ANNEX A

Milton Keynes
Integrated System (Place) Plan

Executive Summary

2018-2019

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Milton Keynes Health & Wellbeing Board

Purpose

- Welcome to our first **Milton Keynes System Delivery Plan**
- Our plain aims to bring together our shared local priorities to support our work as **one system**
- It reflects & responds to our 10 yr. **Health & Wellbeing Strategy**
- It underpins local delivery of the **BLMK Single System Operating Plan.**
- We have grown and developed as a system in the last year, building on our track record of delivery and **collaborative working**
- The plan describes **the ambitions of the transformation programmes** we are undertaking across Milton Keynes
- It sets out the high level actions and **place based** delivery of how we will work together effectively and
- It is underpinned by our **System Charter**

System Charter

WORKING TOGETHER

All the organisations represented on the Health and Wellbeing Board understand that working in partnership is essential to the effective delivery of this strategy.

Day to day this means:

- Focus on our agreed priorities for MK people
- Being empowered to break through organisational boundaries to do the best for MK
- Focus on prevention and early intervention to keep people healthy
- Openly sharing our knowledge, information and resources to drive major change
- Understanding each other's organisations, services and perspectives; supporting and speaking well of each other
- Recognising people as experts in their own health and wellbeing, and involving local communities, vulnerable people and service users to harness their expertise and experience
- Making decisions collectively
- Acknowledging that we're equal partners
- Acting with integrity, sticking to our decisions and keeping our promises

The Health and Wellbeing Board will monitor the progress being made.

To find out more go to **www.milton-keynes.gov.uk/social-care-and-health/health-and-wellbeing-board**

What do we need to address?

Health Profile – Adults

- **Indicators that are improving**
- Smoking prevalence
- Incidence of TB
- Suicide rate

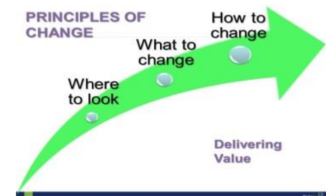
- **Indicators that are significantly worse than similar local authorities**
- Excess weight in adults and the proportion of adults who are physically active
- Hospital stays for alcohol-related harm (improving in under 18s)
- Hip factures in over 65s
- Excess winter deaths

Health Profile – Children & Maternity

- **Indicators that are improving**
- Infant mortality and stillbirths
- Low birthweight babies
- Under 18 conceptions

- **Indicators that are deteriorating**
- Population coverage of MMR (2 doses at 5 years old)
- Immunisations for children in care
- Smoking status at time of delivery

- **Indicators that are significantly worse than similar local authorities**
- Proportion of children aged 2.5 years who are offered an ASQ-3
- Emergency admissions in children aged 0-19 years (A&E attendances low)
- Hospital admissions for gastroenteritis in infants under 1 year
- Hospital admissions for respiratory tract infections in children aged 1 year
- Hospital admissions for epilepsy and asthma in under 19s



Respiratory disease
- Non-elective spend £2.8m higher than 'Best 5' and 11,600 more bed days
- Largely driven by influenza and pneumonia, acute and chronic lower respiratory infections and COPD
- Opportunities to improve annual reviews for asthma and COPD and flu immunisation in COPD

Cardiovascular disease and diabetes
- CVD non-elective spend is £2.2m higher than 'Best 5' and 5,700 more bed days
- Lower than expected levels of recorded diagnoses across all cardiovascular conditions
- Opportunities to improve detection and management of hypertension, AF and diabetes in primary care

Maternity and early years
- Low flu vaccine uptake for pregnant women
- 2,533 more non-elective admissions for under 5s than 'Best 5', including gastroenteritis, lower respiratory tract infections and injuries (lower A&E attendances)

Mental health and dementia
- Fewer adults with depression receiving assessments and having a review recorded
- A lower proportion of adults enter IAPT, more wait >6 weeks, fewer complete and outcomes are worse

What Outcomes do we want to achieve

- That every person in Milton Keynes can live healthy lives for as long as possible. People will have the knowledge and support to live healthy lives and to manage long-term conditions. We will be investing in tackling lifestyle behaviours that have a negative impact on health (smoking, alcohol, obesity).

- That every resident has access to community, primary and social care that is personalised and organised around the individual. Primary care networks using the primary care home approach, where GPs work hand-in-hand with specialists across community and social care, pharmacy and therapies are established for every community.

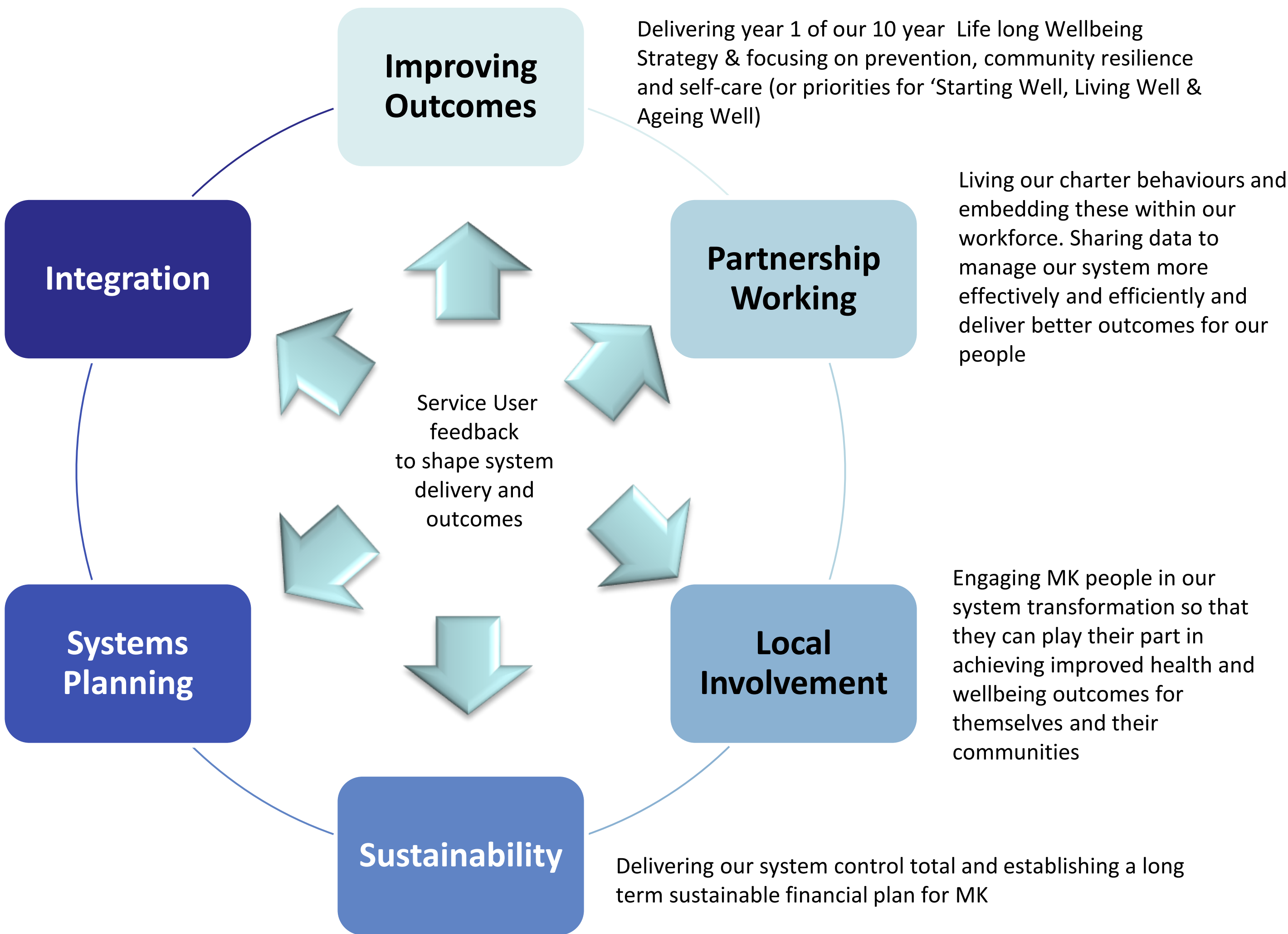
- That there is parity of esteem for mental health and learning disability services, with services built around the needs of residents.

- That the hospital provides services for their population, with every resident having access to world-class specialist care as close to home as possible.

- That care records are shared so there is real continuity of care, and data is used to predict and plan health care interventions and proactively meet the demand for services.

- For Milton Keynes to operate as an Integrated Care Partnership (ICP) – with shared financial, performance targets, goals and aspirations for continuing to improve health outcomes and care services for local people.

Agreed focus for our work together



Delivering year 1 of our 10 year Life long Wellbeing Strategy & focusing on prevention, community resilience and self-care (or priorities for 'Starting Well, Living Well & Ageing Well)

Living our charter behaviours and embedding these within our workforce. Sharing data to manage our system more effectively and efficiently and deliver better outcomes for our people

Engaging MK people in our system transformation so that they can play their part in achieving improved health and wellbeing outcomes for themselves and their communities

Delivering our system control total and establishing a long term sustainable financial plan for MK

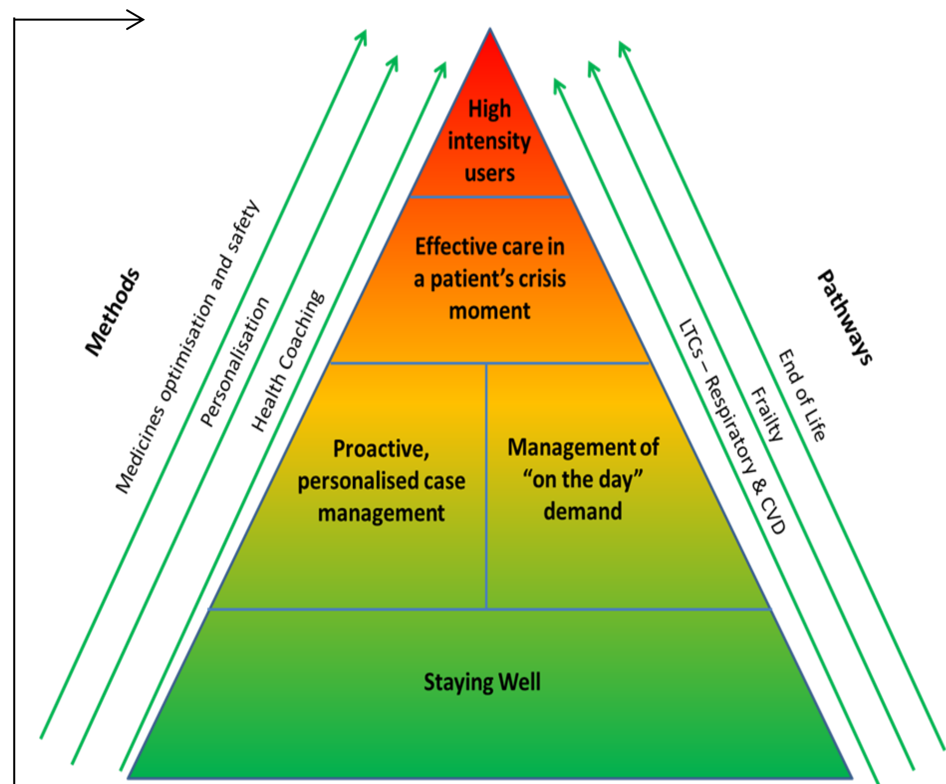
Agreeing one MK operational plan, focussing our resources on system initiatives that reduce non-elective activity and help people to stay well at home; Testing new contractual models to incentivise collaboration and delivery of our system plan

Co-locating key teams in MK to accelerate joint working and signal the removal of organisational barriers. Increasingly sharing functions, key roles and services to remove organisational barriers and deliver better value for the MK £

Our Approach

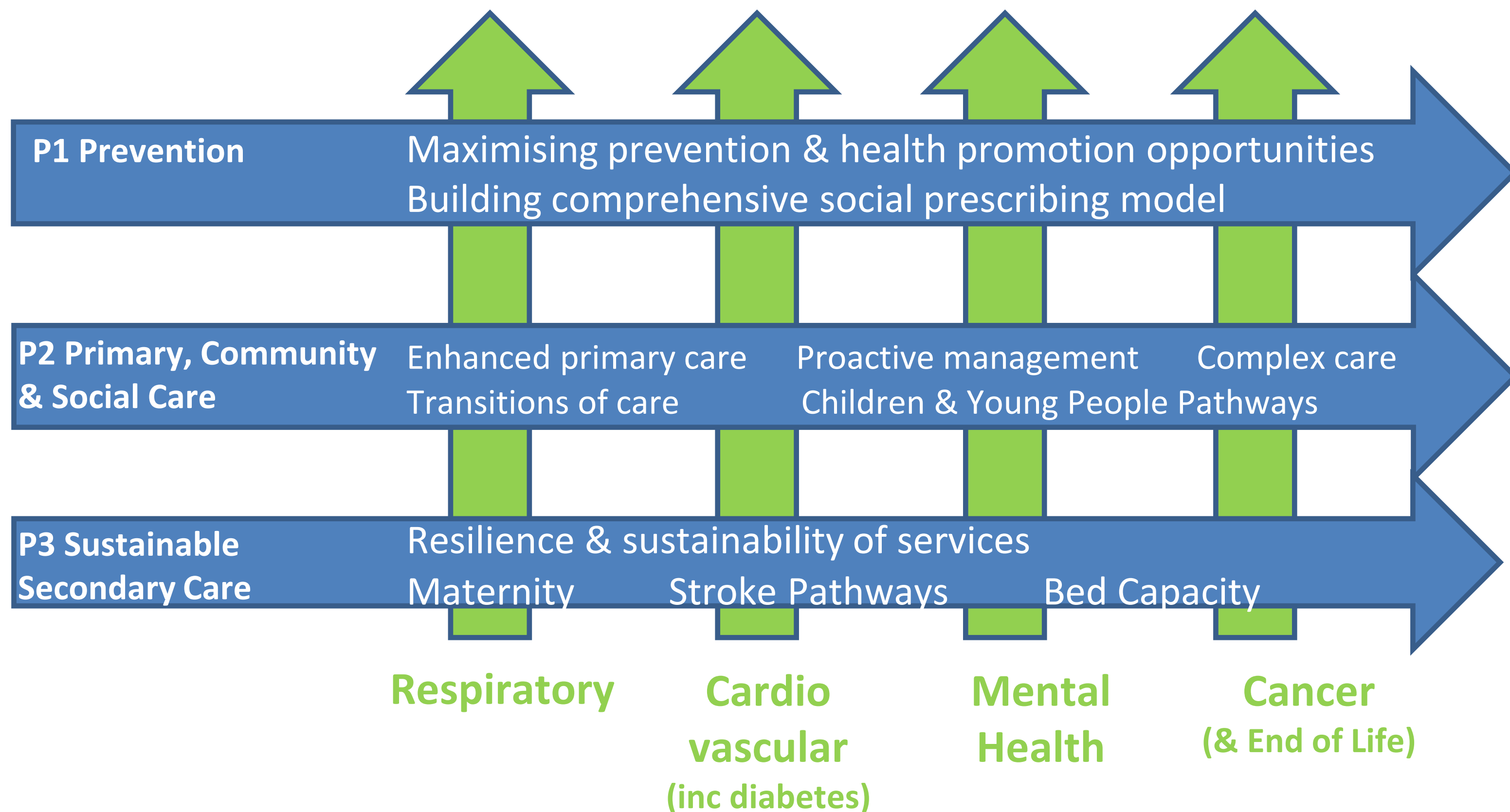
- Working with residents, all health and social care partners and stakeholders in Milton Keynes to improve the **health and wellbeing** of our residents
- We recognise that increasingly we need to do this by **working beyond our individual organisational interests** to focus on achieving the best outcomes for our population
- Collectively we know we need to significantly **reduce unplanned activity** to hospital by strengthening primary, community and social care responses
- Our MK System Plan for focuses on a **whole system integrated approach**
- Areas it covers include:
  - ❑ Targeted prevention and promotion of self-care
  - ❑ Transforming management of 'on the day' demand
  - ❑ Proactive case management of patients at risk of admission to hospital
  - ❑ Responding to and delivering effective care for patients in crisis
  - ❑ Personalised care to reduce demand on services – is the **'golden thread'**

Case Management & Care Navigation Approach includes social and clinical support within the system



Priorities

Our MK System Plan for 2018/19 includes the following local priorities for action which should begin to address sustainable solutions:-



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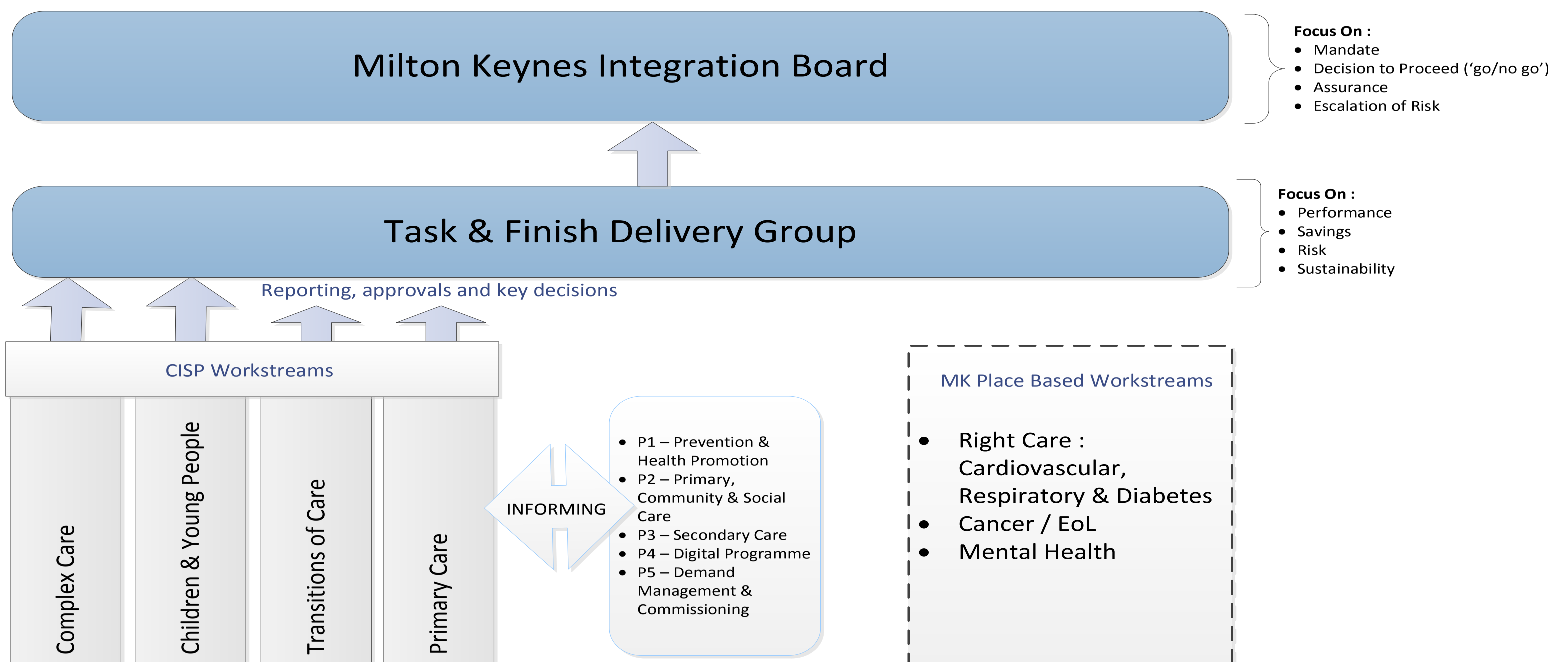
Milton Keynes Health & Wellbeing Board

Oversight & Governance

- **Milton Keynes Integration Board** will continue to influence the strategic direction for commissioning to deliver local transformation and make recommendations to the Health and Wellbeing Board on the direction of travel for local health and social care improvement plans

- **As 'Sponsoring Group' for MK system-wide schemes**, the Integration Board will
  - Provide decision making authority to proceed for new initiatives to deliver place based solutions
  - Financial oversight and scrutiny for all MK system savings schemes
  - Overall quality assurance aligned to the BLMK Governance framework is appropriate



Delivery Highlights- 2018/19

Prevention and Health Promotion (P1)

Local Action	H&WB Priorities
Targeted Prevention & Self Care Implementing patient/client self help programmes focusing on: ▪ Stretch targets for flu vaccination uptakes ▪ Pre diabetes health checks ▪ Identification and testing of undiagnosed hypertension and Atrial Fibrillation ▪ Greater focus on smoking cessation for vulnerable groups, pregnant women and patients with mental health disorders ▪ Wider implementation of Healthier Weight programme ▪ Promotion and increased understanding of self-care	Starting Well - SW3 Living Well - LW5 Ageing Well - AW3

Primary, Community and Social Care (P2)

Local Action	H&WB Priorities
Proactive Care ▪ On going development of primary care home network development programme to incorporate greater community focussed support interventions - **e.g. care navigation/case management health coaching pathways** ▪ Dovetailing improvement plans and access to **psychological therapy** focusing on respiratory and diabetes in children and young people ▪ Increased capacity for high intensive users support and low acuity social prescribing for adult residents with non-clinical presentations	Living Well - LW5 Ageing Well - AW1
Responsive Care for patients in acute care ▪ Optimising ambulatory pathways to support patients treated closer to home ▪ Rollout of urinary tract infection (UTI) hydration scheme and advanced care planning documentation in Care Homes ▪ System wide approach focusing on a points of access to improve patient/client satisfaction (e.g. online booking enhancements to NHS 111 service)	Ageing Well – AW1 & AW3

Delivery Highlights - 2018/19

	Local Action	H&WB Priorities
Sustainable Secondary Care (P3)	**Management of 'On the Day' demand**: ▪ Single front door stream for emergency care by integrating urgent care pathways ▪ Configuration of bed stock allocation to match case mix **Facilitated effective discharge pathways** ▪ Optimisation of non bed stock pathways to facilitate rehabilitation and re-enablement **Resilience & Sustainability** ▪ Focusing on service provision at scale to ensure consistency with national standards ▪ MK system wide bed stock review focusing on patient flows, case mix and resources to inform configuration for optimal bed based 'models of care	Starting Well - SW3 Living Well - LW5 Ageing Well - AW3 & AW7
	Local Action	**H&WB Priorities**
5YFV & National Drivers	**Cancer & End of Life** ▪ Localised pathway(s) and implementation of faecal immunochemical testing (FIT) in GP networks to improve rapid access ▪ Continued focus on national cancer waiting times ▪ Implementation of improvements to discharge planning including advance care planning from community and acute settings into palliative care **Local Maternity System (LMS) – Better Births** ▪ Continue to improve maternity services in line with LMS plan **Mental Health** ▪ Continue to deliver 'parity of esteem' agenda focusing on provision of aftercare assessments and services **Children and Young People** • Focusing on multi agency 5 year programme including single point(s) of access and brief intervention services to meet the needs of children and young people mental health and emotional well being **Diabetes** Focusing on national diabetes improvement programme to support with compliance of treatment targets **Respiratory** ▪ Implementation of 'one stop' community respiratory hub focusing on early diagnosis and specialist multi-disciplinary management	Starting Well – SW2, SW3 & SW7 Living Well – LW2, LW3 & LW5 Ageing Well - AW3, AW4, AW5, AW6 & AW7

Delivery Highlights - 2018/19

Enabler - Digitalisation (P4)

Local Action

Digitalisation and Technology

Electronic Patient Record (EPR)

- Implementation of full EPR with healthcare record sharing across health sectors

Shared Care Record

- Care homes undertaking Information Governance (IG) tool kit assessment to establish access to patient records
- Core roll out of electronic health record to ambulance service
- Extension of summary care record to Continuing Health Care services

Developing whole population health analytics capability

- See below.

Enabler – System Reengineering (P5)

Local Action

Build a sustainable model of Out of Hospital Care in MK

Health & Care partners have committed to work closely together to collectively manage non-elective demand & reduce unplanned admissions to hospital. Development during 2018/19 of an agreed system strategy & steps to delivering desired model of care using STF and local funding streams.

Development of MK Integrated Care Partnership

During 2018/19 work will continue both at BLMK and ‘place’ level in MK to design and establish an operational Integrated Care System by 2019/20

Whole Population Health Analysis

Development of a whole population analytics ‘snapshot’ linking data sets from providers at place level MK acting as ‘test site’ for whole population analytics approach. In 2018/19 an Analytics Report of linked data from acute, community, MH, primary care and social care will be available to inform strategy and give a deeper insight in how best to meet local needs of our population

Resources & Investment

- To support a **comprehensive Care Navigation/Health Coaching approach**, delivered at scale will require investment if the changes proposed are to be fully embedded and sustainable for the future.

- Potential funding/resourcing streams already identified include:-

  a)BLMK STF funding
  - up to £500k additional investment.

  b)MK CCG funding
  - Up to £800k investment in support of the GP Forward View (GPFV) to reduce non elective activity, promote prevention, stimulate and promote cluster working etc.

- Additional investment will be required in future years to enable delivery of the full framework and other sources will need to be identified in collaboration with system partners in time.

- Areas to look at could include:-

  ✓ Targeted investments from CCG held funds on an "invest to save" basis
  ✓ Agreed investments from the funds generated by MRET/Readmission tariff reductions, held by the CCG
  ✓ Ensuring existing Better Care Fund investments support strategy implementation
  ✓ Application of resources deployed to ensure "parity of esteem" for mental health services
  ✓ Redeployment of staff within provider organisations to meet the aims of the strategy
  ✓ Cost savings arising from pooling of some health and social care budgets
  ✓ A diversion of funding originally set aside to finance growth in acute hospital admissions.