MK Together | Health and Care Partnership

Item 7

Locality/Neighbourhood working in Milton Keynes

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Executive summary

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

Recommendations:

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

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1. Background

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

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

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

2. Policy background

2.1 An overview of neighbourhoods, places, and systems.

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

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

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

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

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

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

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

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

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

2.3 Fuller Stocktake (2022)

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

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

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

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

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

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

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

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

The report recommended:

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

3. Locality/Neighbourhood working in Milton Keynes

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

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

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

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

4. Opportunities to pilot new approaches within Milton Keynes

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

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

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

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

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

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

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

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

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

5. Proposed next steps

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

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

Appendix One

Primary Care Networks in Milton Keynes

Total registered population 328,790 (July 2022)

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

Appendix Two

Service specification for Integrated Community Service Team

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

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

Overview of the service

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

Care Co-ordinator: (New role)

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

MKC Support Work: (New Role)

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

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

Physical Health Nurse: (New Role)

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

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

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

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

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

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

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

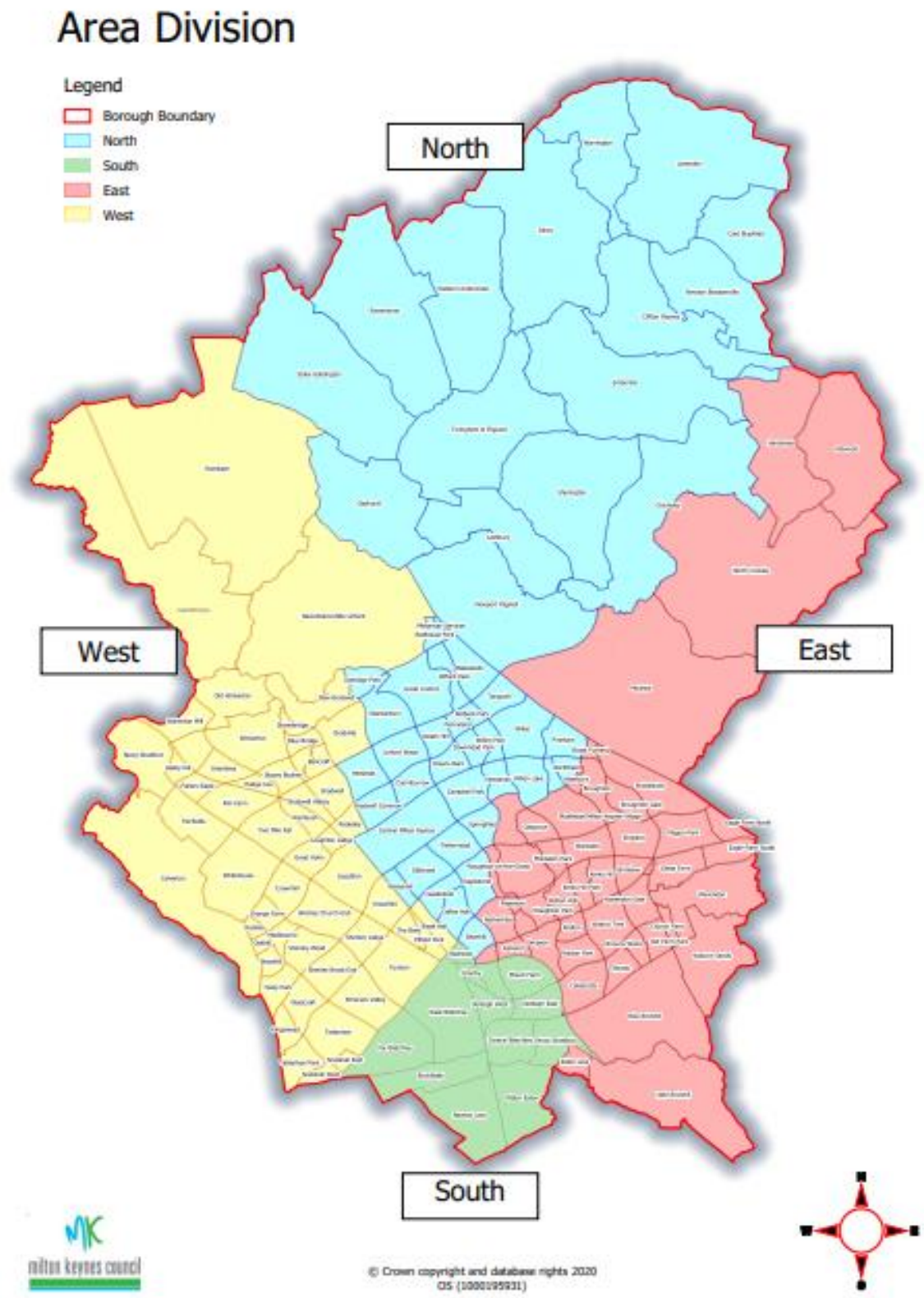
Appendix Three

GP Practices: District Nurse Teams Alignment Milton Keynes

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

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

Appendix Four



Appendix Five

Milton Keynes Council – Housing patches

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