MILTON KEYNES COUNCIL

Milton Keynes NHS
Primary Care Trust

Joint Strategic Needs Assessment

2011/12

1. Introduction

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 underpin strategic commissioning plans across the Health and Social Care Economy and the Council as a whole.

The JSNA builds upon (and should be read in conjunction with) other broad reaching assessments of the health and wellbeing of the Milton Keynes public, such as the public health annual report.

This document is the JSNA for Milton Keynes, and is supported and completed 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 annually but the data from which it is derived is continuously updated on the MKi Observatory site. This third 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.

2. Population Level

2.1 Population Numbers

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 is more than three times what it was at designation in 1967.

Most of the growth is focused in the New City, which is now estimated to be over four times larger than in 1967.

The growth is expected to continue although the number of dwellings expected to be built is now set locally. A realistic annual total to 2026 has been set at 1,750 dwellings. This allows for the growth of the borough population to continue into the future.

The effect this can be expected to have on the population and demography of Milton Keynes can be broken down into the effects on three main components of the population.

Further information may be found in the Population Bulletin 2011/12.

Young People

The growth in the population of young people will be strong and exceed that observed nationally. For example, the growth in 0-4 year olds to 2026 is expected to be around 10% in Milton Keynes, compared to a 7% increase in this age group nationally. The school age population is also expected to grow by over a third in Milton Keynes, compared to an 8% increase in the school age population nationally.

Working Age Population

The working age population of the Borough is expected to increase, both as a result of natural or demographic growth, and as a result of migration. Young adults are the most likely age group to migrate. Substantial migration will help keep the younger than average age structure in Milton Keynes, and partially counteract the aging of the population which is notable throughout Britain. The 17 to 24 year old age group of young adults is expected to show growth in Milton Keynes of around 14% to 2026. National projections to 2026 show a reduction in the size of this age group. In Milton Keynes it is anticipated to grow by 10%, although it will reduce as a proportion of the population.

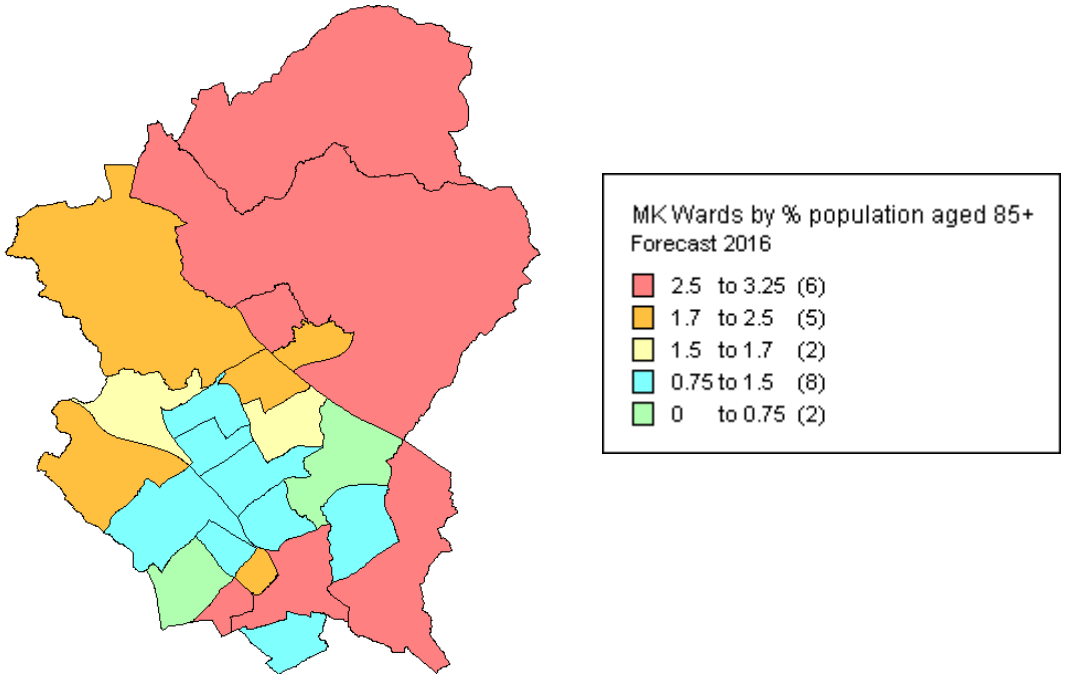
There are similar differences in the older working age groups. Nationally the 25-59 year old age group will grow by 7% but reduce as a proportion of the total population from 47% to 45%. In Milton Keynes in 2009 25-59 year olds made up 51% of the total population. The population in this age group will grow by almost 10% to 2026. However, this age group will only form 45% of the total population.

Older People

The Borough has historically had a younger age profile than England as a whole, and a relatively small older population. In 2009 there were around 38,850 persons aged 60 and over living in the Borough, which was just over 16% of the total population. By 2026 this age group will have grown to around 71,770 and will form 24% of the Borough population. This group shows the largest increase nationally to 2026 of 34% but will grow by around 85% in Milton Keynes.

The number of very old people, aged 85+, is forecast to grow from 6,970 in 2009 to around 16,160 in 2026 – growth of 132%. This can be forecast to have an impact on services. These figures incorporate the opening of the extra-care village, and the possibility of another such facility in the future. However a major concern must be the tendency for more of the older people to be based in the rural areas of Milton Keynes, and the impact this will have on service delivery. This is illustrated in figure 1 below.

Figure 1: Percentage of the ward population expected to be aged 85 plus by 2016

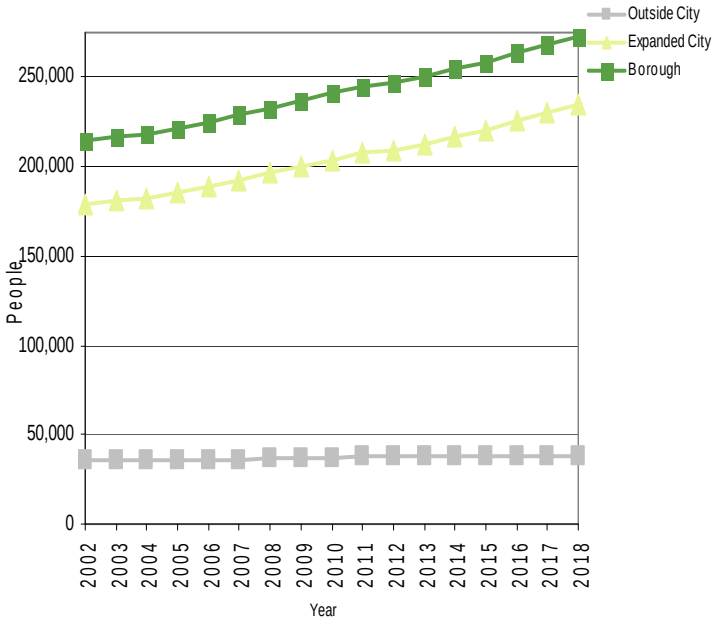


2.2 Total Growth

Despite the reduction in the number of dwellings to be built, Milton Keynes is still forecast to continue to grow into the future. This is a combination of natural growth, and in migration. Between 2009 and 2019, over 18,000 houses are anticipated to be built in the Borough, allowing for a projected growth in population of over 40,000 people.

- The population of the Borough of Milton Keynes is expected to increase by 36,080 people, to 272,740 by the year 2018, an increase of 15% from 2009.
- The majority of the growth will occur in the expanded city, which will reach a population of over 234,200 by 2018.

Figure 2: Population Growth

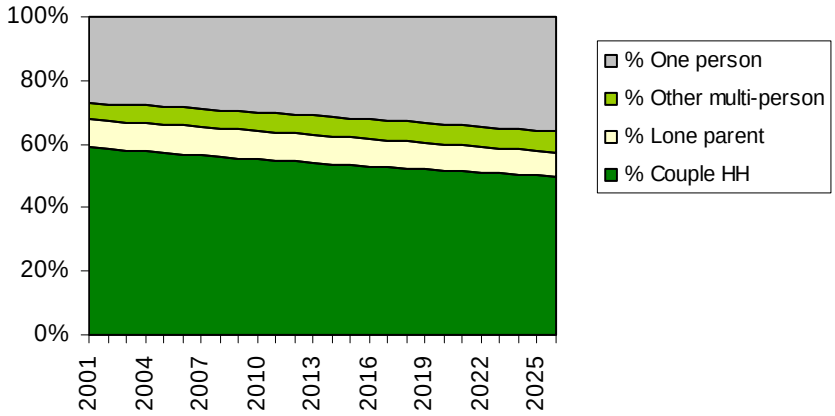


Population Growth To 2026

These projections illustrate the aging that will be expected to occur in the population between 2001 and 2026. This will occur independently of the growth. In-migrants, who have a younger age profile, help to offset the impact of the natural population aging. However, even with in-migrants, the population is expected to change such that almost 25% of the population will be aged 60 plus by 2026. This compares to around 14% in 2001.

Households and Household Size

Figure 3: Difference in Projected Household Types over Time



Nationally, average household size has fallen from 3.1 persons in 1961 to around 2.4 persons in 2004 for Great Britain. The decline since the 1970s can be largely attributed to an increase in the number of single person households, itself a result of divorce/separation, the greater economic independence of people enabling them to live alone, as well as an increase in the elderly population and a nationally declining birth rate. However, in spite of the growth of single person households most people in Great Britain live in a family household. In 2004 eight out of ten people lived in a family household, compared to nine out of ten in 1961.

The reduction in household size is set to continue, both nationally and in Milton Keynes. It is notable that the number of single-person households has risen dramatically, accounting for much of the fall in average size. In 1991 only 24% of households in Milton Keynes comprised a single person. By 2001 27% of households were single-person, which accounts for two thirds of the growth in households nationally. Updated forecasts predict that by 2026 over 36% of all households in Milton Keynes will contain a single person. This is more marked in the rural area, where almost 38% of households are expected to be single person. Using these forecasts, the average household size in Milton Keynes is expected to fall to just 2.2 by 2026. This can be understood by looking at the change in household types which has been projected to continue into the future. However changes in the type of property types built, or if a campus university is situated in Milton Keynes, may alter the projected household types.

Growth in Households

Households are derived from dwellings by taking into account household types, vacancy and sharing rates. The number of households in the borough is estimated at 98,590 in 2009 and this is expected to increase by almost 12,000 households, or 12% by 2019. This is a result of a number of factors. These include continued population increase from a net inward migration and high natural growth plus household factors such as a slight reduction in average household size and a reduction in the number of vacant properties.

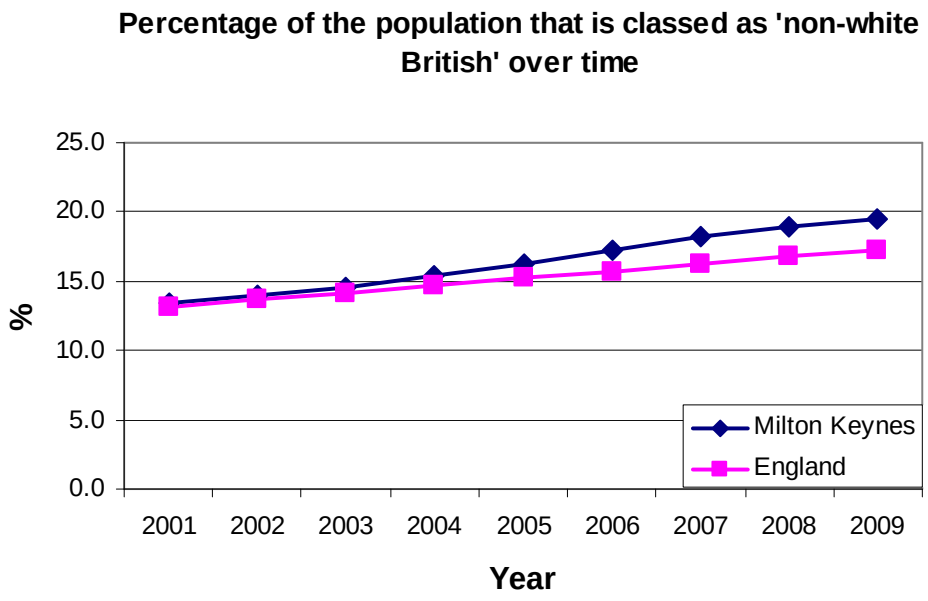
Table 1: Growth in Households

Year	Household Types		
	Rural	Urban	All Households
2009	16,500	82,090	98,590
2010	16,630	83,180	99,805
2011	16,780	84,320	101,100
2012	16,930	85,400	102,330
2013	17,060	86,430	103,480
2014	17,180	87,480	104,660
2015	17,300	88,510	105,810
2016	17,430	89,600	107,040
2017	17,570	90,670	108,240
2018	17,680	91,690	109,370
2019	17,790	92,710	110,500

2.3 Ethnicity

The estimates of the population by ethnic group produced by ONS give an indication of some of the changes that have occurred to the population of Milton Keynes since the last census in 2001. These can be seen in the chart below:

Figure 4: Percentage of the population that is classified as 'non-white British' over time



This indicates that, from a similar position in 2001, the ethnic diversity of the total Milton Keynes population has increased more than that for England as a whole. In 2001, 13.2% of the total population in England were from an ethnic group other than 'white British'. In Milton Keynes the comparable figure was 13.4%. By 2009, 17.2% of the population of England was estimated to have an ethnic group other than white British while the comparable group in Milton Keynes has risen to 19.4%.

Figure 5 below illustrates the changes that have occurred in the ethnic composition of the population. This illustrates that the Indian ethnic group has grown from 1.9% of the population to 3.5%. This is the largest single ethnic group and also the largest increase. The population size is estimated to be 8,200. The Pakistani group has grown by 1%, from 0.8% of the population in 2001 to an estimated 1.8% in 2009: an estimated population size of 4,300.

Figure 5: Change in ethnic group in Milton Keynes, 2001 to 2009

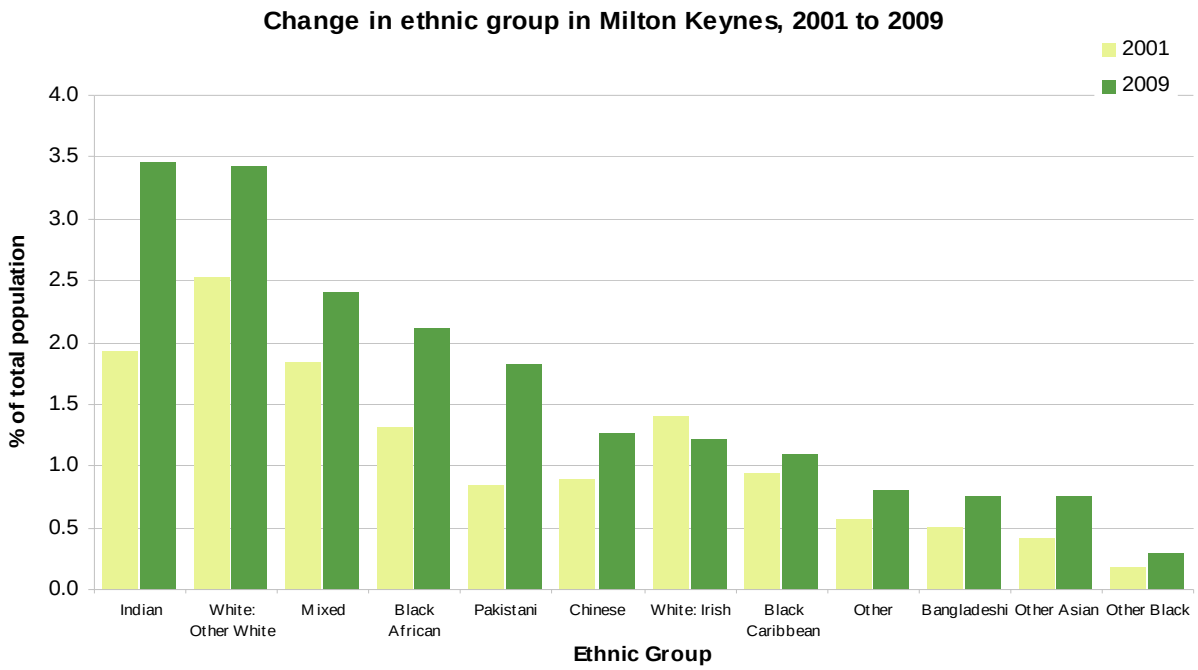


Table 2: Ethnic mix of the Milton Keynes and England population, 2009

	Milton Keynes		England
	Persons	%	%
White: British	190,500	80.5	82.8
White: Irish	2,900	1.2	1.1
White: Other White	8,100	3.4	3.6
Mixed	**5,700**	**2.4**	**1.8**
Asian or Asian British	**16,100**	**6.8**	**6.1**
Asian or Asian British: Indian	8,200	3.5	2.7
Asian or Asian British: Pakistani	4,300	1.8	1.9
Asian or Asian British: Bangladeshi	1,800	0.8	0.7
Asian or Asian British: Other Asian	1,800	0.8	0.7
Black or Black British	**8,300**	**3.5**	**2.9**
Black or Black British: Black Caribbean	2,600	1.1	1.2
Black or Black British: Black African	5,000	2.1	1.5
Black or Black British: Other Black	700	0.3	0.2
Chinese or Other Ethnic Group	**4,900**	**2.1**	**1.6**
Chinese or Other Ethnic Group: Chinese	3,000	1.3	0.8
Chinese or Other Ethnic Group: Other	1,900	0.8	0.8
All Groups	236,700	100.0	100.0
Total Non-White British	46,000	19.4	17.2

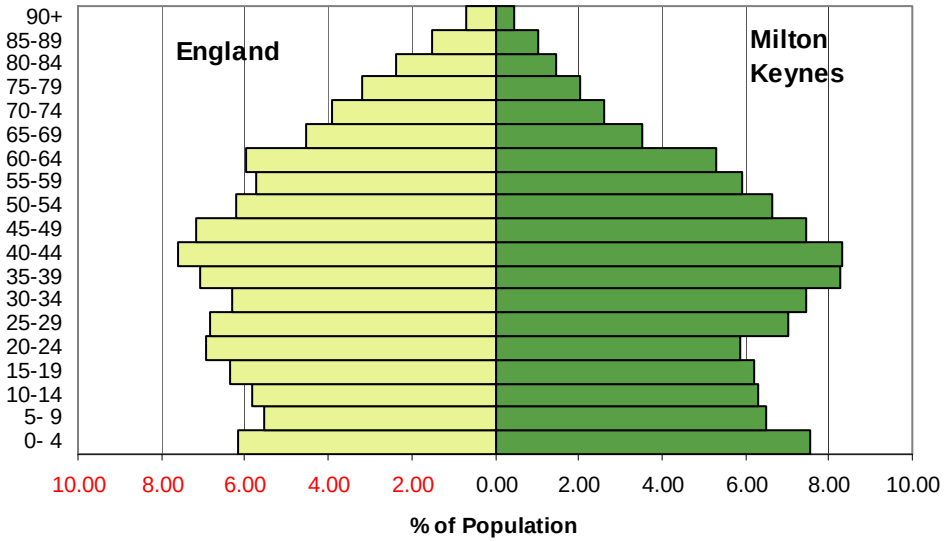
The 'other white' group has also risen, by 0.9%, to an estimated population size of 8,100. This is the group that would include European migrants from the expansion of the EU. The only ethnic group which has fallen as a proportion of the population is the white Irish which now forms 1.2% of the population of Milton Keynes or 2,900 people.

2.4 Age

Age Structure

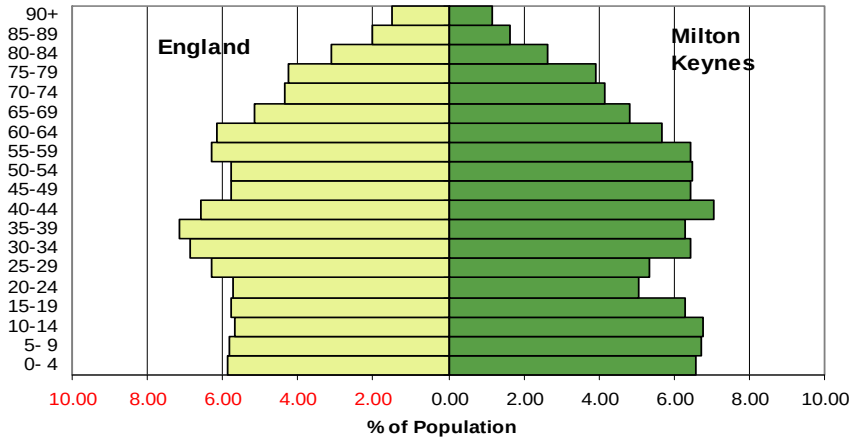
Figures 6 and 7 below show the age structure of the population of Milton Keynes Borough in 2009 and 2026 compared with England. The borough's population age profile is younger than that for England as a whole, with half of the borough's population aged 36 years or younger (the median age). Nationally, the median age is 38. The 30-44 year olds in Milton Keynes are the largest proportion of the population. 40-44 year olds are the largest 5-year age group.

Figure 6: 2009 Age Structure



By 2026, the borough's population will have changed. The median age will be around 40 years because of migration and births to current residents. The age profile will still be different to that for England, although it will also have a median age of about 40 years. The 40-44 age will still be the single largest age band in the Borough although 35-39 is the largest band nationally. This age band is the only one which will have decreased in number in the Borough.The number of 50-54 year olds will have seen a large increase in the Borough, and the number of over 60 year olds will experience a very large jump. The proportion of the population in all age groups older than 55-59 will have risen as the population profile becomes more similar to that seen nationally.

Figure 7: 2026 Age Structure



Age Groups in the Borough

Figure 8 illustrates the changes expected up to 2026 for specific age groups in Milton Keynes Borough. Changes compared with national trends are highlighted below.

Early Years – 0 to 4 years old

The Borough's number of children in their early years is expected to increase from 17,900 in 2009 to 19,700 in the year 2026, an increase of 10%. The national 2008-based projections show a 7% increase between 2009 and 2026 for the 0 to 4 year olds.

School Age Population

There will be a 26% increase in the number of children aged 5 to 16 in the Borough between 2009 and 2019, and a 33% increase between 2009 and 2026. In contrast, the figures for England show a 8% increase to 2019, and 13% growth to 2026.

Young Adults – 17 to 24 years old

The young adults in the Borough are expected to increase in number from 22,500 in 2009 to 25,700 in 2026, an increase of 14%. The most substantial growth in this age group occurs after 2021. Between 2009 and 2026 national projections anticipate this age group decreasing by 4.6%.

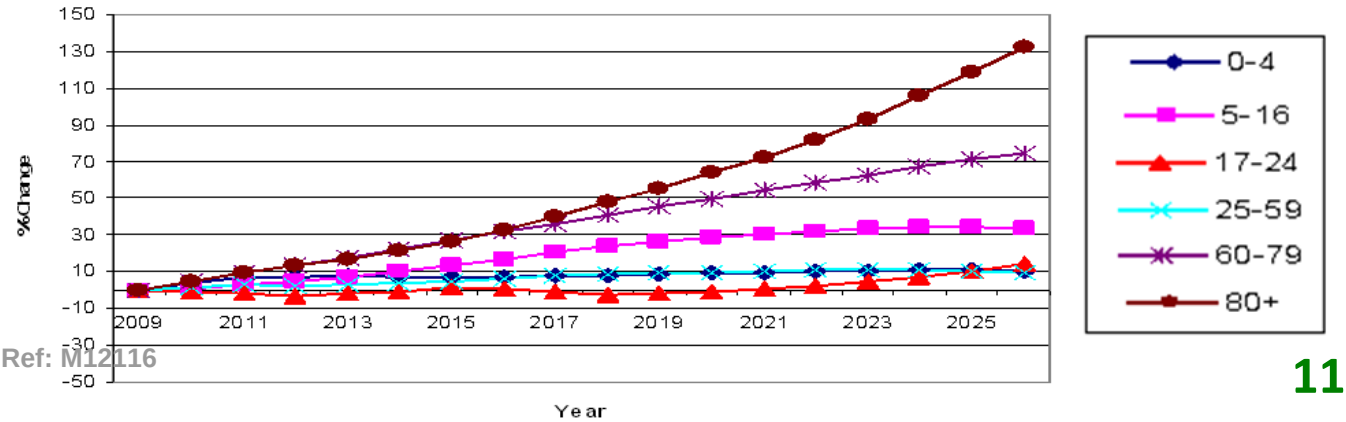
Adults – 25 to 59 years old

The number of people aged 25 to 59 in the Borough is expected to increase over the period 2009 to 2026 from 121,100 to 132,800, a rise of 10%. For England, an increase of 7% is expected over the same period. In Milton Keynes, the percentage growth seen in the 25-34 age group is 2%, and the 35-59 group is 13%. In England, growth of 13% is forecast in the 25-34 group, and 5% in the 35-59 age group.

Older People – Aged 60 and over

In 2009 there were 38,800 people aged 60 and over in the Borough, and this number is expected to increase by 85% to over 71,800 by 2026. The corresponding percentage increase nationally is 34%. In Milton Keynes the older age group, aged 60 to 80, is forecast to grow by 75% in this period. However, the 80+ age group is forecast to increase by over 130%, from 7,000 population to over 16,100.

Figure 8: Percentage change in age groups from 2009 to 2026 in Milton Keynes



Birth and Death Statistics

Live Births 2010	3,912
Total Fertility Rate 2010	2.4
Deaths 2010	1,609
Standardised Mortality Ratio 2010	104

2.5 Deprivation

The national index of deprivation was published on 24th March 2011. [1] The methodology was broadly unchanged from the previous iteration, to allow comparability with the index of deprivation 2007. The index was released at the lower super output area (LSOA) geography.

Key Results for Milton Keynes:

- Milton Keynes has a local authority rank of 211, compared to 212 last time – where 1 is the most deprived.
- Authorities ranked closely to Milton Keynes include Cheltenham (214); Chichester (213); Solihull (212); Braintree (210); East Devon (209).
- 7 lower super output areas are in the 10% most deprived in England, compared to 6 in the 2007 index.
- 18 lower super output areas are in the 20% most deprived in England, compared to 15 in the 2007 index and 13 in 2004.
- 17 lower super output areas are in the 10% least deprived in England, compared to 14 in the 2007 index.
- 51 lower super output areas are in the 20% least deprived in England, compared to 49 in the 2007 index and 40 in 2004.
- This continues the trend, seen between the 2004 and 2007 indices, of increasing numbers in the most and in the least deprived quintiles of the national population

Further information can be found in the 'Deprivation & Social Issues' theme on the Observatory. [2]

3. Social and Place

3.1 Living Arrangements

3.1.1 Housing

Who's at risk and why?

The condition and design of general housing has an important impact on the health and wellbeing of individuals and communities.

The Draft Milton Keynes Strategic Housing Market Assessment Update 2009 (MAU09) [3] showed that there were 12,404 households identified as living in unsuitable housing in Milton Keynes. This was 13.2% of all households in Milton Keynes. The criteria for unsuitable housing included:

- Homeless or with insecure tenure
- Overcrowding
- Households having to share a kitchen, bathroom, washbasin or WC with another household
- Home too difficult to maintain
- Children living in high-rise flats
- Households with support needs
- Problems with condition of property
- Social issues like harassment.

Analysis of the condition of housing stock in the MAU09 report showed that only 1.6% of all pensioner households reported that they had a serious problem with their home. This compared to 9.4% of groups of adults with children and 8.9% of lone parent households. This suggested that children in families were more likely to be living in properties with serious problems than older people living on their own.

Analysis of households living in unsuitable housing in the MAU09 report found that 9.9% of all pensioner households were living in unsuitable housing. This compares to 35% of group of adults with children households and 24.5% of lone parent households. This again suggested that pensioners were less likely to be living in unsuitable housing than young children and young adults.

Although the previous analysis suggested that older person households did not have significant issues, the MAU09 also included a profile of older person households, which suggested that there are some issues that need to be considered. The profile divided the analysis of older person households into “all older” households, where at least one person in the households was aged over 60 years and no-one in the household was aged under 50 years and “some older” households, where at least one person in the household was aged 60 years or over, but at least one member of the households was aged under 50 years.

The older person household profile showed that all older households were most likely to be living in a property that they owned outright, with almost 60% of all older households owning their current home outright. Almost 40% of some older households owned their current home outright and almost a further 40% owned their current home with a mortgage. This compared to just over 10% of households with no older people owning their current home outright and almost 50% of households with no older people owned their current home with a mortgage. Although the majority of all older households owned their current home outright, a higher proportion of all older households rented from the Council or Housing Association than some older and no older households.

The majority of households in Milton Keynes were satisfied with their current home. However the older person household profile showed that households with older people were slightly more likely to be satisfied with their current home than households with no older people. This suggested that older person households were more likely to want to remain in their current home than move. This was reinforced when households were asked whether they wanted to move. Only 9% of all older households and 13% of some older households wanted to move. This compared with 27% of households with no older people who wanted to move. This suggested that the older people population in Milton Keynes may be planning to stay in Milton Keynes and probably in their current home. This will have implications for the existing health and social care services because as the older person households age, they are likely to require more care and support in their current home and therefore create a further demand on the existing services.

For those older households who wanted to move, the reason for wanting to move was either because their current home was too large or because it was unsuitable for their needs. This may reflect the changing needs of older people as they age and their health deteriorates and begins to have an impact on their current housing situation.

The profile also showed that households with older people were more likely to have someone in their household who suffered from a health problem, as 45% of all older households and 43% of some older households had at least one member who suffered from a health problem. This compares to 13% of households with no older people.

20% of all older households and 17% of some older households in the profile said that the health problem of the member of their household affected their housing needs. However only 5% of all older households and 7% of some older households claimed that their current home did not meet the health needs of the member of the household with a health problem, this amounted to around 1,525 homes across Milton Keynes that currently contain older people who do not have their housing needs met due to the health problems of the household. This suggested that there were households in Milton Keynes who require either physical adaptations made to the property or a move to a more suitable property to ensure that their home meets their health needs.

Of those older person households who reported that their current home does not meet their housing needs due to the health problems of the household in the household profile, 80% of all older households and 68% of some older households reported that their current home could be adapted to meet their needs. However 10% of all older households and 32% of some older households felt that they would need to move to another home, which was more suitable for their needs. Therefore it appeared that of the 1,525 homes across Milton Keynes that currently contained older people who did not have their housing needs met due to the health problems of the household, only 200 households required to move to a home that was more suitable for their needs. This suggested that there is a demand for new housing to be built specially to meet the health needs of these households.

The emerging MKSHMAU09 also provided a profile of households with supported housing and health needs, which would also be useful for the Milton Keynes Joint Strategic Needs Assessment. The profile found that currently there were 24,162 people living in Milton Keynes who reported having health problems. This was around 10.3% of the population. Some of the people who reported to have health problems lived in the same household, which meant that there were 20,869 households in Milton Keynes that contained at least one member with a health problem. This represented around 22% of all households in Milton Keynes. The main health problems experienced were with walking and mobility problems (just over 4% of all people), diabetes (1.5% of all people) and difficulties due to old age or frailty (almost 1.5% of all people). Other health problems reported were visual impairment (almost 0.5% of all people), hearing impairment (just over 0.5% of all people), wheelchair user (0.3% of all people) and mental health problems (just over 0.5% of all people).

According to the profile of households with supported housing and health needs, 41% of households who rented from the Council, 41% of households who rented from a Housing Association and 31% of household who owned their home outright contained at least one person who has a health problem. This compared to just over 10% of households who rented from a private landlord and 13% of households who owned their home with a mortgage who had at least one person in their household who had a health problem. Over 80% of households with health problems lived in social rented housing. This may have implications for the landlords of the social rented housing in particular with regard to ensuring that the properties were suitable to meet the health needs of the households but also the recognition of the vulnerability of their tenants.

The profile also showed that of those households who had at least one member in their household with a health problem, 31% (7,550) of households needed some form of care or support. Of those households that needed some form of care or support, 10.5% (790) of households did not receive any care or support. This suggested that the current health and social care services were not necessarily supporting all households in Milton Keynes who require care and support.

The profile identified that of those households who had at least one member of their household with a health problem, 35.2% claimed that their health problems affected their housing requirements. Of those households who had at least one member of their household with a health problem and claimed that their health problem affected their housing requirements, 35% felt that their homes were not currently adequately adjusted to meet their health problems. This equated to 2,500 households (2.7%) in Milton Keynes. Problems identified by households who had at least one member of their household with a health problem and felt that their homes were not adequately adjusted to meet their health needs were with bathing and showering, climbing stairs and general mobility. 71% of these households felt that their current home could be adapted to meet their needs and that the majority of these households required bathroom adaptations, stair lifts and handrails to be fitted. Of those households who required adaptations, 49% felt that they were responsible for them but they could not afford them. This equated to 510 households across the borough. This could indicate the level of demand in Milton Keynes for Disabled Facilities Grant, a means tested grant available for households who require physical adaptations but are unable to afford to have them fitted.

The profile also found that 17.4% of households who contained at least one member of the household with a health problem and who felt that their current home was not adequately adjusted to meet their health problem felt that they would need to move to another home which was more suitable for their needs. This equated to 390 households in Milton Keynes. However when asked whether they wanted to move, only 140 households wanted to move. This could indicate the level of need for housing specially designed to meet the health needs of the borough. Of those households who contained at least one member of the household with a health problem, who felt that their current home was not adequately adjusted to meet their health problem and who felt that they needed and wanted to move to another home which was more suitable for their needs, 213 households wanted to move to a Council or Housing Association property. Again this could indicate that households who had health problems who wanted to move may expect to move to a Council or Housing Association property, which may create a further demand on these properties.

The profile also showed that there were approximately 14,000 properties in Milton Keynes that already have adaptations fitted, however around 5,343 of these properties were occupied by households who did not have a member of the household with health problems.

Projected service use and outcomes

The population has increased, and is projected to increase as follows:

Table 3: Growth in Population

Year	Urban	Rural	Borough
2009	199,680	36,980	236,660
2010	203,580	37,410	240,990
2011	207,440	37,840	245,280
2012	209,220	37,880	274,100
2013	212,550	37,970	250,520

No significant determinants that indicate prevalence of unsuitable housing has changed or segmentation, but evidence suggests:

- increase in houses in multiple occupations (HIMO)
- increase in number of people housed in temporary accommodation

3.1.2 Transport

Accessibility

Transport enables access to work, education, social networks and services that can improve people's opportunities. However, the relationship between transport and health are multiple, complex and socio-economically patterned, for example there is a clear social gradient in access to work and services, with greater freedom to travel, linked to increased car ownership, as income increases.

Increased levels of car ownership and use have provided greater opportunity for travel, however nearly one in three households nationally do not have access to a car, for reasons that include cost, disability, environmental reasons and personal choice.

In Milton Keynes there is higher than average car-ownership in the borough, with only 19% of households not having access to a car compared with 27% nationally. In 2001, car ownership rates in Milton Keynes were 0.51 cars per resident or 1.26 cars per household. This rate is between 10% and 15% higher than the national average, and is a similar rate to affluent and predominantly rural districts. The rate is much higher than urban centres with a similar population.

Car ownership in deprived estates such as Netherfield (57%), Beanhill (60%) and Coffee Hall (65%) is much lower than the rest of Milton Keynes. The quality of the bus service is therefore critical to economic and social inclusion, as well as quality of life. Residents of the areas with low car ownership are less able to access jobs, hospitals, shops, facilities and other key services. Table 4 provides more details:

Table 4: % Households with no access to car by Ward, including IMD and walk time

Milton Keynes Urban Ward	% of households with no access to a car	Contains residential areas within the 15% most deprived in England	Contains residential areas within the 15-20% most deprived in England	Contains residential areas within the 20-25% most deprived in England	Above average walking time to bus stop
Wolverton	22%		✓	✓	
Campbell Park	18%		✓	✓	
Bradwell	17%		✓		
Stantonbury	17%		✓		
Linford North	15%				
Woughton	15%	✓	✓	✓	✓
Walton Park	14%				✓
Eaton Manor	13%	✓			✓
Linford South	13%				
Bletchley and Fenny Stratford	11%		✓	✓	✓
Milton Keynes	*12%*	-	-	-	-
2001 Census	*19%*	-	-	-	-

Source: Office of National Statistics, 2007 and Milton Keynes Household Survey, 2010

Lack of car accessibility exacerbates the plight of those already living in pockets of deprivation and social exclusion across the city. The table below also shows that elderly people and single occupancy households are among the most disadvantaged.

Household Type	Number of Households	% of HH with car availability	% of HH with no Car availability
One Person	22,488	59%	41%
Pensioner	8,102	31%	69%
One Family and no others	55,968	89%	11%
Other households	4,901	84%	16%
All households	83,357	81%	19%

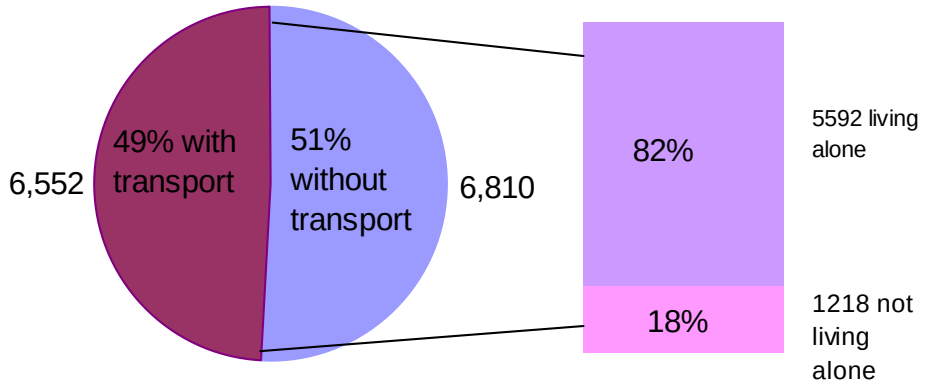
Source: United Kingdom 2001 Census (Office of National Statistics 2001) and *TEMPRO 6.1* (Department for Transport, 2008)

Research identifies a number of transport barriers that older people face when undertaking journeys, both on foot and by public transport. These include physically inaccessible transport vehicles, pedestrian environment, safety concerns, and attitudes of transport staff.

Access to Healthcare

For older people, accessing healthcare services can often become a regular part of their lives. For many older people accessing these services can be difficult either due to mobility problems (which can prevent them using traditional public transport services) or for financial reasons (cannot afford the transport costs). For some older people who are used to driving private cars, health or financial reasons can mean that they have to give up using their cars and they become reliant on public transport services; it is important that these people receive information and, where required, training to enable then to use the public transport network. The figure below shows the proportion of older people (state pension age) with access to transport and living circumstances.

State Pension Age households with or without transport (2001)



The Social Exclusion Unit reported that 31% of people without a car have difficulty travelling to their local hospital, compared to 17% of people with a car. Over 1.4 million people say they have missed, turned down, or chosen not to seek medical help over the last 12 months because of transport problems. Milton Keynes hospital, because of the limited bus routes in the urban area, is especially difficult to get to by public transport from certain areas.

Access to other Services

Impact of car ownership and accessibility to other services

Access to fresh food shops:

- 16% of people without cars find access to supermarkets difficult, compared to 6% of the population as a whole.
- Where access to supermarkets is restricted, socially disadvantaged groups are forced to buy their food from more expensive local shops.

Access to social, cultural and sporting activities:

- 18% of people without a car find seeing friends and family difficult because of transport problems, compared with 8% of car owners.
- People without cars are also twice as likely to find it difficult to getting to leisure centres and libraries.

Participation in such activities is very important to peoples' quality of life and can play a major part in improving health. Transport is a particular barrier to older peoples' participation in activities such as leisure, day centres, caring and volunteering. Research by the DFT has shown the importance to older people of simply getting out of the house.

Extract from 'A Transport Vision and Strategy for Milton Keynes. LTP3 – 2011-2013'

There are pockets of high levels of multiple deprivation in Milton Keynes, typically matched by lower levels of car ownership. With regards to accessibility, almost 20% of Milton Keynes residents do not have access to a private car, with approximately 50% of working age population residents not having access to a car at some point during the day. Access to key services is perceived to be poor by residents anecdotally. Membership of the current community transport service is capped and currently full. With a 102% increase in the elderly population between 2011 to 2031 from 28,400 to 57,300, 'mainstreaming' services (i.e. making the public transport network as accessible as possible and reducing dependence on Community Transport) will become essential if Community Transport is to be funded and provided across the entire borough. Preventing this aim from being achieved are public transport network accessible constraints for people with mobility or sensory impairments. Fast grid roads are a safety concern for bus operators with buses turning or merging onto grid roads, as well as providing an uncomfortable journey experience if buses need to accelerate or break suddenly.

3.2 Economic Health

3.2.1 Employment

Who's at risk and why?

There is a strong link between unemployment and deterioration in physical and mental health and well-being. Unemployment is shown to increase rates of sickness, disability and mental health problems, and to decrease life expectancy. It also results in an increased use of medication, medical services, and higher hospital admission rates. This is particularly of note for those unemployed for a year or longer.

Level of need in the population

In Milton Keynes, the unemployment rate for July 2009-June 2010 was 8.9 per cent of the population aged 16 years and over. For the same year, the unemployment rate for Milton Keynes was greater than the rate for the South East region (6.1%). The unemployment rate for Milton Keynes was not significantly different from that for England.

The start of the recession saw unemployment in Milton Keynes rise from 2% in May 2008 to its highest levels of 4.8% in May 2009, falling to 4.4% in May 2010. In 2000 unemployment in Milton Keynes fell to 1.2% but since then rose gradually. Since January 2010 unemployment in Milton Keynes has fallen at a faster rate than in the South East and England.

Unemployment in Milton Keynes was 3.4% in December 2010, compared to 2.4% in the South East and 3.6% in the UK.

Comparison of unemployment rates between Milton Keynes and the South East Midlands Local Enterprise Partnership area showed Luton as having highest levels of unemployment and Aylesbury Vale having the lowest rates (1.7% in December 2010).

Rural unemployment in Milton Keynes rose from 1.6% in December 2008 to 2.1% in May 2010 compared to urban unemployment rates of 3.3% in 2008 to 4.9% in May 2010.

The proportion of female claimants in Milton Keynes rose from 24% in 1998 to 30% in May 2010. In contrast the proportion of male claimants fell from 76% in 1998 to 70% in May 2010.

Male unemployment in Milton Keynes, the South East and UK between December 1998 and December 2010 showed both the South East and the UK had higher percentages of male unemployment than Milton Keynes. Indeed male unemployment in Milton Keynes fell faster than in the South East and the UK between December 1998 and December 2010.

Young people were impacted heavily when unemployment rose rapidly, to a point when 27.3% of all those unemployed and claiming unemployment benefit were under 24 years of age. Youth unemployment stood at 20.1% in December 2010.

Over the past year the number of people claiming unemployment benefits has risen from 6,183 to 6,601 claimants. This is a rise of 418 claimants (6.8%).

Milton Keynes unemployment rate (4.1%) is above the UK rate of 3.9% and is higher than the South East (2.6%). Milton Keynes has a similar unemployment rate to other areas in the South Midlands - Northampton 3.9% and Bedford 4.0%.

Wards with significantly higher than average unemployment rates are Eaton Manor (7.9%), Woughton (7.3%) and Campbell Park (7.0%).

Evidence of what works and policy drivers

Returning to work from unemployment results in significant health improvements and increases the self-esteem of individuals. The improvements in health that result from returning to work can reverse the negative health effects of unemployment.

Being in work is shown to be beneficial to those with ongoing health conditions. Work can help people recover from sickness and reduces the risk of long-term incapacity.

The positive health effects of work mean that sick and disabled people should be supported to return to, or remain, in work if their health condition permits it.

3.2.2 Young people Not in Education, Employment or Training (NEET)

Who's at risk and why?

Young people aged 16 to 19 years are at risk of being NEET (Not in Education, Employment or Training). Some factors and characteristics are more likely to be associated with being NEET. Understanding these issues will assist in developing targeted and preventive interventions.

Young people who are NEET have an increased risk of subsequent unemployment, having a criminal record and experiencing depression. [(4)] The increased risk of unemployment is particularly pertinent in the current economic climate. Unemployed young people aged under 20 years made up 6.1% of the unemployment claimant count in December 2010 whilst those aged 20 to 23 years of age made 14% of the claimant count. [(5)]

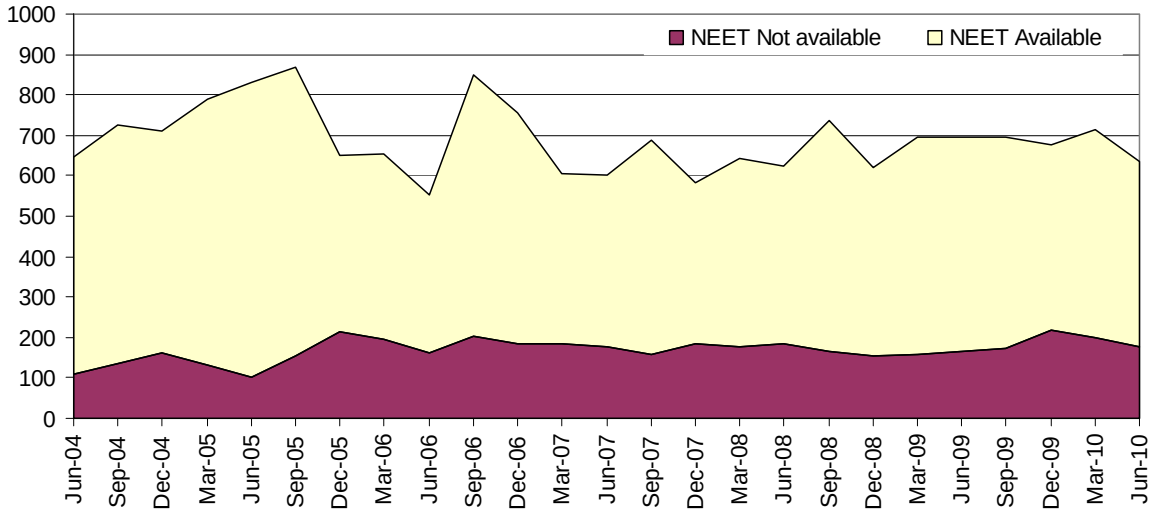
Level of need in the population

The population of young people aged 17 – 19 years, who are NEET can be divided into two sub-groups: those who are available for education, employment and training (EET) and those who are not available.

The number of young people who were not available for EET each month has been essentially constant (150 to 220) from December 2005 to June 2010 (Figure 11). At least 70% of those who were not available were females who were either pregnant or caring for their own child. [(6)]

Since March 2009, between 460 and 540 young people were NEET and were available for EET each month.

Figure 9: Number of young people aged 17-19, who were NEET



At the end of June 2010 the following wards had the highest proportions of young people who were NEET: Woughton (14.11%), Denbigh (11.83%), Eaton Manor (11.52%) and Campbell Park (11.08%).

Analysis of the cohort of young people who were NEET at this time showed that almost 20% were educated at an out of area school in year 11. This means that they either moved to Milton Keynes post 16 years of age, or lived in Milton Keynes but went to school elsewhere. 12.9% were in Alternative Education in year 11. [6]

Most of the young people who were NEET and available for EET were hoping to find employment rather than further education. The job choices specified suggest that young people who were NEET at the time of the snapshot would face competition for entry level jobs from foreign workers, school leavers and possibly graduates.

The Milton Keynes Local Economic Assessment (2011) [7] reported that there is a shortage of apprenticeships and that good work experience places are sometimes hard to find.

There is no strong evidence to suggest that learners within Milton Keynes are undertaking learning outcomes that reflect what is happening within the labour market, or being guided by labour market information when making choices. A decrease in employment opportunities appears to be associated with an increase in the proportion that remained in education on leaving compulsory education. This appears to delay NEET status so that young people aged 18 and 19 years are more likely to be NEET than those aged 17. There are concerns that post-16 education for clients with Learning Difficulties and Disabilities may have a similar effect.

The recent report on Milton Keynes young people who are NEET [6] identified some individuals and groups who appear to have particular difficulties in entering EET. These include those young people who have been NEET on a number of occasions and those who have been NEET for a long period of time. It also showed that the following groups have a relatively large proportion of young people who are NEET, suggesting similar difficulties:

- Young people supervised by the Youth Offending Team (YOT)
- Young people who were in alternative education in year 11 or who were not registered in education

- Young people with a Learning Disability or Difficulty (LDD)
- Young women who are pregnant or mothers
- Looked after children and care leavers
- Young carers

Table 5: Milton Keynes 2010/11 (financial year): former National Indicators associated with education, employment and training

Ref	Indicator (former National Indicator)	MK ACTUAL		Target 2010/2011	Trend	LATEST BENCHMARK	
		2009/10	2010/11			Nat	SN Average
EMPLOYMENT AND SKILLS							
NI 117	% young people aged 16-18 who are not in education, employment or training (NEET)	5.8	**5.1**	5.9	↑	6.0	5.6
NI 148	% of care leavers aged 19 who are in education, employment or training	67.9	**67.9**	70.0	→	62.1	67.0
NI 45	Proportion of young offenders who are in suitable education, employment or training (%)	68.3	**66.2**	75.0	↓	73.3	-

Current Services in relation to need

Information on current services has been sourced from service plans for 2011/12.

The Integrated Youth Support Service (IYSS) delivers local authority statutory requirements for:

- Impartial careers information, advice & guidance
- Encouraging and supporting young people to enter or remain in education, training and employment
- Section 139a Assessments (an assessment of a young person with a learning difficulty that results in a written report of his/her educational and training needs, and the provision required to meet those needs.)

Services target the following groups: young people with LDD; teenage mothers; young offenders; care leavers.

The YOT pursues increased provision for education training and employment (ETE) with the aim that the number of those aged 16+ who are NEET is reduced and suitable provision means less time is spent out of ETE with fewer placement breakdowns.

The YOT also aims to increase engagement in full-time ETE by exploring Speech, Language and Communication Needs (SLCN).

Children and Families Service Groups may also impact on the number of young people who are NEET through the following activities:

- Work with providers to secure a range of high quality curriculum opportunities that enable all young people (14-24), particularly vulnerable learners, to progress into suitable training and employment;
- Work with employers and the voluntary sector to ensure that young people are better prepared to meet the needs of the local economy, and have access to opportunities such as apprenticeships;
- Support and challenge schools to ensure there is impartial information and advice on all 16-18 education and training opportunities;
- Support schools and other providers to assist them in enabling young people to remain in education (as defined in Raising the Participation Age);
- Support the effective transition process for Learners with Learning Difficulties and Disabilities;
- Provide leadership for effective partnership working and joint strategic planning in order to raise attainment and share best practice.

Projected service use and outcomes

Changes in budget have reduced capacity for Connexions services leading to less ambitious performance targets than in previous years and more targeted resource allocation.

Targeted work aims to reduce the number of young people who are NEET, especially vulnerable young people including those identified as LDD, clients of YOT, Children in Care.

Evidence of what works and policy drivers

Skills remain the key to enhancing employment opportunities in the labour market in Milton Keynes or anywhere else in the country. Skills for Life data showed that literacy and numeracy at level two were low among the working age population in Milton Keynes wards where historically there have also been high levels of unemployment. [5] These wards include Woughton, Eaton Manor and Campbell Park, which are also among those with the highest proportion of young people who are NEET. This might suggest areas that would benefit from input to raise aspirations in the early years.

A national report from the Children's Communication Coalition (2010) [8] identified strong associations between speech, language and communication needs (SLCN), and unemployment and offending. Locally, the YOT provided figures that suggested similar links. [6] SLCN could be targeted in the early years.

User view

The NEET Peer Research Project [6] conducted in June-July 2010, found that young people who were NEET did not feel that the available courses would help them to progress into paid employment. Since leaving school, most had already embarked on some form of training, most commonly E2E, childcare, hairdressing or IT. However, 55% of those who started to attend a course did not complete it. Those who participated in the NEET peer research project said that the following were important to them:

- Help to gain the skills needed in everyday life such as job skills, computing, and cookery, as well as activities to build confidence.
- Opportunities for practical activities and learning, away from the classroom
- Opportunities to develop skills without losing any of their existing income (from benefits)
- Help with the transition from training to employment

What are the priorities and what are we going to do as a result?

Children and Families Service Groups identified the following priorities in service plans for 2011/12:

- Improving outcomes for vulnerable groups, identifying the following groups: young people identified as LDD; teenage mothers; young offenders; children in care and care leavers.
- Develop and agree a new strategic framework for the development of high quality 14–19 (14-24) curriculum and work related opportunities.

Recommendations for further research/ needs assessment

If Milton Keynes Council is to further reduce the numbers of clients who are NEET, it must continue to develop its understanding of their needs and employment aspirations, and work towards providing suitable opportunities. It must also continue to develop effective pre-emptive action with school age young people who are at risk of becoming NEET in the future. [6]

3.2.3 Fuel Poverty

The Fuel Poverty Indicator has recently been updated using 2001 census data and 2003 English House Condition Survey data. The new indicator has been developed by the Centre for Sustainable Energy and Bristol University, to predict the level of fuel poverty at small area across England.

Headline Results

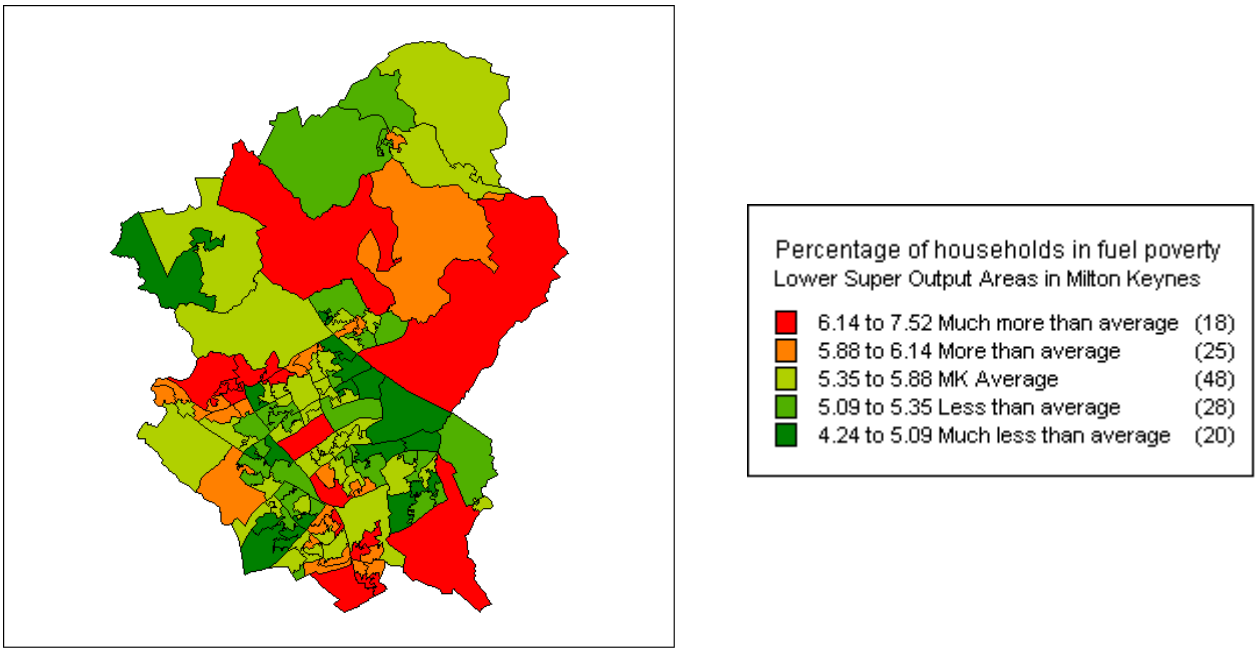
The data indicate that around 7,456 households in Milton Keynes may be experiencing fuel poverty. The data are released at lower Super Output Area (SOA) level, each of which comprises around 400 households. The range for Milton Keynes is from 4.24% of households, in parts of Middleton up to 7.52%. The areas in Milton Keynes where the greatest proportion of households experience fuel poverty are in Wolverton where over 7% households experience fuel poverty.

Ward Data

When examined by ward, on average four wards have more than 6% of residents who are likely to be experiencing fuel poverty. These wards are Bletchley & Fenny Stratford (6.11%); Sherington (6.15%); Eaton Manor (6.16%) and Wolverton (6.69%). Wolverton has both the greatest proportion overall, and the single area with the highest fuel poverty. Each lower SOA in Wolverton has in excess of 6% of households experiencing fuel poverty.

However, Stony Stratford is the ward with the highest number of households who are likely to experience fuel poverty, with 348 households, simply because this is the ward with the largest number of households.

Figure 10: Estimated prevalence of fuel poverty in Milton Keynes



(Where MK average is within +/- .5 standard deviations of the mean and much more than/less than average is more than 1 standard deviation from the mean)

3.2.4 Deprivation and Child Poverty

Who's at risk and why?

Children who grow up in poverty are at risk of poor outcomes during childhood and a reduction in life chances into the future. Health-related outcomes and educational attainment are among the outcomes that might be negatively affected, and subsequently impact on future life chances. Socio-economic disadvantage has been shown to be both a cause and a consequence of poor outcomes. [5]

Level of need in the population

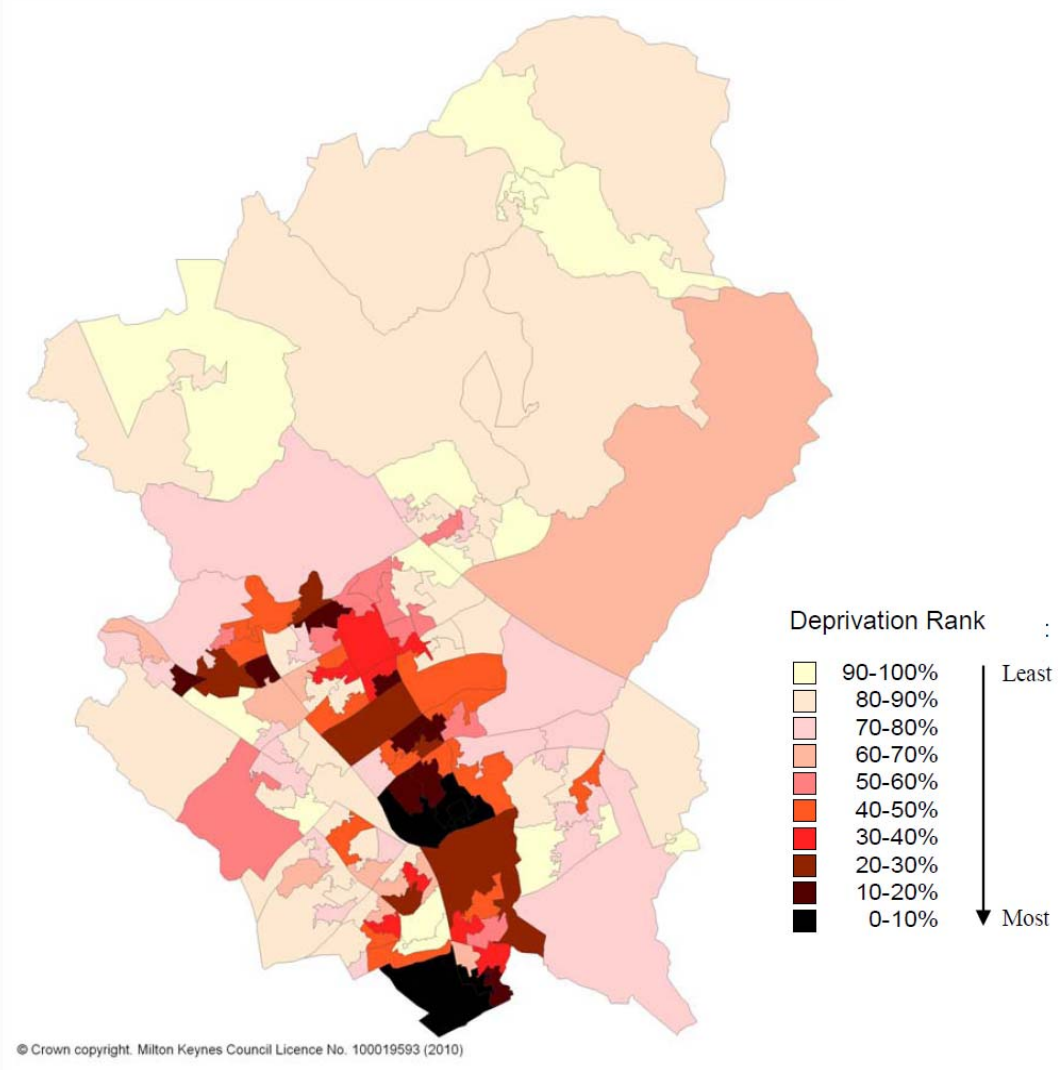
Evidence in this section has been sourced from the Child Poverty Needs Assessment. [5]

Deprivation

In the Index of Multiple Deprivation 2010, Milton Keynes is ranked 211 out of 354 Local Authority Districts (with one being the most deprived). [1] Milton Keynes was ranked 212 in the index of 2007 and 204 in the index of 2004. [9]

Figure 11 shows that the most deprived Lower Super Output Areas (LSOAs) in Milton Keynes cover a large part of Woughton Ward and part of Eaton Manor Ward. [9] The most deprived areas are likely to experience the highest concentrations of children living in poverty. However, it is also recognized that some children live in poverty in the least deprived areas where they might be hidden by the relative affluence that surrounds them. [5]

Figure 11: Areas of deprivation in Milton Keynes



Approximately 18.1% of the overall Milton Keynes population and 18.0% of children and young people (9,200) aged 0–15 years live in areas that are among the 30% most deprived in England. 21.4% of children and young people aged 0-15 live in areas classed as being in the 30% lowest child wellbeing areas as classified by the Child Wellbeing Being Index 2009 (Sources: IMD 2007, Child Wellbeing Index 2009, ONS Mid-2009 Population Estimates for Lower Layer Super Output Areas, provided by MKi). [10]

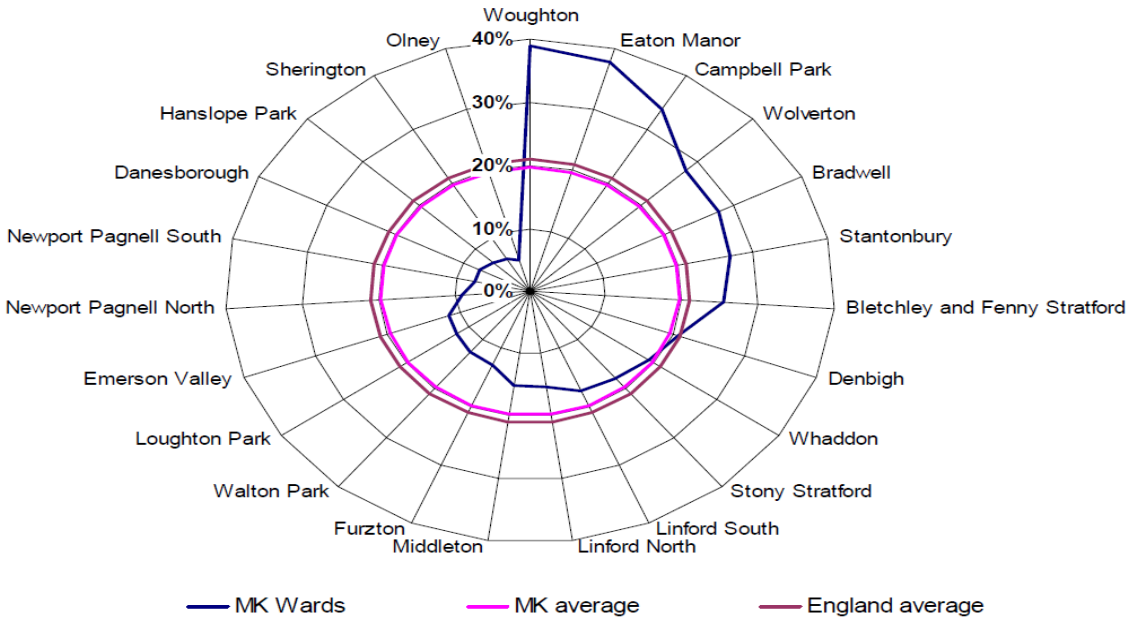
Further information on can be found in the 'Deprivation & Social Issues' theme on the Observatory. (2)

Measures of Child Poverty

A former national indicator (NI 116) measures child poverty with the following definition: the proportion of children in families in receipt of Income Support (IS) or Jobseekers Allowance (JSA), or in receipt of tax credits where their reported income is less than 60% median income. The most recent data available indicated that 19.6 % of Milton Keynes children (11,255 children) lived in income-deprived families in 2008. The same proportion was reported for 2007. Nationally, 20.9% of children were living in poverty in 2008.

Data for NI 116 are also available by ward and have been used to generate Figure 12. Woughton had the largest proportion of children living in poverty (38.9%) and Olney had the smallest (5.1). Woughton, Campbell Park and Wolverton were the wards that had the largest number of children in poverty, with each having in excess of 1,000. This tends to reflect the urban areas of deprivation. Olney ward had the smallest proportion of children in poverty, as might be expected from the deprivation data. However, this was equivalent to 100 children, a relatively small but still significant group. All of the least deprived rural wards have some children living in poverty but with generally low population density in those areas, the numbers are small.

Figure 12: Percentage of children living in poverty by ward, August 2008



In 2011, Save the Children Fund published a research briefing (11) on severe child poverty, based on the following definition: *'children are living in severe poverty if they live in a household with an income of below 50 per cent of the median (after housing costs), and where both adults and children lack at least one basic necessity, and either adults or children or both groups lack at least two basic necessities'.*

This suggested that 12% of children (6,000 individuals) in Milton Keynes were living in severe poverty in 2008/09, in comparison to 13% in England and 9% in South East region. Unsurprisingly, severe child poverty tends to be associated with areas of high unemployment.

Lone Parent Families

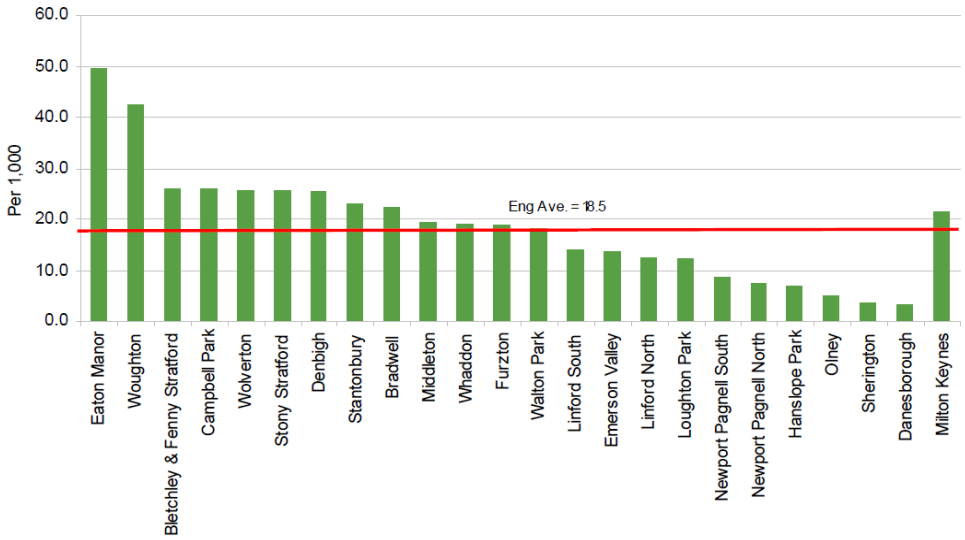
In August 2008, 8,585 of the 11,255 children living in poverty were living in families in receipt of IS or income-based JSA. Of these, 7,000 were lone parent families.

Similarly there were 1865 children in low paid working poor families of whom 1410 were in lone parent households. More than 60% of all children in poverty in Milton Keynes were aged 10 or under. This is equivalent to 7,425 children. [12]

MK Social Atlas [9] includes information about IS claimants, sourced from Department for Work and Pensions (DWP). In August 2009, 3,385 lone parent families claimed IS in Milton Keynes. This is a rate of 21.5 per 1,000 working age population and is higher than that of England as a whole (18.5 per 1,000). It also represents a slight decrease in comparison to August 2008 when the rate was 22.1 per 1,000 working age population.

In 2009, there were 12 wards in Milton Keynes with a higher rate of lone parents claiming Income Support than the England average. Eaton Manor and Woughton Wards were more than twice the national average.

Figure 13: Lone Parent Income Support Claimants for Milton Keynes Wards, August 2009



Housing and Council Tax Benefit

There were 24,052 housing and council tax benefit claimants in Milton Keynes in June 2010. This is equivalent to 237.3 per 1,000 households. This has risen for the second year in succession, probably reflecting the current economic situation. The highest rate is 585 per 1,000 dwellings in Beanhill, a rate which has fallen from 615 per 1000 in 2009 (MKi Social Atlas, 2010). Beanhill is one of the estates located within Woughton ward.

Beanhill, Netherfield, Tinkers Bridge and Fishermead had housing and council tax benefit claimant rates which were equivalent to more than 50% of dwellings. However, the relatively affluent area of

Olney (least deprived Milton Keynes estate in terms of IMD 2007) also had a high number of claimants. Olney had a claimant rate of 121.4 per 1,000 households which is equivalent to 343 claimants. This is considerably higher than the 216 claimants living in Tinkers Bridge (MKi Social Atlas, 2010). This further suggests that small but significant pockets of poverty can be found in affluent, rural areas.

Free School Meals

The number of children eligible for free school meals is a traditional indicator of disadvantage that shows large variation across estates. The Milton Keynes average in March 2011 was 14% of pupils and the highest was 47%, in Beanhill, the estate with most difficulties in terms of MKi Social Atlas, 2010. Rates are substantially lower in the rural areas but, again, numbers identify small but significant pockets of poverty in Hanslope (14 children), Olney (31 children) and Newport Pagnell (75 children).

Summary

The data specifically suggest that children in Eaton Manor and Woughton wards are more likely to experience poverty, and other urban wards also include estates where child poverty rates are high. In addition, small but significant groups of children also live in poverty in more rural, affluent areas where access to services and employment opportunities might be an issue.

Current Services in relation to need

Early Years and Extended Services deliver the Sure Start agenda through early intervention and prevention, delivered through a range of services, settings and provision. In addition, the Extended Services agenda aims to give greater access to services such as 'wrap around' childcare, increased activities for children and young people outside of the school day, improved access to a range of services for parents and carers and improved access to facilities for communities with the service. This contributes to the Local Authorities statutory responsibilities of the Childcare Act 2006 [(13)] and The Apprenticeships, Skills, Children and Learning Act 2009 [(14)], through the following activities:

- Strategic plan for the delivery of Children's Centres and Extended Services
- Assess the local childcare market and take a lead in planning and commissioning childcare
- Provide information for parents and carers
- Embed the Early Years Foundations Stage
- Secure sufficient high quality integrated early learning and childcare places for 3 and 4 year olds

Children's centres play a key role in improving outcomes for all young children and reducing inequalities in outcomes between the most disadvantaged children and the rest. The idea of children's centres is to focus on the local needs of the area they are in and particularly, to provide for children most in need, so resources will be targeted where there is most deprivation. There are 20 Children's Centres provide services across Milton Keynes borough.

Projected service use and outcomes

The Milton Keynes information Observatory (MKi) has produced population projections for Milton Keynes up to 2026. These reflect assumptions about local fertility and mortality rates, the migration profile and the house-building trajectory. The future population might differ from these projections if the underlying assumptions are not fulfilled.

Table 6: Population projections from 2009 to 2026

Age	2009 Population	2026 Population	% change
Total	**236,700**	**298,450**	**26.1%**
0 - 4	17,800	19,700	10.7%
5 - 9	15,400	20,050	30.2%
10 - 14	14,900	20,250	35.9%
15 - 19	14,700	18,800	27.9%
All aged 0 - 19	**62,800**	**78,800**	**25.50%**

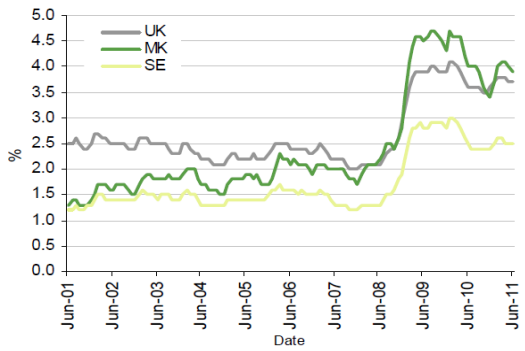
The size of the population aged 0-4 is set to increase by 10%, from 17,800 to 19,700. A larger percentage increase is seen in the population aged 5 -14 which will increase by 33% from 30,300 to 40,300. Such increases in population are likely to impact on demand for services.

Population figures are also available for the urban and rural areas within Milton Keynes borough. The rural area is defined as Danesborough, Hanslope, Newport Pagnell, Olney and Sherington Wards. The urban area covers the remainder of the Milton Keynes Wards (Milton Keynes Borough - Past Population and Projections to 2026, Mki 2010 [15]).

In 2009 it was estimated that 84.4% of the population lived in the urban area and 15.6% lived in the rural area. The proportion living in the rural area has slowly but consistently reduced since 1967, and projections indicate that this trend will continue at least to 2026. This reflects a higher level of population growth in the urban area than in the rural area.

Demand for services to address child poverty is closely linked to the current economic situation, particularly unemployment rates.

Figure 14: Unemployment Rates (claimants) Milton Keynes, South East and UK, Jun 2001 – Jun 2011 (NOMIS) [16]



Evidence of what works and policy drivers

The Child Poverty Act 2010 placed a legal obligation on all local authorities and their delivery partners to cooperate with a view to reduce and mitigate the effects of child poverty in the local area; to conduct a local needs assessment, produce a child poverty strategy and take child poverty into account in the production and revision of their Sustainable Community Strategy. [5]

The government's intention to take a broader approach in their strategy that will tackle the underlying causes of inter-generational disadvantage is reflected in Milton Keynes Council's ambition for all agencies to work more effectively together to provide people with the support and skills to make a better life for themselves. Milton Keynes Council will seek to improve children's life chances, and increase their aspirations and educational success by supporting families to turn around their long-term economic prospects. [5]

New welfare reform measures may present additional challenges for lone parents. Lone parent obligations (LPO) were introduced from November 2008 and meant that lone parent customers with a youngest child aged 12 or over would no longer be entitled to income support (IS) solely on the grounds of being a lone parent. Since then, the age has been reduced so that by autumn 2010, those with a youngest child aged seven and over lost entitlement. The coalition government announced in the June 2010 emergency budget that these obligations will be extended so that lone parents will lose their eligibility to IS when their youngest child reached five years. [5]

User view

Local children, young people and families have been consulted on issues relating to child poverty and their views will be included in a final report to be submitted to the Milton Keynes Children and Families Partnership in 2012. [17]

What are the priorities and what are we going to do as a result?

Accountability for taking forward actions to address the findings from the Child Poverty Needs Assessment rests with the newly established Milton Keynes Children and Families Partnership. The partnership has established a multi-agency Child Poverty Commission to develop recommendations for effective local strategies to tackle child poverty. [5]

At national level, the government has carried out an independent review into child poverty resulting in the following reports:

- *The Foundation Years: preventing poor children becoming poor adults - The Report of the Independent Review on Poverty and Life Chances* [18]
- *Early Intervention: The Next Steps* [19]

They offer a range of actions that can be taken to ensure today's children living in poverty do not grow up to be poor adults raising the next generation of poor children.

In April 2011, the government adopted these recommendations in *A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives.* [20] Similar themes are covered in *Opening doors, breaking barriers: A strategy for social mobility*, [21] April 2011, which aims to ensure

that the circumstances of children's backgrounds should not prevent them from fulfilling their potential.

In Milton Keynes the Child Poverty Commission will consider these recommendations alongside any actions that can be taken locally to reduce the numbers of children living in poverty today. [17]

3.3 Educational Attainment

Who's at risk and why?

Some groups of young people are at risk of poorer educational outcomes than the Milton Keynes population as a whole.

Level of need in the population

Attainment data in this section is reported by academic year and is sourced from the Research and Statistics Gateway at the Department for Education website.

Foundation Stage Profile (FSP) is an assessment of children in reception year (aged 5) in primary schools. A former national indicator (NI 72) measures achievement of at least 78 points across the Early Years Foundation Stage with at least six in each of the scales in Personal Social and Emotional Development and Communication, Language and Literacy. From 2008 to 2010 a growing proportion of Milton Keynes children achieved this required standard. The proportion fell slightly in 2011 but performance remains better than the national average (Figure 15).

Milton Keynes pupils who live in the most deprived areas do not do as well as Milton Keynes pupils as a whole in the FSP. This attainment gap has narrowed considerably, such that it is now smaller than the equivalent national figure (Figure 16). Nevertheless, it is important to recognise that a gap still exists as 18% of Milton Keynes children aged 0 – 15 years live in the 30% most deprived Lower Super Output Areas of England. If children do not get the best possible start in the early years, they might continue to lag behind throughout their school career.

Figure 15: Percentage of children achieving the standard specified in NI 72

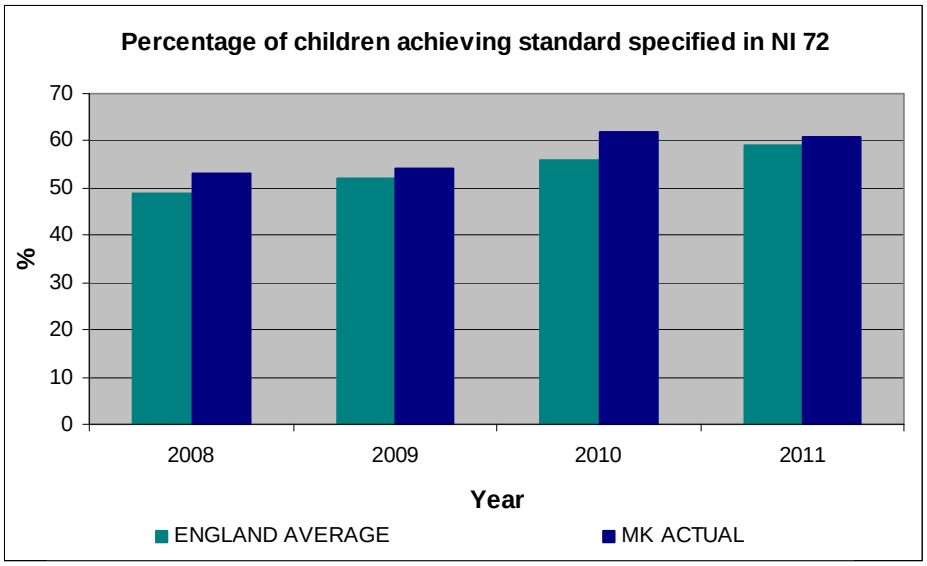
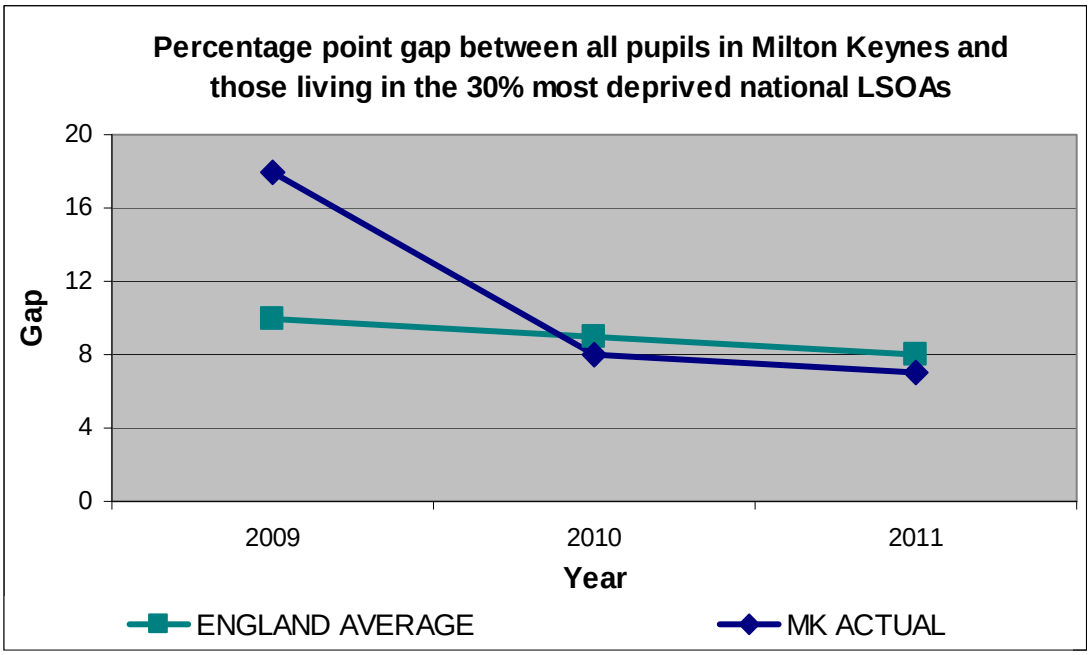


Figure 16: Impact of deprivation on FSP achievement



Attainment data for Key Stage 2 (KS2) and Key Stage 4 (KS4) were extracted for Looked After Children and were analysed by ethnicity and eligibility for Free School Meals (FSM). Eligibility for free school meals is generally considered to be a proxy for child poverty.

KS2 is the stage of the National Curriculum between ages eight and 11 years. A number of former national indicators relate to tests taken by pupils at the end of KS2, some of which are reported in Table 7 below. Performance has improved for Looked After Children and for children who were eligible for FSM, as well as for all pupils as a whole. However, Looked After Children and children eligible for FSM generally had poorer test results than all children as a whole.

Table 7: Former National Indicators measuring attainment at KS2

Ref	Indicator	MK ACTUAL		Target 2010/2011	Trend	LATEST BENCHMARK	
		2009/10	2010/11			Nat	SN Average
KEY STAGE 2							
NI73	% of pupils gaining level 4+ at KS2 including English & Maths	74.5	75.7	78	↑	74	75
NI 99	% of looked after children reaching level 4+ at KS2 English	22.2	41.7	16.6	↑	50	-
NI 100	% of looked after children reaching level 4+ at KS2 Maths	11.1	33.3	25	↑	48	-
NI 102i	Achievement gap between pupils entitled to free school meals and their peers achieving level 4 at KS2 (%)	24.7	21	17	↑	20	25

(NB Department of Education suppressed data for indicators concerned with Looked After Children and did not publish them nationally due to small numbers.)

The data also suggest that some black and minority ethnic groups in Milton Keynes do less well in Key Stage 2 tests in comparison to all pupils. The shading in Table 8 indicates the significant areas of underperformance (i.e. at least five percentage points less than the overall figure for all pupils).

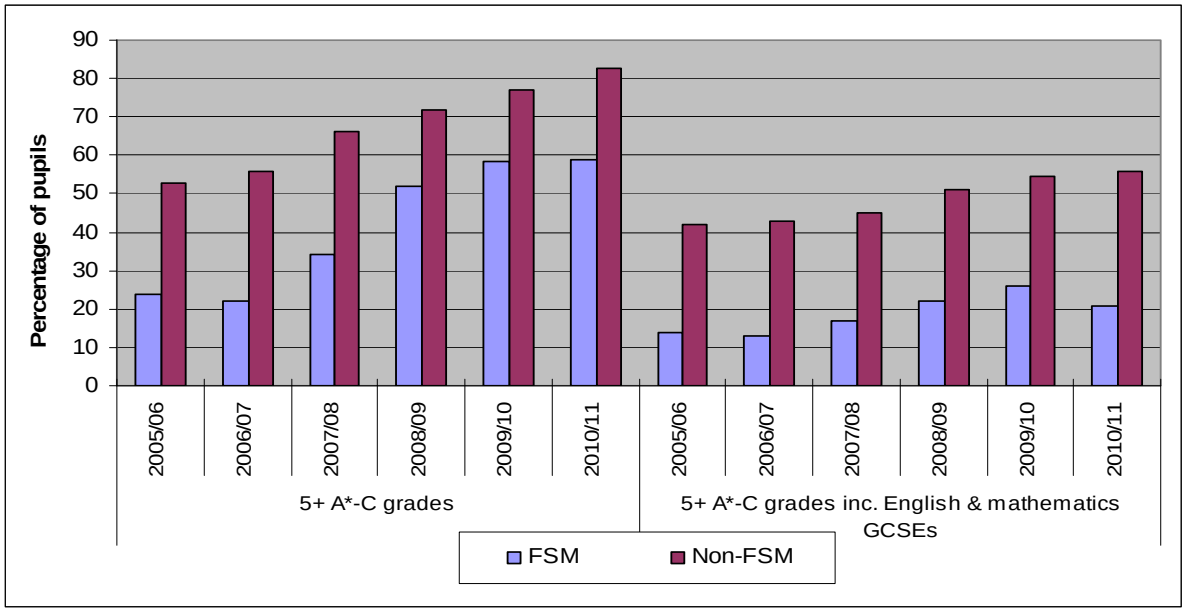
Table 8: Key Stage 2 results for Milton Keynes ethnic groups that are low attaining in comparison to all pupils.

Key Stage 2 test results	MK cohort 2011	% of pupils achieving Level 4+ English & Maths		
Pupil Characteristics		MK 2010	MK 2011	National 2011
All Pupils	**2860**	**74.3**	**75.7**	**74.0**
Girls	1390	76.2	77.0	77.0
Boys	1470	72.4	73.5	72.0
Any Other White	107	65.3	68.2	68.0
Black Caribbean	26	62.5	53.8	67.0
Black African	220	70.5	64.5	70.0
Black Other	44	70.8	69.8	67.0

Shading indicates significant areas of underperformance (i.e. at least 5 percentage points less than the comparative figure for all MK pupils)

At GCSE (KS4), Milton Keynes pupils not eligible for Free School Meals (FSM) continued to outperform those who are known to be eligible (Figure 17). The gap in the proportion achieving five or more A*-C grades at GCSE narrowed considerably between 2006/07 and 2009/10. There has only been a small decrease in the equivalent gap in attainment of five or more A*-C grades at GCSE including English and mathematics as attainment has increased at similar rates in both groups. In 2010/11 the attainment gap grew with regard to both of these measures.

Figure 17: GCSE attainment in Milton Keynes by free school mean eligibility



Data reported in Table 9 show that looked after children also did less well at GCSE in comparison to all Milton Keynes pupils, and in comparison to national averages. Caution is required because of the very small cohort.

Table 9: Former National Indicators measuring attainment at KS4

Ref	Indicator	MK ACTUAL		Target 2010/2011	Trend	LATEST BENCHMARK	
		2009/10	2010/11			Nat	SN Average
KEY STAGE 2							
NI 75	% of pupils achieving 5+ A*-C at GCSEs including English and Maths	51.5	**52.1**	56.6	↑	58.4	60.3
NI 101	% looked after children achieving 5+ A*-C GCSEs including English and Maths	4.8	**0.0**	23.5	↓	12.8	-
NI 102 ii	Achievement gap between pupils entitled to fee school meals and their peers achieving 5+ A*-C GCSEs including English and Maths	27.4	**35.1**	23.0	↓	27.5	34.1

(NB Department for Education suppressed data for indicators concerned with Looked After Children and did not publish them nationally due to small numbers.)

Table 10 identifies specific black and minority ethnic groups that were associated with lower attainment at Key Stage 4, in comparison to all Milton Keynes pupils. Shading indicates significant areas of underperformance (i.e. at least five percentage points less than all pupils).

Table 10: Key Stage 4 results for Milton Keynes groups that are low attaining in comparison to all pupils

Key Stage 4 results	MK cohort 2011	% of pupils achieving 5+ A* - C including English & Maths		
Pupil Characteristics		MK 2010	MK 2011	National 2011
All Pupils	**2709**	**51.5**	**52.1**	**58.4**
Girls	1327	56.8	56.2	61.9
Boys	1382	46.5	48.0	54.6
Any Other White	95	44.2	53.7	54.3
Mixed White Black Caribbean	39	35.7	33.3	49.1
Pakistani	51	44.6	41.2	52.6
Any other Asian	55	40.0	43.6	62.2
Black Caribbean	27	42.3	33.3	48.6
Black African	191	36.0	46.1	57.9
Black Other	51	42.4	37.3	52.6

Shading indicates significant areas of underperformance (i.e. at least 5 percentage points less than the comparative figure for all MK pupils)

In summary, educational attainment in Milton Keynes was lower for those who were eligible for free school meals and for looked after children. Low attainment was also identified in some black and minority ethnic groups.

Current Services in relation to need

Children and Families Service Groups work with partners to ensure Early Years and school provision meets the needs of all children and young people in Milton Keynes so that they can realise their full potential and be ready for work.

Service groups deliver a number of the local authority's statutory responsibilities including the following duties:

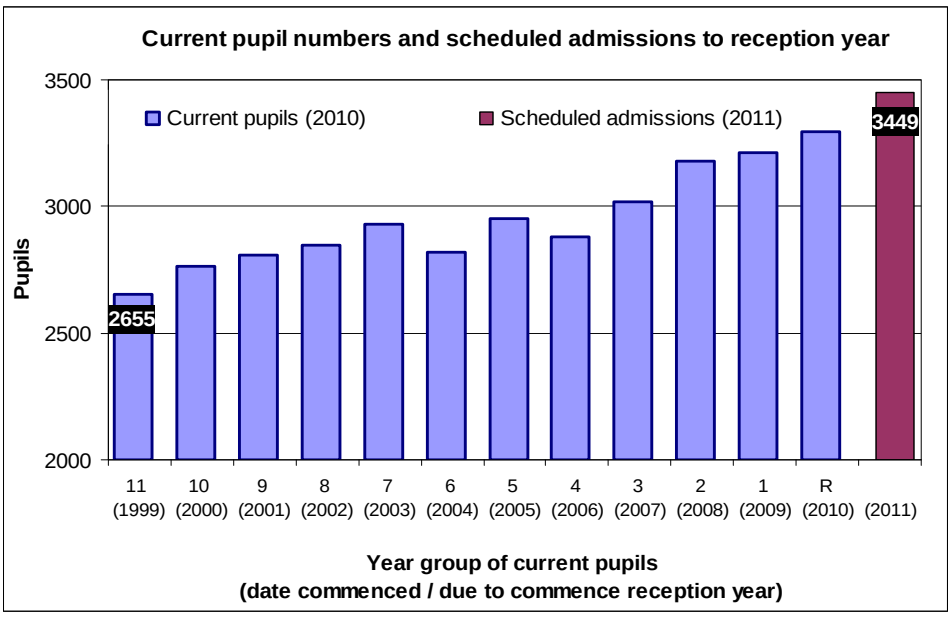
- To intervene in those schools and settings where the needs of children and young people are not being fully met;
- To work with schools and settings to promote high standards for all;
- To uphold the Equalities Act 2010;
- To eliminate discrimination, harassment and victimisation.

The School Improvement Service supports and challenges schools to raise standards of achievement across Milton Keynes. The Closing the Gap Service works towards closing the gap for vulnerable learners, through early intervention and prevention across a range of services and settings.

Projected service use and outcomes

Milton Keynes has a young, growing population that is increasing in ethnic diversity. [5] This is reflected in the growth in pupil numbers, demonstrated in Figure 18 below. Demand for school places has generally increased with each annual intake of pupils. Projected growth of the Milton Keynes population as a whole suggests that this trend will continue.

Figure 18: Pupil population by year group



Data sourced from the School Organization Framework and School Admissions.

Evidence of what works and policy drivers

The Academies Act received Royal Assent in July 2010 which enabled more schools in England to become academies. Those that have academy status have greater freedom to determine how they will operate and deliver the curriculum. They will also have the freedom to determine the nature of their future relationship with their local authority. In Milton Keynes, more than half of the secondary schools are now academies.

A key priority is to ensure children and young people currently in our schools and approaching the end of key stages achieve as highly as they can through making accelerated progress. To realise this ambition, the Local Authority intervenes early in schools where children and young people are at risk of underperforming. During 2009-10, 6 schools and 1 Pupil Referral Unit (PRU) were placed in an Ofsted category of concern following inspection. In addition, the Local Authority identified a further 10 schools at risk of declining and they were also placed in intervention. Each school is allocated a dedicated consultant to work alongside leadership teams to deliver a bespoke change programme focusing on improving aspects of leadership and management and the quality of teaching and learning to raise standards. All intervention and national challenge schools / PRUs are now allocated a targeted improvement board chaired by a senior local authority officer to monitor activities to ensure they impact positively on children and young people's outcomes. They will continue to provide comprehensive review and analysis of support and progress as well as a high degree of challenge to leadership teams. In-year monitoring indicates that pupils in intervention schools are making accelerated progress although standards are still too low. One school in intervention and not in an Ofsted category of concern has very recently been subject to a monitoring visit. While the HMI judged progress towards addressing the areas for improvement as satisfactory, he judged the school's capacity to improve to be good and commented on the good quality of LA support. [22]

What are the priorities and what are we going to do as a result?

To support and challenge schools and settings to improve educational outcomes for all our children and young people particularly those who are vulnerable and/or underperforming. [23]

Services have the following priorities:

- Improve and maintain outcomes in all schools, so that more are judged good or better when inspected by Ofsted.
- Improve and develop diverse and secure learning opportunities which benefit all pupils and recognise the needs of local communities.
- Sustain all Early Years Settings and ensure they have robust programmes which have a positive impact on parents and young children.
- Raise attainment for vulnerable and underperforming groups.

3.4 Vulnerable Groups & Groups with Additional Needs

3.4.1 Learning Disability

Who's at risk and why?

Adults with Learning Disabilities can experience significant disadvantages in terms of their health and physical and emotional well being. National reports and media coverage have demonstrated that there is a need for constant assurance of the safety of health and social care services, along with action to minimise inequalities in service delivery.

Level of need in the population

National prevalence data suggests 874 (0.47%) of people will be known to learning disability services in Milton Keynes. However, the actual number known to services as at 22 March 2011 was 690 (0.37%).

PANSI estimates that there are 4,835 people aged 18+ in MK with a Learning Disability. Based on evidence from the World Health Organisation (WHO) and Institute of Health Research, Lancaster University, this is broken down by level of Learning Disability as follows:

Mild Learning Disability	3,684	84%
Moderate Learning Disability	570	13%
Severe / Profound Learning Disability	131	3%
Total	**4,385**	**100%**

Current Services in relation to need

The Joint Learning Disability Service, comprised of staff from MKC and MKCHS, provides a range of services including day activities, supported living, short breaks and a step down unit for people leaving more restrictive settings out of area. All of these services are also provided on a smaller scale by the private and voluntary sector, which also provides residential care in and out of the area.

Projected service use and outcomes

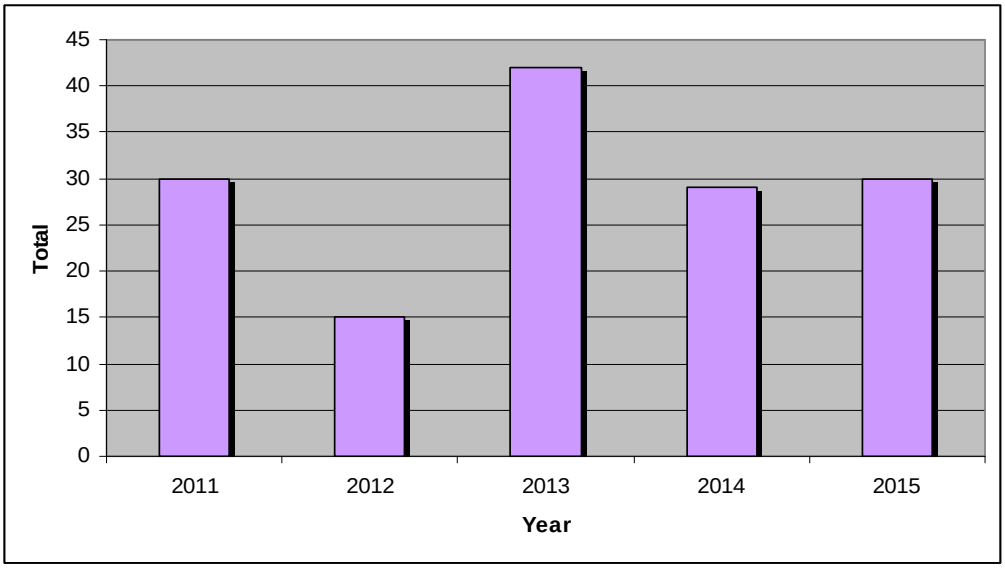
The development of personal budgets is the opportunity to widen choices in services available to people with learning disabilities. In addition, service specifications and the monitoring of contracts are becoming more outcomes focussed, supporting people with learning disabilities and their families to state their aspirations and to work towards achieving them. To this end, block contracts for services have been almost completely phased out and a number of new providers have contributed to a directory of services from which users can choose.

As part of the Annual Learning Disability Health Self-Assessment, Milton Keynes PCT reports on the take-up by GPs of the LES (Local Enhanced Service) to deliver annual health checks to people with learning disabilities.

In 2010-11 132 health checks were carried out. By October 2011 23 out of 28 GP Practices had signed up to the LES and 11 practices had received training in carrying out health checks. A steady increase in the number of checks is required in 2011-12 and subsequent years.

Transition from children's to adult services is particularly important in health services, where young people and their parents move from involvement with a paediatrician to a range of different adult clinicians. To support this transition, it is important to be able to report trends in numbers and needs of school leavers with learning disability.

School leavers expected to come into Adult Social Care services from 2011 – 2015 are as follows:



The needs of an aging population of people with learning disabilities require pathways that taken into account the prevalence of certain conditions including dementia.

Evidence of what works and policy drivers

The Six Lives Report, the Michael report and related policy documents have resulted in a higher emphasis on the safeguarding of people with learning disabilities in both health and social care settings. Monitoring by the Safeguarding Adults Board (through its Quality Assurance sub-group) and the PCT Board (through the Clinical Quality Review Groups) are prescribed in the Six Lives Guidance.

User view

The Milton Keynes Learning Disability Partnership Board (LDPB), working through its sub-groups where appropriate, involves people with learning disabilities and family carers in strategic planning. It is recognised that more family carers are needed for the PB.

The modernisation of services and personalisation have been embraced by many, especially for those in transition from school to adult services. However, there is also a substantial group of people who find too much change disruptive, for whom traditional services remain attractive.

The LDPB has sponsored two Big Health Days, where people with learning disabilities and family carers have been able to contribute to discussions about how to make local health services appropriate and accessible for their needs. In preparation for the Big Health Day in 2012, a simple system to provide feedback using electronic trackers.

The British Institute for Learning Disability led a series of workshops on personal budgets, where people with learning disabilities and family carers contributed to the debate on the process in MK.

What are the priorities and what are we going to do as a result

A high priority is the continuation of work to improve access of people with learning disabilities to safe, high quality health services. This will include:

- Improving access to cancer screening
- Work with MK/Northants PCT to ensure accurate data is collected about the health needs of people with learning disabilities
- Further extension of annual health checks to all GP practices
- Follow up work to ensure health check information is acted upon
- Systematic evaluation of the experience of patients with learning disabilities at MKHFT, leading to a comprehensive action plan
- A review of the work of the Health Action Team

In addition priorities of the MKLDPB include:

- A review of the appropriateness of LD services to the needs of people from BME Communities
- Work to address difficulties experienced by people with learning disabilities in the Criminal Justice System.

Recommendations - options for H&WBB

It is recommended that there should be a review of Learning Disability Services in Milton Keynes to establish their effectiveness, efficiency and economy in the light of changes and constraints, nationally and locally.

3.4.2 Prison and Young Offenders

Who's at risk and why?

HMP Woodhill is situated in Milton Keynes and is a male core local prison which also holds Category A prisoners. There is also a Close Supervision Centre which holds a small number of prisoners who are among the most difficult and disruptive. Woodhill currently has capacity for 819 prisoners.

In general prisoners tend to have poorer physical, mental and social health than the general population. Mental illness, drug dependency and communicable diseases are dominant health problems.

Level of need in the population

1) Mental Health

The Bradley Report identified that prisoners have significantly higher rates of mental health problems than the general public as shown in the table below.

	Prisoners	General Population
Schizophrenia and delusional disorder	8%	0.5%
Personality Disorder	66%	5.3%
Neurotic disorder (e.g. depression)	45%	13.8%
Drug dependency	45%	5.2%
Alcohol dependency	30%	11.5%

Source: The Bradley Report 2009

Suicide rates are also higher in among the prison population with 114 per 100,000 prisoners in 2007 committing suicide, compared to the general population suicide rate of 8.3 per 100,000 population.

The latest Prison Health Needs Assessment identified that 41% of the prison population had a recorded psychiatric history, although it estimated that there were potentially over 100 inmates needing the services of the Mental Health Team at any one time.

2) Substance Misuse

The prison health needs assessment identified that 58% of prisoners had a record of current/ongoing history of drug abuse. Over the last year a third of new receptions self reported a substance misuse problem. The main primary problem substance for those aged 25 to 44 years old was heroin, whereas older prisoners in treatment were more likely to primarily have a problem with alcohol.

Around 15% of drug misusers in treatment are Prolific and Priority Offenders, those with the most complex needs.

3) Learning disabilities

Estimates of prevalence of learning disabilities among offenders range from 1% to 10%. In addition 20-30% of offenders have learning difficulties or learning disabilities that interfere with their ability to cope within the criminal justice system.

4) Infectious diseases

The prison Health Needs Assessment reported that one in ten prisoners is likely to be infected with Hepatitis B (Hep B) and one in ten with Hepatitis C (Hep C). However this is a lot higher for Intravenous Drug Users (IDUs) with one in three likely to be infected with Hep B and half for Hep C. Estimated prevalence rates for HIV among male prisoners is around 0.3%.

5) Chronic Diseases / Long Term Conditions

Prevalence figures from the Toolkit for Health care needs assessment in prisons (2000) suggested that 18% of the prison population would have diagnosed or treated asthma and around 0.8% would have diabetes. Information from the Chronic Disease Register used in the needs assessment suggest that 20% of the prison population have asthma and 2% have diabetes. A further 8% of prisoners were recorded on the register as having coronary heart disease.

6) Dental Health, Podiatry and Opticians

Prisoners generally have a lower level of oral hygiene and are four times more likely to get tooth decay. Although national guidance suggests there should be at least one session for every 250 prisoners, current dental services are over subscribed with a long waiting list for routine treatments. On average, seven patients a month are seen by the podiatrist which meets demand. The optician service provided in the prison is equivalent to that in the community and levels of eye disease in the prison is similar to the community levels. The service provides two sessions every fortnight.

Current Services in relation to need

Primary health care services in HMP Woodhill are generally currently provided by the Milton Keynes Community Health Service. The psychosocial element of substance misuse treatment is provided by trained prison staff, however substance misuse services, both psychosocial and clinical at Woodhill are currently being retendered.

Secondary care is provided by Milton Keynes General Hospital.

What are the priorities and what are we going to do as a result?

Key priorities for 2012-13 - continue to provide a health service equivalent to the standard that is within the community by:

- Ensuring rates of Hep B vaccinations increase from 58% to 80%;
- Increasing the detection rate of BBV;
- Increasing detection rates and support for those with learning difficulties and disabilities;
- Re tendering the current provision for substance misuse within Woodhill into one cohesive service;
- Decreasing the rate of dental ill health by providing an onsite dental service; and
- Decreasing the rates of self harm and suicide attempts by working cohesively with the prison side and healthcare to minimise and contain risk.

3.4.3 Disability (including Visual & Hearing Disability)

Who is at risk and why?

A **disability** may be physical, cognitive, mental, sensory, emotional, and developmental, or some combination of these. *Disability* is an umbrella term, covering impairments, activity limitations, and participation restrictions.

An **impairment** is a problem in body function or structure; an **activity limitation** is a difficulty encountered by an individual in executing a task or action; while a **participation restriction** is a problem experienced by an individual in involvement in life situations. Thus disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives.

—*World Health Organization*

The definition used above indicates that disability can affect anyone and the impact of disability on the individual can be wide ranging and complex. Research has indicated that:

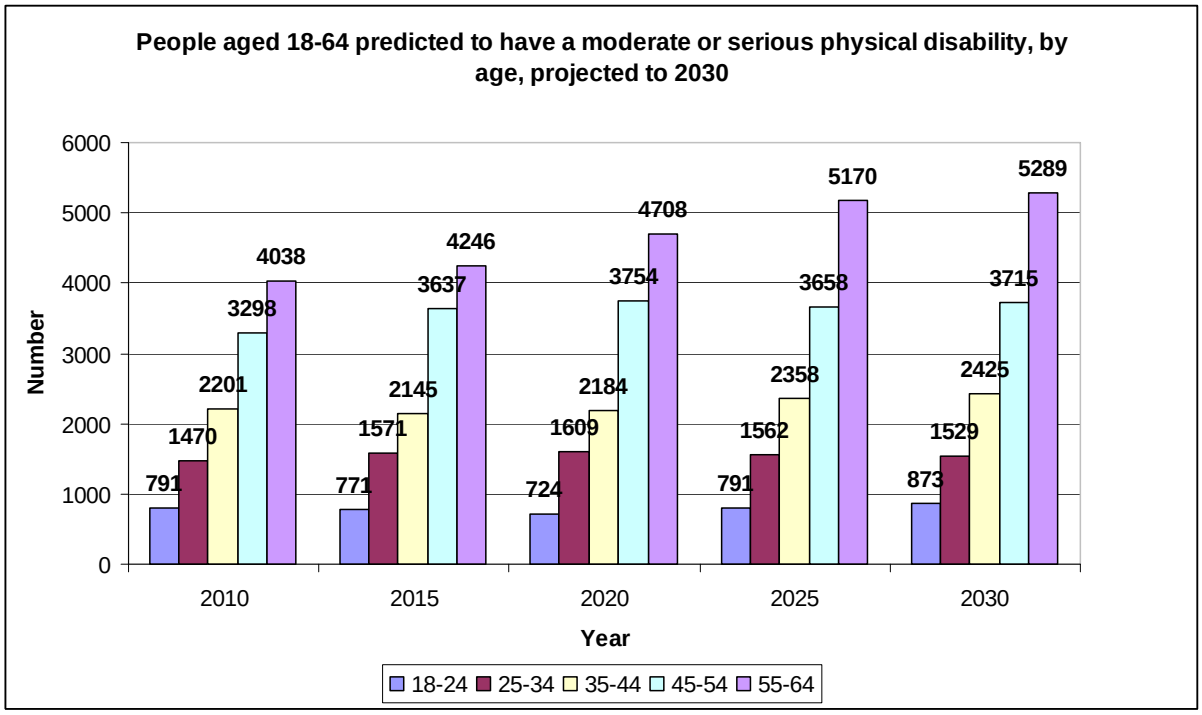
- Disabled people are significantly more likely to experience unfair treatment at work than non-disabled people. In 2008, 19 per cent of disabled people experienced unfair treatment at work compared to 13 per cent of non-disabled people. (Fair Treatment at Work Survey 2008 [25])
- Around a third of disabled people experience difficulties related to their impairment in accessing public, commercial and leisure goods and services. (ONS Opinions Survey 2009 [26])
- Children with a learning disability are often socially excluded and 8 out of 10 children with a learning disability are bullied. (Mencap)
- Around three in four people believe there is some level of prejudice in Britain towards disabled people. (Office for Disability Issues)
- In Milton Keynes, MK LINks has identified that with people with a hearing difficulty face difficulties in accessing healthcare services due to the lack of interpreters. Often, sensitive information about diagnosis and treatments is relayed to the person with a hearing loss through their carer, which compromises patient confidentiality.

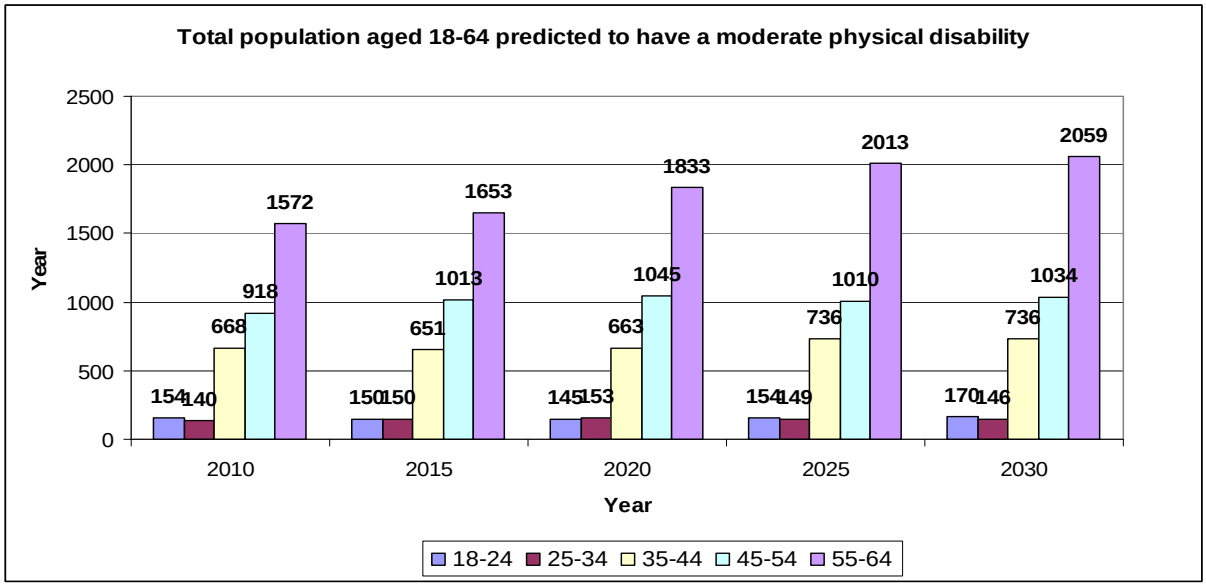
Given the wide definition of disability, it can be assumed therefore, that a significant number of people resident in Milton Keynes will be at risk of disadvantage as a result of their disability.

Level of need in the population

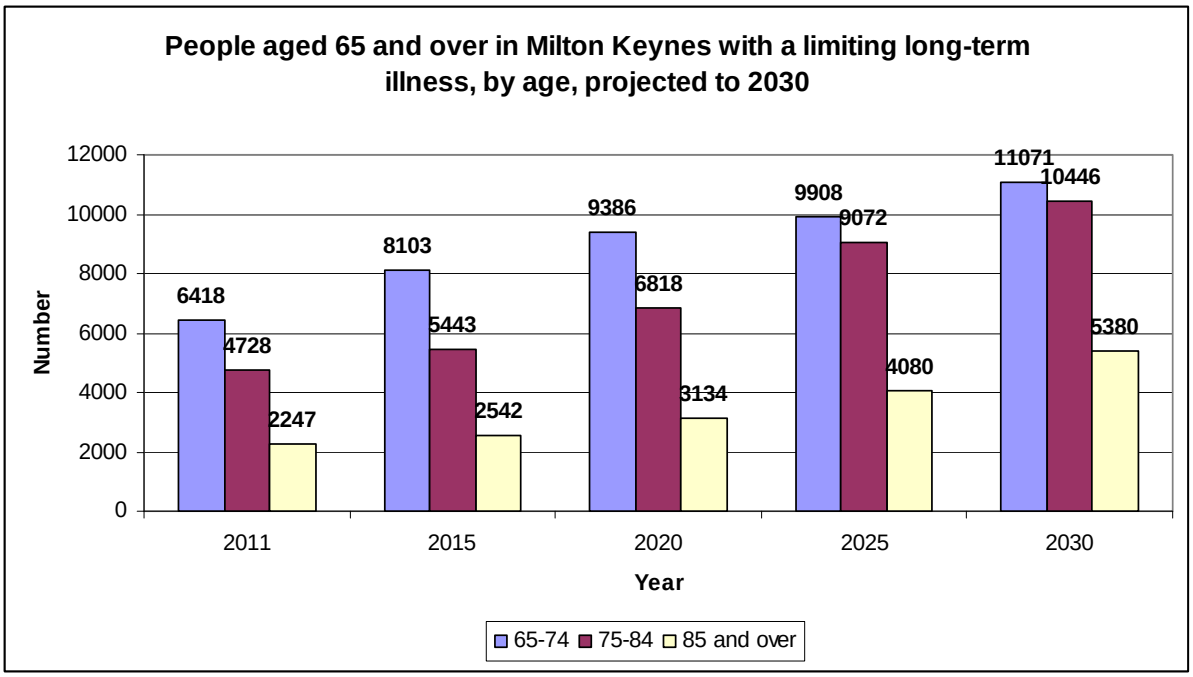
The following data has been downloaded from PANSI [27] and POPPI [28] databases and outlines the estimated levels of need in Milton Keynes for physical disability and sensory impairment projected to 2030.

The tables below demonstrate that there will be an increase in the numbers of people with a serious disability, hearing impairment and visual impairment between 2011 and 2030. Of these, approximately 8,000 will have a condition of such severity that they are unable to work.





Charts produced on 10/06/11 10:53 from www.pansi.org.uk version 4.1



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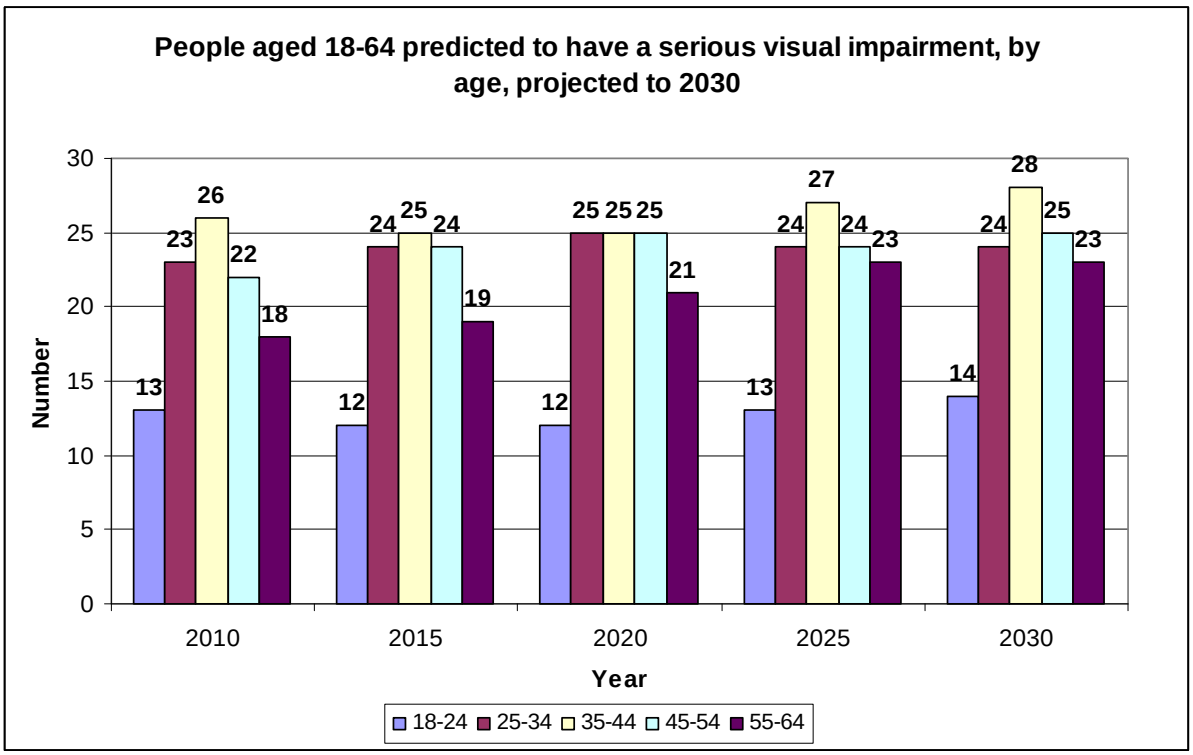

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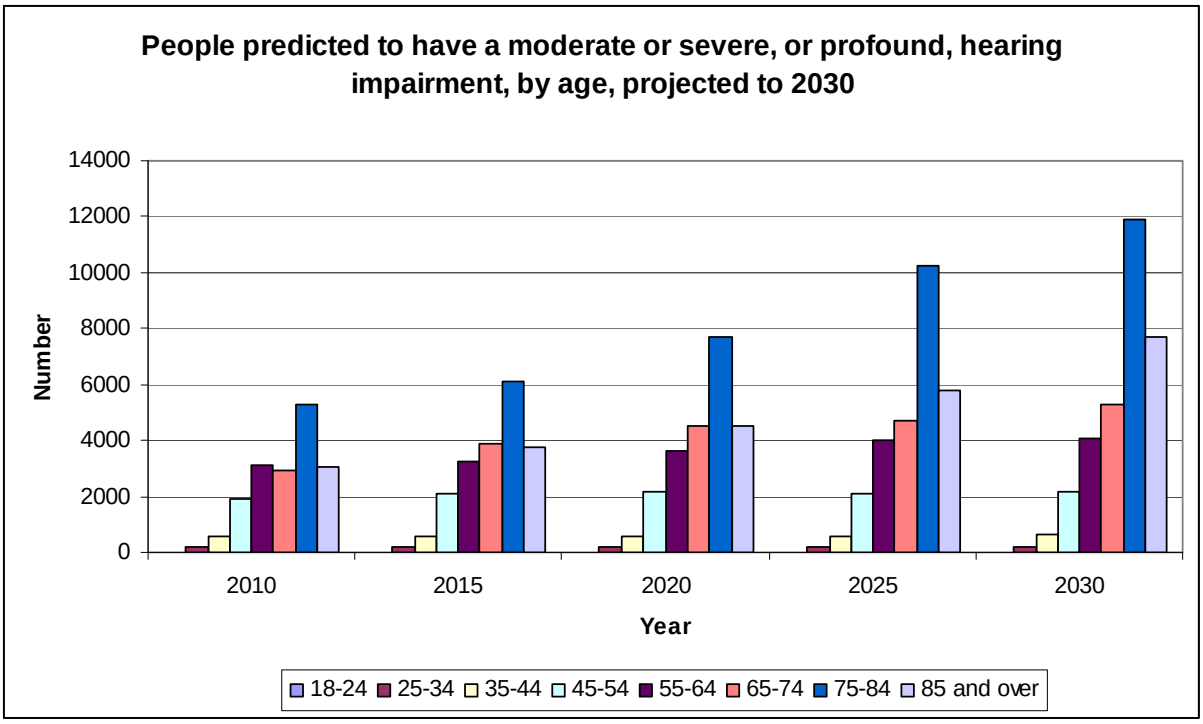

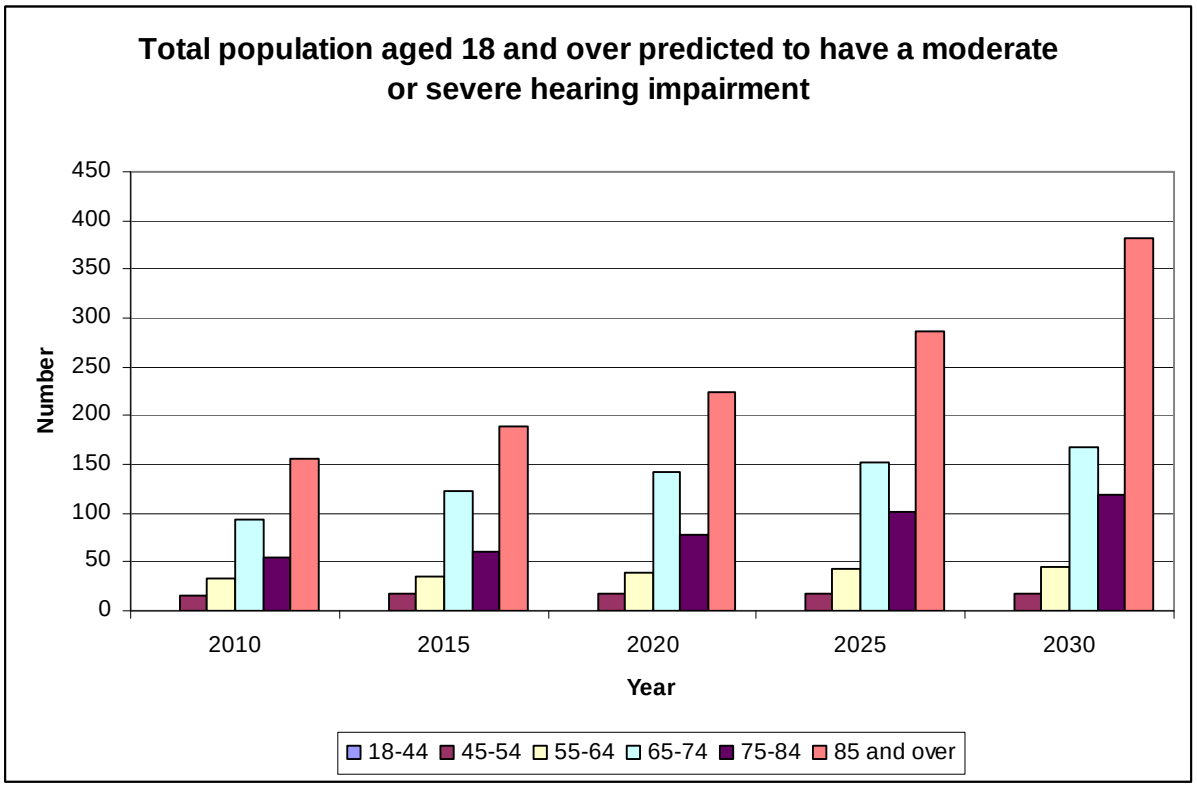

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Woughton Ward and Eaton Manor wards within Milton Keynes have more than average numbers of people who are claiming Disability Living Allowance or Invalidity Benefit.

Other indicators of disability are collected on an estate or settlement basis and presented in the Social Atlas published by Milton Keynes Council.[29] Data is available on the number of people with a disability per estate/settlement who are in receipt of social care support from Milton Keynes Council (MK average 8.9 per 1000) and the number of people eligible for disabled concessionary travel fares (MK average 11.7 per 1000). The areas of Milton Keynes showing higher than average values for these indicators are:

- Beanhill (fares 38.1 per 1000, MKC clients 42.1 per 1000)
- Coffee Hall (fares 26.3; MKC clients 25.1)
- Granby (fares 15.6; MKC clients 30.3)
- Hardmead (fares 19.1; MKC clients 27.2)
- Hodge Lea (fares 25.8; MKC clients 14.4)
- Pennyland (fares 23.6; MKC clients 19.9)
- Stacey Bushes (fares 33.7; MKC clients 17.5)
- Tinkers Bridge (fares 20.9; MKC clients 19.8)
- Willen Park (fares 25.4; MKC clients 30.6)

To summarise, the numbers of people with a physical disability and/or sensory impairment is going to rise significantly in the years to 2030. Within Milton Keynes itself, there are certain areas of the borough where proxy indicators highlight above average rates of disability, which may require specific locally focussed activity to help address need.

Current Services in relationship to need

There are a range of services for both people with a disability:

- The Integrated Community Equipment Service, which provides a range of equipment to support people with a range of disabilities and long term conditions to live as independently as possible in their own home and local community.
- Milton Keynes Council provides adult social care services for people with a range of disabilities. A comprehensive assessment is carried out to determine level of need and, depending on the outcome of the assessment, services are put in place to meet these needs
- Milton Keynes Community Healthcare Services assesses and provides a wheelchair service for local people to assist with mobility and improve quality of life
- A range of services are provided by Milton Keynes Community Health Services to help support people to live independently. These services include the Milton Keynes Intermediate Care Service; the Neurological Rehabilitation services; Community Nursing Services; Occupational Therapy services; Physiotherapy services.
- Telecare and telehealth services are available to support people with a disability.
- Milton Keynes Centre for Integrated Living provides a range of information and support services for people with disabilities and their carers.

- Carers Milton Keynes offers support services for carers of people with a range of disabilities, including advice and information; training for carers; counselling services; emotional support; peer support groups and social events.
- The Milton Keynes Sensory Service offers a range of assessment and rehabilitation support for people with a visual and/or hearing impairment; including people who are deaf-blind.

Projected Service Use and Outcomes

Please see above section for the estimated levels of need in the local population up to 2030. Given that the number of people with a disability is going to rise significantly between the years 2012 – 2030, then service provision will need to keep pace with this expected rise in levels of need.
Given the diverse nature of disability, it is very difficult to establish how many people are currently accessing services. However, demand for items of community equipment has increased. In the month of January 2011, 394 items of equipment to assist with activities of daily living were issued. In June 2011, this number had risen to 612 (55% increase over that period). Similarly, in January 2011, 597 items of equipment to support a medical need were issued. In June 2011, this had risen to 859 items (43% increase over the 6 month period).

Evidence of what works and policy drivers

Policy Drivers

Personalisation was described in the White Paper 'Our Health Our Care Our Say' 2006. It puts the individual at the centre of the decisions about their care, their health and how they live their lives. It offers disabled people greater choice and control; enhancing independence through self care and self management, increasing access to employment and education and offering disabled people opportunities to play an active part in their families and community.

The context in which Health and Social Care is based is evolving and there has been a shared aim across government to put people first through a programme of far reaching changes in public services. A strategic shift towards early intervention and prevention is seen as key in the drive to improve the health and wellbeing of the population and reduce inequalities.

Greater education and awareness of self care and the development of individual's skills and ability to manage their conditions more responsibly are seen as vital; reducing and preventing the potential for high cost, long term interventions and treatment.

Health and Social care can no longer work in isolation; greater emphasis is now being placed on the establishment of partnership working and collaboration across service areas such as Health, Leisure, Community Safety, Transport, Education and Employment in order to achieve change and improve the quality of life for people with a physical disability.

The Welfare Reform Bill 2011

This proposed legislation aims to reform the benefits and tax credit system to make it simpler and fairer for all. This legislation will affect people with disabilities in that there will be changes to the Disability Living Allowance, which supports people with a disability whether they are in work or out of work. The changes, if adopted by Parliament, will result in a new benefit the Personalised Independence Payment. Levels of payment will depend on a detailed assessment of needs.

User view

Regular engagement with service users takes place within the services and each service completes an annual satisfaction survey on their experiences. The results of these surveys are then fed into planning forums and drive service improvement. In addition, commissioners and service providers meet regularly with the Disability Advisory Group (DAG), a consultative group working with the Council to ensure that the needs of people with disabilities are included in policy and service development.
Commissioners also work with the Physical Disabilities and Sensory Impairment Consultative Group, which is a sub group of the DAG on specific issues relating to physical disability and sensory impairment. For example, a group of service users have been working with commissioners to develop a service specification for the Milton Keynes Sensory Service, to ensure that the service meets the needs of the people that use it, within available resources.

What are the priorities and what are we going to do as a result?

People with a physical disability and sensory impairment are faced with more difficulties than non-disabled people when accessing services. Sensory loss in particular can lead to increased social isolation and dependency without the provision of personalised support.
Service provision should enable people to be independent members of the community, making their own decisions, with access to the same opportunities as the rest of the local population.
The priorities for disability services are as follows:

- Maintain relationships with the Disability Action Group and other service user groups to ensure that the needs of people with a range of disabilities are reflected in the health and social care planning frameworks to inform priority setting.
- Increase the numbers of people with a physical disability and sensory impairment using individual budgets to purchase their care. By 2011-2012, 30% of clients will be receiving Individual Budgets.
- Develop and implement telecare/telehealth for people with a physical and sensory disability.
- Enhance the Milton Keynes Sensory Service so that it delivers a personalised support for people to promote their independence.
- Review interpreting services locally and carry out an options appraisal to ensure value for money.
- Redesign the Community Equipment Service and Wheelchair Services
- Ensure that the transition from children's services to adult social service is person centred and managed efficiently and effectively.

Recommendations – options for H&WBB

People with a disability often face exclusion from the opportunities everyone else takes for granted. Often they are a silent minority because their particular disability makes full engagement with ordinary life difficult. This isolation can lead to dependence on others, social isolation, frustration and mental ill

health. It is important for the Health and Well Being Board to ensure that the needs of people with a range of disabilities are considered when health and social care services are being developed.

Recommendations for further research/needs assessment

- Needs assessment and research locally has concentrated on quantitative data. There is a need for increased qualitative data focusing on the experience of people with a disability and how barriers within society can be minimised to ensure that they can participate in the local community like everyone else.
- Research the options available to facilitate communication for people with a sensory loss.
- Consultation and engagement with young people and their carers to support the improvement of planning between children's services and adult social care service for the transfer of care from one service to another.
- Research need in areas of deprivation to underpin targeted interventions in these areas.

3.4.4 Children in Need and Children in Care

Who's at risk and why?

Some children, either because of their own additional needs or because of less advantageous circumstances will need extra help to be healthy and safe, and to achieve their potential.

In Milton Keynes, Children and Families Service Groups want to offer help and support to these children and to their families at the earliest point, in a voluntary way that does not leave them feeling singled out as different. The Common Assessment Framework facilitates early intervention when a child's needs are not being fully met.

Referral to Children's Social Care Services is required when the needs of the child are so great that intensive or complex intervention is required to keep them safe or to ensure their continued development. The child is likely to be at risk of significant harm or their development will be seriously impaired if services are not provided. [24]

Where it is not possible for a child to remain within their own family, the local authority aims to provide stability and security to children in care so that they are able to achieve their full potential. [30] However, children in care and care leavers are at risk of poorer outcomes in terms of academic achievement, the likelihood of being NEET (not in education, employment or training) and, consequently, are at risk of future poverty. [5]

Level of need in the population

2009/10 was a very busy and pressurised year for Children's Social Care as a result of the 'Baby Peter' effect which caused a large increase in referrals , assessments, care proceedings and a 16% growth in numbers of children in care (from 225 to 260). This large increase in workload was managed whilst achieving good performance for assessment timescales and child protection. Numbers of care proceedings and children in care stabilised in 2010/11. There have been no Serious Case Reviews since 2009. [30]

From January 2009 the Children in Need service has led the rollout of the Common Assessment Framework (CAF) in Milton Keynes, establishing area forums and CAF panels. The number of CAFs completed increased three-fold by March 2011 and working together across services for children with additional needs improved. Similarly Children in Need led on the Family Intervention Project in 2009/10, working intensively with families involved in the criminal justice system. The impact of these initiatives is hard to measure beyond an individual basis, but the numbers of children in care remained relatively low at 4.6 per 1000 compared to an England average of 5.9 at the end of March 2011.

Referrals to Children's Social Care [5]

The following represent some of the important, commonly agreed indicators that families and children are experiencing problems:

- Absence from school
- Exclusion from school
- Failure to progress satisfactorily in school
- Teenagers not in education, employment or training
- Anti-social behaviour
- Bullying as perpetrator or victim
- Under 18 conceptions
- Contact with the criminal justice system as perpetrator or victim
- Referrals to Children's Social Care
- Obesity
- Dental caries

The problems cited above present as difficulties at the level of the individual family or local estate, although they frequently emerge as a consequence of a range of wider adverse social circumstances. For example:

- Lack of community cohesion
- Poverty - financial and aspiration
- Adult unemployment
- Homelessness
- Frequent housing moves
- Parental ill health or disability
- Substance or alcohol misuse
- Domestic violence
- Poor parenting

- Parental neglect and abuse
- Parental involvement with the criminal justice system

Children who are safe and cared for and who do well in school are more likely to experience positive outcomes and better life chances. Children and young people who are not well cared for and who do not do well in schools are those who cause concern for teachers and other professionals and who are at risk of becoming entrenched in an escalating spiral of social problems.

Table 11 below shows that high population estates, such as Bletchley and Newport Pagnell, produced higher numbers of referrals, but lower incidence when figures are expressed as a proportion of the child population (0-17 years). Incidence is highest in the most socio-economically deprived areas of Milton Keynes where the take up of benefits, free school meals, and levels of unemployment are also at their highest.

Table 11: Referrals to Children's Social Care in 2009/10

Estate	Number of Referrals	Referrals as % of 0-17 population	Estate referrals as % of all referrals	Social Atlas Rank
Water Eaton	293	10.9%	8.2%	6
Fishermead	176	12.4%	4.9%	9
West Bletchley	148	6.5%	4.2%	24
Netherfield	145	12.7%	4.1%	2
Newport Pagnell	125	3.8%	3.5%	68
Far Bletchley	121	7.9%	3.4%	27
Beanhill	110	20.9%	3.1%	1
Oldbrook	93	6.3%	2.6%	22
Fullers Slade	85	13.9%	2.4%	5
Conniburrow	84	9.3%	2.4%	7
Broughton & Atterbury	82	11.2%	2.3%	36
Wolverton	80	4.6%	2.2%	32
New Bradwell	73	9.8%	2.1%	14
Coffee Hall	71	12.5%	2.0%	4
Greenleys	71	11.1%	2.0%	16
Stantonbury	69	7.5%	1.9%	10
Bradville	68	5.9%	1.9%	21
Heelands	66	7.7%	1.9%	26
Central Bletchley	60	7.1%	1.7%	25
Hodge Lea	50	15.5%	1.4%	15
Stacey Bushes	41	13.0%	1.2%	8
Tinkers Bridge	35	12.5%	1.0%	3
Fenny Stratford	35	12.5%	1.0%	11
Central Milton Keynes	34	17.8%	1.0%	19

Looked after children 2007-10 [5]

A 2010 report considered the distribution of referrals to Children's Social Care which resulted in children becoming looked after (new episodes), by settlement areas. The report also considered any changes in trends which could indicate the effectiveness of early interventions or preventative services available within those areas.

The report shows that whilst most newly looked after children tend to come from areas of socio-economic disadvantage, this is by no means the whole picture. There are only a small number of these settlements, i.e. Netherfield, Water Eaton and Fishermead which continue over time to feature in the list of estates with the highest level of newly looked after children. Other areas such as Bradville, Wolverton and West Bletchley have fluctuating numbers, and some new areas (Broughton and Newport Pagnell) began to feature in 2009/10. Some of the other high need areas – Conniburrow and Fullers Slade - have seen a steadily reducing number of children becoming looked after over time, which may indicate the success of preventative services operating in those areas.

Corporate Parenting Panel: Annual Report 2010/11 [31]

There were 225 children in care in March 2009, 260 children in March 2010 and this number has risen to 271 children in March 2011. The increase in 09/10 was primarily because of an increase in care proceedings concerning younger children, including children moving into Milton Keynes, and an increase in young people aged 16 and 17 some of whom were homeless. This increase has not been so great in 2010/11, but the number of care proceedings concerning young children has continued to be high.

There are 211 children in foster care placements (146 with MKC foster carers); 23 in residential provision (3 MKC provision); 19 are at home with parents, 11 are in forms of supported lodgings and seven in residential family centre or special school.

The demography of children in care, as of March 2011, is as follows:

- 208 children and young people are on interim care orders, care orders or placement orders and 63 are Section 20 (voluntary) care or on remand (remanded to LA care by the youth court until trial).
- 207 are white/white British, 22 are of Caribbean or mixed background, 23 are of Asian background, 16 are Black African and three are from another ethnic group. 12 are young asylum seekers. 126 are female and 145 male. 71 are aged 0-4; 132 aged 5-14; and 68 are 15 or over.

Current Services in relation to need

Children's Social Care Services deliver the Council's statutory functions under the Children Act 1989 as amended by subsequent legislation and regulation. This provides the basis for both children in need and children in care services.

The Council has a statutory responsibility to take measures to ensure that children do not suffer significant harm and to promote the welfare of children in need. Where children cannot be brought up within their own or wider family the Council has a duty to 'look after' them as any parent would. Children's Social Care Services lead on and fulfil most of these functions for the Council.

The Children in Need service provides child protection and family support services to children and families where there is a risk of significant harm or of family breakdown. This service aims to support children within their families wherever possible, using Family Group conferencing and intensive family

support to find solutions and similar services for children. Support is also provided to children with disabilities and their families, including a range of short breaks and practical help at home.

Where it is not possible for children to remain within their own family or their wider family, the Children in Care service arranges and provides foster care, adoption, residential care and leaving care services for children in the care of Milton Keynes Council. These services aim to provide stability and security to those children in care so that they achieve their full potential.

There are two residential care homes, one for disabled children in care and one providing respite care for disabled children. Children and Families Service Groups also include the children in care education support team (virtual school for children in care) and the emergency social work team which provides an out of hours service for both children and adult social care.

Children's Social Care also oversees the safeguarding service which provides arms length scrutiny of the child protection process, the child care review process for children in care, and quality assurance. CSC also provides the staff to support the multi-agency safeguarding children partnership which provides the strategic overview and co-ordination of partners as the Milton Keynes Safeguarding Children Board (MKSCB).

Projected service use and outcomes

Children's Social Care services are highly regulated and have to respond to demand through nationally agreed processes. Demand increased significantly from 2008 to 2011. This service area is one of high risk to the Council and the service must remain responsive while delivering budget savings.

Service provision (e.g. the number of children in care and how they are cared for) is dependent upon demand and the individual needs of the children themselves. A plan is in place to reduce placement costs. [30]

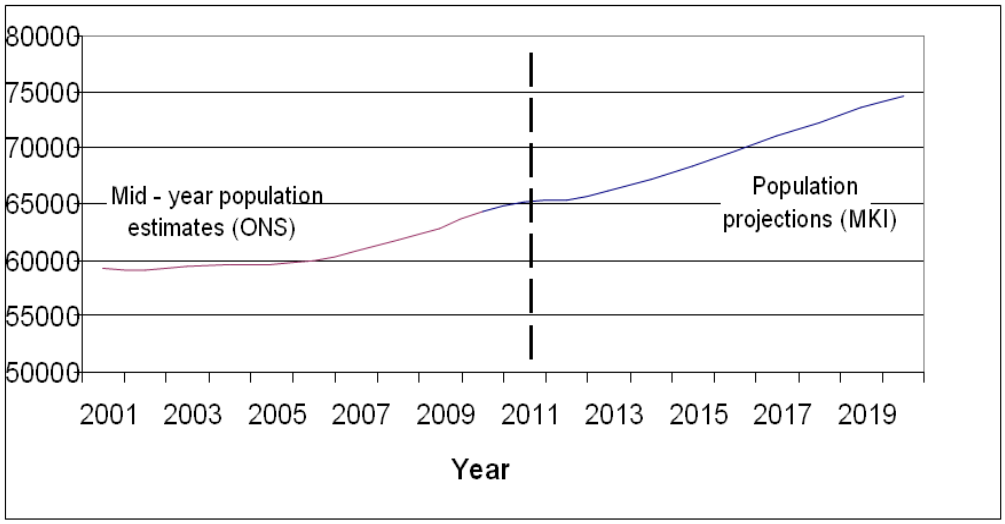
Milton Keynes has a young, growing population that is increasing in ethnic diversity. [5] Projected growth in the population of children and young people suggest that this trend will continue.

Where there is an increasing population of young people, it is likely that this will be associated with an increase in the demand for Children's Social Care.

Figure 19: Projected growth in the population of children and young people aged 0-19 in Milton Keynes

Data for 2001-2009 are mid-year population estimates produced by the Office for National Statistics.

Data for 2010-2020 are population projections produced by Milton Keynes Intelligence (Sept 2010), based on mid-year estimates, assumptions about migration, fertility, mortality and house-building completion rates.



Evidence of what works and policy drivers

The Children Act 1989, as amended by subsequent legislation and regulation, provides the basis for both children in need and children in care services. (30)

The Government and Ofsted expect that all Children's Services and partner agencies will have a well developed and well understood Common Assessment Framework embedded in their area. The importance of this is made clear by the following recommendations from the second Serious Case Review into the death of Baby Peter by Haringey's Local Safeguarding Children Board:

"The Children's Partnership must fulfil its duty to ensure early intervention in the lives of vulnerable children by addressing with urgency the development of local delivery teams, the widespread use of the Common Assessment Framework (CAF), and the role of the lead professional. It should report on progress to LSCB and invite the Board to audit the safeguarding dimension of the delivery of the services." (Haringey LSCB: Serious Case Review: Baby Peter - Feb 2009, 6.8(32))

The key challenge for 2011/12 is to maintain an effective and responsive service to meet demand without delay and to deliver high quality assessment and interventions (care plans) to children in need, including those in need of protection and those with disabilities. (30)

In addition Children's Social Care services seek to drive up the stability, well being and overall achievement of children in care. Services must be delivered within the current regulatory and inspection regime and within the available resources. (30)

Children's Social Care services are part of wider Children and Families Service Groups and must be ready to adapt and develop in response to the national Munro review and local organisational transformation. (30)

User view

Service users provide feedback on their individual experience. Services listen to their needs and what is important for them via:

Stakeholder groups; Children In Care Website; Gozzip Magazine for Children In Care developed with young people; forums for Children In Need and exit interview feedback. (30)

What are the priorities and what are we going to do as a result?

Services identified the following priorities for 2011/12:

- To support children and young people to grow and develop within their families wherever possible
- All children in care grow up in stable, nurturing placements where they are supported to achieve their full potential
- MKC and multi-agency systems to protect children from harm are robust and effective

3.4.5 Falls

Who's at risk and why?

A fall is defined as 'an event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness other than as a consequence of paralysis, epilepsy or overwhelming external force'. (Tinetti et al 1997[33])

Older people have a greater risk than any other age group of accidental injury (for example from falling) that results in hospitalisation. (Cryer, 2001[34])

The key issue of concern for the older person is the combination of the high incidence of falls and high susceptibility to injury. (Rubenstein, 2001[35])

Level of need in the population

As detailed in section 2.1, the population of older people in Milton Keynes is expected to grow in the range from 85% (from 2009 to 2026) for the over 65s to 132% for the over 85s – the most at risk people.

The Royal Society for the Prevention of Accidents (ROSPA) estimates that one in three people aged 65 years and over experience a fall at least once a year – rising to one in two among 80 year olds and older.[36]

These population and incidence estimates infer that the level of falls in Milton Keynes would be expected to rise from roughly 13,000 in 2009 to approximately 24,000 in 2026. The level of need in relation to falls can be split into two types:

- Those people who have been identified as being at risk of a fall and who are requiring general preventative falls advice and interventions.
- Those people who have fallen and who need treatment and help to regain their independence, confidence levels or simply more personalised advice and preventative interventions.

Current Services in relationship to need

The Joint Commissioning Team currently commissions the following services:

- Falls service within MKCHS to provide assessment and education re falls prevention to the public as well as health and social care professionals.
- South Central Ambulance service to identify where people are falling in Nursing and Residential homes and targeting these homes for preventative visits from the Falls Service.
- A Pharmacy Advisor to work in Nursing Homes re Medicines management and reduce the prescribing of anti-psychotics.
- Falls Prevention Handyman Service, from the voluntary sector, carrying out minor practical work in the person's home to reduce the risk of falls occurring.

In addition, Milton Keynes Council has a strong telecare service. Public Health and GP colleagues also have a key role to play in ensuring an integrated and overall effective Falls Pathway exists.

Projected Service Use and Outcomes

The Falls Service received 1,193 referrals in 2010/11. From these 353 multi-factorial assessments were undertaken. These identify and address future risk and the person is offered individualised intervention aimed at promoting independence and improving physical and psychological function. This includes the Otago Home Exercise programme, where felt appropriate.

The service also undertook 86 care home assessments and ran 32 training sessions for public and staff.

The level referrals, whilst subject to periodic peaks and troughs, has remained reasonably consistent since 2007/8 (1,139). Referrals represent less than 10% of the expected number of people over 65 who fall in a year.

Any work to improve the volumes of people identified as needing falls prevention assistance in Milton Keynes, as per the Action Plan referred to below, should increase this level of referrals to the Falls Service. Any such increase is likely to magnify the already significant rise in population service demand expected from the projected expansion in the numbers of older people towards 2026.

Evidence of what works and policy drivers

A selection of relevant policy drivers in relation to falls are:

- NICE Clinical Guidance 21 (2004) states that a multi factorial falls risk assessment should be offered to older people who have fallen or who are at risk of falling. Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a health care professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, multi factorial intervention.
- Strength and balance training is recommended. Those most likely to benefit are older community dwelling people with a history of recurrent falls and/or balance and gait deficit. A muscle strengthening and balance programme should be offered. This should be individually prescribed and monitored by an appropriately trained professional (NICE 2004).
- The Otago Home Exercise programme was designed specifically to prevent falls. It consists of a set of leg muscle strengthening and balance retraining exercises progressing in difficulty, and a walking plan. The exercises are individually prescribed and increase in difficulty during a series of five sessions by a trained instructor. The exercises take about 30 minutes to complete. Participants are expected to exercise three times a week and go for a walk at least twice a week.
- To help them adhere to the programme participants record the days they complete the programme and the instructor telephones them each month.
- The National Service Framework for Older People emphasised the long established link between falls and medicines management. All people over 75 on four or more medicines should be targeted for a review every six months, as set out in the GP contract. Where possible these reviews should be conducted in the surgery by the GP or other health professional such as a practice pharmacist or non-medical prescriber. Opportunistic review should also take place, particularly if some-one has had a fall. Community pharmacists are able to provide support to patients through Medication Use Reviews. These focus on the practical aspects of taking medicines rather than the clinical ones.

- FRAX is the 10 year fracture tool developed by the WHO (World Health Organisation) and alongside NOGG (National Osteoporosis Guideline Group) guidelines, have been introduced to guide therapy. Based on the algorithm patients are referred for a DXA (Dual emission x-ray absorptiometry) Scan or receive appropriate treatment. This is considered as an opportunistic and effective way of identifying fracture risk patients in primary care.
- Telecare monitors and detectors can be used effectively in the prevention of falls in older people. One of the main fears older people have of falling is the fear of not being found, especially when they live alone. This can be aided with telecare monitors as, should a person fall, the monitor would trigger an alarm at a central control centre alerting that the person has fallen. This would ensure that the person is assisted in an appropriate time by the most relevant person, whether this is an ambulance, health care professional or member of their family.

The financial cost of falls to health and social care services are considerable. In 2008/9, 2009/10 and 2010/11, the cost of hospital admissions for fractures of femur and neck of femur were well in excess of £1million each year. (For most fractured wrists, the person has treatment in outpatient services, which means the true financial costs will be much higher.)

Following hospitalisation, there are then ongoing costs, for example community based rehabilitation programmes and increased domiciliary care needs. These cannot be accurately determined, but as the detrimental affects of falling on a person's independence can be long term, these costs are likely to be significant.

The cost of each hip fracture has been estimated at £15,000. Only a handful of reduced occurrences, as a result of increased investment in a fuller adoption of appropriate policy drivers in Milton Keynes, would therefore make clear financial sense.

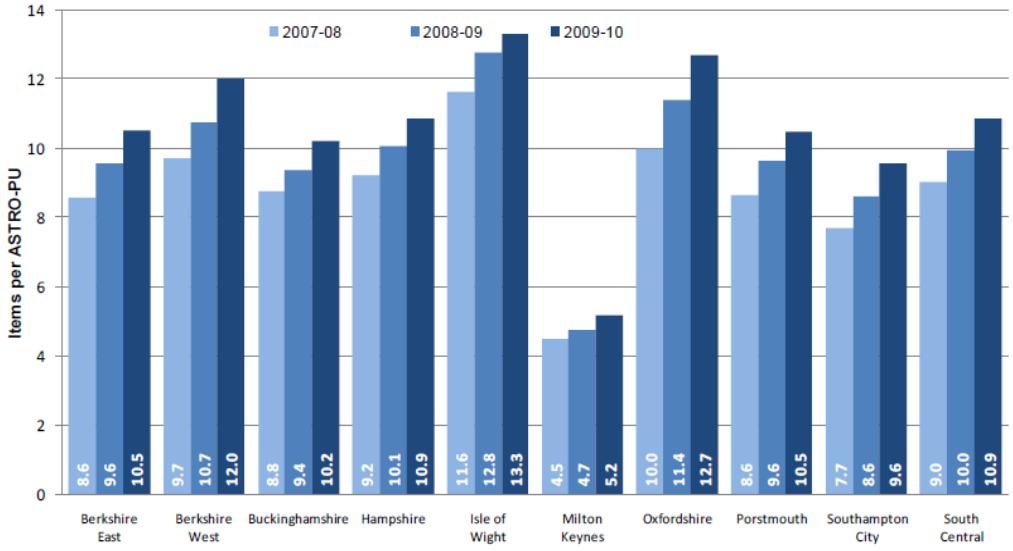
User view

A review of user feedback collected from MKCHS Falls Programme sessions from April to October 2011 shows that people find these worthwhile. They are clearly helpful to people to regain their confidence and improve their physical functioning regarding preventing further falls.
The minor practical work commissioned from the voluntary sector provider is highly appreciated by people, increasing their feeling of safety in their own home.

What are the priorities and what are we going to do as a result

Across the whole of health and social care current falls related services are fragmented, with pockets of good performance (for example work undertaken by the Falls Service within MKCHS), but areas needing attention (for example regarding the appropriate prescribing of drugs which help with bone strength, as shown below).

Figure 23. Prescribing of bisphosphonates and other drugs: items per ASTRO-PU by PCT, South Central SHA (2007/08 to 2009/10)



Source: ePACT (accessed 2 June, 2010)

Detailed falls data per se is not collated nationally or locally, but some published indicators can be assumed to reflect overall falls pathway and service performance.
It appears that Milton Keynes has an average occurrence of falls, but that when people fall they are more likely to sustain serious injury than in other areas of the country. For example, the indicator relating to hip fractures in the over 65s (published in late 2010) showed that in 2008/9 Milton Keynes did not measure favourably.

Over the summer of 2011 the Joint Commissioning Team undertook the following activity as a result of this performance:

- Held a workshop to bring together key people who are involved with falls prevention across the health and social care economy.
- Action Plan drawn up and taken to the Unplanned Care Program Board to gain GP sign up.
- Further workshop held with members of Age UK, Social Care and Reactivate MK.
- Initiated the decision taken by the Unplanned Care Board to integrate this work into both the Intermediate Care Strategy and Reablement Plan.

Newly published information shows a consequential improved position, with MK moving from Red to Amber in terms of hip fracture performance, but there is more to do.
The Action Plan from the workshops includes the need for the following key cross organisational tasks to be undertaken:

- A lead Public Health colleague needs to be assigned to falls and then proactively work with GPs to ensure improved primary interventions in relation to falls.
- Need to develop a Fracture Liaison Post within MKFTH working with the MKCHS Falls Service.
- Review current Falls Strategy and develop a cross organisational health and social care Falls and Bone Health Strategy.
- Develop a clear and well publicised pathway of treatment and care to support the revised strategy.

In addition, the likely impact of additional falls prevention activity on the appropriate level of available specialist falls resource needs to be considered. Spend to save investment is likely to be required.

Recommendations for further research / needs assessment

From the Unplanned Care Board's Action Plan for Falls and Bone Marrow health, the following additional research and needs assessment is required:

- GPs to review the low level of bi-phosphonate prescribing (bone density) at a practice level.
- GPs and Public Health to undertake a co-morbidity investigation for pre-disposition to falls and fractures.
- Pro-active identification of vulnerable patients per GP practice, for example for those people at greater risk of osteoporosis.
- Analyse the age of people who have fallen and injured themselves, to determine if falls specific services need to be opened up to the under 65s.

3.5 Crime and Disorder

3.5.1 Youth Offending

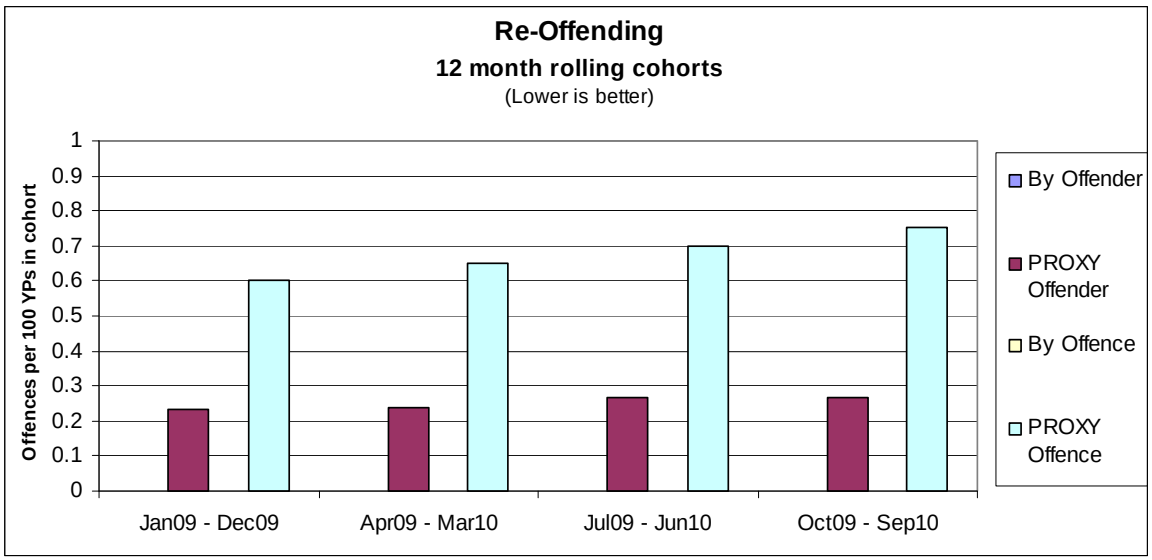
Initial Police National Computer (PNC) data has not yet been released and so only the proxy data is available.

The measure looks at ***all*** young people receiving a substantive outcome in the relevant year and then tracks them for 12 months to give:

i) A binary measure (shown as 'By Offender') – which measures the number of young people in the cohort who have offended and

ii) A frequency measure (shown as 'By Offence') – which measures how many offences have been committed divided amongst all members of the cohort.

Figure 20: Re-Offending



The first statistical release of the new re-offending data is due later this autumn so the above are proxy figures to illustrate how the new measure would be presented. They indicate that although the numbers of individuals in the cohort who have re-offended is fairly constant the number of offences they commit can be varied and seems to be increasing. The national data will show trends back to 2005 so this will help us understand how the most recent figures compare over a longer timeframe.

The figures above include offending by Milton Keynes looked after children placed outside of the area. The new national figure will not show this but will show offending by looked after children from other local authorities placed in Milton Keynes (e.g. at private children's homes). It is not clear what impact this may have on the overall re-offending profile of Milton Keynes, it is possible the changes will result in a neutral position.

Figure 21: Proxy First Time Entrants (FTEs)

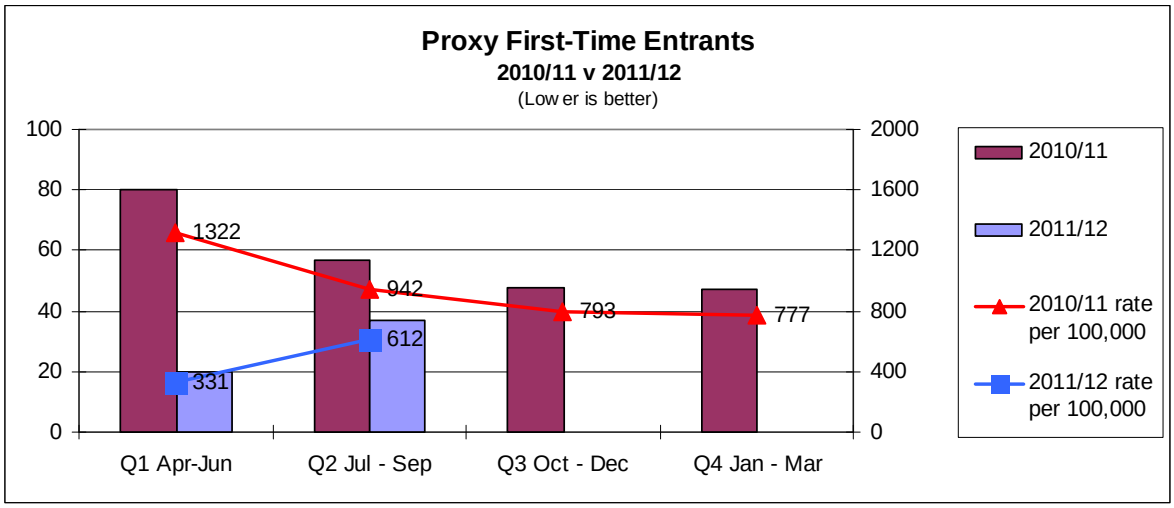


Figure 22: First Time Entrants: Rate Per 100,000

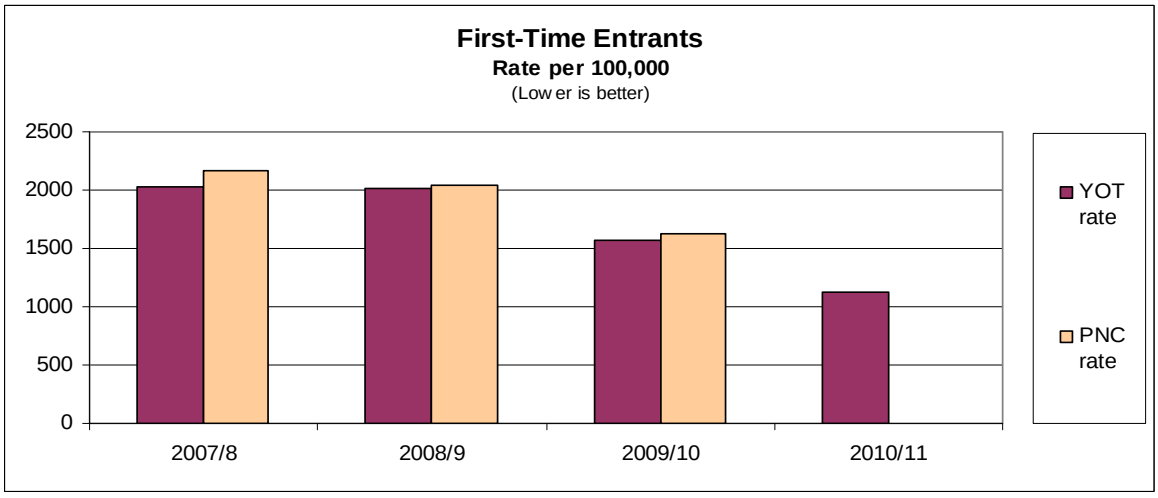
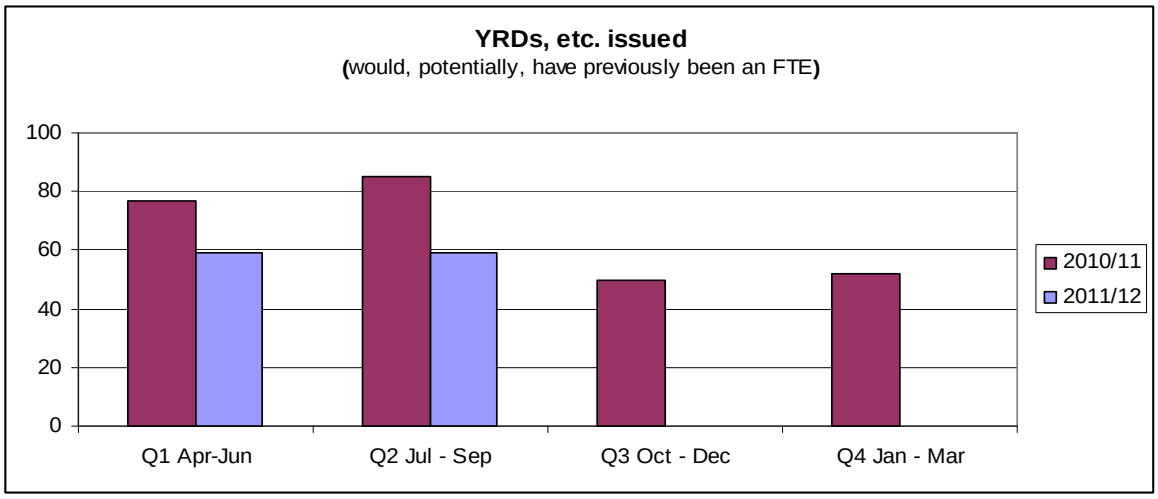


Figure 23: Youth Restorative Disposals (YRDs) Issued



The ethnic breakdown of substantive First Time Entrants for the last quarter is:

	White	Mixed	Asian	Black	Chinese
Male (25)	17 (68%)	6 (24%)	0	2 (8%)	0
Female (12)	8 (66%)	1 (8%)	3 (25%)	0	0

Whilst for those given a Youth Restorative Disposal it was:

Male (36)	29 (80%)	4 (11%)	1 (3%)	2 (5%)	0
Female (23)	17 (74%)	3 (13%)	0	3 (13%)	0

The primary offences committed were:

	Shoplifting	Other theft	Violence	Damage	Other offences
Male FTE	10	11	9	6	23
Female FTE	5	2	9	0	11
Male YRD	10	1	23	0	2
Female YRD	11	0	11	1	0

Although the numbers of FTE in Q2 are double those in Q1 the year on year trend is still downwards and the rate per 100,000 shows improvement on any previous year.

It is noticeable that the numbers of YRD's seem to have reduced considerably year on year suggesting we have reached the bottom of the curve in terms of their impact on the FTE figure. This may be reflected in an upturn in the number of referrals for Final Warnings.

There remain some sign of potential 'disproportionality' in decision making with Mixed Race boys more likely to get a Reprimand or Final Warning rather than an YRD. White girls are most likely to be dealt with by YRD.

3.6 Adult Social Care

The population of the UK is ageing. The proportion of people aged over 65 rose from 15% to 17% from 1985-2010, an increase of 1.7m people, and is projected to reach 23% by 2035, according to the Office of National Statistics. Of most significance for the social care system is the growth in the number of people aged over 85, which doubled from 690,000 in 1985 to 1.4m in 2010 and is set to reach 3.6m, or 5% of the population, by 2035.

Elderly people account for the majority of adult social care service users and of public spending on adult care. NHS Information Centre figures for 2009-10 in England show:-

- 77% of the 225,600 council-funded people in residential or nursing homes were aged over 65.
- 65% of the 1.54m council-funded users of community-based social care were aged over 65.
- 56% of the £16.8bn spent by councils on adult social care was for people aged over 65.

In Milton Keynes there will be a significant rise in the population over-65, table below show the increase in the population:

	2015	2020	2025	2030
People aged 65-69	29%	30%	43%	62%
People aged 70-74	23%	70%	71%	88%
People aged 75-79	18%	49%	106%	108%
People aged 80-84	11%	38%	73%	138%
People aged 85-89	4%	28%	64%	108%
People aged 90 and over	31%	62%	115%	200%
Total population aged 65 and over	**21%**	**45%**	**69%**	**96%**

Living status is also a predictor of use of services, as older people with an informal carer are more likely to remain in their own home. Table below show the number of people predicted to be living alone.

Living Status					
Total population aged 65-74 predicted to live alone	4,010	5,070	5,910	6,210	6,930
Total population aged 75 and over predicted to live alone	6,180	7,069	8,691	11,432	13,800

Who's at risk and why?

Adult and young carers

Adult carers are more likely than non carers to suffer from a range of health conditions, including:

- Stress/nervous tension:
- Depression: Mostly women
- Anxiety

- Back injury: This is mainly amongst carers doing heavy physical caring for those with physical disabilities, but also is significantly higher amongst those people caring for someone with high dependency because of learning disabilities.
- High blood pressure: Those caring for someone with dementia have this complaint more than other carers. This can lead to strokes or heart attacks.

Carers are also for more likely to neglect their own health and therefore suffer from badly managed chronic conditions such as diabetes, asthma, arthritis, COPD and heart problems.

Research has found that young carers can experience substantial physical, emotional or social problems, and encounter difficulties in school and elsewhere.

Level of need in the population

Figures from Carers UK indicate nationally that one in eight adults are carers (12.5%). 2001 Census information indicated that nationally one in 10 of the population identified themselves as carers. In Milton Keynes the percentage of people identifying themselves as a carer is in the 2001 census is lower than the national average, at 8.4% of the population (one in twelve). Based on this prevalence, there would be approximately 25,000 carers living in Milton Keynes in 2009. Work is being undertaken to establish how many are known to adult social care.

With such fast population growth the number of carers increases every day. In addition, the lower than national prevalence rate is probably due to the low proportion of older people, but as stated above, this percentage is set to increase. This is likely see an exponential growth in the number of carers. Furthermore, there may be a disproportionately high number of unidentified carers in Milton Keynes.

From the 2001 census data, of the 17,400 self acknowledged carers in Milton Keynes, 70% (12,180) provided less than 20 hours a week, 10% (1,740) provided between 20 and 50 hours a week and the remaining 20% (3,480) provided more than 50 hours a week unpaid care. Census figures show that people providing more than 50 hours of care a week are twice as likely than non carers to suffer from poor health, becoming permanently sick and disabled themselves.

Other issues that emerge from national reports [37] and that impact on the number of carers in Milton Keynes include:

- Overall the incidence of mental health problems is slightly lower than the national average; however in 3 geographic areas the incidence is considerably higher. These areas are known areas of deprivation in Milton Keynes.
- The % of the adult population known to Learning Disability services in Milton Keynes is marginally fewer than the estimated administrative prevalence (numbers known to the service) for England as a whole (MK 0.44%: England 0.46%).
- Carers provide an estimated 95% of the health and social care provided in the UK so supporting carers is a core way of supporting the people cared for.
- Nationally, the unpaid help that carers provide saves the UK economy an estimated £57 billion a year; the equivalent of the cost of the NHS.

Current Services in relation to need

Prevention and low level support available to all carers

- Information
- Advice
- Emotional support
- National carers organisations and helplines
- Benefits advice
- Training on manual handling, back care, dealing with stress etc

Support in the Home

- Sitting services (Crossroads, Age Concern, independent domiciliary care agencies)
- Domiciliary care for the person cared for
- Meals on Wheels
- Live-in care for longer breaks
- Help with housework and shopping
- Carers Support workers
- Direct payments for carers

Support Outside the Home

- Day Care for the person cared for
- Rehabilitation services for the person cared for (lessening the dependence on the carer)
- Carers Support Groups (MK Carers, Alzheimers Society, Brooklands Day Centre, those run by staff in statutory services)
- Carers Counselling sessons at the City Counselling Centre.
- Professionals working with the person cared for
- Carers services such as help with getting around; taxis, driving lessons

Residential Respite Care (Carers' Breaks)

- Residential respite care
- Supported holidays
- Residential breaks for carers

Hospital and Specialist Care

- MK General Hospital
- Willen Hospice
- Bletchley Community Hospital

Evidence of what works and policy drivers

Policy drivers

- Carers (Recognition and Services) Act 1995
- Carers and Disabled Children Act 2000
- Carers (Equal Opportunities) Act 2004

User view

- Carers survey
- Consultation for Social Care Reform

4. Lifestyle Determinants of Health

4.1 Exercise

Who's at risk and why?

Over the past 40 years people in the UK have become less physically active in their everyday lives and a smaller proportion of the population take part in physical activity for leisure. We have fewer manual jobs, more labour saving gadgets and cars have meant a 25% reduction in travel by foot or bicycle. The impact on health of this cultural change in everyday behaviour has resulted in sedentary lifestyle related health problems like, coronary heart disease and strokes, becoming major causes of death and ill health in many developed countries as well as the UK.
Promoting physical activity as a cultural norm offers significant benefits for enhancement of the quality of life of Milton Keynes residents. It also offers savings to NHS and Social Care costs and the potential for minimising days lost from work to the local economy is also considerable. For example, the estimated national benefit of minimising days lost from work due to physical inactivity is £8.2 billion a year collated.

Level of need in the population

The Active People Survey is the largest ever survey of sport and active recreation to be undertaken in Europe. This datasheet shows the results for all the Local Authorities in England and comparative results for Active People Surveys 1, 2, and 3.
On 15 October 2009, Active People Survey 4 (2009/10) commenced. Active People Survey 4 ran until 14 October 2010, the results were published on 16 December 2010.
The survey provides by far the largest sample size ever established for a sport and recreation survey and allows levels of detailed analysis previously unavailable. It identifies how participation varies from place to place and between different groups in the population.

KPI 1 Participation is defined as taking part on at least 3 days a week in moderate intensity sport and active recreation (at least 12 days in the last 4 weeks) for at least 30 minutes continuously in any one session. Participation includes recreational walking and cycling.

	APS1 (Oct 2005-Oct 2006)		APS2 (Oct 2007-Oct 2008)		APS3 (Oct 2008-Oct 2009)		APS4 (Oct 2009-Oct 2010)		
Local Authority	**%**	**Base**	**%**	**Base**	**%**	**Base**	**%**	**Base**	**Statistically significant change from APS 2**
Milton Keynes UA	20.2%	1,015	20.7%	496	20.3%	493	19.2%	551	No Change

KPI 2 Volunteering is defined as 'Volunteering to support sport for at least one hour a week'.

Milton Keynes UA	5.1%	1,025	2.9%	500	5.3%	502	4.0%	557	No Change

KPI 3 Club membership is defined as 'being a member of a club particularly so that you can participate in sport or recreational activity in the last 4 weeks'.

Milton Keynes UA	23.5%	1,025	28.2%	501	25.2%	502	21.6%	551	Decrease

KPI 4 Receiving tuition is defined as 'having received tuition from an instructor or coach to improve your performance in any sport or recreational activity in the last 12 months'

Milton Keynes UA	18.5%	1,025	22.2%	501	19.6%	502	18.7%	552	No Change

KPI 5 Organised Competition is defined as 'having taken part in any organized competition in any sport or recreational activity in the last 12 months'.

Milton Keynes UA	13.4%	1,025	13.1%	501	15.8%	502	14.4%	550	No Change

KPI 6 Satisfaction is the percentage of adults who are very or fairly satisfied with sports provision in their local area.

Milton Keynes UA	78.3%	918	73.2%	448	75.5%	455	75.7%	490	No Change

Organised sport is defined as the percentage of adults who have done at least one of the following: received tuition in the last 12 months, taken part in organised competition in the last 12 months or been a member of a club to play sport.

4.2 Smoking

Who's at risk and why?

Smoking continues to be the leading cause of preventable death and is the single biggest cause of health inequalities between socio economic groups in the UK. Smoking is responsible for 80% of respiratory illnesses and is linked to many cancers. 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. [38]

Smoking tobacco kills 50% of its long term users. Smoking increases the likelihood of cot death and lower birth weight in babies. Babies exposed to second-hand smoke are more likely to have coughs and colds, asthma attacks and middle ear disease.

Level of need in the population

Current smoking rates in England stand at around 21%, with the rates for routine and manual workers and hard to reach groups range around 26-29%. In Milton Keynes the prevalence is estimated to be similar to the national figures. Nationally the highest prevalence of smoking in adults is still between 25–34 years. Stopping smoking reduces the smoker's health risks and also reduces the health risks for those who live with them. Youth smoking prevalence rates has declined in the ten years between 1998 and 2008 but there is still much to be done. Young people are more likely to smoke if their families and friends smoke. One in seven 15 year olds is a regular smoker and most smokers start young. [39]

Three in ten children, aged 11 to 15, have tried smoking at least once and 6% of children were regular smokers (smoking at least one cigarette a week) in 2009. Girls were more likely to smoke than boys (10% of girls compared to 8% of boys).

In Milton Keynes our objective in line with government aspirations is to reduce smoking in 11 to 15 year olds (the national average is at present 6%) and in 16 to 17 year olds (the national average rate is 16%) by 50% by 2020.

Current Services in relation to need

In 2009/10 757,537 people in England sought help from NHS Stop Smoking Services (a 13% increase on 2008/9) and 49% (11% increase on 2008/9) successfully quit at four weeks. [40] People are four times more likely to quit with NHS Stop Smoking Services than without assistance. The NHS Milton Keynes Stop Smoking Services are provided through GP practices and participating pharmacies. All GP practices in Milton Keynes now provide a service where an appointment can be made within a maximum of five days from the point of referral. The service is free and medication is available at prescription charges.

The stop smoking sessions are provided on a one to one basis and provide intensive pharmacological and psychological support together with and advice. Patients may self refer through their GP reception or participating pharmacy or can be referred through hospitals, schools, workplaces and children centres.

Evidence of what works and policy drivers

The government recommends [41] that tobacco control alliances increase awareness of the harms of tobacco and encourages the de-normalising of tobacco use. This can encourage people to access stop smoking services and supports young people to make healthy lifestyle choices, including not taking up the use of tobacco. The TCAs aim to educate on the risks of using tobacco, motivate tobacco users to think about quitting and provide advice on how to quit in the most effective ways. In 2009/10 approximately 4000 people set a quit date in Milton Keynes with over 2600 people who smoke quit at 1 month. Milton Keynes Stop Smoking Service has a quit rate of over 55%. NHS Milton Keynes aims to continue to strengthen this very successful Stop Smoking Service in 2011.

The government also recommends that communities are encouraged to see 'not smoking' as the norm and for TCAs to communicate information about second-hand smoke and how to make their homes and family cars smoke-free.

Milton Keynes Tobacco Control Alliance was formed in early 2009 and now has a dynamic and diverse membership. The aim of the TCA is to forge partnerships with influential groups and stakeholders such as Milton Keynes Council, NHS Milton Keynes, Buckinghamshire Fire and Rescue, the Public Safety Partnership, Healthy Schools, MK Bar watch and the commercial and voluntary sector. A Milton Keynes tobacco strategy has now been developed to underpin further work by the TCA.

The Alliance aims to address the recommendations of the National Strategy (2010), [42] the Tobacco Control Plan for England (2011) and the Health Act (2009). The aims of the strategy are to reduce underage sales through vending machines, the introduction of plain packaging and the ending of 'point of sale' displays in shops and supermarkets (A Smoke Free Future 2010). From April 2012 tobacco items should not be visible in larger shops and by 2013 in smaller shops. Cigarette vending machines will not be available after 2012.

What are the priorities and what are we going to do as a result?

- Although smoking rates in young people continues to fall, work to advise on tobacco information and support to stop smoking within schools, still remains a key issue.
- Stop smoking advice and support should be underpinned by strategic tobacco control policy development and implementation.
- Tobacco use is the single most preventable cause of death and kills almost half of its long term users and as such efforts should continue to create further opportunities for access to stop smoking clinics in Milton Keynes, particularly for those working during the day and those who do not have easy access to transport.
- To further develop the work of the Milton Keynes Tobacco Alliance actively encouraging new partners and stakeholders.
- To utilise the funding from the Regional Strategic Health Authority to develop a tobacco information and stop smoking training programme for secondary schools. This will be evaluated in 2011 to indicate whether further work will be undertaken.

4.3 Diet/Obesity

Who's at risk and why?

Obesity is when a child or adult is carrying too much body fat for their height and sex. For adults it is defined as a Body Mass Index (BMI) of 30 or more and in children it is measured using growth charts. Being obese increases the risk of developing serious diseases such as type 2 diabetes, cardiovascular disease and cancer. Nationally, obesity is a growing public health concern. In Milton Keynes in 2010, over 9% of Reception class children and 17% of Year 6 pupils were clinically obese, and it is estimated that over a quarter of adults are obese.

Level of need in the population

In England 24.2% of adults are estimated as obese. The figures for Milton Keynes are slightly higher than England, with an estimated figure of 26.5% of our adult population being obese. The levels of childhood obesity are also of concern, with over 22% of children in Reception and over 31% of Year 6 children either overweight or obese. NHS Milton Keynes now has four years of NCMP data to compare the progress of childhood obesity. The findings for Reception children show that there has been a small decrease in the levels of obesity, with over 10.1% in 2006/2007 compared to 9.5% in the 2009/2010. The figures for obese children in Year 6 had started to show a decrease, but have increased in 2009/10. It is clear from these findings that Milton Keynes must continue their efforts to tackle obesity.

Current Services in relation to need

- The Motiv8 programme as part of the partnership between NHS Milton Keynes and Milton Keynes Dons SET, continues to support children and their families to lead healthier lifestyles and control their weight. Since the beginning of the scheme, over 100 families have benefited from the weight management support of the Motiv8 programme.
- There are a great variety of activities taking place in Milton Keynes to support Change4Life. In 2010 the campaign has widened its audience from families to include adults and early years.
- During 2010 there has been an increased emphasis on raising awareness of obesity and its associated risks among partner organisations. This has resulted in a number of partnership projects to combat this very important issue.
- The obesity care pathway for Milton Keynes was finalised in early 2010 and promoted through the healthy weight leads within each GP practice.
- **The Active MK: Exercise Referral Scheme** (AMKERS) now has 15 sites actively involved across the city. In 2010 the scheme received an average of 55 referrals per month.
- In 2009 we recommended that more work should be done to provide opportunities for individuals to incorporate physical activity into their daily lives. In 2010 the **Cycle MK Challenge** was launched, a three week challenge which took place during June and July where businesses could sign up and compete against other businesses in a workplace cycle challenge.

- Over the last year, the **Reactivate Bucks** programme has become more established. A number of regular activities take place each week, as well as a number of activity courses.
- The community food project began in 2008 with an aim to increase fruit and vegetable consumption and promote healthy eating and diets in Milton Keynes. Due to the recent restructure of NHS Milton Keynes, we are unable to continue this work in 2011. Efforts have been made to ensure that the activities are sustainable where possible.

Evidence of what works and policy drivers

In 2007, the Foresight Report [43] proposed for the first time that we live in an 'obesogenic' environment and that without intervention an estimated 40% of Britons will become obese by 2025 and the majority by 2050, with associated costs to the NHS reaching a staggering £9.7 billion per year.

What are the priorities and what are we going to do as a result?

- Develop community weight management interventions such as HALO (Health and Lifestyle Opportunities) to be more accessible to patients in the community.
- Continue the work of the Healthy Places, Healthy Lives project to encourage active travel amongst school children. Develop the work further once the findings from the pilot have been evaluated.
- Ensure the training for the HENRY (Health Exercise and Nutrition for the Really Young) programme is spread according to the needs of the population, concentrating on Marmot principles and where there are high levels of obesity in Reception Year children.

4.4 Alcohol

Who's at risk and why?

Alcohol remains a major public health problem. In Milton Keynes, hospital admissions for alcohol specific conditions are relatively high in the South East region and the trend is upwards. Half of admissions due to alcohol related injury in Milton Keynes are in people aged 25 to 44 years. Many people think that the alcohol problems experienced in the country and in Milton Keynes generally relate to binge drinking and alcohol dependency. This is a myth. The biggest challenge for the NHS continues to be effective communication about the serious health impacts of regularly drinking above the recommended guidelines, a level of drinking which is usually socially acceptable.

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

Level of need in the population

Evidence base is drawn from existing data and previously prepared Needs Assessment. [44]

Alcohol continues to be detrimental to the health of people in Milton Keynes. More than 25% of the population aged 16 and over drink above the recommended guidelines. It is estimated that 37,000 people drink at a level of increased risk, 9,000 at a level of high risk and 40,000 binge drink. There are significant health and social harms caused by drinking alcohol excessively. Milton Keynes has one of the highest rates of alcohol-related hospital admissions in the South East region at 1,837 for every 100,000 people.

Current Services in relation to need

Multiple agencies, including Milton Keynes Council, NHS Milton Keynes, 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. As part of the work of this group throughout 2010, a new Drug and Alcohol strategy [44] was developed.

- Research is currently being undertaken with local residents to establish what mechanisms we can use to deliver the messages about socially acceptable drinking behaviours and their potential to impact on health and social wellbeing.
- In addition to offering general medical services, GP practices can also provide enhanced services. Services called Identification and Brief Advice (IBA) are being commissioned, for the identification of all patients registering with the GP surgery who are drinking above the recommended guidelines. The patients identified can either be offered support through the GP practice to reduce their alcohol consumption or be referred to specialist alcohol services.

- During 2010, a multi-agency group and treatment service users were involved in the process of selecting new drug and alcohol service providers. The next challenge for the alcohol services is to ensure that IBA interventions in primary care and other settings are developed further to work in synergy with these services.
- An IBA programme has been piloted within Brook Sexual Health Services. A total of 1318 clients were screened to assess their level of alcohol intake. Of these, 987 were identified as low risk drinkers, 265 as increasing risk drinkers, 29 as higher risk drinkers and 23 as potentially dependent drinkers requiring referral into the alcohol services. Of the 265 clients identified as at increasing risk, 60 (23%) reduced their drinking levels to low risk. Of the 29 higher risk drinkers, 10 (34%) have reduced their drinking levels to low risk drinking. This has been a very successful pilot and we will be developing these IBA services through Brook into the future.
- 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.

What are the priorities and what are we going to do as a result?

- Monitor the new drug and alcohol service to ensure that alcohol continues to be a priority within these joint services.
- Use the findings of the social marketing research to inform our communications about the health impacts of drinking above recommended guidelines.
- Continue to develop innovative approaches to IBA (identification and brief advice) services

4.5 Drug Abuse

Who's at risk and why?

The National Treatment Agency report that about a third of the population in England admit to taking drugs at some stage of their lives and about a quarter of young adults say they have used drugs in the last year, but only a small proportion go on to develop serious problems. Drug dependency is a complex health disorder with social causes and consequences. Risk for addiction is influenced by a number of factors such as personality, social environment, biology etc. The more risk factors a person has, the greater the chance taking drugs can lead to addiction.

Drug addiction amongst young people under 18 is rare. Drug use statistics show a downward trend in drug use amongst school pupils and young people. However, evidence does suggest that a small minority who are misuse drugs are doing so more problematically.

Level of need in the population

Recent prevalence estimates provided by the Centre for Drug Misuse Research at the University of Glasgow show that the number of opiate and/or crack users (OCUs) in Milton Keynes is around 997, with a lower estimate of 879 and a higher estimate of 1,151. This is around 6.15 per thousand population in Milton Keynes. Of these it is estimated that around 30% inject. Over 46% of estimated OCUs are aged between 25-34 year olds, with 15% under 25. Across England it is estimated that the number of people who use opiates and crack have fallen.

Currently, 87% of clients receiving structured treatment for drugs in Milton Keynes are OCUs. A further 8% are receiving treatment for cannabis and cocaine misuse. Generally, drug misuse is more prevalent among men, with 30% of clients in treatment being female. However, the previous substance misuse needs analysis showed that often females seek treatment further into their addiction than males. Over three quarters of clients in treatment are aged between 25 and 45 which matches the prevalence estimates.

There are no equivalent prevalence estimates for young people. The majority of young people in treatment primarily misuse cannabis and/or alcohol and are aged between 15 and 16 years old. There are currently no OCU clients in the young people's treatment service.

Current Services in relation to need

During 2010/11 the substance misuse treatment services in Milton Keynes were re-commissioned reducing the number of adult services from five to one, bringing all elements of treatment together. Since April 2011, CRI have been commissioned to provide an outcomes-based substance misuse service which delivers structured treatment and brief interventions for adult alcohol and drug misusers. Compass continue to deliver the commissioned intervention service for young people with substance misuse issues.

These commissioned services work closely with other agencies including Milton Keynes Council, NHS Milton Keynes, HMP Woodhill, Thames Valley Probation, Thames Valley Police, the Community Safety Partnership (Safer MK) and the National Treatment Agency to reduce substance misuse in Milton Keynes.

What are the priorities and what are we going to do as a result?

Priorities for adult substance misuse treatment services are to increase the number of clients who successfully complete treatment and focusing on recovery and re-integration of individuals into society for example increasing the number in employment or education and reducing the number with housing problems. It is envisaged that the outcomes based contract will improve the quality of service not just the numbers in treatment.

Priorities for the young persons substance misuse service is to identify the need amongst young people and engage more with vulnerable children for example looked after children or young people on the verge of entering the criminal justice system.

4.6 Sexual Behaviour

Who's at risk and why?

Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease (National Sexual Health and HIV Strategy, 2001). [45]

Inequalities in sexual health are found nationally with young people, men who have sex with men and some minority ethnic groups having the greatest burden of sexual ill health. These inequalities are reflected in Milton Keynes, and the sexual health strategy recommends that resources are directed towards those geographical areas and communities where the burden of sexual ill health is the greatest.

Level of need in the population

The evidence base has been drawn from existing data and previously prepared (Health) Needs Assessment, strategies and similar documents

With the exception of warts, Milton Keynes had a higher rate of diagnosed STI's than that of the Strategic Health Authority area overall and lower rates of chlamydia, gonorrhoea, syphilis and warts when compared to England rates. Milton Keynes now has a diagnosed HIV prevalence of 2.09 per 1,000 (15-59 year old population) meaning that it is one of 37 Primary Care Trusts defined as an area of high prevalence by the Health Protection Agency. By the end of 2009, 337 people resident in Milton Keynes had been diagnosed with HIV and were accessing care, 58% of the diagnosed Milton Keynes population were women.

There has been a year-on-year increase in the numbers across all probable routes of infection (low numbers within the mother to child transmission group prevent yearly comparisons). 72% of the diagnosed cases are amongst the Black African population. The majority of cases are amongst heterosexual people (78%) and 14% of cases were diagnosed in men who have sex with men.

Despite increasing numbers of HIV tests and new diagnosis over the past years, Milton Keynes sees a higher proportion of late diagnosis of HIV than other areas within South Central.

Current Services in relation to need

The Chlamydia Screening Programme in Milton Keynes was launched in March 2006. Milton Keynes is one of the few Primary Care Trusts to achieve the target of screening 25% of its 15-24 year old population in 2009/10 having the highest screening rate amongst Primary Care Trusts in the South Central Strategic Health Authority area. Brook Sexual Health Services and a team of peer outreach workers have been particularly successful in encouraging young people to test.

In Milton Keynes, HIV testing is available from the sexual health centre at Milton Keynes hospital, and HIV Quick Testing (where results are available in one hour) is available twice weekly from two GP practices in Milton Keynes. This year has seen the decommissioning of the Dandaro HIV prevention project (targeting the sub-Saharan Black African population) with the redundancy of the project worker post. The associated condom distribution scheme and HIV quick testing have continued, and the Primary Care Trust is exploring the option of making HIV testing more widely available by offering it

routinely at new GP registrations. Free condom distribution schemes are in place and targeted at groups where HIV prevalence is greatest.

A needs assessment of HIV prevention, treatment and care will be completed in 2011 incorporating the recommendations of NICE Guidance to increase uptake of HIV testing amongst men who have sex with men and Black African Population.

Between April and January 2010, 144 individuals accessed community based HIV Quick testing, 3% of those testing had a positive result and were linked into the sexual health centre for confirmatory testing and support.

Evidence of what works and policy drivers

Long Acting Reversible Contraception (LARC), (which includes subdermal implants, intrauterine devices and injectable contraceptives) are the most effective forms of contraception. The National Institute for Health and Clinical Excellence (NICE) produced guidance in 2005 recommending that LARC should be offered to all women as part of their contraceptive choice. Following a revised audit of clinicians, training requirements provision has been enhanced and locally more clinicians are able to provide LARC.

Around one in four of all HIV infections are undiagnosed; without treatment HIV infection results in a destruction of the body's immune system and a progressive increase in illness. Identification and treatment of a HIV positive pregnant woman together with careful management at delivery reduces the likelihood of transmission to the baby. A diagnosed HIV positive individual using antiretroviral treatment will have a reduced level of infectiousness and also be more likely to take appropriate precautions to reduce onward transmission. Contact tracing also provides opportunities to diagnose individuals who have not accessed testing. It is important therefore that people living with HIV are diagnosed promptly and tested appropriately.

It is important to ensure sexual health services in Milton Keynes have the capacity and skills required to meet the needs of the population. This year has seen a full review of sexual health services resulting in the Sexual Health Strategy Group's proposal for one service to integrate family planning, STI testing (including national Chlamydia screening programme), community gynaecology, vasectomy services, training, psychosexual counselling, health promotion and management of HIV services, this more comprehensive service will enhance accessibility for the public.

What are the priorities and what are we going to do as a result?

- The Sexual Health Strategy Group should continue to assess need, set strategy and develop and monitor action plans.
- Enhanced HIV testing should be introduced in line with Health Protection Agency recommendations.
- The development of an integrated sexual health, family planning and reproductive service.
- Continue to increase the awareness of LARC through professional education and training and public campaign.

5. Health

5.1 Mortality

5.1.1 All Age All Cause Mortality

Who's at risk and why?

The risk factors and causes for many of the diseases that lead to ill-health and early death, particularly those for heart and cardio-vascular disease [47], lung cancer and colorectal cancer [48] are well understood. There is a significant burden of these chronic diseases on the individual, on society and on the NHS.

The health impact from these chronic conditions – especially on the chances of premature death – can be significantly reduced since smoking, excess alcohol consumption, lack of physical activity; obesity and poor diet all contribute to the problems. People will substantially reduce their risk of developing a chronic disease and dying prematurely if they:

- Do not smoke.
- Achieve the recommended levels of physical activity.
- Eat a healthy balanced diet, which includes at least five portions of fruit and vegetables a day.
- Do not exceed the recommended sensible drinking guidelines.

Cancer and circulatory diseases remain the leading causes of death in Milton Keynes- each accounting for around 26% of all deaths and nearly two thirds of all premature deaths before the age of 75.

In 2009, the deaths from circulatory diseases in under 75s fell again to their lowest level yet and the mortality rate from coronary heart disease In under 65 year olds also fell, having been on the rise for the previous two years. The reduction in the proportion of younger people dying from acute myocardial infarction compared to those dying as a result of chronic cardiac disease is of particular note.

Lung cancer remains the commonest cause of cancer death In Milton Keynes. In 2009 It accounted for 23% of all cancer deaths and 23% of all cancer deaths in the under 75s.

There has been a marked decrease in deaths due to chronic obstructive pulmonary disease (COPD) and for the first time in many years the standardised mortality rate is lower than the national average.

Since 1993 each year there has been a gradual reduction in the death rates from stroke in people aged less than 65 years In Milton Keynes. In 2009, the premature deaths from stroke resulted in 324 years of potential life lost in under 75s.

What are the priorities and what are we going to do as a result?

Work will continue towards addressing the inequalities that influence health and life expectancy. The reduction of the differences in life expectancies between wards in Milton Keynes remains a key objective of NHS Milton Keynes.

NHS Milton Keynes will continue to work closely with other commissioners, including the emerging Clinical Commissioning Groups, and providers of health and social care to provide services, education, support and enablement for people who have chronic conditions. The local health and social care economy is working together to identify common features of programmes and devise ways of bringing these together in a more seamless way to provide value for money and strengthen the opportunities for people to be proactively involved and empowered in their self-care.

5.1.2 Life Expectancy

Who's at risk and why?

Life expectancy for men and women in England and for those living in Milton Keynes continues to rise where it has risen from 78.8 years for females in 1992-1994 to 82.2 years in 2007-2009. For males, life expectancy has increased from 74.3 years to 77.9 years during the same period. Since then, male life expectancy in Milton Keynes has dipped slightly and is now is 10 weeks lower than the national average of 78.1 years, but female life expectancy has shown a small rise and is equal to the national average of 82.2 years.

Furzton has replaced Middleton as the least deprived ward, where on average people will live 9.1 years longer than those in the most deprived ward — this remains a significant inequality although life expectancy in Woughton (the most deprived ward) has risen over the same period by around four months compared with the last report (2004-2009).

Level of need in the population

In Milton Keynes, local life expectancies are calculated over a 5 year time span in an attempt to smooth out the natural fluctuations that can occur in small populations. Over the period 2005-2009 in Milton Keynes the average life expectancy was 79.9 years, a rise of 6 months from the previous 5 year average.

Statistics clearly illustrate the association between life expectancy and where people live. Although there are year to year changes in the order of ward rankings on life expectancy these changes are often just statistical variations.

5.1.3 Main Causes of Death

Who's at risk and why?

The total number of deaths in Milton Keynes in 2009 was 1,574 (779 males and 795 females) of which 616 (39%) were in people aged under 75 years (376 males and 240 females). Deaths in people less than 75 years of age are considered to be premature deaths.

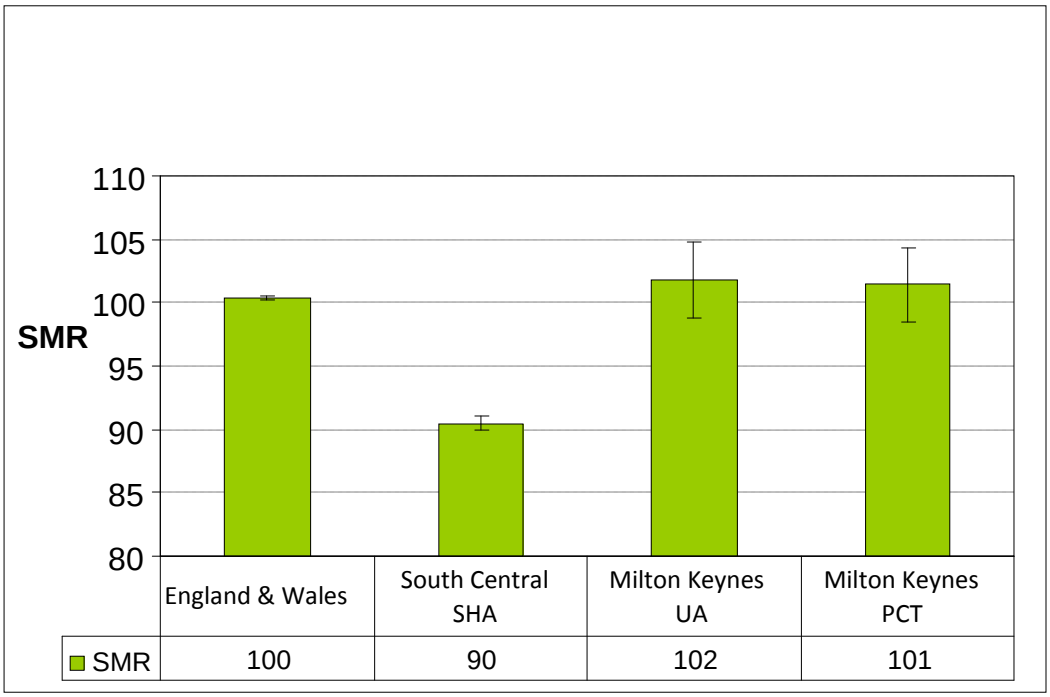
In 2009, 59% of all deaths in Milton Keynes were caused by circulatory diseases and cancers (all circulatory diseases, 32.0%; all cancers, 27.1%). Coronary heart disease and stroke accounted for 18.0% and 6.7% of total deaths respectively. Lung cancer was the most common cancer, causing 6.2% of all deaths in Milton Keynes across all age groups. The next most prevalent cause of death was pneumonia which caused 8.4% of deaths in Milton Keynes. Most of these pneumonia deaths (87.2%) occurred in persons older than 75 years of age.

In 2009, the primary causes of premature death in men were cancers (33.5% of premature death) particularly lung cancer (9.3%), circulatory disease (31.6%), particularly coronary heart disease (21.3% of all premature deaths) and acute myocardial infarction (7.7%). In women, the top causes of premature death were all cancers (46.7% of premature deaths), with breast cancer (11.3%) and lung cancer (7.9%) predominating and circulatory disease which accounted for 19.6% of female premature deaths (coronary heart disease 9.6%).

Level of need in the population

Figure 24 shows the pooled Standardised Mortality Ratio (SMR) for all causes of death in Milton Keynes for 2007-2009 and the 95% confidence intervals. At 101, the all cause SMR in NHS Milton Keynes, is almost identical to that for England and Wales but statistically significantly higher than for the South East region (SMR 92) and the South Central Strategic Health Authority (SHA) area (SMR 90) as it has been historically. This reflects the fact that, when it comes to factors that influence health, Milton Keynes is more similar to the rest of the country overall than the relatively more affluent South East.

Figure 24: SMR, all causes (ICD10 A00-Y99, all persons, all ages 2007-09 pooled data)



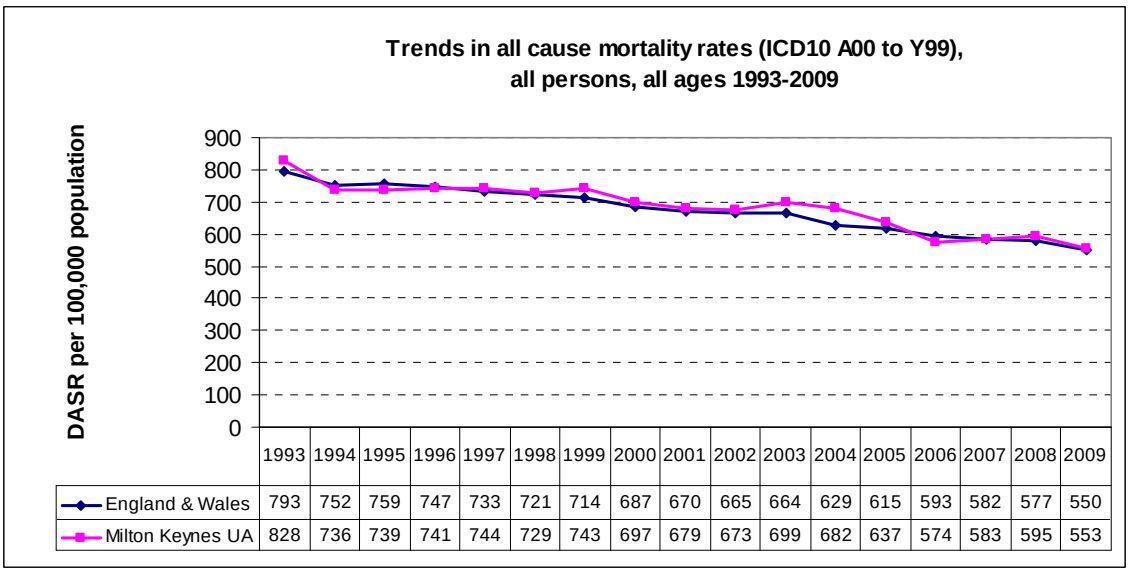
Current Services in relation to need

Smoking is the most important major avoidable risk factor for circulatory and respiratory diseases, coronary heart disease, stroke, COPD and various cancers, especially lung cancer. In addition, taking regular physical activity, having a balanced diet and maintaining a healthy weight all reduce the risk of developing diabetes and circulatory disease, including coronary heart disease and stroke.

Projected service use and outcomes

The Directly Age Standardised Mortality Rates (DASR) for Milton Keynes Unitary Authority and England and Wales have declined since 1993 (Figure 25). The DASR for England and Wales in 2009 was 550 deaths per 100,000 population and for Milton Keynes was 553 deaths per 100,000. Although the Milton Keynes rate is just above the national rate this is not significant in statistical terms.

Figure 25: Trends in all cause mortality rates (ICD10 A00-Y99, all ages 1993-2009)



	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
England & Wales	793	752	759	747	733	721	714	687	670	665	664	629	615	593	582	577	550
Milton Keynes UA	828	736	739	741	744	729	743	697	679	673	699	682	637	574	583	595	553

What are the priorities and what are we going to do as a result?

- In the same way that people with diabetes have their care planned within a systematic review structure, and are fully involved in the planning of their care and agreeing their goals with their health professional, this approach will continue to develop for people with other long term conditions such as cardiovascular disease and cancer. The widespread use of care plans will continue to be encouraged and professional competencies developed to place the individual at the centre of decisions about their care and health.
- Targeted interventions need to be broadened and intensified to continue to concentrate on the following key areas:
    - Ensuring people have the information, access to services and support appropriate to their needs to allow them to make healthy lifestyle choices.
    - Providing education, information and rehabilitation to allow people with chronic conditions to optimise their self care with appropriate support.
- Having seen the Impact of the concentrated work to reduce the inequalities in mortality from respiratory diseases, NHS Milton Keynes will continue to:
    - Focus on areas and groups with the highest need.
    - Target stop smoking services, train health care workers to support smokers to quit and work with others to enforce tobacco control measures.

  - Focus on better management of medication and where shown to be effective, commission rehabilitation at all levels of care.
  - Provide opportunities for patients to Increase their understanding of their health conditions to prevent deterioration and support better self management.
- The implementation of the cancer strategy will also address areas of inequalities including the uptake of cancer screening programmes and the lifestyle Issues of physical activity, diet and obesity. The planned age extension for breast screening (47-49 and 71-73 years) and bowel screening (70-74 years) should take into account the need to increase the participation among social groups with the lowest uptake.

5.1.4 End of Life Care

Who's at risk and why?

End of life care (EoLC) is a strategic priority for NHS Milton Keynes, Milton Keynes Council and The Milton Keynes Foundation Hospital NHS Trust.

For people nearing the end of life this will mean timely end of life care which is planned, where possible and delivered by the appropriate person to meet the needs of the patient and family 24 hours a day. This care will respond flexibly and rapidly to changing need.

Level of need in the population

Following on from the baseline review in 2007, a local and national End of life care strategic review and Next Stage Review (NSR), detailed work has been taking place locally to meet the end of life care of Milton Keynes population through the development of the Joint Palliative Care Steering Group, links to South Central Strategic Health Authorities End of Life programme board and associated regional and local work streams.

The NSR work which included a wide range of stakeholders from across health and social care including each PCT led to the development of an EoLC pathway. NHS South Central has also been working closely with NHS Milton Keynes and constituent PCTs to embed end of life care in their operating, spending and implementation plans and to ensure there is an infrastructure in place to support improvements in EoLC, as such each PCT has an EoLC group which includes stakeholders from across health and social care and an EoLC Strategy which reflects the work being done at a regional level.

The aim of the Joint Palliative Care Steering Group is to embed choice and good quality end of life care into the delivery and provision of all health and social care services in Milton Keynes. In doing so, we believe we can bring cost savings for the health economy and improve the patient/carer experience at the end of life.

Projected service use and outcomes

When this programme is complete, the end of life pathway will be widely implemented as a base for individual patient care. Patients and their carers will be able to expect to have their needs assessed, a care plan initiated and their advance wishes recorded and acted upon. This will create a more

responsive and inclusive service which communicates with patients and families, involves them in decisions about how, where and what services are provided, managing expectations and expedites provision of those services.

Survey data suggest that these will very often involve supporting patients to die at home or in a care home rather than in hospital.

More explicit care planning at end of life will minimise interventions of limited clinical value and improve systematic support. A 'key worker' will be assigned to patients entering the end of life care pathway.

- All health and social care staff will be better trained and therefore more confident and competent in supporting patients and their carers in the end of life stage.
- Provision of out of hours support will be improved to support the pathway, aiming to prevent admissions to hospital wherever this is possible and appropriate.
- There will be a single point of contact for each patient from where an appropriate emergency response can be put into place from a range of options.
- Patients on the end of life care pathway will be included on a web-enabled electronic register supported by relevant clinical data accessible by all members of the health and social care team who may need to tailor an appropriate response for that individual when their day-to-day healthcare team are not available.

Early identification of people entering the last twelve months of life and advance care planning will support increased effectiveness of intervention, with a focus on supportive care. This should minimise interventions of limited clinical value at end of life, including unplanned hospital admissions, prescribing for long-term prevention in primary care, and treatment interventions which will be futile in acute care.

What are the priorities and what are we going to do as a result?

- Identification of the key areas that can deliver quality and productivity savings across the care pathway and working with PCTs to ensure these are delivered:
- Identification of those nearing the end of life and communication of this across settings and sectors.
- This will in turn lead to an assessment, care plan and anticipatory care planning and prescribing/advance care planning, availability of medicines and equipment which offsets need for crisis admission. Roll out region wide of the unified DNACPR policy will begin the impetus for this.
- Enhanced community care services which build on current community teams providing rapid response services but also ongoing care and both assessment pre admission and facilitated rapid discharge to reduce length of stay and emergency admissions.

5.2 Disease Prevalence

5.2.1 Obesity

Who's at risk and why?

Over 26% of adults In Milton Keynes are estimated to be obese. Over 9% of Reception children and over 17% of Year Six children are obese In Milton Keynes.
The MotIv8 programme as part of the partnership between NHS Milton Keynes and Milton Keynes Dons SET, continues to support children and their families to lead healthier lifestyles and control their weight. There are a great variety of activities taking place in Milton Keynes to support Change4Life.

What are the priorities and what are we going to do as a result?

Refer to the priorities in 4.3: Diet/Obesity.

5.2.2 Infectious and Communicable Diseases

Who's at risk and why?

Food poisoning accounted for the largest number of notifications of communicable diseases in Milton Keynes.

There were five confirmed meningococcal disease cases in Milton Keynes. Following the national trend, the highest proportion of cases was seen in children less than five years of age.

The Tuberculosis (TB) incidence rate in Milton Keynes was 12.3 per 100,000 population. This represents a decrease of 16% in the incidence rate compared with 2009.

A significant increase in the uptake of both MMR (measles, mumps and rubella), vaccine doses has been achieved, the uptake rates are now 91% for the first MMR (by 2nd birthday) and 82% for the second MMR (by 5th birthday).

What are the priorities and what are we going to do as a result?

In view of the outbreaks of measles within Europe, targeted work should continue to ensure an increase in the uptake of both doses of the MMR vaccination.

Strengthen the seasonal influenza programme to increase the uptake of immunisation in the 'at risk' groups to at least 60%.

5.3 Pregnancy and Childhood

Who's at risk and why?

The population of Milton Keynes continues to increase as the Borough expands, a significant proportion of which are young people. The number of births in Milton Keynes has risen to double the national figure, and this impacts on maternity services before any other secondary healthcare services.

Providing safe and effective maternity care is essential to protect the health and wellbeing of expectant women and to give babies the best possible start in life.

Pregnancy and childbirth outcomes are important markers of social equality, and variation in outcomes can be linked to inequalities of opportunity. Infant mortality can be significantly reduced by addressing child poverty, reducing obesity, reducing smoking in pregnancy and reducing teenage conception rates.

Child poverty reduces the life opportunities of children. The recent Marmot Review [(49)] into inequalities recommended that giving every child the best start in life should be the highest priority as disadvantage starts before birth and accumulates throughout life. Such disadvantage can lead to lower life expectancy, higher rates of disability, lower educational achievement and higher mortality rates.

Women who are obese have a higher risk of complications during pregnancy and childbirth [(50)], including pre-eclampsia, pre-term babies, small for gestational age, and higher Caesarean Section rates. There are similar risks identified for smoking in pregnancy, with an additional risk of an increase in cot death.

There are six wards in the Borough identified as teenage conception rate hotspot areas that are amongst the highest 20% in England. Three of these wards are in the top 20% of most deprived wards in England. Children and young people account for approximately a quarter of the local population of Milton Keynes.

The teenage conception rate has fallen by 21.5% since 1998, and Milton Keynes is in the top 25% most reduced local authority areas in the country. The proportion of teenage conceptions that result in abortion is 51%, which is a small increase from 2009. The number of young people attending local sexual health clinics continues to rise.

Childhood immunisation rates (for diphtheria, tetanus, whooping cough, haemophilus Influenza B, meningitis C and pneumococcus) have remained stable in Milton Keynes at 95%. Local breastfeeding rates remain above the national average but need to continue to increase to meet local targets.

User view

The increasing birth rate and changing demands of the population demographics, coupled with a regional shortage of midwives, has placed considerable demand on local maternity services. NHS Milton Keynes has worked closely with local maternity services to ensure safe and effective provision of care, and supported the implementation of a hospital action plan to address recommendations made by the Care Quality Commission. In 2010 the Primary Care Trust supported the requirements placed on local services by regulatory bodies in commissioning capacity to support 1:1 care in established labour, and is working closely with stakeholders, such as the hospital, the local authority and Maternity:MK (the local Maternity Services Liaison Committee) to monitor the improvements in patient experience.

What are the priorities and what are we going to do as a result?

- Mothers-to-be and fathers-to-be who smoke during pregnancy should remain a priority target for stop smoking services, refer to priorities in 4.2: Smoking.
- In order to tackle the cycle of deprivation for children, NHS Milton Keynes will work closely with Milton Keynes Council and the Children's Trust to develop a strategy to tackle child poverty, to improve life chances for young people.
- Ninety per cent of pregnant women should book for antenatal care with a healthcare professional by 12 completed weeks of pregnancy.
- Pregnant women will receive the NICE recommended number of antenatal and postnatal appointments.
- Identifying young people most at risk of teenage pregnancy remains a challenge. It is recommended that all vulnerable young people identified under the Common Assessment Framework (CAF) have their sexual health needs assessed by a Sexual Health Outreach Nurse with appropriate intervention.
- It is recommended that all secondary schools review their policies and practise re-enabling young people to access sexual health services on school premises.
- Mothers should be encouraged and supported to continue to breastfeed for longer. This can be achieved through: the actions of midwives and health visitors; expanding the peer support groups across the city; and promoting breastfeeding-friendly locations throughout the city.
- Continue to commission capacity to support one to one care in established labour in local maternity services.

5.4 Mental Health

Who's at risk and why?

Mental health problems are linked to a range of wider issues, poor physical health, poor educational achievement and sickness absence. Half of all mental illness starts by the age of 14, but by ensuring a positive start in life, up to a half of these are preventable.

Nationally 1 in 4 people at any one time experience mental health problems. In Milton Keynes suicide rates, whilst remaining low, are no longer statistically significantly low.

Level of need in the population

In 2007, The Office for National Statistics (ONS), psychiatric morbidity survey [51] found that 1 in 4 people at any one time experience mental illness. According to the ONS survey, the most common form of mental illness is mixed anxiety and depression (9%), followed by general anxiety (4.4%) and depression without the symptoms of anxiety (2.3%).

Current Services in relation to need

Access to the community mental health services is via the Assessment and Short Term Intervention (ASTI) team; this service has been designed to care for those people who present with a severe and enduring mental health illness. Access to acute inpatient services is via the Assessment and Home Treatment Team. Both teams work very closely together to ensure there is a short, clear pathway between them.

Projected service use and outcomes

Using the ONS estimated prevalence of common mental health problems; it is possible to broadly estimate the prevalence of mental health illnesses for the Milton Keynes population.

Table 12: Prevalence of mental illness in Milton Keynes

Mental Health Problem	National Prevalence - All Persons All Ages	Estimated Affected Population in Milton Keynes
Mixed anxiety and depression	9	21,700
Generalised anxiety disorder	4.4	10,600
Depressive episode	2.3	5,600
All phobias	1.4	3,400
Obsessive compulsive disorder	1.1	2,700
Panic disorder	1.1	2,700
Any neurotic disorder	16.2	39,000

MK Population figures - Population Bulletin 2010

What are the priorities and what are we going to do as a result?

Several audits have been undertaken by Milton Keynes Community Health Services and presented to the NHS Milton Keynes Quality Assurance Group. An action plan is being developed referencing the preventing suicide toolkit [52] to ensure full compliance with the national strategy for suicide prevention. [53] The local Mental Health Strategy is being reviewed, objectives are being developed to enable the achievement of the objectives of the prevention strategy.

The Increasing Access to Psychological Treatment programme aims to ensure that evidence-based cost efficient therapies are made available to people in the community with mild-to-moderate depression and anxiety. The Increasing Access to Psychological Treatment (IAPT) programme is currently provided to 12 GP practices and will reach all 28 practices by March 2012.

New skills training is being provided to enable roll out the of the IAPT programme; the service currently provides for 4% of the required need for the Milton Keynes population. There is confidence that the target of 10% for the end 2011/12 will be achieved.

5.4.1 Older People with Mental Health Problems

Who's at risk and why?

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. This section describes the particular mental health conditions and prevalence rates that impact on older people's health in Milton Keynes.

Level of need in the population

National Overview: There are approximately 820,000 people with some form of dementia in England. Its incidence (the number of new cases per year) and prevalence (the number of cases at any one time) rise exponentially with age and it affects men and women from all social and ethnic groups. It is estimated that by 2021 there will be one million people with dementia and this is expected to continue to over 1.7 million people by 2051. [54]

Dementia can affect people of any age but is most common in older people. It is anticipated that one in 14 people over the age of 65 and one in six people over the age of 80 have a form of dementia. [55] Onset before the age of 65 is known as 'early onset dementia' and it is estimated that there are approximately 16,000 people in the UK with early onset dementia, however, it is also recognised that this figure could be up to three times higher because not all those with early onset dementia will seek help during the early stages.

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.

National data shows that 64% of older people with dementia are cared for in the community, mostly by

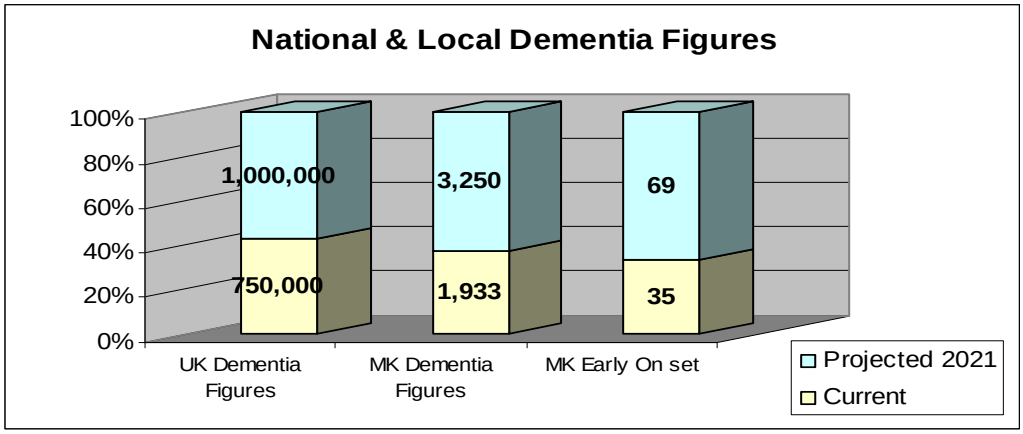
unpaid carers, and 36% live in care homes. Dementia affects 50-80% of people live in residential, nursing and elderly mentally infirm (EMI) homes.

Table 13 shows the overall prevalence of dementia in the over 65s. Applying these rates to the population estimates of older people in Milton Keynes predicts the numbers of people suffering from dementia in 2009. Based on these figures, the total estimated number of people in Milton Keynes with dementia is 1,820.

Table 13: Prevalence of dementia in over 65s

Age	Women %	Men %	Total %	Women (number)	Men (number)	Total (number)
65 – 69	1.0%	1.5%	1.3%	41	62	103
70 – 74	2.4%	3.1%	2.9%	76	91	167
75 – 79	6.5%	5.1%	5.9%	178	110	289
80 – 84	13.3%	10.2%	12.2%	282	142	424
85 – 89	22.2%	16.7%	20.3%	372	139	511
90+	32.0%	28.8%	30.6%	246	80	326

Figure 26: National and local dementia figures



Depression

Depression is the most common mental health problem for older people and prevalence rises with age. Women are more often diagnosed with depression than men. 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. Table 14 shows the estimated 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.

Table 14: Number of over 65s with depression in Milton Keynes in 2009

Age	Women %	Men %	Women (number)	Men (number)
65 – 69	22%	28%	1309	1154
70 – 74	19%	20%	604	588
75 – 79	18%	24%	493	516
80 – 84	22%	27%	466	375
85 – 89	31%	39%	524	324
90+	40%	43%	308	112

Depression can have a profound effect on quality of life, and may also adversely affect physical health. 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.

Suicide

Suicide rates are also higher among older people, particularly men, and increase with age.

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, which equates to 380 to 760 people in Milton Keynes. Among older people living in the community 10-24% (1,900 to 4,600 in Milton Keynes) show symptoms of anxiety. The prevalence of anxiety among older people living in care homes is 6-30%.

Schizophrenia and other severe mental health problems

Relatively few older people suffer from schizophrenia, bipolar disorder and other severe mental health problems, but those who are affected in later life have very complex needs.

Delirium

Delirium is a condition which affects the functioning of the brain and occurs as a result of disease or physiological imbalance. One of its main clinical features is cognitive impairment which makes assessment difficult. Delirium is the most frequent complication of hospital admission for older people. It develops in up to 50% of older patients post-operatively.

Alcohol

Data from the General Household Survey 2007 indicate that 23% of men and 14% of women aged 65 and over exceed the recommended levels of alcohol consumption. This equates to approximately 2688 men and 2046 women over 65 years of age in Milton Keynes. In addition, national survey data indicates that 8% (935) of men aged 65 and over and 3% (439) of women in the same age group drank heavily on at least one day during the previous week of the survey.

Current Services in relation to need

Dementia services in Milton Keynes are delivered by the Milton Keynes Community Health Services, the council and the voluntary sector:

Milton Keynes Council

- Telecare
- Sheltered Housing
- Domiciliary Care
- Intermediate Care
- Residential / Nursing Care

Milton Keynes Community Health Services

- In-patient assessment unit
- Community and recovery teams
- Day hospital
- Memory assessment service
- Working age dementia service

Voluntary Sector support includes Alzheimers, Age UK and costs approximately £1million per annum

Evidence of what works and policy drivers

National Dementia Strategy key priorities:

- Good quality early intervention diagnosis for all
- Improved community personal support services
- Improved quality of care for people with dementia in general hospitals
- Living well with dementia in care homes
- Reducing the use of Anti-psychotic drugs.

5.5 Dental Health

Who's at risk and why?

Children

Oral diseases are among the most common chronic diseases, making them important public health issues. Oral diseases are largely preventable and share common risk factors with other diseases e.g. poor diet, tobacco and alcohol use.

Adults

A British adult dental health survey (ADHS) has been carried out every 10 years since 1968 and one of the most dramatic changes in the oral health of adults over this period is the percentage of adults who have no natural teeth (edentulous). In 1978 28% of the survey population had no natural teeth. By 2009 this figure had fallen to 6%. The survey data also show that more people are retaining their teeth into old age with 53% of all adults over the age of 85 having some natural teeth.

Level of need in the population

Children

Results from recent surveys have shown that there continues to be an improvement in the oral health of the children in Milton Keynes. Data from the 2007/08 survey of five-year-old children showed that the level of decay in children in Milton Keynes was the same as the England average. In addition, results from the 2008/09 survey of 12 year old children showed that Milton Keynes children had, on average, fewer decayed, missing or filled (adult) teeth than the England average.

Adults

Poor oral health can be associated with social factors. It is generally accepted that adults need at least 21 teeth for a functional dentition and the ADHS found that those from managerial and professional occupational households were more likely (91%) to have 21 or more teeth than adults from routine and manual occupation households (79%).

The changes in adult oral health will alter the future need for some dental services. As more people retain their own teeth into old age they are likely to require additional restorative treatment services, for example fillings, whereas in previous years there may have been a greater demand on denture services.

Current Services in relation to need

The local Oral Health Promotion (OHP) Service continues to work with a variety of groups across the city. The majority of their work is carried out within “early years” settings. This work is delivered in partnership with a variety of agencies such as the community dieticians, health visitors and family support workers. All of the OHP early year’s activities take place in partnership with the Milton Keynes Children Centre’s.

All dental practices in Milton Keynes have now been visited by the Dental Practice Advisor as part of

the ongoing practice visit programme. They have been quality assured and supported to meet decontamination and Care Quality registration requirements.

In 2010 an oral health survey of adults in Milton Keynes with learning disabilities began. The results from this survey will provide valuable information about the oral health of this vulnerable group. It will also be possible to compare the data from this survey with the 2009 ADHS results and the information will be used to inform future commissioning plans.

NHS Milton Keynes is working with Oxford Postgraduate Dental Deanery and other Primary Care Trusts on the further development of a scheme to support dentists who are in difficulty. The scheme will provide mentoring, support and advice to dentists and its aim is to ensure that dentists are supported to maintain professional standards thereby protecting the public.

Milton Keynes is working with four other Primary Care Trusts in the South East on various projects including specialist dental services, access to NHS dental services and contracting arrangements.

User view

Regular dental surveys are carried out and the information is used to assess the local population's oral health.

In 2009 an Adult Dental Health Survey (ADHS) [56] was carried out in England, Wales and Northern Ireland. The results are not available at a regional level but the national results can be applied locally to give an indication of how adult oral health in Milton Keynes has changed over recent years.

What are the priorities and what are we going to do as a result?

Despite the improvement in the number of patients accessing a dentist in Milton Keynes in recent years, Department of Health data has shown that out of the 152 Primary Care Trusts in England, NHS Milton Keynes commissions the fifth lowest ratio of NHS dental service capacity per head of population (Department of Health data, December 2010). The Primary Care Trust will need to monitor the results from future patent surveys and other information to determine whether patients are able to adequately access NHS dental services within the city. As the population in Milton Keynes continues to grow, additional capacity will be required and if patients are having difficulties accessing dental services the Primary Care Trust will need to consider whether additional services should be commissioned.

NHS Milton Keynes should continue to support the national NHS dental epidemiology programme. The data from these surveys provide valuable information that can be used to inform future commissioning plans.

As the Primary Care Trust moves into cluster arrangements with NHS Northamptonshire good practice, concerning preventative, commissioning and treatment services, should be shared between the Trusts. This will reduce duplication and increase knowledge within the teams.

6. Summary of Findings and Recommendations

A number of recommendations are outlined throughout the document, and these will be used to develop the priorities of the Health and Wellbeing Strategy. Whilst some of the findings don't differ significantly year-on-year, some key overarching themes are emerging.

Population

- The current estimated population of Milton Keynes is 245,280 – this represents an increase of 16% since 2001, which was when the last Census was undertaken
- The population is expected to increase to 272,740 by the year 2018, an increase of 15% (from 2009)
- Milton Keynes has a significantly higher proportion of people in the younger age groups.
- There will be a 26% increase in the number of children aged 5 to 16 (from 2009)
- The proportion of older people is low, but this is set to rise significantly. There will be an 85% increase in the number of people over-60 by 2026 (from 2009)
- The number of very old people, aged 85+, is forecast to grow from 6,970 in 2009 to around 16,160 in 2026 – this is growth of 132%. This is significant as it will have an impact on the services provided to older people
- The GP registered population is 239,613 – this is important to know if so we understand peoples' access to primary care

BME (Black Minority Ethnic) Groups

- The BME population has increased from 28,500 in 2001 (13.4%) to 46,000 in 2009 (19.4%)
- England average is 17.2%
- The largest single ethnic group after White British is Indian (3.5%)
- Pakistani BME Group had the highest growth – 1800 people in 2001 to 4,300 in 2009.
- BME Groups represent 32.8% of school pupils (2011 – increase of 12.1% since 2005)
- More than 30 different first languages are spoken across Milton Keynes

Recommendations for Milton Keynes

An understanding of population characteristics and changes, such as age, ethnic make-up and growth, help determine the need for certain services. It also gives an indication of the prevalence of certain illnesses and conditions.

This population profile means we need to commission services that

- Recognise different groups with different needs, with varying access to services and outcomes
- Are targeted and reflective of its comparatively young population
- Also crucial that the vast increase in the elderly and very elderly population are planned for
- Note the higher prevalence of certain conditions developing in Black and Asian groups, such as diabetes

Groups with Specific or Additional Needs

- Estimated 25,000 carers living in Milton Keynes in 2011– approx 5000 providing more than 50 hours care a week
- In 10/11 143 people were housed in temporary accommodation, compared to 84 in 09/10 (70% increase, national trend downwards)
- 12,404 (13.2%) households identified as living in unsuitable housing (2009) across all housing types
- 7,456 households in Milton Keynes experiencing fuel poverty (2009)
- 13,393 people over 65 with a limiting long-term illness (2011)
- 690 people are known to Learning Disability services – national prevalence data suggests this should be 874
- Numbers of diagnosed cases of HIV have trebled in six years**.** People of sub Saharan African origin are affected disproportionately

Recommendations for Milton Keynes

For the groups of people within the population with specific needs, we need to understand and quantify how many people are affected.

We need to ensure:

- Informal carers are supported – the number of estimated carers is far higher than the number receiving services
- As demand for housing increases, recognise the link between poor housing conditions and ill-health
- We look at strategies to ensure a healthy 'old-age'
- HIV prevention and treatment is a priority

There are information gaps in the JSNA around certain groups, including lesbian, gay, bisexual, transsexual and transgender population, asylum seekers, refugees and gypsies and travellers. This needs to be addressed for future iterations.

Income deprivation

- Large parts of Woughton ward, and parts of Eaton Manor ward and Fullers Slade are in the most deprived 10% on the National Scale for Income Deprivation Domain
- This trend is increasing as more affluent areas become less deprived
- 20.6% of children living in poverty (1% increase)
- 11.4% of working age population claiming out-of-work benefits (England 12%)
- 6,492 (4%) people claiming jobs seekers allowance, this is higher than the England average of 3.8% (Jul-Sep 2011)
- 1,105 (17.1% of claimants) unemployed for more than a year (Jul-Sep 2011)
- The overall level of income support claimants in Milton Keynes is lower than the England average, but nearly double in Woughton and Eaton Manor wards
- Woughton ward has twice national average for disability benefits claimants

Recommendations for Milton Keynes

- Deprivation increases the risk of early death and is associated with higher rates of illness and disease
- Deprivation is linked to 'risky' behaviour e.g. smoking
- Income is a key detriment of health – we need work with partners and contribute to strategies aimed at reducing income deprivation, which will lead to a reduction in health inequalities
- Long-term unemployment needs to be reduced

Lifestyle

- 23.1% of adults smoke (0.2% increase, England average 21.2%) - Smoking is one of the main causes of avoidable ill-health and preventable deaths. The greater prevalence of smoking in disadvantaged communities accounts for 50% of the mortality gradient between the most and least deprived areas
- 25.3% of adults are obese (England average 24.2%) - Obesity is associated with increased risk of a range of chronic illnesses including Type II diabetes, coronary heart disease, hypertension, stroke and some cancers. The cost to the NHS of treating obesity and associated consequences is estimated as £9.7 billion per year nationally
- 10.9% adults are physically active (0.8% increase, England average 11.5%). An active lifestyle improves physical and mental health, reduces all cause mortality and the risk of chronic illnesses
- 24.2% adults drink above the recommended levels of alcohol which increases the risk of a range of conditions (and increased risk of mortality) including cancer, heart and liver disease and stroke
- High rates of hospital stays for alcohol related harm – 1,853 per 100,000, increasing in line with national trend

Recommendations for Milton Keynes

Lifestyle choice is a key determinant of health and wellbeing. Lifestyle issues such as smoking, obesity and excessive alcohol consumption are related to chronic health conditions which have implications for lifespan and disability lost life years.

- Although the number of people who smoke or are obese is decreasing, they remain above the England average – we need to ensure this decreasing trend continues
- High levels of alcohol consumption in the population is an issue

Mental Health

- Up to 39,000 people experiencing some kind of mental health problem at any time
- 0.58% of population on disease register for schizophrenia, bipolar disorder and other psychoses – there are higher levels in deprived areas
- High number of hospital stays for self-harm compared to the rest of England

- Number of people with dementia current estimate 1,933 – for 2021 this rises to 3,253. This represents an increase of 68% over next 11 years

Recommendations for Milton Keynes

Given the size and range of people experiencing mental health problems, we need to ensure:

- Services are designed to meet need and not age
- We need to continue to plan for the increase in number of people with dementia

Children and Young People

- Educational attainment (5 GCSEs incl English / Maths) – although improving, below national average – Milton Keynes 51.8%, England average 57.9%
- Gap between attainment for different ethnic and income groups remains stubbornly persistent
- There are 541 young people not in education, employment and training, 279 children in care
- The teenage conception rate has fallen by 21.5% since 1998, and Milton Keynes is in the top 25% most reduced local authority areas in the country
- Childhood immunisation rates have remained stable in Milton Keynes at 95%
- Local breastfeeding rates remain above the national average
- 14.6% of primary age pupils are eligible for free school meals – the England average 19.2%
- 9.8% of children in reception year and 19.9% in Year 6 are classed as obese (Compared to the national average of 9.4% at reception year and 19.0% at Year 6)

Recommendations for Milton Keynes

A child's early years have long-term effects on their physical and mental health, and early intervention can improve the outcomes for children and young people. There are inequalities in the outcomes of children and young people across Milton Keynes.

Older People

- There will be a significant increase in the over 65 Population:

Year	2015	2020	2025	2030
% increase	21	45	69	96

- 10,190 people over 65 are living alone (2011)
- 6,810 pensioners living in Milton Keynes without access to their own transport (2011)
- There are currently 3,160 carers over 65 (2011)
- Number of over 65s having falls –13,000 in 2009 to 24,000 in 2026 – related hospital admissions will increase by 15% over 5 years
- By 2030 the number of people receiving community based services such as homecare, day services and meals on wheels, will increase by 96%

Recommendations for Milton Keynes

The increase in the number of older people will mean an increase in the coasts associated with looking after frail and vulnerable older people. We need to plan for this by:

- Having preventative services that maintain older peoples' independence
- Looking at the broader determinants of health and wellbeing, including isolation
- Establish strategies encouraging people to have a healthy old age

Key Mortality Statistics 2011

- Excess winter deaths 92 – this is the number of people aged 65 or over who die in winter months over and above the number expected
- Life expectancy (male) 77.9 has dipped and is just below the national average. Life expectancy (female) 82.2 is rising and now matches the national average
- The difference in average life expectancy between the least and most deprived wards is 9.1 years and remains stubbornly persistent
- Infant deaths 19 – this has remained stable, and is slightly above the England average
- Smoking related deaths 282 – this is a slight increase from the previous year, and lung cancer remains the most common cancer, causing 6.2% of all deaths in Milton Keynes across all age groups
- Early deaths: heart disease and stroke 159 – this is the number of people aged under 75 who die from heart disease and stroke over and above the number expected – Coronary heart disease and stroke accounted for 18.0% and 6.7% of total deaths respectively in 2009

- Early deaths: cancer 236 – this is the number of people aged under 75 who die from cancer over and above the number expected
- The major causes of death are cardiovascular disease (the commonest cause of death), cancers (the commonest cause of death under 75 years) and respiratory disease. These are also leading causes of disability especially cardiovascular disease
- Death rates from coronary heart disease (including heart attack), pneumonia and accidents were all statistically significantly higher than the average for the country.

Next Steps

Milton Keynes population is growing in terms of size and diversity, and its age profile is also changing. Different groups and populations have different needs, different access to services and different outcomes. Service provision needs to reflect this varying and changing need.
We think these are the emerging priorities based on what we have found so far. These will be scoped out further as we develop a Health and Wellbeing Strategy

- Wider programmes that impact on health and well being and wider determinants e.g. impact of poverty, housing, education
- Dealing with demographic changes
- Prevention and Early Intervention
- Heath inequalities and tackling underlying determinants

We also recognise the JSNA needs to be developed further – we need to look at:

- Ensuring it meets statutory guidance due in January 2012
- Establish timetable of data and intelligence refresh throughout year
- Develop a programme of needs assessments for those areas where there are gaps in information
- Make better use of information we have about patients and clients – we have used lots of estimated data based on anticipated prevalence rates, we need to compare this with actual number of people

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