## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>4</td>
</tr>
<tr>
<td>Year in numbers</td>
<td>7</td>
</tr>
<tr>
<td>Primary Services</td>
<td>8</td>
</tr>
<tr>
<td>Health Visiting</td>
<td>8</td>
</tr>
<tr>
<td>School Nursing</td>
<td>9</td>
</tr>
<tr>
<td>School-age immunisations team</td>
<td>11</td>
</tr>
<tr>
<td>Perinatal Service</td>
<td>12</td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies (IAPT)</td>
<td>14</td>
</tr>
<tr>
<td>Urgent care</td>
<td>15</td>
</tr>
<tr>
<td>Mental Health Hospital Liaison Team</td>
<td>15</td>
</tr>
<tr>
<td>Liaison and Intensive Support Team (LIST)</td>
<td>15</td>
</tr>
<tr>
<td>Rapid Response</td>
<td>16</td>
</tr>
<tr>
<td>RAIT</td>
<td>17</td>
</tr>
<tr>
<td>Assessment and Short Term Intervention (ASTI) Team</td>
<td>18</td>
</tr>
<tr>
<td>Street Triage</td>
<td>19</td>
</tr>
<tr>
<td>Acute Home Treatment Team</td>
<td>20</td>
</tr>
<tr>
<td>Long-term care</td>
<td>20</td>
</tr>
<tr>
<td>Children with Complex Needs</td>
<td>20</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services (CAMHS)</td>
<td>21</td>
</tr>
<tr>
<td>Community Paediatrics</td>
<td>22</td>
</tr>
<tr>
<td>Paediatric Speech and Language Therapy</td>
<td>23</td>
</tr>
<tr>
<td>Children’s and Young People</td>
<td>24</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>25</td>
</tr>
<tr>
<td>Haemoglobinopathy Service</td>
<td>26</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>27</td>
</tr>
<tr>
<td>District Nursing</td>
<td>28</td>
</tr>
<tr>
<td>Community occupational therapy</td>
<td>29</td>
</tr>
<tr>
<td>Pulmonary rehabilitation</td>
<td>30</td>
</tr>
<tr>
<td>Neuro Specialist Conditions Services</td>
<td>31</td>
</tr>
<tr>
<td>Podiatry Service</td>
<td>32</td>
</tr>
<tr>
<td>Musculoskeletal Assessment Service</td>
<td>33</td>
</tr>
<tr>
<td>High Impact Team</td>
<td>34</td>
</tr>
<tr>
<td>Tissue Viability Service</td>
<td>35</td>
</tr>
<tr>
<td>Early Intervention in Psychosis Team</td>
<td>36</td>
</tr>
<tr>
<td>Recovery and Rehabilitation Team</td>
<td>37</td>
</tr>
<tr>
<td>Milton Keynes Adult</td>
<td>38</td>
</tr>
<tr>
<td>Speech and Language Therapy</td>
<td>39</td>
</tr>
<tr>
<td>Specialist Therapies Team</td>
<td>40</td>
</tr>
<tr>
<td>Assertive Outreach Team</td>
<td>41</td>
</tr>
<tr>
<td>Specialist Memory Service</td>
<td>41</td>
</tr>
<tr>
<td>Staying Steady MK</td>
<td>42</td>
</tr>
<tr>
<td>Patient Transport Services</td>
<td>43</td>
</tr>
<tr>
<td>Diabetes Specialist Team</td>
<td>44</td>
</tr>
<tr>
<td>Adult Hearing Service</td>
<td>44</td>
</tr>
<tr>
<td>Wheelchair service</td>
<td>45</td>
</tr>
<tr>
<td>Community Dermatology Service</td>
<td>46</td>
</tr>
<tr>
<td>Continence Service</td>
<td>46</td>
</tr>
<tr>
<td>Learning Disability Team</td>
<td>47</td>
</tr>
<tr>
<td>New developments this year</td>
<td>48</td>
</tr>
<tr>
<td>Inpatient care</td>
<td>48</td>
</tr>
<tr>
<td>Campbell Centre</td>
<td>48</td>
</tr>
<tr>
<td>The Older Person’s Assessment Service (TOPAS)</td>
<td>49</td>
</tr>
<tr>
<td>Cherrywood Mental Health Rehabilitation</td>
<td>50</td>
</tr>
<tr>
<td>Windsor Intermediate Care Unit</td>
<td>50</td>
</tr>
</tbody>
</table>
Foreword

At CNWL we are incredibly proud of the work we do in supporting our resident families, patients and carers across Milton Keynes. It is with great pleasure that I present the first annual review of 2016-17 to show you some of our highlights from the last year.

We have worked hard to recruit new staff to join our teams and reduce our use of agency in challenging times. We have also partnered with community and voluntary sector providers to encourage more local people to consider job opportunities within the NHS. The year between April 2016 and March 2017 saw many innovations and developments in our services.

Our services for adults support patients to live better and manage conditions in their own homes, or to return home after an episode of hospital care. This year we have seen an even larger number of patients, delivering high quality evidence-based care in patient homes, dedicated clinics and inpatient settings. These include:

- The Rapid Response service, a team offering care for people at home IAPT (Talking Therapies) so a hospital admission is not needed.
- Following a successful pilot in 2015/16, the High Impact Team was successful in the bid to expand its work across Milton Keynes; the team supports care home residents to prevent them being admitted to hospital; the team allows people to remain in the care home, avoiding the trauma of being admitted to hospital.
- The Perinatal service, which offers assessment and management for pregnant and postnatal women experiencing mental health difficulties.
- Investment in a new Primary Care Plus Mental Health Service, which provides mental health advice and support to four GP practices.
- New investment to expand hospital liaison mental health services that strengthens the urgent care pathway for people experiencing mental health difficulties.
- The Campbell Centre achieved Accreditation for Inpatient Mental Health Services (AIMS) – a recognised quality standard for Inpatient Wards – Working-Age Adults.
- Development of peer support workers programme at the Campbell Centre, providing professionals with advice and support from staff with lived experience of mental health.

Our children’s services are managing a number of projects, including: developing shared clinical reports, working with a group of families to develop shared care plans within the service, and ensuring family choices are reflected in their children’s care plans.

- CAMHS (Child and Adolescent Mental Health Services) have improved how they work and have relocated to a single base on the Milton Keynes hospital campus.
- The community paediatric service has also changed the way it runs, meaning that it can see more patients.
- Universal Children’s Services have continued to develop over the course of the last year, implementing new and innovative programmes to meet the needs of our caseloads. Such innovations include the ‘Little Connections’ parenting course, the publication of a new handbook to help
health and social care staff to increase their understanding of the specific emotional health needs of the young people who are looked after, and the development of new School Nursing posts to provide a more clinical focus for children with additional or complex health needs, reflecting the needs of the increasingly complex caseloads in mainstream schools.

• Urgent care pathway (including winning a bid to set up Home Liaison Team)

Plans for 2017/18

We are working closely with other primary and secondary care providers across Milton Keynes, Bedfordshire and Luton as part of the BLMK STP (Sustainability and Transformation Plans). CNWL has a large part to play in the delivery of the five key priorities of the STP. Our focus is on developing services in the community for people with physical and mental health care needs and our commitment is to do this in partnership with the community. We will continue to involve HealthWatch in designing our services.

This year developments are leading us to join services together – reducing the chance of gaps in services and duplication. In mental health services, we are grouping services into:

• Primary care services
• Secondary services
• Acute care
• CAMHS and lifespan

The Home 1st project sees services from CNWL and the Council joining together to offer care and rehabilitation for people in their own homes. This is a major reorganisation of our community services that sees our nurses and therapists putting care and rehabilitation in place for people coming out of hospital, discharged from A&E as well as people who are unwell at home.

Mental health services will undertake a review of the primary care offer to GPs across Milton Keynes. This will include a bid to expand IAPT provision in a staged development to achieve 25% access over the next three years.

A review of the Healthy Ageing pathway will be undertaken and will be co-produced with the Council, MK CCG, third sector and service users and carers. The aim of this review is to deliver better care to people using the same resources.

Adult community mental health services will be reviewed to ensure services remain efficient and responsive to the changing needs of the population. The review will also consider the interface between secondary mental health services and how care coordination could be strengthened for the different care groups supported by these services.

Work will continue to implement the new urgent care pathway. This includes development of a new front door to secondary mental health services, supported by a new unified assessment screening tool. It will also include the introduction of a telephone triage service that releases capacity for staff to undertake more urgent face to face assessments.

CAMHS services will implement the Children and Young People’s IAPT model.

CNWL is investing in the infrastructure to provide care; we have a major investment in IT to support our clinicians working on the move. We are looking at how we can introduce hubs for services
across the City and we are innovating in health technology. The Adult Hearing Service will be the first NHS community service piloting ‘self-learning’ hearing aids.

Quality improvements

The emphasis on continuing to improve our services culminated in 2016/17 with preparation work for the Trust wide Mental Health CQC re-inspection. The re-inspection followed the Trust’s rating of ‘Requires Improvement’ in 2015. Following this a service improvement programme took place across the London Boroughs and Milton Keynes. Locally this work consisted of changes to the ensuite facilities at the Campbell Centre and single sex accommodation at TOPAS, which enhanced the arrangements for patients to have privacy and dignity.

During 2016/17, the project work for preparing our services for re-inspection by the CQC spanned across all our local mental health services. This project work included a programme of service reviews. These highlighted areas of good practice, empowered staff to be confident during an inspection and provided assurance that clinical standards were met. At the Campbell Centre, the newly appointed Peer Support Worker - a former patient on the ward - was integral to inspection preparation and helped with ideas such as showcasing our approach to organisational learning and making service improvements. This approach was also reciprocated at the TOPAS service, where the inclusive ethos of care was depicted in a ‘building blocks’ of TOPAS wall display. This approach helped staff to remember all the good things they were doing, which contributed towards the excellent care people received.

The feedback from CQC on Milton Keynes Mental Health Services was highly complimentary and a copy of the final report can be found on the CQC website. On 18 August 2017, the Trust was rated as Overall ‘Good’, which reflected the high level of care being provided across CNWL.

The Trust was also commended for achieving an ‘Outstanding’ rating for being caring and ‘Good’ for the domains of effective, responsive and well led. The Trust received ‘Requires Improvement’ for the safe domain and has started a Trust wide project to reduce the need for physical interventions such as restraint and consistency in following policies and procedures. It is anticipated that this will improve outcomes to patients greatly.

At the Campbell Centre this work has seen a renewed focus on Access to Psychological Therapies and interventions to help people re-build their lives. During the mental health community inspection, local services were asked to improve staff access to hand held alarms in clinical areas. This action has now been completed and has enhanced the safety of staff and the protection of our patients.

Work continues to improve and learn from inspections which have taken place across the range of mental health services within the London boroughs and also in Milton Keynes.

I hope you enjoy reading this report. If you have any feedback please email me at graeme.caul@nhs.net

Yours sincerely

Graeme Caul
Diggory Divisional Director
Year in numbers

- 30,357 patients for 175,787 appointments
- 739 admitted to our beds
- 3,048 babies supported into families in Milton Keynes
- 1,532 Admissions avoided by intermediate care services
- 60% of Rehabilitation patients reported an improvement
- 1,100 people employed by CNWL in Milton Keynes
- 90% mental health early intervention service referrals are seen within two weeks
- 95% of patients would recommend our services to a friend or family member
Primary Services

Health Visiting

The Health Visiting service comprises teams of a mix of disciplines working across the north and the south of Milton Keynes.

There are about 4,000 births in Milton Keynes each year.

The service mainly involves:

- Delivery of the Healthy Child Programme to children and young people aged 0-5 years across Milton Keynes. This is a service for all children and families living in Milton Keynes. It supports parents at this crucial stage of life, promotes child development, improves child health outcomes and ensures that families at risk are identified at the earliest opportunity.
- Safeguarding children and working to promote health and development
- Transition to parenthood and the early weeks
- Maternal mental health (perinatal depression)
- Promoting breastfeeding (initiation and duration)
- Healthy weight, healthy nutrition and physical activity
- Managing minor illness and reducing hospital attendance and admission
- Health, wellbeing and development of the child age 2 – 2½ year old review and support to be ‘ready for school’.

Activity (all figures are approximated and provided for context only)

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>8,064</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>40,802</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>100%</td>
</tr>
</tbody>
</table>

New developments this year

Awarded Level 1 UNICEF BFI Breastfeeding. Introducing Nursery Nurses to support the Universal Service. The service now provides care to all families and children living within the Milton Keynes postcode area irrespective of which GP practice they are registered with. This has increased the number of GP practices and partner agencies that the service directly works with. CNWL gives annual awards to its staff. This year, the Annual Gem Award for Compassion was given to a member of the Health Visiting Team in Milton Keynes for their commitment to the delivery of the Care of Next Infant Team, the service as a whole also won Community Placement of the Year for nursing students.
**Plans for 2017/18**

The focus for 2017/18 is to improve access to families by developing a fully integrated 0-19 Universal Children’s Service. Some of the work planned to achieve this:

Development of a Single Point of Access by reorganising the administration team into a corporate hub with one single telephone number to make it easier to contact your Health Visiting team.

To implement a Health Visitor/ School Nurse duty desk to enable a responsive approach to service user contact with the service. Implementation of a ‘choose and book’ style system to improve access to appointments for developmental review.

Mobile working and IT to make it easier for Health Visitors to work ‘on the road’.

Adopt a new approach to school readiness for children working more closely with the School Nursing service.

Introducing social media as a way of service user engagement and sharing information about our services with key public health information.

The service will also work to achieve the Level 2 UNICEF BFI award during the year.

---

**School Nursing**

The School Nursing Service works with about 42,000 school age children attending 111 Schools in Milton Keynes.

The main delivery of services involves:

- Delivery of the Healthy Child Programme to children and young people aged 5-19 across Milton Keynes.
- Safeguarding children is a core part of the service, underpinning all aspects of service delivery.
- Advice and support on:
  - allergies and anaphylaxis training
  - bereavement support etc.
  - emotional and mental health and wellbeing
  - enuresis and soiling
  - poor attendance
  - sexual health
  - Targeted support for children, young people and families
  - Intensive and multi-agency packages of support where additional health needs are identified.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse clinics in schools</td>
<td>947</td>
</tr>
<tr>
<td>Reception screening</td>
<td>3,852</td>
</tr>
<tr>
<td>Year 6 screening</td>
<td>3,291</td>
</tr>
<tr>
<td>Enuresis clinic caseload</td>
<td>120</td>
</tr>
</tbody>
</table>
Patient experience measures (feedback):

- “You are Amazing”
- “I want to talk to the nurse, she’s not a teacher”

School feedback, “The drop in clinics are essential for the wellbeing of our children”.

In addition a further number of contacts were carried out from managing safeguarding and attending conferences and family support meetings.

New developments this year

- Nurse-led drop-ins have been offered to all Primary Schools this academic year giving families the opportunity to discuss any health concerns with the Nurse, who in turn is able to offer advice, carry out health screening, help to write a health care plan or signpost to other services as required.

- Pilot School Nurse-led drop-in offered to a Secondary School in Milton Keynes. Held every other week, the Nurse had 87 contacts with young people seeking advice for a range of health issues. The pilot was successful in creating a proactive service:
  - improved visibility within school
  - improved relationships with school staff
  - improved referral process through more effective communication
  - More visits to the schools reduced follow-up work done in-between visits
  - Band 5 Registered Nurses have begun to hold a Safeguarding caseload; they have undertaken competencies and attend regular clinical supervision.

Plans for 2017/18

- Continue and extend the drop-in clinic offer to all Primary schools for the next year.
- Develop plans to extend the drop-in clinics in secondary schools
- Development of a Single Point of Access by reorganising the administration team into a corporate hub with one single telephone number to make it easier to contact your School Nursing team.
- Introducing social media as a way of service user engagement and sharing information about our services with key public health information.
School-age immunisations team

This is a service run alongside the School Nursing service providing an immunisation programme to school-age children and young people in Milton Keynes. The immunisation programme for children and young people is agreed nationally and delivered locally.

The immunisations are delivered in schools, though special arrangements are made for children not able to attend, eg home-schooled children.

Meningitis ACWY – 82.5% of all year 9 (14 year olds) school aged children

Diphtheria, Tetanus & Pertussis 81.6% - of all year 9 (14 year olds) school aged children

Human Papilloma Virus dose 1 - 89.1% - of all year 8 school aged (13 year old) girls

Human Papilloma Virus dose 2 - 87%

New developments this year

The service was only commissioned for one year whilst a more formal tendering process was undertaken for the service to be delivered across Bedfordshire, Luton and Milton Keynes. The service has been decommissioned in Milton Keynes and the service covering the larger area will start in June 2017.
Perinatal Service

The service, provided by CNWL, offers assessment and management for pregnant and postnatal women experiencing mental health difficulties. It is for women who:

- are planning a pregnancy and need education and advice about their mental health
- are pregnant or have given birth in the last 12 months, and have experienced mental health problems in the past
- experience a relapse of a previous mental illness during pregnancy or in the first 12 months after their baby is born
- develop a mental illness for the first time during pregnancy or in the first 12 months after birth.

The service offers:

- Preconception advice for women with complex or severe mental health problems
- Assessment and care for women with mental health needs during pregnancy and for 12 months after birth.
- Many women do not need to be seen for the whole 12 months
- Advice on the risks and benefits of using mental health medication in pregnancy and breastfeeding
- Care planning for women with more severe mental health problems who are booked for delivery
- Planning for the postnatal period to promote wellbeing and prevent relapse
- Identification and management of the impact of obstetric complications on a woman’s mental health
- Facilitating access to the most appropriate type of psychological interventions
- Support and advice on the mother and baby relationship.

Activity 2016-17 Outturn

| Referrals     | 95 |

New developments this year

This is a new service launched as part of the national initiative and as well as offering assessment and treatment it provides training for multi-agency professionals working who also provide services to these women.

Plans for 2017/18

Launch of Perinatal Mental Health Pyramid Training Programme – a multi-agency training scheme offering awareness through to specialist training for staff working with mothers, babies and families during the perinatal period

There are plans to provide perinatal provision across the STP. Milton Keynes professionals are therefore working with the respective commissioners and providers in Luton and Bedford to submit a bid that will deliver a more consistent level of service across the three localities.
Buckinghamshire priority dental services

Buckinghamshire and Hillingdon are a priority Dental service that is a referral only service.

The service is commissioned by NHSE and receives referrals from healthcare professionals, mainly dentists and in some circumstances self-referrals.

The service criteria for acceptance are:

- Patients with learning and physical disabilities
- Anxious and phobic children and Adults
- Mental Health Patients
- Medically compromised patients

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>5,150</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>14,220</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>96%</td>
</tr>
</tbody>
</table>

New developments this year

- The installation of wheelchair tipper in Milton Keynes which negates the need to hoist wheelchair patients.
- The upgrade of the Brookside Dental clinic including the compliant decontamination room
- Successful accreditation of sedation training

Plans for 2017/18

- Look at rationalising clinics, Buckingham and Neath Hill with commissioner agreement.
- Look at business opportunities for service development
- It is likely that the dental service we provide in Buckinghamshire will be tendered and we will be developing a bid to continue to provide the service.
Improving Access to Psychological Therapies (IAPT)

Milton Keynes Improving Access to Psychological Therapies (IAPT) is a free, confidential NHS service providing psychological treatment for depression and anxiety disorders. The service offer treatments such as:

- Individual cognitive behavioural therapy (CBT) for depression, anxiety, post-traumatic stress disorder and phobias.
- Workshops for sleep, mood, anxiety, stress, wellbeing and work and employment related issues.
- Self-help resources and interventions.
- The team can also provide advice and support on:
  - How to deal with everyday problems, such as leisure, work and social life.
  - Employment and how to cope with work-related stress and advocacy in difficult employment situations.
  - Sign-posting to information about a wide range of organisations and services that can offer additional help.
  - Self-help tools, homework exercises, links to online CBT resources, self-help reading and guided self-help information.
  - Telephone sessions for ease of therapy in your own home.

New developments this year

IAPT is working with the Pulmonary Rehabilitation team; delivering training that will help people to overcome and manage the anxiety that comes with having COPD.

Plans for 2017/18

IAPT services have been working with ASTI to streamline access points to services. As part of this development a new Access Team has been developed that will screen all incoming referrals from GPs as well as other community stakeholders. The service has also secured investment to pilot IAPT services as part of the Mental Health Treatment Requirement. This initiative allows for treatments to be prescribed as part of the sentencing arrangements in the criminal justice system.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>5,894</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>17,455</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>97%</td>
</tr>
</tbody>
</table>
Urgent care

Mental Health Hospital Liaison Team

The Mental Health Hospital Liaison Service at Milton Keynes Hospital offers integrated care for patients who have physical and mental health problems.

The team is based at Eaglestone Health Centre within the hospital and provides rapid access to assessment and interventions for people with mental health difficulties in the emergency department and across all hospital wards.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>1,692</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>100%</td>
</tr>
</tbody>
</table>

New developments this year

In spring 2017 the service prepared a bid to NHSE for monies to provide “CORE 24 compliant” services. These monies were secured in the same period.

Plans for 2017/18

The expansion of the service is a key priority for CNWL and we will be working with the CCG and Milton Keynes Hospital to make this happen.

Liaison and Intensive Support Team (LIST)

The Mental Health LIST service at Milton Keynes Hospital offers integrated care for young people who present at A&E with physical and mental health problems.

The team is based at Eaglestone Health Centre within the hospital and provides rapid access to assessment and interventions for young people with mental health difficulties in the emergency department and across all paediatric wards. The service also provides a limited home treatment support function. The service also provides the clinical administrative support to place young people in specialist CAMHS Tier 4 inpatient services where this is deemed necessary. On occasions where Tier 4 beds are not available the team provides in-reach to the Campbell Centre and paediatric wards for those patients that are placed there as a place of safety measure.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals</td>
<td>462</td>
</tr>
<tr>
<td>Number of referrals</td>
<td>901</td>
</tr>
</tbody>
</table>

New developments this year

The service home treatment offer was implemented during this year.

Plans for 2017/18

The team will be co-located with the Adult Hospital Liaison Service with a view to becoming an integrated life span service.
Rapid Response

The Rapid Response Service is an admission avoidance service that helps to prevent people being admitted to hospital when they can stay at home. Patients are referred to the service through a variety of channels including GP’s, the Ambulance Service, A+E and Social Care, as well as the Urgent Care Centre based at Milton Keynes University Hospital.

The scheme started in October 2016. It is a short term service offered to patients experiencing an acute episode of illness or frailty including Urinary Tract Infections, chest infection or exacerbation of a long term respiratory condition, falls, and cellulitis for up to 10 days.

The service includes Health Care Assistants (HCA) to provide care and assistance at the patient’s home, as well as providing a speciality physiotherapist to assess and evaluate chest infections, or where there has been a sudden worsening of long term respiratory conditions. The physiotherapist can also assess the home safety of the patient and provide equipment as required.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>359</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>100%</td>
</tr>
<tr>
<td>Number of admissions avoided</td>
<td>262</td>
</tr>
</tbody>
</table>

New developments this year

The team was formed in October 2016 and has been building capacity and refining how it works.

Plans for 2017/18

The team will introduce the night care team on 1 April 2017, to be able to accept referrals from care professionals overnight.

From July, the team will be able to offer telephone advice to nursing and residential care home patients.

The team will broaden its skills to be able to address more health issues.

The Rapid Response team will join the Home 1st Team during 2017/18. Home 1st brings all the teams together to work as one team.
RAIT

The Rapid Assessment and Intervention team is a short term therapy service. Their role is to:

• prevent people being admitted to hospital unnecessarily
• support people coming out of hospital
• reduce people’s dependence on long-term care
• prevent premature admission into a care home

Patients are assessed in their own home; the patient’s goals will be discussed a plan will be agreed with the patient centred period of reablement will be planned to maximise independence and functional ability, reduce risks in patients own home.

The team works closely with Council services, particularly the Reablement at Home Team (RaHT) that provides short-term care at home. The team can organise same day essential equipment.

The service works from 9am to 9pm Monday to Friday and 9am to 7pm weekends. Referrals are only accepted from local clinicians and social workers.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>2,628</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>8,184</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>100%</td>
</tr>
</tbody>
</table>

New developments this year

The team has developed its relationship with the Council’s Reablement at Home Team (RaHT) to provide co-ordinated care for patients in their own home.

Plans for 2017/18

The team will trial the use of virtual beds – giving the same therapy and care input for a patient at home as they would receive in a rehabilitation bed.

CNWL Community teams in collaboration with Milton Keynes Council are under transformation to provide an integrated health and social model of care to be known as ‘Home 1st’.

Home 1st will receive referrals from the access hub, following clinical triage the most appropriate Clinician (Trusted Assessor) will provide the assessment to avoid hospital discharge, support early discharge, and reduce the level of long term care and premature admission to long term care. The service will operate 24 hours a day.
Assessment and Short Term Intervention (ASTI) Team

Milton Keynes Assessment and Short Term Intervention Team (ASTI) is a community team which assesses people who have severe and/or enduring mental illness. The ASTI service provides a single point of access into mental health service for people of all ages.

On completion of an assessment, a mental health practitioner may provide advice or information, introduce a care plan for support and/or, if the person's needs more complex treatment, refer to Milton Keynes Memory Assessment Service, Milton Keynes Recovery and Rehabilitation Team or Milton Keynes Community Dementia Service.

Referrals are accepted from any individual experiencing severe and/or enduring mental health difficulties or who are having a mental health crisis. Their family and carers and any other partner referrer may refer e.g. general practitioners (GP), primary care professionals, statutory and non-statutory agencies.

New developments this year
- Service established and operational.
- Plans developed and underway to reconfigure the urgent care pathway.

Plans for 2017/18

As part of the re-design of the urgent care pathway, ASTI will transform into the Urgent care service. This new team is designed to provide rapid assessment for people presenting in crisis who are not known to secondary services.

Activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>3,142</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>2,308</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>88%</td>
</tr>
</tbody>
</table>
Street Triage

The project sees police and mental health professionals working together to ensure people get appropriate care at the earliest possible opportunity. The scheme allows the police to call on the Street Triage Team to attend incidents where they can begin to work with vulnerable people in crisis. The scheme offers:

- Improved experience for people experiencing a mental health crisis.
- Fewer detainees are being released with no further need for mental health services suggesting more appropriate use of powers.
- Better outcomes for people; where pathways have been identified people are remaining in services for longer increasing their rate of recovery.
- Savings in police time when dealing with mental health incidents allowing them to resume other duties.
- Officers report that mental health triage allows them to react faster, make more informed risk assessments and hence better decisions. Officers report that they are gaining in confidence when dealing with mental health crises.

New developments this year

Together with Thames Valley Police we published a video about the Street Triage Scheme, which sees police and mental health professionals working together to ensure people get appropriate care at the earliest possible opportunity.

Plans for 2017/18

The service is established and operational.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals</td>
<td>675</td>
</tr>
</tbody>
</table>
**Acute Home Treatment Team**

Milton Keynes Acute Home Treatment Team helps avoid admission to a mental health inpatient ward by providing intensive support to people in acute mental crisis in their homes.

The team works closely with the inpatient service based at the Campbell Centre, and is also supported by the Trust’s Out of Hours Urgent Advice Line. All service users are provided with a crisis card with details of how to contact the appropriate service in an emergency.

All admissions to inpatient beds at the Campbell Centre are received through the Milton Keynes Acute Home Treatment Team.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>1,040</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>1,650</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>100%</td>
</tr>
</tbody>
</table>

**New developments this year**

The service provides the gatekeeping function to the inpatient services.

**Plans for 2017/18**

Service is established and operational. New social care function introduced to support the care of service users.

---

**Long-term care**

**Children with Complex Needs**

Milton Keynes Children with Complex Needs service provides nursing care and support to families of children who have complex medical needs, palliative care needs, including End of Life Care, Complex Epilepsy, Neurodisability and degenerative conditions.

The service is available to children who are registered with a Milton Keynes GP or where there is an agreement in place with a neighbouring clinical commissioning group (CCG) to provide the service. To use the service, individuals must be aged under 19 and meet one of the following three criteria:

- Have a severe, unpredictable or complex medical condition and/or disability or a range of complex medical conditions that indicate a very high use of healthcare services.
- Have a life-threatening or life-limiting illness where it is expected that they will not reach adulthood.
- Have a long-term or complex condition, which makes them medically unstable and requiring input from a health professional and/or regular hospital admissions or:
  - Attend a special school in Milton Keynes
  - Have complex epilepsy
  - Require medical supplies
  - Have complex continence needs that require specialist input

<table>
<thead>
<tr>
<th>Activity</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>496</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>4,581</td>
</tr>
</tbody>
</table>
New developments this year

The service worked with the adult epilepsy service to develop a transition clinic – for children with epilepsy who are entering the adult service.

The team developed a checklist for children having surgery, especially in a specialist hospital. The list looks at preparation for surgery and the services and equipment that are likely to be needed when they come home.

With another member of the team completing her training, one third of the team is able to prescribe medication for the children they look after.

Plans for 2017/18

The team will be working on the transition of children to adult services; we will be adapting the Ready, Steady, Go process. The team will start with epilepsy.

The team will develop its IT and make more use of the secure electronic patient records. The team will share records, tasks and medication changes directly with GPs.

Child and Adolescent Mental Health Services (CAMHS)

Milton Keynes Child and Adolescent Mental Health Service (CAMHS) supports families and professionals who are concerned about children and young people who may be experiencing mental health difficulties.

Some of the difficulties the team can help with include:

- Significant behaviour problems
- Depression
- Self-harm
- Anxiety disorders (including phobias)
- Obsession/compulsion
- Tic disorders
- Attention deficit hyperactivity disorder (ADHD)
- Eating disorders
- Family relationship problems
- Trauma, including post-traumatic stress disorder (PTSD)
- Psychosis

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>2,617</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>9,362</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>85%</td>
</tr>
</tbody>
</table>
New developments this year

As part of the Milton Keynes Local Transformation Plan (LTP) there is an ambitious plan to improve the mental health services available to children and young people in Milton Keynes.

The service has changed location and is now based on the hospital campus at Eaglestone.

Plans for 2017/18

The second year of the transformation plan for CAMHS includes developing the single point of access to the service and staff receiving training on CYP IAPT. A number of mental health professional posts will be developed to assist services who support children with complex and challenging behaviours. The complex and challenging behaviour service will be established. The service will also establish assessment clinics in some of the Family and Children’s Centres in Milton Keynes. Transition protocols will also be reviewed in line with the different care pathways.

Community Paediatrics

Community Paediatricians are specialist children’s doctors with training and expertise in developmental paediatrics and disability, social paediatrics (including child protection), educational paediatrics and public health for children.

Our Community Paediatricians manage children who have long term problems which often require long-term follow up care. They offer a range of services, which include:

- Services for children with disabilities and complex health needs
- Services for looked after children and to support adoption process
- Services to provide medical information for children undergoing an assessment of their special educational needs
- Services for children with neurodevelopmental concerns such as social and communication difficulties/autistic spectrum/developmental delay/motor co-ordination difficulties
- Safeguarding and protecting children.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>1,106</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>1,273</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>85%</td>
</tr>
</tbody>
</table>
New developments this year

- Service review undertaken looking at making most efficient use of team resources
- Changes to ASD pathway allowing more people to assess for and diagnose this condition
- New appointment booking system introduced that has increased parental choice and helped reduce waiting times
- Increased clinical psychology input into the team
- Redesigned administrative support within the service to increase clinical capacity.

Plans for 2017/18

- Changes to Looked After Children service enabling increased multi-disciplinary input and more choice over appointment times.
- Review of ‘Transition to Adulthood’ plans
- Continue to develop patient-reported outcome measures.

Paediatric Speech and Language Therapy

The MK paediatric SLT service provides assessment and intervention for children up to 16 years within mainstream schools and 19 years within specialist provision and up to 25 years for young adults attending MK College.

Preschool provision is mostly clinic and home based with school-aged children being funded by the Local Authority to be seen within their educational setting. The team provides highly specialist services to the acute wards at Milton Keynes University Hospital (Children’s ward, Paediatric day care Assessment Unit and the Neonatal ward), the Youth Offending Team, the Adult Learning Disability Team and Milton Keynes College.

As well as providing assessment and a range of interventions, the teams regularly deliver training to parents/carers and other professionals. We have a highly successful parent training programme for children with social communication difficulties (More Than Words) and language delay (It Takes Two to Talk). We provide the accredited Elkan training programme to school staff. Our SLTs within the Learning Disabilities Service provide frequent training on eating and drinking difficulties and communication difficulties. We have a range of care pathways and packages that are used across the service to ensure a consistently high standard of clinical decision making and service delivery that is equitable.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>1,518</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>10,099</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td></td>
</tr>
</tbody>
</table>
New developments this year

- Involvement in the national Royal College of Speech and Language Therapy outcome measures project, looking at how an electronic platform can share information about parent/child aspirations and outcomes for EHC planning
- A review of some packages of care in the service to ensure:
  - The evidence behind the packages of care is up-to-date
  - Pathways are up to date with current care packages
  - That the team is working consistently to the care pathways
- New service delivery model for the EY team, based on a graduated response to SLCN, parent-empowerment (self-management) and opt-in intervention choices.
- Document jointly produced with the LA SEN Team for schools to provide guidance on minimum standards expected for universal and targeted provision for children with SLCN
- Trialling the use of the Therapy Outcome Measures system within ALD
- Funding given for a part-time SLT to work as part of a primary mental health intervention team, supporting children and families who are sub-threshold for CAMHS support. This was identified as part of the multi-agency Complex and Challenging Needs pathway working party, led by MK CCG
- Appraisal of the intervention services offered to pre-school children and their families with Autism Spectrum as this group makes up 60% of the SLT caseload
- SLT Advice telephone helpline launched at the CDC to provide responsive support to parents when they need it.

Plans for 2017/18

- Moving to a gum based thickener for clients with dysphagia
- Review of EY care pathways for Dysphagia to reflect learning from recent case reviews
- Update packages of care for specific communication stages in the ASD pathway
- Extend the library of easy-read docs that we have across the service
- Extend the use of Therapy Outcome Measures across other teams.
Children’s and Young People Occupational Therapy

This service consists of four therapists who work with children and young people aged 0-18 years (up to 25 years if attending special schools) and their families. Typically, those children we work with will need support with everyday functional skills to help to be as independent as possible. The kind of support we offer generally relates to:

- **Self-care**: getting dressed, using the toilet, preparing simple meals, using cutlery, participating in hygiene routines
- **Productivity**: handwriting, using tools and materials in the classroom, following school routines, attending to tasks, adopting self-regulating behaviours, using computers and technology, participating in PE sessions
- **Leisure and play**: playing sports, shopping with friends, doing hobbies, playing age-appropriate games

Our Occupational Therapists (OTs) can suggest alternative ways of doing activities, providing advice on learning new approaches or assist by recommending different types of assistive equipment. OT’s may assess and advise in areas such as seating, bathing, cutlery, dressing, moving and handling e.g. hoists and slings. In addition to providing advice and a range of assistive equipment, we also assess for complex adaptations to allow people to live independently in their own home for as long as possible. This means working in partnership with, for instance, Social Services, Housing, and Community Health Services.

Every child has a therapy care plan that details goals, which are set in collaboration with the therapist and are regularly reviewed to measure the improvement in their wellbeing.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>394</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>1,272</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>88%</td>
</tr>
</tbody>
</table>

**New developments this year**

- The service successfully increased the capacity for the number initial assessments through introducing Screening Clinics. Waiting times were reduced from over 18 weeks down to a consistent 15 weeks.
- 40% of our caseload is of children on the autistic spectrum or where sensory issues have been identified as the main concern. The introduction of a parent talk session has helped parents support their child.
- We are working with physiotherapy and speech and language therapy services to provide a group for children with Developmental Co-ordination Delay (DCD)
- Introduction of a Motor Skills Group to work with child, parent and school to develop functional skills such as using buttons, cutlery and holding a pencil.
- We are proud of our developments within SEND and continue to strive to work with the CCG and Milton Keynes Council in improving pathways and learning across the services.
Plans for 2017/18

- We are looking at how we measure the difference the service makes to each child and are planning to adopt AusTOMS – a way of measuring functional outcomes
- The service will review its provision within schools, aiming to improve parent and teacher satisfaction and child outcomes
- We will continue to work with Milton Keynes Council and MK Community Equipment Service to ensure the cost-effective provision of equipment.

Haemoglobinopathy Service

Sickle Cell Disease is the most common serious genetic disorder in England and Milton Keynes has a high prevalence. This small service offers support for children and families with Haemoglobinopathy, most often Sickle Cell Disease. It promotes awareness of Sickle Cell Disease, most commonly found in families with an African or Caribbean family background. Sickle cell disease is a serious and lifelong condition, although long-term treatment can help manage many of the problems associated with it.

Children are picked up by the service at birth and they remain with the service until they are an adult.

<table>
<thead>
<tr>
<th>HBO Care Pathway</th>
<th>Caseload</th>
<th>Patient Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn Screening outcome baby affected with Sickle Cell Disease</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Caseload of Children with Sickle Cell Disease</td>
<td>81</td>
<td>101</td>
</tr>
<tr>
<td>Caseload of Transition Teenagers with Sickle Cell Disease to Adult Services- New clinic started 16.11.17</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Joint Sickle Cell Disease Out-patient Clinic</td>
<td>53</td>
<td>85</td>
</tr>
</tbody>
</table>
New developments this year

The service is using the Ready, Steady, Go tool to help children make the transition to adult services. The sessions arranged had very positive feedback from the teenagers who attended.

The service was instrumental in setting up the MK Sickle Cell “our way” group. A group of professionals, friends, families and people living with Sickle Cell Disease have come together to form a group to make life better and raise awareness for people living with Sickle Cell in Milton Keynes.

The nurse in the service has extended her skills in Genetic Risk Assessment and Counselling, meaning that more counselling can be offered.

Plans for 2017/18

- To improve the use of computer systems to support the service to work more effectively and collect data to improve patient care
- To support the MK Sickle Cell “Our way” group and any further events
- Increase awareness of Haemoglobinopathy amongst health professionals.

Eating disorders

This small specialist service provides evidence-based integrated nutritional, medical and psychological care for people with severe eating disorders, such as anorexia nervosa, bulimia nervosa and other eating disorders. The service is for adults but works closely with the CAMHS team who also provide eating disorder treatments for Children and Young people under the age of 18 in Milton Keynes as part of a generic CAMHS.

Interventions for outpatients, usually delivered in the form of one session per week (reducing as the patient progresses), include:

- Cognitive behavioural therapy (CBT)
- Cognitive analytic therapy (CAT)
- Family/systemic therapy
- Supportive clinical management

Given the nature of the eating disorders, motivational work is a key part of each of these treatments.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>69</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>752</td>
</tr>
</tbody>
</table>

New developments this year

As part of the local transformation plan there has been investment from the CCG to expand the CAMHS eating disorder treatment and move towards a life span eating disorder service. This has started and recruitment into new posts is underway.

Plans for 2017/18

To complete the development of a life span integrated eating disorder service in Milton Keynes with a focus on transition and needs driven treatment.
**District Nursing**

The District Nursing (DN) service provides nursing care to housebound people either to promote and maintain independence or to ensure people with long term care needs and end of life care are supported with their nursing needs.

District Nursing also supports families and carers, ensuring patients have seamless access to services by other health and social care providers where these are more appropriate. The service promotes healthier lifestyles; physical, psychological and social wellbeing; protection for vulnerable adults and offers support and encouragement for people with disability and long term conditions to live independent lives.

The service provides advice and a comprehensive range of treatments that enable an individual to avoid unnecessary GP appointments or admission to hospital.

Where hospitalisation is necessary, the District Nurses ensure the service facilitates early, safe discharge back into the community.

The service is provided seven days a week 9-5pm and a Twilight Service 8pm to 1am.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>3,751</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>128,948</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>100%</td>
</tr>
</tbody>
</table>

**New developments this year**

- Review of responsibility and roles of third year students on placement within Community Nursing to enable them to visit and review a small caseload.
- Introduction of leg ulcer clinics with transport for District Nursing patients to be seen.
- Relocation of senior management team to same site as community nursing specialist services

**Plans for 2017/18**

- Provide nursing care to the virtual bed pilot
- Review of service hours of provision
- Review of urgent referral process into District Nursing
- Review of role and competency of HCAs to include more clinical aspects
- Review of transfer of care from other providers into the service
- Introduce ‘mobile working’, allowing nurses to record information in the electronic patient record without needing to return to base.
- Scope potential for providing more intravenous antibiotics in the community.
- Scope potential for introduction of Band 2 HCA Role
Community Occupational Therapy

A jointly commissioned service, Community Occupational Therapy provides a holistic assessment of activities of daily living for people age 18 or over, who live in Milton Keynes and who have a permanent or long-term condition.

In carrying out assessments, the occupational therapists mostly work with people and carers in their own homes. In addition to providing advice and a range of assistive equipment, we also assess for complex adaptations to allow people to live independently in their own home for as long as possible. This means working in partnership with, for instance, Social Services, Housing and Community Health Services.

The needs of people using the service range from low level to much more complex, such as environmental controls and major adaptations. The service therefore provides a range of information, sign-posting, advice on alternative techniques, and the provision of a wide range of equipment.

The service makes significant cost benefits within health and social care. For example, a wet room (£4,500) can facilitate independence and reduce the need for a 30 minute care package (£2,555 per annum) based on one carer for 30 minutes per day for a strip wash.

New developments this year

- Same day Equipment Clinic: The service successfully increased the capacity for the number of basic equipment assessments by introducing an Equipment Clinic in partnership with MK Community Equipment Stores.

- Waiting times for basic equipment assessment was reduced from 12 weeks for an assessment and a further five days for the delivery of equipment to six weeks with issuing equipment on the same day.

- The service has a positive approach to skill-mixing and recruitment is targeted to meet the expected pressures.

- The joint commissioner review stated the service has an “…ability to consistently deliver a good service to individuals, despite the increased referral pressure…” and “…has consistently strived to improve its efficiency…”

- There continues to be an upward trend in people achieving their agreed goals.

Plans for 2017/18

- Continue to creatively address the challenges of meeting the increasing referral demand on the service

- Develop an in-house training programme to better equip staff to respond to the increasing

- Working with MK Adult Social Care and MK Community Equipment Service to develop an online self-assessment to facilitate self-management of basic equipment.

- The service is interested in integrating with other community services to reduce the waiting time for clients, whilst providing support and training to staff.

Activity

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>2,358</td>
</tr>
<tr>
<td>Number of episodes discharged</td>
<td>2,546</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>95%</td>
</tr>
</tbody>
</table>
**Pulmonary rehabilitation**

Pulmonary rehabilitation programmes are multi-component, multi-disciplinary interventions, which are tailored to the individual patient’s needs. They should incorporate physical training, disease education, and nutritional, psychological and behavioural interventions.

At present, pulmonary rehabilitation within Milton Keynes can be accessed from within the hospital setting or at two venues in community halls.

The community programme currently provides rehabilitation to appropriate patients with MRC 2-4 as per Department of Health Pulmonary Rehabilitation Service Specification recommendations (2012). The community programme provides supervised exercise and tailored education during a two hour session once a week for at least six weeks.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>348</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>1,390</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>98%</td>
</tr>
</tbody>
</table>

**New developments this year**

The service has linked with IAPT (Improving Access to Psychological Therapies) to jointly deliver part of the programme to address the management of anxiety in patients with breathing difficulties.

The team has developed home exercise logs to allow patients to take more ownership and control of their condition. These logs allow a more formal way of continuing the learning from the programme to be part of the patient’s everyday life.

Based on feedback, the education sessions have been modified to allow for two sessions of breathing technique/sputum clearance and inhaler technique training within the programme.

Dysfunctional breathing pattern is common within our patient group therefore the importance of nose breathing, breathing techniques and pacing is addressed throughout the patients programme.

**Plans for 2017/18**

The focus for 2017/18 is to increase the capacity within the Pulmonary Rehabilitation Team to meet the increased demand for the service as waiting time for initial appointments and start dates for the programme continue to grow.
Neuro Specialist Conditions Services

We consist of three teams, Neuro Clinical Specialist Team (NCST) Neuro Rehabilitation Service (NRS) and the Early Stroke Rehabilitation Team (ESRT). We provide specialist condition management and rehabilitation to people in MK with neurological conditions over the age of 18 and have combined caseloads of 2,400 people. We are staffed by a specialist team of physio, speech and language and occupational therapists, nurses, psychologists and healthcare assistants. Group and individual sessions are provided and we work in close partnership with voluntary organisations such as Parkinson’s UK, Epilepsy Action, Motor Neuron Disease Association and the Stroke Association amongst many more.

We also have close working relationships with GPs, hospital consultants, dieticians, podiatrists, equipment services, mental health services and social care.

The aim of the service is to enable people to return home from hospital as soon as possible and to prevent further admission by ensuring that people can manage their long term condition and gain maximum benefit from rehabilitation to reach their personal potential and participate in activities that are important to them.

As specialist services we also provide training to other professionals, patients and their carers. This ranges from condition management sessions for individuals and small groups to delivering talks to national conferences.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>927</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>7,471</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>100%</td>
</tr>
</tbody>
</table>

New developments this year

- The team coped brilliantly with continuing to provide the service when the building they work from was out of action for three months after the drains collapsed.
- Review of referral process for NRS to increase patient therapy time, which has provided one central access point for NRS and NCST. These teams now work in closer partnership to ensure smooth referral to rehab services and provide closer partnership work to support our patients to manage their long term conditions.
- NCST has moved to fully electronic notes – meaning that the information is available to GP’s and other clinicians working with the patient.
- The physiotherapists within NRS have developed Aquatherapy as a clinical treatment for patients in partnership with local leisure centres.
- ESRT have developed continence assessment and support services specifically adapted for their patient needs.
- The Epilepsy Clinical Specialist has developed patient held information and records packs in partnership with MK Hospital and Epilepsy Action.
Community support groups have been developed for our brain injury and stroke service users.

**Plans for 2017/18**

- Continue the development of partnership work across the three teams to enable groups and clinics which will benefit patients and self-management of long term conditions.
- Develop and implement audit plans to support improved patient experience.

---

**Podiatry Service**

We provide services aimed at increasing patient mobility and independence and reducing the need for hospital admission. The service provides assessment, diagnosis and treatment and management of a broad range of foot pathologies and lower limb disorders. These include:

- Working with Milton Keynes University Hospital NHS Trust (MKUHT) to provide a highly specialised MDfT (multi-disciplinary foot team) managing patients with foot complications associated with diabetes.
- Minor surgery (nail surgery).
- Biomechanics assessment and treatment
- Monitoring and treatment of foot and lower limb conditions e.g. ulceration, injury and problems arising from conditions such as diabetes, vascular and neurological diseases. This includes managing foot pain.
- Providing footwear advice and orthotics as part of personalised care plans
- Advice on falls prevention and maintaining mobility and independence.

---

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>5,190</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>22,079</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>100%</td>
</tr>
</tbody>
</table>
New developments this year

In 2016 we started the MDfT with MKUHT; this is a multidisciplinary team focused on the diabetic foot and working with patients to develop the most effective course of treatment to prevent limb and life threatening complications of diabetes. In its first year the service has contributed to a reduction in lower limb avoidable amputation from 29 to just two.

In 2017 we have been successful in a joint bid with the CCG and MKUHT for additional funding to support this work. From September 2017 the MDfT Clinic will be running every week. We will be working with the front door teams at the hospital to better manage Active Foot Disease and this will include; weekend working for Podiatry; in reach work into the hospital, and a training programme for front line staff on the “Diabetic Foot Attack”.

Plans for 2017/18

From June 2017 the eligibility criteria for the Podiatry service will be changing, which will reduce the number of patients eligible for NHS funded podiatry care. This change will bring the MK services into line with other podiatry services nationally.

The service is looking at how it can continue to support these patients and is looking at whether it can launch a private podiatry service where patients will pay for treatment.

Musculoskeletal Assessment Service

A community-based physiotherapy service for adults in Milton Keynes with musculoskeletal problems. The service was established to provide an alternative to referrals to hospital orthopaedic services. The service has evolved over the years it has been running. There are two parts to the service.

The first provides a general adult orthopaedic lower limb, upper limb, and spine and neck service. It is run by a GP with a special interest in orthopaedics, along with two physiotherapists, an occupational therapist and two podiatrists.

The second provides a comprehensive pain management service for basic mechanical pain management, including:

- Conservative pain management measures
- Steroid injections to soft tissue and joints
- Sacro-iliac joints, facet joints and epidural injections

The service runs from locations in the south and north of Milton Keynes.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>2,171</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>6,133</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>97%</td>
</tr>
</tbody>
</table>

New developments this year

The team improved and expanded the pain management service.

Plans for 2017/18

The service was decommissioned in March 2017.
**High Impact Team**

The High Impact Team (HIT) is commissioned to reduce the number of Accident and Emergency attendances and hospital admissions from acutely unwell residents of 26 nursing homes in the Milton Keynes area. The service receives referrals from carers, staff nurses and GPs. However, there can be referrals from the Ambulance Service and social workers.

The team is made up of physiotherapists, nurses and health care assistants (HCAs). Each individual has undergone specific additional education in the accurate assessment and diagnosis of acute illnesses.

The physiotherapy staff are heavily involved in maintaining the respiratory health of care home residents. However, they also conduct extensive mobility assessments and monitor for the risk of falls.

The HCAs are a new initiative to the service, and it is intended that they will be involved in many of the functions that are performed by both the physiotherapists and nurses.

There is a strong educational component to the work done by the team, which involves both planned and unplanned teaching to the care home staff and other community-based services.

The role of the team is to make nursing home residents’ lives better. The team members do this by providing care and advice that reduces the need to go to hospital and the distress and disturbance associated with this.

### Activity

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>2,512</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>4,645</td>
</tr>
</tbody>
</table>

As many of the care home residents live with advanced dementia, it is very difficult to obtain accurate feedback from the patient group. Therefore, we are more reliant on obtaining feedback from the care home staff, GP’s and ambulance crews.

Overall, the feedback that the team receives is very good. Of note, it is recognised that when reviewing the feedback that the team has received all respondents are either satisfied or very satisfied with the service.

**New developments this year**

The team has increased its educational provision for the care homes, offering a number of different sessions, including vital signs, diabetes monitoring, management of dehydration and constipation. The training is focused on addressing topics that are relevant to the care home and the residents they care for. If their home has experienced high incidences of a particular problem, we will offer training that aims to prevent these in the future.

A programme of joint training with the Ambulance Service was initiated and undertaken. This venture focused on ‘red flags’ and reflection on previous 999 calls made by the care home staff.

A quarterly generated newsletter is created by the team, and circulated to all of the care homes that the HIT supports. The aim is to keep the care home staff up-to-date with the activities of the team and offer another medium for education and learning.

The team went through a period of recruitment, and now the HIT and its sister team Rapid Response have a broader base of clinical
experience. A number of staff have moved from critical and acute care to join the teams, bringing a different dimension to the services offered.

**Plans for 2017/18**

The High Impact Team will join the Home 1st team during 2017/18. Home 1st brings all the teams together to work as one team.

This process aims to develop a more flexible and responsive service, where patients in their own homes, and residents living in care homes will be referred to the merged service through the same referral pathway.

The commissioned service hours will increase and advice will be available through the night.

It is intended that the newly appointed HCAs will conduct follow-up visits for patients who are already on the service caseload and assist with triaging the care homes on a daily basis.

### Tissue Viability Service

The Tissue Viability (TVN) Service provides advice and guidance for patients presenting with complex wounds across the wider health economy, and supporting the District Nursing Service in the assessment of patients with chronic and acute wounds.

The focus of the Tissue Viability Service is the reduction of pressure ulcers, with the aim to be ‘no harm’ for patients in receipt of CNWL services in Milton Keynes. They do this by:

- Training and support for clinicians working in the community in Milton Keynes
- Assessing and advising on treatment of the most difficult cases
- Work with services to reduce the harm done by pressure ulcers
- Look at how pressure ulcers have come about and recommend improvements in practice to prevent them happening again.

Training is for all clinical staff in CNWL and care homes. The training ranges from identification and prevention of pressure ulcers to the assessment and management of complex wound management.

The team provide a series of clinics during the week, to see and treat patients. Often, the team will see a patient with their Community Nurse and together develop a treatment plan for recovery.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>793</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>1,718</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>100%</td>
</tr>
</tbody>
</table>
New developments this year

There has been a significant reduction in the development of pressure ulceration for patients cared for by the District Nursing Service, with a noticeable reduction in the development of heel pressure ulcers following the implementation of a low cost foam heel offloading device, which is available through the non-prescription AMCARE wound formulary. The Podiatry Service also has access to the device, which can be prescribed for patients using their services who are assessed as being at risk of heel pressure ulceration.

The Tissue Viability Service secured transport for one morning per week for patients to attend the Leg Ulcer Clinic for assessment and treatment of lower leg wounds and who are under the care of the District Nursing Service. The TVN clinic is supported by community nurses for training to increase skills in the management of Leg ulceration and of assessment of competencies following attendance at the two-day leg ulcer course.

Plans for 2017/18

The service wants to bring more patients to clinic for treatment and establish more clinics across the city.

The service will audit current practice and the assessment of patients. They will review practice and develop training to address any gaps in knowledge.

Early Intervention in Psychosis Team

Milton Keynes Early Intervention in Psychosis Team provides assessment and treatment for people aged 14-35 experiencing their first episode of psychosis. The team is made up of psychiatric nurses, an occupational therapist, a social worker and a psychiatrist.

The aims of the team are:

- The assessment and treatment of the symptoms of psychosis
- To provide a range of psychosocial interventions
- To provide support for family and significant others
- To work with other agencies to support the person.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new referrals seen</td>
<td>74</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>1,290</td>
</tr>
</tbody>
</table>
New developments this year

10 October 2016 – Early Intervention in Psychosis Team celebrated its 10th Anniversary. Very successful event attended by staff, patients, carers. A video of event can be found on https://www.youtube.com/watch?v=zRaWCv0bBzI and shows the positive impact that EIPT can have; and the dedication of the clinicians running the service.

Physical Health – the autumn of 2016 saw the initiation of Physical Health Clinics focussing on Rehabilitation and Recovery and EIP service users in Westcroft. The challenge of changing a culture for service users who thought / felt that physical health needs are attended by GP’s was gradually being overcome by running three successful clinics.

Plans for 2017/18

Working with Milton Keynes Council, the team is setting up a job club for service users.

The team is working towards creating peer support workers; this year they are looking at how to use the valuable skills of service users to act as volunteers.

The team will work with MK carers and other organisations to re-establish carers groups for mental health teams.

Recovery and Rehabilitation Team

Milton Keynes Recovery and Rehabilitation Team enables people with complex mental health needs to live safely in the community with the appropriate support.

The team brings together a range of healthcare professionals who have specialist skills in working with people who have complex and severe mental health problems. The services aims to deliver excellent integrated, recovery focused and evidence based health and social care.

The role of the team includes:

- Assessing, treating and reviewing symptoms
- Taking optimistic views about recovery-focused interventions
- Providing a wide range of psycho-social interventions and support
- Providing support and intervention for family and carers
- Assessing social care needs and providing social care services through personalised budgets
- Working in partnership with a range of statutory and non-statutory services.

All team members understand the distress that goes with mental illness. They can offer psychological support, encouragement and practical help to service users and their families and carers.

The team has a base where they can see people. They are also able to work in a range of other places, such as GP surgeries, day centres, hostels and people’s own homes.

The team provides focused and person-centred care over a longer period to enable individuals to remain supported within the community.
### New developments this year

The team has implemented a new physical health monitoring initiative to service users. The service was reviewed as part of the CQC community inspection and received a positive report.

Medical establishment review implemented in Q4.

### Plans for 2017/18

The new physical health interventions will continue to operate and the plan is for all services users to have received a health check by the end of the year. The service will develop an improvement plan, which will address access to therapies, care coordination, and pathways that take account of risk and safety as well as actions that respond to CQC recommendations.

### Milton Keynes Adult Speech and Language Therapy

MK Adult Speech and Language Therapy Team works with people across Milton Keynes who have communication and / or swallowing difficulties as a result of acute illness, neurological conditions, oncology diagnoses, ear, nose and throat conditions and aging.

The team provide an in-patient service to wards at Milton Keynes University Hospital, as well as in outpatient clinics, their own homes and occasionally in the workplace. The team is embedded in several multi-disciplinary teams throughout Milton Keynes Community Health services and Milton Keynes University Hospital.

As well as providing speech and language therapy, the team regularly delivers training packages throughout the community and hospital, to proactively support management of communication and swallowing difficulties in our local community by educating and training key workers, giving them new skills.

### Activity

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>115</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>5,712</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>83%</td>
</tr>
<tr>
<td>Number of referrals</td>
<td>1,926</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>3,274</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>100%</td>
</tr>
</tbody>
</table>
New developments this year

Ongoing staff shortages have limited the capacity for service development, but the team continue to evaluate service provision and respond to drivers of change and quality improvement.

Projects have included:

- reviewing of patient information leaflets
- successful business case to increase staffing on the Acute Stroke Unit
- updating of standard operating procedures across the service
- further development of training packages
- revision of the skills needed to work with patients with the Aphasia Competency Framework.

Plans for 2017/18

Service objectives relate to wider Specialist Therapy Services and CNWL objectives and include:

- To review demand and capacity across adult SLT services, including review of data collection
- To improve referral-treatment times
- To continue to develop, implement and evaluate provision of communication and dysphagia training in partnership with Milton Keynes Council and service users
- To update and improve written information for service users
- To incorporate outside innovations into current team working (ie the planning of transition from starch to gum-based thickeners, new IT)
- To implement the new Aphasia Competencies Framework
- To foster leadership throughout the team, as applicable to individual roles and potential.
Specialist Therapies Team

The team offers assessment and treatment for people with Serious Depression or Anxiety, Trauma, Obsessive Compulsive Disorder and Personality Disorder. The team offers evidence-based Talking Therapies, which enable the individual to:

- Understand their difficulties
- Choose ways to manage these difficulties
- Change through therapies, self-help and activities
- Achieve recovery as defined by the individual.

Interventions are mainly group-based and are underpinned by Mentalisation-Based Therapy (MBT), Cognitive Behavioural Therapy (CBT) and Dialectical Behavioural Therapy (DBT) and Risk Management.

Additionally people in therapy will have access to peer group and carer support. The team may also refer people to the adult mental health social care team for social care assessment and intervention to address eligible wellbeing needs in line with the Care Act.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>253</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>9,491</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>88%</td>
</tr>
</tbody>
</table>

New developments this year

Service is established and operational. A review of the service commenced in Q4 in order to address waiting times. An improvement plan was developed as part of this initiative.

Plans for 2017/18

The implementation of the improvement plan, including finalising the skill mix review of the team and recruiting new therapists into this will see a reduction in the waiting times.
Assertive Outreach Team

Milton Keynes Assertive Outreach Team works with service users who are difficult to engage and need help with activities of daily living or social inclusion. This may be because they are not taking their prescribed medication or may need motivation to attend activities.

The team provides support for people aged over 18 who have a primary diagnosis of severe and persistent mental disorder associated with a high level of disability, multiple complex needs and who have difficulty maintaining lasting and consenting contact with services.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number of patients first seen</th>
<th>Number of appointments / visits</th>
<th>Patient experience measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients first seen</td>
<td>9</td>
<td>2,850</td>
<td>100%</td>
</tr>
</tbody>
</table>

New developments this year

- Service established and operational.
- Medical establishment review implemented.

Plans for 2017/18

The service will be part of the Community Transformation Plan, which will be initiated in the last quarter of 2017.

Specialist Memory Service

The service offers a comprehensive psychiatric and neuro-psychological assessment of an individual’s memory, ensuring that if a diagnosis of dementia is made, the diagnosis is given as soon as possible. Following diagnosis the service offers post diagnostic support, which can include advice, information or guidance and is offered to the individual, loved ones or carers. The service provides therapeutic group work including Cognitive Stimulation Therapy and support for carers. Where required the service will make referrals to any appropriate services that are identified or assist in signposting to relevant organisations. The service also accepts referrals for individuals diagnosed with dementia that are experiencing, Behavioural and Psychological Symptoms of Dementia (BPSD), challenging or complex behaviour and require advice, support or management strategies. This service will be provided at the individual’s home address and appointments will be made at a time convenient to the individual, family or carer. The service also offers support to a wide range of settings in the local community including care homes and primary care.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number of referrals</th>
<th>Number of appointments / visits</th>
<th>Patient experience measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>690</td>
<td>2,159</td>
<td>94%</td>
</tr>
</tbody>
</table>

New developments this year

- The service was established and operational.
- The team moved to Stantonbury in the spring.
- A medical establishment review was also completed.
Plans for 2017/18

The service is working towards its re-accreditation of the Memory Service National accreditation process (MSNAP). The service received investment to provide a specialist Care Home Liaison Practitioner to work with care homes and acute hospitals. Further investments planned to expand this service to work into primary care and care homes and the acute hospital.

Staying Steady MK

Staying Steady Milton Keynes provides specialised assessment and treatment for people who have fallen or who are considered to be at risk of falls. The team offers tailored assessment, treatment and advice on how to reduce the risks of falling and helps people, primarily over the age of 65 years, to cope after a fall.

The service also provides training for health professionals, social workers and volunteers working with people in the community, as well as carers working in residential and nursing homes.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>1,546</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>2,487</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>100%</td>
</tr>
</tbody>
</table>

New developments this year

- New single point of access commissioned June 2016 which is run by B-Well Therapy; known as Milton Keynes Community based Falls Prevention service. They triage all referrals and based on identified need, forward the referral to Staying Steady MK or complete their own assessment.
- Staying Steady MK was known as Milton Keynes Falls Management and Prevention Service but the service changed its name in June 2016 to reflect the work that it does to help people remain steady when mobilising.
- Working with the new provider to meet the needs of people who have fallen or are at risk of falling.
- Referrals also accepted for people under 65 years of age where they are falling or are at risk of falling, for example due to an underlying medical condition.
• Staying Steady MK leads the Falls Operational Group, which is attended by representatives from health, council and voluntary organisations and changes have been made to include training to enhance knowledge about services and medical conditions.

• Developed closer working relationship with Intermediate Care services due to relocation of service.

• All leaflets reviewed following change of name.

Plans for 2017/18

• Based on feedback from attendees at the exercise group changes to the exercise book are to be made

• Continue to work with B-Well Therapy to develop services to reduce falls in Milton Keynes

• Continue to work closely with Home 1st

• Deliver a three-day training package to care home staff to increase their knowledge about falls and risk reduction in care homes. Staying Steady MK coordinate the training with sessions delivered by other CNWL, MK Council and voluntary services.

Patient Transport Services

PTS provides a non-emergency ambulance service for Windsor Intermediate Care Unit, Neuro Rehab Services, Podiatry and the Falls Service. In all cases, the service provides transport for patients to attend clinics who meet the following criteria:

• Where the medical condition of that patient is such that they require the skills or support of PTS staff during/after the journey

• Where it would be detrimental to the patient’s condition or recovery for them to travel by other means

• Where the patient’s medical condition impacts on their mobility to such an extent that they would be unable to access healthcare if they did not receive PTS

The service undertook 1,756 patient journeys during the year April 2016 to March 2017.

New developments this year

The service will provide transport for patients to attend the Tissue Viability Clinic.

Plans for 2017/18

The service will be looking for opportunities to serve more clinics and support patients with their transport needs.
Diabetes Specialist Team

The team supports the care provided by GPs and practice nurses. It manages the care of patients with difficult to control or complicated diabetes.

The service supports people who are struggling with their diabetes to self-manage their condition. People are seen in clinic or, in the case of housebound patients, in their own home.

Diabetes specialist nurses also support carers and those involved in the care of patients with diabetes, for example, staff in nursing or residential care homes.

The service also offers care for young people with Type 1 Diabetes and supports their transition from Children’s to Adult Services.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number of referrals</th>
<th>Number of appointments / visits</th>
<th>Hearing aids issued</th>
<th>Patient experience measures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>608</td>
<td>2,268</td>
<td>1,480</td>
<td>100%</td>
</tr>
</tbody>
</table>

New developments this year

The team has been working with Milton Keynes University Hospital and GP practices to develop a new service for Milton Keynes’ residents.

Plans for 2017/18

From April 2017 the team is working with the hospital diabetic team and the specialist diabetes team from Newport Pagnell Medical Centre to pilot a community-based integrated diabetes team.

Adult Hearing Service

We are small and innovative Audiology Service that constantly strives to provide a high quality hearing assessment and fitting service to meet the growing needs of the adult population in MK.

We have a modern approach to our pathway and are at the forefront of our use of Audiological technology in the NHS. All staff are multi-skilled allowing the team to work in a fluid way to ensure waiting times remain low.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number of referrals</th>
<th>Number of appointments / visits</th>
<th>Hearing aids issued</th>
<th>Patient experience measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total activity</td>
<td>1,289</td>
<td>5,010</td>
<td>1,480</td>
<td>100%</td>
</tr>
</tbody>
</table>

New developments this year

- We have been developing our website to include videos from various suppliers – this work is currently with the Communications Team
- Reviewing all our client literature to update and reflect our modern approach
- Introduced new style ear moulds which offer a more discreet fitting for people with larger hearing losses
- Working closely with commissioners to develop our service specification to provide value for money while maintaining our high standards of patient satisfaction and quality service delivery
Plans for 2017/18

- Using a 3D scanner to upload 3D images of ear moulds direct to the manufacturer in Poland – this will speed up the manufacturing process. Also if a client loses their ear mould within 12 months, they will not require a clinical appointment as we will still have the image on record.

- Developing a ‘carers’ information pack for family and carers

- We will be the first NHS community hearing service piloting ‘self-learning’ hearing aids – truly state of the art technology

- Trialling new style aftercare drop-in clinics for existing clients.

Wheelchair service

The service provides clinical assessments for manual and electronically powered wheelchairs; the service also assesses and provides custom/moulded seating services for people with mobility needs. The service is for adults and children who have permanent need of a wheelchair and require a chair for indoor mobility.

After carrying out mobility, postural and pressure care assessments for individuals with long term disabilities, the service provides the most appropriate equipment for each individual’s needs. The overall aim of the service is to increase mobility and independence.

All powered and manual wheelchair equipment is provided by Millbrook Healthcare, which is also responsible for the repair and maintenance of equipment.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new patients seen</td>
<td>288</td>
</tr>
<tr>
<td>Number of existing patients reviewed</td>
<td>571</td>
</tr>
<tr>
<td>Number of registered users</td>
<td>1,761</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>67%</td>
</tr>
</tbody>
</table>

New developments this year

The service was under notice to be tendered out and there were limited developments as a result to this.

Plans for 2017/18

A new service bringing together the clinical assessment (currently provided by CNWL), the supply and repair of wheelchairs will start in the autumn of 2017. CNWL will not be running this service.
Community Dermatology Service

The Community Dermatology Service is a nurse-led service but does receive support from a Consultant Dermatologist based in Milton Keynes. The service takes referrals from any clinician and sees both adults and children.

Clinics are run in GP practices around Milton Keynes bringing care of patients closer to home.

Patients have a wide variety of skin conditions and we offer advice on treatment and ongoing support to enable them to manage their conditions in the long-term.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>1,375</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>3,859</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>100%</td>
</tr>
</tbody>
</table>

Average wait time for first appointment is currently 40 days.

New developments this year

Changes in the team have seen two new part-time nurses recruited to the service as the Team Leader has reduced her hours.

Plans for 2017/18

Development of new staff to include undertaking a nurse prescribing qualification and a Diploma in Dermatology Nursing.

The service will be working in partnership with Milton Keynes University Hospital and the local Clinical Commissioning Group to look at the wider Dermatology pathway.

Continence Service

The continence Service aims to provide the following:

- Specialist adult continence assessments to any patient registered to any GP practice within the Milton Keynes catchment area
- Specialist advice and initiate any treatment plans within the scope of the service
- Continence related training to MK-CNWL community staff
- Specialist continence advice to staff, family and carers of any patient within our catchment area.

We also administer the “home delivery service” (provision of continence products to Milton Keynes residents either in residential care homes, nursing homes or their own home) ensuring safe and appropriate assessment of a patients continence needs.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>455</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>721</td>
</tr>
<tr>
<td>Patient experience measures</td>
<td>100%</td>
</tr>
</tbody>
</table>

We received in excess of 250 telephone calls per month, including home delivery queries, patient and staff enquiries and self-referrals.

We also offered bespoke training to staff and patients carers on an as and when required basis and promoted our service at a health fair.

Around 550 patients are registered on our case load at any given time.
New developments this year

The service increased the continence training available to clinical staff in CNWL who work with patients who have continence issues.

Work was started to create a new catheterisation policy and procedure to be adopted throughout CNWL.

Introduction of bariatric continence products to better meet patient’s needs.

Plans for 2017/18

The service will run a project looking at nursing homes. The aim is to improve the current process for continence assessment and product selection with emphasis on patient outcome. The team will be working with the Clinical Commissioning Group to find ways of reducing the cost of continence products without affecting the quality of care that patients receive.

We will look at how the service is organised to reduce the number of patients who do not turn up for their appointment.

Learning Disability Team

The Joint Learning Disabilities Service is an integrated service of health and social care professionals led by Milton Keynes Council. The Service consists of the Community Team for Adults with Learning Disabilities (CTALD), Day Activities, Learning and Work, Short Breaks Service and Shared Lives.

Services offered include:

- Specialist health assessments and treatment. Health professionals include: Psychiatry, Psychology, Nursing, Speech and Language Therapy, Physiotherapy, Dietetics and Occupational Therapy
- Social Care Assessments and reviews for service users and carers under the Care Act 2014
- Care Management
- Day opportunities (internally provided for those with ‘Profound and Multiple Learning Disabilities and or people whose behaviour may cause concern) and externally purchased activities and supported employment
- Short Breaks includes internal provision for those with complex needs
- Shared Lives (a partnership between an agency Shared Lives MK) and self-employed local people (Shared Lives carers)
- Services purchased from the independent sector

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>765</td>
</tr>
<tr>
<td>Number of appointments / visits</td>
<td>499</td>
</tr>
<tr>
<td>Social care assessments completed</td>
<td>90</td>
</tr>
<tr>
<td>Transitions from child to adult service</td>
<td>15</td>
</tr>
</tbody>
</table>
New developments this year

A series of changes have been implemented under a transformation programme to be delivered in two phases. The first phase has seen a change in the offer for day opportunities and Supported Employment and Short Breaks services.

Transforming Care plan delivered in partnership with Bedford and Luton (BLMK partnership).

Plans for 2017/18

The plans for phase two of the transformation programme includes:

• Reviewing the Community Team for Adults with Learning Disabilities in line with best practice
• Supporting more people where possible to move into their own accommodation rather than residential care
• Supporting more people with learning disabilities into employment

The implementation of the clinical patient record system, SystmOne, that is used by local GPs and other health services.

Inpatient care

Campbell Centre

The Campbell Centre is a 38-bed acute inpatient mental health unit. It has two wards, Hazel Ward and Willow Ward. These are mainly for working-age adults who require a hospital admission when suffering from a mental health problem. The wards are staffed 24 hours a day and the team consists of nurses, occupational therapists, doctors, pharmacy staff and domestic staff.

A range of therapeutic activities are available both in groups and as individuals and support is also given to families through our family support service. There is access to the Citizens Advice Bureau and regular surgeries for both housing and carers support.

The unit works closely with the Milton Keynes Home Treatment Team and all the other community based services to ensure a smooth transition between services.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of admissions</td>
<td>467</td>
</tr>
<tr>
<td>Occupied bed days</td>
<td>11,854</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>26 days</td>
</tr>
<tr>
<td>Bed occupancy</td>
<td>86%</td>
</tr>
</tbody>
</table>
New developments this year

The Centre went Smoke Free in October 2016. A new gym has opened in the Centre for patients; this is part of the push for greater physical health amongst people suffering mental ill health and recognises the value of exercise in promoting wellbeing. This initiative has been developed with the MK Dons who provided the training.

Two peer support workers were recruited in Q3 to the unit to improve the patient experience and work towards recovery objectives.

Plans for 2017/18

The peer support workers are developing a patient notebook for the centre, which is co-produced with service users. The unit has also provided multi-agency awareness training on ‘Living with Psychosis’ which has received excellent reviews. A resource pack is also in development to support discharge, providing information on activities in the community that enable re-integration and develop an individual’s build recovery capital – an important aspect of building resilience and avoiding isolation.

The Older Person’s Assessment Service (TOPAS)

The Older Person’s Assessment Service (TOPAS) is a 20-bedded ensuite unit, staffed by qualified psychiatric nurses and healthcare assistants. The service provides assessment and treatment predominately for older people who have complex or acute mental health needs.

The service supports people to return to independent living wherever possible.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of admissions</td>
<td>55</td>
</tr>
<tr>
<td>Occupied bed days</td>
<td>6,306</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>172 days</td>
</tr>
<tr>
<td>Bed occupancy</td>
<td>77%</td>
</tr>
</tbody>
</table>

New developments this year

A new medical team was recruited to the service in Q3. The service was subject to a CQC inspection and received a positive review. An action plan was developed based on the CQC recommendations.

Plans for 2017/18

The Directorate is undertaking a Healthy Ageing review which is designed to develop community resources for older persons that will reduce inpatient admissions. This work will be co-produced with, service users and carers, MK CCG, MK Council and CNWL clinicians.
**Cherrywood Mental Health Rehabilitation**

Cherrywood Mental Health Rehabilitation Unit provides short-term (up to one year) residential rehabilitation to help service users return to independent living. The unit enables people with severe and complex mental health problems to gain or regain the confidence and skills in everyday activities, which will enable them to fulfil their potential for recovery and independence.

The team provides support for people who:

- Are residents of Milton Keynes or registered with a Milton Keynes GP
- Are over 18 years old
- Have severe and complex mental health problems and are eligible for secondary mental health services.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of admissions</td>
<td>7</td>
</tr>
<tr>
<td>Occupied bed days</td>
<td>2,187</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>90 days</td>
</tr>
<tr>
<td>Bed occupancy</td>
<td>92%</td>
</tr>
</tbody>
</table>

**New developments this year**

An additional bed was created at the facility. The service now offers seven rehabilitation placements. A medical establishment review was also completed in Q3.

**Plans for 2017/18**

The unit will provide placements within the PEP scheme initiative.

---

**Windsor Intermediate Care Unit**

The service provides 19 beds for the rehabilitation/reablement of local people over the age of 18. The unit admits people from acute hospitals who do not need acute hospital care, but need more help to be fit enough to go home; it also admits patients from their own homes who require rehabilitation but do not need a hospital bed.

Staffed by nurses, rehabilitation assistants, a physiotherapist and assistant: an occupational therapist and assistant: a nutritional assistant, a housekeeper and a ward clerk.

A GP supports the medical needs of patients in the unit and is in the unit for two hours each day Monday-Friday. Telephone advice and visits are available for urgent issues at other times.

Referrals can be made to social workers, dieticians, speech and language therapists, a psychologist and specialist neurology nurses.

Therapy activities are run seven days per week.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of admissions</td>
<td>210</td>
</tr>
<tr>
<td>Occupied bed days</td>
<td>6,395</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>30 days</td>
</tr>
<tr>
<td>Bed occupancy</td>
<td>92%</td>
</tr>
</tbody>
</table>
New developments this year

The service extended the provision of rehabilitation to include weekends.

Plans for 2017/18

MKCCG is consulting on the future of community beds in Milton Keynes and we await the outcome of this exercise.

CNWL is trialling the use of virtual beds – giving the same therapy and care input for a patient at home as they would receive in a rehabilitation bed to enhance independence and promote early recovery and the ability to stay in their own home.