MILTON KEYNES COUNCIL

Milton Keynes NHS
Primary Care Trust

Joint Commissioning Strategy 2006 - 2011

Contents

Contents **2**

1. Introduction and background **3**

2. Milton Keynes **4**

3. Joint Commissioning Team: Recent History **6**

Older People *6*

Learning Disability *7*

Carers *7*

Adult Mental Health and Older People Mental Health Services *7*

Physical Disability *8*

Sexual Health and HIV *8*

4. Commissioning Strategy **8**

Commissioning Vision and Principles *8*

The Vision *9*

5. Commissioning Approach **10**

Population Based Needs Assessment *11*

Setting priorities *11*

Procurement (including tendering and service specification development) *12*

Market Management *12*

Outcome based monitoring and review *13*

6. Challenges for the future **13**

1. Introduction and background

This strategy document sets out the vision and aim for adult health and social care services commissioned by Milton Keynes Primary Care Trust and Milton Keynes Council's Joint Commissioning Team.

The new White Paper – "Our health, our care, our say: a new direction for community services" was published in January 2006. Early review of the White Paper from a commissioning perspective confirms three key messages for health and social care systems – the approach they take should:

- Strengthen the personal control of care through more access to direct payments, individual budgets and a new deal for carers - fitting services round people not people round services.

- Strengthen the focus on prevention and well being by tackling health inequalities and promoting public health. Health and social care will provide better prevention services and earlier intervention. This refocusing should enable health and social care to deliver a shift of the balance of spending towards prevention.

- Strengthen joint working and move to shared strategic planning and commissioning. Develop an integrated commissioning framework that enables sharing of good practice and streamlines local commissioning and contracting arrangements. This approach provides Health and Social Care with the opportunity to locally agree the best service delivery model.

Locally the Council and Primary Care Trust are well placed to deliver on the direction outlined in the White Paper, and to develop an integrated commission function that includes community health, public health, adult social care, housing and primary care. They are also well places to develop this approach and include a wider range of services across all tiers of local government.

The strategy recognises the role that universal health and social care services play in peoples day to day lives and describes an approach to service development and service delivery that starts with the person in need of the service; where they have greater control and choice about how and where the service is delivered -a person centred approach.

The service areas covered by this strategy include Older People, Adults with a Physical Disability, Adult Mental Health services, Older People Mental Health services, Adults with a Learning Disability. Cross cutting service areas are also reflected e.g. Carers, Sexual Health and HIV and Long Term Illness.

This strategy pulls together the key messages from the different service areas and identities overarching issues and challenges. More details about service area commissioning issues are found in the service area's strategy.

The strategy has an overview of the spectrum of services from prevention through to specialist or tertiary level and the different settings considered, including: in people's own homes, in a residential setting, intermediate, acute and tertiary level.

The content of this strategy is based on extensive discussion with stakeholders, local people, service users and service user groups, carers, providers, staff and clinicians and the voluntary and independent sector.

2. Milton Keynes

This section describes the current context in which commissioners are operating and issues they will need to consider for the future.

Milton Keynes is a unique, dynamic and vibrant place to live and work; its strategic location is at the heart of one of three designated growth areas identified by the Office of the Deputy Prime Minister. Milton Keynes is distinct from any other new towns or growth areas because of the continuous development and the scale and pace of that development; it has been growing for the last 30 years. Current plans see growth continuing and by 2031 Milton Keynes emerging as one of a small number of "city regions".

Current age profiles and information from the planning departments and MKi indicate that 46% of the population are aged 30 years or under compared with 41% nationally, and that Milton Keynes also has the highest percentage of the population aged 16 years or under of 376 local authorities in England. The city has a mean age of 36 years compared with England's mean age of 40 years.

In contrast, there are relatively few 20 to 24 year olds living in Milton Keynes and relatively few people aged over 65 years. However the numbers of "young" elderly are rising rapidly and the number of people aged between 65 and 74 years is expected to increase by nearly 50% between 2001 and 2011. It is important to note that although the percentage increase in the number of older people is significant, the overall numbers are relatively small; but as this population ages, the requirement for supportive health and social care services to maintain people's independence will increase and services will need to be able to respond.

44% of the population are couples in their 30s with young families compared to the South East average of 19%, and Milton Keynes has almost twice the South East average for single parents and young adults with children on income support (6.5%).

The proportion of people from black and minority ethnic groups (9.3%) is similar to that of the country as a whole (9.1%). However, the proportion of school-aged children from non white ethnic groups is 17% and it is likely that the future adult population in the city will become increasingly multi cultural.

The number of people unable to work because of disability (including learning disability, mental ill health and physical disability) in Milton Keynes is 3.9% compared to a national average of 3.4% (census 2001). The reported incidence of people having a limiting long term illness in Milton Keynes is 14%; slightly lower than the National Average of 18%. The national prevalence of people with a disability is estimated at 26.8% which suggests a figure of approximately 18,000 disabled people in Milton Keynes, rising by 2,000 every five years (DWP 1998).

There is no data that reflects the number of people living with a physical disability either nationally or locally.

Nationally 1 in 8 people identify themselves as carers in Milton Keynes this figure lower with 1 – 12 reporting themselves to have a caring role.

Overall the incidence of mental health problems is slightly lower than the national average; however in 3 geographic areas the incidence is considerably higher. These areas are known areas of deprivation in Milton Keynes.

The % of the adult population known to Learning Disability services in Milton Keynes is marginally fewer than the estimated administrative prevalence (numbers known to the service) for England as a whole (MK 0.44%: England 0.46%).

There are no major differences between Milton Keynes and the rest of England in the proportion of population in the different socio-economic classes. Despite high levels of employment and relative affluence there are significant pockets of deprivation and poverty within the Borough. Eaton Manor and Fenny Stratford wards are identified as having multiple dimensions of deprivation as are Campbell Park, Walton Park and Wolverton. According to the government indices of deprivation 2000 the Woughton ward in Milton Keynes is amongst the 10% most deprived wards in England. In contrast Newport Pagnell North, Newport Pagnell South and Olney are amongst the 10% least deprived wards in the country. This presents a 9 year gap in the life expectancy between 'richest' and 'poorest'.

Economically, socially and in relation to health, Milton Keynes is closer to England and Wales as a whole than the more affluent longer living southeast and neighbouring Buckinghamshire.

Milton Keynes has a history of successfully targeting areas of deprivation, often bidding for and winning one-off pump priming funds, but the statutory services have struggled to sustain investment in Community development and community capacity building. This work is not central to any one organisation and requires a partnership approach. The Local Strategic Partnership has recognised this issue and through the leadership of public health is developing a plan to ensure that regeneration and tackling social exclusion are at the heart of development.

Milton Keynes was designed with low density housing and with a grid road system to enables cars to get around quickly. It is often described as the city of the car. These design elements, however result in a poor public transport system, with not enough people needing to or choosing to use a bus, and journeys from one estate to another or across the city taking a long time. Estates were designed to be separate from the roads, behind landscaped areas redways, and designed with underpasses to enable people to walk around. This has resulted in estates and areas e.g. redways perceived as unsafe by the community. The position of the shopping centre is unusual, in other cities this would be an out of town development, in Milton Keynes it is at the heart of the city.

Discussions are currently underway to identify how and where Milton Keynes should grow, by expanding into new areas on the outskirts of the city creating more new centres or by regenerating and rebuilding and adding to the current areas. Health and social care should contribute to this discussion and show how the different models will impact on the health and social care system.

Investment in health and social care in the Milton Keynes area has not been adequate in the past, but agencies have responded creatively to the challenges this has created. Investment has been attracted in from central government and from local prioritisation.

Milton Keynes is set to continue to grow and change rapidly. The city is increasingly becoming ethnically diverse and multicultural. There is and will continue to be a young population with significantly larger proportions of children and young adults and a smaller number of older people than the average for England as a whole.

This demography presents challenges to Joint Commissioners and the health and social care economy, planning for services that meet the future needs of the future population. The health and social care system needs to work together to ensure and deliver the right service, at the right place and at the right time delivered by the right person to enable people to stay as close to home as possible.

3. Joint Commissioning Team: Recent History

The Council and Primary Care Group set up the Joint Commissioning Team in mid 2000 (NHS responsibility passed to the Primary Care Trust later in 2000). The team rapidly grew and has responsibility for commissioning services for Older People, Adults with a Physical Disability, Adult Mental Health services, Older People Mental Health services, Adults with a Learning Disability. It also covers cross cutting service areas e.g. Carers, Sexual Health and HIV and Long Term Illness. The team is also the lead for developing partnerships and supporting integration of health and social care. Introducing the Joint Commissioning Team into the health and social care system signalled the beginning of a significant change.

In 2000 the concept of commissioning was new to all service providers, both internal Council and Primary Care Trust providers and external providers e.g. voluntary and independent sector organisations. There was not a clear understanding of the role of commissioners, or the impact commissioning would have on the on the system or the changes it would stimulate. An early role of the team was to engage into discussion and negotiation about the team's role and function with providers.

In 2000 the Joint Commissioning Team and the newly formed contracts team inherited a large list of providers with outdated contractual arrangements and some providers unused to a contractual relationship. There is now an agreed timed programme for tendering and service reviews in place.

Over the passed five years the Joint Commissioners have worked with the wide range of health and social care stakeholders to agree a vision for the future and gain agreement to the priorities that come forward from that vision. The Commissioners working with providers have put in place the building blocks to deliver the change and modernisation of services. Examples of achievements include:

Older People

Implementing the Residential and Nursing Home Strategy for Older People (2002), notably the new contract with Excelcare which delivers state of the art care homes at the local authority rates for older people (and older people with mental health problems) and the development of an "Extracare retirement village", has had a positive impact on the council's position within the local care market. There has also been success in reducing acute hospital delays in transfer of care from an average of over 30 a week in 2001 reduced to 3-4 per week in 2004/5. Joint Commissioners supported by providers reviewed the provision of services and were able to introduced new models of care. This has

expanded the range and type of services available to older people which promote independence and enable people to remain in their own home as long as possible and includes Orchard House (intermediate care in a residential setting), short term beds in nursing homes, and direct access to home care from NHS staff.

In November 2004 Intermediate Care services were integrated following a consultation and a formal partnership agreement and pooled budget planned for 2006-7.

Learning Disability

Joint Commissioning working with providers led the integration of the Learning Disability services in 2004. Pooled budgets for the services were agreed and implemented from 2005-6.

Commissioners working with providers have undertaken a needs assessment / demographic planning exercise to confirm the expected increase in the number of service users expected from 2006 - 2010. This information enables better planning and development of services that will meet people's needs.

The Joint Commissioners have led on the modernisation of day services in line with the Valuing People White Paper. Working on behalf of the Learning Disability Partnership Board, a multi-agency steering group was formed to consult on the changes that were needed. Specific recommendations include the creation of an Opening Doors Team to help new users plan a person-centred plan of day activities.

Carers

Following ongoing discussion with carers, the Joint Commissioner for Carers has commissioned new services that broaden the spectrum of services available. Currently there is a targeted Carers Needs Assessment nearing completion, which will give much better information about current service gaps, the links between carers and inequalities and unidentified carers. The carers support services contract has been successfully retendered and a new provider will be in place by April 2006

Adult Mental Health and Older People Mental Health Services

Joint Commissioning supported by providers, led the integration of Mental Health services in October 2002, Older People Mental Health followed in April 2004. Pooled budgets for these services were agreed and implemented from April 2004 (AMH) and April 2005 (OPMH).

In 2004 the Joint Commissioning Manager for Mental Health commissioned a major multi stakeholder needs assessment. This involved service users, carers, providers and staff working across the health and social care system. The needs assessment confirmed the need to reconfigure and modernise community mental health services and provide a 7 day extended hours response. The outcomes of the needs assessment are currently being implemented.

The retendering of the Voluntary Sector Day Care service and the Return to Work project has provided a more streamlined and effective pathway for service users.

Physical Disability

The equipment budget was pooled under Section 31 partnership arrangements in 2004. The review of the equipment pathway led by Joint Commissioning has delivered increased efficiency to maintain the target of delivering equipment within 7 days whilst delivering an extra 25% of equipment. Service redesign has also created a single point of contact for access to Social Work and Community Occupational Therapy services.

Rehabilitation services for people who are deaf and blind have been successfully retendered and a needs assessment for deaf/blind people is underway.

Currently Joint Commissioning is facilitating a discussion with local providers to identify how they can better work together and improve the service response to people with a physical disability.

Sexual Health and HIV

The Joint Commissioner provided evidence to enable significant increase in funding to develop the service in line with Medfash guidance (the medical foundation for aids and sexual health).

4. Commissioning Strategy

The recent policy direction outlined in a range of national and local documents (NHS plan, Modernising Social Services, NSF's, Adult Social Care Green Paper, Commissioning a patient led NHS, and local priorities as identified in the Community Strategy, and MKC Priorities) confirms the need for commissioners to deliver a shift to community based responses that enable people to remain as independent as possible and that offer choice and involvement. This policy direction requires commissioners to oversee the development of a plurality of provision in health and social care and to work with local providers to sustain that plurality. Whilst close working with the voluntary and private sectors is a relatively new concept with health, social care has a longer history of commissioning services from external providers. There is local experience of shifting services; the Council directly provides a small proportion of the overall provider market, varying between 5% for residential care to 40% for homecare. The PCT has been exploring the wider use of non-statutory voluntary and private sector provision.

Commissioning Vision and Principles

This section describes the vision, aims and high level objectives for the local health and social care system for current and future providers of service. It gives a broad outline of the needs and future needs of the population and how those needs should be met. Increasingly, this joint strategy needs to link closely with others' area strategies to ensure a holistic overarching approach to the community. It will need to build and maintain links with a range of statutory and other sectors:

- **Housing**
- **Transport**
- **Leisure & Lifelong learning**
- **Primary Care**
- **Community groups & Faith communities**
- **Pensions and benefits**

- **Crime and Community safety**
- **Acute Hospital**

The Vision

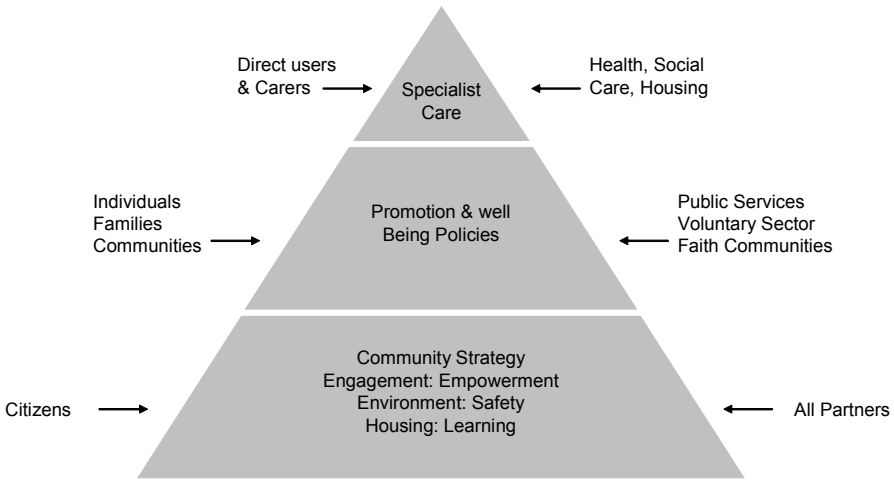
The Vision was developed from discussions with local stakeholders including service users, carers, and local people. It sets out the agreed direction of travel and what the health and social care system wants to achieve

The Joint Commissioning team will commission services that:

- enhance the quality of life
- promote the Independence
- promote the Social Inclusion
- reflect the diversity

of the population of Milton Keynes

Our intention is to shift the balance of resources to a focus of promotion of well being and the extension of universal services away from high cost specialist services. To advance a strategic approach that promotes the quality of life of people and their engagement in the community. The diagram below shows the current service delivery model



Currently most commissioning activity is focused at the top of the triangle, and there is some work underway at the top end of the middle section. However there is little co-ordination across the different sectors of the triangle, which results in service gaps. The activity underway in the middle section needs to continue and to expand so that there greater choice and range of services available to help prevent people moving up into the high cost specialist sector. Commissioners need to develop strong links with those organisations and departments responsible for the bottom section of the triangle so that there is a holistic response to the community including social inclusion and wellbeing responses. Commissioners will ensure that responses to issues are; where possible

joined up and not fragmented or unsustainable and will lead the development of pathways across sectors and services to support that.

Increasingly Local Authority Social Services and NHS Primary Care Trusts are required to deliver services through greater efficiencies, not just through new investment in services from central government. This is referred to as service re-engineering and so there will be in some areas, a shift of funds from existing services that are no longer needed or appropriate, which will be re-invested in improving other services or to create new services.

This vision is high level and to achieve it requires changing the way services are commissioned, managed and delivered, redesigning roles and changing the workforce and shifting investment to deliver the following outcomes for people:

- **Living healthier lives**
- **Improved quality of life**
- **Further opportunities for employment**
- **Making a positive contribution**
- **Economic well being**
- **Greater independence**
- **Better informed**
- **More involved in decision making**
- **Exercise of choice and control**
- **Freedom from discrimination or harassment**

These outcomes will be used to test and challenge how far health and social care are moving towards delivering the vision.

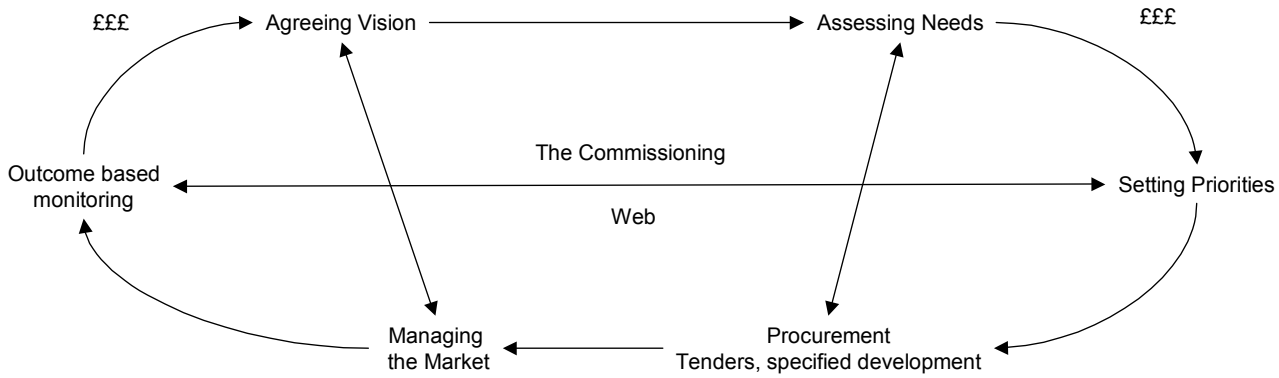
5. Commissioning Approach

The Joint Commissioning Unit from its inception in 2000 used the audit commission definition of commissioning.

> ***"Commissioning is taken as the process of specifying, securing and monitoring services to meet individual's and population needs both in the short and long term. As such it covers what might be viewed as the purchasing process as well as a more strategic approach to shaping the market for care to meet future needs." (Audit Commission)***

As commissioning has become embedded and better understood in the local health and social care system, the definition has been refined and developed to reflect the change in culture and understanding.

The diagram below shows the commissioning web. Commissioning covers a collection of different elements, which are broadly cyclical, but there is an interrelation and cross fertilisation of the different elements at different times in projects. The elements included are:



Population Based Needs Assessment

Commissioners should ensure they access a variety of data sources to ensure they have a comprehensive analysis of the needs of the local population. These sources should include qualitative and quantitative data, service user and staff consultations and surveys, public health data including mortality and morbidity. These will be collected and collated to give a robust overview of need relating to a particular issue, disease or client group. Models or tools are required to predict the needs of future populations and to meet the growth agenda. Joint Commissioners have undertaken or commissioned a range of needs assessment including Intermediate Care (2002) and Older People (2003) Mental Health (2005), Carers (due to be completed early in 2006). It is clear that needs assessments work will need to be reviewed on an ongoing basis, to pick up changes e.g. demographics or mortality and to cover new issues (e.g. telecare). This area of commissioning needs strengthening.

Setting priorities

Health and social care services are provided within a financial limit. Commissioners need to ensure that there is a range of services available that meet the needs of the population, provide choice and deliver high quality results. Commissioners need to continue to working across health and social care, translating information and data and presenting it clearly and concisely. This will enable the development of shared agreement and understanding about joint commissioning priorities.

Current commissioning priorities include:

- Planning for growth ensuring the needs of a culturally diverse and rapidly changing city can be met.
- Ensuring that the needs of all groups are assessed and understood.
- Putting well-being/self help at the centre of strategic planning.
- Developing new innovative partnership arrangements with providers and other stakeholders that meet the needs of the local population.
- Delivering multi functional community services.
- Managing and developing the local health and social care market.

- Developing outcomes for contracts and service level agreements.
- Ensuring that there are choices available.
- Managing risk and not stifling innovation.
- Ensuring that public information and involvement are of a high standard.

To help make difficult decisions, criteria have been developed against which priorities are checked to ensure that service delivery reduces health inequalities and delivers high quality health and social care services. Currently the Commissioning Decision Group (CDG) reviews all health developments. In the Local Authority Joint Commissioners work with providers to share and ensure commissioning priorities are taken forward through the medium term planning route. Commissioners are endeavouring to gain agreement to 'joining up' the health and social care financial and planning mechanisms to ensure that the system is developed holistically. There should be discussion at a Local Strategic Partnership level to influence the mechanisms used in other agencies and other areas to consider bringing together all statutory funding streams to reduce the risk of duplication and to ensure that as far as possible funding is used to target areas and issues e g social inclusion, ill health economic deprivation etc.

Each service area has produced or is developing a service specific strategy. This work involved reviewing the list of commissioning priorities and putting them into an order that reflected the needs of each service area.

Procurement (including tendering and service specification development)

Procurement arrangements between Milton Keynes Council, the Primary Care Trust and the private and voluntary sector market have evolved considerably since 1997; informal 'partnership agreements' with providers had been established over many years, funded through grant payments. These arrangements lacked focus, were not based on any real form of needs analysis and were not measurable. To develop and sustain a plurality of providers and to deliver small local service responses, the partnership approach needs to develop and be underpinned by a robust and open and transparent process and agreements. Where appropriate, more robust contracts and service level agreements are in place, underpinned by specifications, which are in turn based on analysis of need. This has resulted in significant block contracts being awarded through open tendering processes, and subject to high levels of scrutiny. Continual service improvement and effectiveness, efficiency and economy (value for money) are key considerations for all commissioning relationships and will continue to be key pillars in working towards further integration in health and social care and other sectors.

Market Management

Commissioners need to understand and influence their local market. In order to do that joint commissioners are committed to developing a strong local market, working in partnership with the statutory, voluntary and independent sector to achieve a vibrant mixed economy of health and social care provision. Where possible and appropriate they will ensure that services employ local people and purchase goods from the local community. Where appropriate and where it adds value, competition will be used as a means of managing the market. The aim is to achieve services that are efficient and effective and economic – i.e. ones that offer value for money. Commissioners will ensure that service users and carers are involved and helping them understand the local market.

Commissioners will endeavour to provide high quality information and advice to providers; voluntary and community organisations, to build their capacity and develop partnerships and win and retain contracts.

There are a number of different markets and market sectors operating locally and different service areas with differing needs. Commissioners have analysed the market in relation to their service area (and will continue to) and have agreed or are developing a strategy for this work.

Outcome based monitoring and review

Commissioners will move from defining and measuring outputs that show that services are 'doing things right' or quality assurance to developing outcome measures and/or indicators that show that services are 'doing the right things'. The outcomes outlined earlier will be agreed as part of new contracts and service level agreements process. Commissioners will regularly test how far servcies are helping the system to reach the vision i.e. checking that the system is moving in the right direction and 'doing the right thing', for example shifting resources from acute/tertiary services to prevention or enabling more people to stay closer to home.

6. Challenges for the future

Although the development of new models of care will lead to a reduction in reliance on acute hospital beds and shorter length of hospital stays, with a rapidly expanding population, there will still be a requirement for an increase in acute hospital capacity. There should be consideration given as to where and how the citizens of Milton Keynes receive tertiary and specialist services in the future.

The Milton Keynes and South Midlands Study (MKSM), the strategic group planning for growth in the region over the next 25 years, has recently predicted an anticipated increase of 127% in the number of people requiring hospital admission by 2031. However, the new models of care which are being developed to create more capacity in the community, which enable more people to be cared for in their own homes and therefore reduce the length of hospital stay, means that hospital beds are predicted to reduce up to 2021; between 2021 and 2031 there is only a 10% predicted increase in bed numbers.

Joint Commissioners should endeavour to support the Local Strategic Partnership in tackling deprivation; promoting public health and supporting communities, through capacity building and development.

Joint Commissioners should endeavour to support the development of shared IT systems.

The Council and the Primary Care Trust are co-terminous, which has enabled partnership working to develop across health and social care. It is planned to continue to take all opportunities to integrate services, where that makes sense from a user perspective and in line with the approach outlined in the White Paper "Our health, our care, our say: a new direction for community services" (January 2006). If it is to be successful and maximise potential for the future then the system needs to take a strategic decision about how much and how far to join up.

Robust information systems should be developed that bring together the information needs of the local authority alongside the NHS information strategy.

Workforce development is a local and national issue. The national recorded shortages in such areas as therapy and other specialist roles are reflected locally. Additionally local services struggle to recruit to other care roles as there are high levels of employment. This makes it difficult to attract people into work in a field where the skills level is high, but the pay is low.

Some progress in joining up or redesigning roles has made in Intermediate Care, Mental Health and Learning Disability due to the development of joint services. This has resulted in a reduction in duplication and a sharing of skills and expertise. However if the services are to deliver to a growing and rapidly changing population role redesign and review must continue.

In the future local people will experience a fundamental change in how decisions are made about their care. There is to be a strong emphasis on personal responsibility and choice. Self-assessment and self care will play a significant role in identifying their needs. Through the wider use of personalised budgets, people will be able to choose the services they wish to purchase and who they wish to deliver them. Individual budgets will make these choices accessible to a wider population.

Growth results in more people and a rapidly changing needs of the population. The health and social care system struggle to keep up, finances lag behind the population and services struggle to grow to meet need. This situation is due to continue and Joint Commissioners will need to develop better tools and information systems to advise and inform service providers to enable them to respond and develop new service models, to increase current capacity.

An important message for Milton Keynes is the clear indication that health and social care and other universal services should increasingly work more closely together, in order to maximise the benefits of partnership working to deliver better outcomes for people, and minimise duplication of effort.

Milton Keynes Council and Milton Keynes NHS Primary Care Trust intend to continue to work in partnership, expanding the extent of our partnership working where it makes sense to do so. Further integration and further pooling of budgets will follow the strategic leadership provided by the Joint Health and Social Care Board.

In order to ensure each service area focuses on its main issues and challenged Joint Commissioners have or are developing a service area commissioning strategy which gives detail about the commissioning activity being undertaken or planned within that area.