Joint Strategic Needs Assessment 2009/10

We welcome feedback on this plan and the way it is implemented. We are interested to know of any possible or actual adverse impact that this strategy may have on any groups in respect of gender or marital status, race, disability, sexual orientation, religion or belief, age or other characteristics.

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Approved By:
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Document History

Version	Date	Author	Reason
V1.0	2 September 2009	Alison Joyner	Initial refresh of data
V1.1	November 2009	Ivo Haest	Figures updated New chapters added
V1.2	December 2009	Diane Gray	Text updated
V1.3	January 2010	Diane Gray	Further updates on text, especially re. Unemployment statistics
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Table of Contents

Foreword

Every local authority and PCT in England, led by their Directors of Public Health, Adult Social Services, and Children's Services, has developed a joint strategic needs assessment (JSNA) that identifies the health and wellbeing needs (and inequalities in those needs) of their local population. The JSNA will be used widely: to inform the Community Strategy and the Local Area Agreement for the area, and to underpin strategic commissioning plans of both council and PCT.

The JSNA builds upon (and should be read in conjunction with) other broad reaching assessments of the health and well-being of the Milton Keynes public, such as the public health annual report. The key findings from those assessments have been summarised here with web links to the full reports.

This document is the JSNA for Milton Keynes, and is supported and complemented by the MKi Observatory website (www.mkiobservatory.org.uk) which holds the pan-Milton Keynes data used to develop it.

Needs assessment is a continuous process. This JSNA document will be refreshed and improved upon annually but the data from which it is derived is continuously updated on the MKi Observatory site. This second JSNA includes the key findings from a large number of needs assessments that were carried out this year. The process of developing the JSNA has also thrown up how it can be improved; for example, there is a raft of information sources that can be included in subsequent iterations to produce an even richer assessment of how Milton Keynes people live, now and in the future.

1. Background

1.1 Background to Joint Strategic Needs Assessments

In 2006, the Department of Health White Paper *Our health, our care, our say* set out a new direction for improving the health and wellbeing of the population in order to achieve:

- better prevention and early intervention for improved health, independence and wellbeing
- more choice and a stronger voice for individuals and communities
- tackling inequalities and improving access to services
- more support for people with long term needs.

Our health, our care, our say identified the need for Directors of Public Health, Adult Social Services and Children's Services to undertake regular strategic needs assessments of the health and wellbeing status of their populations, enabling local services to plan, through Local Area Agreements, both short and medium term objectives. Later that year the Local Government White Paper, *Strong and prosperous communities*, outlined a vision of responsive services and empowered communities, including a Community Call for Action across local public services.

The Local Government and Public Involvement in Health Act (2007) places a duty on local authorities and PCTs to produce a JSNA. The JSNA should underpin the Community Strategy and, in turn, Milton Keynes' Local Area Agreement. It should inform NHS Local Operating Plan, Children's and Young People's Plan, and Milton Keynes' Health and Wellbeing Strategy.

In late 2007, the government produced guidance to support local areas in the development of their JSNAs.

1.2 Background to Milton Keynes

The Borough of Milton Keynes is one of the fastest growing districts in the country. The population increased by almost two thirds between the 1981 and 2001 censuses, and, at 228,450 (mid 2007 population estimate), is now almost 4 times what it was at designation in 1967. A visual demonstration of how the population will continue to grow over the next 20 years can be found at: http://mapping.mkiobservatory.org.uk/planweb2/mkc_photographs/mkpopPyramid.html

Most of the growth is focussed in the New City, which is now estimated to be over four times larger than in 1967. The growth is expected to continue and accelerate to reach an estimated 317,500 by 2031, a rise of almost 50% in the absolute size of the population since 2001. This estimate is lower than those used in previous needs assessments and reflects the slowing housing market as a result of the economic downturn.

The population of Milton Keynes has a younger profile than the national average, with a substantial population size of children and young, working age people. As a proportion, the older and retired population is smaller than average.

The relative affluence of the Milton Keynes population can be described in relation to the Index of Multiple Deprivation (IMD 2007) for all English wards. (More information about the IMD 2007 is available from the DCLG web site: http://www.communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07/)

The wards in Milton Keynes have been ranked according to which of five bands of deprivation they fall within, from the 20% least deprived to the 20% most deprived wards (Map 1). The ward level averages of IMD 2007 are illustrated in Table 1 with the most deprived ward at the top of the table and the most affluent ward at the bottom of the table. Woughton Ward is within the 20% most deprived wards in the country while Olney Ward is within the 10% least deprived. In particular, Eaton Manor and Woughton wards are within the 10% most deprived wards in England in relation to education, skills and training. Woughton is among the 20% most disadvantaged wards for a further four of the seven deprivations (income, employment, health and disability and crime). Although ward averages may disguise pockets of extreme deprivation, they provide a useful summary.

Figure 1: Multiple Deprivation - Index of Multiple Deprivation 2007 rank by Super Output Area
(Super Output Area ranking based on total England Super Output Areas. The lower the ranking the greater the deprivation.)

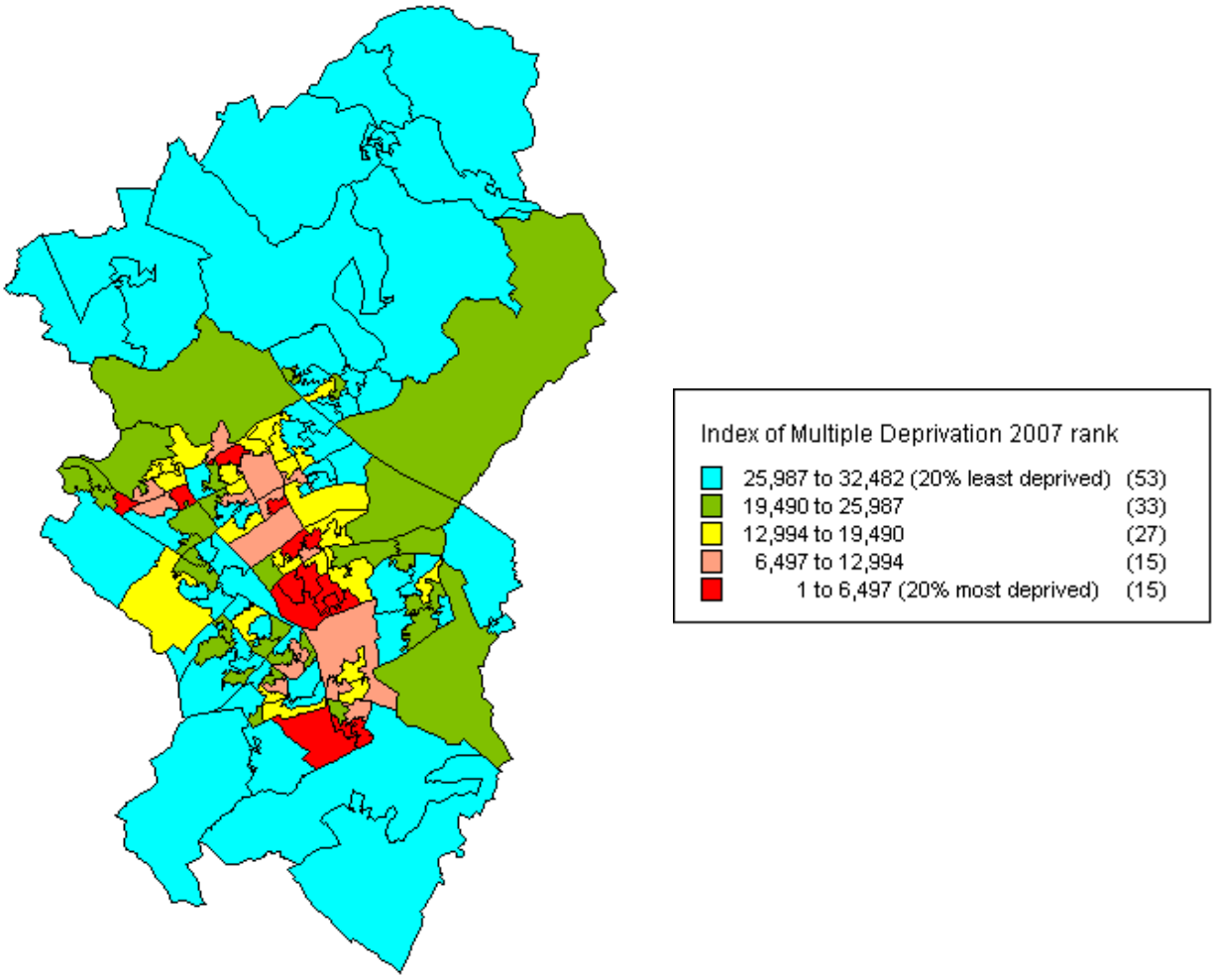


Table 1: Ward-level averages of Index of Multiple Deprivation, 2007 (Milton Keynes Social Atlas, 2008)

Average percentile rank for wards compared to England

Within 10% most deprived in England, on average
Within 20% most deprived in England, on average
Within 30% most deprived in England, on average

Within 10% least deprived in England, on average

Ward	Average IMD percentile	Average income percentile	Average employment percentile	Average health & disability percentile	Average education, skills & training percentile	Average housing and services percentile	Average crime percentile	Average living environment percentile
Woughton	15.3	14.8	15.0	16.8	8.5	68.6	12.2	84.5
Eaton Manor	26.9	26.7	25.2	35.9	9.1	70.5	23.0	88.7
Campbell Park	39.1	31.1	43.0	46.8	34.7	56.4	16.2	79.1
Wolverton	39.5	34.2	44.9	48.3	26.7	72.1	17.4	66.2
Stantonbury	52.3	46.2	50.8	54.4	39.3	60.1	33.3	83.5
Bradwell	52.4	41.6	53.0	53.7	39.1	64.6	33.9	82.1
Bletchley & Fenny Stratford	54.3	45.3	50.8	55.3	36.8	77.6	47.7	72.8
Denbigh	56.9	55.8	51.7	61.0	26.9	86.4	39.6	82.5
Wheddon	64.1	55.9	62.8	66.1	39.4	67.1	53.3	88.8
Linford South	65.8	59.5	60.6	59.7	59.1	60.2	47.4	89.1
Fuzzton	67.2	56.4	68.5	64.1	61.3	36.2	53.1	92.2
Stony Stratford	69.7	60.3	67.4	65.9	64.0	68.0	46.6	76.0
Middleton	70.9	61.9	83.6	81.0	71.8	38.6	22.7	94.0
Linford North	72.9	58.5	65.3	63.6	63.0	71.0	65.7	92.4
Shenington	77.3	77.1	93.0	84.5	77.0	16.3	76.2	64.8
Walton Park	77.6	63.5	75.8	69.9	76.7	49.4	63.2	93.6
Loughton Park	78.8	64.8	75.5	70.2	74.5	53.0	68.9	96.1
Newport Pagnell North	79.9	75.3	83.5	77.6	80.1	40.3	73.9	81.4
Emerson Valley	81.3	66.0	82.0	72.8	75.7	36.2	77.0	98.4
Danesborough	85.8	76.9	87.9	80.5	85.6	50.1	69.3	70.2
Newport Pagnell South	86.1	76.9	84.4	75.7	67.3	84.3	62.5	70.2
Hanslope Park	86.2	84.2	83.0	85.1	70.4	60.4	71.9	80.9
Olney	93.7	84.0	94.1	90.3	86.2	64.4	79.9	79.2

One method of describing further characteristics of the population by postcode is to use Experian's Mosaic profiles. Over 60% of Milton Keynes residents fall into 3 Mosaic Groups. All of these groups are over-represented in Milton Keynes when compared to the English population profile.

Mosaic Public Sector Group B - ~ 37% of the population

The key characteristic of Mosaic Public Sector Group B is the presence of children. Encompassing young couples and families, the focus is very much on housing, children and family needs. This Group typically reside in housing that is pre 1980s but post 1950s with homes either owned outright or mortgaged. Levels of debt are above the national average, with mortgages, credit card repayments, loans, holidays and the presence of 2 cars all tugging at the purse strings.

Due to their age profile, this group generally are in good health; they are aware of the benefits of a balanced diet and exercise although time constraints can mean that both occasionally suffer. These Groups are light, social drinkers and unlikely to be smokers. Particular health concerns lie in the uptake of MMR immunisations and complications due to labour and delivery. Upper respiratory infections are above the national average.

This group is internet savvy and digital media appeals. Communications should play to family interests, their appreciation of outdoor pursuits and convenience. Crèche facilities can dictate gym memberships, shopping habits and leisure activities.

Mosaic Public Sector Group H - ~ 15% of the population

Mosaic Public Sector Group H typically live in what were once council estates but where tenants have exercised their right to buy. Household composition is varied however there is a presence of single parent families and older children. This Group do not necessarily have the best education, tending to work in manual occupations and also within the personal services and care industries. Levels of debt within this group are high.

General health amongst Group H is poor. Heavy smoking, drinking and poor diet contribute to high hospital admissions. This Group is unlikely to partake in much exercise. Incidence of diabetes, COPD, obesity, heart disease and asthma are all above the national average. Teenage pregnancy is also an issue within this Group.

Communications should be via more traditional methods. This Group is price conscious and mass market advertising appeals. Products are chosen based on price and reliability rather than designer labels or features.

Mosaic Public Sector Group A - ~ 12% of the population

Mosaic Public Sector Group A is the most affluent of all the groups. They live in sought-after locations and benefit from rewarding careers. Likely to be composed of families, this group has twice the national average children studying away from home. Education is generally very good, with this Group being the most informed of health issues.

General health amongst Mosaic Public Sector Group A is good; healthy diets, frequent exercise and low uptake of smoking have led to below average hospital admissions. There is a tendency amongst this Group to be frequent drinkers, with alcohol consumption after work common.

This Group is likely to make informed decisions before purchasing products or adopting certain behaviours. Well read, they tend to gather information from the internet and paper review sections in broadsheet newspapers and magazines. Communications should be informative and contain technical detail.

Further detail of Mosaic as applied to the Milton Keynes population can be found by contacting the Public Health Information Team at NHS Milton Keynes.

2. Undertaking a JSNA in Milton Keynes

2.1 JSNA project team

A core group was established that included a PCT public health consultant, the MKi Observatory analyst, and senior managers from the Council's directorates of Children and Young People's Services (CYPS) and Community Wellbeing. This team took on the responsibility for project managing the JSNA's completion, on behalf of the Director of Public Health, the Director of Adult Social Services, and the Director of Children's Services. The Milton Keynes Health and Wellbeing Executive group acted as the project's overview board and the Health & Wellbeing Thematic Partnership (a partnership under the Milton Keynes Local Strategic Partnership) is the project sponsoring group.

2.2 Data collation

Milton Keynes is fortunate in having a repository of data and information on its population already established in the form of the MKi Observatory (www.mkiobservatory.org.uk). In addition, there is a well-rehearsed process for pulling together information on the state of the public's health for the Director of Public Health's annual report. Members of the JSNA project team were also responsible for finding additional data sources from within their own directorates/organisations.

2.3 Developing the questions

The JSNA is the latest in a series of assessments of health and wellbeing needs that have been undertaken in Milton Keynes:

- The Milton Keynes 'Story of Place' developed for the Local Strategic Partnership in late 2007 to aid the identification of priorities for the current Community Strategy
- The PCT's 2008-13 strategic commissioning plan and its 2009 refresh had assessed and prioritised disease areas that merited focussed attention to improve life expectation and reduce health inequalities (cancer, cardiovascular disease, respiratory disease, lifestyle habits, and improving the value of urgent care)
- The Milton Keynes Children & Young People's Plan 2009-11 had identified priority areas for improving the health of children and young people in Milton Keynes
- The children's data for the JSNA come from the 2009 comprehensive needs assessment coordinated jointly between CYPS Knowledge & Information team and NHS MK.
- Needs assessments into areas such as older people mental health, dementia, prison health, learning disabilities, drugs and substance misuse, alcohol, end of life, housing strategic assessment have recently been completed, and their findings were used to inform the commissioning of related services

Given the breadth of needs assessment activity already undertaken, the function of the JSNA was to build upon these rather than to repeat them. In effect its aims were to:

- Ensure that there were no other areas of need or inequality that had been overlooked, and
- Take the long view over 5-10 years to see if other unmet needs were on the horizon

3 Other assessments of health and wellbeing in Milton Keynes

3.1 Milton Keynes 'Story of Place'

Available at http://www.miltonkeynes.gov.uk/partnership-working/displayarticle.asp?DocID=16818&ArchiveNumber

The paper sets out the Milton Keynes Story from a local perspective as presented to the Local Strategic Partnership in December 2007. The story is a result of ongoing discussions throughout 2007 and seeks to highlight 'what is Milton Keynes, where we are from and where we are going'.

The paper attempts to set out the facts about the area's performance over time, drawing on evidence received through the Community Strategy consultation. It aims to identify underperformance issues and relevant policy issues and changes. It also seeks to highlight key strengths and opportunities for the future as well as local ambitions and political vision.

The next iteration of the Story of Place is due in 2010 in preparation for the new Sustainable Community Strategy for Milton Keynes: the 2050 vision. It will use the findings of this JSNA in conjunction with contributions from other thematic partnerships, stakeholders and the public.

The key points from the 2007 Story of Place are:

Where we are

1. The city is a key focus for growth in the South East and is one of the fastest growing districts in the Country. Over the next 25 years growth will bring an additional 100,000 people. We are at the centre of the Milton Keynes/South Midlands growth area, one of the fastest growing regions in Europe.

2. Part of the excitement is the city's existing residents. Their lives and contributions, energy and enthusiasm make the city what it is today. The experience of existing communities must match the best of the new communities that we will be delivering through growth.

3. Alongside its economic success the Borough has neighbourhoods which are amongst the most deprived 10% in the UK. Without careful planning, growth will only exacerbate the divide and services need to ensure that they address under performance and prevent areas falling behind.

Civic Society

4. Milton Keynes has a strong partnership culture which has a clear and distinctive vision set out in the *Milton Keynes Community Strategy: Our handbook for Change 2004-2034*. The vision 'The City that Thinks Differently, Embraces Evolution and Champions Change' captures the unique approach of people in this city, which demonstrates a pioneering spirit excited by new approaches to traditional issues.

5. A significant strength of the city is the vibrancy of the community. This is evidenced through the strength of the community and voluntary sector and a commitment from public agencies to work with the sector in the achievement of the City's progress.

6. There are a number of key assets which contribute to this vibrancy, including the extent of parish councils across the whole area and a strong Community Foundation. Culture, the arts and sport contribute to the development of a community sense and pride of place underpinning our sustainable community. Nourishment of this sector has been an important part of establishing the city and its communities.

7. The location of the city on periphery of the south east region and at the confluence of three government office regions has raised strategic issues in planning and securing agreement for key infrastructure development.

Growth

8. The amount of ongoing development planned for the city presents a range of challenges, many of which have been addressed in other areas of this section.

9. The need for a range of new homes continues to be an important issue in the south east and Milton Keynes since its designation has served a role in achieving this goal. Local housing assessments show that we require 4,196 new homes to be built in Milton Keynes each year to keep pace with the demands and needs of the population. This is a considerably higher than the 3,000 new homes each year suggested by the Milton Keynes and South Midlands Sub-Regional Strategy.

10. Central to the growth agenda is the imperative to ensure that the community can continue to function and grow sustainably without compromising the needs of the existing population. Planning and delivering infrastructure which serves and benefits all is at the heart of this issue. Associated with this is the management of new development on our existing built, natural, historical and cultural assets.

Transport

11. Milton Keynes was designed for the car, with high-speed roads and plentiful parking. While the urban grid road structure provides the opportunity for fast bus services the need for buses to enter residential grid squares to pick up passengers means that many routes are slow and unattractive as an alternative to the car. This, combined with ease of car access, has resulted in low levels of bus usage in comparison with similar sized towns and cities.

12. Public transport contributes to a number of positive outcomes. It is an important factor in generating social inclusion, economic development, environmental sustainability and can contribute to community cohesion as well.

13. The transport challenges confronting Milton Keynes are not perhaps fully understood across the community and debates about potential solutions typically generate controversy about the most appropriate way forward. The success of the transport network will be a pre-requisite to prosperity and quality of life in the growing city.

Our Population

14. The population is younger than that of England and Wales.

15. Particular issues which face us include a strong growth in the numbers of young people, which, in some age groups runs counter to national trends. The forecasted increase in the

number of older people is particularly significant since we anticipate growth of the proportion of those over 60 to be three times the national figure.

16. 2004 estimates indicate that 13% of the population is drawn from minority ethnic communities. Data from schools and evidence of recent high levels of international migration lead to a conclusion that this figure probably does not reflect current circumstances and actual numbers are higher. Evidence suggests that the BME community is younger than the average profile of Milton Keynes population.

17. Rapid demographic changes much of which is caused by inward migration of both nationals and non-nationals creates unique policy issues for Milton Keynes. Planning and delivery of services in this environment requires good evidence and flexible services and infrastructure.

Our Health

18. The principal health issues facing our community are relative high levels of respiratory diseases, alcohol misuse and obesity. As with the national trend, the leading causes of death locally are circulatory diseases, cancer and respiratory diseases. Collectively we need to reflect on these issues and identify how as a community we can address these issues.

19. Mental health affects around one in ten of the population. Opportunities exist to improve collaboration around mental health issues and promote the well being of young people and those at high risk of mental health problems.

20. Health inequalities between the most and least affluent areas in Milton Keynes are an important issue. In Milton Keynes there is a strong relationship between socio economic deprivation and ill health, this is demonstrated by the lower levels of life expectancy in wards with the lowest levels of income.

21. Together we can realise the benefits of longer life expectancy through improving our health and supporting people to lead independent lives. Greater emphasis on prevention An aspect of this is to help all ages of the community realise their health by developing healthier habits, particularly around physical activity.

Our Economy

22. The Milton Keynes economy is consistently strong, with high levels of economic activity across the population, low unemployment, and annually 3,000 new jobs are created. The service sector dominates, accounting for 83% of activity. Particular strengths in this sector are logistics, retail, hotels and restaurants, banking, finance and insurance, and business services. The city has a strong entrepreneurial spirit with high numbers of business start ups.

23. Milton Keynes is emerging as an important regional centre, its economy serves a large catchment, half the country's population live within a two hour drive time. One third of the working population comprises inward commuters. The city serves the wider region for shopping, theatre, cinema and cultural facilities and is increasingly well known for alternative leisure activities. The opening of MK Dons football stadium in 2007 together with a new conference centre, shopping and hotel facilities is further evidence of this strong economic growth.
24. [To reflect this strong regional presence and developing sporting pedigree, Milton Keynes is a candidate host city for the 2018 World Cup bid.]

25. Despite this overall strength there are aspects of underperformance. Worklessness and low skills attainment amongst residents is an important issue to be tackled. A polarisation between the highly skilled well paid jobs and basic occupations is developing across the city. The challenge of raising aspirations to both maintain the prosperity of the city and reduce poverty needs to be addressed.

Community Safety

26. In comparison with many cities in the UK, Milton Keynes is a relatively safe place to live. Although fluctuating there have been falls in rates of most categories of crime. There is also evidence from public surveys that the fear of crime has fallen in Milton Keynes (although it has risen nationally).

27. Nevertheless there remain a number of major challenges to be addressed including anti social behaviour, alcohol misuse, violence in public places and domestic violence. Creation of a safe place for all our communities necessitates a vigilance around hate crime.

Skills and Education

28. Educational attainment and skills amongst our population was becoming increasingly an issue for the city's future. Emphasis was also needed on the maintenance of young people in education and training post 16 and their transition into economic activity.

Environment

29. Milton Keynes is well known for the green spaces, most of which is parkland. The green environment and the extensive biodiversity are often cited as an asset. Balancing priorities with a desire to enhance and maintain these areas will remain a policy challenge for the community.

Deprivation and Social Exclusion

30. Socio economic data show that there are aspects of the life which are significantly underperforming. Much of this manifests itself in small areas of often intense deprivation. Approximately 9000 people live in neighbourhoods which are amongst the nations 10% most deprived areas. A further 11,000 in the 20% most deprived. The neighbourhoods are the inner areas Woughton and Campbell Park, and the peripheral estates the Lakes and Fullers Slade. This deprivation is multidimensional. Poor health, crime, child poverty, worklessness and poor educational attainment and an absence of qualifications all contribute to social exclusion.

This analysis has resulted in the identification of the following six high level outcomes that form the basis for action planning in the Sustainable Community Strategy and a framework for the selection of the 2008 Local Area Agreement indicators:

- Health & Wellbeing
- Community Belonging
- Economic Prosperity
- Community Safety
- Children & Young People
- Transportation

3.2 Milton Keynes Public Health Annual Report 2008

Available at: http://www.miltonkeynes.nhs.uk/default-ContentID-2759.htm

See also Milton Keynes Health Profile (Appendix 1)

Purpose

1. The data presented in this report on the state of health in Milton Keynes describe many of the characteristics of the population of Milton Keynes and the health issues and challenges that the city faces. The conclusions of previous reports remain relevant, but the data presented in this report add to and extend these earlier reports. In particular, there is further information about the growing impact of rising alcohol consumption, obesity and certain communicable diseases – tuberculosis (TB) and HIV in particular. This year's report also includes a new section on prison health.

2. A number of key points emerge in the report. These include:

Demography

- Milton Keynes continues to grow rapidly and ethnic diversity is increasing with a migration into the area of many people with different cultural backgrounds. The 2009 school census figures show that over 29% of all pupils come from a non-white ethnic group: this is a rise from 12% recorded in the 2001 Census.

- Milton Keynes is a young city and is anticipated to continue as such, with a projected increase in 13-19 year olds of 11% between 2008 and 2021 compared to a national decline of 5% in this age group.

- The growth in older age groups will also be extremely substantial: 65-74 year olds will increase by over 80% and the 75 years and over age group will grow by 73%.

Health

- Life expectancy in Milton Keynes continues to rise: male life expectancy (78 yrs) is now seven months above the national average and female life expectancy (81.5 yrs) is just two months below the national average.

- The total number of deaths in Milton Keynes in 2007 was 1,500, of which 40% were in people aged under 75 years.

- Circulatory diseases and cancer remain the leading causes of death in Milton Keynes – they also account for almost 50% of premature deaths (deaths in people less than 75 years of age).

- The local infant mortality rate (deaths under one year) remains higher than national and regional rates. However, the perinatal death rate (deaths in the first week of life) has fallen by a fifth over the past two years.

- Mental health is a priority in the work of NHS Milton Keynes – new initiatives such as the Increasing Access to Psychological Therapies (IAPT) are being developed and holistic work

continues through national campaigns, such as Change for Life, and local initiatives, including Healthy Schools and SureStart, to promote mental health and well-being.

- Smoking prevalence in Milton Keynes is estimated to be 25%, with the highest prevalence in younger age groups. Smoking is the major cause of Chronic Obstructive Pulmonary Disease (COPD) which has a mortality rate in Milton Keynes that is consistently higher than the national average.

- Alcohol remains a major public health problem. In Milton Keynes, hospital admissions for alcohol specific conditions are relatively high in the South East region. Half of admissions due to alcohol related injury in Milton Keynes are in people aged 25 to 44 years.

- Nationally, obesity is a growing public health concern. In Milton Keynes in 2008, one in 10 Reception class children and one in 6 Year 6 pupils were clinically obese, and it is estimated that nearly a quarter of adults are obese.

Inequalities

- Inequalities in life expectancies between wards have improved on last year. Those in the least deprived wards on average now live 8.8 years longer than those in the most deprived wards – this still remains a significant inequality (See Figs 2 and 3).

Figure 2: Life expectancy by deprivation deciles, Milton Keynes PCT, Males, 2004-8. Slope index of inequality (i.e. gap between poorest 10% and richest 10%) = 8.4 years

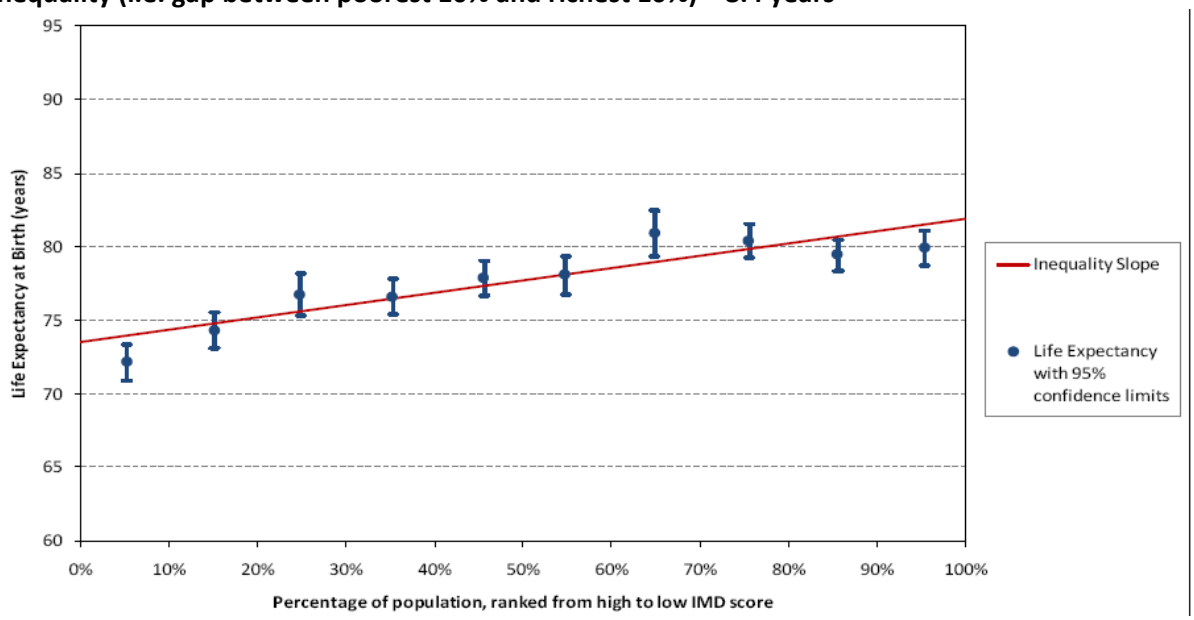
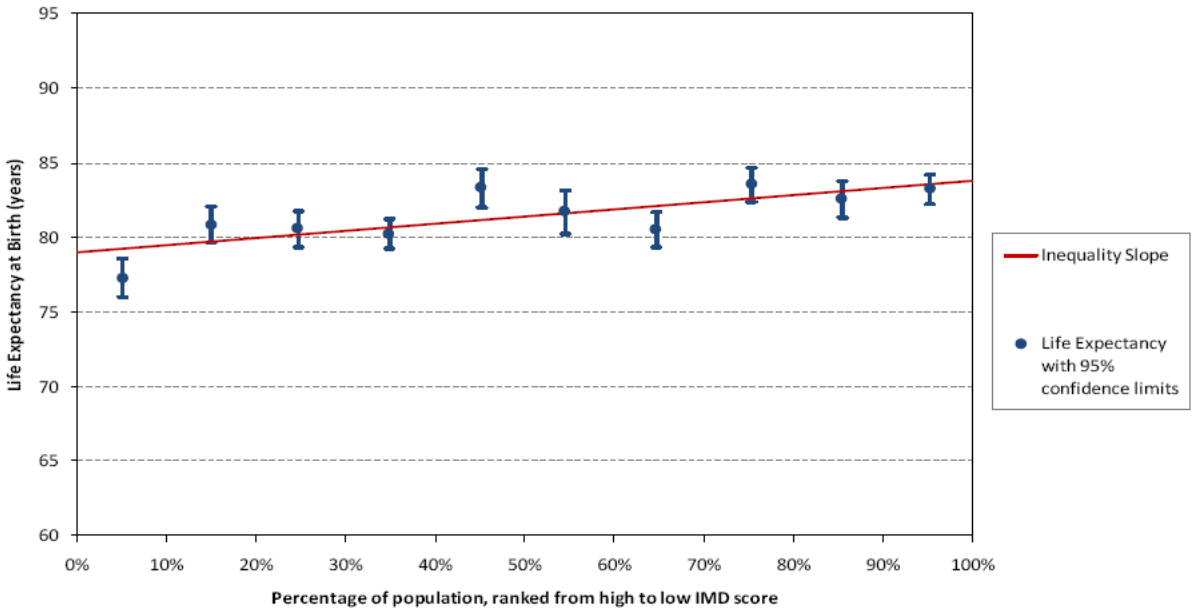


Figure 3: Life expectancy by deprivation deciles, Milton Keynes PCT, Females, 2004-8. Slope index of inequality (i.e. gap between poorest 10% and richest 10%) = 4.8 years



- Netherfield has consistently been ranked as having significant difficulties, as has Beanhill. Their relative positions are unaltered as the two areas where residents are most likely to need council services.

- In HMP Woodhill, a high security prison situated in Milton Keynes, the main health needs (as defined by a recent health needs assessment) include: mental illness, drug dependency, and communicable disease. 40% of medical records on prisoners recorded a mental health issue, but this is thought to be an underestimate. 58% prisoners had a record of current or ongoing drug abuse and 28% alcohol abuse.

3.3 Milton Keynes PCT Strategic Commissioning Plan 2008-13 and 2009 refresh

The PCT's strategic commissioning plan sets out what the organisation wants to achieve with the resources made available to it, to provide health and social care that improves health, reduces inequalities in health, and promotes access to high quality services. The strategic commissioning plan used the findings of the Public Health Annual Report and the previous JSNA. Additional information provided in the strategic commissioning plan includes:

- There is a growing proportion (>20%) of single adult households (without children and under pensionable age)
- Starting from a low base, there will be a large % increase in elderly people. For example, the number of people aged 60 years or more is expected to rise by 25% between 2006 and 2016. The proportion of the population aged 65+ is forecast to increase from 10.5% in 2006 to almost 19% in 2031.
- The dependency ratio, the number of children under working age plus the number of people over retirement age to the number of people of working age, is set to rise from 0.56 in 2006 to 0.75 in 2031. This implies that for every ten people of working age (19-64) there will be between 7 and 8 children and retired people. The proportion of the population that is of working age is set to fall from 64% to 57%.
- The average number of decayed, missing or filled teeth in Milton Keynes children is above the national target for dental decay, with decay present in 41% of five year olds in 2005. High rates of accidental injuries and deaths from accidents in older people
- In recent years, rates of serious accidental injuries related to hospital admissions in the 65+ age group have increased above national rates. In addition, Milton Keynes has higher than average rates of deaths from accidents – especially among elderly women, often following falls and hip fracture.

Major killers

- Cardiovascular disease is responsible for more deaths than any other disease each year (501 deaths in 2007).
- Cancers are responsible for most years of life lost in Milton Keynes each year (3,289 in 2007)
- Deaths from respiratory disease (asthma, chronic obstructive pulmonary disease [COPD] and bronchopneumonia) are significantly higher than expected each year (standardized mortality ratio for COPD in 2005-7 was 120).

3.4 Milton Keynes Children and Young People's Plan 2009-11

Available at: www.mkchildrenstrust.org

'Be healthy'

The Children and Young People's Plan has been based on a comprehensive assessment of needs of children and young people in Milton Keynes undertaken jointly between MK Council's Children and

Young People's Services directorate and NHS Milton Keynes. There are two aspirations for the Be Healthy part of the CYP Plan:

- All children and young people whatever their backgrounds and needs, however complex, are at their optimal level of fitness and health and knowledgeable about how to keep themselves that way.
- All children and young people are able to access a wide range of quality services, opportunities and leisure activities to ensure their emotional and physical wellbeing.

In addition to these overarching aspirations, specific areas of focus have been identified:

Although the obesity levels in Milton Keynes are not dissimilar to national levels, they are worryingly high, with one in eight (12.1%) reception age children clinically obese (compared to 9.6% nationally), rising to one in six (16.1%) in year six (compared to 17.4% nationally). Additionally, the average number of decayed, filled or missing teeth in five year olds is high.

Whilst teenage pregnancy rates have fallen significantly, they are still unacceptably high. We will need to maintain a strong focus in order to achieve the 2010/11 target rate of a reduction of 41% from the 1998 baseline.

Whilst the number of children who died before their first birthday has fallen to 14, it is 14 too many and we need to continue to focus on effective maternity and postnatal care.

A relatively low number of young people aged under 25 currently access drug and alcohol treatment services, indicating that needs are potentially not being met. The strategy for meeting young people's substance related needs, specifically their needs for specialist treatment interventions, includes as one of its highest priorities for 2009/10 improving young people's services. It particularly prioritises supporting families and ensuring that preventative and early intervention services are in place, so that young people can be diverted away from a long term involvement in substance misuse.

In surveys children and young people identified smoking as one of the top issues that affect quality of life.

We need to deliver improved and integrated services for children with disabilities and good transition to post 16, adult and community services.

All health indicators are worse in areas of socio-economic deprivation and low educational attainment. Additionally, when children and young people have limited access to consistent, positive adult support, this can result in low self esteem. Therefore, we need to invest in supporting the emotional health and wellbeing of young people, to ensure that these health inequalities do not continue into adult life.

4. Reviewing the findings of the Milton Keynes JSNA 2008

4.1 A city for children and young people

4.1.1 Childbirth and infant mortality

2008 recommendation: if Milton Keynes is to provide its young population with the best possible start in life, there needs to be a sustained focus on the level and quality of provision of pre-conception, maternity and neonatal care.

Since the original recommendation was written, the numbers of births in Milton Keynes has continued to climb and the number of births in 2009 was just under 4000. Infant mortality rates have remained higher (but not statistically significantly higher) than the national average (see Figures 4 and 5 and Table 2 below). Once terminations of pregnancy and lethal congenital anomalies are excluded from the statistics, there were 16 stillbirths and 8 early neonatal deaths in Milton Keynes in 2008. The numbers are therefore small but important to monitor as lower rates are a marker of good maternal health and high quality obstetric care.

Figure 4: Adjusted stillbirth rates by PCT against average PCT rate and 95% confidence intervals, England, 2008

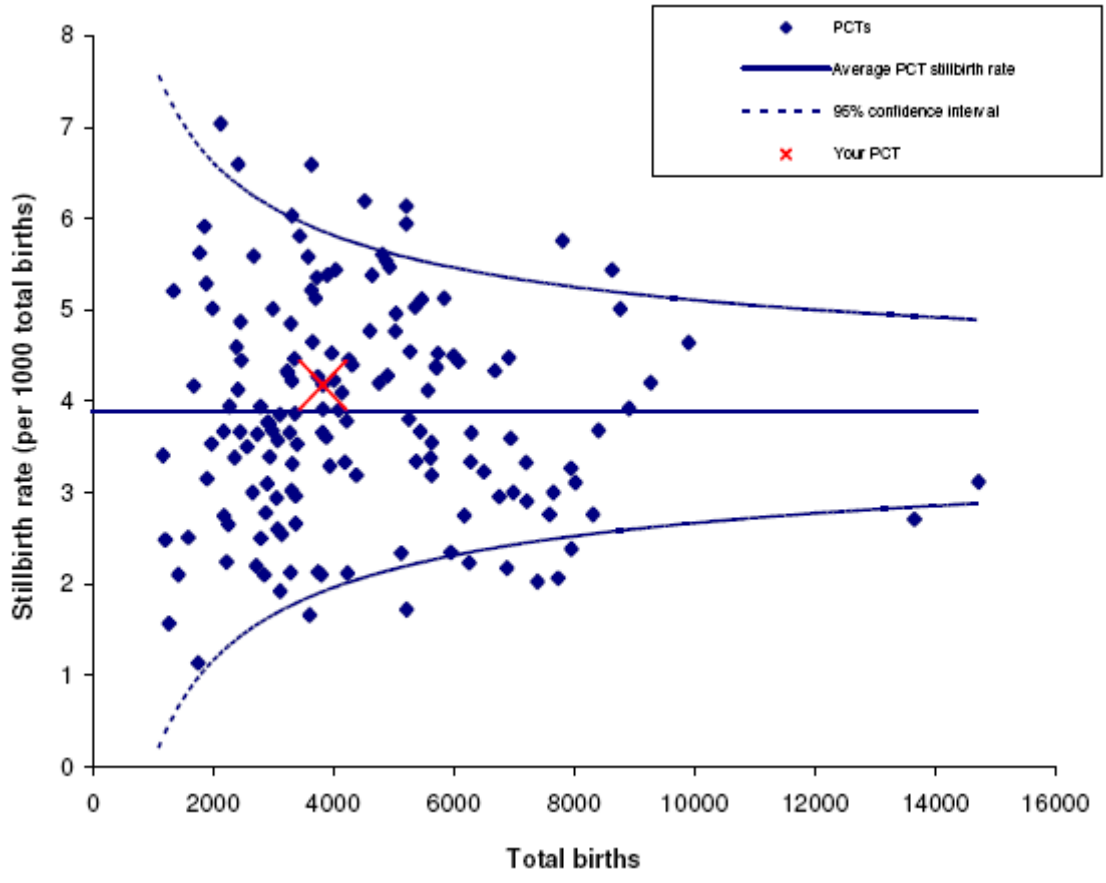


Figure 5: Adjusted neonatal mortality rates by PCT against average PCT rate and 95% confidence intervals, England, 2008

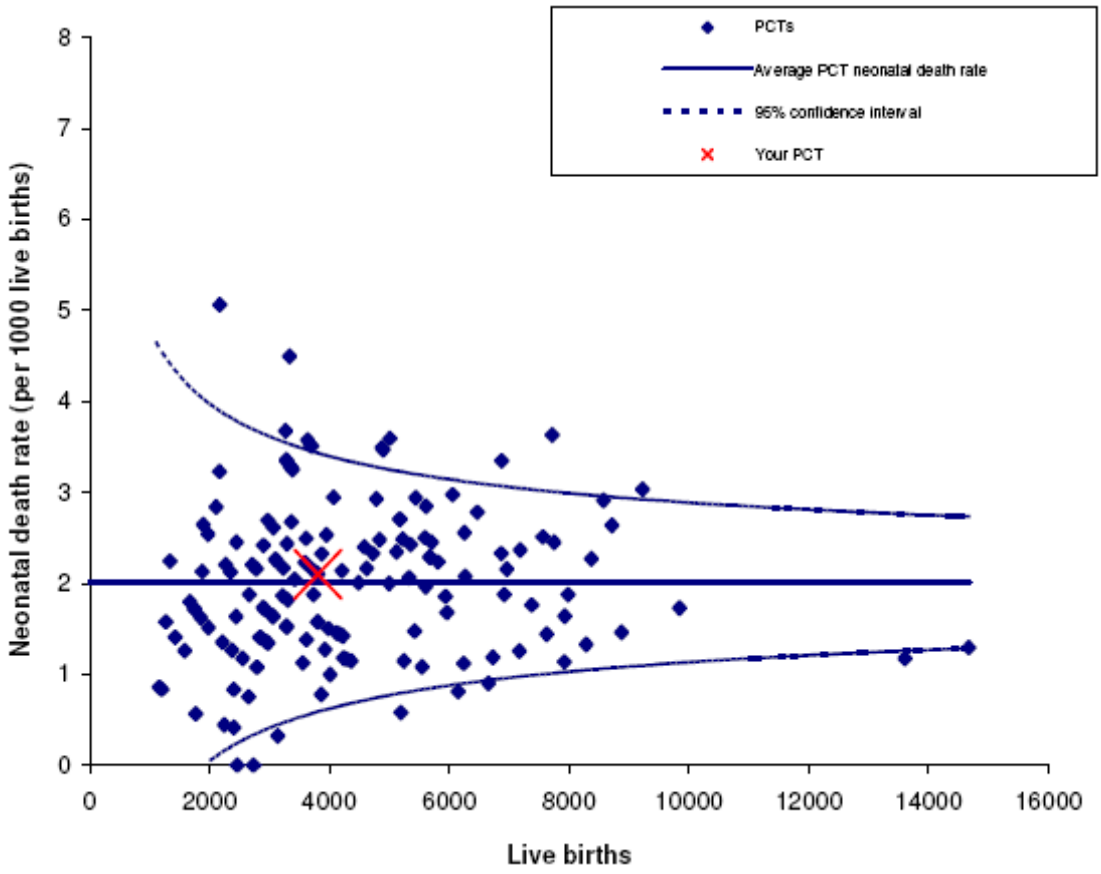


Table 2: Milton Keynes stillbirth, perinatal and neonatal mortality rates, 2008. Rate (95% confidence intervals)

	Stillbirth (per 1000 total births)	Perinatal death (per 1000 total births)	Neonatal death (per 1000 live births)
Milton Keynes PCT	**4.2 (2.6-6.8)**	**6.3 (4.2-9.4)**	**2.1 (1.1-4.2)**
South Central SHA	**3.5 (3.0-4.0)**	**5.0 (4.5-5.7)**	**1.9 (1.6-2.3)**
UK (minus Scotland)	**3.8 (3.7-4.0)**	**5.4 (5.2-5.5)**	**2.1 (2.0-2.2)**

Whilst improvements in maternity and neonatal care have occurred during 2008, the family-orientated demographics of Milton Keynes dictates that this will remain one of the most important aspects of good health for the next and future generations of Milton Keynes residents.

Therefore, this recommendation remains valid in the 2009 JSNA.

4.1.2 Teenage conceptions

2008 recommendation: Although the rate of teenage conception is falling slowly, the association between sex and alcohol consumption and the high and growing proportion of conceptions ending in termination are worrying and indicate the need for continued efforts to improve the knowledge of young people on safe sex and their ability to say "no".

The teenage pregnancy rate for 2007 was 39.1 per 1000 girls aged 15-17, which is a 24% decrease since baseline. Statistics for the first three quarters of 2008 suggest a teenage pregnancy rate of 40 per 1000 girls aged 15-17. The numbers of conceptions in the three wards with highest teenage pregnancy rates have fallen year on year between 2005-2008.

The introduction of the Family Nurse Partnership programme in 2008-9 into Milton Keynes developed a focus on breaking the cycle of teenage pregnancy. In addition, community pharmacists have been trained to be able to offer free emergency contraception to girls aged under 18, with 12 pharmacies running the service across MK, and expectations of more taking this on in 2010.

The main sexual health service for young people, Brook, has increased the number of schools in which it operates drop-in clinics. In the latest (2009) schools health related behaviour questionnaire, over two-thirds of secondary school pupils sampled knew where to obtain condoms free of charge and half knew about the young people's sexual health service. More young people in the sampled Milton Keynes schools said their self-esteem was high than in the reference population (44% compared to 37%).

In early 2010, Brook is moving to new premises where they will have a bigger clinic with more consulting rooms, enabling more young people to be seen. They will also be extending their opening hours, meaning more accessible services.

Whilst the rate of teenage pregnancy is still higher than the national target, numbers are falling and there have been strides in prevention of first and subsequent teenage conceptions. Therefore, the 2009 JSNA's recommendation is that **best practice in prevention of teenage conceptions and sex and relationship education should be shared and become 'normal practice' across schools and communities in Milton Keynes**.

4.1.3 Deprivation: the root of poor outcomes?

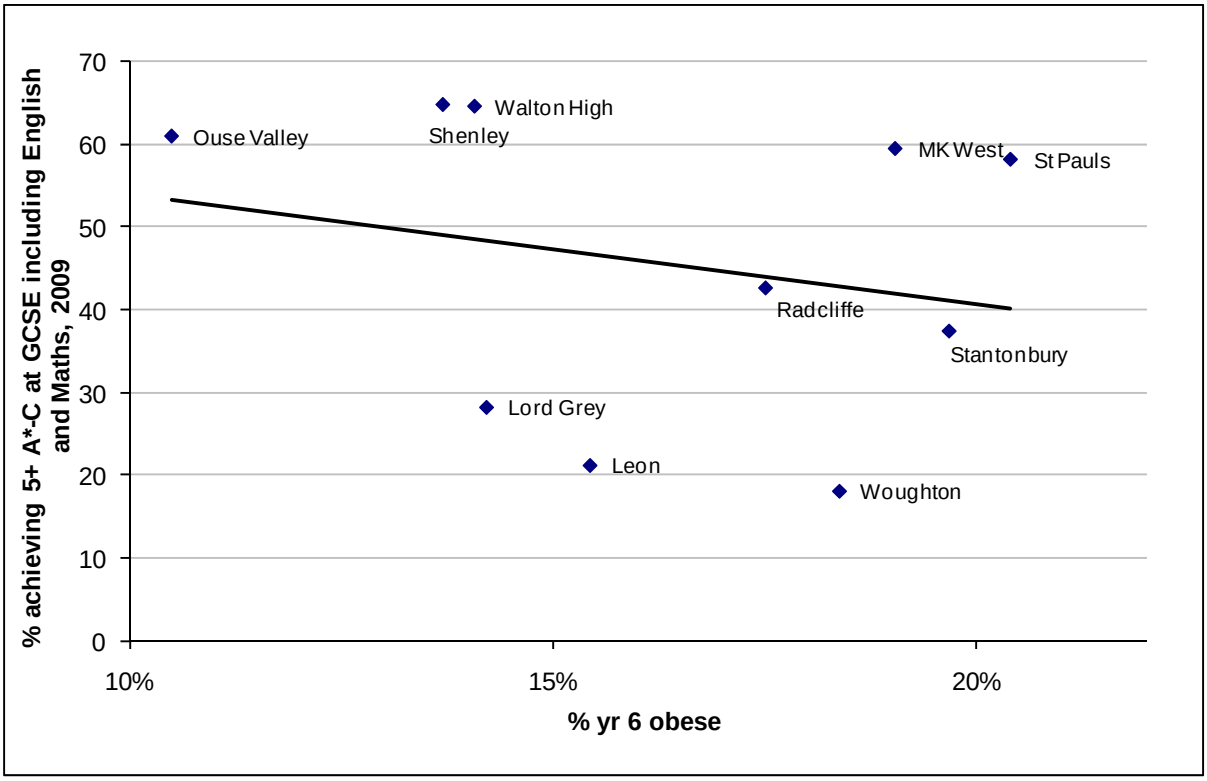
2008 recommendation: All public sector staff, whether in health, education or other sectors, should work in partnership to address underlying issues of deprivation and lack of aspiration and self-esteem. This is likely to be more effective than working separately on the manifestations of those issues.

The 2008 JSNA looked at one of the main determinants of good health – education – in Milton Keynes and suggested that poor education outcomes occur in the same groups of children who have poor health status. Efforts to improve educational attainment in schools remain a high priority for the Children's Trust. Exam results improved in 2008-9, but obesity levels have not changed significantly, and the underlying issues of child poverty and families living in relative socio-economic deprivation remain (Figure 6). There is no "quick fix" for socioeconomic deprivation. Therefore, the actions set out in the Children & Young Peoples' Plan 2009-11, which includes an ambition that "All children and young people are able to access a wide range of quality services, opportunities and leisure activities to ensure their emotional and physical wellbeing", need to happen in conjunction with the Milton Keynes neighbourhood regeneration strategy, which aims to transform the life prospects of the most deprived residents. One of the principles espoused in the regeneration strategy is co-operation and partnership working between all the agencies operating within a neighbourhood and the people living there. The benefits in terms of improved outcomes would be clear.

Therefore, this recommendation remains valid in the 2009 JSNA.

(See also section 5.5 in this JSNA)

Figure 6: Relationship between GCSE exam results and obesity by Milton Keynes school cluster group, 2008-9 (NB: GCSE results are unvalidated)



4.1.4 Children with disabilities

2008 recommendation: The information on looked after children, children with disabilities and special needs requires more unpicking. Future updates of the JSNA will explore these areas in more detail.

The recent children and young people's comprehensive needs assessment and review of support for children and young people with special education needs have added greater understanding to the numbers and services available to support children with disabilities in Milton Keynes. Whilst further work may identify still more data on disabilities, some initial conclusions can be reached from what is already available.

It is estimated by the OPCS that there are 32 children under the age of 16 with a disability per 1000 in the general population, (though it should be noted that the term "disability" might cover a range of conditions from quite slight to very complex). This would imply around 1500 such children currently living in Milton Keynes. In fact, over 1000 (1,025 in August 2008) children and young people had disabilities severe enough to warrant them claiming Disability Living Allowance.

The term 'special educational needs' (SEN) has a legal definition, referring to children who have learning difficulties or disabilities that make it harder for them to learn or access education than most children of the same age. The emphasis of education bodies is to prevent inequalities in educational attainment between those categorized as having SEN and those who are not. Indeed, as educational attainment is a fundamental determinant of good health and wellbeing, this should be important to a wider audience than just education services.

Table 3 shows that the proportion of children and young people with a statement of SEN in Milton Keynes is in line with national levels. Although relatively fewer of them are being educated in a mainstream school than nationally, the proportion is increasing and continued increase is a priority in the current draft 2009-11 inclusion strategy.

Table 3: Children and young people with Learning Difficulties and Disabilities (LDD) in Milton Keynes: basic statistics

	January 2008			**January 2009**		
	MK		**National**	**MK**		**National**
	No.	**%**	**%**	**No.**	**%**	**%**
% of school age children and young people with a statement of SEN	1139	2.9	2.8	1234	3.1	2.7
School age children with a statement of SEN educated in a maintained mainstream school (including departments)	489	39.7	55.5	624	47.4	54.0

The educational outcomes for children and young people with SEN in Milton Keynes are mixed. Compared with England, a higher proportion of pupils with SEN were in the bottom 20% at Foundation Stage. Attainment at Key Stage 1 was in line with national averages in most subjects for pupils with SEN, with some subjects better than national average performance. Yet, at Key Stage 4, significantly fewer pupils with SEN than the national average achieved 5+ A* to C including English and Maths. Despite this, a high proportion of Milton Keynes young people aged 16-18 with learning difficulties and disabilities are in education, employment or training.

Therefore, the 2009 JSNA's recommendation is to **ensure better outcomes at all stages by supporting children and young people with disabilities to stay well, aspire and achieve, so that they continue into adulthood confident and healthy**.

4.2 A truly multi-cultural city

2008 recommendations: With some conditions having increased incidence and prevalence in non-white populations (e.g. sickle cell disease, diabetes, and high blood pressure), these changes will have substantial impacts on health care services over the coming decades, some of which will run contrary to national trends.

With the continued demand for labour in the building and business sectors in Milton Keynes, it is likely that this influx of young, single men (presently coming from Eastern Europe) will continue at least for the next 5-10 years. Their use of health care will tend to be predominately for urgent care: minor injuries requiring treatment in either general practice or Accident & Emergency, but this need may also include management of lifestyle issues such as binge drinking.

Since the last JSNA, Milton Keynes has become even more ethnically diverse: in the 2009 school census, pupils from black and minority ethnic (BME) groups made up 29.2% of the total, up from 24.9% in the 2007 census. In Nursery and Reception, this proportion had increased from 31% (2007) to 35.5% (2009). Overall the Black African ethnic group remains the largest, with 7.4% of pupils (up from 5.7% in 2007 and 3.1% in 2004). The proportion of pupils of mixed ethnicity accounts for 5.2% of pupils, up from 4.6% in 2007.

Other indications of the level of migration into Milton Keynes come from statistics on workers. The European Union Workers' Migration Scheme registers workers from EU accession countries when they arrive for work in the UK. The numbers of such workers arriving in Milton Keynes have almost halved between 2006/7 (960 workers) and 2008/9 (515 workers), and fewer are coming with reported dependants under 17. (This tallies with the school census data in which the proportion of "white other" pupils has levelled off over the last couple of years at around 3.7%.) Almost three-quarters of workers registering are from Poland. The data on allocation of new National Insurance (NI) numbers to people with Milton Keynes postcodes in 2008/9 confirms that most accession country workers in Milton Keynes come from Poland. However, accession country workers make up just over 1/3 of new NI numbers allocated (compared with over ¾ in Bedford and almost all in Peterborough), suggesting that most new workers in Milton Keynes are coming from outside the European Union.

In terms of health consequences, the first recommendation remains relevant: that **the health and social care system should be preparing to manage the increasing impact of conditions more prevalent in non-white populations**. However, the changes both within the UK in terms of the housing market and economic climate and across Europe with increasing relative prosperity in new EU countries means the second recommendation is now less relevant.

4.3 New city = new housing stock = no problems?

2008 recommendations: health and social care services should be aware of and be addressing the particular problems with access to their services that may be faced by the residents in Sherington and similar rural areas.

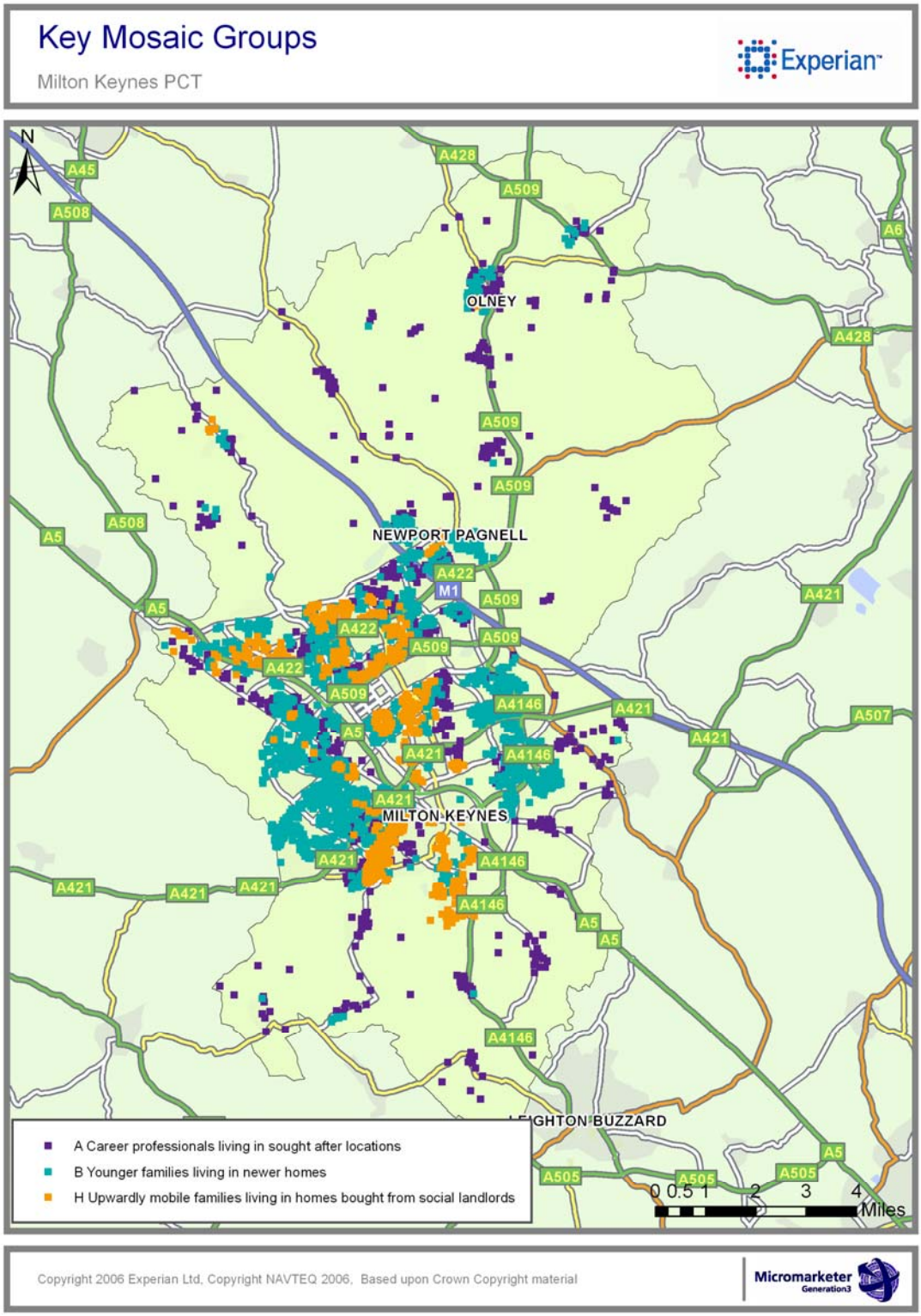
With the promotion of mixed tenure communities amongst new housing developments in Milton Keynes, it may become increasingly difficult for health and social care services to detect early those pockets of people in most need.

The previous JSNA considered evidence from the 2007 Index of Multiple Deprivation (IMD) in drawing conclusions about the access to services in the more rural parts of Milton Keynes borough. The data informing the IMD have not been updated. However, further information on the nature of the residents in these settlements has been obtained from the 2009 Mosaic dataset on population characteristics. This suggests that, although services may be further away, the population tends to be in a position to access them, since the vast majority are career professionals or younger families, with cars and able (and willing) to travel to reach services. Indeed, compared with the population within the urban part of Milton Keynes, Mosaic data suggest that the lifestyles of those living in the rural areas are significantly healthier, with less smoking, more exercise and healthier diets (Figure 7). This would suggest that the 2008 recommendation is no longer relevant.

Similarly, there are no updates to data on self-assessed health status at estate level that allow a review of the correlation between socially rented housing and poor health. However, the Mosaic dataset again allows a more granular (to postcode level) analysis of where need is likely to arise. With an aspiration to move to more proactive rather than reactive health and social care services, using this information to pinpoint areas for targeted efforts will become increasingly important. For example, the information held on Mosaic group H (shown in orange on the map in Figure 7) describes how they typically live in what were once council estates but where tenants have exercised their right to buy. Household composition is varied however there is a presence of single parent families and older children. This Group do not necessarily have the best education; tending to work in manual occupations and also within the personal services and care industries. Levels of debt within this group are high. General health amongst Group H is poor. Heavy smoking, drinking and poor diet contribute to high hospital admissions, and this Group is unlikely to partake in much exercise.

Therefore, the 2009 JSNA's recommendation is to **make use of population profiling datasets in planning and delivering health and social care services, in order to ensure that services are being delivered to the right areas and in a manner to which the clients are likely to be most receptive.**

Figure7: Key population types in Milton Keynes using Mosaic group classification, 2009



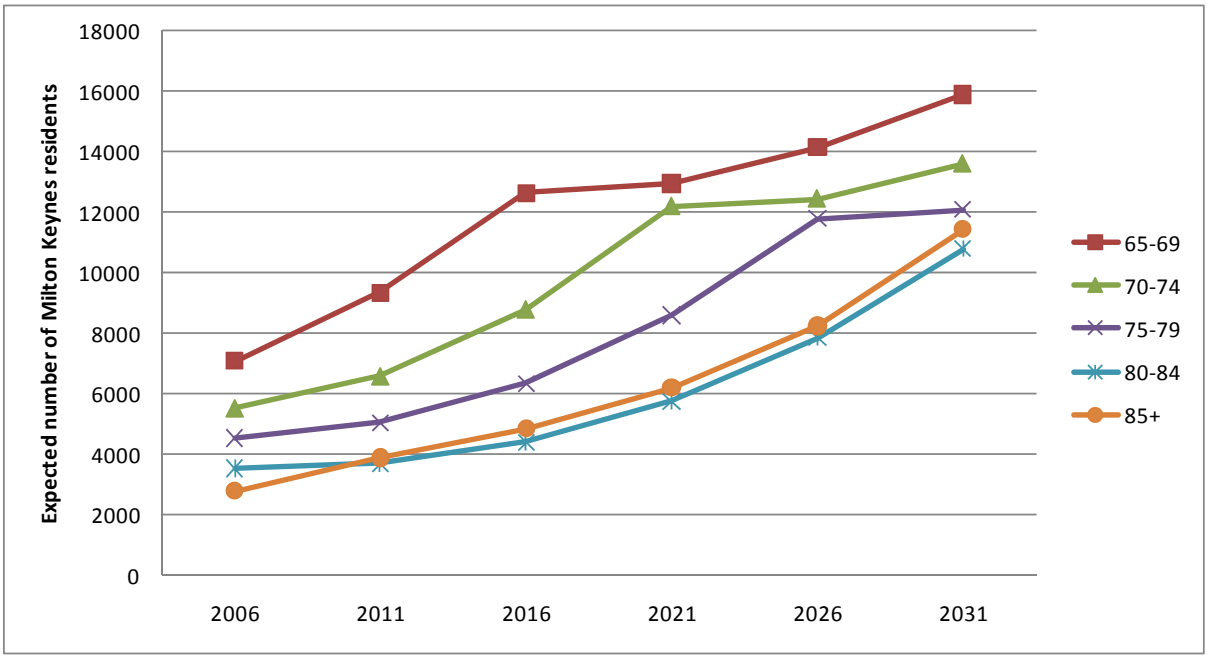
4.4 Does MK have an "old people" issue?

2008 recommendation: Given the time lag in creating the local market for provision of such care, the local health and social care economy should be considering now how it achieves this.

There is no indication of a slowdown or reversal in the significant increase in the numbers and proportion of older people in Milton Keynes described in the last JSNA. The latest population projections (Figure 8) show that between 2006 and 2031 the percentage of residents aged 75 and over is expected to double from one in 20 people to one in 10, and the number of people aged 85 and older will rise from 2,800 in 2006 to 11,450 in 2031.

Therefore, this recommendation remains valid in the 2009 JSNA.

Figure 8: Expected change in population numbers by age band over time, Milton Keynes borough



In 2008, 1,566 Milton Keynes residents died, 60% of whom were people aged 75 or over. The majority of patients die in hospital (53.7% of deaths between 2004-7), compared with 16.9% deaths occurring at home). Because the care for those nearing the end of life is not coordinated effectively amongst different service providers and is not designed around people's wishes, it has emerged as a recent discrete area for health and social service improvement. When end of life services in Milton Keynes were reviewed, the main findings were a bias in specialist palliative services towards people with cancer, largely due to the historical developments of services, and therefore a need to expand good quality end of life care to a wider range of people regardless of the condition limiting life. In Milton Keynes, there is also concern that choice at end of life for patients and carers is restricted and that best practice in end of life care is not systematically being followed.

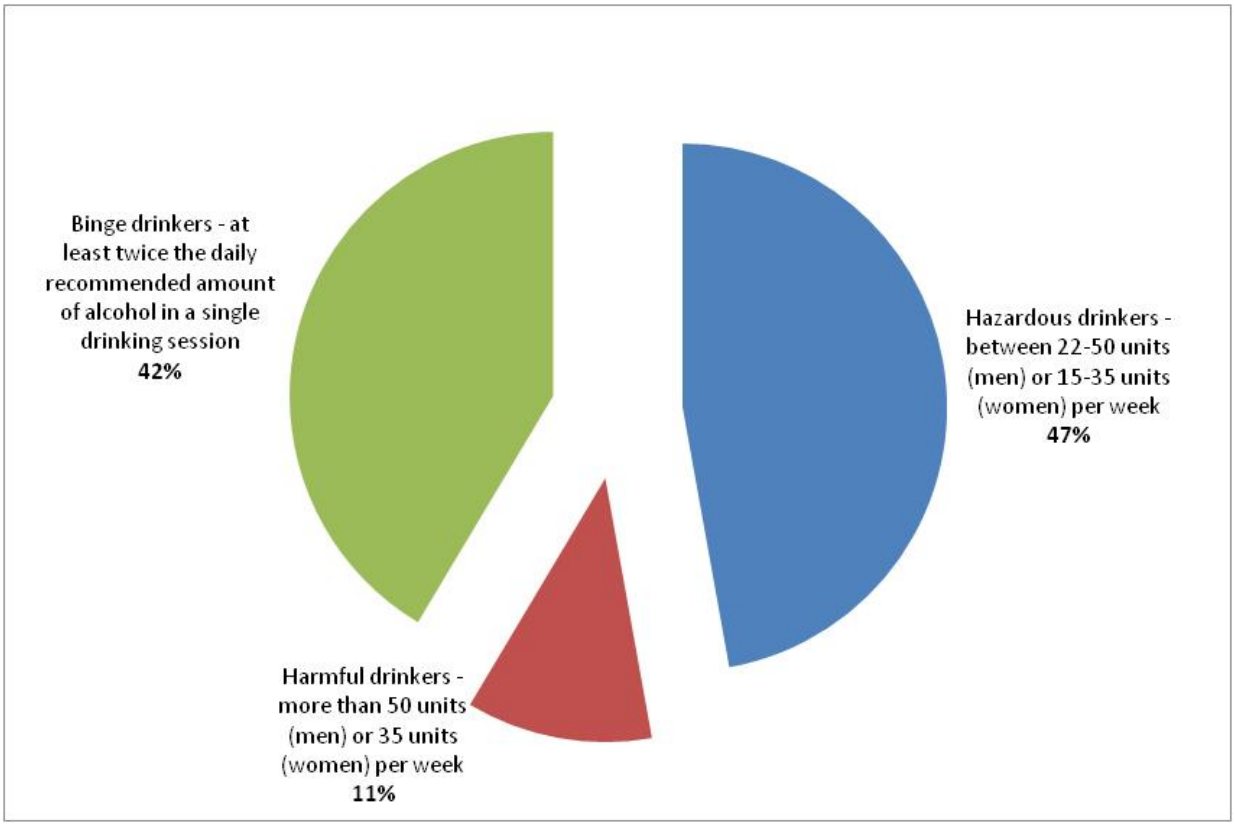
Therefore, an additional recommendation in the 2009 JSNA is that **health and social care services work together to improve access to evidence-based end of life care and support in the community and available 24 hours a day for people of all ages and with any underlying condition.**

5 Exploding more urban myths: the findings of the Milton Keynes JSNA 2009/10

5.1 Alcohol: just a Friday night issue?

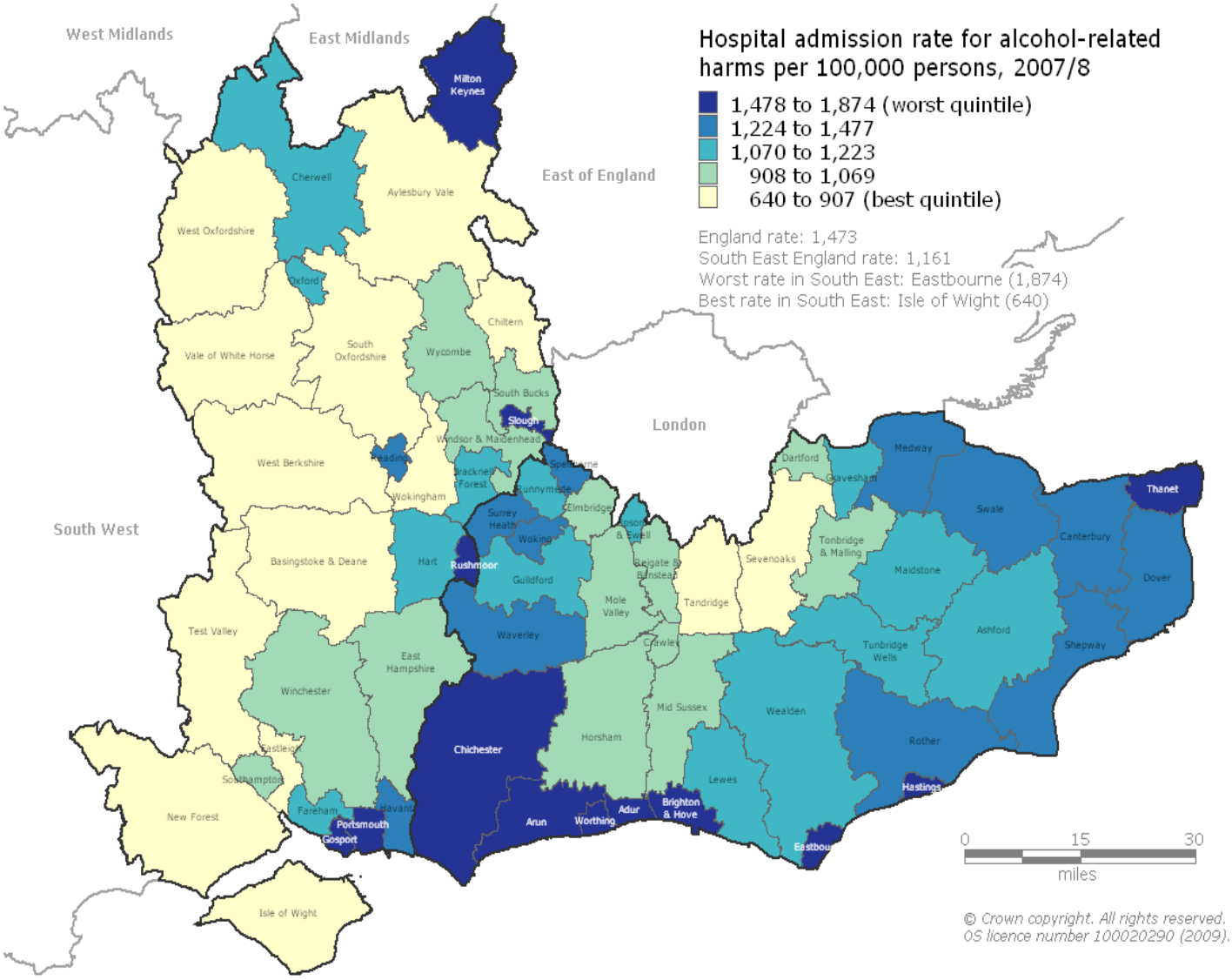
Many people think that the alcohol problems we experience in our country and city generally relate to binge drinking and alcohol dependency. This is a myth. Of the estimated 72,000 people in Milton Keynes thought to have alcohol misuse problems, less than half would be classified as binge drinkers (i.e. that consume at least twice the daily recommended amount of alcohol in a single drinking session – 8 or more units for men and 6 or more for women – Figure 9). Indeed, many people consume more alcohol than they think: a 750ml bottle of 12% wine contains nine units, more than double the daily recommended amount for men and triple the daily recommended amount for women.

Figure 9: Estimates of numbers of Milton Keynes residents with alcohol misuse problems



We know that more than 25% of our population drink above the recommended limits for alcohol consumption which are 14 units and 21 units of alcohol/week for women and men respectively. We also know that Milton Keynes has one of the highest rates of alcohol-related hospital admissions in the South East region (see Figure 10 below). In addition, we have higher rates of alcohol-related crime (and violent crime) compared to the England and regional averages, and rates in Milton Keynes have not changed significantly in the last three years.

Figure 10: Rates of hospital admissions for alcohol-related harms, South East region, 2007-8



Further information about alcohol consumption in Milton Keynes can be found in the summer 2008 alcohol needs assessment, the Public Health annual report 2008 and the local alcohol profiles website (http://www.nwph.net/alcohol/lape/pctProfile.aspx?reg=q38)

Drinking alcohol above the recommended limits directly impacts on health: people are at increased risk of liver disease, cancer, stroke, heart disease and sexually transmitted diseases. In addition, alcohol is involved in a wide range of other social and health issues; offending behaviors such as domestic violence; suicide and deliberate self-harm; child abuse and child neglect; mental health problems; unwanted pregnancies and homelessness.

Many agencies, including MK Council, NHS MK, HMP Woodhill, Thames Valley Probation, Thames Valley Police, the Community Safety Partnership (Safer MK), the Fire and Rescue Service, the National Treatment Agency and the Government Office for the South East are part of the Drug and Alcohol Strategic Group (DASG) and involved in reducing alcohol harm.

The main priorities for the next two years are to develop a strategy for the multiagency response to alcohol problems in Milton Keynes. This will include actions that will reduce alcohol harm such as: the establishment of an alcohol arrest referral scheme; an integrated offender management scheme; the 'Think Family' alcohol treatment to parents (breaking the cycle of misuse within families); improved information collection within A&E, providing information to police to help them identify hotspots of violent crime; ensuring that quality services for the prevention, identification and treatment of alcohol-related ill health are in place.

All interventions will be based on the principle of 'progressive universalism' which aims to ensure that there will be equality in the outcomes achieved relating to the need. This approach will reduce inequalities in health and will ensure that additional resources are targeted in areas where more resources are required to engage and enable these individuals to change their lifestyles.

The measures of success will be determined in the following way:, the number of people receiving brief advice on better managing their intake of alcohol, from GP practices, Brook Sexual Health Services and the Stop Smoking Services; the number of patients whose drinking levels have dropped to below the recommended limits following extended brief advice; a reduced trend or decrease in alcohol related hospital admissions (National Indicator); and finally a reduction in violent crime in Milton Keynes.

Early signs of an impact may be seen from the results of the 2009 Health Related Behaviour Questionnaire in five local secondary schools. This showed a gradual increase over time in the proportion of young people who never drink: from 12% in 2005 to 22% in 2009.

The first step in dealing with alcohol misuse is to recognise that there is a problem. Therefore, the 2009 JSNA's recommendation is **to increase awareness of how common alcohol over-use can be and to ensure adequate and appropriate support is in place for people with alcohol problems.**

5.2 We care for those most vulnerable and least heard – don't we?

Although many of the residents of Milton Keynes are able and willing to contact public agencies to seek help or express their opinions, there are some parts of the population less able to do so.

5.2.1 Learning disabilities in Milton Keynes

Valuing People (2001) defines learning disability as including "the presence of a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with a reduced ability to cope independently (impaired social functioning): which started before adulthood, with lasting effect on development." The definition covers adults with autism who also have learning disabilities, but not those with a higher level autistic spectrum disorder – such as some people with Asperger's Syndrome.

In 2009, the British Institute of Learning Disability (BILD) undertook a needs assessment of people with learning disabilities (LD). In the adult population, there are approximately 700 people with LD known to services at present (and therefore likely to have moderate-severe intellectual disability), and the rate of increase in adults with LD receiving services in Milton Keynes is faster than the England rate. As well as those receiving services, there are likely to be an additional 4000 people with mild learning disability in Milton Keynes who, although they do not require support by the public sector, may still experience some of the social and physical problems associated with more severe forms.

Data from general practice via the 2008/9 Quality and Outcome Framework suggest that only 538 people aged 18 and over are recognised by their general practice to have a learning disability. This would suggest under-recognition in primary care, where perhaps the greatest potential sits for assessing and managing health problems.

As well as potentially affecting people's ability to participate in their community, learning disabilities can also be associated with specific health complications:

- Respiratory disease is the leading cause of death for people with learning disabilities (46%-52%) and is much higher than for the general population (15%-17%)
- The incidence of cancer amongst people with learning disabilities is rapidly increasing due to increased longevity
- Coronary heart disease is the second most common cause of death amongst people with learning disabilities. Almost half of all people with Down's syndrome are affected by congenital heart problems, a much higher rate than the general population
- People with learning disabilities are between 8.5 and 200 times more likely to have a visual impairment compared to the general population and around 40% are reported to have a hearing impairment. People with Down's syndrome are at particularly high risk of developing visual and hearing loss
- 36.5% of adults with learning disabilities and 80% of adults with Down's syndrome have unhealthy teeth and gums

Evidence suggests that, with the expected demographic changes, the ability of services to support people with more complex disabilities in the community and the increased expectations of disabled people, health and social care services will struggle to meet people's needs. The challenge is therefore to support as many people as possible to access ordinary community resources and a range of lower level services (including greater use of telehealth) which will enable them to become and remain as independent as possible for longer, while also developing specialist services for those with complex needs.

The inequalities in health between people with LD and the rest of the population are of concern. The needs of people with LD can get lost in the transition between child and adult services, between community and hospital services, and between specific learning disability and mental health services.

For people with learning disabilities this means developing their inclusion as citizens who can influence local policies, not just in health and social care but also in employment, transport, lifelong education, community development and the growth of Milton Keynes. By using the "Think Family" approach, promoted by the Cabinet Office and led nationally by Department of Children, Schools and Families, agencies should be collectively supporting both individuals - and the family unit in which they sit - to do just that.

The 2009 JSNA's recommendation is therefore **for primary and community based health care to recognise the potential needs of people with learning disabilities earlier and proactively support these individuals and their families to maintain independence and good health.**

5.2.2 Older People with mental health needs

Old age is a major risk factor for mental health problems that can significantly impact on quality of life. There are a number of conditions that older people are more likely to experience, particularly as this group are prone to social isolation and loss. Some 1 in 15 people over 65 are affected by depression whilst dementia affects 1 in 25 people over 65, a ratio which increases to 1 in 4 of those over 85. Smaller numbers of older people will have other mental health difficulties. Social isolation and loss can trigger mental ill health in those psychologically vulnerable. There are high levels of co-morbidity amongst older people affected by mental health problems.

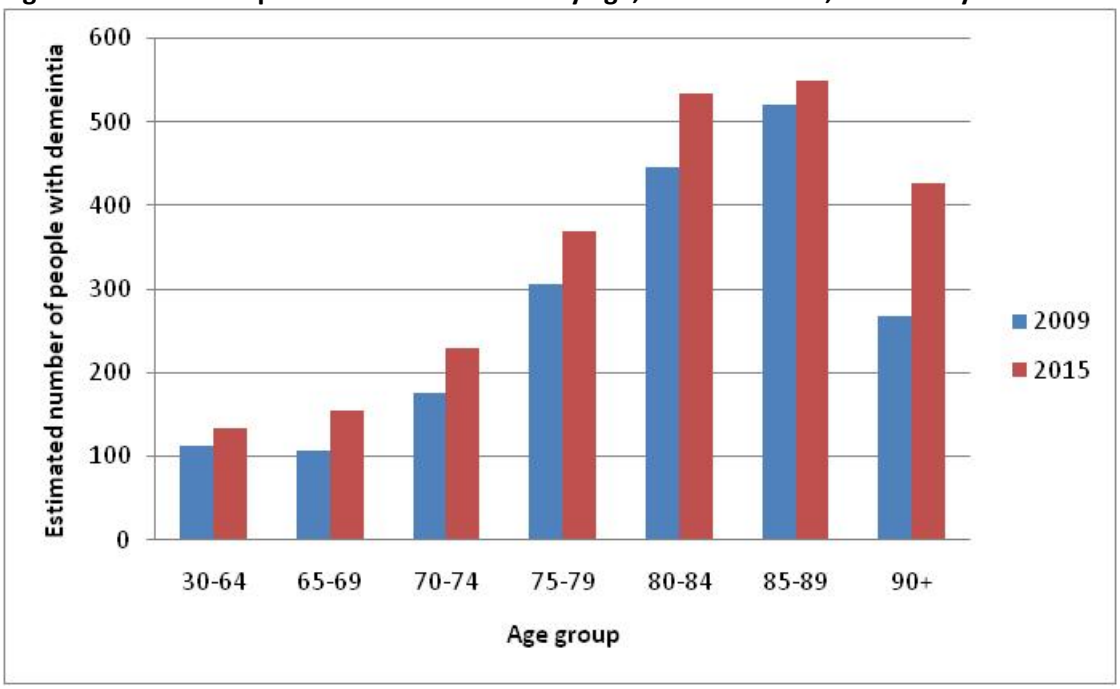
(a) Dementia

The term 'dementia' is used to describe a collection of symptoms, including a decline in memory, reasoning and communication skills, and a gradual loss of skills needed to carry out daily activities. These symptoms are caused by structural and chemical changes in the brain as a result of physical diseases such as Alzheimer's disease.

There are approximately 570,000 people with dementia in England. It is predominantly a disorder of later life, but at least 15,000 people under the age of 65 have the illness. Its incidence and prevalence rise exponentially with age (Figure 11) and it affects men and women from all social and ethnic groups. Based on these figures, the total estimated number of people in Milton Keynes with dementia (including those below 65) at present is 1,933, and likely to rise to 2,400 in 2015 and 3,250 in 2021.

However, data from general practice via the 2008/9 Quality and Outcome Framework suggest that only 744 people - less than half the expected number - are recognised as having dementia by their local general practice. This suggests that many older people are not being detected at an early stage when medication may help the course of their condition.

Figure 11: Estimated prevalence of dementia by age, 2009 and 2015, Milton Keynes

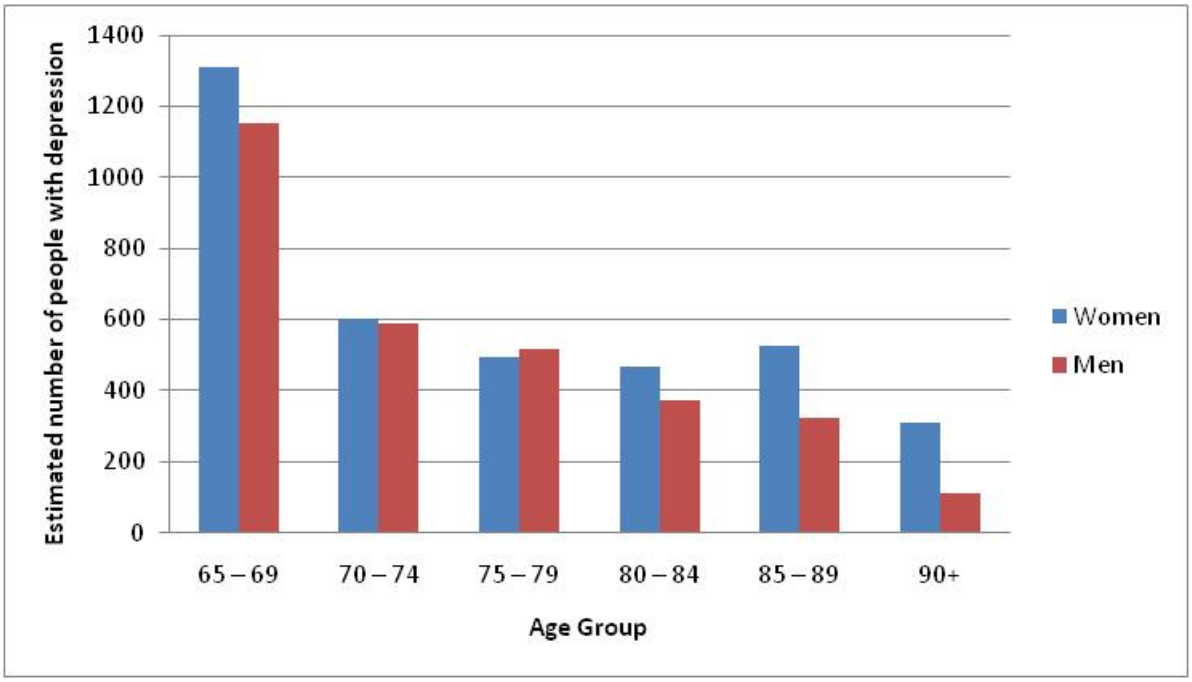


National data shows that almost two-thirds of older people with dementia are cared for in the community, mostly by unpaid carers. Dementia affects 50-80% of people living in care homes.

(b) Depression

Depression can have a profound effect on quality of life, and may also adversely affect physical health. It is the most common mental health problem for older people and prevalence rises with age. Women are more often diagnosed with depression than men, although men are more likely to commit suicide. At any one time, around 10-15% of the over 65s population will have depression and 25% will show symptoms of depression. The prevalence of depression among older people in acute hospitals is 29% and among those living in care homes is 40%. More severe depression is less common, affecting 3-5% of older people. Figure 12 below shows the predicted number of older people with depression in Milton Keynes in 2009. The total number of older people with depression is estimated to around 6,800. Although numbers of older people with depression are not routinely counted, in Milton Keynes the total number of people with depression is below what might be expected, and this is likely to also be the case for the older age group as evidence shows that two-thirds of older people with depression never even discuss it with their GPs, and of the third that do discuss it, only half are diagnosed and treated. This means of those with depression only 15 per cent, or one in seven, are diagnosed and receiving any kind of treatment. Even when they are diagnosed, older people are less likely to be offered treatment than those aged 16 to 64.

Figure 12: Estimated number of people with depression, by age group and gender, Milton Keynes, 2009



(c) Anxiety

Generalised Anxiety Disorder is a common mental health problem in later life, with predicted prevalence rates of 2-4% among older people living in the community, i.e. 380-760 people in Milton Keynes. Among older people living in the community 10-24% (1,900-4,600 in Milton Keynes) show symptoms of anxiety. The prevalence of anxiety among older people living in care homes is 6-30%

(d) Conclusions

There are some common themes across these different mental health issues:

- An apparent under-recognition of the problem in general practice
- Higher prevalence in care home settings
- Strong links and associations with physical health problems

All of these themes point to development of greater awareness and skills in primary and community-based care, to diagnose and manage dementia, depression and anxiety. The 2009 National Dementia Strategy aims to increase awareness of dementia, ensure early diagnosis and intervention and radically improve the quality of care that people with the condition receive. Proposals in it include the introduction of a dementia specialist into every general hospital and care home and for mental health teams to assess people with dementia. This approach, of improving care across the entire pathway, from initial diagnosis to long term care and in all care settings, is required too for depression and anxiety. People should be supported at home – which may include different types of housing provision for older people – as long as possible by primary and community care with access to specialist advice and services when necessary. For those where admission to a care home is

necessary, staff in care homes should be trained sufficiently in the care of people with dementia and depression to minimise unplanned or crisis interventions, such as emergency hospital admissions. When such an intervention occurs, greater levels of integration and liaison across the whole system of care should enable the older person to return to normal functioning (for them) more quickly than is currently the case.

The 2009 JSNA's recommendation is therefore **for greater education and training for primary, community and care home staff on mental health needs of older people and the importance of early diagnosis and ongoing support, with the aims of increasing numbers of older people recognised to have dementia, depression or anxiety and yet reducing numbers of unplanned interventions.**

5.4 Domestic violence – it doesn't happen here ..... does it?

Domestic violence is defined by the government as "any threatening behaviour, violence or abuse between adults who are or have been in a relationship, or between family members. It can affect anybody, regardless of their gender or sexuality. The violence can be psychological, physical, sexual or emotional. It can include honour based violence, female genital mutilation, and forced marriage."

During 2008/9 in Milton Keynes, 4,500 crimes and incidents were reported to the police as domestic abuse, and 44% people reporting domestic violence experienced it more than once in the preceding year. This is higher than the national proportion of repeat domestic violence victims (38%) and the proportion in Milton Keynes in 2007/8 (34%). Around 83% of repeat victims were female, and 84% of victims were 18-44 years old. In 2008/9, the MK ACT Crisis Intervention Service was contacted by 429 clients, of which 96% were female. Of those who gave their ethnicity (365) 70% were White British and 30% were from black and minority ethnic groups. More than three quarters of victims had dependent children, suggesting children were a factor in contacting a service for help. During 2008/9, Multi-Agency Risk Assessment Conferences (MARACs) in Milton Keynes reviewed 146 high risk cases. Despite having this number of cases reviewed at MARACs, repeat occurrence is high.

There is a strong association between domestic violence and alcohol, with, nationally, 45% of perpetrators of domestic violence under the influence of alcohol at the time. However, as well as a cause, alcohol misuse can also be a result of domestic violence, and women who experience domestic violence are 15 times more likely than women who do not to abuse alcohol.

It is estimated that the total country-wide annual cost of violence against women is £20 billion, of which £1.6 billon is the cost of health and social services. Domestic violence is clearly a cross-cutting issue that impacts upon health, criminal justice, housing and children's services. Tackling domestic violence will therefore have implications for achieving many health and non-health related targets and will require preventative work at a number of levels, including working with children and young people, communities and neighbourhoods, and large employers. Because of the involvement of children in a high proportion of cases, actions to recognise and tackle domestic violence should complement those to safeguard children.

As well as MKACT domestic violence intervention services, a Sexual Assault Referral Centre (SARC) is planned for Bletchley. A SARC is a model of service dedicated to addressing forensic, evidential and aftercare of victims; by bringing all resources together in one building it helps to promote comfort of the patient and takes pressure off other resources currently being utilised.

It should be remembered, however, that the government's definition of domestic violence is wider than physical or sexual assault.

The 2009 JSNA's recommendation is, **building on the work to reduce alcohol over-use and by working with communities to change attitudes and raise awareness of domestic violence, to reduce levels of domestic violence overall and repeated incidents of domestic violence in particular**

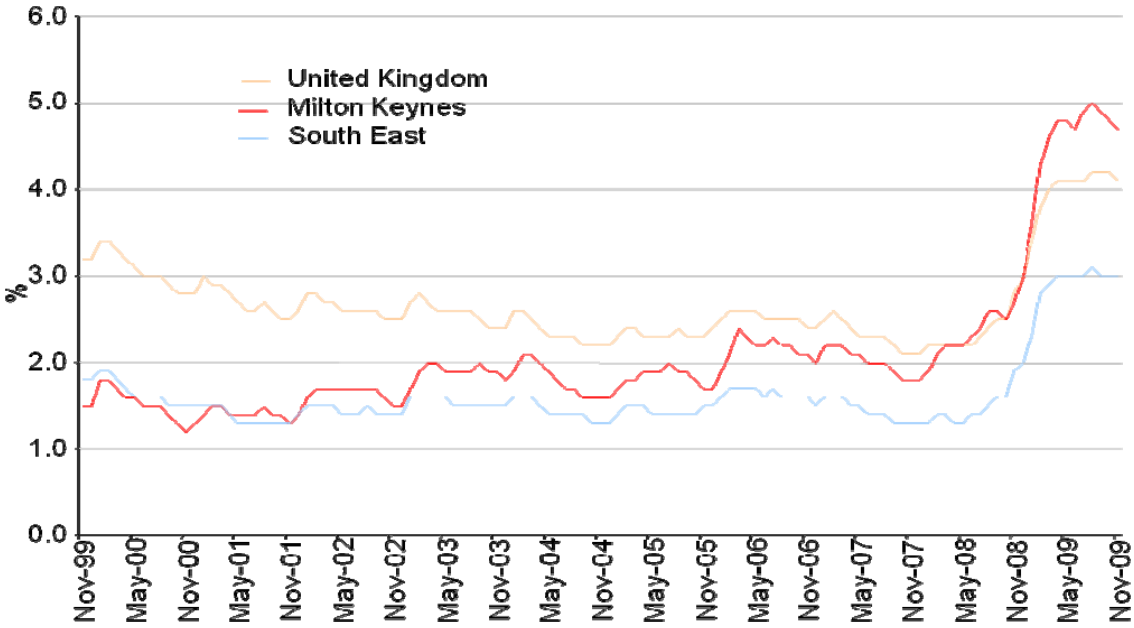
5.5 The economic recession won't worsen health inequalities, will it?

Perhaps one of the biggest changes since the publication of the last joint strategic needs assessment in Milton Keynes has been the global financial recession. As a growing economic centre, Milton Keynes would inevitably feel some of its impact.

5.5.1 Effects of the recession on Milton Keynes

Figure 13 sets out the historic pattern of unemployment rates in Milton Keynes over the last decade. Starting from a relatively low baseline, Milton Keynes rates have not decreased in line with UK unemployment rates and, if anything, had been gradually increasing even before the global recession hit in 2008. Then, in less than a year, unemployment rates doubled in Milton Keynes.

Figure 13: Unemployment rates in Milton Keynes compared with the UK and South East England, 1998-2009



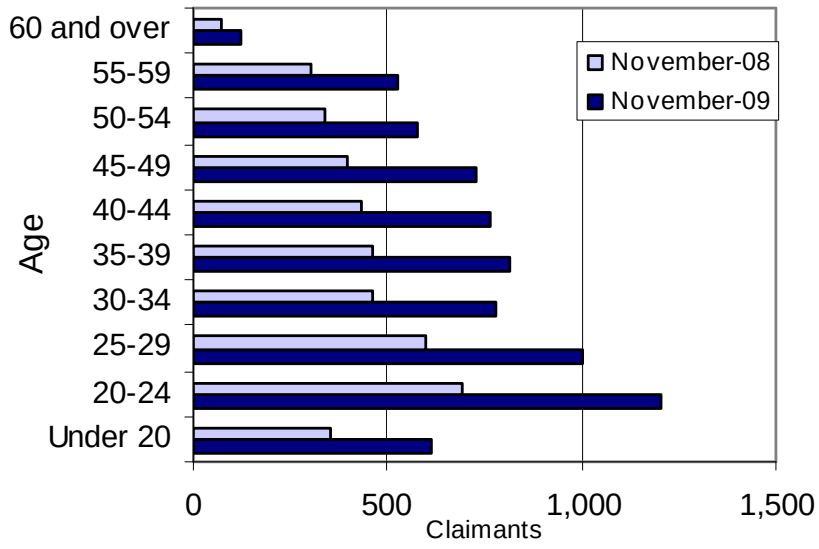
In Milton Keynes, the recession has hit hardest the young, the lower skilled, and areas of highest deprivation.

The Milton Keynes *resident* population generally has a lower skills profile than the *workforce* in Milton Keynes, with a large proportion of (many highly skilled) in-commuters. Lower skilled residents have generally seen more limited improvement in their skill levels in recent years compared to higher skilled residents. This local economic structure and the low skills profile of the resident population have been key causes of the recent rapid rise in unemployment in Milton Keynes, since lower skilled workers tend to be more vulnerable than other workers to job losses in a recession.

In November 2009, 72% of the unemployed claimants were male. White people made up the majority of the claimant count, 5,865 (78.2%) reflecting the MK population profile.

Three wards in particular have had consistently high unemployment rates: Eaton Manor, Campbell Park, and Woughton have had rates between 7-9% for most of the peak of the recession. Given the relatively young age of the populations of these wards, it is not surprising that young people aged under 30 made up almost 40% of the claimant count in November 2009, but, worryingly, the highest numbers of claimants were young people under 25, who comprise 25% of all unemployment claimants (Figure 14).

Figure 14: Age distribution of unemployment claimants, Milton Keynes, November 2008 and November 2009



But even when this recession is over, Milton Keynes is still at risk of high unemployment rates. Growth in the working age population is likely to outstrip employment growth in Milton Keynes over the next 5-10 years, despite the latter being faster than the South East average and comparator towns in the South East. This suggests that out-commuting and/or local pockets of unemployment could be a feature of the Milton Keynes labour market in future. The lower skilled population could imply that higher unemployment could persist longer than during the last two recessions.

Future employment growth is projected to be overwhelmingly in the service sector, which is where the bulk of employment growth has taken place in recent years. According to Experian, much of this growth is expected to be in lower value services, which could expose the labour market in Milton Keynes to future economic shocks.

Being NEET (Not in Education, Employment or Training) between the ages of 16 and 19 is associated with unemployment, low income, poor mental and physical health and associated problems in later life, especially for those who are NEET for extended periods or who repeatedly re-enter the NEET group. In November 2009, 467 young people were NEET (5.7%, compared with a national levels of 9-10%) with highest numbers occurring in Woughton, Campbell Park (the site of YMCA temporary housing), Wolverton and Eaton Manor wards.

Although NEET rates in Milton Keynes are relatively low, more can still be done to create more training and other opportunities to provide young people with skills, focusing on those groups of

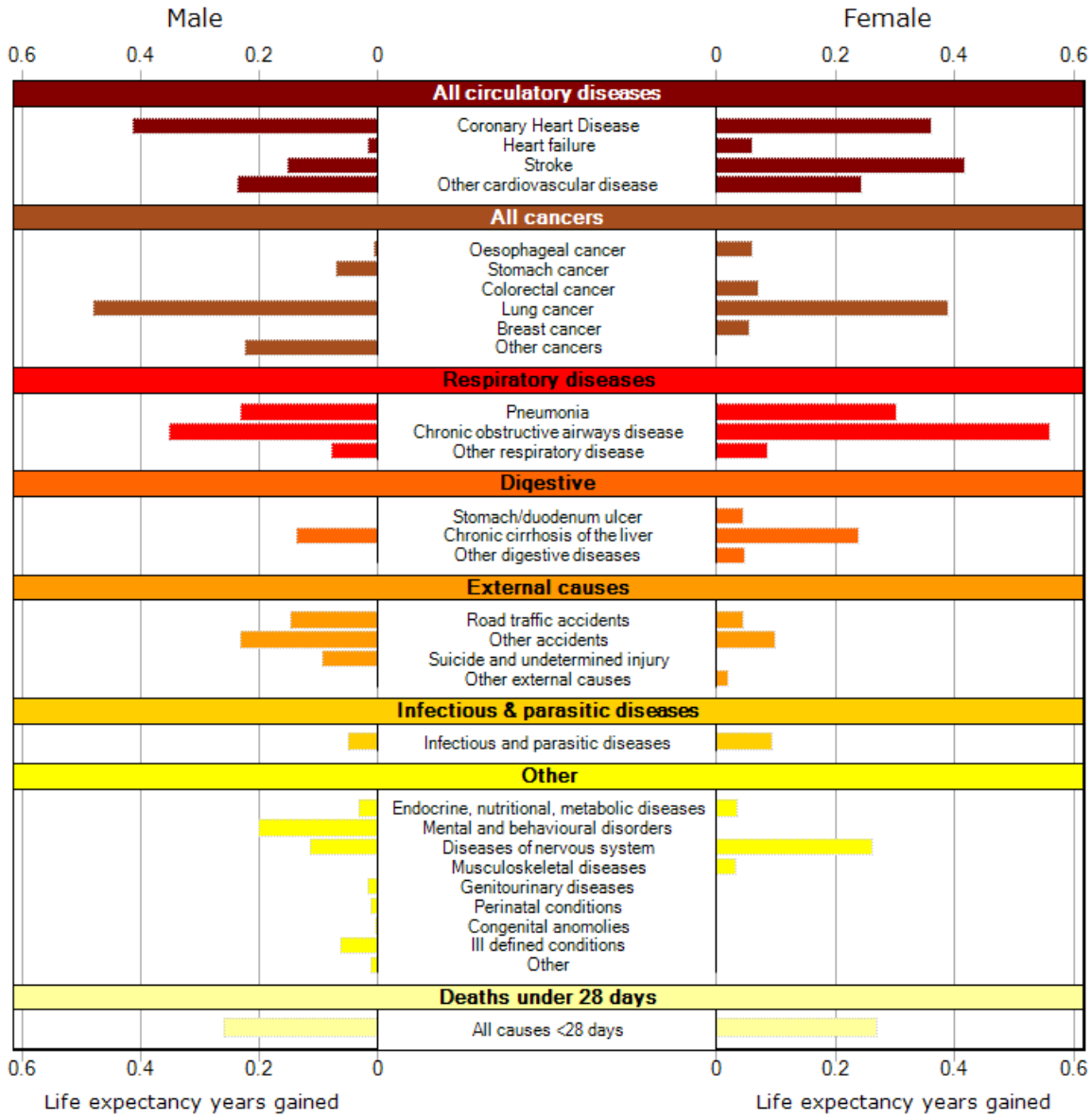
children and young people at greatest risk: those with poor achievement at school, teenage mothers, looked after young people/care leavers, young offenders, those with a history of poor school attendance or exclusion and young people with troubled home backgrounds.

5.5.2 Evidence of inequalities

It is too early to see direct effects of the recession on health, but the wards where unemployment rates have been highest are already those that suffer the worst health in Milton Keynes: the three wards with highest number of deliveries to teenage mothers, as well as the highest rate of teenage conceptions, are Woughton, Eaton Manor and Campbell Park. Life expectancy for both men and women is consistently five to six years below the Milton Keynes average in Woughton and Eaton Manor (see Figures 2 and 3). The underlying health causes of inequalities in life expectancy are set out in Figure 15. The conditions that have the greatest effect tend to be those related to smoking (coronary heart disease and stroke, lung cancer, chronic obstructive pulmonary disease) or alcohol (liver cirrhosis).

There is therefore a real risk that, without intervention, the effect of increased unemployment rates (i.e. more socio-economic deprivation) will widen the health inequality gap between these neighbourhoods and the rest of Milton Keynes.

Figure 15: Life expectancy years gained by gender if the most deprived 20% of the Milton Keynes population had the same mortality rate as the England average for each cause of death, 2008



5.5.3 Concentrating efforts

It is no coincidence that areas of high (and rising) unemployment are also those where health outcomes are worse, educational attainment is most difficult to achieve, and levels of crime are highest. However, until recently, public sector agencies had failed to come together effectively to share resource and intelligence in these same priority areas. Now, the Milton Keynes neighbourhood regeneration strategy provides a vehicle for combining efforts and using the resulting synergies to achieve better outcomes – health, education, and environment – for the people who currently experience the worst.

The approach of the Neighbourhood Regeneration Strategy is driven by the view that services will be improved and communities strengthened only where there is effective engagement and empowerment of the community. It is based on the premise that enabled communities drive the shape of their neighbourhoods and the services they receive to deliver a shared vision for the area.

The strategy's aim is "To close the gap between the most and least affluent neighbourhoods by improving the conditions and life chances of the most deprived." Its objectives include:

- Provide an overall framework for addressing the needs of the more disadvantaged and deprived estates in Milton Keynes
- Provide a basis for partner and community engagement in addressing the issues of deprivation in the estates.
- Coordinate and target new and existing policies and investment on neighbourhood solutions and opportunities for regeneration and revitalising struggling neighbourhoods.

Working at a number of levels, the strategy's implementation brings together senior public sector leaders from across Milton Keynes to create links in and co-ordinate policy and plans across the borough which can then empower front line workers in specific neighbourhoods to co-operate and support those communities. However, the strategy is clear that neighbourhood regeneration or renewal simply will not work if it is 'top -down'. It therefore seeks to provide a framework through which the neighbourhoods themselves are empowered to assess and improve their physical, economic, social and human capital.

The first three neighbourhoods in which this strategy is being implemented are Lakes Estate (Eaton Manor ward), Fishermead (Campbell Park ward), and Tinkers Bridge (Woughton ward).

Based on the initial interest in the Milton Keynes Neighbourhood Regeneration Strategy from communities and the public sector, the 2009 JSNA's recommendation is **to minimise the impact of the financial recession on health outcomes by empowering front line public sector staff in the selected regeneration estates to work flexibly in order to meet both expressed needs and hidden needs of the people in those neighbourhoods.**

6. Recommendations

6.1 Summary of findings

6.1.1 Review of JSNA 2008

The following recommendations remain valid or are updated from the last version of the JSNA:

- If Milton Keynes is to provide its young population with the best possible start in life, there needs to be a sustained focus on the level and quality of provision of pre-conception, maternity and neonatal care.
  Best practice in prevention of teenage conceptions and sex and relationship education should be shared and become 'normal practice' across schools and communities in Milton Keynes.
- All public sector staff, whether in health, education or other sectors, should be reminded that working in partnership to address the underlying issues is likely to be more effective than working separately on the manifestations of those issues.
  Ensure better outcomes at all stages by supporting children and young people with disabilities to stay well, aspire and achieve, so that they continue into adulthood confident and healthy.
- The health and social care system should be preparing to manage the increasing impact of conditions more prevalent in non-white populations.
- Make use of population profiling datasets in planning and delivering health and social care services, in order to ensure that services are being delivered to the right areas and in a manner to which the clients are likely to be most receptive.
- Given the time lag in creating the local market for provision of social care, the local health and social care economy should be considering now how it achieves this in order to meet the significant increase in need over coming years.
- Health and social care services should work together to improve access to evidence-based end of life care and support in the community and available 24 hours a day for people of all ages and with any underlying condition.

6.1.2 New recommendations

- Increase awareness of how common alcohol over-use can be and to ensure adequate and appropriate support is in place for people with alcohol problems.

- Primary and community based health care staff should recognise the potential needs of people with learning disabilities earlier and proactively support these individuals and their families to maintain independence and good health.

- Greater education and training is required for primary, community and care home staff on mental health needs of older people and the importance of early diagnosis and ongoing support, with the aims of increasing numbers of older people recognised to have dementia, depression or anxiety and yet reducing numbers of unplanned interventions.

- Building on the work to reduce alcohol over-use and by working with communities to change attitudes and raise awareness of domestic violence, reduce levels of domestic violence overall and repeated incidents of domestic violence in particular

- Minimise the impact of the financial recession on health outcomes by empowering front line public sector staff in the selected regeneration estates to work flexibly in order to meet both expressed needs and hidden needs of the people in those neighbourhoods.

6.2 Making the JSNA better next time

In this second iteration, the JSNA project team aimed to make the report wider reaching than the first by incorporating data from additional sources such as the Children and Young People Needs Assessment and the Community Safety Partnership Joint Needs Assessment. However, there is still more that could be done, and the following are updated recommendations for production of future versions:

- Include analysis and recommendations on more determinants of health and wellbeing, e.g. environment
- Include more detailed analysis of:
    - substance misuse and its impact on users, families and communities
    - End of life needs of BME groups and other minority groups

- Further promote the role of MKi Observatory as a repository for information and data on Milton Keynes
- Increase the degree of public involvement in the JSNA process, with more stakeholder engagement in the development of new themes to investigate

7. Milton Keynes JSNA Project team members

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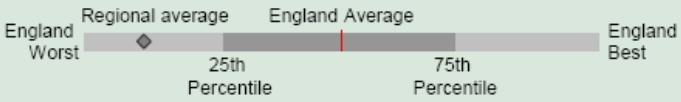
Appendix 1: Health profile of Milton Keynes 2009

The chart below shows how people's health in this local authority compares to the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which is shown as a bar. A green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated

* relates to National Indicator Set 2009



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	23286	10.5	19.9	89.2		0.0
	2 Children in poverty *	9589	20.0	22.4	66.5		6.0
	3 Statutory homelessness	80	0.8	2.8	8.9		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths) *	1152	42.1	48.3	26.5		73.3
	5 Violent crime *	5954	26.5	17.6	38.4		4.8
	6 Carbon emissions *	1621	7.2	7.2	15.7		4.6
Children's and young people's health	7 Smoking in pregnancy	468	14.4	14.7	37.8		3.7
	8 Breast feeding initiation *	2424	75.6	71.0	32.5		92.2
	9 Physically active children *	30010	96.0	90.0	77.5		100.0
	10 Obese children *	305	12.1	9.6	16.2		3.9
	11 Children's tooth decay (at age 5)	n/a	1.7	1.5	3.2		0.0
	12 Teenage pregnancy (under 18) *	192	43.2	41.2	79.1		15.0
Adults' health and lifestyle	13 Adults who smoke *	n/a	23.5	24.1	40.9		13.7
	14 Binge drinking adults	n/a	17.5	18.0	28.9		9.7
	15 Healthy eating adults	n/a	25.4	26.3	15.8		45.8
	16 Physically active adults	n/a	7.2	10.8	4.4		17.1
	17 Obese adults	n/a	24.7	23.6	31.2		11.9
Disease and poor health	18 Over 65s 'not in good health'	4501	21.0	21.5	32.5		13.5
	19 Incapacity benefits for mental illness *	2920	19.5	27.7	59.4		8.7
	20 Hospital stays for alcohol related harm *	3364	1478.2	1472.5	2615.1		639.9
	21 Drug misuse	1107	7.1	9.8	27.5		1.3
	22 People diagnosed with diabetes	7673	3.4	4.1	6.3		2.6
	23 New cases of tuberculosis	28	12.6	15.0	102.1		0.0
	24 Hip fracture in over-65s	64	219.0	479.8	699.8		219.0
Life expectancy and causes of death	25 Excess winter deaths	41	8.5	17.0	30.3		4.0
	26 Life expectancy - male *	n/a	78.0	77.7	73.2		83.7
	27 Life expectancy - female *	n/a	81.5	81.8	78.1		87.8
	28 Infant deaths	17	4.9	4.9	9.6		1.3
	29 Deaths from smoking	272	229.4	210.2	330.2		134.4
	30 Early deaths: heart disease & stroke *	155	81.4	79.1	130.5		39.6
	31 Early deaths: cancer *	220	114.2	115.5	164.3		75.7
	32 Road injuries and deaths *	116	52.5	54.3	188.3		18.4