MK Deal Update

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Purpose of Report

To provide an update on progress within the first six months of the MK Deal and to seek support from the Partnership to agree Bletchley as the priority area for the integrated neighbourhood pilot.

1. Recommendations

1.1 That the update on the first six months of the MK Deal be noted.

1.2 That the recommendation of the Joint Leadership Team to select Bletchley as the area to pilot integrated neighbourhood working be agreed.

1.3 That Joint Leadership Team (JLT) be asked to undertake background work to prepare for a potential start of the Bletchley pilot in September 2023.

2. The MK Deal

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

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

2.3 On 1 December 2022 the MK Deal went live with its first two priorities of Tackling Obesity and Improving System Flow (hospital discharge), Children and Young People's Mental Health commenced on 1 April 2023 and Complex Care

is currently in the pre-start phase to further develop a detailed proposal and start date.

2.4 An update on the first six months of the MK Deal is provided in **Annex A.**

3. Neighbourhood Working

3.1 At the last meeting of the Partnership 'The Fuller Stocktake of Primary Care' was considered. The Fuller stocktake 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

3.2 At the heart of the new vision for integrating primary care is bringing together previously separate 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.

3.3 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.

3.4 The report set out an expectation that ICB areas should aim to have integrated teams up and running in neighbourhoods in the most deprived areas first. 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.

3.5 The Partnership agreed that the best way to approach this work would be to focus on a smaller area initially and test out new ways of working and then

apply them elsewhere in Milton Keynes if we are sure they are having a positive impact.

3.6 The Joint Leadership Team was asked 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 and Care Partnership

3.7 The remainder of this report sets out the proposal for the pilot 'The Bletchley Pathfinder' for consideration by the Partnership.

4. The Bletchley Pathfinder

4.1 Following a review of the population health and other data, the JLT concluded that Bletchley was the most appropriate locality for the focus of the first integrated team pilot.

4.2 The Fuller stocktake recommends that people need to be able to describe the geography of a neighbourhood, Bletchley has a strong neighbourhood identity with an easily recognised area. A number of organisational boundaries, including children's services within MKCC, are already aligned with Bletchley.

4.3 A key part of the Fuller approach is the focus on tackling health inequalities with the recommendation priority should be given to the areas of highest need. 23.4% of people within Bletchley live in the 20% most deprived areas in England compared to 14.1% of people in the ICB overall as defined by the Index of Multiple Deprivation. Underneath this headline figure are a range of 'red' indicators showing Bletchley East in the worse 95% nationally for emergency hospital admissions, life expectancy and mortality.

4.4 The Bletchley Pathfinder would broadly follow the three Bletchley ward boundaries of Bletchley East, Bletchley Park and Bletchley West and will include those residents which are registered with one of the five Bletchley general practices. These are: The Crown Primary Care Network : Whaddon Healthcare (includes the Water Eaton branch surgery) 21,757 patients and The Red House Surgery - 13,518 patients. South West Primary Care Network : Parkside Medical Centre - 10,659 patients, Westfield Road - 7,969 patients and Bedford Street (includes the Furzton branch surgery) - 14,784 patients. In total the registered list size of these practices is 68,687 patients.

4.6 At a meeting with the PCN clinical and business leads across Milton Keynes and subsequent follow up with the Bletchley general practices there was widespread support for the proposed pilot. PCNs from outside of the Bletchley area would like the learning from the pilot to be disseminated quickly to support Fuller development in other areas.

4.5 The response from other public sector organisations who provide services to Bletchley residents to being involved has been encouraging. For example, Thames Valley Police are interested in looking at how they can engage with any opportunities for closer neighbourhood working in the area.

5. Next Steps

5.1 To lay the groundwork for a potential start of the Bletchley pilot in September 2023 the Partnership are asked to task JLT with undertaking a period of intensive background work over the next 12 weeks.

5.2 An outline of this three month development period is attached as Annex B.

5.3 During this initial phase the leadership and governance arrangements through the MK Deal will be developed. This will include detailing the linkages with the wider Fuller programme across BLMK.

5.4 There will be a report back to the Health and Care Partnership at the next meeting on 20 September.

List of Annexes

Annex A – MK Deal the first six months

Annex B – The Bletchley Pathfinder development phase