

ANNEX B TO ITEM 8(a)

Strategic Priority 2: Living Well: Working with Communities to Live Longer and Healthier Lives	
Officer Lead: Matthew Webb, Board Sponsor: Dr Nicola Smith, Lifecourse Support Officer: Becky White	
Key highlights and challenges	Proposed Board Member Action
<p>Priority Focus 1: Reduce Obesity - Updated Q3</p> <ul style="list-style-type: none"> • Multi stakeholder Obesity steering group formed to deliver the Healthy Weight Strategy and meeting 6 weekly. • Obesity Sub-Group met 16th December and agreed implementation plan approach and proxy measures of success. • Core members of Living Well Working Group met on 16th October – other priorities identified were Stroke – pathways including 4 hour admission target and HIV – late diagnosis and treatment. • Re-commissioned Tier 2 weight management services for Children and Young People will commence in January • Expression of Interest to be a lead local authority in a new national initiative led by Public Health (PHE) – A Whole Systems Obesity programme. Unfortunately MK was not picked but received positive encouraging feedback. • Working with Pharmacies to develop 'healthy living pharmacies', scoped accreditation costs and meeting with LPC to discuss model. • Launched Eat Out, Eat Well Award targeting workplace restaurants and one premise successfully awarded. • In collaboration with MK 50 programme (and bid to Big Lottery) developing a 'Reaching Communities' project focused on addressing obesity. This is on hold temporarily while a community consultation takes place. • Developed training package to support workforce with maternal obesity and gestational diabetes, supporting Trust to identify KPI or CQUIN to support. <p>Next Steps</p> <ul style="list-style-type: none"> • Obesity sub-group meeting in January • Living Well working group planned (further scoping/planning) • Agree Plan to deliver to deliver Healthy Weight Strategy • Clarity on action against other key priorities 	<p>A commitment from partners to support the plan currently being developed to deliver the Healthy Weight Strategy</p>
<p>Priority Focus 2: HIV - Updated Q3</p> <p>The number of people diagnosed late in MK has dropped by over 10% from 76% to 65.9% (2012 -2014 data) and work is being undertaken to reduce this further as follows;</p> <ul style="list-style-type: none"> • The number of GP's signed up for Point Of Contact Testing (POCT) has increased further from 7 practices to 17 • HIV testing has been expanded in MK hospital • British Pregnancy Advisory Service (BPAS) are now actively testing and all clients are offered a POCT on registration • A recent innovative pilot to undertake oral HIV testing in a dental practice has been supported by Kevin Fenton Director of Health and Wellbeing PHE. This will be the first of its kind in the UK. The service specification has been written and we are now trying to engage a pilot practice • Looking at signing up pharmacies to allow outreach teams to undertake POCT • Collaborative working among providers is improving testing at local events and a clinic has been set up in Compass (D&A) and the Sexual Health Strategy Group has been set up and now meets regularly • Engaging Faith Leaders via 'In Faith & Love project' targeting black African and other affected communities • Bid successful for M1 corridor project HIV testing and more in large distribution centres • Home sampling for HIV testing at home has commenced (via NHS England) Contracts have now been signed by MK Council and ESPO for this to be commissioned for another year • Council signed up to the 'halve it' campaign but MK Council needs to really engage with this initiative. • HIV training is being agreed for delivery in Oakhill and Woodhill 	<p>Each HWB organisation to commit to the 'halve it' campaign Ensure reducing late diagnosis of HIV continues as a priority</p>
<p>Priority Focus 3: Stroke - Updated Q3</p> <p>The 4 hour target for stroke - This is recognised by the CCG to be a high priority. An external review has been commissioned which reported in mid-November 2015. An action plan is being developed in response and will be available in January 2016. This remains a CCG priority. An external review has been completed and the resultant action plan continues to be implemented. The CCG is now working with the Strategic Clinical Network for Thames Valley to develop a robust commissioning plan to ensure the care for people in Milton Keynes who have a stroke receive the best possible care and have the best outcomes possible.</p>	<p>The action plan will be shared with the Living Well Working group and any issues will be taken to a future HWB</p>
<p>Reduced glycaemic variation in people with diabetes (better control of blood sugar). - Updated Q3</p> <p>The aim is to increase the proportion of people in each practice currently registered with diabetes who have good control of their blood sugar. The target is to double the number of practices meeting the national average (from 4 to 8 (of the total of 27)). Additional consultant-led clinical input is being provided to all practices which includes multi-disciplinary case management with agreed targets for practices to increase the proportion of blood sugar level controls for people on the practice registers diagnosed with diabetes.</p> <p>To note that the CCG and its constituent practices recognise this issue. Specialist diabetes nurses, GPs with a special interest in diabetes and Public Health have raised this at each neighbourhood meeting of practices. The CCG has doubled the capacity for self management classes in diabetes, and is investigating the addition of access to online support for self management. DAFNE (Type 1 Education Programme) has just been commissioned for the service to be delivered locally. Patient education sessions will commence from April 2016 which will increase the current uptake and, further on line training programmes for self-management care will be rolled out between 2016/17.</p> <p>Public Health has funded the Milton Keynes Equality Council to deliver diabetes awareness training tailored to communities of Black and Minority Ethnic groups. BAME awareness sessions within the community groups is underway and gaps identified from these awareness sessions will be incorporated into the integrated model for Diabetes. Practice-level targets are being developed.</p>	<p>To note the action being taken. To promote awareness of diabetes and the importance of self management of diabetes</p>