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Foreword

Working for the NHS across Milton Keynes is a fantastic privilege.

There is a special and close-knit community here, which I get to experience through the prism of the health service.

I get to see the day-to-day efforts teams make to improve patient care under the most trying circumstances.

In this second Milton Keynes Annual Report you will come to understand more about the work we are doing and while we will never rest on my laurels, I am proud of the efforts staff have made in spite of rising demand.

Across Milton Keynes, we have risen to the various challenges thrown our way, continuing to deliver care to around 47,000 people across a variety of services. For this I salute our staff for all they do all the time.

We have a lot of good news stories to tell about care in Milton Keynes.

Among these, I am particularly delighted at the reception the local community has had towards our early intervention mental health service – Primary Care Plus – which has helped fill a gap that previously existed across Milton Keynes.

Healthwatch Milton Keynes’ Primary Care Plus Review found that service user feedback for the early intervention mental health service was overwhelmingly positive, demonstrating the impact on wellbeing of people getting the right treatment at the right time for them.

Recognising its importance, we are looking to further grow this service.

Across the Trust our efforts in improving services have been recognised by the CQC, which has rated CNWL ‘Good’.

The Community Mental Health teams across Milton Keynes have focused on improving Safety, with recommendations made in Milton Keynes specifically to improve lone working and oversight of safeguarding adults’ referrals.

This improvement work included a ‘Skyguard’ mobile device for use when staff are community working and handheld alarms for use in our premises.

This year a feature of our work and transformation has been our Quality Improvement (QI) journey - a proven methodology for working with staff and patients throughout the Trust to identify and deliver improvement in how we deliver care.

Projects have spanned an array of topics including improving the patient and carer experience at the Windsor Intermediate Care (WICU) and improving patient safety at the Campbell Centre. The next wave of development includes the training of QI ‘coaches’ to provide staff working in services with ‘hands on’ support to get projects up and running.

We continue to have a focus on improving care to patients with enduring and severe mental illness by improving access to physical health assessment and interventions.

People with serious mental illness (SMI), such as schizophrenia and bipolar disorder, die earlier than the rest of the population due to preventable disease.

Across Milton Keynes, our Recovery staff in Milton Keynes have been visiting patients from community mental health services at their homes to take various health checks, such as blood pressure, blood tests and to discuss lifestyle choices at the same time as care co-ordinators visit patients to check their mental health.

This demonstrates a cultural shift for staff and patients. The next stage of work will be to refine packages of care for those most at risk of weight gain following the prescription of anti-psychotic medication.

The development of support groups for people with psychosis, including walking, support and social groups has been positive. There is an improved access to carer support, psychological therapies and family interventions.

In Milton Keynes community services the focus of work has been to improve patient safety and learn from pressure ulcer incidents.

In both community health and community mental health services, patient experience surveys have been undertaken.
In MK community services consistently good feedback was received from our patients who built on the success of the 2016/17 survey to demonstrate that we continue to provide a high level of service that is tailored to individual needs.

In MK community mental health services we showed improvement from the previous year in planning and reviewing patient care; however patients also reflected that improvements to crisis care and support with health and wellbeing needed improvement.

We have streamlined the referral process and simplified the urgent care pathways, while we also developed Primary Care Plus.

I need to finally mention new ways of working and partnership working, which is increasingly important across our patch.

We have seen this with the Home 1st Service, which we are running jointly and successfully with Milton Keynes Council, while we are making plans with our partners in the local Sustainability and Transformation Plan (STP) – BLMK.

In a year in which the NHS has rarely been out of the headlines for its financial woes, it’s been good to have something to celebrate – good news stories across Milton Keynes!

Yours sincerely

Graeme Caul
Diggory Divisional Director
The year in numbers

- 47,092 patients
- 357,601 appointments
- 1,840 admissions avoided by intermediate care services
- 555 people admitted to our beds
- 3,323 babies were supported into families in Milton Keynes
- CNWL employs 1,111 people in Milton Keynes

- 77% of patients in rehabilitation reported an improvement
- 93% of people referred to our mental health early intervention services are seen within two weeks
- 96% of patients would recommend our services a friend or family member
1 0-19 nursing teams

The team is made up of the Health Visiting and School Nursing services working across two localities in Milton Keynes, North and South.

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 to 2½ year old review and support to be ‘ready for school’
- 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 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.

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

<table>
<thead>
<tr>
<th>Activity (all figures are approximated and provided for context only)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Number of people referred to this service</td>
<td>9,723</td>
</tr>
<tr>
<td>How many times we saw people</td>
<td>42,671</td>
</tr>
<tr>
<td>Would patients recommend the service to their friends and family</td>
<td>100%</td>
</tr>
</tbody>
</table>
1.1 Plans for 2018/19

The focus for the coming year is to develop a single point of access for 0-19 services to improve the experience of people trying to contact our services. The plan is to bring the administration support together and make sure there is a consistent response to parents and professionals contacting the services.

Health Visiting 2017/18:

1,690 mothers received a first face-to-face antenatal contact with a Health Visitor
2,875 (87%) New Birth Visits within 14 days from birth
3,006 (91%) children received a six to eight week review by the time they turned eight weeks
3,033 (88%) children received a 12-month review by age 12 months

School Nursing 2017/18

School entry:
3,032 children completed height and weight measurement
2,831 children completed vision assessments
2,998 children completed hearing assessment
566 screening questionnaires processed

Year 6:
2,942 children completed height and weight assessments

Epipen Training:
48 sessions run across 43 schools
573 staff trained
Seven sessions on additional topics (eg. Asthma)

School Clinics
92 children seen for Behaviour
22 children seen for Continence
8 children seen for Day Wetting
31 children seen for Emotional Wellbeing
25 children seen for Enuresis
19 children seen for Healthy Eating
67 children seen for General Wellbeing
Three children seen for Hygiene
15 children seen for Long Term/Chronic Conditions
And more!
2 Perinatal Service

The service 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
- 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.

Many women do not need to be seen for the whole 12 months

<table>
<thead>
<tr>
<th>Activity 2017-18 Outturn</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people referred to this service</td>
<td>137</td>
</tr>
<tr>
<td>How many times we saw people</td>
<td>1,532</td>
</tr>
<tr>
<td>Would patients recommend the service to their friends and family</td>
<td>100%</td>
</tr>
</tbody>
</table>

2.1 New developments this year

The service has now been operational for about two years and has recently been successful in an STP wide BLMK bid for further funding; this has allowed the service to expand to meet the increased demand from Milton Keynes parents. This additional funding has strengthened both the consultant and psychology input into the service and also allowed a Nursery Nurse to be employed to support the children of parents experiencing mental health distress.

2.2 Plans for 2018/19

Embedding the service and continuing with the Perinatal Mental Health Pyramid Training Programme will be the main focus for the team over the coming twelve months. This training aims to educate the wider workforce around perinatal mental health and the importance of early intervention. Milton Keynes will also be working in partnership with our STP colleagues in Bedfordshire and Luton.
3 Buckinghamshire Priority Dental Services

Buckinghamshire Community Dental Services (CDS) operate across 11 sites in Milton Keynes, Buckinghamshire and Hillingdon. These services are for vulnerable individuals, who by virtue of their additional needs are unable to access dentistry in high street dental practices.

The CDS specialise in behaviour management related to dental care and aim to enable patients to accept dental care with minimum specialist intervention. Referrals can be made by General Dental Practitioners, General Medical Practitioners, any other health or social care professional or patients who fall into the following categories:

- Adults and children with severe learning disabilities
- Adults and children with complex unstable medical problems
- Adults and children with severe diagnosed mental health problems
- Children with severe anxiety and behavioural management problems

Appropriate treatment under general anaesthetic in a hospital setting is provided in Milton Keynes and Buckinghamshire. A limited range of treatment is provided on a domiciliary basis in Milton Keynes and Buckinghamshire. A dental chair suitable for bariatric patients is available at High Wycombe and many of the sites have hoists for people using a wheelchair.

Dental care in HMP Woodhill in Milton Keynes is provided by the CDS. The service also offers an out of hours emergency service in both Milton Keynes and Buckinghamshire.

The Hillingdon service also provides some specialist treatment services

<table>
<thead>
<tr>
<th>Activity</th>
<th>3,613</th>
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<tbody>
<tr>
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<tr>
<td>How many times we saw people</td>
<td>13,621</td>
</tr>
<tr>
<td>Would patients recommend the service to their friends and family</td>
<td>98.4%</td>
</tr>
</tbody>
</table>

3.1 Plans for 2018/19

The service supports the National Epilepsy Society in Chalfont St Peters and has currently around 100 patients with a wide range of needs. Some of these patients will never be able to visit the service so therefore a domiciliary care pathway is being developed with the support of our commissioners.
4 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 offers 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.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people referred to this service</td>
<td>6,260</td>
</tr>
<tr>
<td>How many times we saw people</td>
<td>17,455</td>
</tr>
<tr>
<td>Would patients recommend the service to their friends and family</td>
<td>97%</td>
</tr>
</tbody>
</table>

By March 2017, more than half of the patients seen by the service were classed as recovered.

4.1 New developments this year

IAPT services have been working with the old Assessment and Short Term Invention (ASTI) team to streamline access points to services. As part of this development a new Access team has been developed replacing ASTI 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.

4.2 Plans for 2018/19

IAPT services have successfully bid for additional funding to meet the new 19% access target. The service will also launch the new Mental Health Treatment Requirement Service in April 2019.
5 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 a 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. 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.

CNWL has been asked to set up a pilot Primary Care Plus service to seven GP practices; it received 313 referrals and saw patients a total of 633 times, all in their GP surgery.

5.1 New developments this year

CNWL has successfully set up a pilot Primary Care Plus service within seven GP surgeries.

5.2 Plans for 2018/19

Due to the resounding success of Primary Care Plus MK CCG has now commissioned expansion to all 27 practices in Milton Keynes, this will be rolled out in late 2018, early 2019.

- PCP - 633 contacts with people by Primary Care Plus.
6 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 works in partnership with Accident and Emergency (A&E) department and across all hospital wards to provide rapid mental health expertise to patients coming to the hospital.

Part of this work has been to work with individuals that use A&E frequently to provide a wraparound, multidisciplinary service to better support their needs. This has seen a reduction in these patients coming to A&E as they are better supported in the community. The work is across mental health services, voluntary groups and social services.

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<tr>
<th>Activity</th>
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<tbody>
<tr>
<td>Number of people referred to this service</td>
<td>2,249</td>
</tr>
<tr>
<td>Would patients recommend the service to their friends and family</td>
<td>100%</td>
</tr>
</tbody>
</table>

Once they are medically stable, the team is asked to see people in A&E where there is a mental health problem. It sees 80% of these people within one hour of being asked. Generally, where this is not met, it is because the team is supporting someone else in A&E.

6.1 New developments this year

CNWL was successful in the NHSE bid for monies and the team has recruited to additional posts and is currently applying for the “CORE 24” accreditation – a nationally recognised quality standard for liaison psychiatry.

6.2 Plans for 2018/19

CNWL has employed a Dual Diagnosis Lead to support the pathway between Compass who provide drug and alcohol support and ourselves. The High Impact Service Users Group has been set up and has had real success in decreasing the number of A&E visits for clients that have a mental health need.
7 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.

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<tr>
<th>Activity</th>
<th>Number of people referred to this service</th>
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<tr>
<td><strong>Activity</strong></td>
<td></td>
</tr>
<tr>
<td>Number of people referred to this service</td>
<td>525</td>
</tr>
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</table>

Of the referrals from A&E, 82% were seen within one hour.

7.1 New developments this year

The team is now co-located with Adult Hospital Liaison Service.

7.2 Plans for 2018/19

- To develop closer links with the equivalent team for adults - the Mental Health Hospital Liaison Team
- To deliver training and support to Milton Keynes Hospital staff and develop opportunities for close working between the teams including the possibility of rotational posts to develop skills in working across all age ranges.
8 Home 1st

Home 1st is an integrated team working across health and social care in the community and reaching in to hospital to provide packages of care to service users to stop them going to hospital when they can be cared for at home and helping people home from hospital.

This provides a better experience for the patient by reducing the gaps and duplication with an integrated pathway for admission avoidance and supported discharge, as well as reducing the need for long term care packages, including care homes. Having one team also makes it easier for other professionals, GPs, ambulance service, A&E to refer to the team.

The service is commissioned by Milton Keynes Clinical Commissioning Group.

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<tbody>
<tr>
<td>Number of people referred to this service</td>
<td>6,444</td>
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<tr>
<td>How many times we saw people</td>
<td>28,268</td>
</tr>
<tr>
<td>Would patients recommend the service to their friends and family</td>
<td>100%</td>
</tr>
</tbody>
</table>
8.1 Windsor Intermediate Care Unit

Windsor Intermediate Care Unit (WICU) provides a short-term programme of nursing and therapy for people who need a period of rehabilitation to help them regain their independence and confidence to return safely to their own home. The unit provides 24-hour nursing care and takes referrals from healthcare professionals for people who are over 18, and registered with a Milton Keynes GP:

- We are part way through a transformation programme for WICU where we are introducing the Red2Green principles which are reducing wasted time in a patient's stay in the unit.
- We are implementing recommendations from a HealthWatch Enter and View programme which looked at user feedback and how we can make the journey better for our patients.
- We have conducted a review of staffing and have altered the skill mix to help us to better meet the more complex needs of the patients.
- The service ran a successful 'virtual bed' pilot during 2017/18. The virtual bed offered the same level of nursing and therapy support as the ward, but in the patient's own home. The pilot showed that more patients can be cared for at home, but also proved the need for beds in a community setting.

<table>
<thead>
<tr>
<th>Activity</th>
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</thead>
<tbody>
<tr>
<td>Number of people admitted to a bed</td>
<td>197</td>
</tr>
<tr>
<td>How many days our beds were full</td>
<td>5,775</td>
</tr>
<tr>
<td>Average number of days each patient stayed in the unit</td>
<td>30</td>
</tr>
<tr>
<td>Proportion of time our beds were occupied</td>
<td>92%</td>
</tr>
</tbody>
</table>

8.2 Staying Steady

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.

- **Staying Steady Service 17/18:** 257 (98%) people report maintained or increased levels of confidence in maintaining their independence following a fall.

8.3 Plans for Home 1st for 2018/19

The Home 1st service is working alongside the CCG on various projects to further support the primary aims of avoiding admission and supporting discharge.

- Care Navigation is a project taking a multi-agency approach to High Intensity Service Users to better identify and meet their needs to keep them at home and prevent frequent admissions to hospital.
- We will place a Rapid Response nurse in A&E to further prevent admissions and evaluate the effect on the Number of people admitted to a bed.
- We will introduce a therapy role into the integrated discharge team within the hospital to facilitate discharges and reduce the numbers of readmissions.
9 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. Results from the scheme shows:

- 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
- That police officers are finding 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.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number of incidents referred to this service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>575</td>
</tr>
</tbody>
</table>

9.1 Plans for 2018/19

To continue to provide this established service in partnership with the police.
10 Acute Home Treatment Team

The Acute Home Treatment Team helps individuals and their families/carers to be supported in their own environments by providing intensive support at home to those experiencing a mental health crisis. This prevents the distress of a hospital admission and enables an alternative and greater choice in recovery. The team also supports patients on discharge from the Campbell Centre enabling patients to return to their own homes and families, hence reducing their stay in an unfamiliar environment.

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.

The team receive all requests for admissions to inpatient beds at the Campbell Centre so that care for those requiring admission can be co-ordinated and to make sure that alternatives to hospital admission have been considered.

<table>
<thead>
<tr>
<th>Activity</th>
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<tbody>
<tr>
<td>Number of people referred to this service</td>
<td>865</td>
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<tr>
<td>How many times we saw people</td>
<td>1,900</td>
</tr>
<tr>
<td>Would patients recommend the service to their friends and family</td>
<td>100%</td>
</tr>
</tbody>
</table>

10.1 New developments this year

New social care function introduced to support the care of service users.

10.2 Plans for 2018/19

Further development of close working across acute home treatment, hospital liaison and urgent care to improve patient pathways and joint working.
11 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>
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<tbody>
<tr>
<td>Number of people referred to this service</td>
<td>1,965</td>
</tr>
<tr>
<td>How many times we saw people</td>
<td>7,282</td>
</tr>
<tr>
<td>Would patients recommend the service to their friends and family</td>
<td>85%</td>
</tr>
</tbody>
</table>

11.1 New developments this year

The single point of access has now been established.

Staff are in the final stages of the Children and Young People IAPT training, this will increase the provision of evidence-based psychological interventions by accredited practitioners. These practitioners will also help the service deliver quality supervision and further embed an outcome-focused approach for our children and young people using the services.

Work on improving transition to adult services has been undertaken.

11.2 Plans for 2018/19

2018/19 saw the continuation of the CAMHS service transformation in line with the Local Transformation Plan and Children and Young People IAPT principles of access, evidence-based practice, outcome measures, participation and leadership. The transformation of services prioritises increasing access to services, urgent response services e.g. LIST, providing outcome-focused and evidence-based interventions, working with vulnerable groups e.g. special educational needs and disability, children in care, youth offending and those transitioning to adult services.

There is ongoing work to:

- Improve transitions to adult services
- Provide opportunities for staff to train in evidence-based interventions, supervision and leadership as part of CYPIAPT programme
- Further develop and streamline the single point of access and assessment team
- Facilitate partnership work with MKCCG to redefine and co-produce improved clinical pathways that reduce delays and improve waiting times
- Introduce an agreed approach to expanded outcome measures
12 Services for children with complex needs

We run several services for children with complex health needs or life limiting illnesses

12.1 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
- Medical Safeguarding Lead

<table>
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<tr>
<th>Activity</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Number of people referred to this service</td>
<td>959</td>
</tr>
<tr>
<td>How many times we saw people</td>
<td>1,305</td>
</tr>
</tbody>
</table>

Community Paediatrics 17/18:
3,905 (99.7%) of YP seen within 18 weeks of referral
12.2 Children with Complex Needs

The 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.

Activity

<table>
<thead>
<tr>
<th>Number of people referred to this service</th>
<th>538</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many times we saw people</td>
<td>7,164</td>
</tr>
</tbody>
</table>

12.3 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.

HBO Care Pathway

<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>

12.4 Plans for 2018/19

The focus for 2018/19 is to increase the capacity within the Community Paediatric Team to meet the increased demand for the service.
13 Paediatric Speech and Language Therapy

The Paediatric Speech and Language Therapy Service provides assessment and intervention for children up to 16 years within mainstream schools, 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 people referred to this service</td>
<td>1,572</td>
</tr>
<tr>
<td>How many times we saw people</td>
<td>10,906</td>
</tr>
</tbody>
</table>

13.1 Plans for 2018/19

- Increased use of social media to promote strategies for communication development and link to the local offer.
- Electronic care pathways are up to date and reflected on System One
- Introduction of an additional outcome measure system (TOMs) to measure impact of intervention within care pathways
- Evaluating the effectiveness of additional SLT early support for pupils at risk of entering the Youth Justice system
- Implement new training packages to support schools development of their provision at universal and targeted levels
- Involving parents in service delivery improvements for the ASD pathway.
14 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. OTs 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 people referred to this service</td>
<td>420</td>
</tr>
<tr>
<td>How many times we saw people</td>
<td>1,132</td>
</tr>
<tr>
<td>Would patients recommend the service to their friends and family</td>
<td></td>
</tr>
</tbody>
</table>

14.1 Plans for 2018/19

The service will look to increase the number of group interventions that it offers for parents and children.
15 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 16 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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people referred to this service</td>
<td>76</td>
</tr>
<tr>
<td>How many times we saw people</td>
<td>751</td>
</tr>
</tbody>
</table>

15.1 New developments this year

A life span integrated eating disorders service has now been established.

15.2 Plans for 2018/19

The service in Milton Keynes is now looking to link with CNWL’s wider Eating Disorders portfolio to continue to develop the service and offer clinical leadership and supervision to the small team in Milton Keynes.
16 Community Nursing

Community Nursing is made up of several services, the main service is District Nursing, but it is supported by specialist teams providing advice and training to the main District Nursing teams as well as some specialist treatment and these are set out in the sections below.

16.1 Community 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.

There are 11 teams across Milton Keynes. Each team links with particular GP practices to provide community nursing to all the residents of Milton Keynes, except Newport Pagnell. There is a small team of phlebotomists who link with each district nursing team.

2017/18 District Nursing

- 151,585 contacts by the District Nursing Service
- 5,608 contacts by the Phlebotomy Service

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 make sure the service facilitates early, safe discharge back into the community.

District Nursing is commissioned to provide 15 slots for intravenous antibiotics across the day and twilight service. The percentage of slots used is monitored monthly.

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

16.2 Continence

The Continence Service provides:

- Training
- Specialist adult continence assessments
- Specialist advice, including starting treatment plans
- Specialist continence advice to staff, family and carers of any patient.

We manage 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.

16.3 Tissue viability

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 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.
16.4 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.

16.5 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 \(^1\) 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.

16.6 Milton Keynes Integrated Diabetes Services

CNWL employs three Diabetes Specialist Nurses working within the MK Integrated Diabetes Service as a proof of concept pilot led by Milton Keynes University Hospital Foundation Trust. The service supports GPs and Practice Nursing in the management of Diabetes.

16.7 Performance

<table>
<thead>
<tr>
<th>Activity</th>
<th>District Nursing</th>
<th>Continence</th>
<th>Tissue Viability</th>
<th>Pulmonary Rehabilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people referred to this service</td>
<td>5,587</td>
<td>356</td>
<td>869</td>
<td>297</td>
</tr>
<tr>
<td>How many times we saw people</td>
<td>157,192</td>
<td>713</td>
<td>1,616</td>
<td>985</td>
</tr>
<tr>
<td>Would patients recommend the service to their friends and family</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) Medical Research Council dyspnoea scale for grading the degree of a patient's breathlessness. This scale does not measure breathlessness itself, but the disability caused by breathlessness
16.8 Plans for 2018/19

Community Nursing

District Nursing is undertaking transformation work to:

- Make sure we have a safe, efficient and effective District Nursing (‘DN’) Service staffed by people with the right skills, to deliver the increasingly high level of service required across the hours needed on a daily basis.
- Make sure the DN team can provide an equitable service to all citizens across Milton Keynes, by streamlining processes, procurement and estates, as well as using our workforce capacity in the most efficient and effective way within our funding.
- Ensuring access to DN services by both the public and health professionals when required.
- Understanding the challenges in relation to workforce; looking at innovative and flexible approach to skill mix as well as being a key and influential part of the wider Milton Keynes area.

Phase 2 started in May 2018 and is scheduled for completion by the end of March 2019. The transformation work includes:

- Development of templates on SystmOne which support mobile working.
- Development of a Single Point of Access for all referrals.
- Co-location of district nursing teams across two distinct areas of the city.

This transformation will support developments under the Primary Care Home model.

Dermatology

GP’s in Milton Keynes send dermatology referrals to the local referral management service for them to be reviewed and forwarded to the most appropriate service. The Dermatology service is starting to support this process, reviewing referrals and ensuring that patients get to the most suitable service.

Continence

We will continue to review the use of continence products and we will sign a new contract for the delivery of these products to care homes and patients at home.

Tissue Viability

This is a small service that will support GP practices and care homes with dressing prescribing.

Pulmonary rehabilitation

The focus 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.
17 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.

The service works very closely with colleagues from social care and housing. Much of the work done by the team is for Milton Keynes Council and the team will transfer to their management in 2018/19.

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.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people referred to this service</td>
<td>2,942</td>
</tr>
<tr>
<td>How many times we saw people</td>
<td>2,372</td>
</tr>
<tr>
<td>Would patients recommend the service to their friends and family</td>
<td>95%</td>
</tr>
</tbody>
</table>

17.1 Plans for 2018/19

The service is to be run by Milton Keynes Council; this change took place on 1 May 2018 when the team moved over to be employed by the Council.
18 Neurological Specialist Conditions Services

The services consist of three teams; Neurological Clinical Specialist Team (NCST) Neurological Rehabilitation Service (NRS) and the Early Stroke Rehabilitation Team (ESRT). The services provide specialist condition management and rehabilitation to people, aged over 18 in Milton Keynes with neurological conditions. They have combined caseloads of 2,400 people.

Staffing consists of a specialist team of Physiotherapists, 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.

The services 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 ensure 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, training is provided 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>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people referred to this service</td>
<td>1,118</td>
</tr>
<tr>
<td>How many times we saw people</td>
<td>12,459</td>
</tr>
<tr>
<td>Would patients recommend the service to their friends and family</td>
<td>100%</td>
</tr>
</tbody>
</table>

Early Stroke Rehab Team 17/18:

171 (79%) of patients who were discharged had an improved rehabilitation score recorded

18.1 Plans for 2018/19

- NRS will work with Milton Keynes Clinical Commissioning Group to look at services that can be provided for people with a Functional Neurological Disorder (FND)
- ESRT will support the work across Bedfordshire, Luton and Milton Keynes to look at creating inpatient stroke rehabilitation beds
- NCST will work with Milton Keynes Hospital to develop more, local services for people with Multiple Sclerosis.
19 Podiatry Service

The Podiatry Service works with service users increases patient mobility and independence and reduce 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.

The service is for children, young people and adults and is provided from a number of clinics across Milton Keynes.

Milton Keynes Clinical Commissioning Group will no longer buy the simple podiatry service that CNWL provided. This is a substantial change to the range of services provided and restricts who will be accepted to those most at risk of harm from two main groups requiring foot care:

- People with a disease which puts the feet at risk (for example, diabetics)
- People with disabling foot conditions (for example, arthritic conditions)

### Activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people referred to this service</td>
<td>3,898</td>
</tr>
<tr>
<td>How many times we saw people</td>
<td>20,470</td>
</tr>
<tr>
<td>Would patients recommend the service to their friends and family</td>
<td>100%</td>
</tr>
</tbody>
</table>

19.1 Plans for 2018/19

The team will work to consolidate its highly specialist support to Milton Keynes Hospital;

The service provides a lot of information for patients and it will review these to make sure that they remain relevant and up to date.

As simple treatments are no longer provided on the NHS, the service will look to establish a private treatment service offering these services at a competitive rate and with the profits used to support the NHS service.
20 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>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new referrals seen</td>
<td>117</td>
</tr>
<tr>
<td>How many times we saw people</td>
<td>1,972</td>
</tr>
</tbody>
</table>

Ninety-three per cent of patients were seen within two weeks.

20.1 New developments this year

Early Intervention in Psychosis are now running successful physical health clinics that are supporting service users in their physical needs, such as, smoking cessation and weight management.

20.2 Plans for 2018/19

The team now wishes to expand on their physical health clinics by investigating and running nutritional classes, covering meal planning and cookery. We hope to run these out of community settings to support social inclusion. A ‘buddy’ system around gym membership is also being considered.
21 Recovery and Rehabilitation Team including Assertive Outreach

21.1 Recovery and rehabilitation team

Milton Keynes Recovery and Rehabilitation Team helps 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.

21.2 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.

21.3 Performance

<table>
<thead>
<tr>
<th>Activity</th>
<th>R&amp;R</th>
<th>AOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people referred to this service</td>
<td>99</td>
<td>9</td>
</tr>
<tr>
<td>How many times we saw people</td>
<td>8,135</td>
<td>3,313</td>
</tr>
<tr>
<td>Would patients recommend the service to their friends and family</td>
<td>83%</td>
<td>100%</td>
</tr>
</tbody>
</table>

873 (97%) CPA annual reviews completed
21.4 New developments this year

The team has worked successfully to offer physical health checks and brief interventions. This has encouraged service users to identify physical health issues and access support and also consider making lifestyle changes to improve their health.

21.5 Plans for 2018/2019

Due to increasing demand the team are exploring opportunities for using new roles such as Peer Support Workers and Recovery Workers to ensure the team can continue to meet the needs of those using the service.
The 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 ageing.

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.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people referred to this service</td>
<td>1,800</td>
</tr>
<tr>
<td>How many times we saw people</td>
<td>2,991</td>
</tr>
<tr>
<td>Would patients recommend the service to their friends and family</td>
<td>100%</td>
</tr>
</tbody>
</table>

### 22.1 Plans for 2018/19

The service is looking at ways to measure how effective are the services it offers. It will look at ways the services can be more effective.
23 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>Number of people referred to this service</th>
<th>232</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>How many times we saw people</td>
<td>8,421</td>
</tr>
<tr>
<td></td>
<td>Would patients recommend the service to their friends and family</td>
<td>88%</td>
</tr>
</tbody>
</table>

23.1 New developments this year

The service is now embedded with all pathways established and running well.

23.2 Plans for 2017/18

The team is developing a new Psychosocial pathway for those that need care coordination in preparation for treatment.
24 Specialist Memory Service

The service offers a comprehensive psychiatric and neuro-psychological assessment of an individual’s memory, making sure 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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people referred to this service</td>
<td>856</td>
</tr>
<tr>
<td>How many times we saw people</td>
<td>3,117</td>
</tr>
<tr>
<td>Would patients recommend the service to their friends and family</td>
<td>94%</td>
</tr>
</tbody>
</table>

24.1 New developments this year

The service has achieved its re-accreditation. The service has had additional funding to provide two specialist posts, one in Primary Care and the other to support care homes. Both posts have been recruited to.

24.2 Plans for 2018/19

Embedding the new posts working closely with Primary Care and care homes.

Working closely with commissioners on ways to improve the diagnosis rate across the MK population.

Milton Keynes is the Mental Health pilot for a new way of using SystmOne to reduce the admin burden and maximise the utility of shared records.

The service is working to improve the number of people who attend the post diagnosis support options.
25 Adult Hearing Service

Adult Hearing is a 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.

The service has a modern approach to hearing pathways and is at the forefront of the use of Audiological technology in the NHS. The service will be piloting the use of state of the art hearing aids that allow the patient to programme the aids themselves. All staff in the service are multi-skilled allowing the team to work in a fluid way to ensure waiting times remain low and customer service remains high.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people referred to this service</td>
<td>1,289</td>
</tr>
<tr>
<td>How many times we saw people</td>
<td>5,010</td>
</tr>
<tr>
<td>Hearing aids issued</td>
<td>1,480</td>
</tr>
<tr>
<td>Would patients recommend the service to their friends and family</td>
<td>100%</td>
</tr>
</tbody>
</table>

25.1 Plans for 2018/19

- Pilot the use of state of the art, self-learning hearing aids
- Introducing sound booths into two main clinic rooms to improve the accuracy of hearing tests
- Improve the experience of using our service by developing carer information packs for families/friends to help them understand how to best support our service users.

Adult Hearing Service

840 (100%) people seen within 6 weeks for Audiology Diagnostics
26 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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people referred to this service</td>
<td>765</td>
</tr>
<tr>
<td>How many times we saw people</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>

26.1 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.

26.2 Plans for 2018/19

The review of the Community Team for Adults with Learning Disabilities under phase 2 of the LD Transformation Programme is starting.

The Transforming Care plan will continue to be delivered in partnership with Bedfordshire and Luton (BLMK partnership)

The clinical system, SystmOne is planned for December 2018 – this system is used by all the GP practices in Milton Keynes as well as the vast majority of health services based in the community.
27 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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people admitted to a bed</td>
<td>389</td>
</tr>
<tr>
<td>How many days our beds were full</td>
<td>11,806</td>
</tr>
<tr>
<td>Average number of days each patient stayed in the unit</td>
<td>22 days</td>
</tr>
<tr>
<td>Proportion of time our beds were occupied</td>
<td>85%</td>
</tr>
</tbody>
</table>

Inpatient MH

An admission has been reviewed by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission.

- 287 (98%) of all eligible admissions were gate-kept
- 75 (96%) people who were discharged from an inpatient ward on CPA received a follow up phone call or face to face visit within seven days of their discharge.

27.1 New developments this year

Work to improve pathways out of inpatient care and back to people’s home continues to move forward. Two peer support workers have now been appointed and their role is proving to be very helpful in supporting people to return home more quickly. A Discharge Coordinator role has also been created. This person will work directly with patients supporting them to resolve obstacles to their discharge, for example working with them to resolve housing or financial problems that are stopping them from returning home. New activity programmes are being delivered for people who are on 1:1 observations, to support their recovery. A new care plan has also been co-designed with patients; the plan is patient-focused and intended to be written by people who are in-patients. Inpatient services are also looking to start a post discharge group to support people who have recently been discharged to make the transition back home better.

27.2 Plans for 2018/19

Alongside the Discharge Resource Pack, Campbell Centre is planning to recruit a Discharge Co-ordinator. A new post of Occupational Therapy Manager is also planned to manage the Social and Recovery Team and the Occupational Therapists within the unit.
28 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 people admitted to a bed</td>
<td>55</td>
</tr>
<tr>
<td>How many days our beds were full</td>
<td>5,293</td>
</tr>
<tr>
<td>Average number of days each patient stayed in the unit</td>
<td>114 days</td>
</tr>
<tr>
<td>Proportion of time our beds were occupied</td>
<td>72%</td>
</tr>
</tbody>
</table>

28.1 New developments this year

The Topas Team have been working on their accreditation with the Quality Network for Older Adults Mental Health. Their Peer Review Inspection was undertaken in September 2018 and we are awaiting to hear the outcome. This process has involved, patients, their carers and all staff.

28.2 Plans for 2018/19

The Healthy Ageing review is now part of a larger, wider review across MK Council services.
29 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>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people admitted to a bed</td>
<td>3</td>
</tr>
<tr>
<td>How many days our beds were full</td>
<td>2,142</td>
</tr>
<tr>
<td>Average number of days each patient stayed in the unit</td>
<td>384 days</td>
</tr>
<tr>
<td>Proportion of time our beds were occupied</td>
<td>84%</td>
</tr>
</tbody>
</table>

29.1 New developments this year

The unit has been successfully taking back placements under the Placement Efficiency Project (PEP) scheme initiative.

29.2 Plans for 2018/19

The Placement Efficiency Project scheme bringing back out of area patients to local services including Cherrywood rehabilitation unit, will continue this year to ensure patients are treated as close to home as possible.

MKCCG has indicated that it will formally review Cherrywood so that it can care for people with more complex conditions.