a leadership role on a clear set of local health and care priorities by convening Local Government and the NHS. MK has succeeded in building effective partnerships with a shared mission and demonstrable progress in delivering improvements for residents."

– Hannah Farrar, CEO of Carnall Farrar

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Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

1. Guidance for Quarter 2

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities (DLUHC), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) In Quarter 2 to refresh capacity and demand plans, and in Quarter 3 to confirm activity to date, where BCF funded schemes include output estimates, and at the End of Year actual income and expenditure in BCF plans
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans, including performance metrics
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting is likely to be used by local areas, alongside any other information to help inform Health and Wellbeing Boards (HWBs) on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

BCF reports submitted by local areas are required to be signed off by HWBs, including through delegated arrangements as appropriate, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template
Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background and those that are not for completion are in grey, as below:
Data needs inputting in the cell
Pre-populated cells
Not applicable - cells where data cannot be added

Note on viewing the sheets optimally
To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste 'Values' only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

5. Please ensure that all boxes on the checklist are green before submitting to england.bettercarefundteam@nhs.net and copying in your Better Care Manager.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the HWB to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the HWB to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time

National condition 4: Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Reablement outcomes (people aged over 65 still at home 91 days after discharge from hospital to reablement or rehabilitation at home), and;
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process.
This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2023-24 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at HWB level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements.
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Capacity & Demand Refresh

Please use this section to update both capacity and demand (C&D) estimates for the period November 2023 to March 2024.
This section is split into 3 separate tabs:

5.1 C&D Guidance & Assumptions

Contains guidance notes including how to calculate demand/capacity as well as 6 questions seeking to address the assumptions used in the calculations, changes in the first 6 months of the year, and any support needs and ongoing data issues.

5.2 C&D Hospital Discharge

Please use this section to enter updated demand and capacity related to Hospital Discharge in the bottom two tables. The table at the top then calculates the gap or surplus of capacity using the figures provided. expected capacity and demand from your original planning template has been populated for reference. If estimates for demand and/or capacity have not changed since your original plan, please re enter these figures in the relevant fields (i.e. do not leave them blank).

In Capacity and Demand plans for 2023-24, areas were advised not to include capacity you would expect to spot purchase. This is in line with guidance on intermediate care, including the new Intermediate Care Framework. However, for this exercise we are collecting the number of packages of intermediate/short term care that you expect to spot purchase to meet demand for facilitated hospital discharge. This is being collected in a separate set of fields. You should therefore:

- record revised demand for hospital discharge by the type of support needed from row 30 onwards
- record current commissioned capacity by service type (not including spot purchasing) in cells K22 to O26
- record the amount of capacity you expect to spot purchase to meet demand in cells P22 to T26.

Spot purchased capacity should be capacity that is additional to the main estimate of commissioned/contracted capacity (i.e. the spot purchased figure should not be included in the commissioned capacity figure). This figure should represent capacity that your local area is confident it can spot-purchase and is affordable, recognising that it is unlikely to be best value for money and local areas will be working to reduce this area of spend in the longer term.

5.3 C&D Community

Please use this section to enter updated demand and capacity related to referrals from community sources in the bottom two tables. The table at the top then calculates the gap or surplus of capacity using the figures provided. The same period's figures has been extracted from your planning template for reference.

If estimates for demand and/or capacity have not changed since your original plan, please re enter these figures in the relevant fields (i.e. do not leave them blank).

Data from assured BCF plans has been pre-populated in tabs 5.2 and 5.3. If these do not match with your final plan, please let your BCM and the national team know so that we can update out records and note the discrepancy in your response to question 1 on tab 5.1. Enter your current expected demand and capacity as normal in tabs 5.2 and 5.3.

HM Government

NHS England

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

2. Cover

Version 3.0

Please Note:

- *The BCF quarterly reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.*

- *At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.*
- *All information will be supplied to BCF partners to inform policy development.*
- *This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.*

		Checklist Complete:
Health and Wellbeing Board:	Milton Keynes	Yes
Completed by:	Mick Hancock	Yes
E-mail:	mick.hancock@milton-keynes.gov.uk	Yes
Contact number:	Via Microsoft Teams	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes	Yes
If no, please indicate when the report is expected to be signed off:	Wed 08/11/2023	Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC Discharge Fund tab.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D Hospital Discharge	Yes
5.3 C&D Community	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Milton Keynes

Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off	

Confirmation of National Conditions

National Conditions	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter:	Checklist Complete:
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Milton Keynes

National data may be unavailable at the time of reporting. As such, please use data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2023-24 planning				For information - actual performance for Q1	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
		Q1	Q2	Q3	Q4					
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	117.0	81.0	153.0	112.0	104.3	On track to meet target	N/A	Our virtual ward, same day emergency care centre and Urgent Community repsonse service have all contributed to the metric. More work is taking place in realtion to avoidable admissions and will focus on falls	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	95.0%	95.0%	95.0%	95.0%	93.48%	Not on track to meet target	Whilst we have seen a slight decline in perfromance in this area we remain confident we will achieve this target. Our new integrated discharge hub will open in December and this will make a significant	N/A	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				2,112.6	314.8	On track to meet target	N/A	We are focussing on falls prevention to further improve this work. A new strategy wil shortly be available and we will be considering options to further integrate our approach to falls.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				481		On track to meet target	N/A	Whilst we have seen a slight increase in the number of new admission to care homes, we remain confident we wil achieve our target. We have consistently achieved this target over previous years. With a new	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				82.2%		On track to meet target	N/A	We continue to remain on track to achieve this target. Our focus on discharge pathway 1 will only improve the situtation as we further integrate our Home First approach.	Yes

Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Milton Keynes

5.1 Assumptions

Question / Response	Checklist Complete:
1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include how learning from the last 6 months was used to arrive at refreshed projections?	
Having worked with the system , the data has remained the same since our last review with no vast changes given the original plan scoped the year. There is additional short term care for homecare capacity referred i	Yes
2. Please outline assumptions used to arrive at refreshed projections (including to optimise length of stay in intermediate care and to reduce overprescription of care). Please also set out your rationale for trends in demand for the next 6 months (e.g how have you accounted for demand over winter?)	
Demand:	
There are no signifcant changes referenced.	Yes
Capacity:	
Same as above , the BCF plan outlines what we have and are planning to commission to tackle any area of deficit.	Yes
3. What impact have your planned interventions to improve capacity and demand management for 2023-24 had on your refreshed figures? Has this impact been accounted for in your refreshed plan?	
Utilising the homecase DPS more effctively has allowed additional capacity in this area with new concepts being commissioned such as bridging and live in care options which have been referred in the main BCF plan. T	Yes
4. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
Internal reablement capacity remians challenging due to staffing and sickness however due to the success of the DPS for homecare this is in place to support , again no spot purchasing is required.	Yes
5. Please outline any issues you encountered with data quality (including unavailable, missing, unreliable data).	
You will see that pathway 0 the figures have been changed to 0 , this is because the last reporting was all discharges. The work to rectify this with the trust is still ongoing. National advice supported this.	Yes
6. Where projected demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?	
We know that demand outweights capacity in reablement/rehab and have a clear plan using the Homecare DPS to manage this. The throughput out of rehab/ reablement beds remains challenging , seeing 5 spot purc	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and question & answer document

5.1 Assumptions

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- actual demand in the first 6/7 months of the year
- modelling and agreed changes to services as part of Winter planning or following the Market Sustainability and Improvement Fund announcement
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

5.2 and 5.3 Summary Tables

The tables at the top of the next two tabs show a direct comparison of the demand and capacity for each area, by showing = (capacity) – (demand). These figures are pre-populated from the previous template as well as calculating new refreshed figures as you complete the template below. **Negative figures show insufficient capacity and positive figures show that capacity exceeds demand.**

5.2 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record their refreshed expectations of monthly demand for supported discharge by discharge pathway.

Data from the previous capacity and demand plans will be auto-populated, split by trust referral source. You will be able to enter your refreshed number of expected discharges from each trust alongside these. The first table may include some extra rows to allow for areas who are recording demand from a larger number of referral sources. If this does not apply to your area, please ignore the extra lines.

This section in the previous template asked for expected demand for rehabilitation and reablement as two separate figures. It was found that, by and large, this did not work well for areas so the prepopulated figures for these service types have been combined into one row. Please enter your refreshed expectations for rehabilitation and reablement as one total figure as well.

Virtual wards should not be included in intermediate care capacity because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, please select the relevant trust from the list.

From the capacity and demand plans collected in June 2023, it emerged that some areas had difficulty with estimating demand and capacity for Pathway 0 (social support). By social support, we are referring to lower level support provide outside of formal rehabilitation and reablement or domiciliary care. This is often provided by the voluntary and community sector. Demand estimates for this service type should only include discharges on Pathway 0 that require some level of commissioned low-level support and not all discharges on Pathway 0. If it is not possible to estimate figures in relation to this please put 0 rather than defaulting to all Pathway 0 discharges.

5.2 Capacity - Hospital Discharge

This section collects refreshed expectations of capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS) (pathway 0)
- Reablement & Rehabilitation at home (pathway 1)
- Short term domiciliary care (pathway 1)
- Reablement & Rehabilitation in a bedded setting (pathway 2)
- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

The recently published Intermediate Care Framework sets out guidance on improving capacity, and use of this capacity. You should refer to this in developing your refreshed BCF Capacity and Demand plans.

As with the 2023-24 template, please consider the below factors in determining the capacity calculation. Typically, this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay.

Caseload (No. of people who can be looked after at any given time).

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility.

Please consider using median or mode for Length of Stay where there are significant outliers.

Peak Occupancy (percentage) - What was the highest levels of occupancy expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

The template now asks for the amount of capacity you expect to secure through spot purchasing. This should be capacity that is additional to the main estimate of commissioned/contracted capacity (i.e. the spot purchased figure should not be included in the commissioned capacity figure). This figure should represent capacity that your local area is confident it can spot-purchase and is affordable, recognising that it may impact on people's outcomes and is unlikely to be best value for money and local areas will be working to reduce this area of spend in the longer term.

5.3 Demand - Community

This section collects refreshed expectations of demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. As with the previous template, referrals are not collected by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the 2023-25 Planning Requirements.

The units can simply be the number of referrals.

As with all other sections, figures from the 2023-24 template will be auto-populated into this section.

5.3 Capacity - Community

This section collects refreshed expectations of capacity for community services. You should input the expected available capacity across health and social care for different service types. As with the hospital discharge sheet, data entered in the assured BCF plan template has been prepopulated for reference. You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to
support recovery, including Urgent Community Response and VCS support. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Please see the guidance on 'Demand – Hospital Discharge' for information on why the capacity and demand estimates for rehabilitation and reablement services is now being collected as one combined figure. Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay.

Caseload (No. of people who can be looked after at any given time).

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility.

Please consider using median or mode for Length of Stay where there are significant outliers.

"Peak Occupancy (percentage) - What was the highest levels of occupancy expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services."

Better Care Fund 2023-24 Capacity & Demand Refrresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Milton Keynes

Hospital Discharge

Capacity - Demand (positive is Surplus)	Previous plan					Refreshed capacity surplus. Not including spot purchasing					Refreshed capacity surplus (including spot puchasing)				
	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	-1332	-1346	-1360	-1375	-1389	83	83	83	83	83	83	83	83	83	83
Reablement & Rehabilitation at home (pathway 1)	-176	-126	-168	-116	-153	-165	-115	-157	-105	-142	-165	-115	-157	-105	-142
Short term domiciliary care (pathway 1)	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15
Reablement & Rehabilitation in a bedded setting (pathway 2)	-27	-27	-27	-28	-28	-27	-27	-27	-27	-28	-22	-22	-22	-22	-23
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	-1	-1	-1	-1	0	-1	-1	-1	-1	-1	3	3	3	3	3

Capacity - Hospital Discharge

Service Area	Metric	Prepopulated from plan: Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Refreshed planned capacity (not including spot purchased capacity Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Capacity that you expect to secure through spot purchasing Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Checklist Complete:
Social support (including VCS) (pathway 0)	Monthly capacity. Number of new clients.	83	83	83	83	83	83	83	83	83	83	0	0	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new clients.	24	24	24	24	24	35	35	35	35	35	0	0	0	0	0	Yes
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new clients.	30	30	30	30	30	30	30	30	30	30	0	0	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new clients.	7	7	7	7	7	7	7	7	7	7	5	5	5	5	5	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new clients.	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	Yes

Demand - Hospital Discharge

Pathway	Trust Referral Source	Prepopulated from plan: Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Please enter refreshed expected no. of referrals: Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Checklist
Social support (including VCS) (pathway 0)	**Total**	**1415**	**1429**	**1443**	**1458**	**1472**	**0**	**0**	**0**	**0**	**0**	
	(Please select Trust/s......)	1415	1429	1443	1458	1472	0	0	0	0	0	Yes
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Reablement & Rehabilitation at home (pathway 1)	**Total**	**200**	**150**	**192**	**140**	**177**	**200**	**150**	**192**	**140**	**177**	Yes
	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	200	150	192	140	177	200	150	192	140	177	Yes
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Short term domiciliary care (pathway 1)	**Total**	**15**	**15**	**15**	**15**	**15**	**15**	**15**	**15**	**15**	**15**	Yes
	(Please select Trust/s......)	15	15	15	15	15	15	15	15	15	15	Yes
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Reablement & Rehabilitation in a bedded setting (pathway 2)	**Total**	**34**	**34**	**34**	**35**	**35**	**34**	**34**	**34**	**34**	**35**	Yes
	(Please select Trust/s......)	34	34	34	35	35	34	34	34	34	35	Yes
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Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	**Total**	**5**	**5**	**5**	**5**	**4**	**5**	**5**	**5**	**5**	**5**	Yes
	(Please select Trust/s......)	5	5	5	5	4	5	5	5	5	5	Yes
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Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Milton Keynes

Community

Capacity - Demand (positive is Surplus)	Previous plan					Refreshed capacity surplus:				
	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	-108	-108	-108	-90	-80	-110	-110	-110	-80	-70
Reablement & Rehabilitation in a bedded setting	-18	-25	-15	-11	-21	-18	-25	-15	-11	-21
Other short-term social care	24	24	24	24	24	20	20	20	20	20

Capacity - Community		Prepopulated from plan:					Please enter refreshed expected capacity:					Checklist Complete:
Service Area	Metric	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	Yes
Urgent Community Response	Monthly capacity. Number of new clients.	386	400	416	358	356	386	400	416	358	356	Yes
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	4	4	4	4	4	20	20	20	20	20	Yes
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	3	3	3	3	3	3	3	3	3	3	Yes
Other short-term social care	Monthly capacity. Number of new clients.	30	30	30	30	30	30	30	30	30	30	Yes

Demand - Community	Prepopulated from plan:					Please enter refreshed expected no. of referrals:					Checklist Complete:
Service Type	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	Yes
Urgent Community Response	386	400	416	358	356	386	400	416	358	356	Yes
Reablement & Rehabilitation at home	112	112	112	94	84	130	130	130	100	90	Yes
Reablement & Rehabilitation in a bedded setting	21	28	18	14	24	21	28	18	14	24	Yes
Other short-term social care	6	6	6	6	6	10	10	10	10	10	Yes

PARTNERSHIP ARRANGEMENTS 2023
October 2023

BLMK INTEGRATED CARE BOARD (ICB)

BLMK INTEGRATED CARE PARTNERSHIP (ICP)

MK Together | Health and Care Partnership

- To enter into formal agreement ('deals') with the ICB with regard to any functions delegated to MK oversee progress
- To ensure multi-agency strategies are evidence based, coherent and align with the wider BLMK strategy and priorities

Membership

The Leader of the Council (Chair)
BLMK ICB Chair (Vice Chair)
BLMK ICB Chief Executive
MKC Chief Executive
MKC Director of Adult Services
MKC Director of Children's Services
MKUHFT Chief Executive
CNWL NHS Trust Managing Director
Primary Care Network representative
TVP Area Commander
Bucks Fire and Rescue Chief Officer
South Central Ambulance Service
MKC Director of Public Health
Healthwatch Chief Executive
VCS representative
MKC Councillor from each group
Independent scrutineer

Four meetings a year
Public meeting

MK Together | Safer MK Community Safety Partnership

- To prepare an annual strategic assessment identifying the crime and community safety priorities
- To produce an annual plan setting out the approach to addressing those priorities

Three meetings a year
Public meeting

SPECIFIC PURPOSE PARTNERSHIPS AND GROUPS

For example:
Domestic Abuse Strategic Partnership
Carers Strategic Partnership

MK Together | Joint Leadership Team

Meeting every three weeks
Not in public

- To provide leadership for delivery and improvement of those functions delegated to the NHS and council
- To be accountable for delegated resources from the ICB or pooled from amongst the partners

Membership

MKC Chief Executive (Current chair)
CNWL NHS Trust Managing Director
CNWL NHS Trust Executive Director
Primary Care Network Directors (two, rotational)
MKC Director of Adult Services
MKC Director of Public Health
MKUHFLT Chief Executive
MKUHFT Deputy Chief Executive
MK Development Director

WORKING GROUPS

- Improving System Flow
- Obesity
- Children's Mental Health
- Bletchley Pathfinder (Fuller)
- People with complex needs (not started)

MK Together | Safeguarding Partnership

Co-ordinating meeting 4 times a year
Not in public

- To co-ordinate the work of partners in relation to safeguarding and improving practice
- To challenge and support partners to deliver on their statutory safeguarding responsibilities

WORKING GROUPS

- Risk
- Tasking
- Review
- Child Death
- Assurance

Membership

TVP LPA Commander (Current chair)
Thames Valley Police (TVP) (two places)
MKC Director of Adult Services
MKC Director of Children's Services
MKC Director of Public Health)
MKUH (two places)
BLMK ICB Chief Nurse Director
CNWL (two places)
Bucks Fire and Rescue
National Probation Service
MK Voluntary Sector Alliance
HMP Woodhill and Oakhill STC
Independent scrutineer

Item 8

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