Milton Keynes System 'Place' Delivery Plan 2018/19

	Delivery Areas		Implementation	Identified funding stream (e.g. BLMK / MK System/Business as usual)	Lead Partner	Other Partners	Q1 Apr - Jun	Q2 July - Sept	Q3 Oct - Dec	Q4 Jan - Mar	2019 - 2020	
	BLMK Priorities & Approach (from 2018/2019 Single System Operating Plan)	**Map to Local Priority** (H&WB Strategy 2018-2028)	**MK Plan & Associated Actions**		**Organisation** leading or coordinating delivery	**Other System Partners** required to achieve delivery	**Timeline & Key Milestones**					
Whole System Redesign	**1. Build a sustainable model of Out of Hospital Care in MK.**	LW3, LW5, LW6, AW1, AW2, AW3, AW4 & AW7	**Strengthening Primary Care & Reducing Admissions to hospital - Whole System Savings Plan** 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	BLMK STF & Local identified sources/streams	MKCCG	MKC CNWL GP Federation GP Practices MKUHFT	Strategy Agreed	Bid for STF Funds Commence delivery →	→	→	→	
	2. Development of MK Integrated Care Partnership	All – supports wider H&WB Strategy	**ICP Development** 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.	BLMK P5 Work stream	MKCCG as SRO	tbc	*Specific actions & milestones needed from P5 18/19 work plan – not yet confirmed*					
	3. Whole Population Health Analytics	All – supports wider H&WB Strategy	**MK acting as 'test site' for whole population analytics approach**. In 2018/19 a 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 population.	BLMK P5 Work stream	MKCCG	MKC CNWL GP Federation GP Practices MKUHFT	→	→	Analysis & Report Complete	→	→	
	1.Reducing non-medical demand on Primary Care	Living Well & Ageing Well Priority LW5/AW1	**Social Prescribing**: a) Continue with High Intensity Service User Support Service provided by multidisciplinary team (MDT) & P3. Expand to manage up to 100 b) Continue to progress low acuity social prescribing to potentially 19% of adult residents with non-clinical presentation	*See Below – detail outlined/captured in Primary, Community & Social Care Workstream*								
			Proactive Mgt: Develop local system approach to Care Navigation/Case Mgt across Primary Care networks, initial pilot across 1-2 clusters to test concept.	*See Below – detail outlined/captured in Primary, Community & Social Care Workstream.*								

ANNEX B

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	Delivery Areas		Implementation	Identified funding stream	Lead Partner	Other Partners	Q1 Apr - Jun	Q2 July - Sept	Q3 Oct - Dec	Q4 Jan - Mar	2019 - 2020	
Prevention	**2. Early Identification & proactive management of residents with rising risk health needs**	Living Well Priorities LW5 LW6	**Cardiovascular** a) Pilot project focusing on identification and testing of undiagnosed hypertension and Arial Fibrillation through community pharmacies - based in deprived areas b) Primary care detection and treatment programme utilising primary care incentive scheme to increase diagnoses (hypertension, e.g., MK Healthy Hearts) to bring practice levels near to expected prevalence levels	BLMK **£20K** MKCCG **£220K**	MKCCG	MK Public Health GP Practices MK Pharmacies	→	BLMK Evaluation		→		
		Starting Well SW3 & SW7 Living Well Priority LW5 Ageing Well AW3	**Increase Flu and Pneumococcal Vaccination Uptake** a) Overall aim is to increase vaccination of eligible population to the national quartile, building on the progress from 2017/18. Focusing on an increase in stretch targets by: -2.9% for 65years+ - 4.6% for <65years (at risk) - 11.5% for pregnant women - 5% in outpatient settings (including carers of housebound patients) - 75% for staff in acute and community settings b) Localise key messages for targets cohorts of population, linked to public health national vaccination campaigns	BLMK STF **£41K**	Public Health & MKCCG	MK Public Health GP Practices MKUHFT Healthwatch	→	→	→	→		
	3. Targeted Prevention Focus	Starting Well Priority & Living Well Priority SW4/LW3	**Healthier Weight Programme** Pilot a new 0-4 year old targeted excess weight prevention offer in collaboration with Children and Family Centres, Public Health and Weight Management Provider	BAU	Public Health	Children & Family Centres MK Pharmacies GP Practices MKC	→	→	→	→		
		Living Well Priority LW3	**Alcohol improvement programme:** a) Increase identification rates and, streamline pathway within acute out-patient settings for patient referral and advice (included in 'Managing Risky Behaviours CQUIN) b) Engage with primary care to in increase identification of patients at risk and maximise appropriate referral and HCP brief interventions through training, knowledge and awareness	BAU	Public Health	MKUHFT (CQUIN) GP Federation GP Practices Local	→	→	→	→		

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	Delivery Areas		Implementation	Identified funding stream	Lead Partner	Other Partners	Q1 Apr - Jun	Q2 July - Sept	Q3 Oct - Dec	Q4 Jan - Mar	2019 - 2020	
			c) Scope 'work place offers' to encompass how to reduce or minimise the harm caused by alcohol			Businesses						
Prevention		Starting Well Priority SW7 Living Well Priority LW3	**Smoking Cessation** a) Develop option appraisal for the digitalisation of services to improve choice and personalised access for residents b) Greater focus on 'vulnerable groups', pregnant women and patients with mental health disorders who find it harder to quit and where prevalence of smoking is higher c) To help people quit smoking by permitting innovative technologies that minimise the risk of harm (e-Cigarettes)	BAU	Public Health	All MK Partners MK Pharmacies Healthwatch	→	→	→	→		
		Starting Well Priorities SW3 & SW7 Living Well Priority LW5 Ageing Well AW3	**Self- Care** System wide approach to support patients and general public awareness, focusing on: a) Working with a wide range of subject matter experts from stakeholder groups, e.g., MK Carers in development and roll out of educational tools to improve knowledge and skills on health social care related decisions into local communities b) Engagement with 'Your MK' on health related aspects to be incorporated into the Housing Needs Assessments regeneration work plan **c)** Evaluating self-help technology to assist with targeting messaging and health literacy	MKCCG **£10K**	MKCCG	All MK Partners HealthWatch Voluntary Sector	→	→	→	→		
	1. Enhanced Primary Care	Starting Well/Living Well/Aging Well Priorities SW3/LW5/ AW1	**GP Collaboration** – develop primary care networks working towards PCH health population based model of care, with support from MK's GP Federation. 2018/19 will focus on delivery of individual cluster development plans.	BAU	GP Federation	GP Practices MK CCG HealthWatch	→	→	→	→		
			Extended access - for patients by providing evening and weekend GP appointments	BAU	GP Federation	GP Practices MK CCG	→	→	→	→		
			Online consultations - providing patients quicker access to information on symptoms/ and treatment in GP Practices	MKCCG **£85K**	GP Federation	GP Practices MK CCG Healthwatch	Phased roll out from July	→	→	→		
			Primary Care Home (PCH) – ongoing development of local model for sustainable primary care across Milton Keynes, supporting greater community focussed support/interventions	MKCCG	GP Federation	MK CCG GP Practices Healthwatch	→	→	→	→		

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	Delivery Areas		Implementation	Identified funding stream	Lead Partner	Other Partners	Q1 Apr - Jun	Q2 July - Sept	Q3 Oct - Dec	Q4 Jan - Mar	2019 - 2020	
			Workforce: Roll out of workforce training and education programme aligned to community education provider networks (CEPN) model to expand MDT working	HEE Transformation Funds	GP Federation	GP Practices MK CCG	→	→	→	→		
Primary, Community & Social Care	**2. Complex Proactive Care (residents with complex needs & those at high risk of deterioration)**	Aging Well AW1	**Care Homes programme (CISP)** – continue to deliver system wide approach focussing on: Care Planning; Medicines Optimisation; localised pathways (Independent Assessor & urinary tract infection (UTI) hydration roll out) digitalisation; Primary Care & MDT support.	BAU	MK CCG	GP Practices CNWL	→	→	→	→		
		Living Well/Ageing Well LW5/AW1	**Proactive Mgt:** Develop MK specific local system approach to Care Navigation/Case Mgt & health coaching across primary care home networks , commencing with initial pilot across 1-2 networks to test concept.	BLMK STF & Local identified sources **£551K**	GP Federation	GP Practices MK CCG CNWL	Proof of Concept & phased roll out	→	→	→		
			Social Prescribing: a) Continue with High Intensity Service User Support Service provided by an integrated system-wide MDT. Expand workforce skill sets to manage up to 100 caseload b) Continue to progress low acuity social prescribing to potentially 19% of adult residents with non-clinical presentation	BLMK STF & National Grant **£123K**	MKCCG	Multiple local partners		Expansion of HISU →	→	→		
	3. Transitions of Care	Ageing Well AW3	**Effective care for patients in crisis (CISP) Adults programme**: – continue to deliver system wide approach focussing on: Points of Access to improve patient/client satisfaction, integrated urgent care service; online booking enhancements to NHS111 service; developing 'on the day' services; discharges (streamlining pathways to support with delayed transfers of care to obtain <3.5% reduction, including Trusted Assessor programme rollout	BAU	MK CCG	GP Practices CNWL MKUHFT SCAS	Phased rollout	→	→	→		
	4. Children & Young People	Starting Well Priorities SW2 SW3	**Caring for children and young people (CYP) programme:-** a) Redesigning services as part of the multi-agency 5 year programme which includes single point(s) of access and brief intervention services to meet the needs of CYP's **mental and emotional wellbeing** b) Maintaining focus to ensure reforms to improve outcomes for CYP with special educational needs and disabilities **(SEND)** are embedded c) Strengthening **urgent care pathway(s)** in hospital services by embedding clinical assessment and triage	BAU	MK CCG	GP Practices CNWL MKUHFT SCAS MKC	→	→	→	→		

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	Delivery Areas		Implementation	Identified funding stream	Lead Partner	Other Partners	Q1 Apr - Jun	Q2 July - Sept	Q3 Oct - Dec	Q4 Jan - Mar	2019 - 2020	
			protocols and increasing referrals into Children's Primary Care Team (CPCT) from urgent consultant GP advice calls d) Continuing to focus on improvements to **high impact care pathways** for a range of conditions that frequently result in admission e) Increasing engagement **in schools, community projects and family centres** focusing on nutrition, physical activity, minor illnesses, immunisations and, support for young people with long term conditions, e.g., **Children with Diabetes** f) Collaborative co-design with local partners to develop a **sustainable community nursing service** to provide system resilience and management demand g) Monitor provision of **children's continuing care** packages which provide care at home and reduces the need for hospital admission or residential placement									
Primary, Community & Social Care	**5. Mental Health delivery of FYFV**	Starting Well/Living Well & Ageing Well Priorities SW2/LW2/ AW5/AW6	**Continue programme to achieve Five Year Forward View ambition targets** & deliver 'Parity of Esteem' agenda focusing on: a) Out of area placements efficiency programme to support rehabilitation, provision of aftercare assessments/services (Section 117) b) Mental health specialist skills sets roll out in Primary care clusters to provide medication reviews and education in the management of stable patients c) Improving access to psychological therapies (IAPT) and dovetailing processes into long term condition pathways d) Development of 'healthy aging pathway' to improve the mental wellbeing of older people (this may fit in with the dementia pathways)	MKCCG Parity of Esteem **£200K** **£19K**	MKCCG CNWL	GP Practices Public Health MKC	→	→	→	→		
	6. Respiratory Care (reduce unwarranted variation & keep people at home)	Starting Well Priority SW3 Living Well Priorities LW5 Ageing Well	**Pathway enhancements** to Improve diagnosis & treatment of patients with respiratory disease focussing on: a) Embedding training and upskilling of primary care HCP's in respiratory care management and optimisation of pharmacological pathways b) Early supported discharge for emergency attendances with specialist (consultant) primary care management support, c) Integrated home oxygen assessment and follow care in		MKCCG	MKUHFT GP Practices MK Federation CNWL Third Sector	→	→	→	→		

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	Delivery Areas		Implementation	Identified funding stream	Lead Partner	Other Partners	Q1 Apr - Jun	Q2 July - Sept	Q3 Oct - Dec	Q4 Jan - Mar	2019 - 2020	
		Priority AW3	patients home d) Piloting British Lung Foundation behavioural change/exercise programme methodology to increase mobility reduce social isolation e) Developing of 'one stop' community respiratory services focusing on early diagnosis and specialist MDT management for complex comorbities	Charity Funding **£28K** STF funds **£115K**			→	→	→	→		
	7. Diabetes (improvement programme)	Starting Well Priority SW3 Living Well Priority LW5 Ageing Well Priority AW3	**Providing patients with access to specialist diabetes** expertise 'closer to home' and continuing to progress delivery on: a) NHS Diabetes Prevention Programme to support people at risk of diabetes and prevent/delay onset b) Patient facing education programmes particularly focusing on 'hard to reach' communities combined with peer to peer support c) Stretch targets in primary care to increase compliance with treatment targets d) Upskilling of front line staff in emergency care on the management of high risk/active foot disease e) Extended psychological therapies in CYP	National **£134K**	MK CCG & STP	GP Practices MKUHFT/ CNWL/ Diabetes UK-MK	→	→	→	→		
Sustainable Secondary Care	**1. Transformation of services**	Living Well priorities LW3 & LW5	**Continue to improve Cancer services and ensure delivery of FYFV ambition targets**. 2018/19 to focus on early Diagnosis for colorectal (MK), lung (Luton), prostate (Bedford) a) Localised pathway for faecal immunochemical testing (FIT) in GP clusters to improve rapid access (MK) b) Review and localise pathways for lung and prostate following evaluation outcomes c) Maintaining cancer waiting times	National **£1.62M** BLMK share	BLMK NHS System Partners	MKUHFT GP Federation GP Practices	Pre-mobilisation and phased roll out	→	→	→		
		Starting Well Priority SW7	**Continue to improve Maternity services in line with Local Maternity System (LMS) Plan**. In line with 'Birth Births' and BLMK system-wide LMS Transformation plans, progress continues locally on: a) Ensuring co-production is embedded into the transformation and the culture of maternity services by delivering training events for key stakeholders and facilitating a coproduction, communication and engagement steering group b) Full implementation of the 'Savings Babies Lives Care Bundle' & development of LMS wide safety action plan c) A range of initiatives to improve choice and personalisation including testing continuity of care	National **£458K**	MKCCG & LMS Partners	All providers Healthwatch	→	→	→	→		

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Sustainable Secondary Care			models; developing care plans, evaluation of community hub pilots and the development of a business case for a midwifery led unit in MK d) Completion of a prevention self- assessment and development of an associated action plan, including improving breast feeding rates and reducing smoking during pregnancy e) Refining the financial model and completing a digital maturity self-assessment to inform consideration of digital solutions f) Development of a bespoke LMS wide reporting framework									
		Living Well Priority LW5 Ageing Well Priority AW1	**Stroke Pathway** a) Conclude evaluation of emergency measure stroke service at MKUFTH b) Results/outputs to inform system wide stroke care across STP		MK CCG	MKUHFT	→	Pilot Evaluation	Outputs from Evaluation			
		Ageing Well Priority AW4	**End of Life (EoL)** a) Roll out of universal EoL training for health and social care professional and, standardisation of documentation and training for new advance care planning to appropriate individual teams b) Audit of anticipatory medication pathway to inform evaluation framework and approved action plans c) Enhancements to advice and support helpline for service users and healthcare professionals **d)** Implementation of improvements to discharge plans to support patients into palliative care from community and acute settings **e)** Increase utilisation of personal health budgets	BLMK STF **£63K**	MKCCG	GP Federation GP Practices MKUFTH Willen Hospice CNWL Care Homes Healthwatch	→			→		
	2. Secondary Care Resilience & Sustainability	Ageing Well Priority AW3 & AW7	**Delivering services at scale** Deliver service provision at sufficient scale to ensure consistency to meet national standards (incl. 7 day working) –	Tbc	MKUHFT	MK CCG BLMK Partners	*Specific actions & milestones needed as relevant from P3 Workstream*					
	3. Review of MK Bed Stock	Ageing Well Priority AW3 & AW7	**MK system wide bed stock review focusing on** patient flows, case mix and resources to inform configuration for optimal bed based 'models of care'	Tbc	MKUHFT	MKC MK CCG MKUHFT			→	→		

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						GP Federation CNWL						
	4. Develop effective Non-bed based care for MK	Ageing Well Priority AW1, AW2, AW3, AW4 & AW7	Simplification of non bed-based care to support admission avoidance/facilitated discharge.		?tbc	MKC MK CCG MKUHFT GP Federation CNWL		*Scope, specific actions & milestones still to be developed.*	→	→		
Enabling Technology	**1. EPR & Shared Care Records**	All – supports wider H&WB Strategy	**Shared Care Record** a) Technology enhancements to MK care homes to enable viewing of patient identifiable information from GP SystmOne units b) Implementation of role based access to HCP's to permit 'real tie' key clinical information documentation to support case management in care homes c) Roll out of IT infrastructure to move legacy care homes on 'paper based' systems to electronic documentation and monitoring	ETTF **£177K**	MKCCG	MKC MKUHFT GP Federation CNWL		→	→	→		
			Electronic Patient Record (EPR) a) Localisation interoperability road map to link MK secondary and primary care IT systems b) Implementation of healthcare information technology (HiE) bi-directional feed to support sharing of patient's clinical information across MK healthcare providers		MKCCG	MKUFTH GP Federation CNWL			→	→		
			N3 Replacement Programme Procurement of Health & Social Care Network (HSCN) to replace N3 connections		BLMK (HBL ICT)				→	→		
			Local a) Localisation of STP clinical pathways/protocols into MK GP SystmOne Unit(s) to support standardisation of patient care b) Evaluation and roll out of unified communication solutions from mobile devices/desktop hard to provide remote access for instant messaging, MDT case discussion		MKCCG	GP Federation MKUFTH GP Federation CNWL			→	→		
	2. Whole Population Health Analytics	All – supports wider H&WB Strategy	Development of a whole population analytics 'snapshot' linking data sets from providers at place level.	See Above– detail outlined in System Redesign Workstream								