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1 Foreword

Hello! I’m Jane Hannon, the new CNWL Managing Director for the division that runs community and mental health services across Milton Keynes.

Joining me in the Divisional management team is Medical Director Dr Simon Edwards, who leads on Quality Improvement across the Trust, and Nursing Director Louise Morton.

The two service directors in Milton Keynes will be known to many people locally – Lesley Halford for Mental Health Services and John Culley for Community Health Services.

Lesley is currently overseeing a transformation of community mental services while John is overseeing a transformation of District Nursing Services.

I am impressed with the people I have met and the services I have seen and I am enjoying getting to know and understand Milton Keynes better. What is clear to me is the importance of relationships and partnership working, both across Milton Keynes and more widely.

Partnerships are vital to enable us to deliver good quality services for local people. We rely on joint working with patients and their families, with staff and with other organisations, such as the people who commission (‘buy’) our services, social services, GPs, universities and the voluntary sector.

In Milton Keynes, examples of partnership working include the Home 1st service, working with Milton Keynes Council, and our joint programmes with the Bedford, Luton and Milton Keynes (BLMK) Sustainability and Transformation Plan (STP). We are reshaping our mental health services to work more closely with GPs and services in primary care. These joint programmes will become ever more important as the year goes on.

We have seen investment in some of our mental health services and there is promise of further growth as part of the NHS Long Term Plan. We look forward to taking the opportunity to develop, expand and improve our services so that we can offer care and treatment to more people and meet the increasing demands on our health and care services. I am in awe of the considerable achievements of CNWL MK staff teams over the last year. Colleagues have worked tirelessly, in the most varied of settings despite many challenges, and I thank everyone for their dedication.

I would like to extend my ‘hello’ – with my thanks – to those who are the reason we are here; our patients and their families. I look forward to talking to you about your experiences and how we can work together for even better services.

Jane Hannon
Divisional Managing Director.
2 Introduction to CNWL and Trust Objectives

CNWL is a large community-facing Trust, caring for people with a wide range of physical and mental health needs in a variety of settings (hospitals, clinics, schools, homes, prisons) for every age. We are the eighth largest provider of mental health and community care in England, rated by income.

We also provide specialised services to communities outside those areas.

We are rated as overall ‘Good’ by the CQC with outstanding services in Learning Disability and Sexual Health.

We have nearly 7,000 staff providing a range of mental health, community, learning disability, substance misuse, sexual health, dentistry and specialised services to a population of around three million in the South East of England, including in North West London, Surrey, Kent, Milton Keynes and Buckinghamshire, treating around 300,000 people either in the community or as inpatients.

CNWL’s services are mainly within three of the 44 regional Sustainability and Transformation Programmes (STPs) for England. STPs are catchments or ‘footprints’ within which all the health and social care community needs to work together with shared objectives and shared financial goals.

For more information about the range of services we provide and how to contact them, please look up https://www.cnwl.nhs.uk/find-hospital-ward-clinic-locations/.
The year in numbers

47,926 patients
396,354 appointments
788 people admitted to our beds
2,899 babies supported (new baby visits completed in 14 days)
4,390 admissions avoided

CNWL employs 1,080 people in Milton Keynes

75% of patients in rehabilitation reported an improvement
94% of people referred to our mental health early intervention services are seen within two weeks
94% of patients would recommend our services a friend or family member
Review of the year

4.1 Performance

Mental Health services

It has been shown that people with a mental health problem don’t always feel able to look after their physical health and as a health service we often perpetuate this. We are committed to addressing this inequity and carry out Physical Health Assessments and Interventions for people with a mental health problem for more than 90% of our patients.

By the end of 2018/19, the Milton Keynes Improving Access to Psychological Therapies (IAPT) team was successful in achieving the 19 per cent access target for people with a common mental health condition accessing our Psychological Therapies Services.

The CAMHS service was not able to hit national access targets in 18/19 which prompted a service redesign project to improve capacity going forward.

People with a mental health problem are often vulnerable after they have left hospital. Discharge of patients from hospital is a recognised risky period and national guidance recommends clinical review within seven days. As of March 2019, all of our former inpatients were followed up within seven days of leaving hospital, whether in person or a phone call to see how they are doing.

Adults and Older People’s Services

The District Nursing service has consistently met its target that 95% of urgent patients being seen within the 24 hours of referral and 48 hours for non-urgent.

Patients referred to the Adult Hearing Service should wait no longer than six weeks for a diagnostic assessment. This is the case for 99% of the 3,500 patients referred to the service each year.

Children’s Services

All children and young people referred to our specialist children’s services were seen and started their treatment within 18 weeks of being referred.

Service Successes and Innovations

- The Home 1st CNWL and Milton Keynes Council evaluation demonstrated that this service avoided 1,200 admissions in three months, generating a net saving of over £3m to the health and social care system over a year. (You can read more about Home 1st on page 13.)
- CNWL provides a Core 24\(^1\) Mental Health Hospital Liaison Team (HLT) at Milton Keynes Hospital. The service sees almost four in every five patients within one hour, and receives about 200 referrals per month.

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\(^1\) Core 24 is a liaison mental health service model provided 24 hours, 7 days a week; it is commonly provided across urgent and emergency care pathways.
A Liaison and Diversion service was established in Milton Keynes. It aims to identify vulnerable people early on to help improve health and criminal justice outcomes. The service works with Berkshire Health NHS Foundation Trust as a part of a Thames Valley-wide service. Operating from Milton Keynes Court and Custody Suite, the service is open to patient of all ages.

CNWL improved their Perinatal Mental Health service for women across Milton Keynes to support more vulnerable mothers and babies. The service also supported the roll out of this service across both Bedfordshire and Luton, as a part of an STP-wide initiative. An NHS England (NHSE) evaluation meeting and review heaped praise on the service and the work they do.

The High Impact Service User (HISU) project, which was delivered in partnership with health, social care and third sector organisations across Milton Keynes, was a national finalist in the National Patient Safety Awards. This is as a result of the huge impact the team makes on the lives of the patients they support, as well as the difference they’ve made in reducing patient need for unplanned and emergency care, whilst also releasing significant financial savings across Milton Keynes to be reinvested in to improving services.

CNWL has been key to the development and trialling of Integrated Community Support Teams (ICS Teams) across Milton Keynes. We initiated a ‘fail-fast’ pilot in one GP Network to prove the impact of this service on patients’ health and wellbeing, as well as reducing demand on A&E and finances. This model is now being rolled out across the city with the new Primary Care Networks (PCNs).

We are piloting Mental Health practitioners working with South Central Ambulance Service to divert patients to more appropriate services. This is in advance of similar plans nationally under the NHS Long Term Plan.

Primary Care Plus, which provides increased mental health support for primary care, is being rolled out to all MK surgeries following a successful pilot and evaluation. The service helps to reduce referrals by GPs as more patients can be managed in primary care, as well as to help people to be stepped down from secondary care services to their GP. (You can read more about this service in the Primary Care Plus on page 11.)

Six of our Queens nurses have established a forum aiming to embed the Nursing Strategy. We are looking to double the number of staff applying to be a Queens Nurse over the next year.

**Partnerships**

CNWL has developed strong links with health and social care partners across Milton Keynes and the wider Bedfordshire, Luton and Milton Keynes (BLMK) integrated care system (ICS). As well as working with health and social care commissioners and providers, we work with HealthWatch to review our services as a part of our continuous improvement programme. HealthWatch have recently commented on how welcoming we are of their work and how open and transparent we are as a provider.

Our Community Dental Service is working with services in Berkshire and Oxfordshire to develop an Integrated Dental Care Service (ICDS). The ICDS will offer safe, responsive and effective specialist dental services to vulnerable people across the Thames Valley area.
CNWL works with East London NHS Foundation Trust as our counterparts across Bedfordshire and Luton to support the BLMK Mental Health Investment Plan and performance delivery against the National Mental Health Five Year Forward View.

We are a key member of the various groups and forums across both the STP and Milton Keynes who are working to deliver the ambitions of the Long Term Plan.

**Patient Feedback**

In terms of 2018 Community Physical Health Survey (unique to CNWL):

- 99% of people said they were treated with dignity and respect. 95% said they had confidence in the people treating them
- 94% overall said overall very good experience of service
- 95% were able to get an appointment
- There was a 6% improvement in people knowing who to contact in they had any concerns. Improving this was one of the targets from last year’s survey.

Across all services in Milton Keynes the Friends and Family Test (FFT) score was 94.10%. MK Community Services consistently score over 95% for the FFT question (January 98.77%, December 97.22%, November 97.03%)

In the 2018 MK Mental Health community survey, our patients reflected increased satisfaction with our services. For example, we identified that there were 13 questions where a 3% improvement on the previous score was noted.

- 92% said we explained treatment or therapy in a way people would understand – 12% above national average
- 97% also knew who to contact with a concern

**Workforce**

Throughout 2018/19 we have identified a number of opportunities to skill mix across roles and teams in response to service and commissioner developments, updates to guidance and to address historical recruitment challenges. There have touched on a number of our workforce groups including Nursing, Psychology and Occupational Therapy.

Our Home First service placement programme was awarded Placement of the Year by Health Education England Thames Valley

We have also successfully planned initiatives to build on this in 2019/20:

- We will be employing and training 10 Advanced Clinical Practitioners. They are highly trained clinicians with the knowledge and skills to take on wider roles caring for patients. They have advanced qualifications and the experience to work independently.
- We will be employing newly qualified nurses into rotational posts – giving them the chance to work in a number of services for six months at a time. The aim is to attract high quality staff to posts that are normally difficult to recruit to.
Clinical quality

CQC Regulation and Compliance

In 2019, the Trust received a CQC inspection which included a review of MK Mental Health community and inpatient services. The Trust was received an overall rating of ‘Good’ and this included an improvement under the ‘Safe Domain’ from ‘requires improvement’ to ‘Good’.

Examples of Positive feedback:

Staff across several services were praised for their supportive, caring and attentive behaviour: “I was in receipt of prompt, professional and caring support very quickly after my stroke. This, I feel, was paramount to get me back on my feet and re-build my confidence.”

Strong communication was a recurring theme, with many patients saying how helpful it was to be kept up to date around appointment times and to be given clear and full explanations about their care and treatment, with time to discuss and ask questions “Such a level of care and kindness, everything was explained so perfectly from reception to the dentist and nurse.

Themes from Complaints:

We also noted that the rate of concerns per 1,000 patients decreased slightly from 0.90 to 0.28 and the rates of complaints decreased from 1.04 to 0.23 per 1,000 patients. Complaints received centred on staff attitudes and communication

Actions taken: staff received training to improve their knowledge regarding eligibility of patients for district nursing services and knowledge of what else can be offered to patients within the service line; a written protocol on the use of the patient hearing booth at the Adult Hearing Service was put in place to reduce the potential for injury; Health Visiting staff attended a Baby Friendly Initiative’ to increase awareness and knowledge.

Learning from Complaints:

The parent of a Paediatric Speech and Language (SLT) patient who had recently moved into the area had been having regular speech therapy prior to him moving to Milton Keynes. His sessions had reduced and with very limited speech he was struggling to communicate. The parent felt that this would impact on all areas of his life and asked for appointments to be booked in a timely way, with goal setting, and for this information to be communicated with all professionals. The parent left contact details. Staff raised this as a concern on Datix. Following investigation it was found that the patient had attended an appointment in September and was on the waiting list for 1:1 therapy. The patient attends a private nursery out of the Milton Keynes are therefore the SLT are unable to visit. The manager explained this to the parent and advised that targets can be set and the nursery can call SLT to discuss. The manager identified that the parent was not accessing any Early Support services from Education. They have now made contact with the parent to look at the support that can be given. The parent has e-mailed the SLT manager to thank her for her help.
Patient Involvement

Patients and carers continue to attend local physical health steering groups. Work continues to support carers’ knowledge and education around a range of care aspects including continence, nutrition, end of life and pressure ulcers. Milton Keynes Community HealthWatch were invited to the WICU (Windsor Intermediate Care Unit) to evaluate patient feedback and have used this information to consider how the service is redesigned and developed, for example the introduction of ‘recovery’ type goals. #The Big Convo MK has been launched to coproduce a transitions process. In response to a patient consultation exercise, the District Nursing service introduced a single point of access. In Dental Services, photo boards, with Makaton symbols and ‘easy read’ leaflets have been developed.

5.2 Milton Keynes Mental Health

Learning from Complaints:

The main learning taken from the complaints was to give patients more time and for staff to provide all the relevant information about services, pathways and crisis teams on discharge so that delivery of care is not delayed. The Campbell Centre is improving support provided to people with Asperger’s or Autistic Spectrum Disorder.

‘You said we did’ example from Specialist Therapies Team Milton Keynes

A patient had been on the waiting list since 2017 and the lack of updates regarding the waiting list times had left them feeling forgotten and unwanted. The service manager spoke with the patient and assured them that they are on the waiting list and nearing the top. They apologised for the wait. A nurse from the team has offered a review appointment to consider their needs for the remainder of the waiting time. The welcome /referral acceptance letter has been reviewed since the patient was referred and it provides more details of wait times and what to do if concerned.

Patient Involvement

The Early Intervention in Psychosis Team (EIPT) in Milton Keynes offered a seven week programme for carers to share understanding of psychosis and possible interventions within a safe non-judgmental setting. This gave an opportunity for carers to grow in confidence and feel better equipped to support their family member whilst caring for their own emotional wellbeing.

The CAMHS Liaison Intensive Support Team (LIST) in Milton Keynes was nominated for the Diggory Excellence in Wellbeing Award due to increased service user engagement by involving them in interview panels and changes to the waiting area.

The Perinatal Mental Health service is working alongside the local Maternity Voices group for co-production of service information to the wider community

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2 Makaton uses signs and symbols to support spoken language for people with communication difficulties. Makaton really can help. Makaton takes away that frustration and enables individuals to connect with other people and the world around them.
and presenting at Clinical Conversations, organised by ICS Bedfordshire, Luton and Milton Keynes Mental Health.

The Trust has baby feeding peer volunteers (including a number of ex-service users) who have been trained to support new mums.

The Directorate has engaged with BAME communities through invitations to local community group meetings and local parish Breakfast Clubs.

The use of Peer Workers has grown and this is having a direct impact on patient experience, with Peer Workers transforming the programme of activities available on inpatient wards. Peer Workers have also been involved in the design and delivery of an on-site Recovery and Wellbeing College.

6 Our services

6.1 Specialist memory services

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.

Patient stories and comments

May 2018

A carer was having difficulty getting a repeat prescription from their GP Surgery despite the details having been given from Specialist Memory Services (SMS) previously. A member of the Admin team called the GP surgery as the carer was very upset and frustrated and arranged for the prescription to be prepared and sent to the Pharmacy. The carer then received a call first from the GP surgery and then 10 minutes later from the Pharmacy to say that the medication was ready for collection. The carer called to say a huge thank you for the prompt and caring action and explained how it had turned her from tears to happiness.

Aug 2018

(from) Senior Link Worker for P3 Charity - People Potential Possibilities

Thank you for your support with Client A. When we first met with you at the memory clinic, I found your approach both professional and empathic. It was
very good to get a diagnosis on the day and as you had explained the process before hand, the whole experience was smooth, calm and generally pleasant. And a big thank you for attending the professionals meeting.

Oct 2018
(From wife of service user R complimenting the allocated practitioner (SQ) who organizes social groups for Young People Diagnosed with Dementia (YPWD).

The activities that YPWD-MK have organized encourage families to get together. This allows relationships to be made with an understanding of what everyone is going through. At the last event a member of staff met a daughter whose dad had dementia. Her insight gave a greater understanding of the possible reasons R is giving us [the family] such a hard time.

The activities you have arranged have been fun and allowed everyone to participate to their own level. They are activities that maybe older people would not be interested in. this was particularly pertinent when D was still doing well and he still talks about your walking group. D and I appreciate everything that you all have done with this group...

Feb 2019
Thank you for running the course. My mother Joan although initially reluctant enjoyed the participation. This has given her the confidence to join a fortnightly memory group, and the weekly Alzheimer's group. Without your support, she would not have been willing to join these. Thank you for your kindness and the help you have given. My mum has been much happier, and it has helped her move forward more positively.

March 2019
The call below came about as part of a Quality Improvement project

Telephone call received from a patient’s daughter thanking us for the Post Diagnosis Information Session she attended yesterday (21.03.19). She said it was very formative session and she gained a lot of information which will be helpful along the family’s journey with Mum who has been diagnosed with Alzheimer's. She stated the whole journey with the Specialist Memory Service has been a very personal, calming and helpful process and wished to thank all the team.

6.2 Primary Care Plus

Primary Care Home is an innovative approach to strengthening and redesigning Primary Care services. The model brings together a range of health professionals as part of a wider multi-disciplinary team to work together to provide an holistic approach to enhanced personalised and preventative care for their local community.

It is important to note that 90% of mental health service users are seen in GP practices for health issues and therefore there is a real opportunity to provide mental health services on an equal setting to other types of clinical interventions in a non-stigmatized setting. This new approach also provides a platform to
forge closer working relationships with GPs and other primary care clinicians, building mental health awareness and capacity in these settings.

The operational context to this model is for staff to come together as a complete care community – drawn from GP surgeries, community, mental health and acute trusts, social care and the voluntary sector – to focus on local population needs and provide care closer to patients’ homes.

**June 2018**

From a GP

"The Primary Care Plus service is excellent so please do continue to expand this"

**Dec 2018**

Feedback from patient in phone call to Mental Health Service Director

Without help of PCP team, patient doesn't know what would have happened. She feels safe now and has emergency numbers if feels low. Her whole experience of being with PCP has changed things for her. Everybody was just brilliant. 'Didn't make her feel that she was a waste of their time'. Went on to say that 'Mental Health gets a lot of bad press but that is not her experience. Very grateful for what they have done. They have saved her.'

**March 2019**

Patient feedback

The service is really great! Staff are extremely compassionate and treated me with utmost care. I am receiving amazing help.

**6.3 Perinatal care**

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 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.

Nov 2018

Feedback from a patient

Comment from Perinatal POEM (Patient Rated Outcome and Experience Measures)
Thank you for making me so much better and giving me my life back. I was at rock bottom after my beautiful baby was born and now it all feels like a dream. Thank you for believing in me and working so hard to improve my life, it means the world and I could not have made such a fast and brilliant recovery without you all.

Feb 2019

Feedback from a patient

Feedback received from Perinatal POEM (Patient rated Outcome and Experience Measure):
The service led me through a journey pre-pregnancy to post-natally and provided me with the information I needed to make informed decisions; this gave me reassurance at anxiety provoking times. The service responded quickly to avoid escalation of my symptoms, managing my mental health when I faced 'blips'. Professionals acted with open and honest conduct which made me confident in their ability to assist particularly where there could have been paranoia on my part. Professionals were sensitive to historical issues and realistic about the intervention and care I would receive; this was assessed at regular intervals and response was appropriate to the situation at the time.

Feb 2019

Feedback from a patient

Comment from Perinatal POEM (Patient Rated Outcome and Experience Measures)
"I think that Perinatal team is brilliant and work very well on what the patient needs. If I didn't address my childhood trauma I would only be in a slightly better place. Because I done trauma therapy I'm in the best place mental I've
ever been. They need to continue addressing the patient main issue and the rest will fix as well”.

6.4  

**Home 1st**

The Milton Keynes Home 1st Service is a jointly delivered service between Central and North West London NHS Foundation Trust (CNWL) and Milton Keynes Council (MKC). It is a 24-hour service that provides fast access to nursing, therapy and reablement to help local residents remain safe and supported in their own home. It promotes continuing independence and hopes to reduce the dependence on long-term care.

A review by CNWL and Milton Keynes Council (MKC) showed that the team is a success in the quality of care given, the work it does supporting people home from hospital and preventing them being admitted to hospital.

The vast majority of patients discharged from the service, 83 per cent managed to stay at home rather than be admitted to care. Within this, 59 per cent of service users under the care of the reablement team, which helps clients recently discharged from hospital to live independently without a formal care package. Seventy-one percent of service users on the therapy pathway had an improved rehabilitation score.

The feedback below is feedback from a relative received in January 2019.

‘Throughout the whole experience we felt that helping [the patient] was their priority. They were able to give her the time she needed whilst managing what must be a very busy and demanding schedule. They made [the patient] (and me) feel that she and we mattered as people, not just clients/patients on a list. They explored options for various aids and also communicated with other professionals on [the patient’s] behalf. In short, they were a credit to your company and, in our opinion, are role models for others. They gave us complete confidence in their judgements and advice, which is so important to people in our situation.’

Other feedback from a Home 1st patient…
She listens to me; she understood how I feel and the most important thing she said she’s not giving up on me.

6.5 District Nursing

As part of the transformation, skill mix and staffing structures are also being redesigned to enable the service to work more efficiently and meet the needs of our patient population in a holistic manner. We are in the process of undertaking a Visible Nurse Leadership Programme, which will help us to identify gaps in the service, areas for development and recognition for best practice and innovation. From this, we will be able to identify immediate focus areas and build upon reshaping in order to provide better standards of care to our patient group and an improved working environment for staff members.

Community nursing services, including District Nursing, have moved from keeping paper records relating to patients to electronic records, enabling record sharing and allowing professionals to have up to date information regarding patient conditions and interventions.

Feedback from a District Nursing patient

During my Chemo treatment, the district nurses have been my rock and are always there when I need them.

6.6 0-19 services

The team is made up of integrated Health Visiting and School Nursing teams working across four geographical localities in Milton Keynes.

The service mainly involves:

- Full delivery of the Healthy Child Programme to children and young people aged 0-19 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’
- Advice and support to children, parents and teachers with a variety of complex health issues
- Targeted support for children, young people and families

Intensive and multi-agency packages of support where additional health needs are identified.
The service has developed a successful Single Point of Access (SPA) and which offers availability of a duty Health Visitor during core 9-5 hours.

A ‘choose & book’ style system is in place for universal developmental assessments allowing choice and flexibility for parents to attend.

Well baby clinics available each morning and afternoon Monday – Friday across the city.

Feedback from a mother using the Health Visiting service:

I feel very supported and surrounded by people who genuinely cared and did their best to advise and help.

7 Quality Improvement in Milton Keynes 2018/19

7.1 What is QI?

Frontline staff, along with the people who use our services, and their carers are the experts and best placed to be able to identify, test and drive what changes need to be made to improve quality. It is about working differently, not harder. The aim of our QI programme is to encourage a culture of continuous learning and improvement. We have partnered with the Institute for Healthcare Improvement (IHI) to help us with this piece of work. The IHI have a long and successful track record in supporting improvement projects both nationally and internationally.

This has been a really busy year for QI across the Trust, and the story of QI in Milton Keynes reflects what we see elsewhere.

Over the year we have seen a shift from a small number of projects led by senior managers who attended the first Improvement Science into Action training, to projects being led by team leaders and other members of staff within frontline services. At the end of the year about a third of all QI projects within Diggory Division were based in Milton Keynes. Such is the enthusiastic uptake of staff that a regular QI forum kicked off in September 2019 with the specific aim “to share learning, explore QI tools and support staff to gain confidence in using QI methods”. These have been spread across all services. Some data from a small selection of these projects has been going on is included in the following paragraphs as an example of the great work that is going on across Milton Keynes.

One project set out to explore whether improving care planning and collaboration between services may improve clinical care, wellbeing of patients and reduce A&E attendances. The data they collected showed that their change ideas have made a difference.

As part of the commitment to this work, we are investing in training.

Reducing the length of stay within the Windsor Intermediate Care Unit (WICU) which has incorporated the Red to Green Approach - is a national initiative - aimed to reduce the average length of stay (LOS) for patients. At the WICU we have been successful at reducing our LOS from 28.6 days to 25 days or less. The experience gained from doing this project has allowed staff to use their new found knowledge in initiating many more projects to improve the services we
provide. Working collaboratively with service users and carers helps to ensure that we develop appropriate information, designed by users for users of our service. (see My rehabilitation Journey below)

The pharmacy team in our acute mental health wards (Campbell Centre) set out to increase patient counselling on medication at discharge from the unit. Their data shows they have achieved their aim of 90% and they plan further work to ensure this is maintained over the coming months.

These give just a flavour of the work that has been going on in the last year.

A number of services will build on initial QI work and our focus for the coming year is on service user involvement and patient safety projects. Our in-patient units, for example, have been contributing to QI charts which are being used to monitor restraints and interventions. This work will be developed further in the next 12-18 months through the Trust wide QI project on reducing falls as well as violence reduction. This will involve many more staff receiving training and working alongside coaches and patients to improve safety within our inpatient settings. In the community projects are being set up to improve management of pressure ulcers.

We have seen a rise in the number of new projects getting started in recent months. CAMHS are using QI to support work to reduce waiting lists and Community Services are identifying a number of projects where QI will support them to make service improvements.