MILTON KEYNES COUNCIL

NHS
Milton Keynes Clinical Commissioning Group

www.mkiobservatory.org.uk/

Joint Strategic Needs Assessment 2012/13

M12390

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1.0 Introduction

The Joint Strategic Needs Assessment (JSNA) is a document which describes what we know about the health and wellbeing of people living in Milton Keynes. The development of a JSNA incorporates user and professional involvement and involves analysis of both quantitative and qualitative data. The aim of the JSNA is to provide information about the current and future needs of the population and to provide clarity about the key priorities for the future.

Publishing a JSNA has been a statutory requirement for all NHS primary care trusts (PCTs) and local authorities since 2008. However, the JSNA now has a more significant role, sitting clearly within the Health and Social Care Act (2012) and acting as a key document underpinning the Joint Health and Wellbeing Strategy. This strategy provides a clear direction for commissioners to buy services that lead to a reduction in health inequalities and an improvement in the overall health of the population.

The JSNA is a dynamic document which requires continual review and updating as new information and challenges emerge. This refresh of the existing JSNA has been developed jointly by a working group with membership from Milton Keynes Council, NHS Milton Keynes, Milton Keynes Clinical Commissioning Group, and Community Action MK and has been informed through the engagement of both statutory and voluntary groups.

Milton Keynes is a growing population both in size and diversity. According to the Census 2011, Milton Keynes borough has grown by 17% in the last 10 years and is now home to 248,800 people. The population will continue to grow but not all age groups will grow at the same rate. Population growth in the 60-79 years and the over 85 years groups is forecast to grow by 64% and 95% respectively by 2026. As new people move into Milton Keynes, diversity is increasing, with only about 66% of children in Milton Keynes' schools being 'White British'.

We know there are certain essentials that need to be met for people in our communities to live a life in which they can participate fully in their community: a decent house to live in; a decent income; a good education; employment; a safe and pleasant environment; efficient transport systems to give access to jobs, shops, services and friends; good relationships; and good health. Communities which have lower levels of inequalities tend to be happier and have fewer social and health problems, benefitting all sections of society.

Overall, the JSNA provides an opportunity to inform the Health and Wellbeing Strategy which will ensure that the future commissioning decisions maximise both social and health outcomes at optimum cost and that there is a strategic approach to the reduction of health inequalities which will be of benefit to the whole of Milton Keynes.

This JSNA provides a description of a range of factors that impact on the health and wellbeing of people who live in Milton Keynes, including physical and mental health and the wider determinants of health such as housing, employment, education,

lifestyles, crime and disorder. It outlines the key areas of success, key areas impacting on health inequalities and priorities for the future.

This JSNA is based on a large range of strategy and assessment documents, consultations and evidence of effectiveness papers which will be referred to throughout the document. In particular reference is made to Milton Keynes Council Social Atlas 2012 [1], The Director of Health Annual report 2011, [2] the two outcomes benchmarking support packs: CCG level and Local Authority level, and numerous health and social "profiles" [3] referenced in the appendix of this JSNA.
All these documents and the full JSNA report are available on the MKi Observatory website which holds the pan-Milton Keynes data sources used to develop it.

2.0 Population and Place

2.1 Population and Growth

Population size and past growth

In 2011, the population of Milton Keynes borough was 248,800. It is one of the fastest growing local authorities in England. Between 2001-2011, there was an increase of 36,100 people, (an increase 17%) making Milton Keynes the 7th fastest growing local authority in this period, exceeded by only 5 London Boroughs and Manchester;

Milton Keynes population grew by 40% between 1991 and 2011. The Borough's residents in 2011 were four times the resident in 1967, when Bletchley, Wolverton and Stony Stratford and fifteen villages together with intervening farmlands were designated as a new town. Most of the growth is focused in the New City areas, which is now estimated to be over five times larger than in 1967.

The high population growth is expected to continue into the future. The Core Strategy, which sets out the local vision to 2026, forecasts an average annual housing completion rate of 1,720 dwellings. This prediction of the rate that houses will be completed is consistent with the average level achieved over the last 20 years (1,610) and will accommodate the expected continued growth of the borough population.

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 age groups of the population.

Further information may be found in the Population Bulletin 2011/12.[4]

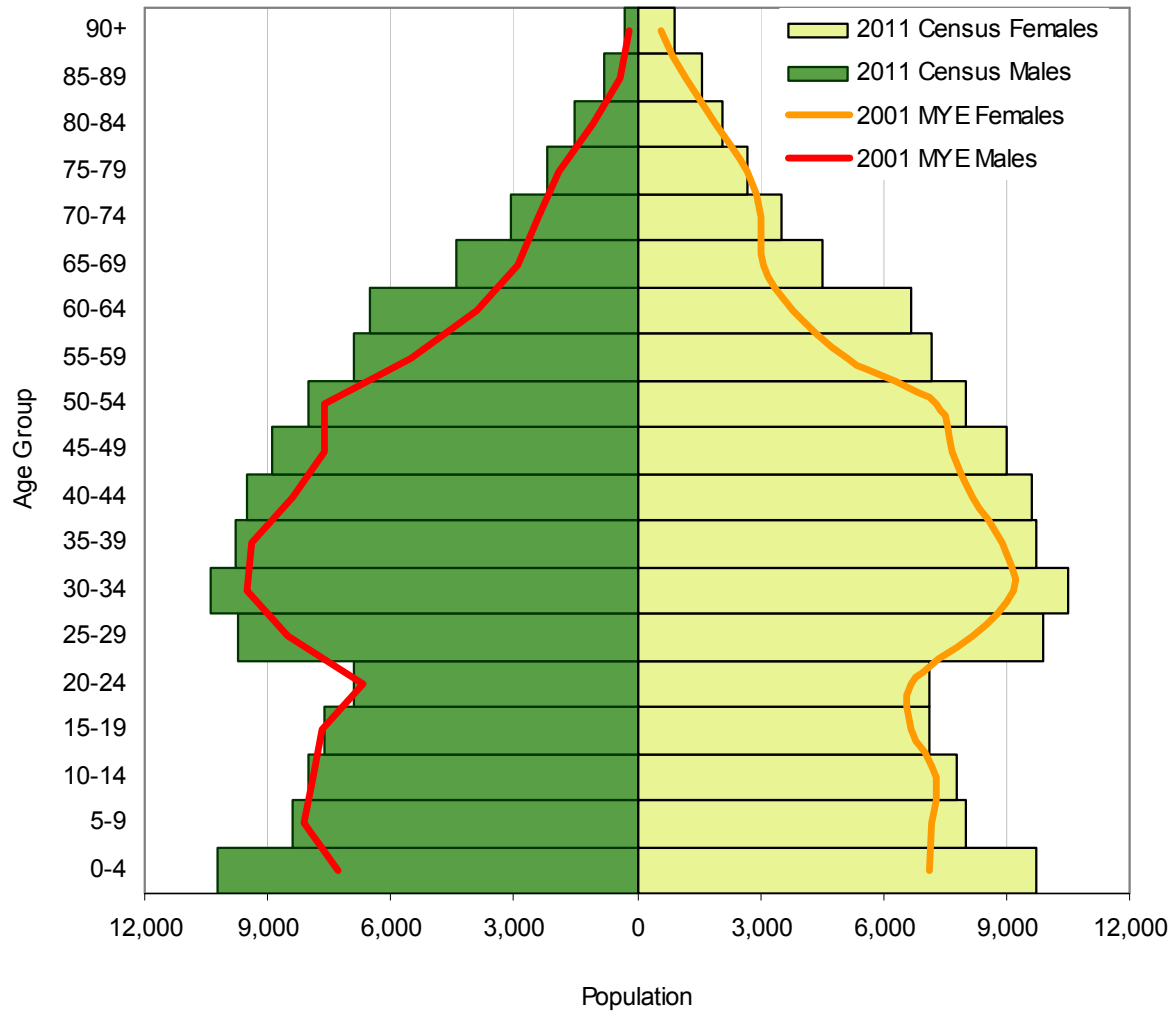

Figure 1: First Results Milton Keynes Intelligence Observatory

Source: Census 2011

The population pyramid (figure 1) provides details of pattern of the Milton Keynes population growth. The pyramid compares the age profile reported by the 2011 census with the age structure in Milton Keynes in 2001. The bars are the 2011 results – male in dark green, females in light green – whilst the 2001 results are the lines - males in red and females in orange.

All age groups grew between 2001 and 2011. However, the highest growth rate occurred in the 60-64 age group; it increased by 74% from 7,600 in 2001 to 13,200 in 2011. Additionally the 0-4 age group also had a high growth rate of 38% or 5,500 people between 2001 and 2011. This is backed up by the number of births increasing for example in 2010 there were 3,900 births in Milton Keynes, in 2000 there were 2,900.

Within the 20-24 age group growth was very low and which is significantly different from the growth among those aged 25-29. In part, this difference may be explained by 20-24 year olds migrating away to other towns and cities for university.

Population projections to 2026

Population projections in this section are taken from the 2011/12 Population Bulletin. They do not take into account the results from the 2011 Census. Population projections based on the 2011 Census data will be released in the summer of 2013.

Young People

Overall the growth in the population of young people will be strong and exceed that observed nationally. For example the school age population is expected to grow by over a third in Milton Keynes between 2011 and 2026, compared to a 13% increase in the school age population nationally. However the growth in 0-4 year olds to 2026 is expected to be just 2% in Milton Keynes, compared to a 5% increase in this age group nationally.

Working Age Population

The working age population of the borough is expected to increase between 2011 and 2026, 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 ageing 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 17% to 2026. National projections to 2026 show a reduction in the size of this age group.

There are similar differences in the older working age groups. Nationally the 25-59 year old age group will grow by 6% but reduce as a proportion of the total population from 47% to 45%. In Milton Keynes in 2010 25-59 year olds made up 51% of the total population. The population in this age group will grow by 8% to 2026. However, this age group will only form 45% of the total population.

Older People

The borough historically had a younger age profile than England as a whole, and a relatively small older population. In 2011 there were around 40,620 persons aged 60 and over living in the Borough, which was 17% of the total population. By 2026 this age group will have grown to around 69,080 and will form 23% of the borough population. This group shows the largest increase nationally to 2026 of 32% but will grow by around 70% in Milton Keynes.

The number of very old people, aged 85+, is forecast to grow from 3,625 in 2011 to 7,060 in 2026 – a growth of 95%. 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 2.

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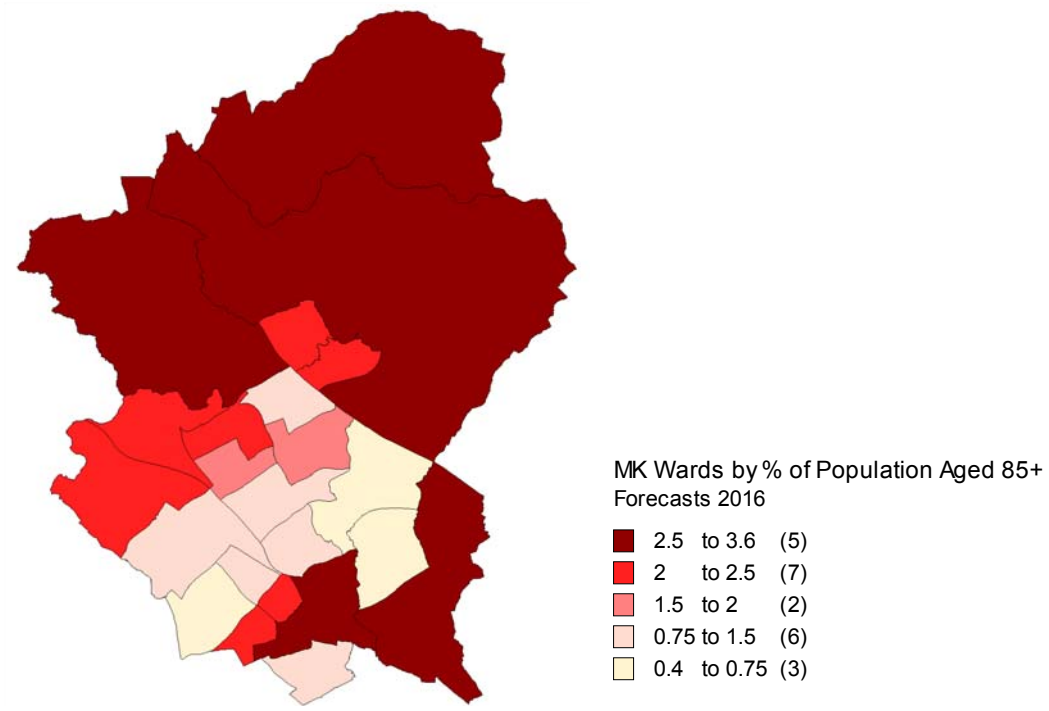


Figure 2: Percentage of the ward population expected to be aged 85 plus by 2016

Source: Census 2011

The population growth in the short term is projected to increase as follows:

Year	Urban	Rural	Borough
2010	204,170	37,330	241,500
2011	208,040	37,710	245,750
2012	210,240	38,220	248,470
2013	212,980	38,920	251,900
2014	217,000	39,480	256,470

Table 1: The population grown in the short term is projected to increase as follows.

Source: Census 2011

It also shows that about 16% of the borough population lives in rural areas, in particular older population. This has important implications for service delivery and housing.

Ethnicity

The 2011 Census[5] produced by the Office for National Statistics can give an indication of some of the changes in ethnicity of the population of Milton Keynes since the last census in 2001. These can be seen in the chart below:

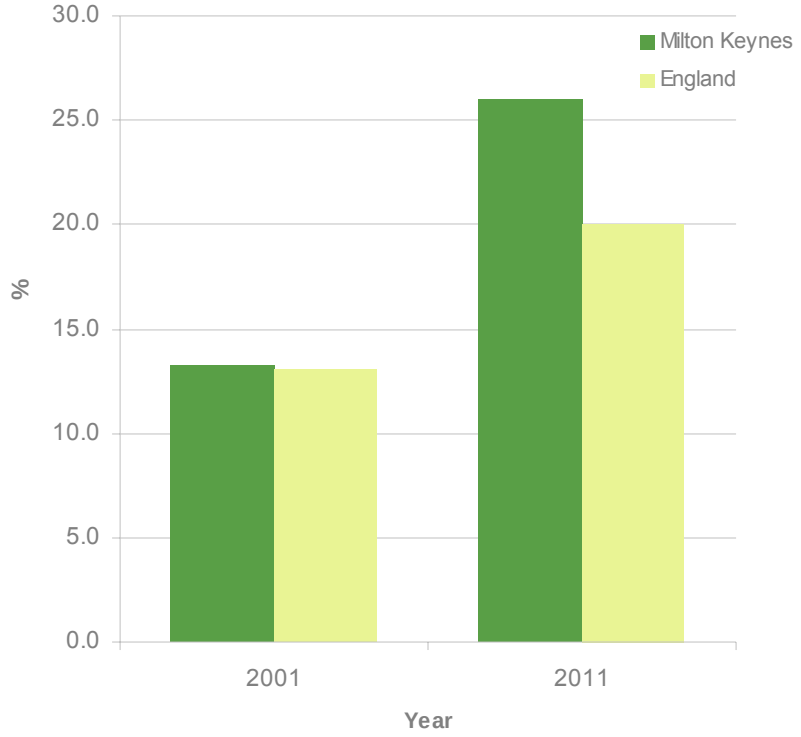


Figure 3: Percentage of the population that is classified as 'non white British' over time.

Source: Census 2011

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 13.2%. By 2011, 20% 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 26%.

Figure 5 below illustrates the changes that have occurred in the ethnic composition of the population. This illustrates that the Black African ethnic group has grown from 1.3% of the population to 5.2%. This is the largest single ethnic group and also the largest increase. The population size is estimated to be 13,100. The 'other white' group has also risen, from 2.5% of the population to 5.1%, this is an estimated population size of 12,600. It is the group that would include European migrants from the expansion of the EU. Mixed ethnic groups have also increased between 2001 and 2011 to form the third largest black and minority ethnic group.

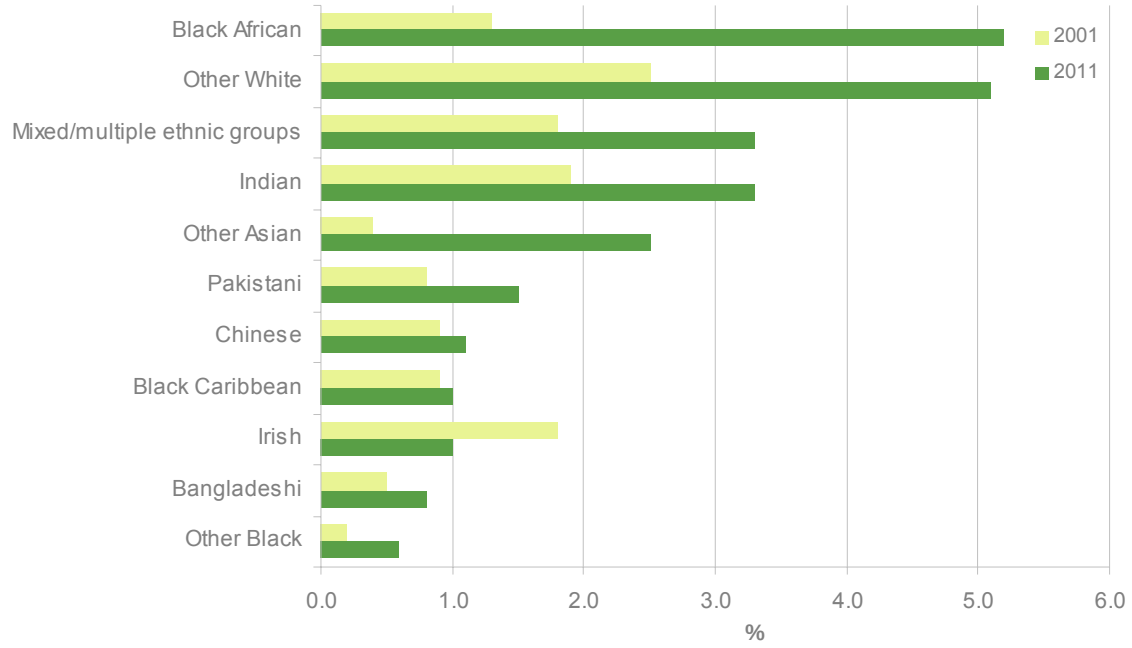


Figure 4: Change to ethnic group in Milton Keynes, 2001 - 2011

Source: Census 2011

	Milton Keynes		England
Ethnic Group	Persons	%	%
White: British	183,934	73.9	79.8
White: Irish	2,498	1.0	1.0
White: Gypsy or Irish Traveller	72	0.0	0.1
White: Other White	12,590	5.1	4.6
Mixed/multiple ethnic groups	8,235	3.3	2.2
Asian/Asian British: Indian	8,106	3.3	2.6
Asian/Asian British: Pakistani	3,851	1.5	2.1
Asian/Asian British: Bangladeshi	1,989	0.8	0.8
Asian/Asian British: Chinese	2,722	1.1	0.7
Asian/Asian British: Other Asian	6,114	2.5	1.5
Black/Black British: African	13,058	5.2	1.8
Black/Black British: Caribbean	2,524	1.0	1.1
Black/Black British: Other Black	1,549	0.6	0.5
Other Ethnic Group: Arab	565	0.2	0.4
Other ethnic group	1,014	0.4	0.6
All usual residents	**248,821**	**100.0**	**100.0**

Table 2: Ethnic mix of the Milton Keynes and England population, 2011

Source: Census 2011

The Indian population accounts for 3.3% of the Milton Keynes population, this is higher than the average for England. 1.5% of the Milton Keynes population are Pakistani, a lower proportion when compared with England.

Age

Age Structure

Figures 6 and 7 below show the age structure of the population of Milton Keynes borough in 2010 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 35-44 year olds in Milton Keynes are the largest proportion of the population. 40-44 year olds are the largest 5-year age group.

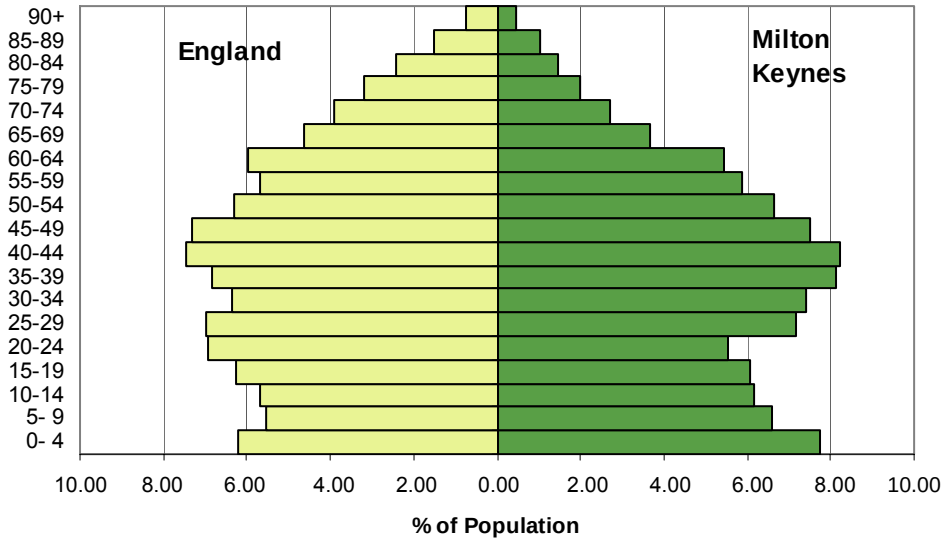


Figure 5: 2010 Age Structure

Source: Census 2011

By 2026, the Borough's population will have changed. The median age will be almost 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 forecast to decrease in number in the Borough, as is the 25-29 age band. The number of people aged over 55 years old will have seen a large increase in the Borough, particularly in the 75-79 age group. 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.

Age Groups in the Borough

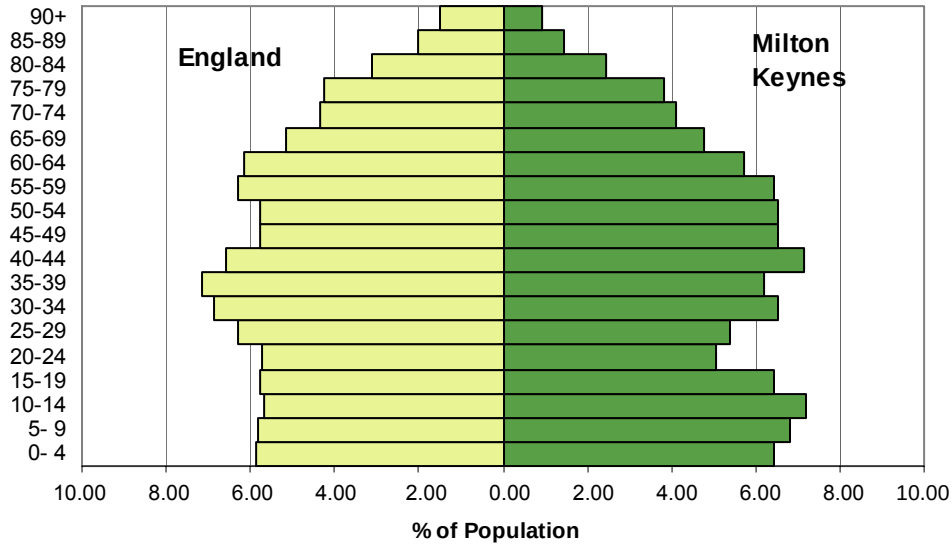


Figure 6: 2026 Age Structure

Source: Census 2011

Figure 6 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 18,730 in 2010 to 19,130 in the year 2026, an increase of only 2%. The population is forecast to peak in 2016, with 9% growth from 2010. The national 2008-based projections show a 5% increase between 2010 and 2026 for the 0 to 4 year olds.

School Age Population

There will be a 35% increase in the number of children aged 5 to 16 in the borough between 2010 and 2026. In contrast, the figures for England show 13% growth to 2026.

Young Adults – 17 to 24 years old

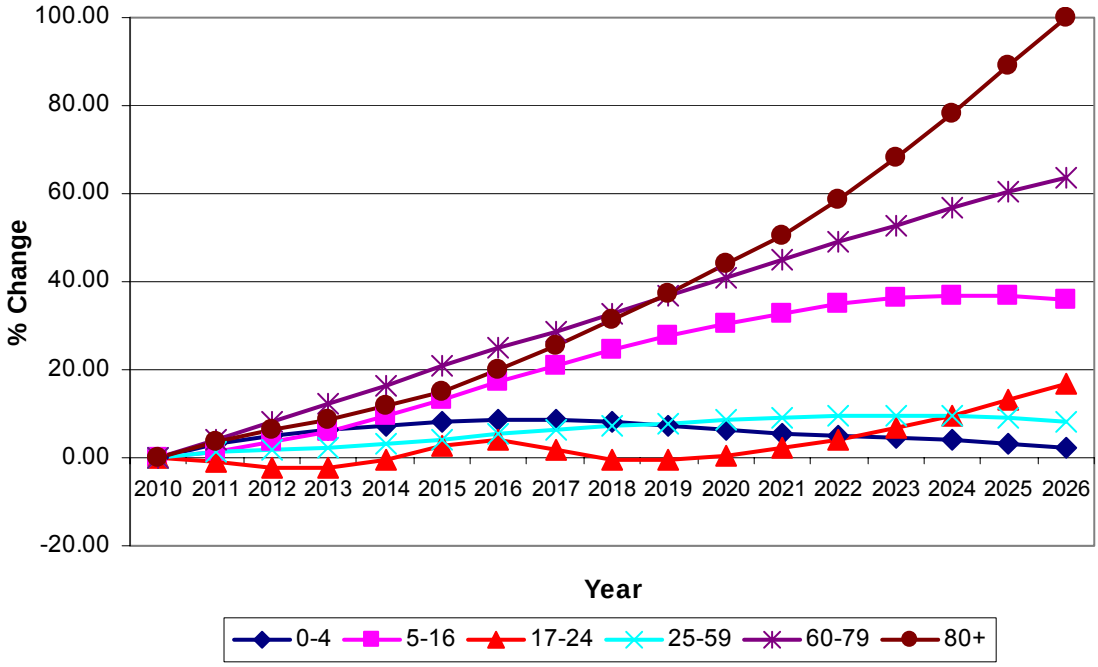
The young adults in the borough are expected to increase in number from 22,110 in 2010 to 25,850 in 2026, an increase of 17%. The most substantial growth in this age group occurs after 2021. Between 2010 and 2026 national projections anticipate this age group decreasing by 4.8%.

Adults – 25 to 59 years old

The number of people aged 25 to 59 in the borough is expected to increase over the period 2010 to 2026 from 123,210 to 133,260, a rise of 8%. For England, an increase of 6% is expected over the same period.

Older People – Aged 60 and over

In 2010 there were 40,620 people aged 60 and over in the Borough, and this number is expected to increase by 70% to over 69,080 by 2026. The corresponding percentage increase nationally is 32%. In Milton Keynes the 60-79 age group is forecast to grow by 64% in this period. However, the 80+ age group is forecast to



increase by 100%, from 7,200 population to 14,400.

Figure 7: Percentage change in age groups from 2010 - 2026 in Milton Keynes.

Source: Census 2011

Birth and Death Statistics

Live Births 2011	3,927
Total Fertility Rate 2011	2.1
Deaths 2011	1,552
Standardised Mortality Ratio 2011	103

Table 3: Birth and Death statistics 2011.

Source: Office for National Statistics. Live Births by Area of Usual Residence of Mother 2011 and Deaths by Area of Usual Residence 2011

Change of Population of children and Young People in Milton Keynes

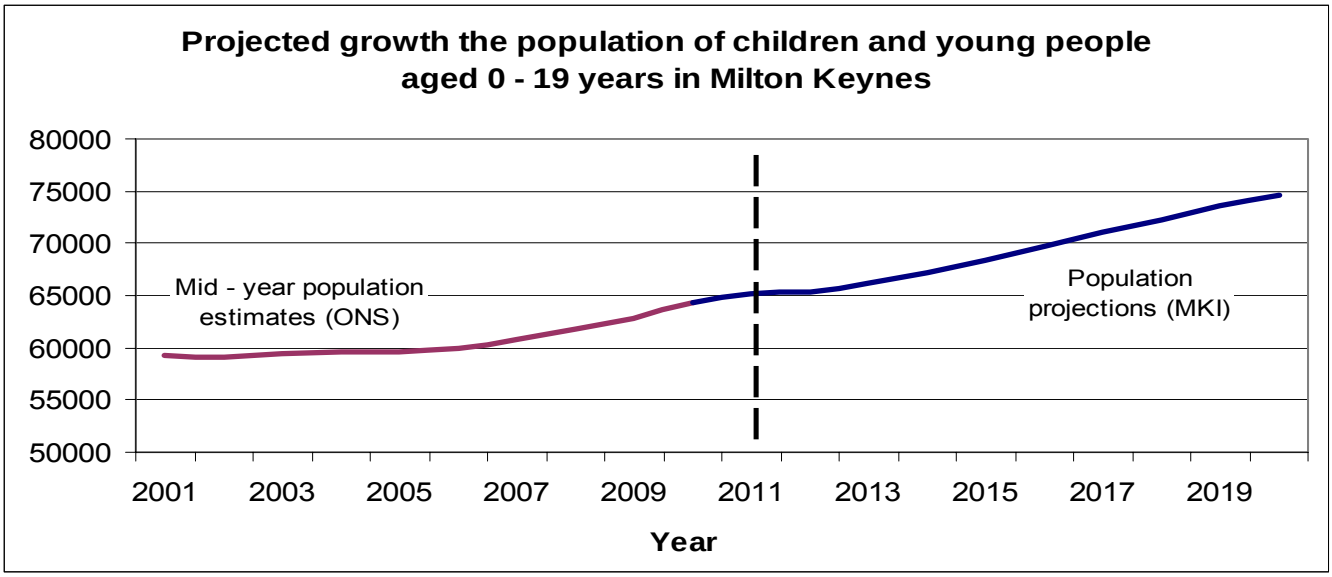


Figure 8: Population growth 0 - 19 years in Milton Keynes 2001-2019.

Source: Data for 2001-2009 are mid-year population estimates produced by the Office for National Statistics (ONS).

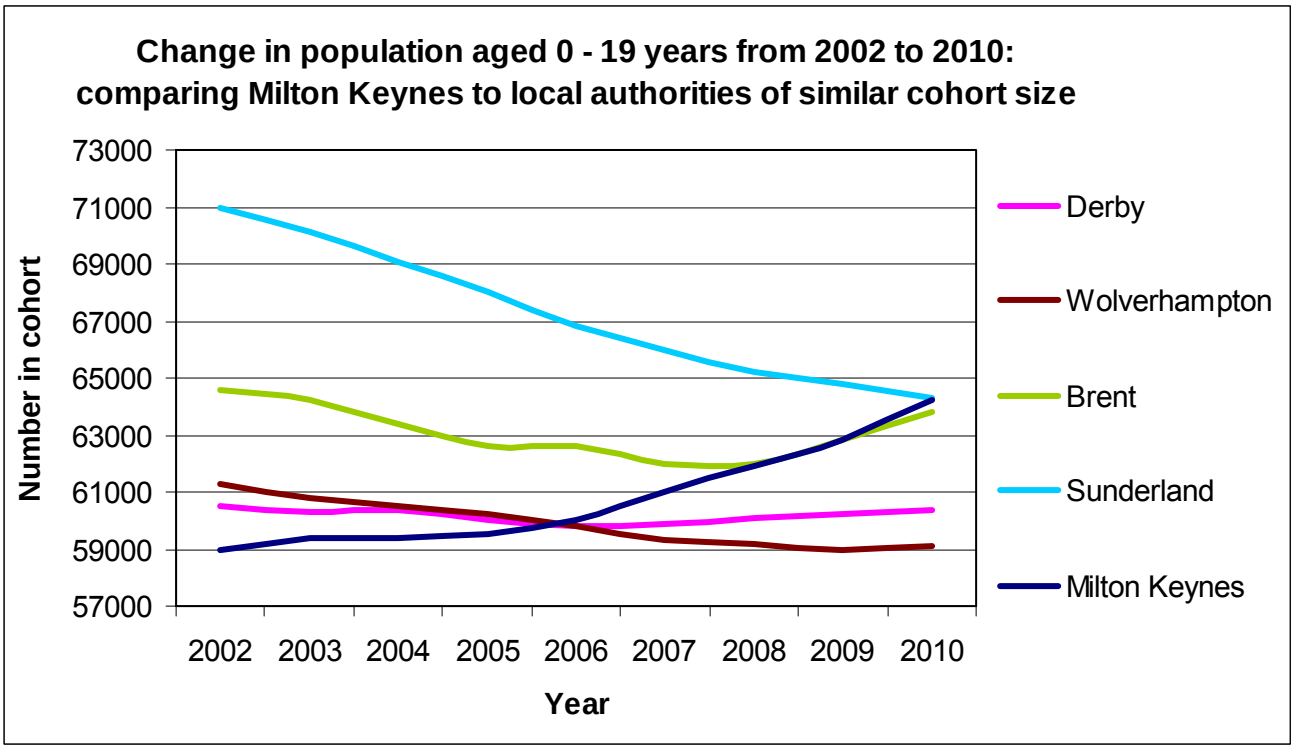


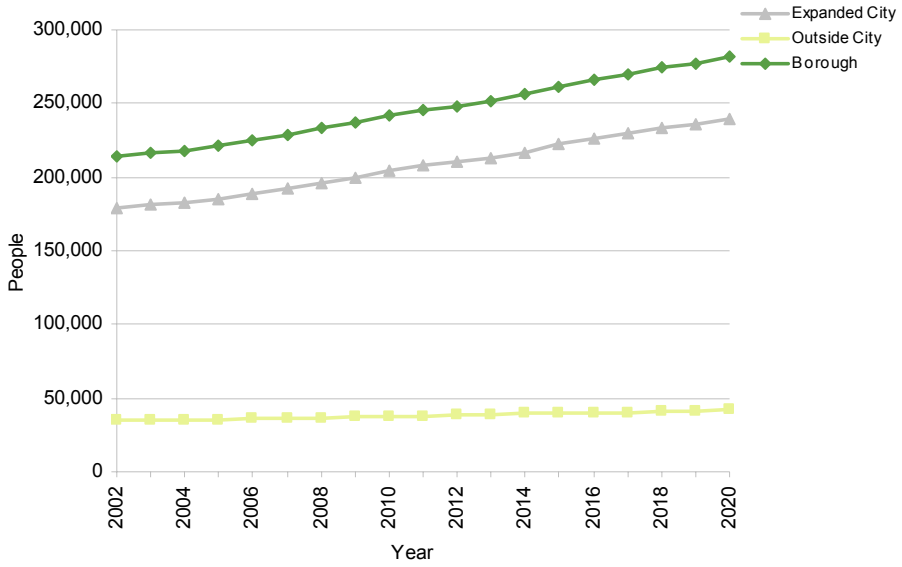
Figure 9: Change in population aged 0-19 years from 2002 - 2010

Source: mid-year population estimates (ONS)

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 2011 and 2020, 17,000 houses are anticipated to be built in the Borough, allowing for a projected growth in population of over 35,000 people.

- The population of the borough of Milton Keynes is expected to increase by 35,590 people, to 281,350 by the year 2020, an increase of 14.5% from 2011.
- The majority of the growth will occur in the expanded city, which will reach a



population of over 239,050 by 2020.

Figure 10: Population Growth to 2026

Source: Milton Keynes Council. Population Bulletin 2011/12

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 23% of the population will be aged 60 plus by 2026. This compares to around 14% in 2001.

Households and Household Size

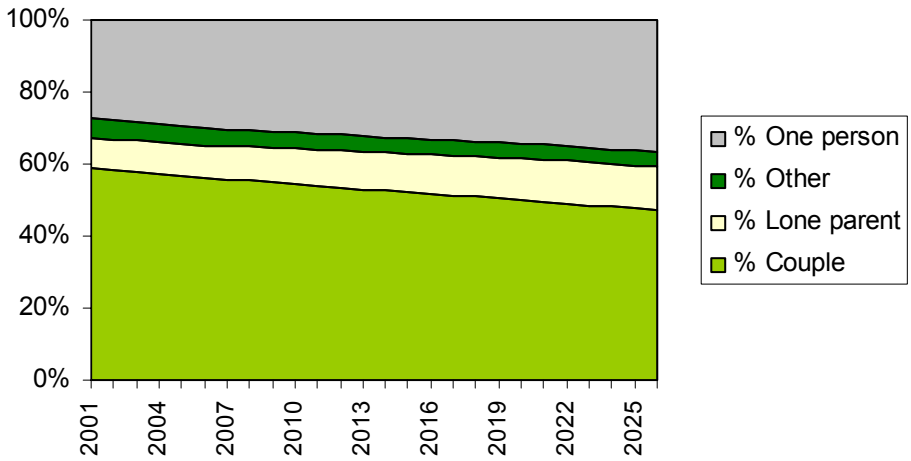


Figure 11: Difference in Projected Household Types over Time.

Source: Milton Keynes Council. Population Bulletin 2011/12

Nationally, average household size has fallen from 3.1 persons in 1961 to around 2.3 persons in 2008 for England. This is forecast to continue declining to 2.2 by 2028. The decline since the 1970s can be largely attributed to an increase in the number of single person households. This is a result of divorce/separation, the greater economic independence of people enabling them to live alone, as well as an increase in the population of older people. Most households in England contain no dependant children: 73% in 2008, which is forecast to rise to 75% by 2028. The proportion of households with no children in Milton Keynes is much lower: 63% in 2008, and forecast to rise to 67% by 2026.

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. Current 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 2.3 by 2026, and 2.2 in the rural area. However changes in the type of property built, or if a campus university is situated in Milton Keynes, may alter the eventual household types.

Growth in Households

Households are derived from dwellings by taking into account household types, vacancy and sharing rates. The methodology used by Communities and Local Government has changed, which has lead to some changes when the household numbers are compared to previous data. The number of households in the borough is estimated at 99,940 in 2010 and this is expected to increase by almost 18,300 households, or 18% by 2020. 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.

Year	Household Types		
	Rural	Urban	All Households
2010	16,610	83,330	99,940
2011	16,850	85,070	101,910
2012	17,110	86,140	103,250
2013	17,430	87,320	104,750
2014	17,670	88,950	106,620
2015	17,750	91,000	108,750
2016	17,830	92,950	110,780
2017	18,010	94,640	112,650
2018	18,340	96,260	114,600
2019	18,660	97,700	116,360
2020	19,090	99,150	118,240

Table 4: Growth in Households

Source: Milton Keynes Council. Population Bulletin 2011/12

2.2 People

Age

The age demographics outlined in Figure 1 highlight only one dimension regarding age. Health needs can be determined by age, also age can influence health related behaviours, such as screening, prevention and lifestyle.

Older Age Considered

The population is getting older, the median age rose from 34 in 2001 to 35 in 2011. Population ageing in Milton Keynes raises fundamental questions for policy-makers. These questions are:

- How do we help people remain independent and active as they age?

- How can we strengthen health promotion and prevention policies, especially those directed to older people?
- As people are living longer, how can the quality of life in old age be improved?
- How do we best balance the role of the family and the services when it comes to caring for people who need assistance, as they grow older?
- How do we acknowledge and support the major role that carers play?

As new policies are created or revised, policy Equality Impact Assessments will address these questions and ensure that health and public sector policies meet the needs of the aging population.

Younger Age Considered

In 2011, 21% of the Milton Keynes population were aged under 15 compared with 17.7% in England. The importance of considering young people was outlined in the Marmot report, titled 'Fair Society, Healthy Lives'[6]. Two of its most important insights were:

- To improve health for all and to reduce unfair and unjust inequalities in health, action is needed across the social gradient.
- What happens in pregnancy and the early years of a child's life has a profound impact on the rest of his or her life.

These insights built upon the findings of previous research that found profound correlations between early years development, life chances and health inequalities. The experiences in the early years influence children as they grow, through primary school, secondary school and into adulthood. For example, one study suggests that children born with very low birth weight are less likely to enter post-secondary education than their peers (30 per cent versus 53 per cent) (Hack et al 2002).[7] In Milton Keynes, 7.9% of all births have a low birth weight compared to 7.5% in England as a whole.

Ethnicity

The census figures in Table 2 provide a snapshot of the ethnic diversity and visible differences between people in Milton Keynes. It shows that 26% of the Milton Keynes population are from a black and minority ethnic group. This compares to 13.2% in 2001 and 20% for England as a whole. The black and minority ethnic groups that have grown the most between 2001 and 2011 are Black African (1.3% of the population in 2001 to 5.2% in 2011) and White Other (2.5% of the population in 2001 to 5.1% in 2011). However this provides little real information about the people's strategic health needs and how this diversity affects an approach to services.

Ethnicity in Milton Keynes Described

There are various shorthand terms for the differences associated with people's backgrounds:

- Race – describes visible and physical difference and can be related to people's ethnicity and some genetic predispositions to medical conditions. For example, Sickle-cell disease, or Sickle-cell Anaemia is more prevalent amongst those who have descendents from tropical or sub-topical areas. The

varied nature of the “Mixed” and “White” ethnic groups has led some to question the appropriateness of using these terms or such a classification.

- Nationality – describes the legal citizenship of a person. The census showed that while 10.1 % of the people of Milton Keynes did not hold a UK passport, and 6.1% did not hold EU passport; 11.3% saw themselves as not having a UK identity and 18.5% were born outside of the UK.
- Ethnic Origin – describes the background of a person (or their descendents) and can be confusing. A Somali child could born in Holland brought up in the UK, but be described as Somali. Or a Pakistani Child could be 3rd or 4th generation English, with descendents from Mirpur, (not officially part of Pakistan). While a first generation “White French Person” who has UK citizenship might describe themselves as white just like those who are 4th or 15th generation English.
- Linguistic Diversity – as important as ethnicity is the linguistic diversity. In Milton Keynes, 10.6% of households have at least one person whose main language is not English and 109 languages are reported to be spoken as first languages.[8] Language can be a barrier to communication and provide an additional need. In 1,255 households (1.3%) no person aged 16 and over in household, but at least one person aged 3 to15 has English as a main language.[5]

When we come to look at the English cities with the highest proportions of resident minorities, there are three types; white + one other; white + two others; white + many others (ODPM, 2006, pp.53)[9].

- The third type, characterised by London, Luton, Oxford and Milton Keynes, has a much broader demographic spectrum, with a number of minority groups, none of which are significantly larger than the others.
- Milton Keynes is one of only three cities in which ethnic minorities are less likely than average to live in the most deprived neighbourhoods. Indeed Milton Keynes has the best distribution in the UK.[10]

Quality Information

Quality data is needed to identify ethnic disparities in health and healthcare and meet concerns over the completeness, accuracy and timeliness of the data can inhibit any proper analytical use of the data. The issues are two-fold:

- The use of the ethnic classification from the census creates broad categories that do not translate easily into strategic objectives.
- A lack of concentration upon the critical ethnically relevant data on mortality and morbidity from Coronary Heart Disease, respiratory diseases, stroke and diabetes.

In 2013, two important local reviews will be published:

- Ethnic Diversity Commission 2013, commissioned by the Children and Young People’s Partnership will look at the issues ethnic diversity raises for services, concentrating on children 0-7 and their families (due to report Late 2013).

- Ethnic Minority Health Needs Assessment, commissioned by Public Health in partnership with Milton Keynes Council, will look at the health needs of Ethnic Minority Communities in Milton Keynes (due to report Spring 2013).

Religion

The people of Milton Keynes hold a wide range of religious beliefs and represent many cultural communities; 62.1% of people in Milton Keynes have a religious identity. Supporting and equipping services in their efforts to offer the most culturally competent care that they can, a guide was created "Religious, Cultural, Pastoral & Spiritual Care" (July 2013, MKC) looking at health issues and providing insights into the different ways people approach our services. Incorporating these insights into the planning and the delivery of care will ensure services take seriously the values and beliefs of those who use our services.
The top three insights in this guide were:

- The individual is the expert when it comes to their culture, religion or spirituality.
- The individual may or may not conform to all the values or practices of a particular culture or faith community.
- People don't need a 'label' to deserve pastoral and spiritual care.

These recognise that pastoral and spiritual care is an integral part of any health need assessment, and that these are best considered on an individual basis.

Disability

Someone has a disability, as defined by the Equality Act 2010, if they have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to do normal daily activities. In 2011, 13.9% of the population had some long term limiting illness in Milton Keynes. Milton Keynes saw the largest growth in unpaid carers in the UK; 11,400 in 2001 to 21,797 in 2011.

Disability in Milton Keynes Described

In Milton Keynes people have the full spectrum of disabilities and there are support groups for the major areas of disability; each type of disability can relate to specific needs or associated conditions.

- Physical disability - any impairment which limits the physical function of limbs or fine or gross motor ability is a physical disability. Other physical disabilities include impairments which limit other facets of daily living, such as severe Sleep Apnea.
- Sensory disability - any impairment of one of the senses. The term is used primarily to refer to vision and hearing impairment, but other and combination of senses can be impaired. Some local people with profound deafness see themselves as part of a distinct cultural group with their own language – British Sign Language (BSL).
- Learning disability - is a reduced intellectual ability and difficulty with everyday activities – for example household tasks, socialising or managing money – which affects someone for their whole life.

- Mental health and emotional disabilities are a psychological or behavioural pattern generally associated with subjective distress or disability that occurs in an individual, and perceived by the majority of society as being outside of normal development or cultural expectations.
- Developmental disability is any disability that results in problems with growth and development. Autism is a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them. The term also encompasses many congenital medical conditions that have no mental or intellectual components, for example *spina bifida.*
- Non visible disabilities - Several chronic disorders, such as diabetes, asthma, inflammatory bowel disease or epilepsy, would be counted as non visible disabilities, as opposed to disabilities which are clearly visible, such as those requiring the use of a wheelchair.

It is, however, too easy to define people by what is wrong with them, not by their abilities and needs.

Removing Barriers

The easiest method of meeting needs is to remove barriers that restrict life choices for disabled people. When barriers are removed, disabled people can be independent and equal in society, with choice and control over their own lives. This is the so called: “Social Model of Disability”. Barriers are not just physical: attitudes found in society also disable people from having equal opportunities to be part of society and from having their needs met.

Participation, both in the design and delivery of plans and services, has emerged as a common priority in the consultations. People with a disability see this as the key to removing barriers and meeting wider health needs. It is characterised by getting local people involved earlier in planning, communication and design of services or in the ways that services develop.[11]

Sexual Orientation

LGBT is a commonly used acronym that is shorthand for Lesbian, Gay, Bisexual, Transgender, Transsexual and Two-spirited identities.

- Lesbian, Gay and Bisexual are related to sexual orientations on the Heterosexual-homosexual continuum.
- Transgender and associated names are related to people with gender dysphora. That is a person whose gender identity, outward appearance, expression and/or anatomy do not fit into conventional expectations of male or female. Often used as an umbrella term to represent a wide range of non-conforming gender identities and behaviours.

Very little is known about the health needs of people who are part of the LGBT spectrum and in 2013 a major review will be published:

- LGBT Health Needs Assessment, commissioned by Public Health in partnership with Milton Keynes Council, will look at the health needs of LGBT in Milton Keynes (due to report Spring 2013)

Gender

The past two decades have seen considerable movement by women to improve the quality of their health and health care. Recently men too have begun to draw attention to the negative implications of “maleness” for their health. In general many of the major concerns for men are the same for women.

Women’s Health

An extensive literature documents the relationship between gender divisions and women's health. Researchers have explored a wide range of social, economic, and cultural factors, showing their links with physical and mental wellbeing. This analysis has focused mainly on the gender inequalities that continue to characterise so many of the relationships between women and men. As well as affecting their health, gender inequalities may also limit women's access to some services or present issues of dignity and respect in care settings.[12]

Men’s Health

Until recently very little attention had been paid to the impact of gender on men's health. This is now changing as the links between “being male” and wellbeing begin to emerge. The main differences between men and women’s health can be observed in how and when they present with issues. A study by the National Pharmacy Association (NPA) has found that men are much less likely than women to take advantage of primary care services, including community pharmacies. They are also unwilling to consult a pharmacist face-to-face or seek treatment when sick.[13] Life expectancy for men is only slightly lower in Milton Keynes than those in England, there is evidence of a general correlation between a ward’s deprivation and the gap between men and women’s life expectancy. The more deprived the ward area the bigger the gap. This showed that there is a link between deprivation and male life expectancy – in many highly deprived wards, male life expectancy is dramatically affected, whereas female life expectancy is not.[14]

2.3 Life in Milton Keynes

Deprivation

The National Index of Multiple Deprivation[15] of calculating 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 LSOAs are in the 10% most deprived in England, compared to 6 in the 2007 index.
- 18 LSOAs are in the 20% most deprived in England, compared to 15 in the 2007 index and 13 in 2004.
- 17 LSOAs are in the 10% least deprived in England, compared to 14 in the 2007 index.
- 51 LSOAs 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

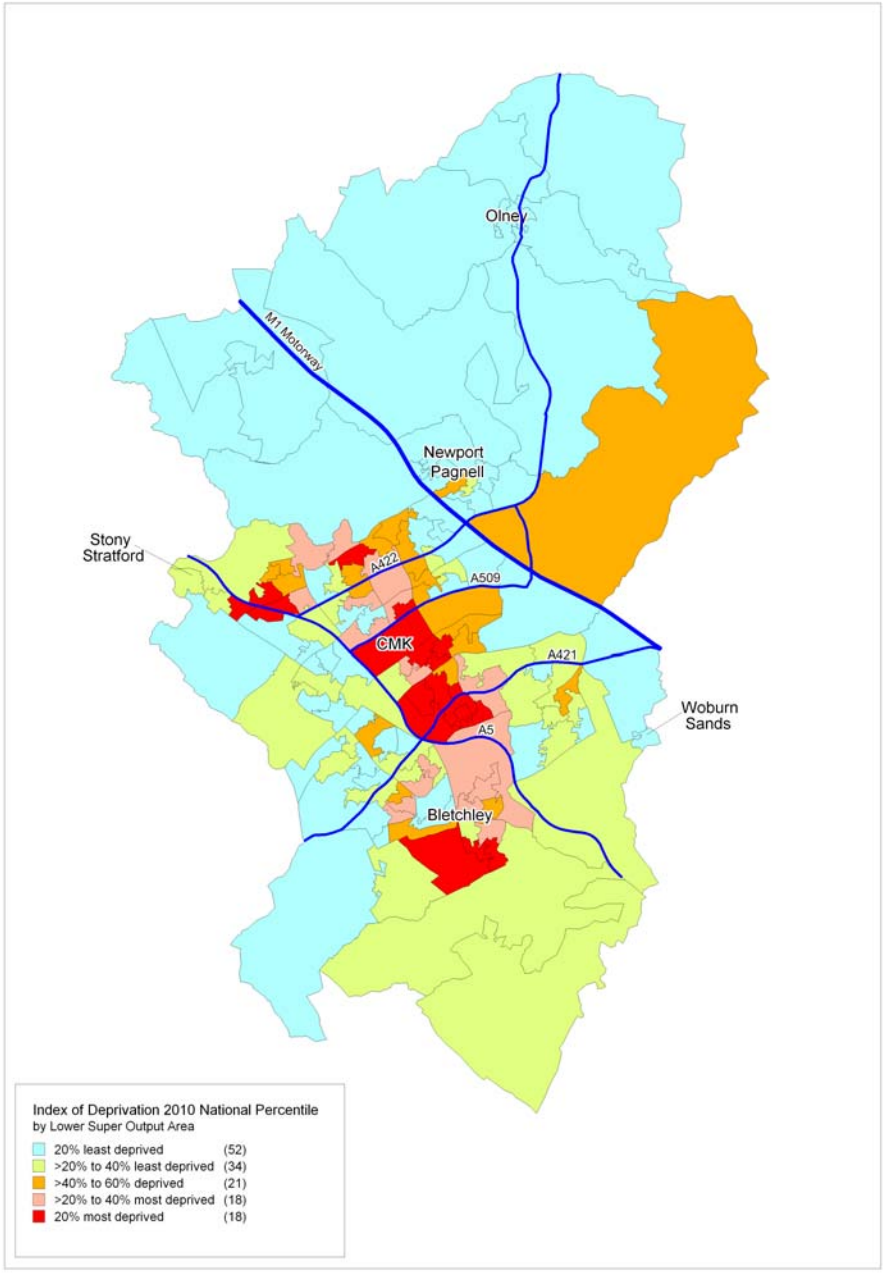


Figure 12: Milton Keynes Lower Super Output (LSOAs) describing deprivation levels by quintile.

Source: English indices of deprivation 2010

Further information can be found in the 'Deprivation and Social Issues' theme on the Observatory.[16]

Mosaic

Mosaic data categorises the population into different geodemographic categories. It shows that Milton Keynes has a higher proportion of people living in couples with young children than England as a whole. More specifically the graph below outlines that Milton Keynes has:

- A much higher proportion of people classified as 'Couples with young children in comfortable modern housing'. 20.2% of people in Milton Keynes are classified in this category compared with 5.6% in England.

- A much higher proportion of people classified as ‘Couples and young singles in small modern starter homes’. 15.6% of people in Milton Keynes are classified in this category compared with 4.5% in England.
- A much higher proportion of people classified as ‘Families in low-rise social housing with high levels of benefit need’. 9.5% of people in Milton Keynes are classified in this category compared with 5.6% in England.
- A much lower proportion of people classified as ‘Young, well-educated city dwellers’. 2.4% of people in Milton Keynes are classified in this category compared with 8.6% in England.
- A much lower proportion of people classified as ‘Residents of small and mid-sized towns with strong local roots’. 4.3% of people in Milton Keynes are classified in this category compared with 8.8% in England.

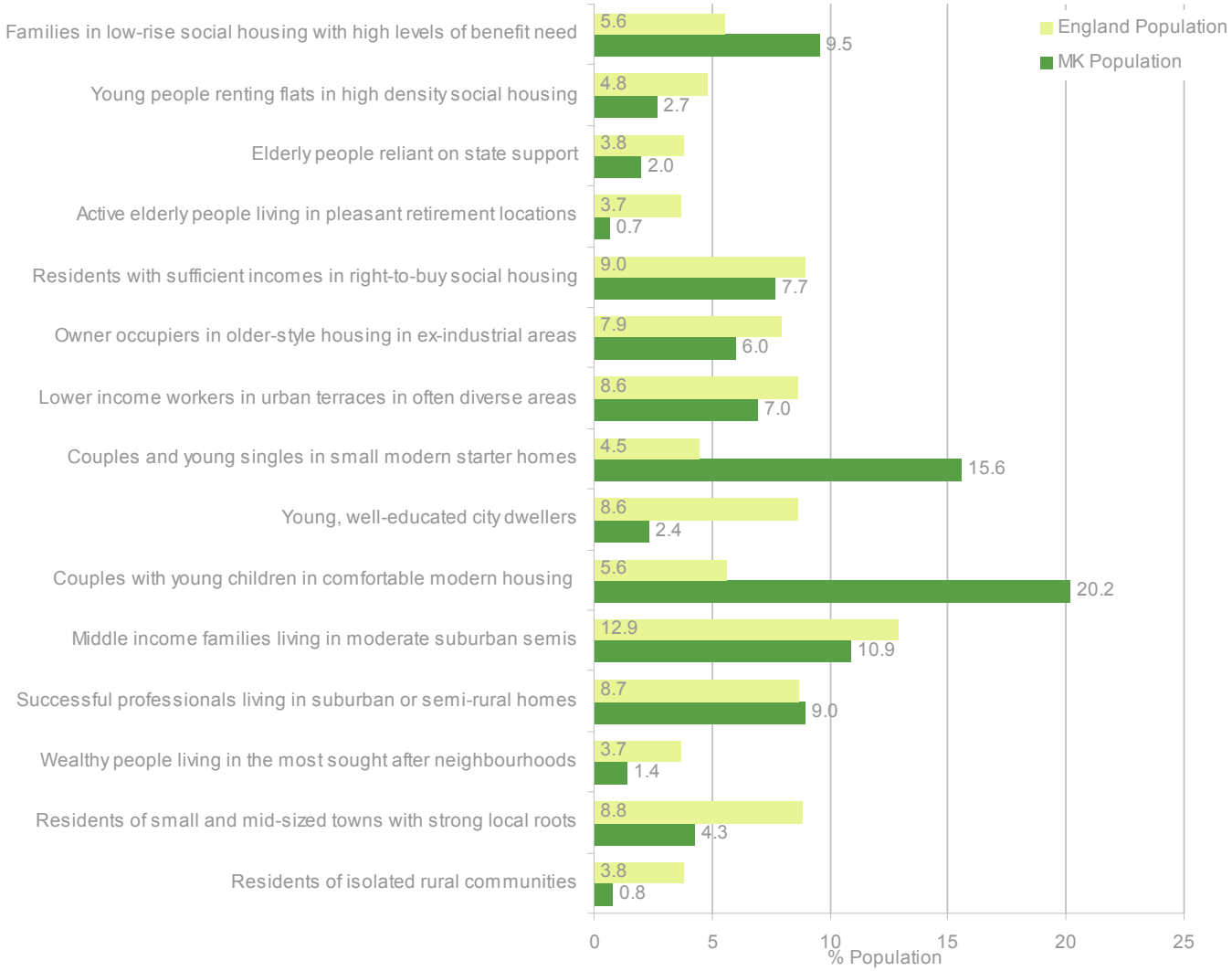


Figure 13: Distribution of Milton Keynes Population Groups Compared with England.

Source: Mosaic

Fuel Poverty

Who is at risk and why?

A household is said to be in fuel poverty if it needs to spend more than 10% of its income on fuel to maintain a satisfactory heating regime (usually 21 degrees for the main living area, and 18 degrees for other occupied rooms). However, in 2010 the government commissioned an independent review conducted by Professor John Hills of the London School of Economics which looked in depth at whether fuel poverty is a distinct issue, its causes and impacts, and whether the current definition is fit for purpose. Department of Energy and Climate Change (DECC) are now consulting on the review's recommendations before deciding on how to implement the findings.

Fuel poverty is a combination of cost of energy, household income and how much energy a household consumes. Two of these factors are economic: the international price of oil and the income of the household. A local authority has no control over the first of these and can only indirectly affect the second by creating a healthy local economy where there is sufficient well-paid employment.

A key factor in energy usage is the energy efficiency of the property, i.e. the construction archetype, the degree of insulation and the efficiency of the heating system. In simple terms the most cost-effective way to improve energy efficiency is to insulate the property in cavity walls and/or loft spaces. In Milton Keynes there is a high proportion of properties that are deemed 'non-standard' construction, which means that they do not have cavity walls and/or lofts; hence installing additional insulation is technically more difficult and, consequently, more expensive.

DECC report biennially on the statistics relating to fuel poverty in England and Wales. The latest, 2012, report contains data from 2010. [17]

The annexes to the report segment the problem in a number of ways such as regionally, household type, tenure, age of household etc. The following are extracts from the official data tables:

By tenure

Tenure	% of households in this group that are in fuel poverty	% of all fuel poor households that are in this group
Owner occupied	15.9%	65.3%
Private rented	18.4%	17.7%
Local authority	18.9%	9.4%
Registered Social Landlord (RSL)	13.9%	7.6%
Total	16.4%	100.0%

Table 5: Fuel poverty in England and Wales 2010

Source: DECC report 2012

By rurality

Rurality	% of households in this group that are in fuel poverty	% of all fuel poor households that are in this group
Urban	15.5%	76.1%
Rural - town and fringe	16.0%	9.2%
Rural - villages, hamlets and isolated dwellings	24.1%	14.7%
Total	16.4%	100.0%

Table 6: Fuel poverty in England and Wales 2010

Source: DECC report 2012

By household composition

Household composition	% of households in this group that are in fuel poverty	% of all fuel poor households that are in this group
couple with dependent child(ren)	6.3%	8.5%
couple, no dependent child(ren) aged 60 or over	17.7%	18.9%
couple, no dependent child(ren) under 60	5.9%	6.4%
lone parent with dependent child(ren)	18.3%	8.9%
one person aged 60 or over	34.9%	31.1%
one person under 60	25.0%	19.6%
other multi-person households	15.3%	6.6%
Total	16.4%	100.0%

Table 7: Fuel poverty in England and Wales 2010.

Source: DECC report 2012.

Whilst these are national statistics, they indicate that the main population group at risk is the older people living in owner-occupied or private rented housing in an urban setting.

Level of need in the population

Government data for local authority level indicates that Milton has 7.9% of the population likely to be in fuel poverty. This makes Milton Keynes the fifth best location in England and Wales in terms of low rates of fuel poverty. Analysis at ward level has been undertaken by the Centre for Sustainable Energy, together with Bristol University; this indicates that fuel poverty within Milton Keynes ranges from 4.24% to 7.52%.

Current services in relation to need

A general increase in economic activity and wellbeing is the best route to alleviating all kinds of poverty, including fuel poverty. In this respect, Milton Keynes is seen as one of the better placed local authorities:

"Experian predicts that employment will rise (in Milton Keynes) by 1.9% each year from 2013-2017, together with an annual increase in output/production of 3.1% - which is measured by Gross Value Added, a standard economic measure similar to Gross Domestic Product." [18]

However, domestic properties in UK generally are in need of improvement to thermal comfort levels, in order to reduce energy consumption. For this, the main target is private households, with the principal activity being in relation the improving energy efficiency and thermal comfort within homes. To accomplish this, Milton Keynes Council works closely with a number of agencies including the local NHS Trust and Age UK to identify those households at risk. Its primary delivery partner is United Sustainable Energy Agency which undertakes a range of fuel poverty related issues on the Council's behalf. The main roles cover advocacy and advice, but also include the administration on various grant funding streams.

To take advantage of the government's Green Deal scheme, which commences on 1 Jan 13, Milton Keynes Council has joined with a number of other organisations to set up the Building Retrofit Network (BRN), a community interest company, to promote Green Deal. A DECC grant of £300k has just been awarded to the BRN to help with marketing and awareness-raising.

In relation to its social housing stock, the council has completed the Decent Homes programme, which had as one of its strands improvement to thermal comfort. There is also an ongoing programme to install double-glazing in those homes that have not yet received it.

From 1 April 2012, the Housing Revenue Account has also started to invest in major refurbishment projects across estates. In 2012-13, around £10 million has been spent to improve the Lakes estate.

In addition, the council continues to investigate all opportunities to improve the worst homes. In the latter part of 2012, a private company approached the council with a proposal to install external wall insulation to private homes, at nil cost to the home-owner, using Community Energy Savings Project (CESP) funding from the major utility companies. Council officers suggested Tinkers Bridge as the most suitable location, and it is expected that around 100 private homes will have been insulated by the end of December 2012.

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

Milton Keynes Council will:

- Work with its partners to identify individual households at risk.
- Work in partnership with United Sustainable Energy Agency on fuel to provide advocacy, advice, and access grant funding.
- Work with other organisations in the BRN, a new community interest company, to promote Green Deal through marketing and awareness-raising.
- Complete programme to install double-glazing in those homes that have not yet received it across Milton Keynes to improve thermal comfort.

- Carry out insulation and fuel efficiency works to the remaining Council houses and bungalows at the Lakes estate over the next three years to improve the stock and significantly reduce heating costs.
- Evaluate the opportunities for alternative communal heating systems in its sheltered housing in 2013/14

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.

Level of need in the population

In the Index of Multiple Deprivation 2010, Milton Keynes is ranked 211 out of 354 local authority districts (with one being the most deprived). Milton Keynes was ranked 212 in the index of 2007 and 204 in the index of 2004.

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.

Lone Parent Families

In August 2008, 8,585 of the 11,255 children living in poverty were living in families in receipt of Income Support (IS) or income-based Job Seekers Allowance. 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.

MK Social Atlas 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 IS than the England average. Eaton Manor and Woughton Wards were more than twice the national average.

Free School Meals

The number of children eligible for free school meals is a traditional indicator of disadvantage that shows large variation across estates.[1] The Milton Keynes average

in January 2012 was 14.7% of pupils in primary schools and 12.2% in secondary schools compared with national England average of 18.1% and 14.8% respectively. Tinkers Bridge is the estate with highest percentage of pupils eligible for free school meals (39.7% in 2012). Rates are substantially lower in the rural areas but, again, numbers identify small but significant pockets of poverty in Hanslope Park (25 children), Olney (35 children) and Newport Pagnell (105 children).

The rate of children claiming free schools meals has increased over the last 4 years from 116.1 per 1,000 pupils in 2009 to 145.1 in 2012.

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.

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 that 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. Reference is made to chapter on demographics (2.1) The size of the population aged 0-4 is set to slightly increase by 2026 but 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. Demand for services to address child poverty is closely linked to the current economic situation, particularly unemployment rates.

Evidence of what works and policy drivers

The Child Poverty Act 2010[19] 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.

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.

In April 2011, the government published *A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives.*

User view

Local children, young people and families have been consulted on issues relating to child poverty and their views are included in a final report to be submitted to the Milton Keynes Children and Families Partnership in 2012.[20]

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

In order to reduce the numbers of children in poverty now, we need a forensic focus on employment for parents. Every contact with a service that reaches parents should be used as an opportunity to encourage employment. In order for that encouragement to turn into real jobs we need:

- Appropriate skills training
- Flexible employment
- Affordable childcare
- Improved advice on benefits and in work calculations.

To reduce the likelihood of poverty in the next generation we need a clear focus on improving outcomes, especially educational outcomes for all children and young people. In order to improve our school results we need to:

- Improve the quality of the early years offer
- Improve the uptake of the early years offer, especially in poor areas
- Do more in schools to develop work aspirations and realistic goals
- Do more in schools to develop the skill set needed by employers.

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.

National recommendations

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
- Early Intervention: The Next Steps.

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. [21]Similar themes are covered in Opening doors, breaking barriers: A strategy for social mobility, April 2011, which aims to ensure that the circumstances of children's backgrounds should not prevent them from fulfilling their potential.

Local recommendations (taken from (Child Poverty in Milton Keynes: Analysis, Experience and Action; April 2012)[22]

Our recommendations below are organised by aged grouping. They are designed to make the most of the current services in place, and do not suggest more, but they do suggest different. We need to make the absolute best use of the fantastic infrastructure of public and voluntary services we have in Milton Keynes. These recommendations give some indication of how that could happen.

The Foundation Years: pregnancy to school age

- From booking in at pregnancy, midwives should be identifying families at risk, and ensuring use of local children's centres. Midwives should also be giving or signposting to advice on maternity and paternity leave, plans to return to work and, as importantly, advice on considering employment at some time in the future if the pregnant woman has never been in the workforce.
- Children's centres should receive detailed data from health services, on where pregnant and new mothers live, to ensure appropriate outreach.
- Children's centres should be offering more courses that result in real employment related qualifications, and should be doing more to encourage users of services to consider employment.
- Neighbouring children's centres should do more joint planning, information sharing and publicity, to increase the variety of what is on offer in an area.
- Job Centre Plus and Citizens Advice should increase the delivery of surgery sessions at children's centres.
- Child related programmes should work on intensive language development to ensure communication skills are school ready.
- Improving the quality and quantity of childcare and early education on offer in the poorest areas is vital to improving school readiness and enabling employment.
- More flexible use of the free fifteen hours a week childcare for all three and four year olds should be encouraged, but not to the detriment of the quality of care.

Primary years

- Changes in rules on IS and Jobseeker's Allowance will make it even more important to encourage parents of primary children to find employment.
- Support is needed for working mothers and fathers through breakfast clubs, after school provision and holiday provision.

- Employers should be encouraged to offer flexible working hours that fit around school terms and hours.
- More could be done in the primary years to introduce children to the world of work and the range of choices open to them.
- Preparation for transition to secondary school is vital for future success.
- Children living in workless households should be sensitively targeted for possible extra support needs.

Secondary schools and post-16 provision

- It is critical to ensure that the 50% of young people who are not bound for university do not miss out on 'employability skills', including literacy and numeracy, team work, communication skills, reliability and persistence to task.
- There needs to be stronger relationships between schools and employers, to ensure skills needed by employers are developed in school and to give young people more opportunities to observe different kinds of work places. This requires a coordinated approach with schools and employers working collaboratively.
- Milton Keynes College, Adult Continuing Education, and other post-16 providers need to work more closely together, to ensure the courses on offer are relevant to workplaces, are accessible for learners, and provide the best possible route into higher education or employment.

Whole family approaches

- Housing is an excellent service to use as a contact point for the most disadvantaged families. The needs of these families for appropriate accommodation, and joined-up advice and support are paramount.
- There is a need to ensure not just co-location of services, but joint policy development and user journey information.
- The establishment of 'lead professional' roles within inter-agency teams is welcomed by service users, and can lead to a more efficient use of services, as a single point of contact for the family, but not an additional layer of professionals.
- There is a need to systematically break down barriers to work. These barriers include not only childcare, but also transport, concern about benefits, appropriate skill levels, and the chance for progression. In-work poverty can be as stressful for parents as worklessness.
- The expectation of employment needs to be built in to every contact with the public service system: health visitors and midwives, children's centres, schools, housing offices; this is not just the job of Job Centre Plus.

In Milton Keynes the Child Poverty Commission is considering the national recommendations alongside actions that can be taken locally to reduce the numbers of children living in poverty today. 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.

Housing

Who's at risk and why?

The supply, condition/ design and affordability of housing has an important impact on the health and wellbeing of individuals and communities. The Marmot Review on health inequalities [23] noted that the health and wellbeing of individuals is influenced by the communities in which they live. Social inequalities in health arise because of inequalities in the conditions of daily life and the fundamental drivers that give rise to them: inequities in power, money and resources. People's health is affected by the nature of their physical environment; living in poor housing, in a deprived neighbourhood with a lack of access to green spaces impacts negatively on physical and mental health.

Level of need in the population

The Draft Milton Keynes Strategic Housing Market Assessment Update (SHMA) 2009 [24] 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.

No significant determinants that indicate prevalence of unsuitable housing has changed or affects changing population groups, but evidence suggests:

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

Current services in relation to need

The Council's Housing Strategy 2012-15[25] identifies a number of issues to be addressed. The issues fall into three key areas of more houses, better houses and improve how the housing market works:

- 1,000 people come to the Council for help with housing every month and there are only 100 social rent vacancies per month.

- Families often have to be housed on a temporary basis, (sometimes in out of town bed and breakfast hotels), causing immense disruption to education, employment and family life.
- There is an increasing divide between the best and worst off estates and communities. A significant number of estates have high levels of deprivation.

Problems and Evidence

Details of the analysis of the condition of housing stock in the SHMA can be found in the MKC inter net website. The key points showed that

- only 1.6% of all pensioner households reported that they had a serious problem with their home 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.
- 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.
- Only 9% of all older households wanted to move. This compared with 27% of households with no older people who wanted to move. 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.
- only around 1,525 older people think their homes do not have their housing needs met due to the health problems but of those 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.
- Over 80% of households with health problems lived in social rented housing vs 10% who rented from a private landlord. 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.
- 10.5% (790) of households with a health problem that need care or support did not receive this. This suggested that the current health and social care services were not necessarily supporting all households in Milton Keynes who require care and support.
- 510 households felt they could not afford to pay themselves for those home adjustments.
- 17.4% of households with a health problem (390 households) felt that they would need to move to another home which was more suitable for their needs but only 140 households wanted to move preferably to a Council or Housing Association property.

Users Views

In the Milton Keynes Citizens Survey (February 2012)[26] affordable housing was one of the issues considered to be both of 'high importance' and 'most in need of improvement'

Evidence of what works

The Marmot Review showed that there are persistent inequalities across a number of key domains, including housing and neighbourhood conditions. Poorer neighbourhoods are often composed of estates of largely socially rented housing. Nearly half of all social housing is now located in the most deprived fifth of neighbourhoods. Tenants of social housing have higher rates of unemployment, poverty, ill health and disability than the average for the rest of the population. "

Consequently tackling housing supply and neighbourhood conditions will help to resolve the social inequalities in health.

Policy drivers

The National Planning Policy Framework sets out the Government's planning policies for England and how these are expected to be applied. It provides a framework within which local people and their accountable councils can produce their own distinctive local and neighbourhood plans, which reflect the needs and priorities of their communities.

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

The Council's Housing Strategy approved in 2012 identifies a number of priorities:

1) More people need housing than the supply available:

- The Council should have 1,750 new homes built each year to meet the housing target which is a vital part of our aim to support the continued growth of Milton Keynes, however the number actually built over the last three years has been less than this
- of which affordable decent housing was one of the issues identified.

2) Housing conditions are not as good as they ought to be:

- We need to spend around £190m on our Council housing over the next five years. For example, around 5,500 of the 14,000 homes owned by the council are of non-traditional build – flat roofs, poor insulation and are very hard to heat. It is unlikely that we will have all the money that we need;
- Around 3,700 private sector homes have a "Category 1" hazard.
- See also fuel poverty section.

3) Making the housing market work better

- Average house prices in Milton Keynes are lower than the average for England and Wales. Average earnings are also higher. However many people cannot afford a deposit to get a mortgage so rent which can be more expensive than mortgage repayments.

- Life time tenancies mean that some people may be in social housing who no longer have a need whilst others cannot afford private rents.

Transport

Transport has a vital role in contributing to the health and wellbeing of the Milton Keynes communities and is important contributory factor to health inequalities if transport needs are not met.

The Transport Vision and Strategy[27] describes the role of transport in achieving health and wellbeing of the Milton Keynes community's needs.

Who is at risk and why?

Table below also shows that older people and single occupancy households are among the most disadvantaged groups. Residents of the areas with low car ownership are less able to access jobs, shops, facilities and other services. With a doubling of the population of older people from 28,400 to 57,300 by 2031, 'mainstreaming' services i.e. making walking, cycling and public transport network as accessible as possible will become essential.

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%*	-	-	-	-

Table 8: Percentage of Households with No Access to a Car By Ward, Inc. IOMD28 and Walking Time to Bus Stop (Household Survey, 2010)

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

Level of need in the population

In Milton Keynes less than one in five adults currently achieve the former Chief Medical Officers recommendations for physical activity, with a high 29% who are classified as inactive. Participating in physical activity helps to prevent and manage at least 20 chronic diseases and also has wider benefits to society. The relationship to transport is clear, with opportunities to walk and cycle for active travel purposes.

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.

Good transport system not only enables access to work, education, and social networks which advance people's opportunities, but also has an important role in encouraging and providing sustainable transport modes which improve the health and wellbeing of the community.

Increasing walking and cycling and access to key services will reduce transport costs, save money and help the environment and improve health and wellbeing. Fewer car journeys can reduce traffic, congestion and pollution, improving the health of communities. Most individuals could meet the recommended physical activity levels simply by adding more cycling to their daily lives.

To promote active travel in Milton Keynes, we know that we need to ensure we have a supportive built environment where people can walk and cycle safely, where key services and destinations are located with pedestrians, cyclists and older people in mind.

Current services in relation to need

Walking and Cycling in Milton Keynes

78% of working age residents in Milton Keynes work within the borough and around 40% of journeys to work in and around Milton Keynes are less than 5km in length (a distance that can be cycled by most people in less than half an hour). Cycle ownership in Milton Keynes quite high according to recent household survey data and 47% of households in Milton Keynes own two or more bicycles. Despite all of this, the proportion of cycling trips for journeys to work in Milton Keynes is just 3% (2001 Census).

Despite having a unique cycling network, cycle modal share is low. The results from the Active People Survey (APS)[29] collected on behalf of the Department for Transport, in Milton Keynes 74% of residents walk for at least 30 minutes at least once per month, and only 14% cycle for the same frequency. When asked the same question but for utility (non leisure) reasons, 34% of people walk for at least 30 minutes at least once per month, but only 3% cycle.

Access by Public Transport

The Transport Strategy supports and encourages more public transport usage through a range of initiatives to tackle the inequalities suffered by some sections of the community.

Transport provides and funds the following initiatives that help towards accessibility and health and wellbeing of the community:

- upgrade and make bus-stops accessible
- community transport for vulnerable and disables members of the community.
- funds non-profit making bus routes to enable access to bus services that would otherwise not be provided by the commercial operators.
- bus information provision through various media i.e. print, at bus stops, on-line website, Real Time Passenger Information (RTPI).
- provides responsive on demand transport.
- currently looking at feasibility of introducing small vehicle transport system.

Problems and evidence

Accessibility

While many residents in Milton Keynes do have access to a car, car ownership in deprived estates such as Netherfield (57%), Beanhill (60%) and Coffee Hall (65%) is much lower.

Residents of the areas with low car ownership are less able to access jobs, hospitals, shops, facilities and other key services. Lack of car accessibility exacerbates the plight of those already living in pockets of deprivation and social exclusion across the city.

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.

Issues/priorities from the needs assessment and what are we going to do as a result?

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).

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. 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. As many older people live in rural areas (see figure in population chapter 2) it is important to ensure that public transport in rural areas is available to people without a car.

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.

Transports contribution in this area is to:

- Promote Active Travel through walking and cycling infrastructure, promotion, education.
- Develop opportunities through improving accessibilities to education, key services, and local amenities, and help create cohesive communities.

Air Quality

Who is at risk and why?

People who live, work or visit Milton Keynes are affected by the quality of the air within the Borough. The major source of air pollutants in Milton Keynes is from road traffic emissions and to a lesser extent from any combustion activity such as commercial and domestic boiler emissions. The main pollutants having a detrimental effect on health are particles, oxides of nitrogen and ozone. In particular there are growing concerns about the health effects of long term exposure to fine particles ($PM_{2.5}$) and more recently of ultra-fine nano particles ($PM_{0.1}$).

Level of need in the population

The mortality burden of particulate air pollution at the local level has not been calculated, however, the Committee on the Medical Effects of Air Pollution (COMEAP) was asked by the Health Protection Agency (HPA) to provide an estimation method. COMEAP published a statement of their technical advice for the HPA to use in more detailed guidance to its practitioners.

In the Air Quality Strategy for England, Wales, Scotland, and Northern Ireland[30] published in 2007 DEFRA reported air pollution is currently estimated to reduce life

expectancy in the UK by an average of 7-8 months per person, with estimated costs of up to £20 billion each year.

Current services in relation to need

Officers from the council's Environment Team, part of the Regulatory Unit, monitor a number of air quality pollutants in Milton Keynes and report the figures annually to DEFRA. This is a statutory function under the Local Air Quality Management (LAQM) regime set out in the Environment Act 1995.[31]

National model projections predict a decrease in pollutant emissions in future years; however, monitoring data have shown that pollutant concentrations are not falling in line with these predictions.

Our understanding of the interactions of different air pollutants within the human body has greatly increased but further research is needed, especially in the field of particulate matter.

Problems and evidence

The Environment Team undertook an air quality review and assessment in 2012, the results of which are published on the council web pages. [32] The assessment contains a summary of new air quality monitoring data collected during the years 2009-2011 and data from previous years is included for comparison to enable any trends to be identified.

The council has three air quality monitoring stations in the borough and air quality is predominantly good. Vehicle emissions are a major contributor to the number of particles and nitrogen dioxide concentration in the air. However the grid road layout has a major beneficial effect on air quality, compared to other towns and cities, because it provides multiple routes through the city, maintains higher traffic speeds and because of wide verges property tends to be sited further away from the source of pollution.

With the exception of the Air Quality Management Area (AQMA) in Olney, air quality objectives are being achieved throughout the Borough. In Olney the poorest levels of air quality are to be found in a small constricted area where approximately 17,000 vehicles a day pass through the town centre. It is thought that the reason for the poor air quality levels is due to the height of the buildings and the narrowness of the road resulting in higher levels of nitrogen dioxide than in any other area of the borough where people live.

It is difficult to control the levels of particles in the air as not all the particles will be generated in Milton Keynes. Many will come from Europe depending on the weather patterns high up in the atmosphere. The section of the M1 motorway in the borough has a flow of 100,000 vehicles per day and is also a significant contributor.

We must also acknowledge that there is a tension between the need to mitigate pollution which is a contributor to global warming, by decreasing the use of fossil fuels and increasing the use of renewable energy sources and the fact that some alterative sources of energy potentially have negative effects on air quality. This is

particularly the case where biomass burning replaces the use of natural gas which leads to an increase in particle emissions.

Evidence of what works and policy drivers

The Public Health Outcomes Framework[33] contains an indicator on air pollution and the Environment Act 1995 requires local authorities to review and assess air quality in its area. The approach in Milton Keynes is to control as much as possible through policies. Nationally there is a strong desire to identify a cost effective solution to improving air quality. In Milton Keynes consideration is given to minimising particles in the environment through strategies such as Transport and Low Carbon.

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

- Continue to operate and improve the air quality monitoring network in Milton Keynes to collect data on pollutant concentrations and compare against national and European statutory objectives.
- Continue to undertake the function of LAQM; review and assessment of air quality within the Borough.
- To undertake actions in the Air Quality Action Plan[34] for Olney in order to contribute to reducing nitrogen dioxide levels.
- Keep up to date with the latest research on health effects of air pollutants and calculate the mortality burden of particulate air pollution at the local level.
- To encourage alternative non-polluting forms of transport such as cycling and walking to reduce emissions and improve health. Details can be found in the Transport Vision and Strategy for Milton Keynes, Local Transport Plan 3 (LTP3).

Employment

Who's at risk and why?

There is a strong link between unemployment and deterioration in physical and mental health and wellbeing. 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 (broad measure 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.

In 2000 claimant unemployment (narrow measure) in Milton Keynes fell to 1.2% but since then rose gradually. The start of the recession saw (claimant) unemployment in Milton Keynes rise from 2% in May 2008 to its highest level of 4.7% in August 2009, falling to 3.4% in December 2010. From January 2010 unemployment in Milton Keynes started to fall and it fell at a faster rate than in the South East region and in England. Between March 2011 and March 2012 the average unemployment rate in

Milton Keynes was 4%. From April 2012 unemployment started falling again reaching 3.6% in October 2012, compared to 3.2% in the South East Midlands Local Enterprise Partnership (SEMLEP) area, 2.5% in the South East region and 3.8% in the UK.

Comparison of unemployment rates between Milton Keynes and the SEMLEP area showed Corby as having highest levels of unemployment at 5.5% and South Northamptonshire having the lowest rates (1.2% in October 2012).

The rates of female claimant unemployment have been rising and stood at 2.9% in August 2011 and 2012 and falling to 2.7% in October 2012 in Milton Keynes compared to no movement in the South East at 1.8% in October 2011 and 2012 and a rate of 2.7% in October 2011 and 2012 in the UK.

In contrast claimant unemployment rates for males in Milton Keynes, the South East and UK, fell from March 2011 to October 2012 (even though rates for males are higher than those for females). Claimant unemployment rates for males in Milton Keynes fell from 5.5% in March 2011 to 4.3% in October 2012.

Young people were impacted heavily when unemployment rose rapidly, to a point when 27.3% of all those unemployed and claiming unemployment benefit were 24 years of old and under. In October 2012 youth unemployment (aged 24 and under) in Milton Keynes stood at 22.3% compared to 26.7% in the South East and 28.4% in the UK.

The number of people claiming unemployment benefit fell from 6,601 claimants (4% of the working age population) in October 2011 to 5,742 claimants (3.6%) in October 2012, a 0.4% rate decrease.

The Milton Keynes unemployment rate of 3.6% in October 2012 compared to rates of 3.8% in the UK, 2.5% in the South East rate and 3.2% in the South East Midland Partnership area. The highest unemployment rate in the SEMLEP area in October 2012 was in Corby at 5.5% and the lowest was South Northamptonshire at 1.2%.

Long term unemployment in Milton Keynes (unemployed for longer than one year) stood at 1% of the working age population, ((1,525 claimants), 26.6% of the claimant count) in Milton Keynes in October 2012, a 0.2% increase on the long term unemployment rate from 0.7% in October 2011. The longer a job seeker is out of work, the more difficult it is to find suitable employment as they will have to compete for jobs with new entrants in to labour market.
Milton Keynes Wards with significantly higher than the average unemployment rate (3.6%) were Woughton (7.1%), Eaton Manor (6.8%), Campbell Park (6.3%) and Wolverton (5.4%).

What are the top priorities from the needs assessment and what are we going to do as a result?

The Council will continue to carry out its statutory 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 Council supports and challenges schools to raise standards of achievement across Milton Keynes., including working towards closing the gap for vulnerable learners, through early intervention and prevention across a range of services and settings.

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.

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. The key vulnerable groups (based on data analysis are):

- Boys at Key Stage 4.
- Pupils Eligible for Free School Meals (FSM) across all key stages.
- Pupils with special educational needs in particular pupils with statements at KS2 and KS4.
- Black Caribbean pupils at KS2.
- Black African, Black Caribbean and Pakistani pupils at KS4.
- Children in Care across all key stages, particularly at the end of KS2 and KS4.
- Care leavers.

Level of need in the population

The Early Years Foundation Stage Profile captures the early learning goals as a set of 13 assessment scales grouped into six areas of learning. Children who achieve a score of 78 points or more across the 13 assessment scales score an average of 6 points per scale. When a child who achieves this overall score also achieves a score of 6 or more in each of the 7 personal, social and emotional and communication (PSE), language and literacy scales (CLL), that child is deemed to be reaching a good level of overall achievement.

	MK 2010	National 2010	MK 2011	National 2011	MK 2012	National 2012
Number of children	3170	n/a	3297	n/a	3476	n/a
78+ points and 6+ in PSE and CLL	63%	56%	61%	59%	67%	64%
Gap between median and bottom 20%	31%	33%	28%	31%	30%	30%

Table 9: The Early Years Foundation Stage Profile

Source: Department for Education (DfE) and Local Authority (LA)

Milton Keynes schools achieved an increase of 6 percentage points from 2011 for those children achieving a good level of development. At 67% the LA remains above the national average of 64%.

The gap between the lowest performing 20% of children and the rest has risen from 28% in 2011 to 30% this year. This is in line with the national average but has resulted in a fall in our ranking when compared to other local authorities from the top quartile to the second quartile for this measure.

The national expected minimum standard at Key Stage 1 at the end of Year 2 is Level 2 in each of reading, writing, mathematics and science. Level 2 is divided into 3 sub-levels; c, b and a. The higher level is defined as a Level 3.

For schools in Milton Keynes all indicators are stable and above or at national averages.

Key Stage 1	MK 2011	National 2011	MK 2012	National 2012
Reading				
L2+	87%	85%	88%	87%
L2b+	75%	74%	79%	76%
L3	26%	26%	29%	27%
Writing				
L2+	81%	81%	84%	83%
L2b+	62%	61%	65%	64%
L3	13%	13%	14%	14%
Maths				
L2+	90%	90%	92%	91%
L2b+	73%	74%	77%	77%
L3	20%	20%	24%	22%

Table 10: Key Stage 1

Source: DfE and LA

The nationally expected level at Key Stage 2 is defined as Level 4. The key measure is the percentage of children achieving Level 4 or above in both English and mathematics. The government floor target for this measure is 60% and the number of schools below this target has reduced significantly from eleven schools in 2011 to one school in 2012. This school is now a sponsored academy.

In 2012 schools in Milton Keynes achieved a 7 percentage point increase from 2011 on the key measure of the percentage of children achieving Level 4+ in English and mathematics combined. This is 2 percentage points higher than the national average and places Milton Keynes in the second highest quartile for all local authorities.

Key Stage 2	MK 2011 test	National 2011 test	MK 2012 test	National 2012 test
English and Maths	75%	74%	82%	80%
English	82%	81%	88%	85%
Maths	81%	80%	84%	84%

Table 11: Key Stage 2

Source: DfE

The key measure for Key Stage 4 is the percentage of young people who achieve 5+ A*-C GCSEs including English and mathematics. For Milton Keynes schools 58.1% of students have achieved this, a significant improvement on 52.1% in 2011.

GCSE	2010		2011		2012		
	MK	National	MK	National	MK	National	SN
5 A* - C inc Eng and Maths	52%	55%	52%	59%	58%	59%	60%
5 A* - C	75%	75%	80%	80%	85%	81%	84%
Average points per pupil	460	440	480	456	510	-	-

Table 12: GCSE

Source: DfE

Key Stage 5: the following indicators are available for A Level results in 2012 at the time of writing:

- The average points score per candidate is 762 compared to 718 nationally and 761 for Statistical Neighbour (SN).
- The average points score per entry is 206 compared to 211 nationally and 210 for SN.

- The percentage of candidates achieving 2 or more A level passes is 98% compared to the national figure of 92% and the SN average of 97%.
- The percentage of candidates achieving 3 or more A Levels graded A*-A is 6.8%, lower than the national and SN figures of 13% and 10% respectively.

Current services in relation to need

The Milton Keynes School Improvement Framework, *Aiming to be Outstanding,*[35] was introduced to schools in January 2010 and confirmed in September 2010. This document has since been revised to reflect changes to the Ofsted framework and details local authority criteria used to categorise schools. These are in line with Ofsted standards enabling the local authority (LA) to intervene early and arrest any decline in standards, supporting our aim of securing consistently high quality provision across Milton Keynes.

There has been significant change in relation to the educational landscape with a centralisation of accountabilities away from local authorities. Through the Organisational Transformation Programme, Strand 2, the LA has reviewed the approach to improving setting and school effectiveness and we are now clear about our role going forward. It is articulated in the Children and Families Service Plan for 2012/13 as:

"Challenging schools, settings and services to be outstanding, enabling them to take the lead in driving up standards and safeguarding children and only intervening when outcomes are not good enough."

In February 2010 Milton Keynes introduced the MK World Class Primary Programme (MKWCPP).[36] The programme prioritised those schools below the Government's floor target and those in Ofsted categories of concern. The programme reflected the new model of school improvement where the best schools supported the rest, with the best leaders and the best teachers sharing best practice across the system, improving system leadership and the quality of teaching and learning.

Problems and evidence

The model for addressing underperformance seeks to provide intensive support for schools causing concern through a bespoke package appropriate to their context. Intervention programmes are evaluated against children's outcomes to ensure value for money and impact. The impact of LA support and intervention in individual schools is monitored through a Targeted Intervention Board chaired by a senior LA officer which holds the school to account for the progress against priorities identified in the schools action plan. An internal Setting and School Effectiveness Board monitors the progress of LA intervention schools through monthly meetings, ensuring consistency in approach and development of an exit strategy to secure ongoing improvement.

Projected Service use and outcomes

The very large majority of services, settings and schools inspected by Ofsted are evaluated as good or better. Childminders and childcare providers are mostly evaluated by Ofsted as good as are nurseries and early years education in primary schools.

Users Views

As this is related to statutory educational outcomes there are no user views.

Individual schools may consult with parents and pupils about the range of curriculum opportunities on offer at Key Stage 4 and 5.

The government is currently considering reform and consulting on education qualifications at 16+.

Evidence of what works and policy drivers

On 27 November Ofsted's Chief Inspector of Education, Children's Services and Skills published his annual report on inspections carried out during 2011/12.[37] In summary the report found that primary pupils in Milton Keynes have a 'fair chance of attending a good or outstanding school – 66.6%'; and secondary pupils also have a 'fair chance of attending a good or outstanding school – 70.1%. Out of all local authorities, Milton Keynes is ranked 90/150 for primary pupils, and 77/150 for secondary pupils.

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

The Council will continue to carry out its statutory 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;[38]
- To eliminate discrimination, harassment and victimisation.

The Council supports and challenges schools to raise standards of achievement across Milton Keynes., including working towards closing the gap for vulnerable learners, through early intervention and prevention across a range of services and settings.

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. The increased risk of unemployment is particularly pertinent in the current economic climate. The impact of unemployment among young people (aged 24 years of age and under) remains an issue regionally and nationally. Young people made up 23.5% of the unemployed in

Milton Keynes in September 2012 (a decrease of 0.4% on the August 2012 proportion), compared to 27.2% in the South East region and 28.9% in the UK.

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.

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

Headline Stats, October 2012		***October 2011***
NEET Total	353	506
Adjusted NEET	382	541
Adjusted NEET% (2011-12 Definition)	5.3%	6.5%
In Learning Total	6324	6965
In Learning %	69.7%	76.0%
Year 12 In Learning %	89.2%	88.3%
Not Known Total	2041	1103
Not Known %	22.5%	12.0%

Table 13: Headline Statistics October 2012

Source: LA integrated youth support database

NEET count and adjusted NEET percentage are well down on Oct 2011. If this is maintained through the target months of Nov, Dec and Jan, we should be well placed to meet our locally-agreed target of 5.2%.

Not Known count and percentage are much higher than Oct 2011. A particular concern is that more than half of the young people who completed Yr13 in 6th form or College during the summer of this year have yet to be tracked. This may, in part, be a result of reduced resources for tracking, compounded by the difficulty in obtaining accurate and timely data from schools. (Whereas previously Connexions Personal Advisers providing careers information, advice and guidance on behalf of MKC and operating from specific schools were able to chase up the information required, following the transfer of responsibility for Information Advice and Guidance to schools this is no longer the case).

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 Learning Difficulty and Disabilities (LDD), clients of Youth Offending Team (YOT), Children in Care.

If current NEET levels are maintained through the target months of Nov, Dec and Jan, we should be well placed to meet our locally-agreed target of 5.2%.

Current Services in relation to need

The local authority statutory requirements for:

- Impartial careers information, advice and 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 Youth Offending Service 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.

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. 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)[39] identified strong associations between speech, language and communication needs (SLCN), and unemployment and offending. Locally, the YOT provided figures that suggested similar links. SLCN could be targeted in the early years.

User view

The NEET Peer Research Project 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?

- The demographic changes to Milton Keynes over the last decade, and especially the last 5 years, have impacted heavily; the dramatic rise in the 0-17 population has included a significant proportion of disadvantaged families.
- High profile cases in the media have been another factor in the rise in referrals, assessments and care proceedings.
- The need for improved early help services, which will be picked up in 2012/13 through the new children and families (CAF).
- The number of referrals is beginning to reduce and there are areas where CAF is starting to embed and professionals are beginning to instigate some creative approaches to problems faced by families.
- Social care interventions are working; reductions in Care Proceedings are considerable compared to the 09/10 figures. The children in care population remain higher than we would like, but the care population is now stabilising.
- Strengthen governance arrangements for corporate parenting.
- Develop our corporate parenting responsibility with involvement of young people supported by the corporate parenting officer, Independent Reviewing Officer's, and advocates.
- Increase the percentage of children in care who are fostered in or close to Milton Keynes.
- Develop culturally appropriate services locally for BME children.
- Reduce the number of children in external residential placements.
- Keep children in touch with their parents and wider network and support them to return home or to the care of their wider family and friends where feasible.

Recommendations for further research/ needs assessment

To further develop an understanding of the needs and employment aspirations of NEET clients, and work towards providing suitable opportunities. Continue to develop effective pre-emptive action with school age young people who are at risk of becoming NEET in the future.

Community Safety and Health

Who is at risk and why?

Anyone can be affected by crime at some point in their lives. For many this often causes little impact on our daily lives for others being a victim or committing crime can have varying and adverse affects on individuals. Specifically with health; surgeries and hospitals respond daily to the health needs to victims of violent crime; they also deal with symptoms of stress caused by the fear of crime, and treat those whose mental health, drug or alcohol problems make them vulnerable to crime and/or more likely to offend.

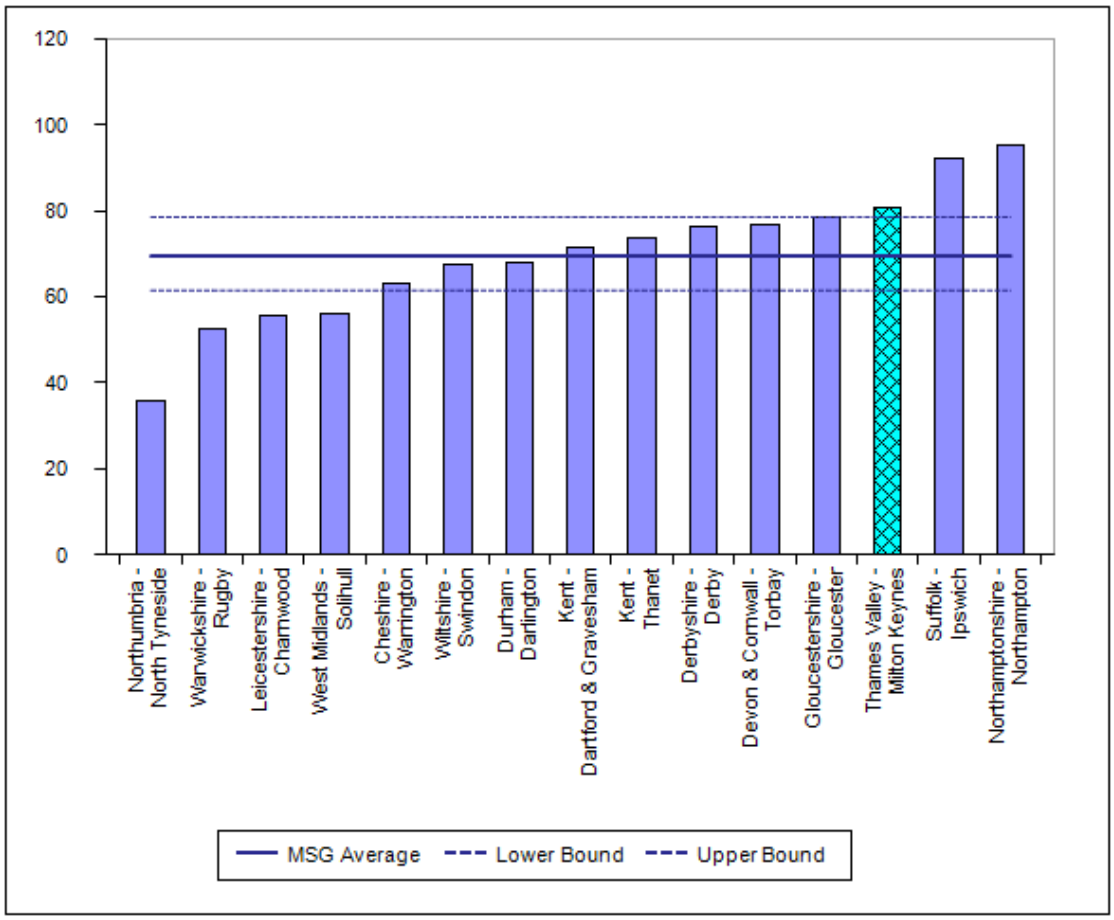


Figure 14: All Crimes per 1000 of the population for 1st Jan 2012 – 31st Dec 2012

Source: IQuanta 31/01/2013

Level of need in the population

Locally both health and community safety has similar correlations regarding geography, there is an increasing understanding that crime and poor health are focused in the same geographical areas. High levels of deprivation, poverty and poor health correspond frequently with community safety concerns. Poor health and high levels of crime can be both a cause and a consequence of social exclusion. Crime and the fear of crime affects people's health and also affects how they cope with their own ways of staying healthy.

Current SaferMK Structure

The Milton Keynes Community Safety Partnership (SaferMK) recognises both as part of the statutory obligation and operationally the importance between health and community safety issues. Both nationally and locally it is recognised how each other can compliment to the contribution of health and preventing crime and promoting community safety.

The Responsible Authorities Group (RAG) oversees the partnership. This is made up of a number of organisations, statutory however RAG has 5 key partners:

- Buckinghamshire and Milton Keynes Fire and Rescue Service.
- Milton Keynes Council.
- NHS Milton Keynes and Northamptonshire.
- Thames Valley Police.
- Thames Valley Probation.

All our partners are affected by crime whether their involvement is prevention, enforcement or post incident. SaferMK supports and coordinates multi-agency approaches to community safety issues across Milton Keynes.

What are the top issues/priorities

The overlap between crime, social exclusion and health inequality demonstrates that there is room for alignment and improved joint working between the wider health and community safety agenda over the coming year.

SaferMK currently has 6 priorities:

- Tackling Domestic Abuse.
- Promoting Social Behaviour.
- Tackling Drug & Alcohol Misuse.
- Reducing Re-offending.
- Preventing Violent Extremism.

- Reducing violence in public places.

There are number of themes throughout the priorities that incorporate health related issues. It is hoped that the partnership continue to strengthen working with the wider health agenda.

Tackling Domestic Abuse

There has been a gradual increase in the number of high risk domestic violence cases that have been referred to Multi Agency Risk Assessment Conference (MARAC) during 2011-12, leading to a consequent increase in the repeat rate which for the year was 22%, a rise of 8 percentage points from the previous year but still within the target of 28%. The increase in the number of cases is in part a positive step as we are beginning to see an improved awareness of domestic abuse and a greater willingness to report incidents, in particular referrals from the voluntary section, probation and health. We are aware that a large proportion of domestic violence goes unreported, with the average victim suffering 35 incidents of domestic abuse before reporting to the police[40], so we are currently encouraging awareness raising to hopefully increase the number of referrals coming in.

Nationally non-police referrals have increased by approximately 3%. This trend is more apparent in Milton Keynes and non-police referrals have increased by approximately 30%. We are seeing a number of cases coming from a variety of agencies showing that domestic abuse is a priority. The current levels of medium risk domestic violence still remain a concern for the Community Safety Partnership. With the repeat rate for medium risk repeat domestic violence standing at 44.5% at the end of 2011-12, a marginal decrease from the previous year but still the highest across Thames Valley, the rate appears to be remaining quite static. The number of incidents increased by 1.8% year on year and the number of repeats fell by 0.9%.

Specific project work is currently in planning stages to directly focus on medium risk victims, working on one estate to assess how effective targeted intervention work will be with a scope to evolving this across a wider area dependant on the success. There is also some research work which is currently being scoped to try and identify any gaps in provision or issues in referral procedures that may be impacting on the problem. There is a good level of service provision in Milton Keynes for victims and perpetrators of domestic abuse.

The following services are available across the borough:

- Multi Agency Risk Assessment Conference (MARAC).
- Fresh Start perpetrator programme.
- Resettlement.
- Refuge accommodation.
- Floating support/outreach.
- Black and Minority Ethnic.
- Support for children.

- Independent Domestic Violence Advisors (IDVAs).
- Specialist Domestic Violence Court.
- The new Sexual Assault Referral Centre satellite has now opened in Bletchley for victims of sexual abuse across Milton Keynes, Oxford, Aylesbury and Buckinghamshire.

Milton Keynes is the only area across Thames Valley that provides all of these services. The greatest concern in terms of provisions is the support we have available for families and children, this is seen as a gap but further research is needed to understand the situation fully.

Tackling Drug and Alcohol

Drugs offences have fallen by 9.4% year on year, with all areas seeing a decrease, it is difficult to say with confidence if this is due to a particular decrease in drug use/dealing etc or whether this is a reflection of a reduction in enforcement activity[41]

As would be expected the majority of offences came from the city centre and a high number were linked to those using the night time economy (NTE), high levels of people and activity always make this a hotspot for detecting drugs offences. The table below shows the top ten areas with the highest levels of offences. Looking at the levels from the previous years there have been increases in three areas, particularly of note are the increases in Furzton and Fullers Slade. Levels in the top two areas, the City centre and Bletchley, have fallen considerably.

Area	2010/11	2011/12	%change
CENTRAL MILTON KEYNES	279	217	-22.2%
BLETCHLEY	210	154	-26.7%
NEWPORT PAGNELL	44	53	20.5%
FURZTON	24	40	66.7%
WOLVERTON	39	38	-2.6%
CONNIBURROW	43	32	-25.6%
FISHERMEAD	46	31	-32.6%
FULLERS SLADE	16	28	75.0%
OLDBROOK	28	27	-3.6%
NETHERFIELD	44	26	-40.9%

Figure 15: Top ten areas with highest levels of offences

Source: Milton Keynes Adult Substance Misuse Needs Assessment 2011-12, pg 17. Author Melanie-Jane Stoneman

There has been a change in the offender profile from 2010/11, male offenders always outweigh female offenders significantly, however during 2011/12, and there was a marginal increase from 10.5% to 11.7% proportionally of female offenders. In both years 18-24 year olds had the highest levels of offending, in the current year 20 was the peak age which is slightly older than the previous year of 18. The age distribution for both genders was similar with 18-24 being the highest group; the only slight difference was that female offenders were distributed evenly between 25-34 and 35-44, whereas for males there was over double the amount of representation at 25-34 than at 35-44.

In order to build a better intelligence picture about the drug market in Milton Keynes a questionnaire was developed by SaferMK and Drug and Alcohol Commissioning analysts, which was piloted with the adult drug treatment service. If successful the idea is to roll the survey out across the partnership and to conduct the survey twice a year. The questionnaire covers the following five areas;

- Use of drugs.
- Availability of drugs.
- Price and quality of drugs.
- Source of drugs.
- Funding sources for drugs.

Reducing violence in public places

The Partnership is currently working with the A&E department at Milton Keynes hospital following a successful bid to the Department of Health to support an initiative to improve intelligence on crimes against the person based on the 'Cardiff model'.[42] Underpinning this model is the concept that Emergency Departments (EDs) can contribute distinctively and effectively to violence prevention by working with Community Safety Partnerships and by sharing, electronically wherever possible, simple anonymised data about precise location of violence, weapon use, assailants and day/time of violence. These data, and the contributions of consultants in partnership meetings, enhance effectiveness of targeted policing significantly, reduce licensed premises and street violence, and reduce overall A&E violence related attendances. It is hoped the process will be established in 2013.

3.0 Lifestyle Determinants of Health

The choices people make about how they live their lives have a significant impact on their health. Some of those choices are obvious and everyone will be aware that smoking impacts on health. Other choices such as physical inactivity have a similar impact on health and very few people think seriously about these as risky behaviours. Another example where a risk is generally underestimated is drinking above the recommended limits of alcohol consumption, with many believing that a beer and a few glasses of wine a day does not put their health at risk.

The choices made are often strongly influenced by the families and communities in which a person lives. Communicating risks in a way which doesn't sound like the 'nanny state' is a significant challenge and we need to utilise information about the communities within which people live before deciding how to communicate lifestyle risks. Great progress has already been made in this area with the development of specific programmes, such as the change4life social marketing programme.[43]

This section looks at key lifestyle factors: smoking; culture; sport and physical activity; healthy weight; alcohol; drug misuse and sexual health. The baseline measures for the Public Health Outcomes Framework[33] provide an assessment of our current performance for some of these lifestyle factors compared to the figures for England (see appendix Section 7).

3.1 Sport, Physical Activity & Culture

Who is 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 reduction in travel by foot or bicycle. Achieving the Chief Medical Officers (CMO) recommendation for physical activity for health as outlined in the Start Active, Stay Active document (2011) will help to prevent and manage over 20 chronic conditions including coronary heart disease, stroke, type 2 diabetes, cancer, mental ill health and obesity. Inactivity not only has consequences for the health of individuals and communities, it places a financial burden on health services and the wider economy through sickness absence and premature death.

As well as an active lifestyle, there is in increasing recognition that people's health and wellbeing is influenced by a range of interconnecting factors. Experiencing the arts and culture can create a sense of wellbeing and transform the quality of life for individuals and communities. What is less well known is that every day the arts are having a significant impact on people's health in hospitals, health centres, GP practices and other healthcare settings within and throughout our communities.

Levels of need in the population

Promoting sport and 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 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. In Milton Keynes that figure is estimated to be more than two million per year. (Source: Department of Health - Be Active Be Healthy, Year: 2006/7). There are also significant benefits to wider society, for example increasing cycling and walking will help to reduce transport costs, save money and help the environment including reductions in traffic, congestion and pollution.

There are significant inequalities in levels of physical activity and participation in sport across Milton Keynes in relation to age, gender, ethnicity, disability and socio economic groups resulting in corresponding inequalities in health outcomes.

Age

Participation in sport and physical activity declines with age. The most recent Active People Survey (APS) found that 13% of adults over the age of 55 in Milton Keynes participated in sport and active recreation, at moderate intensity for 30 minutes on three or more days a week compared to 27.5% in those aged 16-34 and 25.5% in those aged 35-54.

There are currently no statistics for the activity levels of children and young people up to 18 years old. However, there are recommended guidelines for these age groups described within the CMO report Start Active, Stay Active (2011)[44]

Gender

Men are more active than women. APS 6 found that 26.4% of men were active compared to 18.7% of women.

Ethnicity

There is a small difference in participation levels between people of white (22.8%) and non white backgrounds (21.4%).

Socio Economic Status

Lower income groups in Milton Keynes were significantly less active than those on a higher income (16.3% to 28.1%). There is a correlation between sport and physical activity levels and those estates highlighted within the Milton Keynes Social Atlas as being the most deprived and having the lowest life expectancy. The most deprived estates have the lowest participation rates and similarly the least deprived estates have the highest levels of participation

Long term limiting illness and disability

8.9% of people living with a limiting illness or disability were less likely to be physically active compared to 24.7% of people without a limiting illness or disability.

As with physical activity and sport there are inequalities in relation to participation in cultural activities. It is recognised that participation in cultural activities contributes to wider social and economic wellbeing. Volunteering increases the quality and diversity of services and support available in our communities. It also has multiple health and wellbeing benefits, not just for those who receive support, but also for volunteers themselves, communities and society as a whole.

Current services in relation to need

- 'Reactivate Milton Keynes' promotes a variety of different activities and courses running across the area, offering individuals the opportunity to become more active and try new activities during the 'Give it a Go' weeks over the year.
- The Active MK Exercise Referral scheme provides a physical activity opportunity for those with specific health conditions that can benefit from physical activities.
- A local sporting infrastructure (clubs, leisure facilities, volunteers, schools) which is supported through funding applications and workforce development to ensure an increased demand in sport and physical activity can be met.
- The Walking for Health programme provides a free physical activity intervention for adults wishing to keep active in a social setting.
- Involvement in regional and national sporting organisations to deliver programmes to meet sports participation targets such as Get Running, No Strings badminton and Back to Netball.
- A partnership with British Cycling to increase the number of people cycling recreationally in Milton Keynes and maximising the 170 mile Redway route.

There are a wide range of projects identified in the Arts Strategy Delivery Plan that provide the potential for increased access to cultural activities, thereby improving health and wellbeing of Milton Keynes residents. In Milton Keynes there is an increase in volunteering in arts, heritage and libraries due to last summers cultural agenda and positive role of the games makers. People who have participated in Arts on Prescription in Milton Keynes have reported improved health and wellbeing.

- Volunteering opportunities provide benefits in relation to mental and physical health. The majority of volunteers in Milton Keynes are 55+, many of which have health issues. [45]
- Milton Keynes has a higher per capita number of employees working in the sector (per 1,000 people) of 20.1 compared to 12.69 nationally.
- We have over 1,200 groups, the majority of which (about 60%), are very small, with incomes of less than £10,000, surviving (and thriving in most cases!) thanks to volunteers and the commitment of local people. However, to demonstrate the broad nature of the sector, just fewer than 5% of groups have an income of over £1m and are considerable employers in the Milton Keynes landscape.[46]
- 48% of the city population are actively and regularly involved in voluntary activity.
- There are approximately 68,000 volunteers currently active in Milton Keynes in roles such as administration to senior management, and within sports, arts and environmental projects, supporting older people and youth work.[47]

Problems and evidence

The most significant problem facing community sports clubs and organisations since the successes of the Olympics is the capacity within the clubs to take more members. A lack of volunteers (coaches and committee members) matched with a lack of additional facility time for some clubs, results in clubs creating waiting lists for courses. Without being able to offer a service straight away, those people that have been enthused could easily fall back to apathetic behaviour traits seen before the Olympics.

Sport and physical activity are not statutory services and because of this are more reliant on external funding to support the delivery of activities. Whilst the changes to the lottery funding distribution has resulted in more money being released for sport, there are more clubs and organisations looking for money to support facility development and create the capacity to meet the demand.

Providing information to people wishing to participate in activities and providing information about the opportunities in Milton Keynes, whilst improved, continues to prove a barrier. The 'Reactivate' brand has increased the visibility regarding opportunities but there is still a lack of a one stop shop for people to access information about courses and programmes taking place in the various leisure facilities within the borough.

Evidence of what works

The new Youth and Community Strategy 2012-2017,[48] from Sport England aims to create a lifelong sporting habit, so that sport becomes a habit for life for more people and a regular choice for the majority. The strategy has an aspiration to increase the number of people (and in particular those age 14-25) participating in at least 30 minutes of sport at least once a week ('1x30' sport). This data is collected via the Active People Survey[49] which is the largest ever survey of sport and active recreation to be undertaken in Europe.

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. The data is collected on behalf of a number of different partners including the Department of Health and Department for Transport; therefore we are able to use the data in a number of different ways.

	APS 2 (2007-2008)		APS 3 (2008-2009)		APS 4 (2009-2010)		APS 5 (2010-2011)		APS 6 (2011-2012)	
	%	Base(n)	%	Base(n)	%	Base(n)	%	Base(n)	%	Base(n)
Milton Keynes	35.5	501	33.0	503	35.7	558	32.3	500	38.5	507

Table 14: Adult participation in 30 minutes of moderate intensity sport once a week.

Source: Sport England

The table above illustrates the participation in sport once a week as measured by APS, it gives a year by year comparison. The table below illustrates the measure of sport and active recreation as reported by Sport England, this is measured as the number of adults taking part in moderate intensity sport and active recreation on at least 3 days a week (at least 12 days in the last 4 weeks) for at least 30 minutes continuously in any one session. This participation indicator includes recreational walking and cycling but does not include active travel, dance or gardening. Once published, the new Public Health indicator for physical activity will give a more accurate measure of the wider physical activity levels of our population.

	APS1 (2005-2006)		APS2/3 (2007-2009)		APS4/5 (2009-2011)		APS5/6 (2010-2012)	
	%	Base(n)	%	Base(n)	%	Base(n)	%	Base(n)
Milton Keynes	20.5	1015	20.9	989	18.9	1049	22.5	999

Table 15: Adults participation in sport and active recreation, at moderate intensity on three or more days a week for at least 30 minutes.

Source: Sport England

Artwalks and Wayfinding trails and Heritage Cycle walks are all initiatives that combine the benefits of people experiencing the arts and heritage whilst also participating in a physical activity thereby potentially improve their mental and physical wellbeing

'Arts on Prescription' provided by Arts for Health is a structured programme of arts activities available on a referral basis for clients with mild to moderate mental health conditions (depression, stress and anxiety) receiving health care in the community.

Active and Positive is a project that began with a series of participatory singing and reminiscence workshops with groups of older people, exploring how stigma and discrimination affect perceptions of older people as active beings. Forty singing workshops were delivered by professional musician across Milton Keynes, to approximately 300 residents and service users at Red Cross Day Centres; Age Concern lunch clubs; Excelcare Care Centres and local centres for dementia care.

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

The current services for increasing sport and physical activity across Milton Keynes are currently limited in terms of time and funding. Moving forward it must be a priority to ensure these services are increased.

- Sport and physical activity should take a lifecourse approach with promotion and opportunities available at every age.
- Sport and physical activity projects to be prioritised for funding, ensuring no loss of service.
- Ensure that brief interventions are offered to support individuals to increase their physical activity levels and uptake of sport.

- Improving the links between sport, physical activity and transport to improve the levels of active travel across the area and also access to facilities via the public transport network.
- Health, physical activity and sport should be linked to ensure that health benefits of increasing sport and physical activity levels are recorded / identified.
- Increase engagement in the Arts through the delivery of the Arts Strategy Delivery Plan.
- Enhance volunteering opportunities in Milton Keynes and build an understanding of the benefit in relation to mental and physical health.

Indicators to measure success would be

- an increase in the percentage of adults participating in sport at least once a week for 30 minutes.
- an increase in the proportion of adults achieving 150 minutes of physical activity per week.
- a reduction in the levels of obesity across the borough.
- A reduction in the life expectancy gap from the wealthiest to the poorest estates.
- An increase in number people engaged in the arts and cultural activities in Milton Keynes as it can help people with or improve their health issues
- Increase in number of people volunteering in Milton Keynes, particularly older people who may also gain access to other support through the volunteer network.
- Target participation to increase take up of cultural activities by working through schools, health care and statutory services within estates with highest deprivation in a sustained way.
- Self-awareness and recognition that cultural engagement makes a difference to wellbeing.

Policy Drivers

There are a number of strategies and policies which are pushing forwards the sport and physical activity agenda. The single biggest driver though is capturing the enthusiasm generated from the Olympic and Paralympic games and unprecedented summer of sporting success in 2012 and creating a sustainable sporting and physical activity legacy across Milton Keynes.

The Olympics were not just about the sporting events. The Cultural Olympiad which spans the four years before the Olympic Festival included activities inspired by the event – 16 million people are said to have engaged in thousands of performances, workshops and events across the UK for the London 2012 games. Many of these events celebrated the contribution of the arts to people's lives and in doing so places

value on the engagement in activities that are proven to result in people's increased health and wellbeing.

Start active, stay active: a report on physical activity from the four home countries' Chief Medical Officers, 2011[50]

Healthy lives, healthy people: Improving outcomes and supporting transparency Department of Health, 2012[51]

Creating a sporting habit for life 2012-2017
Sport England, 2012[52]

Milton Keynes Health and Wellbeing Strategy 2012 - 2015[53]

Milton Keynes Sport and Leisure Strategy 2009 -14[54]

Milton Keynes International Sporting City Report, 2011[55]

Milton Keynes Cycling Strategy[56]

Arts Strategy[57]

Heritage Strategy[58]

Public Arts Strategy[59]

3.2 Smoking

Who is at risk and why?

Smoking-related disease is still the leading cause of preventable death in the UK. Even though rates of smoking have been steadily declining from 45% in 1974 to 21% in 2011.

8 million people smoke in England, yet smoking remains the primary cause of preventable morbidity and premature death in the country. Over 80,000 people each year in England die from smoking related diseases, most commonly lung cancer, chronic obstructive pulmonary disease (COPD) and cardiovascular disease (Department of Health 2012).

It is estimated that illness and diseases associated with smoking costs the NHS £1.7 billion annually. This includes approximately 459,900 hospital admissions, with direct costs arise from GP consultations, prescriptions for drugs and various other costs related to treating diseases attributable to smoking. This figure has been on the rise since 1996 and is set to continue.

It is estimated that in 2011, 36% (22,500) of all deaths due to respiratory diseases and 28% (37,400) of all cancer deaths were attributable to smoking. In addition, an estimated 14% (18,100) of deaths from circulatory diseases and 5% (1,100) of deaths from diseases of the digestive system were attributable to smoking.

Level of need in the population

Smoking prevalence in Milton Keynes is estimated as 22.9%, (confidence intervals 20.6% - 25.6%). Using the new ONS population projections for 2012, this represents between 39,200 and 48,800 current smokers in Milton Keynes aged 18 and upwards. This prevalence is not significantly different from the overall rate for England (20.7%).

Tobacco use is also the leading cause for health inequalities. Smoking prevalence is higher in more deprived populations and amongst the routine and manual group of workers, estimated at 31.8%. Smokers in Milton Keynes are not evenly distributed through the population – figures show that smoking is also more prevalent amongst the younger age groups of 18-34 years of both sexes.

The profiles also estimate that approximately 34.8% of the population are ex-smokers and 42.1% of the population has never smoked (The London Health Observatory, 2012).

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

Services to help people stop smoking in Milton Keynes

In England, over the past 10 years, over 4 million quit dates have been set with local NHS Stop Smoking Services, and there have been over 2 million successful quit attempts (measured at four weeks).

It is suggested that two thirds (67%) of current smokers reported wanting to give up smoking, with three quarters (75%) reporting having tried to give up smoking at some point in the past (Department of Health, 2012).

In Milton Keynes there are specialist stop smoking advisors available in every GP practice and many pharmacies. The advisors provide a quit programme involving, behavioural support and access to appropriate medications to assist individuals to quit smoking.

In 2011/12, the service has seen 4,144 people setting a quit date with 2366 patients having stopped smoking at four weeks, equally to a quit rate of approximately 60%. Overall for the population Milton Keynes aged over 16 this equates to 1223 smoking quitters per 100,000 compared to the England average of 944.

Addressing Smoking in Pregnancy

Smoking is a significant risk factor for pregnant women, as it can lead to a range of serious health problems, including lower birth weight, complications during birth and is estimated to increase the risk of infant mortality by 40%.

Babies from deprived backgrounds are more likely to be born to mothers who smoke and to have much greater exposure to secondhand smoke in childhood. This passive smoking can also increase the risk of respiratory infections in children such as asthma and middle ear infection. Living in a household in which one or more people who smoke can more than double the risk of sudden infant death. (Royal College of Physicians 2010).

Smoking in pregnancy prevalence in Milton Keynes is 13.1%; though slightly lower the England average of 13.2% (2011/12). The rates of smoking in pregnancy have been falling both locally and nationally since 2008, however it remains a key priority.

Primary Prevention: Smoking in Young People

Half of the young people who take up smoking will die prematurely from a smoking-related disease if they continue to smoke. There is a strong evidence to suggest that children and young people who view smoking as a normal part of everyday life, are more likely to become smokers themselves.

In England, almost two-thirds of current and ex-smokers say that they started smoking regularly before they were 18 years old, with 39% saying that they were smoking regularly before the age of 16.The findings suggest that very few individuals will start smoking after the age of 25.

Although smoking rates among young people are declining, current data shows the rates are still significant. In 2010, 27% of pupils had smoked at least once (compared with 44% in 2001) and 5% reported smoking regularly (NHS Information Centre, 2011).

Young women aged 11 to 15 are more likely to smoke than their male peers (28 % and 25 % respectively) and are more likely to be regular smokers (6 % and 4 % respectively), (Fuller 2011).

Links with other areas to be addressed

Work is required to increase the opportunities for smokers to receive brief advice about quitting smoking and how to access or be referred to local stop smoking support. Smoking advice can come from a range of sources and there is a need to engage with larger proportion of health and social care professionals, workplaces and community settings who have contact with people who smoke; children centres, secondary care, drug and alcohol services and social care.

To continue to drive work and support of the Milton Keynes Tobacco Control Alliance (TCA), in order to maintain partnerships with influential groups and stakeholders including, Milton Keynes Council, NHS Milton Keynes, Buckinghamshire Fire and Rescue, Milton Keynes Hospital Trust and other commercial and voluntary organisations. The work of the TCA will include the enforcement of tobacco legisation including the ban on tobacco point of sale displays in large outlets and working on smokefree homes and family cars.

To encourage local authorities and local NHS organisations to act as exemplars in supporting their staff to stop using tobacco.

To continue to work with and increase access to use local intelligence and data to make stop smoking services available in ways that meet the needs of their community, especially for high smoking-prevalence and high risk groups, such as pregnant women.

Key Messages for Future Services

The aim is to increase the number of people who are signposted and referred to stop smoking support thereby increasing the number of people who quit smoking.
More comprehensive Stop Smoking Service provision is required to address the gaps in smoking support among those groups most vulnerable to the impact of smoking.

To implement a Tobacco Information and Stop Smoking Programme, supporting secondary schools to develop mechanisms to discourage young people taking up smoking and provide brief advice and support to young people who are smokers. This programme also includes development and implementation of smoking polices and in house trained advisors within these settings.

To implement an innovative social marketing campaign to raise awareness of the impacts of smoking in pregnancy within Milton Keynes. To promote the services and support available within Milton Keynes to women who smoke during pregnancy. There is a need to work closely with the maternity services to further develop mechanisms in place to provide pregnant woman with support and guidance to stop smoking.

To increase hospital-based stop smoking support leading to the provision of a full quit programme which has not yet been widely available within the hospital setting. The hospital trust should be encouraged via quality measures within their service contracts to provide an in-house stop smoking support for all patients including both in-patients and out-patients.

Continue to support the practices and pharmacies in the most deprived areas**,** to increase engagement with the local community, to increase the signposting and referrals for people who smoke.

The service requires a unique identity and branding for service delivery across Milton Keynes. We need to provide clear messages and materials to encourage stop smoking brief advice in health and social care as well as increase referrals to stop smoking support services.

Indicators to measure whether we have achieved our priorities

A regular Milton Keynes lifestyle survey which will enable us to better estimate the level of smoking within our population, rather than the current estimates based on the modelling of national data.

The reduction of smoking prevalence among adults, the national ambition is for smoking prevalence in England to be 18.5% or less by the end of 2015.

The achievement of the national target for the number of 4-week smoking quitters that have attended NHS Stop Smoking Services, in Milton Keynes is equates to a target of 2,365 smoking quitters at four weeks.

The reduction in smoking during pregnancy (measured at time of giving birth), the national ambition is for smoking rates in pregnancy to be 11% or less by the end of 2015.

The reduction of smoking prevalence among young people, the national ambition is for regular smoking among 15 year olds in England to 12% or less by the end of 2015.

Evidence of what works and Policy Drivers

Department of Health (2011) Healthy Lives, Healthy People: A Tobacco Control Plan for England 2011. Department of Health, London.[60]

NHS Information Centre (2012). *Statistics on Smoking: England, 2012*. NHS Information Centre, Leeds[61]

Public Health Outcomes Framework (2012)

Milton Keynes Health and Wellbeing Strategy (2012-2015)

National Institute for Health and Clinical Excellence (2010). *Quitting smoking in pregnancy and following childbirth: Guidance*. Nice, London.[62]

National Institute for Health and Clinical Excellence (2006). Brief interventions and referral for smoking cessation in primary care and other settings. Guidance. Nice, London[63]

References

Department of Health (2011) Healthy Lives, Healthy People: A Tobacco Control Plan for England 2011. Department of Health, London.

Integrated Household Survey (2012). Office for National Statistics

London Health Observatory (2012) Local Tobacco Profiles for England.

NHS Information Centre (2012). *Statistics on Smoking: England, 2012*. NHS Information Centre, Leeds

Passive smoking and Children: A report by the Tobacco Advisory Group of the Royal College of Physicians 24 March 2010

Fuller (2011) cited by Sutcliffe K, Brunton G, Twamley K , Hinds K, O'Mara-Eves AJ, Thomas J (2011) *Young people's access to tobacco: a mixed-method systematic review*. London: EPPI Centre, Social Science Research Unit, Institute of Education, University of London.

3.3 Healthy Weight

Who is at risk and why?

Obesity is when a child or adult is carrying too much body fat for their height and sex. Being obese increases the risk of developing serious diseases such as type 2 diabetes, cardiovascular disease and cancer. It can also reduce peoples prospects in

life, affecting their ability to get and hold down work, their self-esteem and mental health.

Level of need in the population

In Milton Keynes a quarter of adults, 9.8% of Reception class children and almost 20% of Year 6 pupils are defined as clinically obese. It is clear that obesity is a growing public health concern.

In 2011, the Department of Health released an obesity call to action, which outlined a new approach to tackling obesity including a national ambition to achieve a downward trend in the levels of excess weight in adults and children. This new approach is underpinned by the latest evidence about the causes of obesity, good practice and engagement with a wide range of partners and experts. It outlines the role for Government and partners at national and local level to transform the environment so that it promotes healthy lifestyles, provides information and supports people to make healthier choices and secures appropriate services to tackle excess weight.

Current services in relation to need

- During 2011 over 60 staff were trained in the core HENRY (Health, Exercise, Nutrition for the Really Young) training, with more than 20 of the staff progressing into the group facilitation course.
- The Motiv8 programme continues to support children and their families to lead healthier lifestyles and control their weight. At the beginning of 2012 an evaluation of the programme was completed.
- HALO (Health & Lifestyle Opportunities) is delivered by the Health Promotion Dietetics service, supporting individuals to lose weight and eat more healthily.
- There are a variety of activities taking place in Milton Keynes to support Change4Life.
- Reactivate Milton Keynes has a variety of different activities and courses running across the area, offering individuals the opportunity to become more active and try new activities during the 'Give it a Go' weeks over the year.

Problems and evidence

In 2007, the Foresight Report[64] proposed for the first time that we live in an 'obesogenic' environment. Levels of obesity are influenced by a number of factors including physical activity, food, psychology, infrastructure and economy.

We must ensure that there is education around obesity and its effects on physical and mental wellbeing, developing a lifecourse approach to reducing the levels in Milton Keynes starting in Early Years, through schools and into the workplace. We must also ensure that services provide opportunities for a variety of different physical activities and sports including those for people who have not previously been active. We must make linkages between transport, physical activity and obesity to promote active travel as a common transport choice introducing innovative ideas to getting people more active, ensuring that pedestrians and cyclists are at the heart of all strategies.

Issues/priorities from the needs assessment and what are we going to do as a result

The current services for reducing obesity in Milton Keynes do not meet the identified needs. Following a recent review of services, it has been highlighted that services have limited capacity and would not be able to respond to an increase in demand as a result of increased referrals. For this reason a significant investment in services is necessary to impact obesity levels in Milton Keynes.

- A multi agency education and promotion programme around the importance of achieving and maintaining a healthy weight is required to initially highlight the issue.
- A life course approach to obesity should continue to be developed, with focus in those areas highlighted as being high risk for obesity. Interventions should be available for all age groups.
- Ensure the learning and insight gained from the HENRY training is implemented into the community and parenting courses are delivered within areas of greatest need.
- Develop community weight management interventions to ensure they are accessible to patients in the community, also to provide a range of solutions as well as specific weight management sessions for individuals wishing to make changes to their lifestyle.
- Ensure that a wide range of activities are delivered at a community level, including cooking on a budget, basic cooking skills and physical activity courses.
- Linkages into other service areas should be pursued to ensure that obesity is combated through a wide range of partners to achieve the greatest impact.
- Ensure that brief interventions are offered to support individuals with weight loss attempts, including those to increase physical activity and sport uptake.
- Increase the opportunities for building physical activity into daily lives, including increasing the opportunities for active travel across the city.

What does success look like?

In order to demonstrate progress and achievement it would be necessary to refer back to the following:

- Public Health outcomes framework
- Proportion of children aged 4-5 years classified as either overweight or obese
- Proportion of children aged 10-11 years classified as either overweight or obese
- Diet: comparison with national dietary targets and guidelines (in development)
- Proportion of adults classified as overweight or obese
- Proportion of physically active and inactive adults

3.4 Alcohol Misuse

Who's at risk and why?

Alcohol is a complex public health problem. There is a general perception that individuals with alcohol problems are either alcohol dependent or are regular binge drinkers. The biggest challenge for the public health 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. Estimates suggest that in Milton Keynes 37,000 people drink at a level of increased risk and 9,000 at a level of high risk.

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

Alcohol continues to be detrimental to the health of people in Milton Keynes due to the significant health and social harms caused by drinking alcohol excessively. It is estimated that more than 25% of the population aged 16 and over drink above the recommended guidelines. Recent modelling work based on the Adult Psychiatric Morbidity Survey (2007)[65] estimates that there are 3,298 dependent drinkers in Milton Keynes who would benefit from some form of alcohol treatment, including Extended Brief Interventions of Brief Treatment. Nearly one in five adults in drug treatment also cite additional problematic alcohol use.

Milton Keynes has one of the highest rates of alcohol-related hospital admissions in the South East region and although the rate of alcohol related crimes has been falling over the past few years, it is still greater than the regional average, influenced by the large night time economy in Milton Keynes.

	Milton Keynes	South East
Admission episodes for alcohol-attributable conditions per 100,000 population (2010/11)	1861.0	1335.3
Alcohol related recorded crimes per 1,000 population (2011/12)	8.5	6.7
Alcohol related violent crimes per 1,000 population (2011/12)	6.5	5.2

Table 16: Alcohol Related Hospital Admissions and Alcohol Related Crimes

Source: NWPHO. Local Alcohol Profiles for England ()

Current Services in relation to need

Since April 2011, Crime Reduction Initiatives(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 delivers the commissioned intervention service for young people with alcohol and drug issues.

Multiple agencies, including Milton Keynes Council, NHS Milton Keynes and Northamptonshire, HMP Woodhill, Oakhill STC, Thames Valley Probation, Thames Valley Police, the Community Safety Partnership (SaferMK), the Fire and Rescue Service, the National Treatment Agency are all involved in reducing alcohol harm.

The SaferMK plan includes alcohol and drug misuse within it top six priority areas.

The following actions are currently being taken to reduce risk in the people of Milton Keynes.

- Alcohol treatment services are regularly monitored to ensure that expected outcomes are being achieved. During 2011/12 over 200 clients received structured interventions for alcohol and we expect this to increase in the forthcoming year.
- Identification and Brief Advice (IBA) interventions in primary and secondary care settings are being developed further, ensuring alcohol services work in synergy with other agencies such as AandE, GP practices, pharmacies and Sexual Health services.
- An alcohol liaison nurse post has been developed in Milton Keyes Hospital which will champion the identification and follow-up of alcohol related attendances and will support those who have been admitted to hospital as a result of alcohol related conditions.
- In addition to offering general medical services, GP practices can also provide enhanced services. Three quarters of our GP practices currently offer IBA to all patients 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, CRI and Compass.

Issues

Problems facing the alcohol treatment system include maintaining the level of investment, particularly in the current challenging financial conditions. This includes ensuring preventative work is continued; that the delivery of Identification and Brief Advice interventions is developed and structured treatment by commissioned services is effective.

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

- Continue to monitor the drug and alcohol services to ensure that alcohol continues to be a high priority within these joint services and that the majority of clients are able to successfully complete their treatment.
- Review the evidence around social marketing research and techniques to

improve our communications about the health impacts of drinking above recommended guidelines.

- Continue to develop innovative approaches to IBA services.
- Ensure alcohol advice is included in various health programmes such as Making Every Contact Count and the National Health Checks programme.
- Ensure that those most in need can access treatment.

3.5 Drug Misuse

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 suggest 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, around 1.9 per thousand population.

Currently, 86% of clients receiving structured treatment for drugs in Milton Keynes are OCUs. A further 10% are receiving treatment for cannabis and cocaine misuse. Generally, drug misuse is more prevalent among men, with less than 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.

There are no equivalent prevalence estimates for young people under 18, however OCU prevalence estimates for 15 to 24 year olds in Milton Keynes are lower than the England average. In addition the level of young people in treatment is similar, and in some cases higher than, surrounding areas with greater prevalence.

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 continues 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 and Northamptonshire, HMP Woodhill, Oakhill STC, Thames Valley Probation, Thames Valley Police, the Community Safety Partnership (SaferMK) and the National Treatment Agency to reduce substance misuse in Milton Keynes.

The SaferMK community safety plan includes drugs and alcohol misuse within it top six priority areas.

The following actions are currently being taken to reduce the risk in the people of Milton Keynes.

Regular monitoring of commissioned services to ensure that expected outcomes are being achieved. During 2011/12, 470 clients aged 18 and over received effective structured treatment for drug misuse, including 45% of the estimated number of OCUS. In addition, 90 young people received structured treatment for substance misuse. We expect both these numbers to increase in the forthcoming year.

- Setting up of five spoke sites around Milton Keynes to make services more accessible in local neighbourhoods to those who need it.
- Working with HMP Woodhill and other key prisons to ensure those leaving prison have access and links to treatment services within Milton Keynes.
- In June 2012 the Thames Valley Custody Intervention Programme commenced in Milton Keynes with the aim of improving identification and referral into treatment services for those in custody who may have substance misuse problems.

Issues and Evidence

Nationally the number of adult's newly entering treatment for heroin and crack use has fallen by 15% in two years, with the number of 18 to 24 year olds in this category halving over five years. The over 40-s have become the largest age group starting treatment. These tend to be entrenched users. This poses the problem of the treatment system being able to support these clients to successfully complete treatment whilst accommodating others with misuse issues related to other substances such as cannabis, mephedrone and other new drugs.

Drug users are more likely to complete their recovery if they have wider support to rebuild their lives, such as support with gaining employment and access to stable

accommodation. This will be a challenge for services in the current economic climate.

Other challenges identified by the National Treatment Agency include maintaining investment levels in drug treatment, the problem of new drugs, prescription drugs and alcohol; the need to help clients sustain recovery through finding employment and accommodation; and the changing organisational structures such as the transfer of public health to local authorities.

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

- Maintain investment and safeguard the gains drug treatment has made in recent years.
- 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.
- Continue to develop integrated care within primary care settings including pharmacies and GP surgeries.
- Continue to develop mutual aid programmes such as AA, NA or Smart Recovery Groups within Milton Keynes.
- Keep up to date with drug use culture for Young People, in particular focusing on legal highs.
- Focus on early intervention for young people as well as providing quality structured treatment.

3.6 Contraception and Sexual Health

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). [66]

Nationally, sexual ill health is not equally distributed amongst the population, with the greatest burden being borne by young adults, men who have sex with men, some black and minority ethnic groups and those living in areas of greatest deprivation. These inequalities are reflected in Milton Keynes where under 25 year olds have the highest diagnosed rates of chlamydia and the highest proportion of terminations of pregnancy. There are also higher rates of some sexually transmitted infections amongst particular ethnic groups. It is for this reason the local sexual health strategy recommends resources are directed towards communities where the burden of sexual ill health is greatest. (Milton Keynes Sexual Health Strategy 2010-13, Milton Keynes Public Health Team).[67]

Level of need in the population

The table below shows the rates of diagnosed sexually transmitted infection per 100,000 population with data for Milton Keynes residents listed in the bottom two rows.

	Chlamydia age 15-24	Chlamydia 25+	Gonorrhoea	Syphilis	Herpes	Warts
England 2011	2219.1	93.3	39.1	5.4	58.1	141.8
East Midlands SHA 2011	2118.2	76.2	22.3	3.7	51.9	124
Milton Keynes 2011	2473.4	99.5	20.7	2.5	43.9	122.6
Milton Keynes 2010	2244.1	75	14.5	3.3	48.9	102.4

Table 17: Rate of diagnosed sexually transmitted infection per 100,000 population

Source: Sexual health balanced scorecard. www.apho.org.uk/sexualhealthbalancedscorecard

Between the years 2010 and 2011, Milton Keynes has seen an increase in the rate of diagnosed chlamydia, gonorrhoea and genital warts but rates remained lower than residents of the East Midlands Strategic Heath Authority and England.

Chlamydia is the most common sexually transmitted infection in the United Kingdom. It is a particular problem because most people have no symptoms and left untreated, chlamydia can lead to long term health problems, including infertility (NCSP 2012). The National Chlamydia Screening Programme, aiming to screen, diagnose and if necessary treat 15-25 year olds, the group amongst which chlamydia is most prevalent, was launched in Milton Keynes in March 2006. In 2011, 9395, 15-24 year old Milton Keynes residents were tested for chlamydia. 5.8% of them had a positive diagnosis and links were made to treatment, contact tracing and prevention programmes. A new diagnostic target for chlamydia comes into force in 2013 aiming to increase the proportion of positive chlamydia screens amongst 15-24 year olds, which will require a more targeted approach. Milton Keynes is already shadowing this target.

Human Immunodeficiency Virus (HIV)

Milton Keynes continues to be an area of 'high HIV prevalence' as defined by the Health Protection Agency. As the figure below shows, there has been a year-on-year increase in the numbers of residents in Milton Keynes diagnosed with HIV. By the end of 2011, 2.46 per 1,000 15-59 year olds adults resident in Milton Keynes had received a diagnosis of HIV and 419 individuals were accessing treatment for their condition.

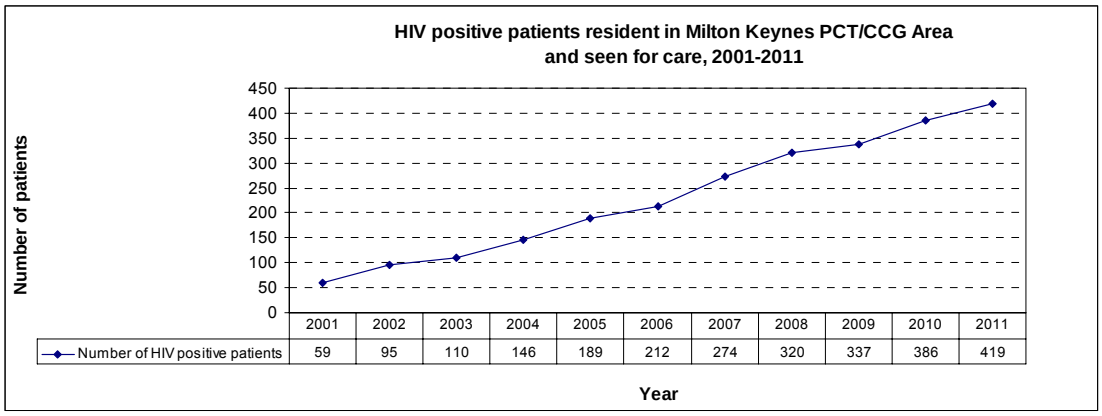


Figure 16: Numbers of Milton Keynes residents diagnosed HIV positive by year.

Source: Survey of Prevalent HIV Infections. Health Protection Agency

Without treatment, HIV infection results in destruction of the body's immune system and a progressive increase in illness. However, HIV is now a manageable condition for individuals diagnosed early and linked to effective treatment programmes and antiretroviral treatments. In Milton Keynes there are a high proportion of individuals diagnosed late and this is of continuing public health concern due to the chance of onward transmission before diagnosis and the poorer outcomes for people diagnosed late.

In 2011 the public health team undertook a health needs assessment of HIV prevention and care. The review looked at current epidemiology and projected the future of HIV in Milton Keynes without any action taken. This was incorporated with best practice review and national guidelines resulting in 27 recommendations relating to commissioning and pubic health practice (HIV Health Needs Assessment, Milton Keynes Public Health Team 2011).

Preventing Unplanned Pregnancy

Access to effective contraception and emergency contraception is key in preventing unplanned pregnancy and reducing termination of pregnancy rates. Reflecting the national picture, in Milton Keynes, the oral contraceptive pill is the most commonly used contraceptive. However, although it is effective when used as the manufacturer intended it does have an increased failure rate due to user error. In comparison Long Acting Reversible Contraception (LARC) like subdermal implants, intrauterine devices and injectable contraceptives, are the most effective forms of contraception (NICE 2005). 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. In Milton Keynes programmes to increase the use of LARC have included enhanced training for professionals and a social marketing campaign aiming to raise awareness amongst younger women. Increasing LARC usage has been a factor in the ongoing reduction in termination of pregnancy and teenage conception rates.

Young People's Contraception and Sexual Health

For women who do have a contraceptive failure, access to emergency contraception is vital. In Milton Keynes In recognition of the difficulties young people can have in

accessing this, a scheme offering free emergency contraception to under 19 year olds from pharmacies was established in 2009. Given that termination rates remain highest in 20-25 year olds it is recommended that this scheme is commissioned formally and developed to extend the age range to 25.

Each year, around 40,000 young women under 18 become pregnant in England. The majority of under 18 conceptions are unplanned with many leading to abortion. While for some young women having a child can represent a positive turning point in their lives, for the majority of teenagers bringing up a child is incredibly difficult (Department of Health 2010). Where young women choose to go ahead with the pregnancy, they are at greater risk of experiencing a range of poor outcomes including those listed below:-

- Teenage mothers are less likely to finish their education, and more likely to bring up their child alone and in poverty.
- The infant mortality rate for babies born to teenage mothers is 60% higher than for babies born to older mothers.
- Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth.
- Children of teenage mothers are generally at increased risk of poverty, low educational attainment, poor housing and poor health, and have lower rates of economic activity in adult life.

As the table below shows, the number of conceptions and terminations amongst under 18 year olds resident in Milton Keynes have fallen year on year. The overall rate of teenage pregnancy has reduced from 51.2 per 1,000 in 1998 to 29.9.per 1,000 in 2010 (ONS 2011). Figures for 2011 show a further reduction in teenage conception.

Period	Total Conceptions	Births	Terminations	No of repeat terminations	Terminations ≤12 weeks	% Terminations ≤12 weeks
2007	174	89	85	N/A	67	78.8%
2008	185	86	99	N/A	79	79.8%
2009	178	85	93	N/A	79	84.9%
2010	128	79	49	4	42	85.7%
2011	116	73	43	0	41	95.3%

Table 18: Conceptions and terminations amongst under 18 year old Milton Keynes residents

Source: terminations from BPAS Database. Births from SUS Sollis Data warehouse

An international evidence base shows the two measures for which there is the strongest evidence of impact on teenage conception rates are comprehensive information advice and support – from parents, schools and other professionals combined with accessible, young people-friendly sexual and reproductive health services (Department of Health 2010).

In Milton Keynes, Brook East of England is commissioned to provide a comprehensive specialist contraceptive and sexual health service for under 25 year olds, operating from a central base with peripatetic nurse provision and targeted outreach. Young people aged under 25 made more than 17,000 visits to this service in 2011. As part of their work Brook also co-ordinate a free condom distribution scheme for under 25 year olds in Milton Keynes and provide support for Relationship and Sex Education (RSE) in some schools.

In 2011 more than 1200 secondary school pupils from schools in Milton Keynes completed a survey of healthy behaviour. In relation to sexual health and contraception, the findings were that parents and school lessons were their main source of information about sex. However, only 35% said lessons were useful or very useful. More than 70% of year 10 pupils said they knew there was a specialist contraceptive and sexual health service for young people locally and overall the preferred location of a young person's contraceptive service was at a health centre or in school (HRBQ 2011).

Nationally myths about sex, fertility and abortion exist amongst young people and awareness about the full range of contraception is low (Department of Health 2010). This was reflected in this survey with some common misconceptions about contraception and sexually transmitted infections.

Along with these findings, there is a lack of current understanding about information provided in Milton Keynes Schools to pupils around Relationships and Sex Education (RSE) and a lack of resource to support work to enhance schools staff's skills to discuss these issues. This, coupled with national evidence that a significant number of parents lack the knowledge and/or confidence to talk to their children about relationships and sexual health issues and suggesting the wider children's workforce are not routinely equipped to do this (Department of Health 2010) all needs to be reviewed locally in order to ensure young people are as well equipped as possible with the confidence, knowledge and skills to protect their sexual health and wellbeing in the future.

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

- Reach out and target those communities and groups most at risk of poor sexual health and unplanned pregnancy through effective outreach and prevention programmes.
- Continue to ensure accessible, young person friendly specialist contraceptive and sexual health services are in place.
- Continue to ensure promotion of Long Acting Reversible Contraception.
- Undertake a review of RSE) and further education settings and put in place a system to ensure quality RSE is in place.
- Support parents and professionals working with children to have the confidence, knowledge and skills required to discuss issues around relationships, contraception and sexual health with young people.

- The opportunity to address alcohol consumption in sexual heath services should be enhanced through effective commissioning of alcohol brief intervention and similar programmes into these services.
- Expedite the recommendations of the HIV Needs Assessment. Particularly routine HIV testing for hospital admissions and new GP registrants.
- Expand the current free emergency contraception scheme for under 19 year olds in pharmacy to also include 20-25 year olds.

Policy drivers

Department of Health. 2010 Teenage Pregnancy Strategy, Beyond 2010 https://www.education.gov.uk/publications/eOrderingDownload/00224-2010DOM-EN.pdf

HRBQ (Health Related Behaviour Questionnaire) 2011. Public Health Department. NHS Milton Keynes.

National Chlamydia Screening Programme 2012. http://www.chlamydiascreening.nhs.uk/ps/index.asp

NICE. 2005. http://publications.nice.org.uk/long-acting-reversible-contraception-cg30

Milton Keynes Public Health Team. 2011. HIV Health Needs Assessment.

4.0 Health

4.1 Pregnancy and Childhood

Analysis and interpretation of health and social data for Milton Keynes population combined with findings of service evaluations and stakeholder engagements reveal that ensuring healthy pregnancies for all mothers is a priority in Milton Keynes. Other priorities are that all babies are given a healthy start to life and a healthy childhood and fewer numbers of children live in poverty.

All local services that contribute to addressing these priorities must be benchmarked against best practice in order to ensure excellent health and wellbeing for all mothers and children. The services must be universal with the capacity to identify, as early as possible, vulnerable children at risk of developing (or who are already showing signs of) social and emotional problems. Targeted, evidence-based additional services can then be provided to vulnerable children and their families. In this way Milton Keynes can reduce health inequalities, increase wellbeing and reduce child poverty.

Ensuring healthy pregnancies, deliveries and postnatal periods

Level of need in the population

A significant percentage of Milton Keynes mothers are identified as smokers at the time of delivery (between March and April 2012, the percentage was 14 %). Smoking in pregnancy increases the risks of health complications for the mother and/or her baby. Increasing the percentage of pregnant women (currently 89.7%) who receive a full health and social care risk assessment and booking before 12 weeks and 6 days of pregnancy will contribute to ensuring that fewer mothers smoke during pregnancy

and babies live in smoke free homes. A focus on school-based primary prevention of smoking offers the possibility of lowering smoking rates prior to conception.

In Milton Keynes, increasing numbers of mothers are having Caesarean sections (CS) and other medical procedures to deliver their babies, as in the case of obese women who have large babies. Yet the evidence is that a woman who experiences normal birth, will require less postnatal care, is less likely to visit her GP with postnatal complications and is more likely to breastfeed. Although Milton Keynes' CS rate (26.6% in 2011) has fallen in recent years, in line with national policy to increase normal deliveries, there is a need for Milton Keynes to reduce its CS rate to 20%.

Being unhealthy, or having an unhealthy life style, during pregnancy increases the likelihood of complications during delivery and of poor health in the postnatal period for mother and baby. This underscores the importance of promoting healthy lifestyles for all women of child bearing age and of targeting additional support for vulnerable women in order to reduce pre-conception levels of obesity, diabetes and coronary heart disease.

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

- School based services to empower children and young people to make informed decisions not to smoke. Health messages that reinforce that tobacco is a dangerous drug should be delivered as part of school based learning about the misuse of drugs.
- Innovative programmes by school nurses/ matrons and youth club leaders that promote the health and social benefits of not smoking to young people and delivers or refers to, a service specifically designed to assist children and young people to stop smoking.
- Fast track pathways to stop smoking services that are tailored for pregnant women. The pathways may be achieved by integrating stop smoking support into services provided by midwives and staff of the Family Nurse Partnership (FNP). This will address the low access and uptake of stop smoking services by pregnant mothers.
- Additional routes are required through which women may contact the maternity service, including dedicated telephone lines for texting, email addresses and webpages. This will help to increase the number of pregnant women who have early antenatal bookings.
- Birth preparation classes, for example commissioned from the voluntary sector, will particularly contribute to supporting vulnerable women in areas of high deprivation during their pregnancies, deliveries and early parenting.
- A midwife led care pathway for low risk women who have had a previous caesarean section is needed. The pathway would enable women in this group to explore the option of vaginal birth after caesarean (VBAC) and when clinically appropriate, could be promoted by GPs and midwives.

Ensuring a healthy start for all babies and a healthy childhood

Level of need in the population

There has been a downwards trend in Milton Keynes' infant death rate since 2000-2, which mirrors the trend in the average infant death rate for England. In 2008-10, Milton Keynes' rate (5.3 deaths /1000 births) was not significantly different from the average rate for England (4.5 deaths /1000 births). However, as Milton Keynes' rate was higher than the best rate in England (2.2 deaths /1000 births) it suggested that further improvements in the health of babies born in Milton Keynes could be achieved".

Despite the current knowledge that breast milk is superior to formula, and in particular, that breast milk enhances resistance to infections and promotes mental development, there has been a small gradual decline in the percentage of mothers who are partially or exclusively breastfeeding at 6-8 weeks (from 58% in 2009 to 53.9% in 2011).

The percentage of babies in Milton Keynes who receive the recommended immunizations against childhood illness at 2, 3 and 4 months remains in line with the national target of 95%. However, the percentage receiving MMR2 and pre-school booster DTaP/IPV(polio) immunisation is as yet to reach the national target. Health workers in Primary care report in some cases encountering mothers in Milton Keynes who persistently fail to attend child immunization clinic appointments.

At a Milton Keynes stakeholders' event, providers of health and social care for children agreed to transform local services with the ambition of ensuring that all children access high quality and appropriately provided care. An additional goal of the transformation was to provide parents, carers and staff greater confidence in community services. The transformation will need to take into account that as Milton Keynes continues to increase in ethnic diversity (in 2009, children from black and minority ethnic [BME] groups made up 35% of Nursery and Reception classes), higher numbers of children will present to the health and social services with conditions that are particularly prevalent in non-white populations.

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

- Local implementation of the national Child Health Programme by expanding and mobilizing the professional workforce found in the Health Visitors (HV) service, the Family Nurse Partnership (FNP) and the new Children and Families Practices (CFPs). This will strengthen the effectiveness of Milton Keynes' progressive universal service during pregnancy and early years of a child's life which includes Early Help for Families to promote sensitive parenting and the involvement of fathers.
- Staff training and policies in line with UNICEF's Baby Friendly Initiative (BFI) in Milton Keynes Hospital and Community Health Services that will ensure strong positive messages about breastfeeding from all health providers. This will also ensure that breastfeeding support is available from health staff as part of services and from peer supporters working in baby cafes and drop-in centres.

- Enhancement of the immunization role of Health Visitor and Family Nursing Partnership staff, through training and partnership working with staff of Children's Centres, public health and primary care. This will enable HV and FNP to better motivate parents to attend immunizations appointments.
- Transformation of community services to redesign paediatric pathways, ensuring access to care that is close-to-home and high quality. Addressing this need will reduce the time spent in hospital by under 19 year olds for health problems that may be managed outside hospital such as asthma, diabetes and epilepsy.
- Expansion of the existing Motiv8 programme and its integration with the Health, Exercise and Nutrition for the Really Young (HENRY) programme and the National Child Measurement Programme. This is presented in detail in the section on obesity.
- Increase in the capacity of services that manage conditions that have higher incidence and prevalence in non-white populations e.g. high quality sickle cell clinics

Ensuring fewer numbers of children live in poverty

Level of need in the population

HMRC reports that as at 31 August 2010, 20.1% of Milton Keynes' children live in poverty (i.e. live in families in receipt of out of work, means-tested benefits or in receipt of tax credits where the income reported is less than 60% of median household income).[68] Among the 23 wards of MK, there is a marked variation in the child poverty rates; Sherington having the lowest 6.2% and Eaton Manor the highest 40.9%. The eight wards that have highest proportion and numbers of children in poverty are Eaton Manor, Woughton, Campbell Park, Wolverton, Stantonbury, Bletchley and Fenny Stratford, Bradwell and Denbigh. Of the 12,305 Milton Keynes children who live in poverty, approximately 74% belong to lone-parent households, 57% in households where the youngest child is aged between 0-4 years and 47% in households in which there are 3 more children.

The Milton Keynes Children and Family Partnership has concluded that addressing child poverty requires all stakeholders to work together to provide employment opportunities for parents and educational support initiatives for disadvantaged children. This includes providing early years help to vulnerable children to ensure that, emotionally and socially, they are ready to learn when they start school.

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

- Strengthening of pathway for identifying disadvantaged 2 year olds and providing 15 hours a week free early education. The pathway will be most effective if it incorporates joint working by midwives, health visitors, FNP and children's centre staff.
- Professional mobilisation of primary school teachers to ensure that they use the pupil premium to provide evidence based approaches for improving learning, educational aspiration and attainment of disadvantaged pupils.

Mobilisation may be through workshops, seminars and exchanges programmes.

- Local schemes to encourage employment whenever parents make contact with health and social services. The schemes should include the signposting and provision of skills training, flexible employment and affordable child care.
- Extension of the criteria for accessing FNP so that more families with young children will be supported, and expansion of the FNP's remit to have a greater focus on signposting young parents to locally available advice that will lead them to employment .

Indicators to measure the progress we make in achieving the priorities are summarised in the table below.

Priority	Measures of Success		Monitored By
Ensuring healthy pregnancies, deliveries and postnatal periods	-Reduction in complications and death from Pregnancy, childbirth and the puerperium - Reduced neonatal mortality and stillbirths - Reduced infant mortality - Reducing proportion of all term babies (>=37 weeks gestation) admitted to neonatal care.	-Increasing score survey of women's experience of maternity services	*Current service specification with MKHFT that ensures best quality of maternity and neonatal care* *Child and Maternal mortality statistics* *Local women involved in service development* *Increased % of Pregnant women seen by 12 wks and 6 days* *Quadruple testing for Downs Screening in place* *Increased Breast feeding % initiated*

Priority	Measures of Success		Monitored By
Ensuring a healthy start in lives for all babies and a healthy childhood	-Reduced unplanned time spent in hospital by under 19 olds for asthma, diabetes and epilepsy that should be managed outside hospital -Reduced numbers/ percentage of lower respiratory tract infections in children that become serious and requiring Emergency admissions *time from first NHS presentation to diagnosis or start of treatment*	-high score on questionnaire of children and young people's experience of healthcare	*Increased breast feeding % totally or partially (6-8 wks)* *Implemented triage and assessment system to respond to acute illness in babies* *% Coverage rates of childhood immunizations meeting local and national targets* *children and families involved in service development* *Reduction in child death rates from specific causes that are amenable to health and/or social care e.g. asthma, pneumonia, sickle cell disease accidents*
	High Quality CAMH Service		*Qualtiy measures for CAMHs Therapy Services*
Ensuring fewer numbers of children live in poverty	*Increased employment rate among parents in the most deprived wards in MK*	*Reduction in the child poverty rate as reported by HMRC's snapshot*	*Decrease number of households income poverty and Income and wealth inequality*
	Rising educational aspiration and attainment among disadvantaged children		*Increasing educational development score for 5 year olds* *Increase in proportion of BME pupils achieving level 4+ at KS2 in both English and maths* *increasing proportion of 16-year-olds getting five GCSEs at A*-C including English and maths* *decreasing proportion of 16 to 19 year-olds not in*

Priority	Measures of Success	Monitored By
		education, employment or training (NEET)

Evidence of what works and policy drivers

NICE guidance on maternal care comprising of 9 guidelines relating to birth and 29 relating to pregnancy, including caesarean section, antenatal care, perinatal mental health, diet, smoking and exercise;
http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7252

High Quality Women's Health Care, a report produced by the RCOG looks at how NHS women's health services could be configured to provide high quality, safe and timely car; http://www.rcog.org.uk/high-quality-womens-health-care

The UNICEF and WHO's Baby Friendly Initiative (BFI) supports maternity hospitals to implement the Ten Steps to Successful Breastfeeding
http://www.unicef.org.uk/BabyFriendly/Health-Professionals/Going-Baby-Friendly/Maternity/The-International-Code-of-Marketing-of-Breastmilk-Substitutes-/

The UK BFI also works to implement the Seven Point Plan for Sustaining Breastfeeding in the Community; http://www.unicef.org.uk/BabyFriendly/Health-Professionals/Going-Baby-Friendly/Community/Seven-Point-Plan-for-Sustaining-Breastfeeding-in-the-Community/

Green Book: Immunisation against infectious disease; http://immunisation.dh.gov.uk/gb-individual-current-chapters/

Child Poverty in Milton Keynes: Analysis, Experience and Action A report from the Milton Keynes Child Poverty Commission, produced on behalf of the Children and Families Partnership April 2012 http://www.milton-keynes.gov.uk/child-poverty-commission/documents/Child_Poverty_Report-_24.05.12.pdf

Transforming Community Services: Ambition, Action, Achievement Transforming Services for Children, Young People and their Families 2009
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102316.pdf

Sickle Cell Disease In Childhood Standards and Guidelines for Clinical Care 2nd edition October 2010: http://sct.screening.nhs.uk/getdata.php?id=11164

A Sickle Crisis? Report of the National Confidential Enquiry into Patient Outcome and Death (2008) http://www.ncepod.org.uk/2008report1/Downloads/Sickle_report.pdf

The Sutton Trust Toolkit of Strategies to Improve Learning Summary for Schools Spending the Pupil Premium (2011) http://www.suttontrust.com/research/toolkit-of-strategies-to-improve-learning/

4.2 Dental Health

Level of need in the population

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.

Results from 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.

Results from the 2011/12 5-year-old survey are not yet available.

An adult dental health survey (ADHS) has been carried out every 10 years since 1968 in England 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.
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%).

Regular ongoing dental surveys are carried out of those who attend dental practices by the Business Services Authority and used to help monitor the quality and accessibility of services.
GP patient survey results from 2010 showed that 88% of those who tried to visit a dentist in the previous 2 years were able to access care, but the percentage is lower than the England average (92%). Those who were trying to access urgent care were less likely to be able to find a dentist (80%) than those who were attending for routine care (91%).

Of those who did not visit an NHS dentist within the previous 2 years, a fifth would prefer to visit a private dentist and a quarter have stayed with their dentist who changed to providing private care. Other common reasons for non-attendance were that respondents didn't feel there were any NHS dentists (18%) or respondents felt they did not need to see a dentist.

Information from 'advice and information' at the PCT reflect similar issues about not

being able to find a dentist for urgent care, and other common concerns are related to pricing of dental services and what services can and can not be obtained 'on the NHS'.

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

There are 3 main priorities for dental health

1. Prevent disease in early years.
2. Work with care homes to prevent disease, increase the skills of carers in oral hygiene measures and ensure access to treatment services.
3. Improve access to general dental services.

Successful prevention of disease in the under 5s not only prevents pain and suffering in small children but can have an ongoing impact in terms of reduction of decay and gum disease in later life.

As more of the older generation retain their teeth, treatment services become challenging both in the complexity of treatment to restore broken down teeth and in the medical and mental health condition of those who require care, especially those in care home settings.

Despite the improvement in the number of patients accessing a dentist in Milton Keynes in recent years, NHS Milton Keynes commissions below average levels of dental services compared to the rest of England and patients surveys have shown particular problems with accessing urgent care. As the population in Milton Keynes continues to grow, additional capacity will be required and the new NHS CB will need to monitor and procure services to meet demand.

There needs to be strong links between oral health promotion services and nursery and early years settings. Health food policies and fluoride tooth brushing schemes together with outreach fluoride varnish schemes in the more deprived areas have shown benefits in Milton Keynes in the past and need to be continued.

General Dental Practitioners (GDPs) have a key role to play in prevention for those who attend the dentist but all health professionals and those involved in the care of children should be aware of the key oral health messages.

More needs to be done within care homes in terms of education of carers and availability of fluoride to prevent deterioration of oral health in those who are vulnerable and unable to access care easily.

CCGs, the local authority, oral health promoters, GDPs and dental commissioners need to work together to ensure that oral health is assessed alongside other medical health needs when people enter residential care and prevention is available alongside dental services for those who need treatment.

NHSCB, PHE and the local authority will need to work together to ensure that dental services meet the local demand for care in the population.

A review of oral health promotion is currently underway to assess how to use the

resources available in the best evidence based way to prevent disease.
The Smile Award for nursery and early years settings should continue so that small children are given healthy snacks and helped to brush their teeth with fluoride toothpaste.

Outreach fluoride varnish schemes where a dental practice attends children's centres to apply a preventive varnish should be extended so that those children most at need are able to access care easily.

Work needs to be undertaken to ensure that those in care homes have an oral health assessment and access to health promotion and treatment services. Education of those who care for the residents needs to be improved so that they are confident in providing oral hygiene measures.

An assessment of need for general dental services is underway to inform future commissioning decision of the NHSCB. Access to urgent care will be part of this review.

Indicators to measure the progress we make in achieving the priorities are summarised below:

- Dental surveys of 5 year olds are undertaken by the National Dental Epidemiology programme and Milton Keynes should strive to have better oral health than the national England average. Benchmarking can continue using the ongoing survey results.
- For older people in care homes, a policy which ensures that oral health assessment is carried out, and training provided for carers in oral hygiene methods would be a positive step towards improving health. Ideally a survey of care home residents and carers should be undertaken before and after steps are put in place to be able to evaluate success.
- Increases in access to general dental services can be measured by monitoring the statistics of the percentage of the population who access care and through patient surveys of ease of finding a dentist.

Evidence of what works and policy drivers

Department of Health (2005) Choosing better oral health. Accessed at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4123253.pdf

Department of Health and the British Association for the Study of Community Dentistry (2009) Delivering Better Oral Health: An evidence based toolkit for prevention. Accessed at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102982.pdf

Department of Health, (2009) NHS Dental Services in England. An independent review led by Professor Jimmy Steele. Accessed at: http://www.dh.gov.uk/en/Healthcare/Primarycare/Dental/DH_094048

4.3 Mental Health

People with Mental Health Problems

Who's at risk and why?

Tackling mental illness and promoting mental wellbeing is essential not only for individuals and their families, but also to society as a whole.

- At least one in four people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time.
- Almost half of all adults will experience at least one episode of depression during their lifetime.
- One in ten new mothers experiences postnatal depression.
- Mental ill health represents up to 23% of ill health in the UK and is the largest single cause of disability.
- People with severe mental illnesses die on average 20 years earlier than the general population

No Health without Mental Health (Department of Health 2011)

Mental health problems are linked to a wide range of issues including poor educational achievement, poor physical health 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.

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 69 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

At present there is a pooled budget between NHS MK and Milton Keynes Council to jointly commission and provide health and social care services for people with mental health problems. Services are commissioned through Milton Keynes Council and the Milton Keynes Clinical Commissioning Group and provided by Milton Keynes Community Health Services provision of joint mental health services.

A service transformation programme has been underway to improve services through creating a single point of access and services that are based around the needs rather than the age of service users.

The gateway to secondary mental health services the Assessment and Short Term Intervention Team (ASTI) is being merged with the Acute Home Treatment Team (AHTT) during 2012/13 to create a Mental Health Assessment Service which will provide a single point access available 24/7.

Two distinct care pathways will be created: a Recovery Pathway for people with (acute and) functional mental health problems and a Pathway for people with dementia where services will be provided to people based on their needs not their age.

A single remodelled Recovery Team will deliver recovery services through early intervention, 3-6 months casework, crisis intervention, alternative interventions to hospital, assertive outreach where required and work with those who present with complex needs such as personality disorder and dual diagnosis.

An Improving Access to Psychological Therapies (IAPT) service is also provided by MK CHS. This provides evidence-based psychological therapy services for people experiencing depression and anxiety disorders.

In addition to the above complementary services such as housing and employment support, independent living skills and counselling services are commissioned from the voluntary sector.

Projected service use and outcomes

Mental health - all people	2012	2015	2020	2025	2030
People aged 18-64 predicted to have a common mental disorder	24,985	25,366	26,141	26,906	27,647
People aged 18-64 predicted to have a borderline personality disorder	697	708	730	751	772
People aged 18-64 predicted to have an antisocial personality disorder	551	558	573	591	607
People aged 18-64 predicted to have psychotic disorder	621	630	649	668	687
People aged 18-64 predicted to have two or more psychiatric disorders	11,204	11,370	11,710	12,055	12,386

Table 19: Milton Keynes - People aged 18-64 predicted to have a mental health problem by type projected to 2030

Source: Projection Older People Population Information, http://www.poppi.org.uk/

Figures may not sum due to rounding Crown copyright 2012

The total number of people with a common mental health problem shows a moderate increase of approximately 10% over the next 18 years. This represents around 7% of the overall rise in adult common mental health disorder in the East Midlands area. It is slightly higher than the predicted overall growth for England.

The rise of those with borderline and antisocial personality disorder over the next two decades is also moderate, with growth expected to be approximately 10% in both categories. The East Midlands is expected to see growth across the region in these two categories of 7.9% and 8.8% respectively. For those with psychotic disorder, again growth is in the region of 10% and this is replicated in the figures for growth in those with two or more psychiatric disorders.

This moderate but steady rise in numbers suggests the ongoing need for the range of services that exist. Planning assumptions about future capacity will need to take into account the predicted rise, but in doing so will need to reflect the changing patterns of service delivery needed to ensure delivery of population mental health and wellbeing. The large numbers of people with common mental disorder suggest the need to build capacity in primary care mental health and other services such as housing support, as well as ensuring the right range of secondary care provision.

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

The Milton Keynes Joint Health and Wellbeing Strategy has designated mental health as one its strategic priorities (Improve Wellbeing) and states its intention:

To improve access to, and quality of, mental health promotion and services through:

- Working within schools and other settings to build self esteem in young people.
- Improving access to a range of psychological therapies.
- Ensuring access to high quality dementia care.
- Investing in the promotion of physical activity.
- Promoting safe levels of drinking.
- Reviewing actions taken to prevent suicide and to support those at risk of suicide.

An interim Mental Health Strategy was produced for 2012/13 which focused mainly on service transformation in the secondary mental health services. It was recognised that a longer term, wider reaching strategy needed to be produced to include the wider range of services that could help promote our populations mental health and wellbeing as well as secondary mental health services. An up to date mental health needs assessment will be required in order to develop the strategy.

A Mental Health Partnership Board has been launched to replace the Mental Health Local Implementation Team; this Board will continue to involve service users and carers in improving mental health services locally. Key themes that include welfare reform, physical health will be discussed at each meeting.

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. Dementia is considered in a separate chapter below. This particular section describes the mental health conditions (apart from dementia) that impact on older people's health in Milton Keynes.

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. The table below 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 be around 6,800.

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

Table 20: Estimated Number of over 65s with depression in Milton Keynes in 2009.

Source: Projection Older People Population Information, http://www.poppi.org.uk/

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.

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.

Recommendations

- Promote the message that stopping smoking, sensible alcohol consumption, healthy eating and physical activity have health benefits even at older ages.
- Re-examine the access to and availability of health and social care services (including the third sector), in the light of changes to health and social care.
- Develop active partnerships with older people in pathway redesign and decision-making for long term conditions using outcome-based measures that reflect patient experience.
- Comply with the requirements of the national Carers' Strategy as identified by the Joint Carers' Strategy for Milton Keynes.

Dementia

Who is at risk and why?

Dementia is a global term used to describe a range of neurological disorders characterised by a decline in intellectual and other mental functions. The symptoms include memory loss, mood changes, and problems with communication and reasoning, language impairment, disorientation, change in personality, self-neglect and behaviour which is out of character. (Department of Health, 2001)

These symptoms are more severe than those experienced in normal ageing and occur when the brain is damaged by certain conditions, such as Alzheimer's disease, or a series of small strokes. The symptoms gradually get worse, with different needs emerging as the illness progresses. The severity of dementia can be categorised as mild (55%), moderate(33%)or severe (12%)

Dementia is predominantly a disorder of later life, but a small percentage of people under the age of 65 have the illness. 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. [70]

These prevalence rates have been applied in the table below to ONS population projections for Milton Keynes of the 65 and over population to give estimated numbers of people predicted to have dementia by 2015. In 2012 there were about 700,000 people with dementia in the UK and 2050 in Milton Keynes.

Prevalence %			
Age	Males	Females	Persons
30-64	0.1	0.1	0.1
65-69	1.5	1	1.3
70-74	3.1	2.4	2.9
75-79	5.1	6.5	5.9
80-84	10.2	13.3	12.2
85-89	16.7	22.2	20.3
90-94	27.5	29.6	28.6
95+	30	34.4	32.5

Table 21: dementia prevalence rates in UK

Source: POPPI

Dementia costs the UK economy £17 billion a year and, in the next 30 years, the number of people with dementia in the UK will double to 1.4 million, with the costs trebling to over £50 billion a year[1].

Of the several different types of dementia, Alzheimer's disease is the best known and the most common, accounting for more than 60% of all cases; dementia related to vascular disease is the next most frequent (17%). A further 10% of cases are related to a combination of the two. The mean survival with Alzheimer's disease is 7.1 years

and 3.9 years with vascular dementia[1]. People with Downs Syndrome have increased risk of getting Alzheimer's due to chromosomal abnormalities

Vascular Dementia
Certain factors can increase a person's risk of developing vascular dementia. These include:

- a medical history of stroke, high blood pressure, high cholesterol, diabetes (particularly type 2), heart problems, or sleep apnoea (where breathing stops during sleep).
- a lack of physical activity, drinking more than recommended levels of alcohol, smoking, eating a fatty diet, or leaving conditions such as high blood pressure or diabetes untreated.
- a family history of stroke or vascular dementia.
- gender - men are slightly more likely to develop vascular dementia.
- an Indian, Bangladeshi, Pakistani, Sri Lankan or African Caribbean ethnic background.

Level of need in the population

The most up to date Milton Keynes population data gives the following predicted numbers of people with dementia in Milton Keynes.

	2012	2015	2021
TOTAL	2067	2340	3250

Table 22: Prevalence estimates for dementia in the Milton Keynes population.

Source: National Dementia Prevalence Calculator

The estimated prevalence for dementia based on the growing population is significantly higher than the number of people currently registered with a diagnosis of dementia on the Quality Outcomes Framework (QOF) dementia register at primary care level.

Total Persons predicted to have dementia	Number with dementia registered with practice (as per data March 2012)	Percentage of predicted number diagnosed	Difference Actual-Expected = diagnosis gap
2067	862	42%	-1205 = 58%

Table 23: Dementia in Milton Keynes- Predicted vs. Reported numbers at GP practice level

Source: QOF data 2010/11, IC -ONS

Of the 862 individuals with diagnosis of dementia in Milton Keynes 83 people were diagnosed by the Milton Keynes Community Health Service (MK CHS) Memory Assessment Service between the service opening in December 2010 and August 2012.

Projected service use and outcomes

There are a number of services in Milton Keynes currently delivering care for people with dementia and their carers. These include a memory assessment service, a jointly funded health and social care Community Dementia service and local nursing and residential homes.

Social and community support services in Milton Keynes

The Referrals, Assessments and Packages of Care statutory returns to central government show in Milton Keynes over 1,600 people were receiving social care for Mental Health problems in 2010 - 11. Of these, 424 were recorded as dementia this equates to 26.5%.

Out of 2067 people predicted to be living with dementia in Milton Keynes 424 people with dementia are known to be in receipt of social care services. Further investigation is required to establish whether people not receiving care are being supported by family and friends, the voluntary sector or paying for independent services or whether this gap represents a level of unmet need.

Primary client type	Total (actual number of customers)	Community based Service	Residential care	Nursing Care
Mental Health (total)	1613	1345	274	76
Dementia	424	242	206	50
Percentage of which dementia	26%	18%	75%	66%

Table 24: Number of clients receiving services provided or commissioned by the CASSR during the period, by age group, primary client type, and service type

Source: RAP 2011 – 2012

There is a clear need to develop a range of local dementia services which will meet the needs of the growing population.

Evidence of what works and policy drivers

The National Dementia Strategy[71] sets out the expectations regarding what should be provided for people with dementia and provides a clear direction to meet this challenge. The National Dementia Strategy contains 17 key objectives which the Milton Keynes Dementia Partnership Board is using to prioritise its work.

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

Priorities have yet to be finalised by the Dementia Partnership Board but are likely to include Implementation of key elements of Milton Keynes' Joint Commissioning Strategy for dementia.

- Good quality early diagnosis by improving public and professional awareness and understanding of dementia and access to services.

- Early diagnosis and effective management help improve the quality of life for people with dementia and their carers.
- Ongoing support of the transformation of Community Mental Health Services to an ageless need-led service which provides dementia services to people of all ages.
- Involvement in the regional Dementia Transparency Project to provide better information for people with dementia and their carers.

Improved experience of hospital care

- Improved pathway from hospital to memory assessment service in place.
- Implementation of Mental Health Hospital Liaison Service to ensure that people with dementia and mental health problems in the Milton Keynes hospital receive the appropriate care.
- Support Milton Keynes hospital in developing a dementia improvement plan.

Improved quality of care in residential/care homes

- Implementation of the QOF by health and social care.
- Effective contract management of residential and care homes.
- Specific focus on the training needs of nursing and care homes.

Improve Personalisation of community care and living well with dementia

- Evaluate the range and capacity of community provision to meet the current and future needs of local population. Identification of options paper as required.
- Good-quality information for those diagnosed with dementia and their carers.
- Ensuring priorities within the strategy are reviewed in light of guidance, customer and carer views and lessons learned.
- Undertaking further work on specifying and measuring meaningful outcomes for customers and carers.

A workforce fit to deliver services to support the care pathway for dementia

- Develop and implement multi-agency training in line with national guidelines.

Service Users and Carers' views

Views on the local dementia services and future development are sought through a service user and carers' sub-group of the Dementia Partnership Board which meets quarterly.

In summary

Raising awareness of dementia will help to improve early diagnosis which will enable people with dementia and their carers to gain timely access to services. A focus on improved carer support, and good quality seamless care along the whole dementia care pathway, will enable people with dementia to maintain their health and wellbeing and stay at home for longer.

Estimating the future number of cases of dementia in PCTs and upper tier local authorities in England
http://www.nepho.org.uk/uploads/doc262_1_brief003_10.pdf

Audit Commission (2000**)** Forget Me Not. Available at www.audit-commission.gov.uk/health/nationalstudies/socialcare/pages/forgetmenot_copy.aspx

Department of Health (2009) Living well with dementia: A national dementia strategy. Available at
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_094051.pdf [Accessed 17 February 2010]

Department of Health (2009) Joint Commissioning Framework for Dementia. Available at
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_100837.pdf [Accessed 17 February 2010]

Department of Health **(**2001) National Service Framework for Older People. Available at
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4071283.pdf [Accessed 17 February 2010]

Housing & Dementia Research Consortium (2009) (Joseph Rowntree). 'Extra Care' Housing and People with dementia: A scoping review of the literature 1998-2008. Available at
http://www.dhcarenetworks.org.uk/_library/Resources/Housing/Support_materials/Other_reports_and_guidance/HDRC_Scoping_Review_Version1.7.doc [Accessed 17 February 2010]

Nice (2006) CG42 Dementia: supporting people with dementia and their carers in health and social care. Available at
http://guidance.nice.org.uk/CG42/Guidance/pdf/English [Accessed 17 February 2010]

Personal Social Service Research Unit (2007) Dementia UK: A report into the prevalence and cost of dementia. London School of Economics and the Institute of Psychiatry, King's College London, for the Alzheimer's Society.
http://alzheimers.org.uk/site/scripts/download.php?fileID=2

Joint Commissioning Dementia Strategy Milton Keynes, 2011-14, June 2011
http://www.miltonkeynes-northamptonshire.nhs.uk/modules/downloads/download.php?file_name=2785.

Care Services Efficiency Delivery Dept of Health care networks website – particularly learning from the 2009 Wirrall older persons project

Child and Adolescent Mental Health Services (CAMHS)

Emotional health and wellbeing (EHWB), which includes being happy, confident and not anxious or depressed, is influenced by family and social circumstances and exposure to risk factors, all of which start impacting from conception. Health and social programmes such as Healthy Child Programme (HCP), Healthy Schools and post-16 education and training participation schemes all have the benefit of promoting mental health. Nurturing and promoting the social and emotional wellbeing of vulnerable children, for example the 20.1% of Milton Keynes children living in poverty or those with a disability or in homeless situations, is accepted as one of the most effective approaches to reducing health inequalities in children.

Local population data, including the 2011 census, has been used to identify wards where children have higher risks of mental health problems to enable additional prevention and care of mental health disorders to be provided. Applying the prevalence rates from national studies to the Milton Keynes child population from the 2011 census predicts that Child and Adolescent Mental Health Services (CAMHS) must have the capacity to provide care for almost 3,900 patients aged 5-16 who are estimated to have one or more mental health disorder.

It is identified that there is a need to provide universal and targeted Milton Keynes awareness programmes to enable family and teachers to manage common minor problems and to access professional care when appropriate. Additional CAMHS needs include the redesign of the pathway for assessing children for ASD, the reconfiguration of CAMHS providers to deliver a crisis service and the provision of additional CAMHS facilities to meet the needs of children from black and minority ethnic groups.

What do we know about the need?

The wider concept of mental health includes both the promotion of positive mental health and also the tackling of mental health problems. Promotion of emotional wellbeing for under 5 year olds has been shown to increase 'readiness for school'. 'Readiness for school' refers to a child's cognitive, social and emotional development that will allow effective learning and participation at school. It is achieved through good parenting and positive interaction with other adults, together with high quality early learning and interaction and playing. Evidence, in particular from the Millennium Cohort Study, demonstrates the maternal and family factors found during pregnancy and the first few months of life that are associated with poor health, behaviour and learning at 5 years. See figure below.

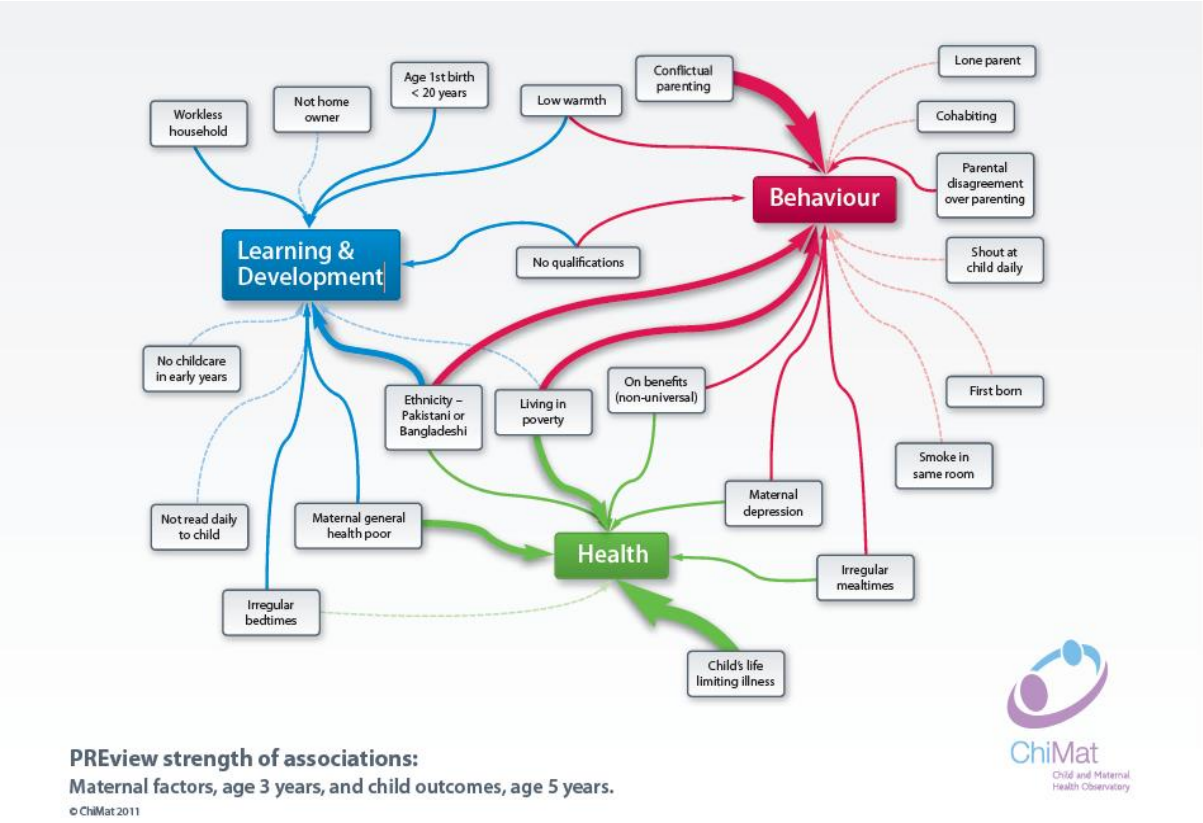


Figure 17: Strength of associations: maternal factors, age 3years and child outcomes at 5 years

Source: PREview provided by Maternal Health Observatory

Schools have the responsibility of providing a nurturing environment for children to develop the range of social, emotional and behavioural skills (SEBS) that contribute towards EHWB. They include; 'Making and sustaining friendships', 'Managing strong feelings such as frustration, anger and anxiety' and 'Recovering from setbacks and persisting in the face of difficulties'. (See textbox for DFS list of SEBS relevant to mental health).

Training schemes and institutions for post 16 year olds increase the likelihood of participants being both physically and mentally healthy as well as providing good social skills, which makes it easier for them to find work and thereby by successful and happy in later life[1]. Research on the 1970 British Cohort Study found that young people participating in education or training between 16 and 18 are less likely by the age of 21 to experience depression and poor physical health.

What is the level of need in the population?

Prevalence of Child Mental Health Disorders in Milton Keynes

According to a study carried out for the Office for National Statistics (ONS)

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What is the level of need in the population?

Prevalence of Child Mental Health Disorders in Milton Keynes

According to a study carried out for the Office for National Statistics (ONS) in 2004[.73]

- one in ten children aged 5 to 16 has a clinically significant mental health problem.
- 5.8% have clinically significant conduct disorders.
- 3.7% have clinically significant emotional disorders.
- 1.5% have clinically significant hyperkinetic disorders.

The table below presents the predicted number of 5-16 year olds with mental health problems currently in Milton Keynes. The predictions are based on the prevalence rates of mental health problems in children found in the ONS 2004 study applied to the number of children in the age group reported in the 2011 census.

As the 0-4 age group had a growth rate of 38% (an increase of 5,500 children) between 2001 and 2011, compared to the 17% increase for the Milton Keynes population as a whole, there will be a need to plan for significantly greater capacity within CAMHS in the future. The increased provision must include a range of services (i.e. assertive outreach, domiciliary, community and day services) so that children and young people are not inappropriately admitted to in-patient units. The level of staffing of Multi-disciplinary CAMHS team within the borough will need to reflect the borough's pattern of deprivation in its wards, as well as taking into account whether the team work in a rural or urban settings.

	5-10 year olds		11-16 year olds		All C &YP 5-16	
	Prevalence %	Estimated. No	Prevalence %	Estimated. No	Prevalence %	Estimated. No
Any Mental disorders	7.7	1550	11.5	2230	9.6	3794
Anxiety disorders	2.2	443	4.4	853	3.3	1304
Depression	0.2	40	1.4	272	0.9	356
Conduct disorders	4.9	986	6.6	1280	5.8	2292
Hyperkinetic Disorder (Severe ADHD)	1.6	322	1.4	272	1.5	593
Less common disorders	1.3	262	1.4	272	1.3	514

Table 25 predicted number of 5-16 year olds with mental health problems currently in Milton Keynes

Source: Census 2011 population data

What is the pattern of need in the population?

Distribution of risk factors and wider determinants of child mental health

Milton Keynes's percentage of 5-16 year old 'not participating in physical activities 'and the percentage of 16-18 NEET has been benchmarked with Local Authorities that are SNs. This provides an indication of the current and future size of the child mental health problem and the effectiveness of current programmes in addressing the problem.

The Community Mental Health Profile (CMHP) for Milton Keynes in 2012 shows that children not participating in physical activities is as common in Milton Keynes as in the 7 LAs that are SNs of Milton Keynes. In Milton Keynes 5.46% of 5-16 year olds do not participate in physical activity which is the lowest rate compared with SNs, the range is 16.89% (Leeds) to 5.46%(Milton Keynes). The England average is 13.64%.[74] The direct health detriment to pupils of not participating in physical education includes reduced concentration and decreased alertness, poor weight management, and low emotional wellbeing and mental health.

CMHP also reveals that one social determinant of mental health problems is as common in Milton Keynes as in the 7 LAs that are SNs of Milton Keynes. In Milton Keynes 5.10% of 16-18 year olds are classified as NEET; the range among SNs is 8.3%(Leeds) to 4.40%(Hertfordshire). The England average is 5.98%.[75] A young person who is NEET is more likely to have poor diet, smoke, drink alcohol and suffer from mental health problems.

Distribution of family circumstances associated with child mental health

A significant number of children have an increased risk of developing mental health problems as a result of their difficult family and social circumstances. In 2011, 3.16% (3,115) of Milton Keynes households were households with dependent children that were led by an unemployed lone parent; in 1 in 4,643 Milton Keynes households with dependent children, one person in the household had a long-term health problem or disability.[76]

Recent estimates of child poverty rates found that 20.1% of children in Milton Keynes live in poverty. As mentioned in chapter 2 "Life in Milton Keynes" the majority of these children live in the wards with the highest Index of Multiple Deprivation. Milton Keynes has a local authority rank of 211, compared to 212 last time – where 1 is the most deprived. The numbers of Milton Keynes LSOAs that are in the 10% and 20% most deprived in England are 7 and 18 respectively. The highest rate of child poverty in Milton Keynes (40.9%) was reported for Eaton Manor Ward and the lowest (6.2%) for Sherington ward. It is estimated that approximately 74% of children living in poverty belong to lone-parent households.

Personal circumstances associated with child mental health
Children and young people with learning disabilities, some of which will be in care, have high rates of mental health problems and behavioural difficulties.

- Whereas studies suggest that 20% of children and adolescents have mental health problems at some point a child with a learning disability is six times more likely to present with a mental health difficulty throughout their lives. (Emerson and Hatton (2007).[77]
- The Count Us Inquiry, conducted by the Foundation for People with Learning Disabilities (FPLD, 2002), reported that 40% of young people (13–25-year-olds) with a learning disability also have a mental health problems.
- Co-morbid disorders such as epilepsy, autism and attention-deficit hyperactivity disorder (ADHD) are also common in this group of children.

Stakeholders have used outcome standards in the Healthy Child Programme (HCP), the National Service Framework for Mental Health and Psychological Wellbeing of Children and Young People and the Early Years Foundation Stage Framework to benchmark Milton Keynes' child mental health programmes and services. Interpreting the benchmarking findings with service evaluations results, the Stakeholders in Milton Keynes have identified service needs, including the following;

- There is an identified need to increase the Tier 1 level (non specialist primary care workers such as school nurses and health visitors) support provided to children diagnosed with Autistic Spectrum Disorders (ASD) and to children while in the assessment process. The proposed Children and Families hub will meet some of the needs in this respect but there will still be a need for primary behaviour support teams provided in schools.
- Milton Keynes currently does not have a crisis team for Autistic Spectrum Disorders (ASD) and has yet to commission a service for ASD post assessment. The absence of these aspects of CAMHS will be critical given that the Community Paediatricians team of MKCHS service, which delivers ASD assessment in children, has reported increased number of referrals for ASD assessment.
- As schools require a diagnosis ASD to fund personalized care (i.e. 1:1 care) for children with behavioural problems, parents frequently request a second opinion when MKCHS does not diagnose ASD. However, obtaining second opinions in a significant number of cases is leading to increased service costs.

There is the need to address this issue to ensure both sustainability of the service and responsiveness to the local populations.

- A renewed focus on meeting the needs of specific black and minority ethnic groups within the local CAMHS is required given the significant increase in the proportion of children who are from BME groups.

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

To address the situation Milton Keynes requires the following;

1. Production and Milton Keynes wide provision of educational materials, tools and courses focusing on the child's early cognitive, social and emotional development. The main audience for this material will be parents, and providers of early education and childcare services.

2. Universal and targeted Milton Keynes programmes to increase parents' and general public's awareness of how mental health problem present in children and young people are critical. As family and friends are commonly the main sources of support when children initially show signs of emotional or behavioural problems some programmes should also provide information on how to manage basic conduct problems. In addition, parents and families must receive information that will assist them to recognise situations in which prompt care should be sought from health and social care professionals.

3. Innovatively redesigned, school-based mental health promotion programme provided in Milton Keynes schools to

- assist teaching staff and parents to work with Tier 1 to manage behavioural problems at early stage, and
- increase children's awareness and knowledge of risk factors for future mental health problems such as alcohol and substance misuse.

4. Provision of increased CAMHS facilities to meet the needs of specific black and minority ethnic groups. For example, recruitment and training of professionals from the ethnic minorities for whom services are being provided, and reviewing the provision and training of interpreters to ensure that best practice is achieved.

5. Redesign of the pathway for assessing children for ASD and providing post assessment support to ensure adequate capacity, efficient use of resources and responsiveness to the needs of children and their carers.

6. Reconfiguration of CAMHS providers to deliver a crisis team with the appropriate access to emergency beds in Milton Keynes Hospital whose remit includes managing crisis situations involving children diagnosed with ASD.

Indicators that will be monitored to measure the success of the programmes and services to promote mental health and manage mental health problems include:

- Reduced unplanned time spent in hospital by under 19 olds for mental health related problems that should be managed outside hospital.
- High score on questionnaire of children and young people's experience of healthcare.
- Presence of high quality CAMHS Therapy Services and high CAMH service rating by users.

In addition, many of the indicators used to measure success in meeting priorities in childhood will provide useful indications of the quality and the impact the child mental health programmes in improved health outcomes and addressing health inequalities. Please refer to the chapter on Pregnancy and Childhood for a table of these measures of success.

4.4 Long Term Conditions

Who is at risk and why?

There are around 15 million people in England with at least one long term condition – a medical condition that cannot, at present, be cured but can be controlled by medication and other treatments or therapy. People with long term conditions are intensive users of health and social care services, including community services, urgent and emergency care and acute services.
There is no definitive list of long term conditions. Examples include high blood pressure, diabetes, asthma, heart disease, stroke, dementia and chronic obstructive pulmonary disease. [1] People live with these conditions for many years, often decades and they can impact on their quality of life by causing disability, loss of independence and early death.

Long term conditions affect people of all ages – in England 4.3 million people under 40 have a long term condition. Long term conditions can have a significant impact on a persons' ability to work and live a full life. People with at least one long term condition are about 10% less likely to be in employment than people with none. People with physical long term conditions are up to 3 to 4 times more likely to experience depression and anxiety disorders.

Complex intensive health and social care needs in older people and people with long term conditions are driven by a number of fixed and modifiable risk factors. The two key factors for developing a long term condition are lifestyle (smoking, poor diet, low physical activity) and ageing. 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. Genes also play a role, as does ethnicity and high levels of deprivation.

What is becoming more evident is that as people living longer, there is a tendency for them to develop more than one long term condition. Often, people have three or more long term conditions occurring simultaneously, the symptoms of which interact with each other, resulting in complex health needs that require significant interventions to resolve and impact significantly on quality of life. Physical health

difficulties can both contribute to and be compounded by depression and anxiety, as well as acute and chronic confusion.

Level of need in the population

As part of the QOF in GP practices (QOF) patients are included in condition-specific registers; the registers are not a comprehensive record of all people with these conditions but provide a reasonable indication. Estimates are that around 18% of the Milton Keynes population are living with one or more Long Term Condition. The following table demonstrates the prevalence of certain long term conditions in Milton Keynes.

Practice registers for long term conditions 28 Practices; Practice population size 265,437	Number of people on register in MK	Prevalence *(not quoted for conditions only 17 years + /adults)*
Coronary Heart Disease Register	6,185	2.3%
Stroke or Transient Ischaemic Attacks (TIA) Register	2,841	1.1%
Hypertension Register	30,939	11.7%
Diabetes Mellitus (Diabetes) Register (ages 17+)	10,143	-
Chronic Obstructive Pulmonary Disease Register	3,683	1.4%
Epilepsy Register (ages 18+)	1,297	-
Hypothyroidism Register	5,881	2.2%
Cancer Register	3,379	1.3%
Asthma Register	14,371	5.4%
Heart Failure Register	1,272	0.5%
Depression Register (ages 18+)	19,843	-
Mental Health Register	1,574	0.6%
Chronic Kidney Disease Register (ages 18+)	4,577	-
Atrial Fibrillation Register	2,553	1.0%

Table 26: Number of people on Milton Keynes GP practice registers at April 2012, with specified long term conditions

Data source: QMAS database - 2011/12 data for Milton Keynes PCT as at end of July 2012, The Health and Social Care Information Centre, Prescribing Support Unit.

The main users of health services are people aged 65+ ('older people'). Over 80% of people aged 70+ suffer from a significant (i.e. in need of treatment) physical illness. At any one time in the UK older people occupy around two-thirds of hospital beds (Department of Health, 2001).

Whilst the majority of people with long term conditions have mild to moderate disease, the very nature of the these chronic conditions is that they often lead to complications and more severe disease. It is estimated that there are approximately 1,600 people in Milton Keynes with a range of complex health and social are needs that would benefit from some form of case management to improve their quality of life and support them to better manage their health.

Current Services in relation to need

People are more likely to see their GP, be admitted to hospital, stay in hospital longer, and need more help to look after themselves than those without a long term condition. The Department of Health GP patient survey indicates that people living with long term conditions currently account for 50% of all GP appointments, 64% of outpatient attendances and 70% of inpatient bed days. In total, around 70% of the total health and care spend on England is attributed to caring for people with long term conditions.

The key to reducing the numbers of people at risk of developing a long term condition lies in prevention. Services to support people in Milton Keynes to give up smoking, become more active and manage their weight are described elsewhere.

Early detection is also important. The NHS Health Checks Programme commenced in Milton Keynes in Autumn 2012. Delivered in GP practices, the programme is for adults aged between 40 and 74, who are offered a series of routine tests that will help identify their risk of developing heart disease, stroke, kidney disease and type 2 diabetes. People with moderate or high risk will be given advice on what action to take to lower their risk and improve their chances of a healthier life, for example, making changes to their diet or becoming more active. Experience from other sites has shown that this programme also identifies people who already have one of the conditions but are unaware.

The majority of people with mild to moderate disease will have their routine clinical care provided by GPs, primary health care teams and community health and social care teams. Depending on the condition, this may be supplemented by hospital out-patient clinical care provided locally. For those with more severe conditions, at high risk or with complex needs there will be more secondary care involvement, sometimes requiring that this be provided by out-of-area specialist services. There are a number of other community-based services locally that support people with a long term condition.

We have the following services in Milton Keynes:

Population Needs	Service type	Service response
General Population	Citizenship, Home and Community; information, lifestyle	Older persons forum; engagement in use of arts, libraries, community facilities; older person's champion, Exercise, walking groups; public health initiatives; provision of information, advice and guidance. Support groups; e.g. Breathe Easy, Different Strokes, Diabetes UK
Low to moderate needs	Practical support; early intervention; enablement;	Handyperson services; minor aids and adaptations; rehabilitation programmes e,g. Pulmonary, neurological, early stroke, post-MI
Substantial needs	institutional avoidance; community support for LTC; enablement	Intermediate Care services; development of Integrated Health and Social care Teams; Falls service; telehealth/telecare; Community Equipment services; Extra Care Housing; Home Care; Community Nursing;
Complex Needs	Intensive support; supported discharge from hospital	Intermediate Care services; development of Integrated Health and Social care Teams; Falls service; telehealth/telecare; Community Equipment services; Extra Care Housing; Home Care; Community Nursing; Sensory Services
End of Life Care	Support for people at the end of life	Hospice at Home; Continuing Healthcare provision, Willen Hospice; District Nursing

Table 27: Community-based services based in Milton Keynes that support people with a long term condition.

Source: Milton Keynes Council

For some conditions e.g. stroke, diabetes, chronic obstructive pulmonary disease (COPD) and end of life care, improvements have been made in the delivery of care across a defined whole-system care pathway over the last five years. For others, such as heart failure and other types of cardiovascular disease, more needs to be done.

Condition-specific services include an Early Stroke Rehabilitation Team that provides home-based rehabilitation and support to patients and carers on discharge from hospital following a stroke and the use of telehealth technology to support people to self-care; the majority of people on this programme have COPD but it is being extended to include patients with other conditions such as heart failure.

The Milton Keynes Director of Public Health's Annual Report contains additional information on a number of long term conditions and their impact.

Projected service use and outcomes

The proportion of people in the Milton Keynes population aged over 65 is set to increase by over 100% by 2030. There will be more people who have a range of complex conditions and who will place additional demands on health and social are services.

The table below indicates that the numbers of people with a long term limiting illness in Milton Keynes is set to rise substantially over the next 20 years – by 100% in those aged over 65.

	2010	2015	2020	2025	2030
People aged 65-74 with a limiting long-term illness	6,097	8,103	9,386	9,908	11,071
People aged 75-84 with a limiting long-term illness	4,618	5,443	6,818	9,072	10,446
People aged 85 and over with a limiting long-term illness	2,129	2,542	3,134	4,080	5,380
Total population aged 65 and over with a limiting long-term illness	**12,844**	**16,088**	**19,338**	**23,059**	**26,898**

Table 28: Estimated and projected number of People aged 65 and over with a limiting long-term illness, in Milton Keynes by age group

Source: Projection Older People Population Information, http://www.poppi.org.uk/

Increases of 100% or more are also predicted for all ages for stroke and chronic obstructive lung disease (COPD and emphysema).

The predicted increase in the proportion of people in the BME groups in Milton Keynes is also going to lead to large numbers of new cases of certain diseases for which there is a pre-existing propensity, for example Type 2 diabetes which can develop at much earlier age in South Asian and African Caribbean people. This is a particular concern, and a specific needs assessment is being undertaken during early 2013. Diabetes is covered within the next section of this chapter.

The implications are that, without intervention, we will continue to see rising numbers of people developing a long term condition.

Evidence of what works and policy drivers

The role of smoking, diet and obesity in the development of certain cancers, respiratory and cardiovascular diseases and the increased risk of type 2 diabetes is undisputed. Interventions to reduce the risk of disease development are imperative. Early detection of disease is also vital as in most instances this can lead to a significant reduction in the health impact on the individual and their likelihood of developing complications. With appropriate medication, regular testing, patient education, care planning, and rehabilitation there can be significant improvements in risk of complications and early death.

The services on offer to people with long term conditions should be commissioned across the whole continuum of care and following an evidence-based care pathway. The clinical evidence for the best type of care for long term conditions is provided in NICE guidance for example that for diabetes[1], COPD[1] and heart failure[1]. In all conditions the evidence points to the use of integrated models of care which need to be commissioned from and co-ordinated across, all relevant agencies, health care, social care and third sector, to encompass whole care pathways.

The important role of the patient in understanding their condition and being empowered to take control and manage their own condition (self-care) is fundamental within the model of care. Such integrated approaches are fundamental to the delivery of high quality care with the results that there are improvements in the ability of individuals to self-care with clinical and social support when required, better health and improved quality of life and a reduction in premature death and the reliance on costly secondary health care.

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There is a large amount of supporting evidence about the types of interventions that seek to shift the focus from hospital-based care to preventative and community-based care.

Service components that have been shown to support this shift are:

- Patient-centred care planning and case management.
- Disease management in relation to long term conditions.
- Provision of psychological services – recognising the mental health impact of long term physical illness and the important contribution to enable ability to self care.
- Integrated care (including multi disciplinary working).
- Preventative interventions.
- Assessment of older people (especially as a prelude to case management).
- Rehabilitation in the community for a range of conditions.

The following interventions have been shown to reduce the demand for hospital-based services and more effective discharge from hospital:

- Housing adaptations and equipment.
- Early supported discharge for older people and people after a stroke.[1]
- Care at home and hospital at home interventions.
- Community hospitals.
- Day hospitals.

There is also some evidence, including local evidence assimilated during the telehealth Commonwell project for patients with COPD, that the following may reduce likelihood of admission and reduce the length of stay in hospital:

- Self-management education.
- Telehealth/telecare (technology in patients' homes with links to clinical support if required).

Policy drivers include an overarching Department of Health Long Term Conditions Strategy – from April 2013, this will be led by the new NHS Commissioning Board. The approach highlights the need for integration of health and social care teams and the importance of self-care.

At a local level the South Midlands "Healthier Together" review of acute NHS services includes a Long Term Conditions report; this is due for ratification in early 2013. It will give recommendations for the delivery of services for Long Term Conditions and should be considered within the wider context of NHS acute services commissioning in the South Midlands.

Supporting each of the wider policies and for many of the long term conditions, there are either National Service Frameworks (NSFs) (e.g. Diabetes) or National (Quality) Strategies (Stroke, COPD) and, in for many specific conditions, series of NHS Commissioning Guides detailing the components and care pathways that should be commissioned.

The Milton Keynes Clinical Commissioning group has prioritised the commissioning of long term conditions care pathways within a multiagency Programme Board. One key area of development is for the integration of health and social care and case management services.

User view

Users and carers from LINk MK (Healthwatch),and the Milton Keynes Patient Congress are represented on the CCG Long Term Conditions Programme Board, and there is lay representation on a wide variety of condition-specific multiagency groups, networks and Local Implementation Teams (LITS) such as the Diabetes Network, Stroke and Respiratory LITs. Peer groups for Diabetes and Stroke have been set up specifically to facilitate user input into commissioning decisions.

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

- Commission integrated health and social care front line teams and services working together to achieve better outcomes for older people and people with long term conditions, including helping them to stay in their own homes for longer
- Implement the findings from the strategic review of the role and capacity of intermediate care, refocusing on prevention of avoidable admission to hospital or long term care and supporting hospital discharge
- Review the community matron model and ensure case management services are better utilised and targeted at those most in need
- Develop a joint NHS and Social care commissioning strategy for telehealth/telecare
- Build older persons involvement in strategic planning and service commissioning

Diabetes

Who is at risk and why?

Diabetes affects 2.9 million people in the UK, a figure that is predicted to rise to 5 million by 2025. It is estimated that 24,000 avoidable deaths are caused annually by diabetes-related complications.[78]

Diabetes represents a huge financial burden to the NHS, with National Audit Office figures showing that the disease costs £25 million a day.[79] Figures produced by the York Health Economics Consortium suggest that NHS diabetes spending could reach £16.9bn over the next 25 years. This figure would represent 17 per cent of the entire NHS budget. [80]

It is estimated that there are an additional 850,000 people with diabetes in the UK who remain undiagnosed. It is also estimated that deaths from diabetes in 2010/2011 resulted in at least 325,000 lost working years.

There are 2 types of diabetes known as Type 1 and Type 2. Both types of diabetes are lifelong health conditions. Type 1 diabetes usually develops early in life and is the most common type of diabetes in children. It occurs when the body is unable to produce any insulin. Type 1 diabetes is treated with insulin injections, or by using an insulin pump. About 15% of people with diabetes have Type 1.

Diabetes develops when the body is unable to make enough insulin, or when the insulin that is produced does not work properly (known as insulin resistance).Type 2 diabetes is the most widespread form of the condition and usually develops later in life.

People over the age of 25 from South Asian and African Caribbean backgrounds and people over the age of 40 from Caucasian backgrounds are most at risk of developing Type 2. Type 2 diabetes can be treated with diet and physical activity alone, or combining these with tablets. Due to the progressive nature of the condition, insulin treatment may be required later in life.

There are also some much rarer forms of diabetes, including gestational diabetes, which affects women during pregnancy.

Lifestyle plays a major part in why some people get diabetes over others, which is why Type 2 diabetes contributes to at least 90-95% of the increase of diabetes in the world population. The time to prepare healthy foods has been cut down by lack of time due to more work pressure, contributing to a less active lifestyle as well. When lack of activity is combined with not eating healthy, nutritious meals the danger of Type 2 diabetes is increased. Genetics also plays a part in cases where people have Type 1 diabetes, but that only contributes to 5-10% of the cases worldwide.

Level of need in the population

It is estimated that in Milton Keynes there are 11,483 people with diabetes, which is a prevalence rate of 4.38% of the population. It is estimated that there are:

- 1,041 people in Milton Keynes with Type1 diabetes - a prevalence rate of 0.40%.
- 8,475 people in Milton Keynes with Type 2 diabetes - a prevalence rate of 3.24%.

There are several risk factors for diabetes including:

- A close family member has Type 2 diabetes (parent or brother or sister).
- being overweight or having a waist measurement of 31.5 inches or over for women; 35 inches or over for Asian men and 37 inches or over for white and black men.
- high blood pressure or preexististing heart or vascular disease
- women who have had gestational diabetes (temporary diabetes during pregnancy).
- Diabetes is more prevalent in South Asian and Black African-Caribbean people at an earlier age (after 25 c.f. 40 for other ethnicities).

Data is available on service user from Milton Keynes Hospital. Between January 2012 and September 2012, there were 116 first attendances related to diabetes and 488 follow up appointments for the same period.

Current services in relation to need

The routine health care of the majority of people with diabetes can be provided in primary care. Some people however require specialist care, in Milton Keynes this is provided by MKHFT.

MKCCG has commissioned a service delivered by MK Diabetes Care. This is a Diabetes specialist support service designed to promote patient choice, improve outcomes and enable diabetes to be managed effectively in primary and community settings, thereby reducing reliance on secondary care and acute hospital provision.

The aim of this service is to help improve clinical outcomes, reduce mortality & morbidity rates and quality of life for people with diabetes by:

- Improving standards of diabetes services in MKCCG.
- Develop and localise the Diabetes National Service Framework (NSF).
- Improve the understanding and empowerment of people with diabetes to enable self-care through the delivery of training courses for people newly diagnosed with diabetes.
- Reduce reliance on hospital services for routine diabetes care.
- Reduce costs associated with diabetes care.

- Ensuring equitable access to services from all members of the Milton Keynes population.
- Working with health care colleagues to support delivery of care and treatment for people with diabetes in primary care.

The outcomes of this team's work includes training and delivery of care planning with a "Year of Care"; within Milton Keynes all GP practices have been trained to use the locally developed system that ensures that people are more closely involved in decisions about their care, setting personal goals and ensuring the best level of clinical support for them. In 2012 MK Diabetes Care supported GPs to ensure that more than 80 people were discharged from hospital outpatient clinics back to their local practice with improvements in their diabetic control.

Milton Keynes Hospital – Consultant-led services are provided by the Milton Keynes Hospital to support people with diabetes, such as routine/specialist outpatient services and a diabetes specialist nurse team. There is also an inpatient service with specialist nurses to address complex cases of diabetes. Hospital-based, specialist diabetes care care is required for children and teenagers with type 1 diabetes, people using insulin pumps, diabetes in pregnancy and others whose control of diabetes is compromised or who have complex requirements.

A Milton Keynes Diabetes Network provides a multiagency forum for commissioners, professional and lay members to determine how to improve local services.

Public Health initiatives regarding obesity, smoking cessation and reducing health inequalities will all have an impact on the likelihood of individuals developing diabetes and need to be monitored to demonstrate this impact.

Early identification of diabetes ensures that the health impact of having high blood sugars can be reduced and people educated about how to manage their condition. The National Health Checks programme commenced in Milton Keynes in October 2012. People over the age of 40 are being invited to their GPs to have the assessment, and the screening tests will identify the risks of developing diabetes based on waist measurement, and where appropriate people will have blood tests to establish if they already have undiagnosed diabetes.

Projected Service use and outcomes

The needs assessment has indicated that the incidence of diabetes in the population of the UK and Milton Keynes is set to rise by almost 75% in the next 15 years. For Milton Keynes, this equates to approximately 20,000 people in Milton Keynes with diabetes by 2025. Increasing rates of obesity and the changes in the ethnic composition of the Milton Keynes population will also result in the number of people with diabetes rising.

The outcomes we would be looking for from services are:

- Increased number of preventative services that address risk factors for diabetes e.g. obesity.
- Early diagnosis with education and treatment, within the most appropriate sector of the NHS.

- Greater empowerment of patients by increased self management of diabetes.
- Care delivered closer to home leading in improved patient experience.
- Reduction in the secondary ill-health and mortality associated with diabetes, including diabetic eye disease (retinopathy), limb amputations, renal and cardiovascular disease, including stroke.
- More GPs and Primary Care staff supporting people with diabetes in the community.
- Improved take up of services for people with diabetes from members of minority communities in Milton Keynes.

Evidence of what works and policy drivers

The Diabetes National Service Framework issued in 2001 is the main policy driver for the development of services for people with diabetes. The strategic objectives contained include:

- Prevention of Type 2 diabetes.
- Identification of people with diabetes.
- Empowering people with diabetes.
- High quality integrated clinical care of adults with diabetes.
- High quality integrated clinical care of children and young people with diabetes.
- Management of diabetic emergencies.
- Care of people with diabetes during admission to hospital.
- Diabetes and Pregnancy.
- Detection and management of long-term complications.

A number of Commissioning Guides from NHS Diabetes detail the NICE appraised evidence-based approach to commissioning the key elements for an excellent diabetes service, including for mental health, end of life, foot, renal, eye and other fundamental components.

What are the top issues/priorities from the needs assessment and what are we going to do as a result?

The priorities for services for the future is to develop a sustainable service to meet the increase in demand and address the particular needs of people who have an increased risk of developing complications of diabetes. This will include the following activities:

- Primary Prevention: Promote awareness amongst the general population on diabetes, particularly amongst at risk groups and young people, to prevent onset wherever possible. This includes working with groups at higher risk of developing diabetes to ensure that they are aware of signs, symptoms and how to access services if they need them. Work has already begun with the South Asian community in Milton Keynes to raise awareness and promote local services.
- Deliver more public health-led, whole population level preventative services such as weight management; physical exercise take up and smoking cessation.

- Promote self-care, education and self management for people newly diagnosed and monitor impact.
- Secondary prevention of complications: Using the NHS Commissioning guides, ensure that services are commissioned within an evidence-based care pathway and resourced to meet the needs of people with diabetes. Priorities identified by the MK Diabetes Network include foot care services, emotional and psychological health needs, education for people newly diagnosed with Type 1 diabetes and transitional care for adolescents.
- Increase the capacity and capability within primary care services to provide care and treatment for people with diabetes.

Users views

MK Diabetes Care engages effectively with local people with diabetes. Key achievements to date include:

- Developed a Diabetes Public and Patient Involvement (PPI) forum with LinK:MK, the Milton Keynes Patient Congress and Diabetes UK in order that service users have a role in implementation and change.
- Work with 3rd sector and national organisations (e.g. Diabetes UK regional team) to ensure public and patient engagement.
- Reviewed and enhanced user representation on Diabetes Network.
- Established good links with representatives from the South Asian communities in Milton Keynes with a view to undertaking a specific project raising awareness of diabetes within these communities to improve diagnosis and access to services.
- The systematic use of a patient questionnaire as part of the care planning process in primary care.
- Regular feedback from participants in Diabetes education programmes.
- Service user participation is embedded in all service development groups relating to diabetes care.

4.5 Mortality

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 are the leading causes of death in Milton Keynes- each accounting for around 28% of all deaths and nearly two thirds of all premature deaths before the age of 75. In 2010 cancer and circulatory diseases resulted in over 5,700 years of potential life lost (YLL), with cancer accounting for 62% of these lives lost before 75 years of age.

In 2010, the deaths from circulatory diseases in under 75s fell once again to their lowest level yet and the mortality rate from coronary heart disease in under 65 year olds also fell sharply. For the 1st time since 2006 the annual standardised rate for Milton Keynes was lower than the England and Wales rate. Also the improvement seen the previous year with fewer younger people dying from acute myocardial infarction (heart attack) continued and there was a noteworthy fall in overall deaths from coronary heart disease.

Nationally each year since 1993 there has been a gradual reduction in the death rates from stroke which has been mirrored in Milton Keynes. However in 2010 the standardised rate of deaths from stroke in people aged less than 65 years In Milton Keynes spiked above the national rate (Milton Keynes = 8.18 per 100,000 population versus England and Wales at 5.64). This is likely to be a random high result, but it does need to be monitored, particularly as the majority of strokes are preventable. In 2010, 18 people aged under 65 died of stroke which resulted in 489 years of potential life lost in this age group.

Lung cancer remains the commonest cause of cancer death In Milton Keynes. In 2010 It accounted for 22% of all cancer deaths and 21% of all cancer deaths in the under 75s. Although this is a minor decrease from the previous year, lung cancer remains a problem in the population. Smoking is the biggest avoidable cause of these deaths.

COPD is also a smoking related disease. It is incurable and its prevalence is higher in more deprived areas. Historically deaths from COPD have been significantly high in Milton Keynes, but a fall in the death rate in 2007 has been sustained and mortality rates are now comparable to the England Average. This progress is welcome and interventions to maintain this improvement need to be sustained.

Pneumonia can be a preventable disease but it remains a leading recorded cause of respiratory death in Milton Keynes. The standardised mortality ratio for pneumonia in Milton Keynes is approximately 50% higher than that of England and Wales. Because of the high mortality and morbidity of this disease in the Borough/PCT it has been made a priority for public health focus in 2012.

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.

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 National statistics show that it has risen from 78.8 years for females in 1992-1994 to 82.2 years in 2008-2010. For males, life expectancy has increased from 74.3 years to 78.1 years during the same period. These figures are slightly below the England average (Females 82.6 years Males78.6 years) but not statistically significantly so.

This overall increase in life expectancy in both genders, masks the inequalities that exist between areas within Milton Keynes. Statistics clearly illustrate the association between life expectancy and where people live. Locally we calculate life expectancy at ward level to better understand differences within the Borough. Although there are some minor year to year changes in the order of ward rankings on life expectancy these changes are often mere statistical variations, and the broad perspective remains similar.

The slope index of inequality measures the difference in life expectancy between the most and least deprived deciles (or tenths) of the population over a five year pooled period. The latest 2012 Marmot indicators" show a gap of 7.3 years for males and 6.0 years for females, which is an improvement from 8.1 for males but a slight increase from 5.2 for females. Milton Keynes is not an outlier in any of the Marmot inequalities indicators.

Level of need in the population

Middleton is the ward, which has made the greatest percentage improvement in life expectancy since 2003-7 and where life expectancy at birth is generally highest (86.7 years in 2010). Woughton ward remains the most deprived ward in Milton Keynes and the ward with the lowest life expectancy (75.2 years in 2010), but in terms of improvement it ranks 7th out of 24where 1st is most improvement. There remains much to be done by the population of Woughton to reduce the inequality in life expectancy they experience and this will take considerable time, but it is reassuring to see that progress is being made.

Main Causes of Death

Who's at risk and why?

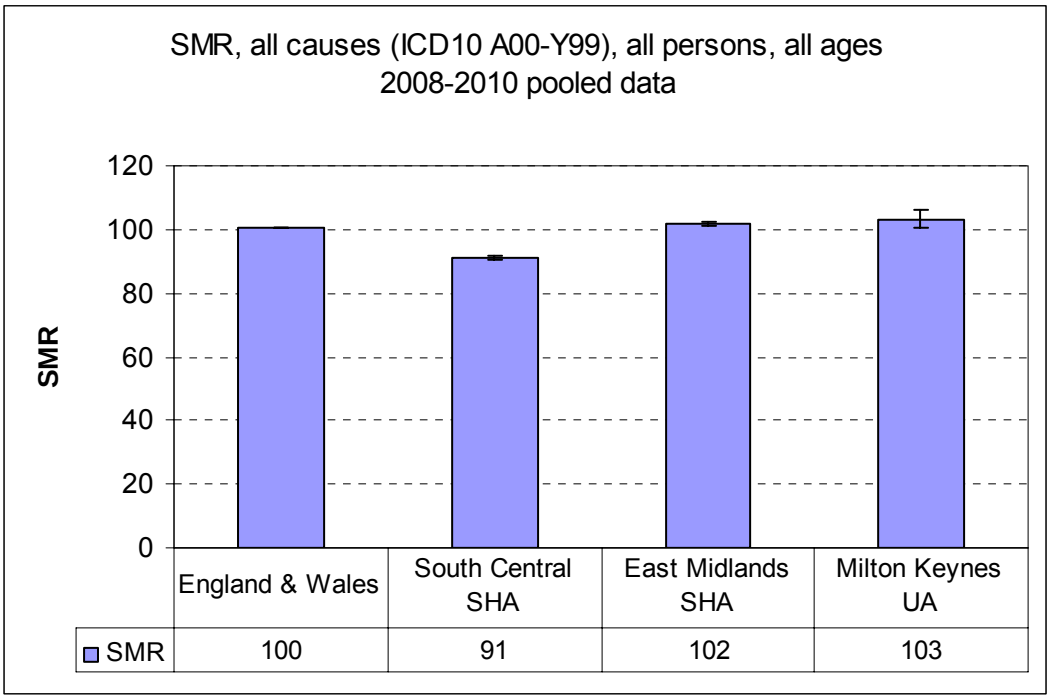
The total number of deaths in Milton Keynes in 2010 was 1654 (805 males and 849 females) of which 659 (40%) were in people aged under 75 years (400 males and 259 females). Deaths in people less than 75 years of age are considered to be premature deaths. Immediately it is possible to see that men are at more risk than women of dying prematurely.

In 2010, the primary causes of premature death in men were cancers (32.8% of premature deaths) particularly lung cancer (8.3%), circulatory disease (26.0%), particularly coronary heart disease (16.0%) and acute myocardial infarction (5.0%). Accidents and Suicide also accounted for 8.8% of male premature deaths. In women, the top causes of premature death were all cancers (46.3% of premature deaths), with breast cancer (10.0%) and lung cancer (7.7%) predominating and circulatory disease which accounted for 18.5% of female premature deaths (coronary heart disease 6.9%).

In the over 75 age group circulatory diseases account for 19.6% of deaths with coronary heart disease accounting for 7.9% of these deaths. The next greatest concern in this age group are the numbers of people dying from pneumonia (6.2%). This is of particular concern as national figures show that the mortality rate from pneumonia in Milton Keynes is 50% higher than that of England and Wales. Reducing these deaths is an area of particular concern in 2012/13.

Level of need in the population

The Figure below shows the pooled Standardised Mortality Ratio (SMR) for all causes of death in Milton Keynes for 2008-2010 and the 95% confidence intervals. At 103, the all cause SMR in NHS Milton Keynes, is almost identical to that for England and Wales and East Midlands SHA but statistically significantly higher than the South Central Strategic Health Authority (SHA) area (SMR 91) 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 18: SMR, all causes (ICD10 A00-Y99, all persons, all ages 2008-10 pooled data)

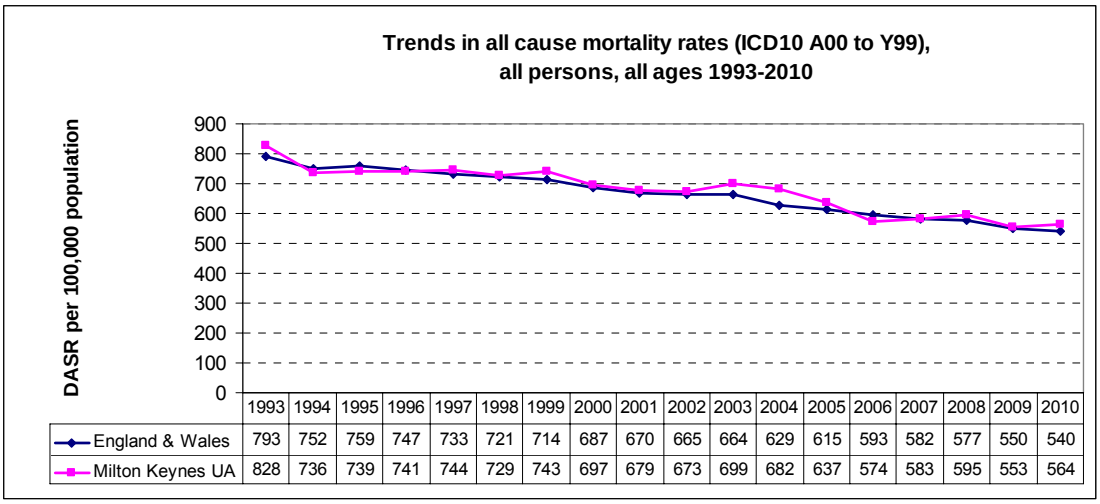
Source: NHS Information Centre - ONS

Current Services in relation to need

Smoking is the biggest 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. The Public Health department offers smoking cessation programmes for smokers wishing to quit, there is also an obesity and physical activity co-ordinator and a Health Promotion Dietician service which delivers weight management programmes and support for children and adults. Active Milton Keynes Exercise Referral Scheme (AMKERS) supports patients with existing health conditions to become more active over a 12 week period.

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 18). The DASR for England and Wales in 2010 was 540 deaths per 100,000 population and for Milton Keynes was 564 deaths per 100,000. This is a small rise on last year but not cause for concern at the moment as overall mortality does fluctuate year on year.



	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
England & Wales	793	752	759	747	733	721	714	687	670	665	664	629	615	593	582	577	550	540
Milton Keynes UA	828	736	739	741	744	729	743	697	679	673	699	682	637	574	583	595	553	564

Figure 19: Trends in all cause mortality rates (ICD10 A00-Y99, all ages 1993-2010)

Source: NHS Information Centre - ONS

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.

End of Life Care

Who's at risk and why?

Everybody dies, but End of Life Care is specifically care that helps all those with advanced incurable conditions to live as well as possible in the last year of life and, wherever possible, die in their preferred place, in their preferred way.

Level of need in the population

In England, about 1,300 people die every day. Around 900 of them will have wanted to die at home, but less than half will do so. Some 975 may have needed palliative care to relieve suffering but 469 will not have received it (Dying Matters Coalition 2010). At this moment, about 25% of all hospital beds are occupied by someone who is dying. The National Audit Office estimates that at least 40% of those people have no medical need to be there.

These statistics mean that nationally:

- Too many people die where they do not wish to, or how they wish to, without a clear medical need for this to have happened.
- Too many people die in pain or discomfort that could have been avoided

Within Milton Keynes this national situation is shared. The proportion of deaths in hospital are around this national average for the roughly 1,500 people who die each year.

End of Life Care is therefore a strategic priority for Milton Keynes Clinical Commissioning Group and Milton Keynes Council.

Current Services in Relationship to Need

Within Milton Keynes, End of Life Care is delivered by a multitude of services including GPs, the Hospital Foundation Trust, the South Central Ambulance Service, Willen Hospice and Milton Keynes Community Health Services.

Operationally, these services meet within the Joint Palliative Care Group. The aim of the Joint Palliative Care 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.

Projected service use

About a third of the deaths in Milton Keynes continue to be attributable to people under 75 years old, often due to major killers like heart and circulatory disease, cancer and respiratory disease.

However, most of us will live longer than previous generations. Increasingly more of us, as we age, will live with the consequences of chronic conditions that can have a debilitating effect on our health and general wellbeing. As the population of older people in Milton Keynes increases in coming years, so too will the prevalence of long term life limiting conditions.

The demand for effective End of Life Care over the last year, and especially the last few weeks, of life is therefore expected to rise in coming years.

Evidence of What Works and Policy Drivers

Studies show that where a patient has an End of Life Care Plan in place (known as "an Advance Care Plan"), and everyone who is involved in the care of that patient knows about that plan, s/he is much more likely to die in their preferred place, in their preferred way. Good community support can realise 70% of deaths at home and halve unplanned hospital admissions (National Council for Palliative Care/Dying Matters Coalition 2011). To achieve this within Milton Keynes, requires a cultural and behavioural shift in how End of Life Care is perceived and in how it is delivered.

Within Milton Keynes, the policy drivers to deliver this change are contained within the 2012 – 2015 End of Life Care Strategy.[81] The key objectives for this strategy reflect national desired outcomes, ensuring people:

- Are treated as an individual, with dignity and respect.
- In familiar surroundings.
- In the company of family and/or friends if they wish.
- Have their psychological, spiritual and religious care needs assessed and met.
- Have pain and other symptoms managed as effectively as possible.

User View

People's preferences regarding place of death were summarised within the 2008 National End of Life Care Strategy,[82] in that "most people would prefer to be cared for at home, as long as high quality care can be assured and as long as they do not place too great a burden on their families and carers".

The 2012 Milton Keynes Public Consultation on the End of Life Care Strategy supported this view. It also demonstrated the importance people place on receiving appropriate information about both what happens when they are dying and what services are in place to help them. People who live in Milton Keynes also clearly expressed their appreciation of Willen Hospice.

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

The priorities for End of Life Care in Milton Keynes are therefore:

- To improve the availability of relevant information to people and to encourage a more open culture towards talking about dying and death.
- Promote the use of Advance Care Planning to enable people to state their End of Life Care wishes about where and how they wish to die.
- Purchase and implement an appropriate software system across health and social care services, to ensure these wishes are known to all service providers and compliance with them can be reviewed.

- Ensure timely identification of the end of life phase and quality End of Life Care, by providing access to appropriate training and education to all health and social care professionals.
- Change the perception of “Death is failure” to “A good death is a successful care outcome”.
- Develop transparent processes for access to rapid response 24/7 End of Life Care in the community, limiting unnecessary hospital admissions and deaths.

The detailed changes required to consistently deliver these priorities have been collectively and individually assigned to all relevant commissioning and provider organisations within the End of Life Care Strategy Implementation Plan. This cross organisational work will be governed by the End of Life Care Strategy and Implementation Group, supported by the Joint Palliative Care Group.

When this programme of change is complete, patients and their carers will be able to expect to have their needs assessed in a timely way, 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 and where they will die, managing expectations and which expedites provision of those wishes.

4.6 Falls Prevention

Who’s at risk and why?

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

In 2008/9 Milton Keynes was the local authority with the highest standardised rate of hip fracture in over 65 year old individuals in all England. At this time Milton Keynes’ rate was 643.5 per 100,000 (200 actual incidents). The rate for England overall was 479.2 per 100,000. Most hip fractures are sustained as a result of a fall.

Subsequently in 2009/10 and 2010/11 the rate improved (472.6 and 544.0 respectively) and Milton Keynes was no longer the worst local authority, but falls prevention and hip fracture rates are still being investigated in detail by the ‘Falls Prevention and Strategy Group’. Falls and associated injuries have also been highlighted as a priority for the newly established Health and Wellbeing Board.

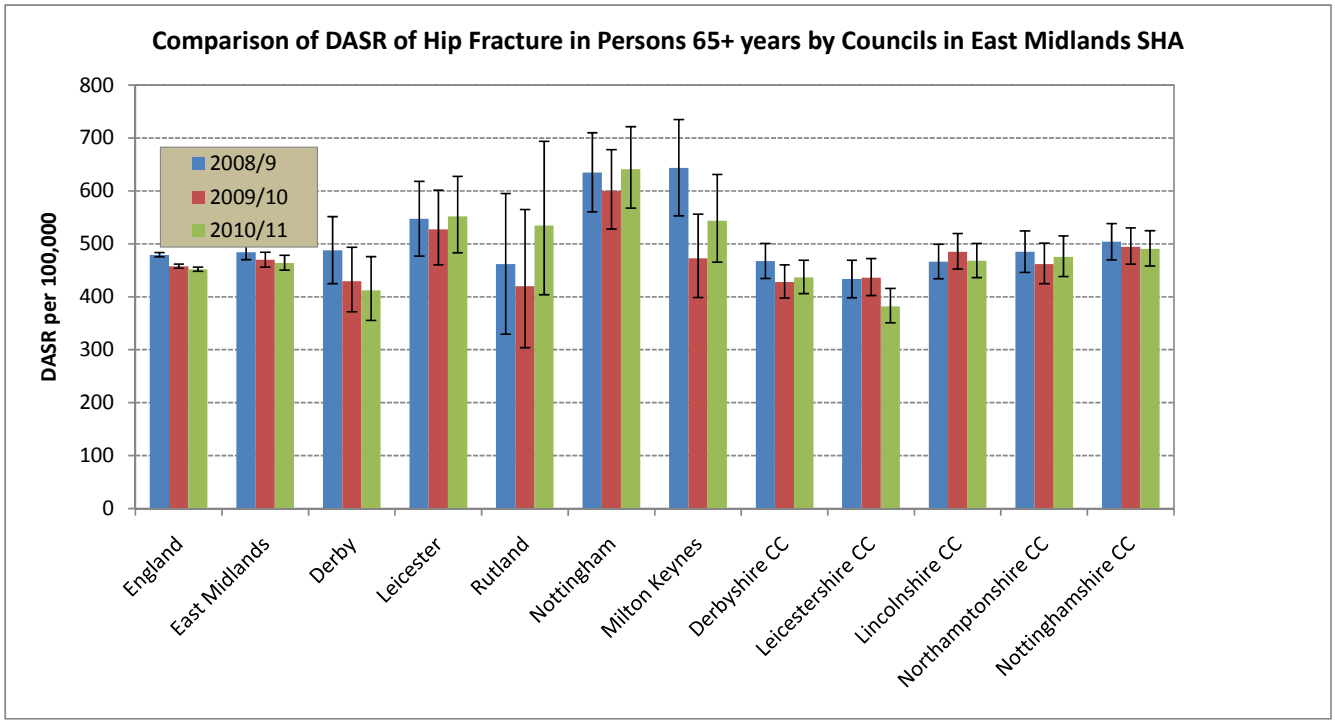


Figure 20: Comparison of DASR of Hip Fracture in Persons 65+ tears by Councils in East Midlands SHA.

Source: NHS Information Centre - ONS

Hip fracture is a serious condition causing pain and immobility. The affected individual requires hospitalisation and mortality is high. Approximately one in five hip fracture patients die within a year of the injury.

Data from the Information Centre shows that deaths from accidental falls for all ages in 2010 in Milton Keynes were statistically significantly more frequent than the England overall rate – Milton Keynes 8.25 per 100,000 England 3.8 per 100,000.

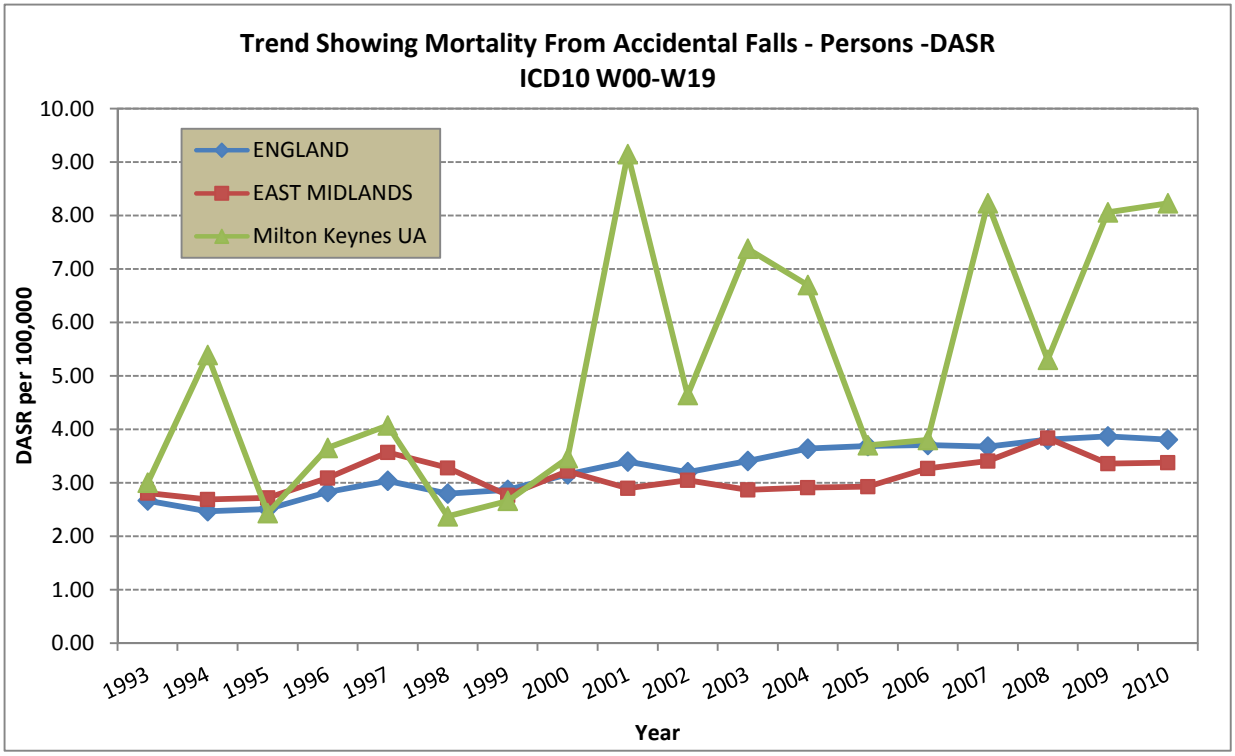


Figure 21: Trend Showing Mortality from Accidental Falls.

Source: NHS Information Centre - ONS

A similar pattern is seen in 'Hospital Admissions due to Fall Injuries for All Ages' (SWPHO Injuries Profile 2012: http://www.swpho.nhs.uk/) where Milton Keynes has a statistically higher level of admissions than the England average (Milton Keynes 543.9 per 100,000, England 498.3). (http://www.apho.org.uk/addons/_115501/atlas.html)

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).

Level of need in the population

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 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. [NICE guidelines 2004]

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 Milton Keynes Community Health Services:
  - To provide information and raise awareness to anyone who needs it, to help prevent falls.
  - To provide assessment and intervention to those who have fallen.
- A Handyman Service, from the voluntary sector, carrying out risk assessments and minor practical work in the person's home to reduce the risk of falls occurring.

The Primary Care Trust also commissions a Pharmacy Advisor to work in Nursing Homes regarding medicines management and reducing the prescribing of anti-psychotics, which can cause people to fall.

Milton Keynes Council has a strong telecare service which helps with falls prevention, both directly and with its links into the other services.

Public Health and GP colleagues also have a key role to play in ensuring an integrated and overall effective Falls Prevention Pathway exists.

All these commissioning and provider bodies are members of the Falls Operational Group which regularly meets and which aims to ensure all falls prevention related services are working together effectively and efficiently. For example, the South Central Ambulance Service identify where people are falling excessively in Nursing and Residential homes so enabling the targeting of these homes for preventative visits from the Falls Service.

Service Use and Outcomes

The Falls Service received 1,167 referrals in 2011/12.
From these 573 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.
During 2011/12, all of the people receiving additional therapy were felt by the Service to have a successful outcome in accordance with their individualised care plan.

The level of referrals, whilst subject to periodic peaks and troughs, has remained reasonably consistent since 2007/8 (1,139). However, the number of these people needing additional therapy in 2011/12 increased by 33% from the 2010/11 figure.

This volume of referrals to the Falls Service represents only 10% of the expected number of people over 65 who fall in Milton Keynes in a year. Robust information about how many people report a fall to all the varied health and social care services that may deal with them, and what the outcomes of this are, is not currently available.

Evidence of what works and policy drivers

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

- NICE Clinical Guidance 21 (2004)[83] 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[84] 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 National Osteoporosis Guideline Group guidelines,[85] 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 recent years, the cost of hospital admissions in Milton Keynes 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 of falls, 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

User feedback collected by Milton Keynes Community Health Services' Falls Programme sessions 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.

Nationally, exercise classes with a falls prevention focus have been shown to be valued by people, improving their general sense of wellbeing.

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. There are pockets of good performance, but some gaps in effective service provision when compared to the evidence base above of what works well.

The greatest priority for Milton Keynes was to have clear accountability for identifying and delivering collective and specific actions required to reduce falls and having effective mechanisms to ensure these actions were progressed.

Responsibility for reducing the incidence of and injuries sustained from falls in Milton Keynes has been taken by the newly established Health and Wellbeing Board. Reducing injury rates from falls in the over 65s is a specific objectives within the Board's 2012 – 15 Strategy.

The Joint Commissioning Team is already arranging for additional falls prevention pilot projects, based in local community settings across Milton Keynes. These will incorporate multi factorial wellbeing assessments (including falls risk assessments and medicines review) and falls prevention specific exercise classes. These pilots will pro-actively target people who may be at risk of falling and will work closely with current falls prevention services.

In addition, a cross organisational Falls Prevention Strategy Group has been set up to deliver and implement an effective Falls Prevention Strategy in Milton Keynes during 2013 - 15. This Group will build on the work led by the Joint Commissioning Team in 2011 and will ensure the Action Plan from those workshops, formally approved by the Primary Care Trust is delivered, including:

- A lead Public Health colleague to proactively work with GPs to ensure improved primary interventions in relation to falls, including
  - 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.
  - GPs to review the low level of bi-phosphonate prescribing (bone density) at a practice level.
  - 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.
- Need to develop a Fracture Liaison Post within Milton Keynes Hospital Foundation Trust working with the Milton Keynes Community Health Services' 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.
- Define and obtain robust information about falls in Milton Keynes and use this to monitor the effectiveness of the falls prevention actions taken during 2012 – 15.

4.7 Infectious Diseases

Infectious diseases remain an important cause of poor health in England and Milton Keynes; 40 per cent of people consult their doctor every year because of an infection; 20% of the population annually suffer from an Infectious Intestinal Disease (IID) such as food poisoning and in 2010/11 MK CCG spent £38 per head to address infectious diseases.

The prevention and control of infectious and communicable diseases is achieved by providing individuals with immunity (vaccination) , detect infection and treating infections before symptoms occur (screening) using surveillance and early notification to stop infections that occur from spreading and becoming outbreaks or epidemics.

As part of the Notifications of Infectious Diseases system, local authorities and health professional s are legally required to notify the Health protection Agency of all cases of 32 specific infectious diseases. These notifications ensure that there is prompt detection and actions to control outbreaks of disease such as acute meningitis, food poisoning, invasive group A streptococcal disease, measles, tuberculosis (TB) and whooping cough. Additionally, constant national and local vigilance is kept against the risk of new and re-emerging diseases.

Who's at risk and why?

The level of risk of contracting a particular infectious disease for an individual in the population depends on a number of factors, including:

- The vulnerability of the individual, including whether they have previously been exposed or, if appropriate, been vaccinated against the disease in question. People with impaired immune function due to age (the very young and older people), pre-existing disease or medication are potentially more at risk of contracting an infectious disease and may experience a more severe or longer lasting illness as a result. They are also more likely to experience complications.
- The characteristics of the infectious disease and the dose required to cause infection.
- Exposure of the individual to sufficient dose of the bacteria or virus; depending on the disease in question this may be through contaminated food or water (e.g. food poisoning), inhalation (e.g. pulmonary TB, influenza), injection (e.g. blood-borne viruses) or transmitted through sexual contact.
- HIV infection is included within the sexual health component in the Lifestyle Determinants of Health section of this report.

Level of need in the population

Food Poisoning

Food poisoning remains the largest proportion of notifications of communicable diseases in Milton Keynes. The commonest (reported) causes of food poisoning in Milton Keynes in 2011 were campylobacter (285) and salmonella (46). They also had the highest incidence rate 118 and 19 per 100,000 respectively. Seven cases of E coli O157 were reported in 2011 which is similar to previous years with the exception of 2009.

Pulmonary Tuberculosis (TB of the lungs)

The TB incidence rate per 100,000 population increased from 12.3 in 2010 to 14.9 in 2011, a 2.6% increase, compared with 2010 (table below).

Year	Rate per 100,000 population*	Annual change in rate (%)
2006	19.1	
2007	18.8	-1.6
2008	16.4	-12.8
2009	14.6	-11
2010	12.3	-16
2011	14.9	21.6

Table 29: Tuberculosis incidence rate in Milton Keynes, 2006-11

Source: Enhanced TB Surveillance (ETBS) System, Thames Valley Health Protection Unit (TVHPU)

In 2011, a total of 36 TB cases were reported to the Enhanced TB Surveillance (ETBS) System and the majority of cases were among, Black African, Indian and Bangladeshi ethnic groups (figure 21).

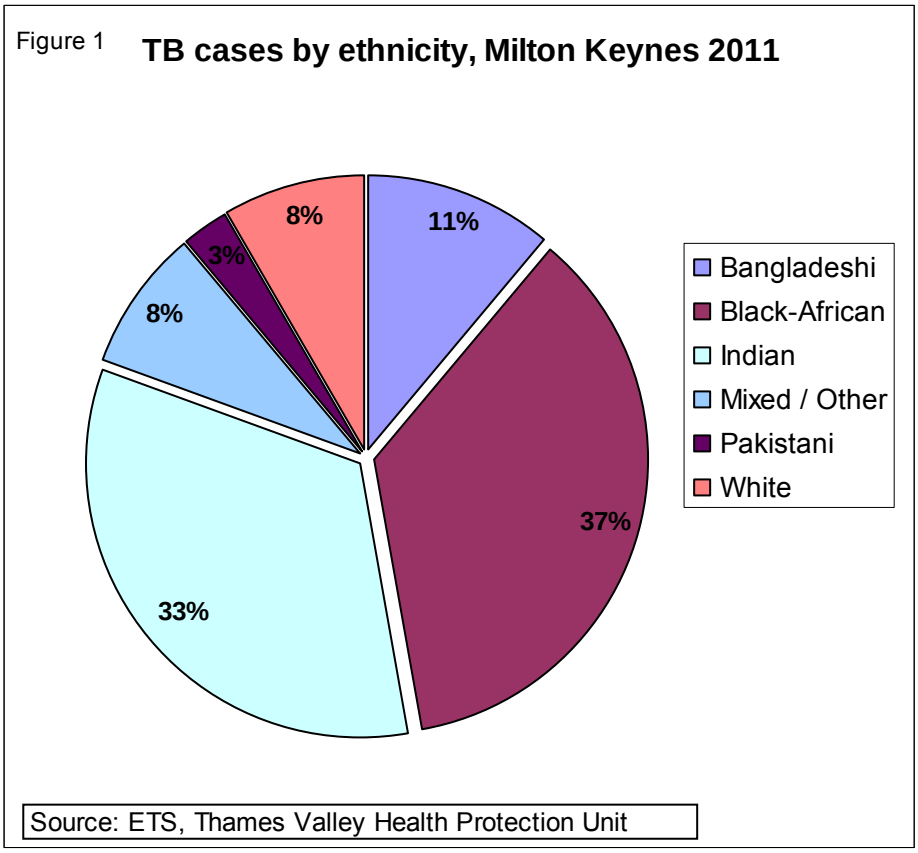


Figure 22: TB cases by ethnicity, Milton Keynes 2011

Source: ETS, Thames Valley Health Protection

In Thames Valley, the treatment completion rate has been higher than 80% for three consecutive years (2007-2010). The Chief Medical Officer's (CMO) action plan set the target of ensuring that all patients diagnosed with TB have the outcome of their treatment recorded, and at least 85% successfully complete their treatment. NHS

Milton Keynes had the highest treatment completion rate in Thames Valley in 2009 (91.2%) with the exception of NHS Oxfordshire (94.5%) (figure 22). The CMO's action plan indicates that 65% of pulmonary TB cases must be diagnosed by laboratory culture.

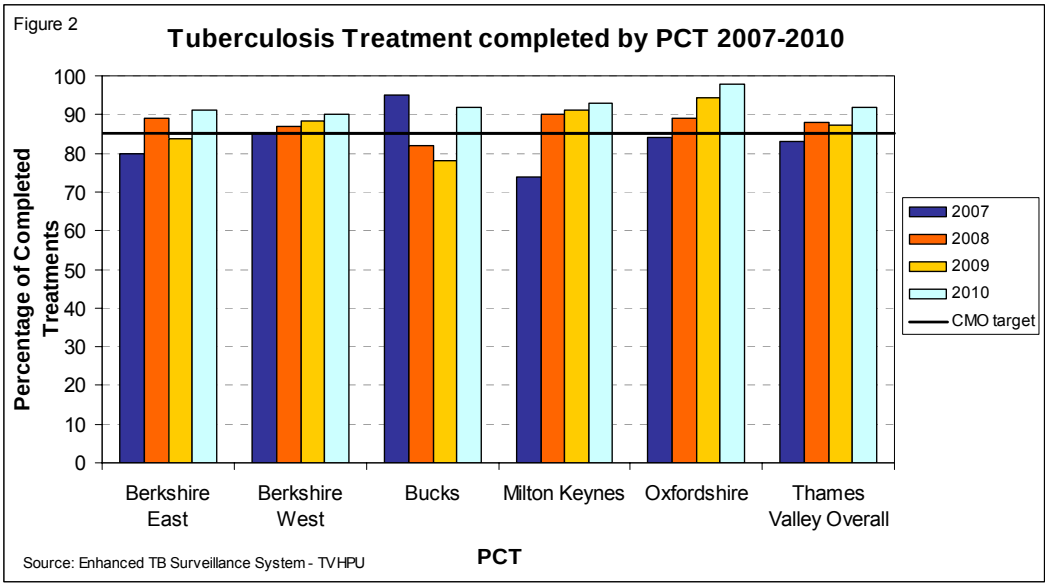


Figure 23: Tuberculosis Treatment completed by PCT 2007 – 2010

Source: Balanced TB Surveillance System – TVHPU

Other notifiable diseases

A number of other notifiable diseases are shown in the table below.

Other notifiable diseases Milton Keynes, 2011

Pertussis (whooping cough) confirmed	7
Invasive GRP A Strep (confirmed)	11
Malaria (confirmed)	13
Measles	18
Mumps	38
Scarlet Fever	16

Table 30: Other notifiable diseases Milton Keynes, 2011.

Source: TVHPU

Seasonal Influenza (flu)

Influenza poses a serious risk to the population with the risk of serious illness being higher amongst those with underlying health conditions. Therefore the objective of the influenza vaccine programme is to protect those who are most at risk of serious illness or death should they develop influenza. The World Health Organisation (WHO) recommends that at least 75% of people 65 years and over are immunised against the flu viruses. Vaccination is also recommended for those aged six months and over with specific chronic conditions, who are at increased risk of flu

complications. For the first time in 2011, the European Union introduced an incremental (by 2014) target 75% uptake for individuals under 65 years with specific conditions.

In comparison to 2010/11, the uptake levels for those aged under 65 years in Milton Keynes was 53.6 an improvement of 3% (Table 32) and was higher than the national average of 51.6. The under 65 years with risk factors will continue to be a priority in 2012/13. For the 65 years and over age-group, Milton Keynes had an uptake of 72%, slightly below the national average of 74%.

At risk under 65s						
	2009/10		2010/11		2011/12	
	Under 65 years at risk	65 years and over	Under 65 years at risk	65 years and over	Under 65 years at risk	65 years and over
Milton Keynes	54.8	70.8	51.6	71	53.6	72
England	51.6	72.4	50.4	72.8	51.6	74

Table 31: Seasonal influenza uptake

Source: HPA Annual flu report 11/12

Pneumonia

Pneumonia can be a preventable disease but it remains a leading recorded cause of respiratory death in Milton Keynes. In 2010, 118 deaths (38% of all respiratory deaths) were due to pneumonia. Pooling three years of data from 2008-2010 shows pneumonia was responsible for 374 deaths, resulting in 605 years of life lost before the age of 75. The standardised mortality ratio indicates that the pneumonia rate in Milton Keynes (156) is significantly higher than in England and Wales. Pneumonia also causes a significant number of hospital admissions. In the financial year to April 2011 there were 691 pneumonia admissions to Milton Keynes hospital. Of these admissions 77 admissions were for patients less than 18 years old and 291 were 75 years or over. These admissions accounted for a total of 8,032 bed days.

Because of high mortality and morbidity, pneumonia was an area of public health focus in 2012. A disease-specific review was undertaken, alongside an audit of pneumococcal vaccinations. This led to an assessment of whether all those eligible had been vaccinated in accordance with the national vaccination protocols.

Current services in relation to need

Immunisation remains the mainstay of prevention for childhood illnesses, influenza and pneumonia. Immunisation programmes are delivered by primary care teams and school nurses.

The majority of infectious diseases are identified and treated without recourse to health care; however some require treatment by a GP or in secondary care, for a longer more complex course of treatment (e.g. TB).

Investigations into single cases of certain diseases and outbreaks are undertaken by teams from Milton Keynes and the Health Protection Units, Environmental Health officers and Health Protection specialists from the Health Protection Agency.

Projected Service use and outcomes

The number of cases of TB is projected to rise in Milton Keynes because of the higher rates seen in people arriving or returning from Asian and African countries where higher rates prevail.

Although rates of food poisoning remain fairly constant food hygiene awareness remains an important issue.

Seasonal influenza occurs annually and the possibility of an influenza pandemic remains a threat. The projections for an increase in the proportion of the over 65's in the population and the anticipated increase in long term conditions that make people more vulnerable to the effects of influenza (e.g. diabetes, COPD) means that increasing the uptake of this and pneumococcal vaccine in these groups is paramount.

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

The seasonal influenza vaccination programme for "at risk" individuals under 65 years is a key priority that requires innovative models of delivery, for example renal dialysis patients immunised in the renal dialysis unit and pregnant women in pre-natal clinics. We will also concentrate on further improving the uptake of flu vaccination in at risk groups and health and social care workers.

Due to the increase in the rate of TB cases by 2.6% in 2011, it is imperative that robust systems are in place for the early diagnosis and treatment of this disease, therefore a new service specification will be commissioned in 2013.

Using the pneumonia review as a baseline, we will identify trends in pneumonia admissions and deaths, such as geographical clusters or seasonal peaks. Because of the increased likelihood of developing pneumonia following influenza infection, we will focus our efforts to provide both influenza and pneumococcal immunisation where or when risk is greatest, for example in care homes.

4.8 People with Particular Needs

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.

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. 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.

Level of need in the population

2011/12 was a busy year for Children's Social Care Services; numbers of care proceedings and assessments increased and numbers of children in care continued to rise (from 271 to 278), but not in line with the previous year's increase.

The service has managed this workload increase whilst achieving improved performance for assessment timescales and good child protection performance indicators. This was confirmed by a second positive unannounced inspection in February 2011. Numbers of care proceedings and children in care have stabilised in 2011/12 but remain relatively high compared to previous years at 49 sets of care proceedings and 278 children in care (31/3/12). There have been no Serious Case Reviews since 2008.

Referrals to Children's Social Care

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.

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.

Number of referrals to Children's Social Care

2009/10	3677
2010/11	3038
2011/12	2385

Table 32: Number of referrals to Children's Social Care.

Source: LA children's social care database

There were 225 children in care in March 2009; 260 children in March 2010; 271 children in March 2011 and 278 children as of March 2012. The last three years have seen Milton Keynes, and many other Local Authorities, experience an upward trend in its numbers of children in care. This is considered largely to be as a result of the impact of the death of Peter Connelly ('baby peter') as well as the continued and rapid growth and diversity of the population locally.

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.

Current issues

- The demographic changes to Milton Keynes over the last decade, and especially the last 5 years, have impacted heavily; the dramatic rise in the 0-17 population has included a significant proportion of disadvantaged families.
- High profile cases in the media have been another factor in the rise in referrals, assessments and care proceedings.
- The need for improved early help services, which will be picked up in 2012/13 through the new children and families.
- The number of referrals is beginning to reduce and there are areas where CAF is starting to embed and professionals are beginning to instigate some creative approaches to problems faced by families.
- Social care interventions are working; reductions in Care Proceedings are considerable compared to the 09/10 figures. The children in care population remain higher than we would like, but the care population is now stabilising.

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 2012. 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.

Milton Keynes has a young, growing population that is increasing in ethnic diversity. Projected growth in the population of children and young people shown in figure 8 of the population chapter suggests that this trend will continue. It is likely that this will be associated with an increase in the demand for Children's Social Care.

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. [86]

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)

The key challenge 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.

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.

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.

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

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

- Strengthen governance arrangements for corporate parenting.
- Develop our corporate parenting responsibility with involvement of young people supported by the corporate parenting officer, Independent Reviewing Officer's, and advocates.
- Increase the percentage of children in care who are fostered in or close to Milton Keynes.
- Develop culturally appropriate services locally for black and minority ethnic children.
- Reduce the number of children in external residential placements.
- Keep children in touch with their parents and wider network and support them to return home or to the care of their wider family and friends where feasible.

Autism

Who's at risk and why?

Adults with Autistic spectrum Conditions (ASC) have been identified in the Autism Act 2009 as being at risk of disadvantage through poor understanding of their needs and difficulties in getting a diagnosis. Lack of awareness in a wide range of agencies leads to problems with finding appropriate housing and support, gaining employment and addressing health needs. These deficits in support can lead to deterioration in the mental and physical health of individuals and their informal carers.

Level of need in the population

The National Autistic Society website[87] gives an estimated national prevalence rate of 1% (The National Autistic Society, 2008). However, a recent study by the Autism Research Centre, Department of Psychiatry, Cambridge University estimated the prevalence to be 157 in 10,000 (1.57%). They state that the increase in reported prevalence rates over time "is likely to reflect seven factors: improved recognition and detection; changes in study methodology; an increase in available diagnostic services; increased awareness among professionals and parents; growing acceptance that autism can coexist with a range of other conditions; and a widening of the diagnostic criteria". (Baron-Cohen et al, 2009)

The ASC prevalence rate is higher in men (1.8 per cent) than women (0.2 per cent). This fits with the gender profile found in childhood population studies. "(Brugha et al, 2009)

Accurate data about local prevalence is difficult to establish because the Autistic Spectrum is wide and services to people with ASC have traditionally been provided by a range of different providers rather than through one cohesive pathway. The Milton Keynes Autism Partnership Board brings together services and agencies that work with people with ASC to share information about prevalence. These partners include the Joint Adult Learning Disability and Mental Health services, Children's Social Care, Education and Health services, Milton Keynes College, Connexions, Job Centre Plus, local providers of specialist services and family carers' groups.

The Autism Assessment and Diagnosis Service (AADS) is a virtual team hosted at the Community Team for Adults with Learning Disabilities. It is now offering diagnostic assessments, with Community Care Assessments where the person is eligible. This process is also contributing to the collection of accurate data.

Current Services in relation to need

The AADS, comprised of staff from MKC and MKCHS, is making significant progress in addressing the need for diagnosis. For some people, particularly among adults who have not been previously diagnosed, this alone can be sufficient to help the person and his or her family to understand the condition and to make adjustments accordingly. However, the improvement in diagnosis has also identified areas for further development in provision.

A further important source of information about current and future needs is The Walnuts School, a community residential special school for pupils with autistic spectrum disorders which opened its secondary service in 2007. Adult Services are working with the 16+ unit of the School to understand the significant needs of pupils. Other schools, both specialist and mainstream, also have a number of pupils with ASC.

From this and other work it is clear that two groups in particular have needs which cannot be met by adult services as they are currently configured:

- People with ASC who do not have a learning disability or a mental illness and who, after or during diagnosis, need assessment for adult social care services. To help meet the needs of this group, the Adult Social Care Access Team (ASCAT) has recruited (November 2012) a specialist social worker to undertake assessments and care-planning with this group. This social worker will also be a member of the virtual AADS Team
- People who are diagnosed as being on the Autistic Spectrum but who are not eligible for Adult Social Care services. They may still, however, face difficulties in accessing some other services where their needs are not well understood. ASCAT has also recruited two community support workers who will undertake short-term work with people in this situation to help them with initial contact with other agencies.

Projected service use and outcomes

A number of specialist providers of social care and health services to people with ASC have begun working in Milton Keynes. This, with AADS and the ASCAT recruitment described above, is broadening the scope of provision.

The development of personal budgets is the opportunity to widen choices in services available to people with ASC. In addition, service specifications and the monitoring of contracts are becoming more outcomes focussed, supporting people with ASC and their families to state their aspirations and to work towards achieving them. Providers have contributed to a directory of services from which users can choose. The development of Framework contracts for Autism services is underway.

Evidence of what works and policy drivers

The Autism Act 2009[88] and its statutory guidance require that local authorities and NHS bodies:

- Should provide autism awareness training for all staff.
- Must provide specialist autism training for key staff, such as GPs and community care assessors.
- Cannot refuse a community care assessment for adults with autism based solely on IQ.
- Must appoint an autism lead in their area.

- Have to develop a clear pathway to diagnosis and assessment for adults with autism.
- Need to commission services based on adequate population data.

Work to meet all of these requirements is underway in Milton Keynes under the supervision of the Autism Partnership Board.

User view

The Partnership Board working through its Action Groups where appropriate involves people with learning disabilities and family carers in strategic planning. They are well represented on the Board and are supported by advocacy organisations to put over their views.

Seven people with Aspergers Syndrome have been trained and are now being supported to train staff in how to work with people with ASC. This group is known as the Autism Trainers and their presentations are highly regarded. They are paid as sessional workers by MKC.

The Autism Partnership Board is sponsoring a major conference in May 2013 aimed chiefly at GPs and other Health Professionals.

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

The main priorities for 2013-14 are:

- To continue to develop systems to collect accurate data about the needs of the population with ASC.
- To promote awareness training and more detailed specialist support for front line staff
- To review and improve the pathway for people with ASC through Health, Social Care and mainstream community services.

Disability (including Visual and 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)[89]
- 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)
- 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, LINk:MK has identified that 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[90] and POPPI[91] databases and outlines the estimated levels of need in Milton Keynes for physical disability and sensory impairment projected to 2030.

The charts 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.

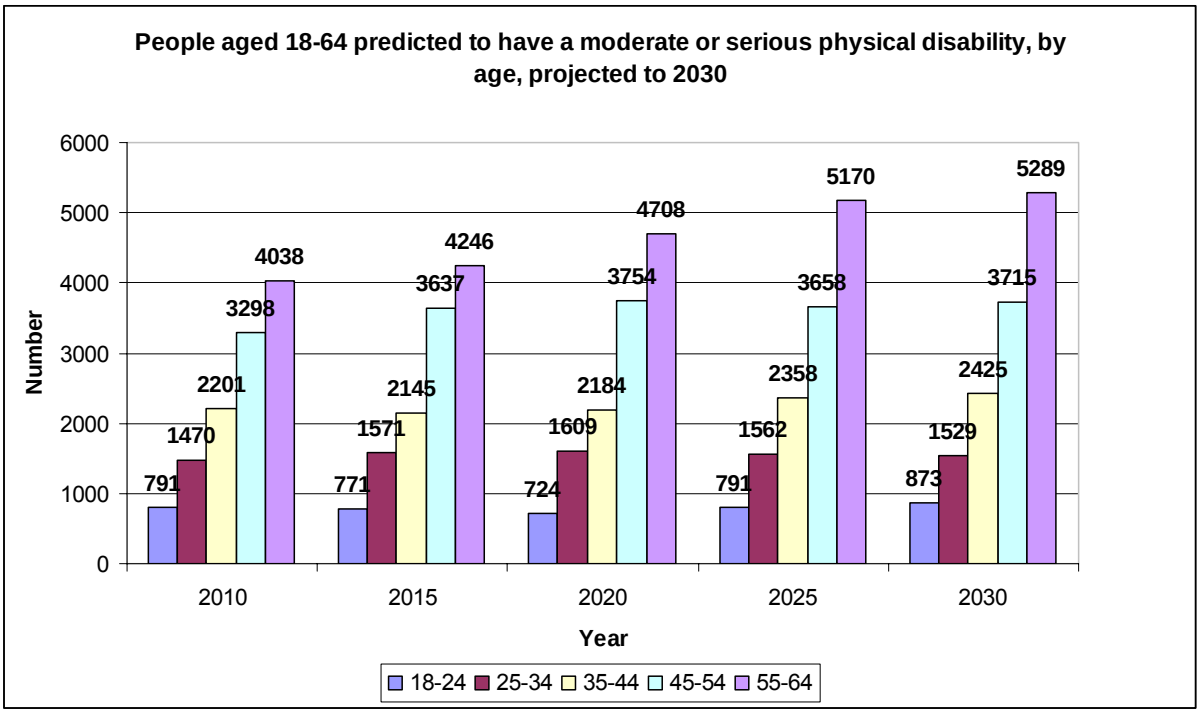


Figure 24: People aged 18 – 64 predicted to have a moderate or serious physical disability, by age, projected to 2030.

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

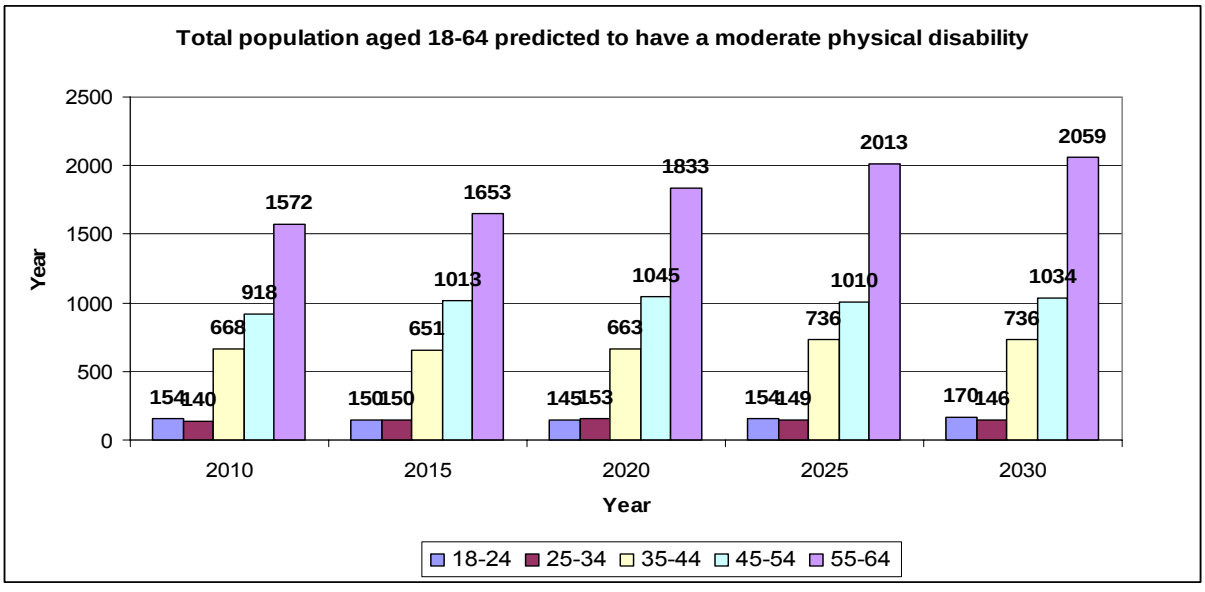


Figure 25: Total population aged 18-64 predicted to have a moderate physical disability

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

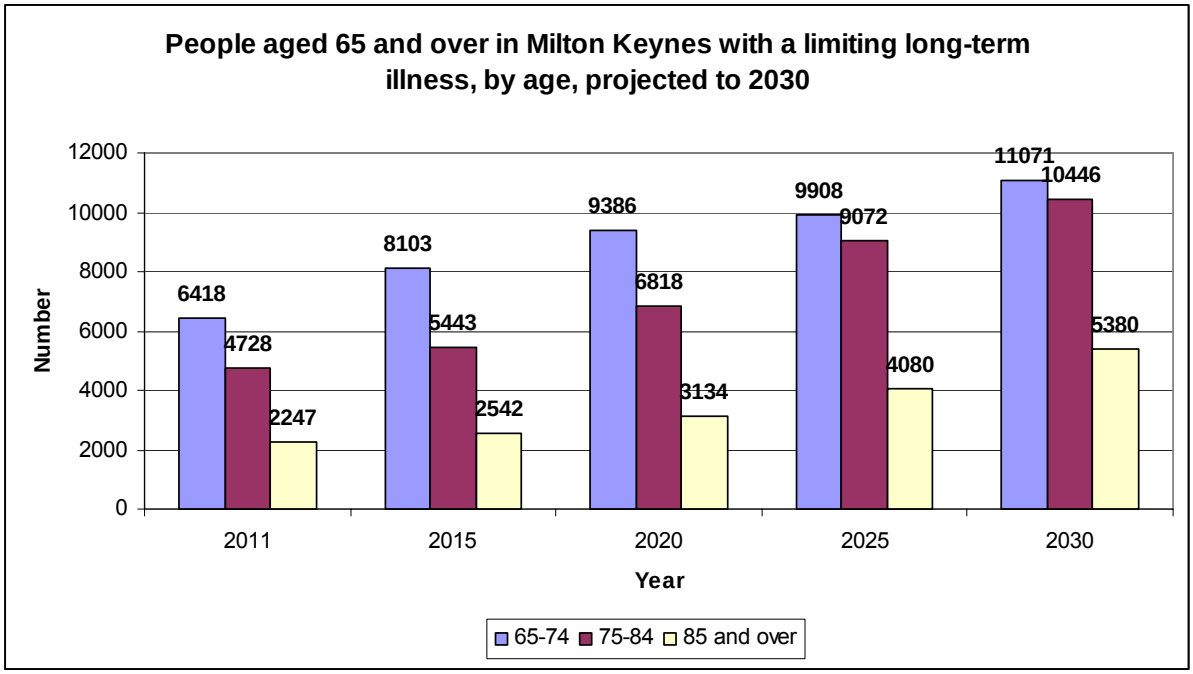


Figure 26: People aged 65 and over in Milton Keynes with a limiting long-term illness, by age, projected to 2030.

Source: Chart produced on 18/11/11 11:55 from www.poppi.org.uk version 6.0

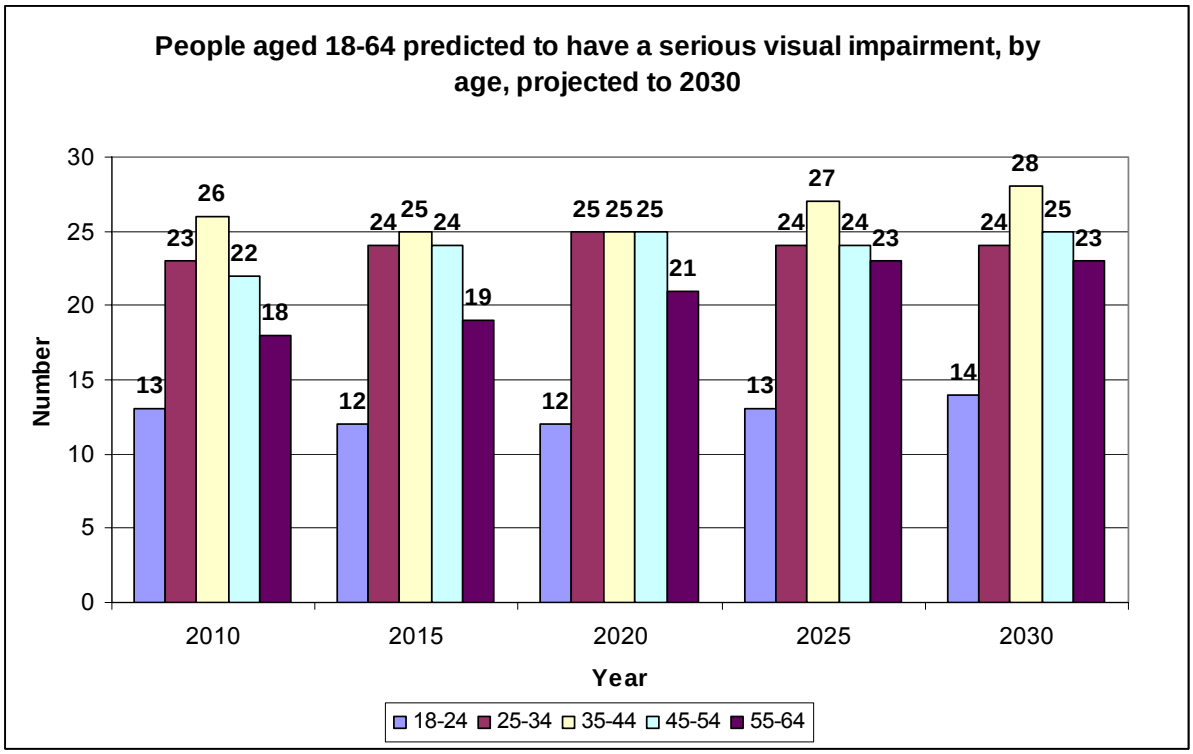


Figure 27: People aged 18-64 predicted to have a serious visual impairment, by age, projected to 2030.

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

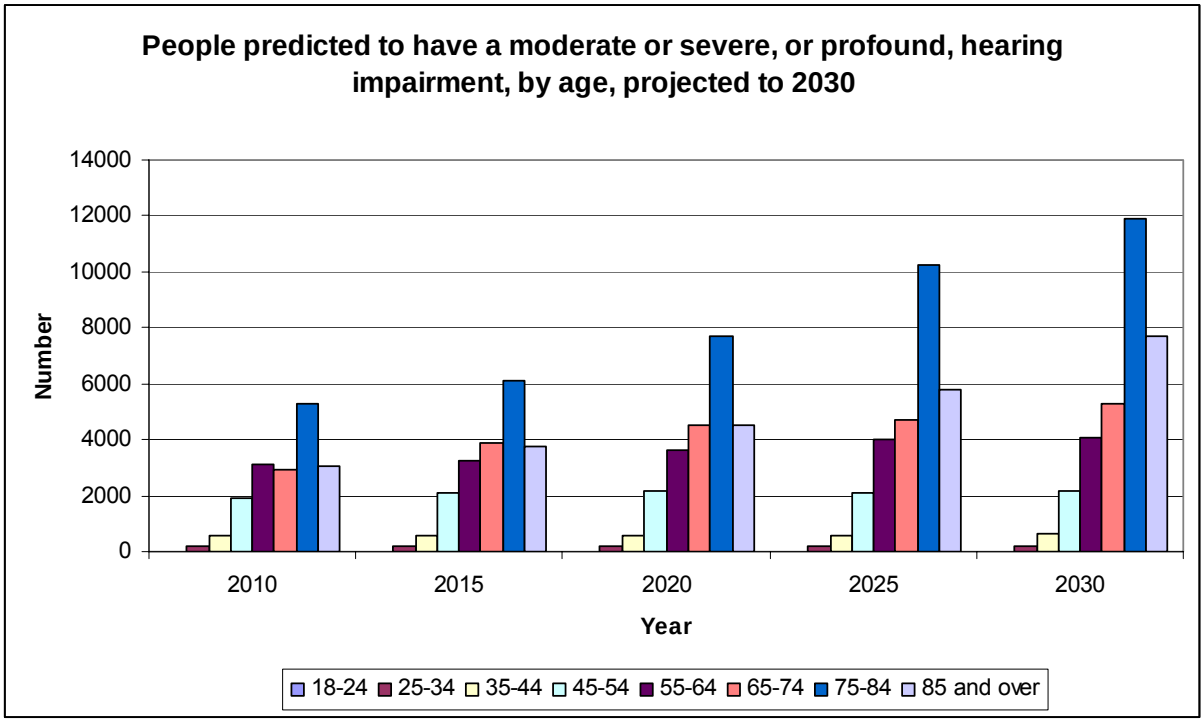


Figure 28: People predicted to have a moderate or severe, or profound, hearing impairment, by age, projected to 2030.

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

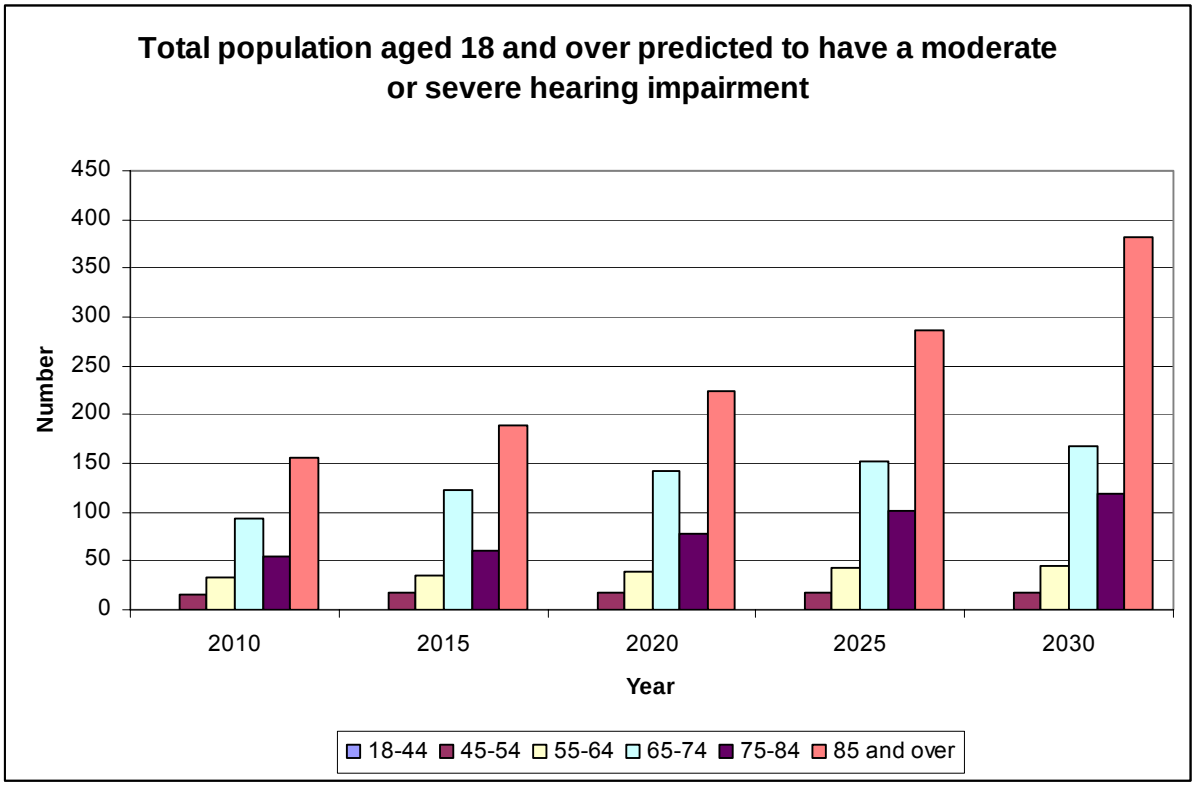


Figure 29: Total population aged 18 and over predicted to have a moderate or severe hearing impairment

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

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.[92] 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 (Milton Keynes average 5.8 per 1000) and the number of people eligible for disabled concessionary travel fares (Milton Keynes average 12.1 per 1000). The areas of Milton Keynes showing higher than average values for these indicators are:

- Beanhill (fares 37.1 per 1000, MKC clients 29.8 per 1000).
- Coffee Hall (fares 48.9; MKC clients 21.1).
- Eaglestone (fares 31.3; MKC clients 6.9).
- Hardmead (fares 20.0; MKC clients 23.3).
- Fenny Stratford (fares 62.0; MKC clients 14.8).
- Pennyland (fares 21.7; MKC clients 19.5).
- Stacey Bushes (fares 31.5; MKC clients 8.6).
- Tinkers Bridge (fares 20.0; MKC clients 2.8).
- Willen Park (fares 22.4; MKC clients 22.2).

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.

Evidence of what works and policy drivers

Policy Drivers

Personalisation was described in the White Paper 'Our Health Our Care Our Say' 2006.[93] 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 Act 2012

This legislation introduces a wide range of reforms to the benefits and tax credit system. This legislation affects 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 introduce a new benefit, the Personalised Independence Payment (PIP) for people aged between 16 and 65 on the day PIP is introduced. Levels of payment will depend on a detailed assessment of needs. In Milton Keynes, the change to PIP will be phased in over the period June 2013 to March 2016.

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 worked 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.
- 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.
- Re- procure 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 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.

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 883 (0.47%) of people will be known to learning disability services in Milton Keynes. However, the actual number known to the Joint Learning Disability Service (including those who are funded by a different local

authority but who are known to Milton Keynes Health services) during the year to 31 March 2012 was 729 (0.39%).

PANSI[90] estimates that there are 4,396 people aged 18+ in Milton Keynes with a Learning Disability. Based on evidence from the World Health Organisation (WHO) and Institute of Health Research, Lancaster University,[94] this is broken down by level of Learning Disability as follows:

Mild Learning Disability	3,693	84%
Moderate Learning Disability	571	13%
Severe / Profound Learning Disability	132	3%
Total	**4,396**	**100%**

Table 33: Level of need in the population

Source: PANSI http://www.pansi.org.uk/index.php?pageNo=388&areaID=8329&loc=8329

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

A Review of Learning Disability services is underway and will be the subject of consultation in the later part of 2012-13 and the following year.

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. The development of Framework contracts for LD services is underway.

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 2011-12, 223 health checks were carried out. By October 2012, 24 out of 28 GP Practices had signed up to the LES. Over 200 Health Passports have been issued to people with learning disabilities. A steady increase in the number of checks is required in 2012-13 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 2013 – 2017 are as follows:

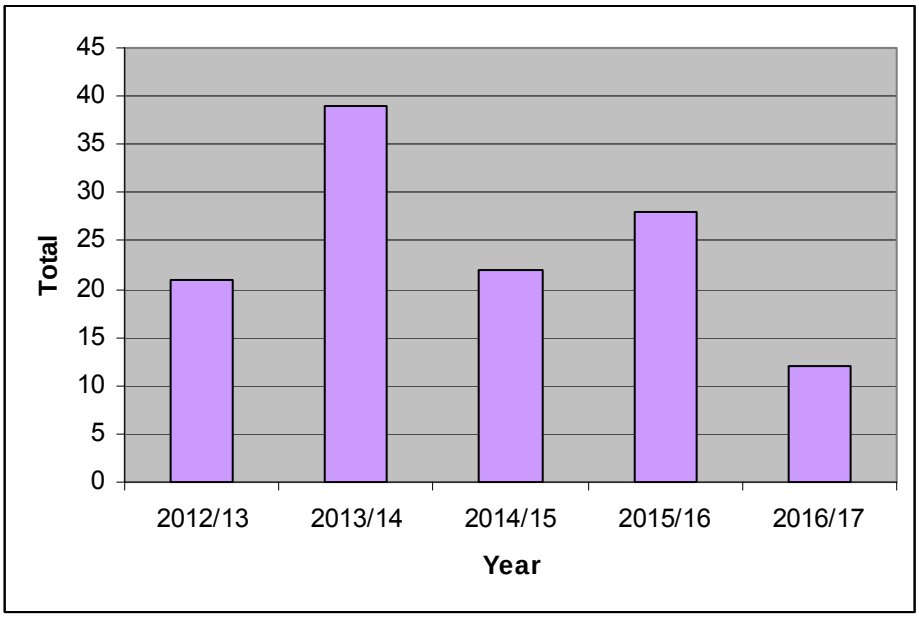


Figure 30: Number of school leavers expected to come into Adult Social Care Services from 2013-2017

Source: Based on unpublished local data collated by the Learning Disability Transitions Social Worker, working in conjunction with Education and local special schools to identify children with SEN who are likely to require adult social care services from the Learning Disability team.

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 outcomes of investigations following the Winterbourne View revelations, following on from thee Six Lives Report,[95] 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 CCG Board (through its Quality Committee) 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 three 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. At the Big Health Day in 2012, a simple system to provide feedback using electronic trackers was trialled. The resulting data has been considered by people with learning disabilities in the LDPB's Check It Out (Quality) sub group. More work, including information for future JSNAs will be done on this method of gathering feedback.

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 the CCG 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.
- In addition priorities of the MKLDPB include:
- Work to address difficulties experienced by people with learning disabilities in the Criminal Justice System.
- Exploring more effective use of assistive technology to support people in their own homes and in short breaks services.

Prisoners and Young Offenders

Who's at risk and why?

Her Majesty's Prison (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.

Oakhill is a secure training centre (STC) based in Milton Keynes housing young people aged between 12 and 17 from across the country who are remanded into a secure setting or meet the criteria for a custodial sentence. The centre is privately run by G4S Care and Justice Services Limited.

Problems and evidence

1) Mental Health

The Bradley Report[96] 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%

Table 34: % of prisoners having a significantly higher rate of mental health problems compared to the general public.

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)[97] 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.

Level of need in the population

Health Needs Assessments

HMP Woodhill

A refresh of the existing health needs assessment was completed n November 2011. However it is recognised that there is a need for a full health needs assessment to be done within the first quarter of 2013. To this end a heath needs assessment has been commissioned and will be completed by March 2013.

The offender heath commissioner will then refresh and update the JSNA to reflect the findings of the health needs assessment.

Oakhill secure training centre

The East Midlands Prisoner and Offender health commissioning unit will take responsibility for the commissioning of the healthcare services for Oakhill STc in April 2013.

There is a need for a full health needs assessment to be completed and this will be done by early summer 2013. The JSNA will be updated accordingly.

Current Services in relation to need

Primary health care services in HMP Woodhill are currently provided by the Milton Keynes Community Health Service. The substance misuse services, both psychosocial and clinical at HMP Woodhill have recently been retendered and from the 1st October 2012 are being provided by Westminster Drugs Project (WDP). MKCHS will continue to provide the clinical element until 31st March 2013. Secondary care is provided by Milton Keynes General Hospital.

Primary healthcare services in Oakhill STC are currently provided by Primecare. Substance misuse services are provided by a dedicated in-house team.

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

Key priorities for 2012-13 are to 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.
- Ensuring a quality substance misuse service is available which has strong links to community providers.
- Decreasing the rate of dental ill health by providing an onsite dental service.
- Decreasing the rates of self harm and suicide attempts by working cohesively with the prison side and healthcare to minimise and contain risk.
- Implementing outcome measures for the substance misuse service at Oakhill STC.

Re-offending

Who is at risk and why?

Young people who may be at risk of offending for the first time or re-offending.

Level of need in the population
First Time Entrants

Definition:

The number of young people who received their first substantive outcome (whether pre-court or at court) during the rolling 12 month period.

Proxy data is produced by using pre-court notifications from Milton Keynes police and cases appearing at Milton Keynes Court.

Official data taken from PNC		
Comparator data: Has not been available until very recently – the latest information available is:		
FTE rate per 100,000	**Jan '11 – Dec '11**	**Apr '11 – Mar '12**
Milton Keynes	663	622
Region	617	579
National	749	712

Table 35: First time entrants - the number of young people who received their first substantive outcome (whether pre-court or at court) during the rolling 12 month period.

Source: PNC

Re-offending

Definition:

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.

Comparator performance:

Binary:	Jul '09 – Jun '10	Oct '09 – Sep '10
Milton Keynes	29.9%	31.2%
Region	31.5%	32.3%
National	34.1%	34.8%
Frequency:	Jul '09 – Jun '10	Oct '09 – Sep '10
Milton Keynes	0.85	0.92
Region	0.91	0.95
National	0.96	0.99

Table 36: Re-offending - Binary and frequency measures.

Source: LA youth offending database; DfE

Current services in relation to need / Projected Service use and outcomes

Based on the most recent figures Milton Keynes now sits towards the top of the second quartile nationally this time last year we were in the fourth quartile. This is particularly encouraging as the impact of the use of Youth Restorative Disposals (YRD) seems to have reached the bottom of the curve and therefore sustained improvement is not purely as a result of increased use of the YRD although that continues to have a major impact.

Regionally we are still below the average but the region contains some of the most affluent areas in the country with very low crime rates.

The proxy data has shown a slight increase in the last two periods and this is consistent with the national picture.

Since the last JSNA we have started to receive the national release of the new re-offending performance data. This is historic information based on quarterly rolling cohorts. The tables above show that re-offending rates nationally and regionally have increased as has the local position but not by as much. It is difficult to say if this two year old data (the binary rate is the measure made available to the public) is of value in terms of 'predicting' performance more recently

Looking at more recent cohorts between 1st October 2011 and 31st March 2012 we reported a notional 'binary rate' of **25**% and this improved even further when looking at the next cohort (1st April to 30th June 2012) where the notional 'binary rate' was **16**%.

Although caution must be applied to these figures as they reflect much shorter periods (i.e. not the 18 months that the official data reports on) there is reason to be optimistic that locally we are not seeing significant rises in rates of re-offending and may be moving downwards again.

Problems and evidence

Performance against national indicators can only provide a partial and largely historical picture. Analysis of the key issues arising during assessment by the YOT can help to illustrate the problems faced by young people who offend. **Asset** is the national assessment tool used by YOTs to analyse a young persons risk and protective factors with respect to likelihood of re-offending risk of harm to others and vulnerability. The results are used to determine the level and type of intervention required.

Evidence of what works and policy drivers

Final Warnings and First Time Entrants

Information regarding the early phase of engagement with the criminal justice process is likely to provide clues to where preventative activity should be focussed. This could be argued to be of particular interest for SaferMk and the newly emerging Children and Families Practices who have now taken on the responsibility for youth crime prevention and tackling youth antisocial behaviour.

The questions asked by Asset are different so direct comparisons cannot be made but as far as possible the analysis covered the same ground.

Most first time entrants receive a Reprimand and consequently do not have an assessment some go directly to court so would have been captured in the information above so the following only refers to those who received a Final Warning.

Of the 79 Final Warning initial assets completed in the period 35 related to first time entrants (fte).

For the overall cohort 47% had experienced some bereavement or loss (22% for the fte sub group): 16% had some indications of abuse (but we are unable to say what form and how serious); 30% were deemed to have received inconsistent parental supervision (13% for fte); in 15% of cases there was some evidence of familial criminality; 15% had evidence of drug use in the family.

Some evidence of self harm was noted in 27% of cases and attempted suicide (self reported) in 8% (6 cases). In 34% of cases there had been contact with mental health services. Again assessors judged significant past events as influencing offending behaviour in 59% of cases.

The assessment tool is less detailed in its collection of information regarding substance misuse at the Final Warning stage but 57% (23% fte) of the sample claimed to have at least tried tobacco and/or alcohol and/or drugs.

As expected at this level the nature and complexity of issues is less serious but there is evidence to suggest that some of the issues faced by those appearing in court are already present at first or early contact with criminal justice agencies. This suggests that early help to focus on problems such as parental supervision, support to cope with bereavement and loss and services to tackle violence in and around the home would help to reduce the risk factors that lead to both the onset of and persistence of offending.

One interesting point to emerge from this limited analysis is the level of contact with mental health services which suggests that they may provide an important opportunity for effective early intervention alongside the criminal justice and 'children and family services'.

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

Family and Personal Factors

In 47% of these cases there was some indication that the young person had either experienced abuse and/or witnessed domestic violence, 40% had experienced bereavement or loss and in 30% of cases inconsistent parental supervision was judged to be associated with offending.

In 30% of cases familial criminality was an issue rising to 45% in those cases that attracted a custodial sentence. Familial substance and/or alcohol misuse was identified in 22% of the sample. Failures in communication also featured significantly (34%) rising to 55% for those sent to custody.

Incidents of self harm were reported in 14% of the total sample but in 18% of those sent to custody. Contact at some point with mental health services was identified in 39% of the cohort but only 5% had a formal diagnosis. In 50% of cases assessors evidenced that significant past events had influenced offending behaviour which would include bereavement and exposure to violence as suggested above.

Substance Misuse by young people

In 69% of cases young people reported recent use of tobacco; 41% recent use of alcohol and 46% recent use of cannabis. Only between 1and 2% reported recent use of any Class A drugs with 10% saying they had tried Cocaine at some point.

18% said that they offended to obtain money for drugs and 20% saw substance use as a positive factor in their lives. Surprisingly there was lower recent use of all substances reported by those sent to custody than those who remained in the community but this may be a mathematical problem caused by the low numbers of custodial sentences handed down to this group.

Overall as expected there are a range of factors influencing those who come before the courts and these tend to become more complex the longer a young person's

offending career goes on or the more serious their offending is as shown by the figures for those in custody.

Perhaps of particular note is the apparently high incidence of exposure to violence and abuse and of bereavement and loss experienced by these children often judged to be influential in offending behaviour. But inconsistent parenting and pro-criminal family influences is also a factor to be borne in mind.

On the positive side use of Class A drugs in this age group is low but the impact of alcohol and cannabis (ref. recent research linking to impaired IQ) remains high and in terms of long term health the early onset of smoking (long considered an early indicator of criminality) is at an alarming level.

Users views

Some views from offenders above.

Older People with Social Care Needs

Who is at risk and why?

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.
Older 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.

Levels of need in the population

Complex intensive health and social care needs of older people and people with long term conditions are driven by a number of fixed and modifiable risk factors, including age, deprivation and lifestyle choices.

As shown in chapter 2.1 on population growth there will be a significant rise in the population over-65 in Milton Keynes. The table below shows the increase in this population up to 2025,. There will be an increase of 58% for the over-65 population, 66% for the 85-89 population and 81% for the over-90s.

	2013	2015	2020	2025
People aged 65-69	11340	12480	12870	14020
People aged 70-74	7290	8290	11710	12070
People aged 75-79	5470	6060	7790	11000
People aged 80-84	3870	4090	5240	6860
People aged 85-89	2500	2630	3140	4150
People aged 90 and over	1440	1570	1980	2600
Total population aged 65 and over	31910	35120	42730	50700

Table 37: Increase in Population over 65

Source: Census 2011

In terms of deprivation, the number of people over-60 claiming pension credit in 2011 was 17.1%, compared to the England average of 14.1%.

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. The table below shows the number of people predicted to be living alone, showing an increase of 55% in the 65-74 population, and an 85% increase in the over-75 population to 2025.

Living Status	2013	2015	2020	2025
Total population aged 65-74 predicted to live alone	4,010	5,070	5,910	6,210
Total population aged 75 and over predicted to live alone	6,180	7,069	8,691	11,432

Table 38: Number of people predicted to be living alone.

Source: Projecting Older People Population Information

Current services in relation to need

Many older people will develop long term conditions and reference is made to chapter 4.4 where these conditions are presented in more detail. The type of service offered depends on the level of need of the potential service user. In order to assess the level of need, a typical pathway would be referral (by self/friend/neighbour/health professional) to the intake team for an initial assessment. They may then provide information and advice, signpost to other, more appropriate services, such as those offered by the third sector, or pass the referral to a social work team for further assessment. This could result in the commissioning of a range of services, including reablement, community based services (such as home care and day care), or residential based services (such as residential or nursing care).

Below details the number of assessments for new service users carried out by Adult Social Care staff between 2008/09 and 2010/11.

Year	Number of new assessments
2008/09	2340
2009/10	2307
2010/11	1023
2011/12	707

Table 39: Number of assessments for new services users.

Source: Referral Assessments and Packages of Care, NHS Information Centre

Although assessments appear to drop, this is due to changed recording practices, and the 2011/12 figure is the most accurate.

Current Service Use and Historical Trends:

The data in table relates to the number of people in receipt of services during the year. 'Community Care' refers to services that enable a person to remain living in the community, such as home care, day care and supported accommodation. 'Residential and Nursing care' relates to 24 hour permanent care in a residential or nursing home.

Service/Year	2008/09	2009/10	2010/11	2011/12
Community Care	5180	4987	3740	4376
Residential and Nursing Care	1120	1097	1045	916

Table 40: Number of people in receipt of services.

Source: Referral Assessments and Packages of Care, NHS Information Centre

Intermediate Care:

The values below present figures relating to achieving independence for older people through intermediate care. The table presents the percentage of people who, after discharge from hospital, received intermediate care and were living independently (with or without support) 91 days after discharge.

During the sample period, 1 October 2012 to 31 December 2012, Milton Keynes assisted 70 people aged 65 or over through intermediate care. Of these, 60 people were living independently at home 91 days after their hospital discharge (84 %). This is above both the East Midlands and the England averages.

Evidence of what works and policy drivers.

Telecare and telehealth

"There is mounting evidence to suggest that telecare can make a difference to individuals and their carers, and to the health and social care system as a whole. It can help to improve people's independence, relieve stress on informal carers and improve clinical and care outcomes" (Care Services Improvement Partnership, 2006).

A UK randomised control trial of telecare and telehealth (launched in 2008 by Department of Health) involved over 6,000 patients and more than 200 GP practices. Findings presented in 2012 show that, if used correctly as part of a service redesign, telehealth can deliver a reduction in Accident & Emergency (A&E) visits, emergency admissions and elective admissions, bed days, and a reduction in tariff costs.[98]

Preventative Services

Reablement is increasingly being used as a cost effective preventative intervention to support older people to regain independence following events such as falls, hospital admissions etc. Research evidence demonstrates that reablement improves independence, prolongs people's ability to live at home, and removes or reduces the need for commissioned care hours (in comparison with standard home care). The best results (McLeod et al., 2009) show that up to 62% of reablement users no longer need a service after 6−12 weeks (compared with 5% of the control group), and that 26% had a reduced requirement for home care hours (compared with 13% of the control group).

Other preventative services include provision of information and advice, as well as early intervention services for dementia such as memory screening.

Support to carers

Informal care is the most important source of care for most older people living in UK today Approximately 80 per cent of people aged 65 and over living in private households, who have help with domestic tasks, rely exclusively on unpaid informal help, that is, help from spouses, other household members, relatives outside the household, neighbours and friends" (Pickard, 2000).

Carers' services and support is covered in more detail in the section below "Carers and Young Carers".

Priorities

The priorities are similar to those reported in the chapter on Long Term Conditons (4.4)

Reablement Services – The benefits of reablement have been demonstrated, both in terms of cost and personal benefits for the service user, such as regained independence, dignity and respect
Assistive Technology – Services such as Telecare can give people peace of mind and provide valuable assistance in times of emergency.
Signposting - This will prevent or delay the need for more expensive interventions from health and social care.

Carers and Young Carers

Who is at risk and why?

The Carers Trust defines a carer as someone who of any age who provides unpaid support to family or friends who could not manage without this help. This could be

caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems. [99]

Carers provide a significant amount of care that would otherwise be the responsibility of health and social care services. With the growth of the older people's population, and the accompanying resource pressure on Health and Social Care services, supporting carers is becoming increasingly fundamental to the health and social care agenda. As illustrated by Forder (2007),[100] the intensity of care packages increases by almost 50% if the customer lives alone. Carers play a major role in terms of providing community based support and the demands of the caring responsibility can be considerable. The impact on carers lives varies depending on the amount of caring time provided, the age of the carer and of course the individual needs of the cared for person.

Responding to the needs of people who care is a major challenge. Carers often experience high rates of depression and stress and can become isolated. Working age adults who provide a lot of care tend to have lower incomes, poorer health and are less likely to be in work. Children and young people need to be protected from inappropriate caring and to be able to have support so that they may learn and develop. Older people who care may have their own ill health problems; they may also be providing long term care for an older person with complex needs. An inability of a carer to cope is often the cause of hospitalisation and admission into residential care.

Level of need in the population

Information from Carers UK indicates nationally that 12.6 percent of the adult population are carers. [101] In Milton Keynes the percentage of people identifying themselves as carers in the 2011 census was 8.7%, lower than the national average,of 10.3 %.
From the 2011 census data, of the 21,797 self acknowledged carers in Milton Keynes, 64%(14,018) provided less than 20 hours a week, 14% (2,991) provided between 20 and 50 hours a week and the remaining 22% (4,788) provided more than 50 hours a week unpaid care. [5]

A further nationally available source of data in respect of numbers of carers relates to Carers Allowance. Carers Allowance is available to carers if they are aged 16 or over and spend at least 35 hours a week caring for a person; however, conditions such as other benefits claimed and employment status apply. Carers in receipt of a state pension are not entitled to receive Carers Allowance, although they have an underlying entitlement to the benefit and therefore are eligible for associated benefits.

The total number of people in Milton Keynes recorded as claiming Carers Allowance during 2012 was 1910 [102] (26% male, 74% female), of these 67% are between 35-59 years.

The Survey of Carers in Households (2009/10)

Results from this survey when applied locally demonstrate the following;

- Carers are more likely to women. 67 per cent of carers in Milton Keynes are likely to be women.
- 92 percent of carers were white, while 8 per cent were from BME groups. Milton Keynes has a higher BME profile than England and therefore there are likely to be higher numbers of carers from BME backgrounds.
- 48 per cent of carers do 20 or more hours caring a week– these people are statistically most likely to be aged 65+ years. In Milton Keynes this equates to 11,140 (rounded) individuals.
- 27 per cent of carers had been looking after their main cares for person for at least ten years. In Milton Keynes this equates to 6,300 people.
- 11 per cent of all carers reported receiving Carers Allowance. This would equate to 2552 in Milton Keynes. In Milton Keynes only 8% of the potential population of carers receive carers allowance.

Older Carers

The number of people aged 64 and over providing unpaid care to a partner, family member or other person is expected to rise nationally by 13% by 2015, growth that will be continual up to 2030. [103]

The first results from the 2011 Census were released in July 2012. At a local authority level this information included the population by five year age bands. The highest growth rate occurred in the 60-64 age group; it increased by 7.4%. The 85+, 65-69 and 0-4 age groups also had high growth rates.

The Princess Royal Trust for Carers carried out a recent survey of older carers. Of the 639 carers surveyed, approximately two thirds reported having long term health problems or a disability. Reported conditions included arthritis and joint problems, back problems, heart problems, cancer and depression.[104] Using Milton Keynes prevalence figures reported above, it may be approximated that around 2691 older carers in Milton Keynes may have health problems.

Current services in relation to need

Carers Counselling

There is a carers counselling service, provided by City Counselling Centre, which is a free counselling service available as 6-8 sessions to carers.

Mental Health Carer Support Workers

Specifically funded from the Carers Grant the support workers are able to provide timely support and information, and help carers maintain their caring role of people with both a functional and organic illness.

Carers' Assessments

Although services provided for the person cared for will have inevitable benefits for the carers, it is important to emphasise that these services are provided for the service user.

A wide range of carers' services are largely provided by the local authority and include direct payments, day care, domiciliary care, information and advice. Carers assessments and services are available for all those who provide 'regular and substantial' care to a person who is eligible under the 'critical and substantial' criteria, regardless of whether the person cared for chooses to have a community care assessment.

During 2010 – 11 a total of 539 carer assessments/reviews were completed. This represents a 72% increase from 314 carer assessments/reviews completed in 2009/10.
Of the 539 carers assessments completed in 2010/11, the majority were for carers aged between 18 and 64 years.

Carers Support Service

During 2011 – 12, Carers Milton Keynes provided a level of support as a minimum of information, advice and guidance to the 2267 carers on their database and received referrals for 363 new carers for the year.

Young Carers

There is a very little local data in relation to the overall prevalence in Milton Keynes of young carers, but several facts have been reported from a national perspective[1]

- The average age of a young carer is 12.
- There are 175,000 young carers in the UK, 13,000 of who care for more than 50 hours a week.
- More than half of young carers live in one□parent families and almost a third care for someone with mental health problems.

In Milton Keynes the main source of information regarding young carers comes from the Carers Milton Keynes Young Carers Service.

The Young Carers Service provides a range of practical and emotional support services to young carers, including:

- One – to – one support.
- Advice and information.
- Access to social and sport clubs.
- Newsletter every three months.
- Activities and outings.

During 2011 – 12 a total of 226 young carers registered with the service with 32 new referrals. 51% of the young carers were between the ages of 8-12 years and 49% aged 13-19.

The service offers three levels of intervention:

Level one –where young carer's needs are assessed, appropriate advice and support is provided and the young carer receives support from universal services.

Level two – are young carers with more complex need that require intervention to ensure the support need of adults and or sibling members are being properly met.

Level three – young carers with enduring needs are provided with ongoing support to recognise and cope with their psychological responsibilities.

Carers MK identified young carers with the following levels of need during 2011-12.

Level 1	141
Level 2	59
Level 3	26

Table 41: Carers MK identified young carers with the following levels of need during 2011-12.

Source: Carers MK

Problems and evidence

A referrals, assessments and packages of care (RAP) 20122-12 comparator report[105] for carers with completed assessments or reviews demonstrates that for Milton Keynes the completed number of carer's assessments as per referrals and assessment packages returns are low. Further work to establish whether this problem is related to the way in which carers assessments are recorded is currently being undertaken.

The White Paper Caring for Our Future (2012)[106] sets out a new vision for a reformed care and support system promoting wellbeing and independence at all stages to reduce the risk of people reaching a crisis points. The new system focus on people's wellbeing, supporting them to live independently for as long as possible and providing better support for carers. The local health and social care services will need to consider any implications for service delivery under a reformed system.

Projected service use and outcomes

The rapidly increasing population of older people in Milton Keynes will give rise to increasing demand upon statutory health and social care services.

Year	2011	2015	2020	2025
No of over 65's	28710	35120	42730	50700

Table 42: Service Use - Over 65 population projections.

Source: MK Observatory

There is the expectation that the proposed social care reform will focus on supporting people to live independently for as long as possible and providing better support for

carers. In addition there is a projected rise in demand on services from the population increase of over 65's.

Evidence of what works and policy drivers

In addition to "Caring for Our Future" (2012) White Paper. A National Carers strategy 'Carers at the Heart of 21st Century, Families and Communities'[107] (published 2008) sets out to achieve the following for carers by 2018:

- Mentally and physically well; treated with dignity.
- Recognised and supported as an expert care partner.
- Enjoying a life outside of caring.
- Not financially disadvantaged.
- Children thriving, protected from inappropriate caring roles.

Legislation and policy changes

The National Carers strategy was refreshed (November 2010), with four priorities outlined for action over the next four years.

The National Carers Strategy
Priority 1 - Supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages
Priority 2 - Enable those with caring responsibilities to fulfil their educational and employment potential
Priority 3 - Provide personalised support both for carers and those they support, enabling them to have a family and community life
Priority 4 - Support carers to remain mentally and physically well

What are the top 5 priorities from the needs assessment and what are we going to do as a result?

A priority objective of the Milton Keynes Council Adult Social Care and Health Group is to enhance support to carers which will enable them to remain economically active, enjoy good physical and mental wellbeing which will empower them to continue to make a key contribution in meeting the support needs of those they care for.

Carers add enormous value to the local health and social care economy. Milton Keynes is to expect considerable growth in the local older population in the next decade. As such there will be increased numbers of people who require care and those providing the care will also be older. Local partners in health and social care have a critical role to play in the support of carers locally. To promote wellbeing and independence at all stages to reduce carers reaching a crisis point, continuing investment in carer support is critical. The following recommendations include,

- Identifying future requirements of carers support in light of “Caring for Our Future” recommendations and in partnership with key stakeholders.
- Improving the information, advice and support provided to carers. Information and advice overall needs to be effectively co-ordinated with partners to ensure accuracy and accessibility.
- Ensuring more carers assessments are undertaken and recorded. Barriers and issues associated with completing carers’ assessments need to be identified and addressed.
- Redevelopment of Joint Strategic Milton Keynes Carers Strategy. Ensuring alignment to transformed local governance structures including the Health and Wellbeing Board.
- Evaluation of the current carers support contract and re commission carers support services.

Users Views

The Carers Partnership Board is in place which provides a forum for gathering views on issues and proposals

5.0 Key Priorities

This section summarises all the key priorities identified in this JSNA and presented below under the relevant chapter and section headings

5.1 Population and Place

The increasing ethnic diversity has important implication for service delivery. Services will become less efficient if they don't reach the increasing BME population. Certain conditions like diabetes, cardiovascular diseases, hypertension, haemoglobinopathies (eg sickle cell disorder), mental health disorders, some cancers, and dementia are more common among specific BME groups. However many ethnic variations in health may be largely the result of differences in socio-economic status rather than ethnicity per se. This emphasises the need to collect socio-economic information alongside ethnicity data when considering health and ethnicity.

The increase in the BME population is mainly caused by young families with school children. The needs of this increasing BME population should be fully understood to ensure the provision of proper quality and access to services. This will include better targeting of preventative services like the screening programmes (cancer, diabetic retinopathy), cancer awareness campaigns, NHS Health checks and Making Every Contact Count programmes, sexual health services and antenatal services.

Routine recording of ethnicity by all services is essential for reliable analysis of the use of services by BME groups and this is a statutory duty under the Race Relations Amendment Act (2000). GP practices in particular should be encouraged to record ethnicity of all their patients, not just new registrations.

It is crucial that we plan for the large increases in the population of older people. This change in population will result in a rapidly increasing prevalence in all long-term conditions including cancer and dementia and the resultant major increases in demand on health and social care services.

5.2 Life in Milton Keynes

A reduction in the persistent and growing health and social inequalities has to remain the focus of attention. There needs to be an increased focus on reducing inequalities in the social determinants of health including education, housing, transport and the built environment. Policies in all of these areas need to address the inequalities identified here.

Improvement in housing can be achieved through three strategic priorities:

1) To increase the supply of housing: meet the annual house building target of 1,750 new homes per year.
2) To tackle housing conditions: tackle poor housing conditions in the council's housing stock and in the private sector, regenerate those areas that need it.
3) To improve access to and affordability of housing.

http://www.milton-keynes.gov.uk/housing-strategy/

Fuel poverty can be further reduced and the council should continue to investigate all opportunities to improve the worst homes in the most deprived areas with lowest life expectancy.

Child poverty often has inter-generational disadvantages. Implementation of the Milton Keynes Child Poverty Commission's comprehensive strategy and action plan is recommended.

Continue to reduce the number of Young People not in Education, Employment or Training (NEET). To further develop an understanding of the needs and employment aspirations of NEET clients, and work towards providing suitable opportunities. Continue to develop effective pre-emptive action with school age young people who are at risk of becoming NEET in the future.

Although average educational attainment figures in Milton Keynes are good it is more important to set clear targets to improve the attainment levels of the known vulnerable groups of boys at Key Stage 4, pupils eligible for free school meals (FSM) across all key stages, pupils with special educational needs (particularly pupils with statements at KS2 and KS4), Black Caribbean pupils at KS2 , Black African, Black Caribbean and Pakistani pupils at KS4 , Children in Care across all key stages, particularly at the end of KS2 and KS4 and Care leavers.

The Milton Keynes World Class Primary Programme (MKWCPP) should continue to prioritise those schools below the Government's floor target and those in Ofsted categories of concern to close the gap for vulnerable learners, through early intervention and prevention across a range of services and settings. The council should continue to carry out its statutory 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; and to eliminate discrimination, harassment and victimisation.

Ensure better outcomes at all stages by supporting vulnerable children and young people to stay well, aspire and achieve, so that they continue into adulthood confident and healthy. The Milton Keynes Safeguarding Children Board should prepare for increased demand due to growth of children's population and prioritise to:

- Strengthen governance arrangements for corporate parenting.
- Develop our corporate parenting responsibility with involvement of young people supported by the corporate parenting officer, independent reviewing officers and advocates.
- Increase the percentage of children in care who are fostered in or close to Milton Keynes.
- Develop local culturally appropriate services for black and minority ethnic children.
- Reduce the number of children in external residential placements.

- Keep children in touch with their parents and wider network and support them to return home or to the care of their wider family and friends where feasible.

Specific action needs to be taken to reduce the rate of repeat domestic violence for those at medium risk, which is the highest rate across Thames Valley (2011-2012) and to strengthen the provision of support available to families and children.

Improve the health of our prison population through: increasing the detection and treatment of blood borne viruses in prisons, such as Hepatitis B, C and HIV and increase the rates of Hep B vaccinations; ensuring a quality substance misuse service is available which has strong links to community providers; implementing the findings of the health needs assessment; and reducing the number of first time entrants into the justice system

5.3 Lifestyle Determinants of Health

Behaviour change and its potential for positively impacting on the health of the population are beyond question and there is strong evidence that many behaviour change initiatives improve health and are cost effective. If we do not invest in prevention programmes for those with and without medical conditions, we will continue to build up the burden of ill-health for the future and we will not have any impact on the health inequalities which exist both locally and nationally.

The key priorities are:

- Invest our resources in a way which seeks to achieve the same level of health across the whole of our population. This will require progressively more investment in services across the social gradient and for some specific groups of people identified as having specific health needs.
- Provide services across the life-course but in particular in the early years which will have the greatest impact on future population health.
- Develop a way of 'industrialising' our initiatives through partnership working. One example of this way of working is through the new national initiative 'Making Every Contact Count' which has the potential to be rolled out across many organisations and services including workplaces, social services, schools, police and fire services.
- Develop capacity to effectively communicate about all lifestyle issues through a robust process of social marketing[1], including communicating the serious health impacts of regularly drinking above the recommended guidelines.
- Strengthen the services which support people to stop smoking particularly pregnant women and those living in areas of deprivation and develop and implement action plans to prevent children from taking up the habit.
- Improve the links between sport, physical activity and transport to increase the levels of active travel across the area and also access to facilities via the public transport network.
- Strengthen services to increase the level of physical activity in Milton Keynes, especially for those with physical and mental ill-health.
- Increase the capacity of the 'identification and brief advice' (IBA) alcohol

services across primary and secondary health care and seek to identify innovative approaches through the National Alcohol Learning Centre.

- Increase the number of clients who successfully complete treatment and focus on recovery and re-integration of individuals into society.
- Continue to drive down the rate of teenage pregnancy, a key factor in the cycle of deprivation.
- Reach out and target those communities and groups most at risk of poor sexual health and unplanned pregnancy through effective outreach and prevention and early identification programmes.
- Implement the recommendations of the Milton Keynes HIV Needs Assessment to ensure early identification and treatment, particularly through routine HIV testing for hospital admissions and new GP registrants.

5.4 Health

Pregnancy and Childbirth (including dental health)

- New routes for pregnant women to contact the maternity service for early antenatal bookings, access to birth preparation classes, parenting guidance and if required to be fast tracked to stop smoking services that are tailored for pregnant women.

- A midwife-led care pathway that enables women who have had a previous caesarean section to explore the option of vaginal birth after caesarean (VBAC), when clinically appropriate.

- Training to enhance partnership working between Children's Centres, primary care and public health practitioners such as health visitors (HVs), school nurses and family nurse practitioners (FNPs) to support all mothers to breastfeed in line with the UNICEF baby friendly initiative and to motivate mothers to ensure that their children receive the second MMR (measles, mumps and rubella) and preschool booster vaccinations.

- Local childcare models in which contact with health (HVs and FNPs) and social services provide access to 15 hours a week free early education for disadvantaged two year olds and support for their mothers to find employment.

- Increase in the capacity of services that manage conditions that have higher incidence and prevalence in non-white populations e.g. high quality sickle cell clinics.

- Expansion of outreach fluoride varnish schemes and dental health education for carers working in early years settings (e.g. nurseries and care homes) ensuring the provision of oral health promotion to those at the highest risk of dental problems.

- Joint commissioning by health and social partners of dental care with the goal of achieving provision that is at least in line with the English average and addressing problems experienced by Milton Keynes residents when seeking access to urgent care.

Mental Health (Adults, Children and Young People)

Adult Mental Health

The large numbers of Milton Keynes residents who are predicted to develop a common mental disorder in the future means that greater capacity is required to promote mental health and to treat and care for patients with mental health problems. Social services such as housing support must also be provided.

The Milton Keynes Health and Wellbeing Strategy has designated mental health as one its strategic priorities and an interim Mental Health Strategy was produced for 2012/13. These strategies state the local intention:

To promote good mental health and prevent mental health problems:

- Working within schools and other settings to build self-esteem in young people.
- Promoting the message that stopping smoking, sensible alcohol consumption, healthy eating and physical activity have health benefits even at older ages.

To improve access to, and quality of mental health services

- Improving early diagnosis and access to care and support services including a range of psychological therapies, memory assessment and high quality dementia care.
- Developing active partnerships with older people in pathway redesign and decision-making for mental disorders and long term conditions that reflect patient experience. The newly launched Mental Health Partnership Board will ensure the continued involvement of service users and carers.
- Implementing the Mental Health Hospital Liaison Service to ensure appropriateness of care.
- Reviewing actions taken to prevent suicide and to support those at risk of suicide.

To improved quality of care in residential/care homes

- Implementation of the Quality and Outcomes Framework by health and social care.
- Effective contract management of residential and care homes.
- Specific focus on the training needs of staff working within nursing and care homes.

Adults with Autism

- To continue to develop systems to collect accurate data about the needs of the population with ASC.
- To promote awareness training and more detailed specialist support for front line staff.
- To review and improve the pathway for people with ASC through Health, Social Care and mainstream community services.
- To use the development of personal budgets as an opportunity to widen choices in services available to people with ASC.

Children's and Young People's Mental Health

Taking into account local child mental health needs and benchmarking local services against national standards, stakeholders in Milton Keynes have identified priorities which include the following:

- The production and Milton Keynes wide provision of educational materials, tools and courses focusing on early years child's cognitive, social and emotional development.
- Universal and targeted Milton Keynes programmes to increase parents' and the general public's awareness of how mental health problems present in children and young people.
- Redesign school-based mental health promotion programme provided in schools to assist teaching staff and parents to work with CAMHS to manage behavioural problems at early stage and increase children's awareness and knowledge of risk factors for future mental health problems such as alcohol and substance misuse.
- Provision of increased CAMHS facilities to meet the needs of specific black and minority ethnic groups.
- Redesign the pathway for assessing children for ASD and provide post assessment support to ensure adequate capacity, efficient use of resources and responsiveness to the needs of children and their carers.
- Reconfiguration of CAMHS providers to deliver a crisis team with the appropriate access to emergency beds in Milton kKeynes Hospital whose remit includes managing crisis situations involving children diagnosed with ASC.

Long Term Conditions and Mortality

Without prevention programmes, early intervention and support to enable people to understand and take control of their risks and condition, the impact on carers and on health and social services will be enormous.

From April 2013 the NHS Commissioning Board will lead on developing a Long Term Conditions Strategy. This has the potential to provide a valuable framework for local commissioners building on the existing condition specific National Service

Frameworks (NSFs), quality strategies (Stroke, COPD) and NHS Commissioning Guides to direct local service developments.

Falls also impact on disability and early death and reducing the rates of falls and fracture injuries is an important priority for Milton Keynes.

The priorities for the future are:

- Ensure that there is good evidence that commissioned interventions are likely to be effective, offer value for money and are designed to be delivered in a way which aims to achieve similar health outcomes across all wards in Milton Keynes.
- Plan for the predicted increase in the proportion of people in the BME groups which will result in a higher prevalence of some conditions.
- Commission healthy lifestyle initiatives alongside screening and diagnostic testing programmes to reduce the number of people developing these long term conditions.
- Provide public education campaigns, including those raising awareness of early signs and symptoms of cancer.
- Ensure the key elements of the strategy to reduce falls includes: proactive work with GPs to ensure improved primary interventions in relation to falls; the appointment of a Fracture Liaison Post within Milton Keynes Hospital Foundation Trust working with the Milton Keynes Community Health Services' Falls Service; defining and obtaining robust information about falls in Milton Keynes which can be used monitor the effectiveness of the falls prevention actions taken during 2012-15.
- Working together, agencies should utilise the valuable framework which will be provided through the national long term conditions strategy, currently in development.
- Milton Keynes Clinical Commissioning Group (CCG) will continue to work closely with other commissioners and providers of health and social care to provide services, education, support and enablement for people who have chronic conditions.
- The CCG will continue to prioritise the commissioning of long term conditions care pathways within a multiagency board.
- Integrated models of care need to be commissioned from and co-ordinated across, all relevant agencies, to encompass whole care pathways. The important role of the patient in understanding their condition and being empowered to take control and manage their own condition (self-care) is fundamental within the model of care. Additionally, the need for psychological services and mental health assessments for people with long term conditions should be considered to be a priority.
- Implement the Milton Keynes End of Life Care Strategy which includes awareness raising and information provision regarding dying and death,

advanced care planning and software systems across health and social care services, and rapid response 24/7 end of life care.

- The local health and social care economy 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.

Infectious Diseases

Infectious diseases remain an important cause of poor health in England and Milton Keynes and require continuous attention

- The seasonal influenza vaccination programme for “at risk” individuals under 65 years is a priority that requires innovative models of delivery, for example renal dialysis patients immunised in the renal dialysis unit and pregnant women in pre-natal clinics.
- We must continue to protect our population from infectious diseases through high quality immunisation and screening programmes and ensure that infection control in health care settings continues to drive down the numbers of healthcare associated infections.
- We must continue to be alert to and plan for the threat of pandemic influenza.
- Due to the increase in the rate of TB cases by 2.6% in 2011, we must ensure that robust systems are in place for the early diagnosis and treatment of this disease. A new service specification will be commissioned in 2013.
- Using the pneumonia review as a baseline, we will identify trends in pneumonia admissions and deaths, such as geographical clusters or seasonal peaks, and will focus efforts where or when risk is greatest, for example in care homes. We will also concentrate on further improving the update of flu vaccination in at risk groups and health and social care workers, because of the increased likelihood of developing pneumonia following influenza infection.
- Take action to ensure the early identification and treatment of HIV infection (see the ‘Lifestyle Determinants of Health section’ of this report).

5.5 People with Particular Needs

Disability (including Visual and Hearing Disability)

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.

It is recommended that disability services:

- 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.
- Develop and implement telecare/telehealth for people with a physical and sensory disability.
- Ensure the newly commissioned Milton Keynes Sensory Service delivers personalised support for people to promote their independence.
- Review interpreting services locally and carry out an options appraisal to ensure value for money.
- Re- procures 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.

In addition, there should be a greater focus on the experience of people with a disability, especially those who experience disability within areas of deprivation. We also need to appraise the options available to facilitate communication for people with a sensory loss.

Learning Disability

- A high priority is to continue improving the identification of people with LD to provide them access to safe, high quality health services, including cancer screening, annual health checks (followed by any relevant action) and exploring the opportunity provided by personal budgets.

- Priorities of the Milton Keynes Learning Disability Partnership are to address difficulties experienced by people with learning disabilities in the Criminal Justice System, to increase the effectiveness of assistive technology to support people in their own homes and to enhance monitoring by the Safeguarding Adults Board as prescribed in the Six Lives Guidance.

Older People with Social Care needs

Many older people with social care needs will have a long term conditions and reference is made to the priorities indicated in that section of the JSNA. Social care needs of older people will continue to increase and priorities focus on:

- Reablement Services – The benefits of reablement have been demonstrated, both in terms of cost and personal benefits for the service user, such as regained independence, dignity and respect
- Assistive Technology – Services such as Telecare can give people peace of mind and provide valuable assistance in times of emergency.
- Signposting - This will prevent or delay the need for more expensive interventions from health and social care.

Carers and Young Carers

With an aging population, supporting carers is becoming increasingly vital. The proposed social care reform will focus on supporting people to live independently for as long as possible and providing better support for carers. Local partners in health and social care have a critical role to play in the support of carers and continuing investment in carer support is critical.

The 'Caring for Our Future' (2012) White Paper and the refreshed National Carers' Strategy (2010) have identified a number of priorities for carers. These have been reflected in the MKC Adult Social Care and Health Group's objectives - to enhance support to carers which will enable them to remain economically active, enjoy good physical and mental wellbeing which will empower them to continue to make a key contribution in meeting the support needs of those they care for.

Priorities include:

- Identifying future requirements of carers support in light of 'Caring for Our Future' recommendations, evaluation of the current carers support contract and recommissioning carers' support services.
- Improving the information, advice and support provided to carers.
- Ensuring more carers assessments are undertaken and recorded.
- Redevelopment of Joint Strategic Milton Keynes Carers Strategy aligned to local governance structures.

6.0 Acronyms and Glossary

AADS	Autism Assessment and Diagnosis Service
ADHS	Adult Dental Health Survey
APS	Active People Survey
ASCAT	Adult Social Care Access Team
ASD	Autistic Spectrum Disorders
BFI	Baby Friendly Initiative
BME	Black, Minority Ethnic
BRN	Building Retrofit Network
CAF	Children and Families
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CLL	Communication, language and literacy scales
CMHP	Community Mental Health Profile
CMO	Chief Medical Officer
COMEAP	Committee on the Medical Effects of Air Pollution
COPD	Chronic Obstructive Lung Disease
CS	Caesarean Sections
CSC	Children's Social Care
DASR	Directly Age Standardised Mortality Rates
DECC	The Department of Energy and Climate Change
DEFRA	Department for Environment, Food and Rural Affairs
ED	Emergency Departments
EHWB	Emotional health and wellbeing
ETBS	Enhanced TB Surveillance system
ETE	Education, training and employment
FNPs	Family Nurse Practitioners
GDP	General Dental Practitioner
GP	General Practitioner
HCP	Healthy Child Programme
HENRY	Health, Exercise, Nutrition for the Really Young Programme
HIV	Human Immunodeficiency Virus
HMRC	Her Majesty's Revenue and Customs
HPA	Health Protection Agency
HVs	Health Visitors
HWB	Health and Wellbeing Board
IBA	Identification and brief advice

IS	Income Support
LA	Local Authority
LAQM	Local Air Quality Management
LARC	Long Acting Reversible Contraception
LD	Learning Disability
LDD	Learning Difficulties and Disabilities
LDPB	Learning Disability Partnership Board
LGBT	Lesbian, Gay, Bisexual and Transgender
LITs	Local Implementation Teams
LSOAs	Lower Super Output Areas
MARAC	Multi Agency Risk Assessment Conference
MK LDPB	Milton Keynes Learning Disability Partnership
MKCCG	Milton Keynes Clinical Commissioning Group
MKCHS	Milton Keynes Community Health Services
MKi	Milton Keynes intelligence Observatory
MKWCPP	MK World Class Primary Programme
MMR	Measles, Mumps & Rubella
NCMP	National Child Measurement Programme
NEET	Not in Education , Employment or Training
NHS	National Health Service
NICE	National Institute for Health & Clinical Excellence
NTE	Night time economy
OCUS	Opiate and/or crack users
ONS	Office for National Statistics
PCT	Primary Care Trust
PSE	Personal Social and Emotional development
QOF	Quality Outcomes Framework
RAG	Responsible Authorities Group
RAP	Referrals, assessments and packages of care
RSE	Relationship and Sex Education
SHMA	Strategic Housing Market Assessment
SHMA	Strategic Market Housing Assessment
SLCN	Speech , language and communication needs
SN	Statistical Neighbour
STC	Secure Training Centre
TB	Tuberculosis
TCA	Tobacco Control Alliance
UNICEF	United Nations Childrens Fund
VBAC	Vaginal Birth After Caesarian
WHO	World Health Organisation
YOT	Youth Offending Team
YRD	Youth Restorative Disposal

Glossary

Child Poverty Commission	The Commission was formed to gain a better understanding of the nature of poverty in Milton Keynes
Decent Homes Standard	Legislation that aims to provide a minimum standard of housing conditions for those who are housed within the public sector.
FRAX	**FRAX** is a diagnostic tool used to evaluate the 10-year probability of bone fracture risk.
MK Social Atlas	The document brings together a wide range of social and economic indicators that give a quantitative description of all estates in Milton Keynes.
LSOA	Small geographic areas designed to improve the reporting of small area statistics in England and Wales. SOAs have a mean population of 1.500.
Morbidity	The extent of disease in a population.
Mortality	The incidence of death in a population.
National Index of Multiple Deprivation	Index of Multiple Deprivation Index of the level of deprivation in an area taking into account income, employment status, health and disability, housing, education and training opportunities, and access to services.
Organisational Transformation Programme	Is a MKC transformation programme that makes strategic changes to ensure the council is effective and efficient in the services it provides.
Population Bulletin	The Population Bulletin provides population estimates and population projections for Milton Keynes. It includes population projections for the borough, wards, estates and parishes.
Statistical Neighbour	A statistical neighbour is another local authority, deemed to have similar characteristics, that has been selected to provide an indication (as measured by various performance indicators) of whether we are performing above or below the level that might be expected.
Telecare	Remote care of old and physically less able people, enabling them to remain in their own homes.
Telehealth	The use of electronic information and telecommunications technologies to support long-distance clinical health care
Ward	Electoral wards are the base unit of UK administrative geography.

Glossary subject to further development

7.0 Appendices

Public Health Outcome Framework 2012, summary spine charts

For the complete profile go to: www.phoutcomes.info

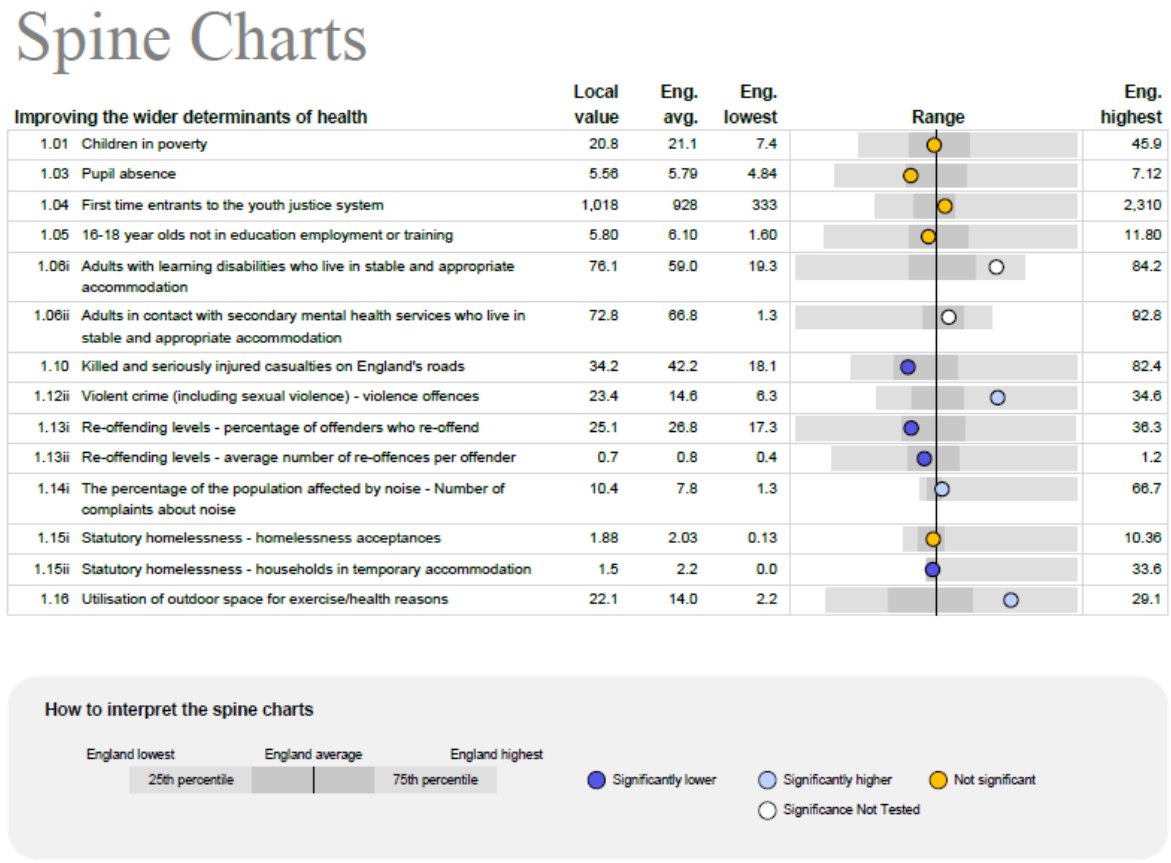


Figure 31: Improving the wider determinants of health

Source: Public Health Outcomes Framework 2012

Health improvement		Local value	Eng. avg.	Eng. lowest	Range	Eng. highest
2.01	Low birth weight of term babies	3.5	2.8	1.8		7.8
2.02i	Breastfeeding - Breastfeeding initiation	75.4	73.7	38.4		92.9
2.02ii	Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	55.9	46.0	19.2		83.1
2.03	Smoking status at time of delivery	12.11	13.52	2.95		33.23
2.04	Under 18 conceptions	29.9	35.4	6.2		64.7
2.06i	Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	23.2	22.6	14.9		28.5
2.06ii	Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	34.4	33.4	24.6		41.9
2.08	Emotional well-being of looked after children	14.4	13.9	10.1		22.8
2.14	Smoking prevalence - adults (over 18s)	22.9	20.7	14.0		31.0
2.15	Successful completion of drug treatment	11.8	12.3	5.1		33.6
2.17	Recorded diabetes	4.7	5.5	3.4		7.7
2.20i	Cancer screening coverage - breast cancer	78.5	76.9	56.2		85.0
2.20ii	Cancer screening coverage - cervical cancer	76.0	75.5	58.8		82.5
2.21vii	Access to non-cancer screening programmes - diabetic retinopathy	75.9	79.2	20.2		97.0
2.22i	Take up of NHS Health Check Programme by those eligible - health check offered	0.0	13.9	0.0		91.1
2.22ii	Take up of NHS Health Check programme by those eligible - health check take up		51.6	8.6		100.0
2.23i	Self-reported well-being – people with a low satisfaction score	23.8	24.3	14.6		30.5
2.23ii	Self-reported well-being – people with a low worthwhile score	22.2	20.1	12.8		25.4
2.23iii	Self-reported well-being – people with a low happiness score	29.7	29.0	19.2		36.6
2.23iv	Self-reported well-being – people with a high anxiety score	39.8	40.1	34.4		48.3
2.24i	Injuries due to falls in people aged 65 and over (Persons)	1,874	1,642	923		3,127
2.24i	Injuries due to falls in people aged 65 and over (Males)	1,356	1,269	610		2,647
2.24i	Injuries due to falls in people aged 65 and over (Females)	2,392	2,014	1,237		3,694
2.24ii	Injuries due to falls in people aged 65 and over - aged 65-79	1,008	959	487		1,822
2.24iii	Injuries due to falls in people aged 65 and over - aged 80+	5,769	4,711	2,831		9,097

Figure 32: Health improvement.

Source: Public Health Outcomes Framework 2012

Health protection		Local value	Eng. avg.	Eng. lowest	Range	Eng. highest
3.01	Fraction of mortality attributable to particulate air pollution	5.8	5.6	3.6		8.3
3.02	Chlamydia diagnoses (15-24 year olds)	2,278	2,220	1,065		5,219
3.03i	Population vaccination coverage - Hepatitis B (1 year old)	100.0	-	33.3		100.0
3.03i	Population vaccination coverage - Hepatitis B (2 years old)	100.0	-	2.4		100.0
3.03iii	Population vaccination coverage - Dtap / IPV / Hib (1 year old)	95.3	94.2	82.5		98.2
3.03iii	Population vaccination coverage - Dtap / IPV / Hib (2 years old)	96.5	96.0	87.3		98.9
3.03iv	Population vaccination coverage - MenC	94.7	93.4	81.0		97.5
3.03v	Population vaccination coverage - PCV	94.6	93.6	80.5		97.8
3.03vi	Population vaccination coverage - Hib / MenC booster	92.5	91.6	74.1		97.6
3.03vii	Population vaccination coverage - PCV booster	90.0	89.3	70.0		98.2
3.03viii	Population vaccination coverage - MMR for one dose (2 years old)	91.2	89.1	75.4		96.8
3.03ix	Population vaccination coverage - MMR for one dose (5 years old)	94.4	91.9	80.7		97.8
3.03x	Population vaccination coverage - MMR for two doses (5 years old)	87.1	84.2	61.0		95.1
3.03xii	Population vaccination coverage - HPV	86.0	84.2	56.4		95.1
3.03xiii	Population vaccination coverage - PPV	75.4	70.5	46.8		76.0
3.03xiv	Population vaccination coverage - Flu (aged 65+)	71.0	72.8	67.2		78.7
3.03xv	Population vaccination coverage - Flu (at risk individuals)	51.6	50.4	35.3		61.5
3.05i	Treatment completion for TB	96.2	84.3	55.6		98.3
3.05ii	Treatment completion for TB - TB incidence	13.1	15.4	1.1		137.0
3.06	Public sector organisations with a board approved sustainable development management plan	80.0	74.3	20.0		100.0

Figure 33: Health protection

Source: Public Health Outcomes Framework 2012

Healthcare public health and preventing premature mortality		Local value	Eng. avg.	Eng. lowest	Range	Eng. highest
4.03	Mortality from causes considered preventable (provisional)	148.7	146.1	100.7		264.2
4.04i	Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke) (Provisional)	64.3	62.0	40.3		116.0
4.04ii	Under 75 mortality rate from cardiovascular diseases that is considered preventable(including heart disease and stroke) (Provisional)	44.3	40.6	23.0		75.1
4.05i	Under 75 mortality rate from cancer (Provisional)	106.6	106.7	82.5		152.0
4.05ii	Under 75 mortality rate from cancer that is considered preventable (Provisional)	60.7	61.9	45.2		98.1
4.06i	Under 75 mortality rate from liver disease (Provisional)	11.0	14.4	8.7		39.3
4.06ii	Under 75 mortality rate from liver disease that is considered preventable (Provisional)	9.7	12.7	7.5		37.0
4.07i	Under 75 mortality rate from respiratory diseases (Provisional)	26.7	23.4	13.7		62.0
4.07ii	Under 75 mortality rate from respiratory diseases that is considered preventable (Provisional)	12.0	11.6	5.3		28.6
4.10	Suicide rate	7.0	7.9	4.3		13.9
4.11	Emergency readmissions within 30 days of discharge from hospital (persons)	12.3	11.8	8.1		13.8
4.11	Emergency readmissions within 30 days of discharge from hospital (males)	13.0	12.1	8.6		14.8
4.11	Emergency readmissions within 30 days of discharge from hospital (females)	11.7	11.4	7.2		13.2
4.12i	Preventable sight loss - age related macular degeneration (AMD)	145.7	109.4	10.0		224.4
4.12ii	Preventable sight loss - glaucoma	18.4	11.8	0.0		36.9
4.12iii	Preventable sight loss - diabetic eye disease	8.5	3.6	0.0		12.9
4.12iv	Preventable sight loss - sight loss certifications	54.7	43.1	2.9		85.7
4.14i	Hip fractures in people aged 65 and over	544	452	341		641
4.14ii	Hip fractures in people aged 65 and over - aged 65-79	249.0	224.2	120.6		330.5
4.14iii	Hip fractures in people aged 65 and over - aged 80+	1,869	1,476	973		2,267

Figure 34: Healthcare public health and preventing premature mortality.

Source: Public Health Outcomes Framework 2012

NHS Outcome Framework 2013/14
http://www.dh.gov.uk/health/2012/11/nhs-outcomes-framework/

The Adult Social care Outcomes Framework 2013/14
http://www.dh.gov.uk/health/2012/11/ascof1314/

CCG and local authority information packs

These information packs set out key data at local authority and CCG level to inform the local position on outcomes. The local authority level packs present high level comparative information on the NHS, the adult social care and the public health frameworks. The purpose of these is to provide CCGs and HWB partners with a quick and easy-to-use summary of their current position on outcomes as they take up their role, building on the data sets in the CCG outcomes indicators and other existing data sets. Where possible other relevant information sources have been signposted that might help build an understanding of the specific issues locally.

- Information packs

    - Outcome benchmarking support pack NHS Milton Keynes CCG: http://www.commissioningboard.nhs.uk/files/2012/12/ccg-pack-04f.pdf

    - Outcome benchmarking support pack Milton Keynes Local Authority: http://www.commissioningboard.nhs.uk/files/2013/01/la-pack-e06000042.pdf

Useful local health and social profiles

The following links may be helpful for further information about the health of the population in Milton Keynes:

- Health and Social Care Information Centre Indicator Portal

    This website gathers together a number of health and social care indicators. Currently these include:

    - **Compendium of Population Health Indicators** A wide-ranging collection of over 1,000 indicators designed to provide a comprehensive overview of population health at a national, regional and local level. These indicators were previously available on the Clinical and Health Outcomes Knowledge Base website (also known as NCHOD).

    - **GP Practice data** This is a collection of practice level data and is designed to improve healthcare and support patients in making better, informed choices about the practice they choose to register with.

    - **Local Basket of Inequalities Indicators (LBOI)** This collection of 60 indicators helps organisations to measure health and other factors which influence health inequalities such as unemployment, poverty, crime and education. These indicators were previously available on the London Health Observatory website.

    - **NHS Outcomes Framework** The NHS Outcomes Framework indicators will be used by the Secretary of State to hold the NHS Commissioning Board to account.

    - **Summary Hospital-level Mortality Indicator (SHMI)** SHMI is the new hospital-level indicator which uses standard and transparent methodology for reporting mortality at hospital trust level across the NHS in England.

    - **Social Care** The first figures for the new Adult Social Care Outcomes Framework (ASCOF). They include data for 14 measures which are designed to enable users to compare the effectiveness of care delivered by councils responsible for adult social care services.

- Measures from the 2011/12 Adult Social Care Outcomes Framework (provisional release)

    The Information Centre collects and publish a wide range of information on adult social care, which you can use to plan, deliver and monitor services.

- Open Data Cabinet

Open Access to Local Data

This site is the **Department for Communities and Local Government**'s first step towards more open, accessible and re-usable data.

It provides a selection of statistics on Local Government finance, housing and homelessness, wellbeing, deprivation, and the department's business plan as well as supporting geographical data.

All of the data is available as fully browsable and queryable Linked Data, and is free to re-use under the Open Government Licence.

- Fingertips: http://fingertips.erpho.org.uk

a rich source of indicators across a range of health and wellbeing themes

designed to support JSNA and commissioning to improve health and wellbeing, and reduce inequalities

Fingertips enables you to:

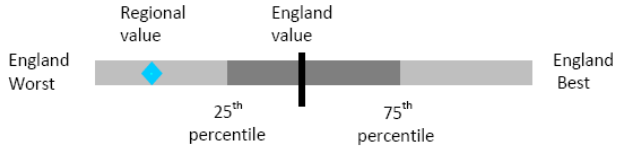
- Browse indicators at top-tier LA, lower-tier LA and PCT level
- Benchmark against the regional or England average
- Export data and graphs to use locally

- Local Authority Health Profiles
- Local Alcohol Profiles for England
- Diabetes Community Health Profiles
- End of Life Care Profiles
- National Obesity Observatory Maps
- Sexual Health Balanced Scorecard
- Skin Cancer Hub
- Local Tobacco Control Profiles for England
- Practice Profiles
- National Cardiovascular Disease (CVD) Profiles
- Excess Winter Deaths (EWD) Atlas for England
- Community Mental Health Profiles (CMHP)
- Injury Profiles for England
- Marmot Indicators for Local Authorities in England

Marmot Indicators for Local Authorities in England, 2012 - Milton Keynes

The chart below shows key indicators of the social determinants of health, health outcomes and social inequality that correspond, as closely as is currently possible, to the indicators proposed in Fair Society, Healthy Lives. Results for each indicator for this local authority are shown below. On the chart, the value for this local authority is shown as a circle, against the range of results for England, shown as a bar.

- Significantly better than the England value
- Not significantly different from the England value
- Significantly worse than the England value



	Indicator	Local Authority Value	Regional Value	England Value	England Worst	Range	England Best
	Health outcomes						
	Males						
1	Male life expectancy at birth (years)	78.1	79.7	78.6	73.6		85.1
2	Inequality in male life expectancy at birth (years)	7.3	7.3	8.9	16.9		3.1
3	Inequality in male disability-free life expectancy at birth (years)	10.4	8.9	10.9	20.0		1.8
	Females						
4	Female life expectancy at birth (years)	82.2	83.5	82.6	79.1		89.8
5	Inequality in female life expectancy at birth (years)	6.0	4.5	5.9	11.6		1.2
6	Inequality in female disability-free life expectancy at birth (years)	9.2	7.0	9.2	17.1		1.3
	Social determinants						
7	Children achieving a good level of development at age 5 (%)	62.1	61.1	58.8	49.5		71.4
8	Young people not in employment, education or training (NEET) (%)	6.2	6.1	6.7	12.3		2.6
9	People in households in receipt of means-tested benefits (%)	13.2	10.1	14.6	32.8		4.7
10	Inequality in percentage receiving means-tested benefits (% points)	28.3	20.2	29.0	55.1		4.6

Table 43: Indicators for Local Authorities in England 2012 – Milton Keynes

Source: Marmot

- Health Inequality Indicators for Local Authorities
- Small Area Indicators for Joint Strategic Needs Assessment (JSNA)

  The PHOs have updated this set of indicators at Middle Level Super Output Area (MSOA, average population of 7,200 people) level for use by organisations carrying out joint strategic needs assessment. The indicators include population estimates, mortality, hospitalisation, lifestyle and socio-economic data.
  They have been divided into domains covering different aspects of health needs:
  - Our community
  - Children's and young people's health
  - Adults' health and lifestyle
  - Disease and poor health
  - Life expectancy and causes of death

  The data are also available through the PHOs' Local Health tool, which provides interactive maps and reports based on the small area indicators. MSOAs can be combined by the user to create custom geographies: the indicators are recalculated within the tool for these new areas.
- Child Health Profiles
- Older People Atlas for England
- Learning disability profiles
- Strategic Health Asset Planning and Evaluation (SHAPE)

  SHAPE is a web enabled, evidence based application which informs and supports the strategic planning of services and physical assets across a whole health economy.

The Strategic Health Asset Planning and Evaluation application:

- Links national datasets for clinical analysis, public health, primary care and demographic data with estates performance and facilities location;
- Enables interactive investigations by SHAs, Local Area Teams, PCTs, Providing Trusts, CCGs, GP practices and Local Authorities;
- Supports key policy initiatives such as QIPP, JSNA and Transforming Community Services;
- Provides you with a range of flexible capabilities; you drive it in the direction you want it to go.

8.0 Bibliography

[1] Social Atlas 2012, Milton Keynes Council
http://www.mkiobservatory.org.uk/page.aspx?id=1655&siteID=1026

[2] Director of Public Health Annual Report 2011, Milton Keynes
http://www.mkiobservatory.org.uk/collection.aspx?id=85&siteID=1026

[3] Health and social Profiles, Association of Public Health Observatories
http://www.apho.org.uk/

[4] Population Bulletin 2011/12
http://www.mkiobservatory.org.uk/Download/Public/1026/DOCUMENT/9967/Population-Bulletin2011-12.pdf

[5] 2011 Census – Office for National Statistics
http://www.mkiobservatory.org.uk/collection.aspx?id=89&siteID=1026

[6] Marmot M (2010) Fair Society Healthy Lives, The Marmot Review.

[7] Hack M, Flannery DJ, Schluchter M, Cartar L, Borawski E, and Klein N (2002) Outcomes in young adulthood for very-low-birth-weight infants, New England Journal of Medicine 346: 149-157.

[8] Milton Keynes Language Service

[9] Office of the Deputy Prime Minister (2006) The State of the English Cities Report. London: ODPM. Available at: http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/07_03_06_english_cities_vol_1.pdf

[10] ODPM, 2006, pp.150–51

[11] Equality Delivery Scheme Consultation March 2012, Health and Wellbeing Board consultation with Disability Advisor Group May 2012 and Health Links Consultation on Sensory Impairment Needs.

[12] Doyal L. Women and health services. Buckingham: Open University Press; 1998.

[13] http://www.guardian.co.uk/society/2012/nov/04/men-failing-seek-nhs-help and Health Profile 2008: www.apho.org.uk/resource/view.aspx?RID=52560

[14] http://www.thebureauinvestigates.com/2012/06/24/mens-health-a-correlation-between-the-gender-gap-and-deprivation/

[15] Department of Communities and Local Government. The English Indices of Deprivation 2010. Department of Communities and Local Government. [Online] 2011. http://www.communities.gov.uk/publications/corporate/statistics/indices2010

[16] MKi Observatory. Deprivation & Social Issues. Milton Keynes Observatory. [Online] http://www.mkiobservatory.org.uk/page.aspx?id=1935&siteID=1026

[17] DECC report. http://www.decc.gov.uk/en/content/cms/statistics/fuelpov_stats/fuelpov_stats.aspx

[18] http://www.businessmk.co.uk/news/art/1043/MK-is-leading-UKs-economic-revival-say-analysts.html

[19] The Child Poverty Act 2010
http://www.legislation.gov.uk/ukpga/2010/9/pdfs/ukpga_20100009_en.pdf

[20] Milton Keynes Council, Child Poverty Commission.
http://www.milton-keynes.gov.uk/child-poverty-commission/

[21] A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives
https://www.education.gov.uk/publications/standard/publicationDetail/Page1/CM%208061

[22] Child Poverty in Milton Keynes: Analysis, Experience and Action; April 2012
http://www.milton-keynes.gov.uk/child-poverty-commission/documents/Child_Poverty_Report-_24.05.12.pdf

[23] Fair Society, Healthy Lives – The Marmot Review - A Strategic Review of Health Inequalities in England post 2010', February 2010, page 126.

[24] Milton Keynes Council. Milton Keynes Strategic Housing Market Assessment Update 2009. MKWEB. [Online] 2009. http://www.milton-keynes.gov.uk/housing-strategy/displayarticle.asp?ID=67310

[25] Housing strategy 2012-15, Milton Keynes Council 2012, www.milton-keynes.gov.uk/housing-strategy

[26] Milton Keynes Citizens Survey (February 2012)
http://www.mkiobservatory.org.uk/Download/Public/1026/DOCUMENT/9984/Citizens'%20Survey%20Report%202011-12.pdf

[27] The Transport and Vision Strategy for Milton Keynes
http://www.milton-keynes.gov.uk/transport/displayarticle.asp?ID=72970

[29] The Active People Survey http://www.sportengland.org/research/active_people_survey.aspx

[30] Air Quality Strategy for England, Wales, Scotland and Northern Ireland 2007. http://www.official-documents.gov.uk/document/cm71/7169/7169_i.asp

[31] The Environment Act 1995 http://www.legislation.gov.uk/ukpga/1995/25/contents

[32] Air Quality Review and Assessment 2012 http://www.milton-keynes.gov.uk/environmental-health/displayarticle.asp?ID=17335

[33] The Public Health Outcomes Framework http://www.dh.gov.uk/health/2012/01/public-health-outcomes/

[34] Air Quality Action Plan for Olney http://www.milton-keynes.gov.uk/environmental-health/documents/Olney_Action_Plan_Oct12.pdf

[35] The Milton Keynes School Improvement Framework, Aiming to be Outstanding
http://www.milton-keynes.gov.uk/teachers/documents/School_Improvement_Framework_09.10.pdf

[36] MK World Class Primary Programme
http://cmis.milton-keynes.gov.uk/CmisWebPublic/Binary.ashx?Document=31816

[37] Ofsted's Chief Inspector of Education, Children's Services and Skills Annual Report 2011/12
http://www.ofsted.gov.uk/resources/annualreport1112

[38] The Equalities Act 2010
http://www.homeoffice.gov.uk/equalities/equality-act/

[39] Children's Communication Coalition (2010)
http://www.rcslt.org/about/campaigns/ccc_report_2010

[40] Tackling Domestic Abuse http://www.cps.gov.uk/news/articles/domestic_violence_-_the_facts_the_issues_the_future/

[41] This may not be specifically in drugs operations but other operations/ patrols the previous period that picked up drugs offences may have been reduced.

[42] The Cardiff Model
http://www.alcohollearningcentre.org.uk/_library/Cardiff_Model_-_violence_prevention1.pdf

[43] Change4life social marketing programme. www.nhs.uk/Change4Life/

[44] CMO report Start Active, Stay Active (2011)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127931

[45] Office for Civil Society (2010)

[46] Community Action:MK (2012)

[47] Volunteer Centre MK (2012)

[48] Youth and Community Strategy 2012-2017
http://www.sportengland.org/about_us/our_news/creating_a_sporting_habit_for.aspx?show=true

[49] Active People Survey
http://www.sportengland.org/research/active_people_survey.aspx

[50] Start active, stay active: a report on physical activity from the four home countries'
Chief Medical Officers, 2011
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128209

[51] Healthy lives, healthy people: Improving outcomes and supporting transparency
Department of Health, 2012
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358

[52] Creating a sporting habit for life 2012-201, Sport England, 2012
http://www.sportengland.org/about_us/our_news/creating_a_sporting_habit_for.aspx

[53] Milton Keynes Health and Wellbeing Strategy 2012 – 2015 - www.milton-keynes.gov.uk/health-wellbeing

[54] Milton Keynes Sport and Leisure Strategy 2009 -14
http://www.miltonkeynes.gov.uk/leisure-facilities/documents/Sports_and_Leisure_Strategy_Exec_Summary.pdf

[55] Milton Keynes International Sporting City Report, 2011
http://www.milton-keynes.gov.uk/leisure-facilities/documents/ISC_Exec_Sum_post_consult_report_FINAL_031111.pdf

[56] Milton Keynes Cycling Strategy
http://www.milton-keynes.gov.uk/transport/displayarticle.asp?ID=13778

[57] Arts Strategy http://www.milton-keynes.gov.uk/arts/documents/Arts_Strategy_2010-14_%5Bprinter-friendly%5D.pdf

[58] Heritage Strategy http://www.milton-keynes.gov.uk/arts/documents/MKHS_2008-13_First_Annual_Review_and_Refresh_Dec_2010.pdf

[59] Public Arts Strategy http://www.milton-keynes.gov.uk/arts/documents/Public_Art_Strategy_2010-14_%5Bprinter-friendly%5D.pdf

[60] Department of Health (2011) Healthy Lives, Healthy People: A Tobacco Control Plan for England 2011. Department of Health, London
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917

[61] NHS Information Centre (2011). Statistics on Smoking: England, 2011. NHS Information Centre, Leeds
http://www.ic.nhs.uk/pubs/smoking11

[62]National Institute for Health and Clinical Excellence (2010). Quitting smoking in pregnancy and following childbirth: Guidance. Nice, London.
http://www.nice.org.uk/nicemedia/live/13023/49346/49346.pdf

[63]National Institute for Health and Clinical Excellence (2006). Brief interventions and referral for smoking cessation in primary care and other settings. Guidance. Nice, London
http://www.nice.org.uk/nicemedia/live/11375/31866/31866.pdf

[64]The Foresight Report 2007 http://www.erpho.org.uk/viewResource.aspx?id=16891

[65] Adult Psychiatric Morbidity Survey (2007)
http://www.natcen.ac.uk/study/adult-psychiatric-morbidity-in-england-2007

[66] National Sexual Health and HIV Strategy, 2001
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003133

[67] Milton Keynes Sexual Health Strategy 2010-13, MK Public Health Team

[68] HMRC http://www.hmrc.gov.uk/stats/personal-tax-credits/cps-la-2010.xls
[69] The Office for National Statistics (ONS), psychiatric morbidity survey
http://www.ic.nhs.uk/pubs/psychiatricmorbidity07

[70] Knapp, M. & Prince, M. (2007) Dementia UK. London: Alzheimer's Society

[71] Department of Health (2009) Living well with dementia: A national dementia strategy. Available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_094051.pdf [Accessed 17 February 2010]

[72] Wider Benefits of Learning research report 3, 8 and 12 [Schuller et al (2002) Learning, Continuity and Change in Adult Life; Feinstein et al (2003) Contribution of Adult Learning to Health and Social Capital; and Sabates et al (2004) Education, Training and the Take-up of Preventative Health Care].

[73] Green, MGinnity, Melzer, Ford and Goodman. 2005. Mental Health of Children and Young People in Great Britain, 2004. London: ONS.

[74] Percentage of pupils participating in physical activity 5-16 year olds in MK and its Statistical Neighbour; MK(94.54), Bedfordshire(94.23), Northamptonshire(91.64), Trafford(89.86) Swindon(83.43), Kent (88.06), Leeds(83.11), Bury(84.62), Hertfordshire (90.02), Stockport (86.43),Solihull(91.02 (English average-86.36, England worst-57.94, England best 100)

[75] Percentage of 16-18 year olds not in employment, education or training in MK and its Statistical Neighbours; MK(5.10), Bedfordshire(4.60) Northamptonshire(5.20), Trafford(4.70), Swindon (6.20,) Kent(4.90), Leeds(8.30), Bury(4.90), Hertfordshire (4.40), Stockport(5.80) ,Solihull (5.40) (English average-5.98,English worst-11.40, English best-2.7)

[76] All households in Milton Keynes = 98,584 (census 2011)

[77] Emerson and Hatton (2007) http://www.emeraldinsight.com/journals.htm/journals.htm?issn=1753-0180&volume=1&issue=3&articleid=1927897&show=pdf

[78] Diabetes UK, http://www.diabetes.org.uk/Guide-to-diabetes/Introduction-to-diabetes/What_is_diabetes/

[79] http://www.nao.org.uk/publications/1213/adult_diabetes_services.aspx

[80]http://php.york.ac.uk/inst/yhec/web/news/impact_diabetes_press_release_25_04_12_final.pdf

[81] 2012 – 2015 End of Life Care Strategy - http://www.google.co.uk/url?q=http://www.milton-keynes.gov.uk/mk-socialcare-articles/documents/Draft_Adult_End_of_Life_Care_Strategy_for_Consultation.pdf&sa=U&ei=rkUeUaPSPM-2hAfu64BA&ved=0CBsQFjAA&usg=AFQjCNFgF2mKUeJLNwZ5YJqMPWxdBH0S2w

[82] 2008 National End of Life Care Strategy http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277

[83] NICE Clinical Guidance 21 (2004) http://www.nice.org.uk/nicemedia/pdf/CG021NICEguideline.pdf

[84] The National Service Framework for Older People http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066

[85] National Osteoporosis Guideline Group http://www.shef.ac.uk/NOGG/

[86] The Children Act 1989 http://www.legislation.gov.uk/ukpga/1989/41

[87] The National Autistic Society website http://www.autism.org.uk/

[88] The Autism Act 2009
http://www.legislation.gov.uk/ukpga/2009/15

[89] Fair Treatment at Work Survey 2008
http://www.berr.gov.uk/files/file52809.pdf

[90] PANSI
http://www.csed.dh.gov.uk/dfAndCapacityPlanning/pansi/

[91] POPPI
http://www.poppi.org.uk/

[92] The Social Atlas – Milton Keynes Council
http://www.mkiobservatory.org.uk/download.aspx?id=10168&siteID=1026&typeID=2

[93] White Paper Our Health Our Care Our Say 2006
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127602

[94] "Epidemiology Of Learning [Intellectual] Disability And Comorbid Conditions. Vee P Prasher, Psychiatry, Volume 2:8, August 2003" http://www.intellectualdisability.info/mental-health/epidemiology-of-learning-intellectual-disability-and-comorbid-conditions/

[95] Six Lives Report
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_120251

[96] The Bradley Report
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694

[97] Toolkit for Health care needs assessment in prison (2000)
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008653

[98] International Congress on Telehealth and Telecare 2012, King's Fund, March 2012
http://www.kingsfund.org.uk/events/past-events/international-congress-telehealth-and-telecare-2012

[99] Definition of Carer
http://www.carers.org/what-carer accessed November 2012

[100] Forder J (2007) Self funded social care for older people: an analysis of eligibility, variations and future projections, PSSRU Discussion Paper 2505, PSSRU and CSCI

[101] Carers UK Policy and Briefing September 2012

[102] Nomis 2012

[103] www.poppi.org.uk

[104] Always on Call, Always Concerned: A survey of the Experiences of Older Carers. The Princess Royal Trust for Carers, 2011

[105] The Health and Social Care Information Centre – NASC10003 Referrals, assessments and packages of care RAP 2011 – 12 Comparator Report

[106] Caring for Our Future: Reforming Care and Support (2012) HM Government
http://www.local.gov.uk/c/document_library/get_file?uuid=cbc6f20a-34d5-4c16-a613-1b5be90f8f99&groupId=10171

[107] Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085345

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