CNWL services directory
June 2013

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Acute service line

Service type	**Home treatment teams**
About the service	Home treatment teams help avoid admission to a mental health inpatient ward by supporting people in acute mental crisis in their homes. The teams have doctors, nurses, social workers, occupational therapists and support workers who are available 24 hours a day, 365 days a year to support patients, carers and their families. The teams also help people who have been discharged from hospital as they make the transition back into the community. The home treatment teams are supported by out of hour crisis lines. All patients are provided with a crisis card with details of who to call in an emergency.
Eligibility criteria (who is the service for?	Patients aged over 18 in an acute phase of serious mental illness*, or those patients suspected to have an acute mental illness*. *These may include patients with a dual diagnosis, ie. Learning Disability, Substance Misuse, etc. Those patients suffering a relapse of a long term mental illness, and presenting as vulnerable or at risk of harm to themselves or others; who cannot be safely supported in a community setting without an increased level of support, care and treatment. The following presentations would not be appropriate for care from a Home Treatment Team: • Patients who are not in an acute phase of a serious mental illness. • Patients who could not be safely treated within a community or residential setting, due to risks posed by environment or individual. • Patients with a primary diagnosis of alcohol or other substance misuse, or a learning disability, or a physical problem, without a co-morbid mental health problem. • Patients of any age with a primary organic diagnosis, ie. Dementia. • Patients whose crisis is social in nature, and where there is no current evidence of acute mental disorder. • Mentally disordered offenders, whose level of acuity cannot be safely managed in the community.
How can someone be referred?	The Home Treatment Team only accepts referrals from other secondary mental health services; these will include:

	• Community Mental Health Teams; • Early Intervention Teams; • Assertive Outreach Teams; • Any other secondary specialist teams, as funded locally; • Psychiatric Liaison Services; • Acute Inpatient Wards (to facilitate early discharge); • Other (out of area) hospitals where a CNWL resident has been assessed to need admission; • Self-referrals (including relatives and carers) – only where it has been stated in the patient's Crisis Plan they can contact the HTT direct. This would need to have been agreed in advance between the patient's Care Co-ordinator and the HTT. The Home Treatment Team cannot accept referrals from: • GPs – who should refer to the Assessment and Brief Intervention Service / Community Recovery Team Duty Service as appropriate, in hours; or A&E Liaison out of hours. • Hostels and other non-statutory services, such as supported houses or day centres - who should use the referral pathways as above. • Police – Section 136 presentations will be assessed as per local agreement.
Service times	Home Treatment Teams are operational 7 days a week and have the following service times: Brent: 24 hours Harrow: 8.00am – 9.00pm Kensington Chelsea, Westminster and Hillingdon: 8.00am-10.00pm
Choose and Book	NO
Service locations	Brent Home Treatment Team Park Royal Mental Health Centre, Central Way, off Acton Lane , London, NW10 7NS 020 8955 4456 Harrow Home Treatment Team Northwick Park Hospital, Watford Road, Harrow, Greater London, HA1 3UJ 020 8869 2690 Hillingdon Home Treatment Team Maple Lodge, Hillingdon Hospital, Pield Heath Rd , Hillingdon, Greater London, UB8 3NN 01895 891056 North Kensington Home Treatment Team St Charles Hospital,

	Mental Health Unit, Exmoor Street, London, W10 6DZ 020 3315 8906 North Westminster Home Treatment Team St Charles Hospital Mental Health Unit , Exmoor Street, London, W10 6DZ 020 8206 7055 South Kensington Home Treatment Team South Kensington & Chelsea Mental Health Centre, 1 Nightingale Place, London, SW10 9NG 020 8206 7055 South Westminster Home Treatment Team Gordon Hospital, Bloomburg Street, London, SW1V 2RH 020 3315 2653

Service type	**Inpatient mental health wards**
About the service	Inpatient mental health wards provide a safe and therapeutic environment for people with acute mental health problems. CNWL has a number of inpatient mental health wards at locations across five London boroughs. We are committed to providing a local bed for those who need it. All our wards have single, same-sex accommodation, as well as same-sex living areas and garden space. Intensive treatment is provided on inpatient wards and recovery is promoted from the very beginning of admission. The wards have a weekly programme of activities which can include therapies such as arts, cooking, exercise classes and group meetings. Wards are staffed by nurses, psychiatrists, therapists, pharmacists, junior medical staff, healthcare assistants and activity coordinators.
Eligibility criteria (who is the service for?	Inpatient wards are for the following types of service user: Adults with an acute phase of a serious mental illness. Suspected to have an acute mental illness or suffering a relapse of long term mental illnesses that, due to the level of identified risks to self or others, cannot be safely assessed and treated anywhere but in an acute mental health hospital. Detained under the Mental Health Act (including CTO recalls) Present as vulnerable, at risk of harm to self or others as a result of an acute phase of a serious mental illness and cannot

	be safely supported in a community setting despite increased level of support, care and treatment. Who have a co-existing diagnosis of learning disability, substance misuse etc. however the primary reason for in-patient care is an acute phase of a serious mental illness. The service will **not accept** admissions of people who: Are not in an acute phase of a serious mental illness Could be treated safely within a community or residential setting Have a primary diagnosis of alcohol or other substance misuse in the absence of an acute mental illness. This would include patients requesting a detoxification without any suggestion of mental illness and patients who have a mental illness and are at risk of serious physical withdrawal symptoms from alcohol who should be on a medical ward. Have a primary diagnosis of learning disability without a co-morbid mental health problem. Have a physical problem without a co-morbid mental illness or have a mental illness but also have an acute physical illness that requires medical admission Are in crisis where the crisis is social in nature and where there is no evidence of acute mental disorder. Are between the ages of 16 and 18. Are mentally disordered offenders whose level of acuity cannot be safely managed in an open acute environment or are referred from the Courts or Prison. Patients of any age with primary organic illness or significant physical frailty should be offered admission to Healthy Aging for Older Adult wards rather than Triage, negotiated on a case-by-case basis
How can someone be referred?	All referrals to inpatient wards have to come via Home Treatment Teams. The patient will then be assessed by the Home Treatment Team who (with the AMHP for Mental Health Act assessments) gate keep all admissions. Home Treatment Teams only accepts referrals from other secondary mental health services; these will include: • Community Mental Health Teams; • Early Intervention Teams; • Assertive Outreach Teams; • Any other secondary specialist teams, as funded locally; • Psychiatric Liaison Services; • Acute Inpatient Wards (to facilitate early discharge);

	• Other (out of area) hospitals where a CNWL resident has been assessed to need admission; • Self-referrals (including relatives and carers) – only where it has been stated in the patient's Crisis Plan they can contact the HTT direct. This would need to have been agreed in advance between the patient's Care Co-ordinator and the HTT.
Service times	Inpatient Wards are operational 24 hours a day 365 days a year
Choose and Book	NO
Service locations	Amazon Ward, Danube Ward, Ganges Ward, Thames Ward St Charles Hospital, Mental Health Unit, Exmoor Street , Kensington and Chelsea, London, W10 6DZ 020 8206 7290 Ferneley Ward, Eastlake Ward Northwick Park Hospital, Watford Road, Harrow, London, HA1 3UJ 020 8869 2255 Frays Ward, Crane Ward Riverside Centre, Pield Heath Road , Hillingdon, Greater London, UB8 3NN 01895 891124 Mulberry South Ward South Kensington & Chelsea Mental Health Centre, 1 Nightingale Place, London, SW10 9NG Pond Ward, Pine Ward, Shore Ward Park Royal Mental Health Centre, Central Way, off Acton Lane, London, NW10 7NS 020 8955 4490 Vincent Ward, Ebury Ward, Gerrard Ward Gordon Hospital, Bloomburg Street, London , SW1V 2RH 020 3315 5659

Service type	**Psychiatric intensive care units (PICU)**
About the service	These wards create a safe and controlled environment to look after acutely disturbed psychiatric patients, whilst also respecting privacy and dignity. Psychiatric intensive care units provide mental health care and treatment for people whose acute distress, absconding risk and suicidal or challenging behaviour needs a secure environment beyond that which can normally be provided on an open psychiatric ward. High staffing ratios allow for intensive input to resolve issues quickly. PICU wards specialise in the assessment and comprehensive treatment of people with a broad spectrum of acute and

	enduring mental health needs. They provide care and treatment to inpatients who are experiencing the most acute phase of a mental illness. Our aim is to manage and reduce the risks associated with acute episodes of mental illness. Our proven programme of care and therapy develops the living skills, insight, education and confidence required for patients to return safely to an open ward or to the community.
Eligibility criteria (who is the service for? • Identify the relevant client base, especially any/all restrictions and exclusions that may apply.	**Criteria for admission** 1. Patients admitted to the PICU will have behavioral difficulties which seriously compromise their physical or psychological well-being of themselves or others and which cannot be safely assessed or treated in an open acute inpatient facility. 2. Patients will only be admitted if they display a significant risk of aggression, absconding with associated serious risk, suicide or vulnerability (e.g. due to sexual disinhibition or over activity), in the context of a serious mental disorder. 3. Each of the three Male and one female PICU units will offer a 24 hours- a -day emergency service. Anyone referred for admission to the unit should meet one or more of the admission criteria. Decisions relating to an emergency 'out- of- hours' admission are made by the site bed manager/ coordinator, the PICU nursing team in consultation with the on call medical staff and the Mental Health Act assessment team as appropriate. Referrals from 'out of area' will not be accepted outside of normal working hours. **Additional criteria – Inclusion** 1. Patients admitted will be aged 18 or over. Patients will not normally be over the age of 65. 2. Patients will normally be detained under the appropriate completed assessment/treatment Section of the Mental Health Act/Order. DOH and NICE guidance currently state that patients on short-term sections should not be admitted to PICUs. In that sense admissions of patients on Section 4, 5/2, 5/4 or 136 on a case by case basis if it's in patient's best interest or clinical presentation warrants PICU care **Additional Criteria – Exclusion** 1. Restricted patients should not be accepted unless there is provision to transfer them to an open ward if warranted

	by their clinical condition, i.e. Section 41 and all criminal sections, Sections 35, 36, 38, 47, 48, etc. 2. The patient has a primary diagnosis of substance misuse. 3. The patient's behaviour is as a direct result of substance misuse and they are not suffering from an exacerbation of their mental disorder at the time of referral. 4. The patient has a primary diagnosis of dementia. 5. Primary diagnosis of learning disability 6. Young people aged 18 or under. 7. The patient's physical condition is too frail to allow their safe management in a PICU. 8. The patient is informal
How can someone be referred?	**Referral pathway** Referrals to the PICU can be made by: • Patient Flow/Bed Manager/ Home Treatment Team (HTT) • Acute Treatment wards • The Community Recovery Team in conjunction with HTT as part of their CPA care / risk management plan • Patients referred by the Courts/Prison will generally be managed initially in a PICU environment and will have initial assessment including risk assessment before being accepted and do not require HTT gatekeeping • In the case of Colne Ward, referrals from Immigration Removal Centre (IRC) Home Treatment Team (HTT) will be involved in all assessments where hospital admission is being considered. This is to ensure that all patients will have the choice, where it is safe to do so, of receiving their care in the least restrictive environment and guarantee appropriate gatekeeping PICU admission may be recommended in the following circumstances: a) A period of crisis management is required because the patient has needs that are felt to be beyond the resources of the HTT and acute admission/treatment wards to manage safely b) The admission to PICU will facilitate a resolution of crisis to allow early discharge with HTT or transfer to an Acute Treatment Ward. c) The patient is subject to detention under the MHA 1983 and cannot be managed safely on an acute treatment ward.
Service times	PICU Wards are operational 24 hours a day, 365 days a week

Choose and Book	NO
Service locations	Caspian Ward Park Royal Mental Health Centre, Central Way, off Acton Lane, London, NW10 7NS Colne Ward Riverside Centre, Pield Heath Road, Hillingdon, Greater London, UB8 3NN Nile Ward St Charles Hospital, Mental Health Unit, Exmoor Street, London, W10 6DZ Shannon Ward St Charles Hospital, Mental Health Unit, Exmoor Street , London, W10 6DZ

Addictions and substance misuse service line

Service type	Centre for Compulsive and Addictive Behaviour
About the service	The Clinic for Compulsive and Addictive Behaviours (CCAB) provides psychological treatment of a range of compulsive behaviours, or behavioural addictions. The difficulties treated by the clinic include: • Compulsive internet use • Gaming addiction • Compulsive use of pornography • Compulsive buying Our treatment packages include assessment of your problem; cognitive behavioural therapy (CBT); talking therapy focusing on reducing your problem behaviour; increasing positive behaviours; activities and thinking; and investigating any underlying factors. Our treatment is provided by NHS-trained and registered psychologists with extensive experience of working with behavioural addictions.
Eligibility criteria (who is the service for?	Adults (aged 16 and over). Patients with a co-existent substance misuse problem may be directed to their local substance misuse treatment service first.
How can someone be referred?	The clinic accepts both self and professional referrals. Generally, the service is appointment only. Walk-in service is not currently available
Service times	The service provides assessment and individual treatment Monday to Friday 9.00am to 5.00pm.
Choose and Book	No
Service locations	Soho Centre for Health & Care, 4th Floor, 1 Frith Street , London, W1D 3HZ Tel : 020 7534 6699

Service type	National Problem Gambling Clinic
About the service	The National Problem Gambling Clinic provides treatment for problem gamblers living in England and Wales aged 16 and over. We assess and treat the needs of problem gamblers as well as their family members or carers. This service is led by a consultant psychiatrist and staffed by psychologists, family therapists and debt advisors. Our outcome data shows most people who complete treatment overcome or significantly reduce their gambling problem. Our services include:

	• Comprehensive assessment • Individual and group treatment over a number of weeks • Regular support groups while you make changes in your life • Help if you relapse • Working with you to manage your money better • Advice on employment, social and relationship difficulties • Practical support for your family or people close to you who may also be affected • Employer assistance programme for businesses linked to gambling
Eligibility criteria (who is the service for?	Adults (aged 16 and over). Patients with a co-existent substance misuse problem may be directed to their local substance misuse treatment service first.
How can someone be referred?	The clinic accepts both self and professional referrals. As a national clinic, remote advice and treatment may be provided by email. Generally, the service is appointment only. Walk-in service is not currently available.
Service times	The service provides assessment and individual treatment Monday to Friday 9.00am to 5.00pm. An evening group work programme exists following assessment.
Choose and Book	No
Service locations	National Problem Gambling Clinic Soho Centre for Health & Care, 4th Floor, 1 Frith Street , London, W1D 3HZ Tel : 020 7534 6699 Email : gambling.cnwl@nhs.net

Service type	**Club Drug Clinic**
About the service	The Club Drug Clinic is an innovative service for adult clubbers and LGBT people who have developed problems with a range of `club drugs' including : • cocaine • methamphetamine / crystal meth • GHB/GBL • ketamine • legal highs • MDMA • Mephedrone • Stimulants (amphetamine and cocaine) • 'legal highs'

	Our highly specialist team includes specialist addiction doctors and psychologists, nurses, counsellors and peer mentors with 'lived experience'. The team is based in Chelsea & Westminster Hospital, and offers a wide range of support including: • Assessment of your problems and planning how to improve the situation • Medically assisted withdrawal from substances or detoxification. We are highly expert at a range of community and in-patient detox including drug plus alcohol detox and GHB/GBL detoxifications. • Symptomatic prescribing programmes to help with the side-effects of coming off stimulants, mephedrone etc • Talking therapies, led by psychologists, counsellors, and peer mentors who have and overcome their problems. • On-site sexual health screening and support • Liaison and referral for physical problems including bladder and kidney problems; HIV and blood borne viruses; mental health problems etc
Eligibility criteria (who is the service for?	Adults (18 years and older) living anywhere in England.
How can someone be referred?	The clinic accepts both self and professional referrals. As a national clinic, remote information and advice may be provided via the email address
Service times	The service is open Monday, Wednesday and Friday for drop-in and assessments
Choose and Book	No
Service locations	Club Drug Clinic Chelsea and Westminster Hospital, 369 Fulham Road , London, SW10 9NH Tel : 020 3315 6111 Email : clubdrugclinic.cnwl@nhs.net Website : www.clubdrugclinic.cnwl.nhs.uk

Service type	**Community drug and alcohol treatment and recovery services**
About the service	We provide high quality, Care Quality Commission registered substance misuse services in a range of London boroughs, to help people overcome their dependence and achieve recovery. Our community drug and alcohol services have highly skilled, multi-disciplinary teams which include consultant addiction

	psychiatrists; clinical psychologists; nurses; social workers; employment specialist; peer support workers and 'experts by experience' recovery staff. We work in partnership in local systems with local voluntary sector substance misuse services and mutual aid organisations including Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and SMART recovery. We treat all kinds of substance misuse problems and specialise in providing treatment for those with severe dependency or complex needs. Our services all provide assessment and personalised care planned treatment and recovery packages. We provide: • Alcohol treatment, including community detoxification with psychosocial support to either control drinking or maintain abstinence • Heroin treatment (medication assisted recovery on oral or injectable substitute prescribing with recovery support OR detoxification with recovery support) • Stimulant treatment (crack, cocaine, methamphetamine, etc) • Cannabis treatment • 'Club Drugs' and 'legal highs' treatment • Blood-borne virus testing and treatment • Needle exchange schemes • Psychological therapies • Carer and family support including couples and family therapy
Eligibility criteria (who is the service for?	Most of our service are borough based (they see people resident in the borough), and are for adults (18 years and over). All our services work in partnership and can signpost any person to the team that is right for them in their locality.
How can someone be referred?	The clinic accepts both self and professional referrals. Self referrals: Most teams have a drop-in sessions and bookable appointments. Contact your local service for details. Professional referrals: can come via health, social care or criminal justice agencies (GP, social worker, probation officer). Service use borough based partnership referral forms. Contact your local service for copies.
Service times	All our Community Drug & Alcohol teams are open Monday to Friday 9am to 5pm as standard. Most services have evening and/or weekend sessions available. Contact your local service for details.
Choose and Book	No

Service locations	Brent Junction Drug & Alcohol Service 27 Station Road, Harlesden, London, NW10 4UP Tel : 020 8961 7007 Ealing RISE (Recovery Intervention Service Ealing) Lancaster House, Leeland Road, West Ealing W13 9HH Tel : 020 8566 1122 Hammersmith & Fulham Community Drug and Alcohol Service (CDAS) Crowther Market, 282 North End Road, London, SW6 1NH Tel : 020 7381 7766 Hillingdon Drug & Alcohol Services (HDAS) Old Bank House, 64 High St, Uxbridge, Greater London, UB8 1JP Tel : 01895 207 777 Kensington & Chelsea Community Drug & Alcohol Service 69 Warwick Road, Earls Court, London, SW5 9HB Tel : 020 3315 5800 North Westminster Drug and Alcohol Service 474 Harrow Road, London, W9 3RU Tel : 020 7266 6200

Service type	**Max Glatt Inpatient Unit**
About the service	Our world-renowned inpatient unit provides 24-hour medically managed detoxification and stabilisation for NHS and private patients with drug and alcohol dependency. We treat every level of complexity including those with physical and mental health issues. Our medically managed treatment is provided by an expert team of consultant addiction psychiatrists, nurses, clinical psychologists, art and music therapists, peer support workers and mutual aid (AA, NA and SMART recovery). We also provide a range of treatments including complex detoxifications and ground-breaking GHB/GLB detox. We work closely with each client and their local area treatment service to prepare for an inpatient stay. Detox admission can last from 4 to 28 days depending on need and funding availability. Pre-admission, we also set up local provider services to offer support post-discharge. We will provide recovery telephone support for up to a year after discharge. Our unit provides comprehensive assessment, stabilisation or detoxification from illegal, illicit and prescribed drugs and/or alcohol. Each person will receive individually tailored medical

	interventions and a bespoke programme of one to one and group activities and therapies. This may include: individual recovery planning; mutual aid; art therapy; music therapy; relaxation and shiatsu; health education; nutritional advice and cooking skills; gym; and psychologist-led sessions including relapse prevention. We also offer advice and support to relatives, carers and friends of people in our care and offer formal behaviour couple therapy which is proven to help build support and prevent relapse.
Eligibility criteria (who is the service for?	The service is for adults (18 year and over). We take referrals from local substance misuse teams, and from acute hospitals (eg. those requiring an operation who are alcohol dependent), and self-referrals.
How can someone be referred?	NHS clients should talk to their local care co-ordinator or key worker. Private clients can contact the unit directly.
Service times	The inpatient unit is staffed 24/7 unit, but general enquires are best directed during office hours
Choose and Book	No
Service locations	Max Glatt Unit South Kensington & Chelsea Mental Health Centre, 1 Nightingale Place, London, SW10 9NG Tel: 020 3315 3153

Service type	Professor Nutt National Pharmacology Clinic
About the service	This highly specialised outpatient clinic is a national resource which can diagnose and treat complex adult ADHD, non-respiratory sleep disorder and 'difficult to diagnose' cases involving brain dysfunction. The clinic is run by Professor David Nutt, eminent brain scientist and clinician. Also on the team is Professor Anne Lingford-Hughes whose expertise is in psycho-phamacology. This service provides secondary care for NHS patients with complex needs. Patients would normally require referral and funding agreed by their local GP. Private patients can refer themselves directly. Our service includes : • Comprehensive assessment • An initial treatment plan which would normally include medication and behavioural interventions • A review of the initial treatment plan • Ongoing treatment or liaison with patient's local area

	services to take over clinical management
Eligibility criteria (who is the service for?	The clinic accepts NHS referrals from local health services or individuals if funding for secondary treatment or diagnosis has been prior approved.
How can someone be referred?	The clinic accepts NHS referrals from local health services or individuals if funding for secondary treatment or diagnosis has been prior approved. Private patients can refer themselves.
Service times	The clinic runs weekly on a Tuesday. Information about the clinic is on the CNWL website, or can be accessed by calling the Club Drug Clinic number below
Choose and Book	No
Service locations	Professor Nutt National Psychopharmacology Clinic Chelsea and Westminster Hospital, 369 Fulham Road, London, SW10 9NH Tel : 020 3315 6111

Assessment and brief treatment service line

Service type	**Assessment and brief treatment teams**
About the service	Assessment and brief treatment teams work with service users who are new to mental health services. They will provide a detailed assessment in order to understand fully an individual's needs. Services will aim to identify the nature of the problem for which the person has been referred, and the best way to treat the person referred to the service. This may involve an agreed brief package of care carried out within the assessment and brief treatment service (such as a talking treatment or supervised medication) or a referral to another type of mental health service, such as Improving Access to Psychological Therapies (IAPT), Primary Care Counselling, Wellbeing Centres or a service, such as the community recovery team.
Eligibility criteria (who is the service for?	Serves the resident adult population of Brent, Harrow, Hillingdon, Kensington & Chelsea and Westminster. Services are also provided for people of No Fixed Abode and Foreign Nationals in any of the Boroughs above. The ABT will triage all referrals for adults aged 18 or above, unless they fall into one of the exception categories below. All will be offered an assessment, unless following discussion with the referrer it is thought appropriate to signpost to a more suitable resource. Exclusions: • Those with physical frailty, irrespective of age – Older People and Healthy Ageing Service Line • Those being referred with a primary problem of memory difficulties – Older People and Healthy Ageing Service Line • New referrals aged 70 + would be offered choice as to whether they were seen in ABT or Older People and Healthy Ageing Service Line • Those resident in 24 hour staffed accommodation – Rehab Service Line • Those whose needs can be met by a specialist service, for example Eating Disorders, Learning Disability or Offender Care. • Under 18 – CAMHS • First onset psychosis aged 14-35 - Early Intervention in Psychosis Team • Referrals for MHA assessment.
How can someone be	Access to the service is by referral only, teams may be

referred?	contacted by letter, fax or telephone. Referrals are accepted from any source including self referral. All referrals are triaged prior to an assessment being offered and may be signposted to a more appropriate service should this be in the best interests of the service user. Walk in services are not offered and face to face contact is by appointment only.
Service times	Monday – Friday: 9.00am – 5.00pm
Choose and Book	NO
Service locations	Brent Assessment and Brief Treatment Team 13-15 Brondesbury Road, London NW6 6BX Telephone: 020 8937 6320 Forced Migration Trauma Service 7a Woodfield Road, London W9 2NW Telephone: 020 7266 9575 Harrow Assessment and Brief Treatment Team 839 Honeypot Lane, Stanmore, Middlesex HA7 1AT Telephone: 020 8951 3770 Hillingdon Assessment and Brief Treatment Team Mill House, 38 Riverside Way, Off Rockingham Road, Uxbridge UB8 2YF Telephone: 01895 206800 Kensington & Chelsea Assessment and Brief Treatment Team South Kensington & Chelsea Mental Health Centre, Pall Mall Centre, 150 Barlby Road, London W10 6BS Telephone: 0208 206 6969 North Westminster Assessment and Brief Treatment Team 7a Woodfield Road, London W9 2NW Telephone: 020 7266 9700 South Westminster Assessment and Brief Treatment Team 190 Vauxhall Bridge Road, London SW1V 1DX Telephone: 020 7854 4243

Service type	**Primary Care Psychological Therapies: Improving Access to Psychological Therapies (IAPT) and Counselling**
About the service	There are times when everyone feels stressed or unhappy. Generally these bad times pass, but sometimes there are problems that do not go away and it gets harder and harder to cope. Talking about your problems can really help and IAPT and counselling services give you time to talk. These services can help you learn ways to help yourself so you feel more able to

	cope with your problems. Specialist staff can provide talking therapies and self-help courses to help with common mental health difficulties such as stress, worry, low mood and relationship problems. Improving Access to Psychological Therapies (IAPT) is a national NHS programme increasing the availability of services across England offering treatments for people with depression and anxiety disorders. Counselling provides an opportunity to talk through problems to help you think through current difficulties
Eligibility criteria (who is the service for?	IAPT and Counselling are suitable for those with problems which have arisen fairly recently. Feelings of low mood, anxiety, particular fears or problems coping with daily life and relationships, are all suitable for brief focussed talking therapies. These are free, confidential NHS services which provides psychological treatment for depression and anxiety disorders in primary care. They are available to all adults over 18 including those over 65 years of age who are registered with a GP in the local area. Patients seeking help with difficulties other than depression or anxiety, or whose difficulties require more specialist or intensive treatment which cannot be provided in a primary care setting, are directed to the appropriate specialist or secondary care mental health services.
How can someone be referred?	Westminster IAPT: the service can accept referrals from GPs, other health professionals, and self-referrals via telephone (030 3333 0000) or email (westminster.iapt@nhs.net). Counselling is available via GP referral to practice counsellors or Westminster Mind (these counselling services are not provided by CNWL). Hillingdon Primary Care Counselling and IAPT: Referrals to the service can only be made by a GP or other mental health professional. Access to Brent & Harrow IAPT services is only via GP at this stage. If professionals or clinicians wish to refer to Brent & Harrow IAPT service, this needs to be requested via the GP as well. At this stage Brent and Harrow IAPT services do not accept self referrals at the request of the CCGs who have commissioned the service. However, anyone who self refers is assisted by notifying their GP. IAPT service provision is by appointment only. Up-to-date Brent referral form attached

Service times	Westminster: Monday – Friday: 9.00am – 5.00pm, plus evening availability by appointment. Hillingdon: Monday – Friday: 9.00am – 5.00pm Brent and Harrow: Monday – Friday: 9.00am – 5.00pm plus 8am appointment available on request. Harrow IAPT Monday evening 5-8 pm Brent IAPT Tuesday evening 5-8 pm
Choose and Book	NO
Service locations	Brent IAPT Roundwood Centre, Harlesden Road, London, NW10 3RY Telephone: 020 8438 1777 Harrow IAPT Northwick Park Hospital, Management Suite 2, London, HA1 3UJ Telephone: 020 8869 2325 Hillingdon Primary Care Psychological Therapies: Counselling and IAPT Mt Vernon Hospital, Rickmansworth Road, Northwood, Middx HA6 2RN Telephone: 01923 844 667 Westminster IAPT 11 Praed Street , London, W2 1NJ and 192-198 Vauxhall Bridge Road, London, SW1V 1DX Telephone: 030 3333 0000

Service type	**Primary care liaison**
About the service	Many patients seen in GP practices can have multiple physical health, mental health and social needs. Primary Care Liaison works proactively with GPs and patients to address the identified problems. These may include: • Social exclusion • Lack of occupational activities • Benefits problems • Poor engagement with mainstream services • Poor physical health • Ongoing mental health problems • Life coaching Primary Care Liaison teams usually have community mental health nurses and one consultant psychiatrist who liaise with five GP practices to identify patients who need access to mental health support. • Mental health support can include:

	• Screening • Assessment • Advice • Sign-posting • Access to therapies Recovery underpins all care and treatment and the Liaison service also provides support for family members and wider support networks. For patients with more complex mental health needs the service works with team members from the rest of the other mental health services, as well as GPs, therapists and counsellors.
Eligibility criteria (who is the service for?	Serves the resident adult population of Kensington & Chelsea with common mental health problems. Services are also provided for people of No Fixed Abode and Foreign Nationals in any of the Boroughs above.
How can someone be referred?	The Primary Care Liaison Service will triage all referrals for adults aged 18 or above. All with common mental health problems will be offered an assessment, unless following discussion with the referrer it is thought appropriate to signpost to a more suitable resource including secondary care. Service Users may self refer, though no walk-in service is provided.
Service times	Monday – Friday: 9.00am – 5.00pm
Choose and Book	NO
Service locations	Kensington & Chelsea Primary Care Liaison Service Boots, 127A Kensington High Street, London , London, W10 6BS Telephone: 020 8962 4762

Service type	**Wellbeing centres**
About the service	Wellbeing Centres are a place where anyone can go to find out about mental health, wellbeing, staying healthy and feeling well. Wellbeing centres help people to take control of their own lives, participate in their family and community, and work productively to earn their living. The team will help you access different types and levels of support to enable you to do these things. The centres are staffed by a range of specialists from a variety of organisations who can help with any queries you may have. This includes diet, drugs and alcohol, being a carer, housing advice, relationship advice, welfare and benefits, and many more.

Eligibility criteria (who is the service for?	Serves the resident populations of Hillingdon & Westminster. Services are also provided for people of No Fixed Abode and Foreign Nationals in any of the Boroughs above.
How can someone be referred?	Referrals are accepted from any source, including self referral and walk-ins.
Service times	
Choose and Book	YES / NO
Service locations	Hillingdon Wellbeing Service Boots, 128 Chimes Shopping Centre, Uxbridge, Greater London, UB8 1GA Westminster Wellbeing Team Soho Centre for Health1 Frith Street, 3rd Floor, London W1D 3HZ

Child and adolescent mental health services

Service type	**Children's community services**
About the service	Community child and adolescent mental health services work with children and young people up to the age of 18 and their families. We work with children, young people and their families with complex mental health difficulties, in a range of different ways depending on their needs. The type of difficulties dealt with by the teams may include: • Complex emotional and behavioural problems • Anxiety and depression and very rarely serious mental illness such as psychosis and eating disorders • Family relationship issues and parenting • Hyperactivity or poor concentration (ADHD, ASD) • Challenging behaviour • Eating, sleeping or toileting problems • School refusal • Children with mental health needs related to learning difficulties, physical illness or disability Our psychologists, psychiatrists, and therapists provide assessment and treatment packages for children and young people and their families. Treatment may include cognitive behavioural therapy (CBT), family therapy, play therapy, individual and group psychotherapy. Medication is also used when appropriate and carefully monitored by the doctors. We provide consultation to other professionals, such as teachers, youth workers, social workers and other health professionals. We work within schools and offer teachers support and training on spotting and dealing with mental health difficulties in children and young people. We involve children and young people in the development of our services. They get involved with consultations, training, recruitment and undertake a variety of projects to ensure their voice is heard throughout the service.
Eligibility criteria (who is the service for?	The service is for children and young people under the age of 18 and their families who require specialist mental health assessment or treatment.
How can someone be referred?	Referrals are accepted primarily from health services such as GPs and Paediatrics. Some services also accept referrals from education or social services. Self referrals are also considered by

	each team.
Service times • Details of the times/days when the service is available.	The services are primarily open between 9am and 5pm, Mondays to Fridays although some services offer late evening clinics
Choose and Book	NO
Service locations	Behaviour and Family Support Team (BFST) Isaac Newton Centre for Professional Development, 108a Lancaster Road, Kensington and Chelsea, London, W11 1QS Bell House145 High Road, Willesden, NW10 2SJ Brent Adolescent TeamWarranty House, Dudden Hill Lane, London, NW10 1DL Brent Child and Family ClinicWarranty House, Dudden Hill Lane, Brent, London, NW10 1DL Cheyne Child Development CentreChelsea & Westminster Hospital, 369 Fulham Road, London, SW10 9NH Harrow CAMHS332 Northolt Road, Harrow, London, HA2 8EQ Hillingdon Child, Family and Adolescent Consultation Service 1 Redford Way , Uxbridge, Greater London, UB8 1SZ Kensington & Chelsea Child and Adolescent Service Chelsea & Westminster Hospital, 369 Fulham Road, London, SW10 9NH Marlborough Child and Family Centre 38 Marlborough Place , London, NW8 0PJ Parkside Clinic 63-65 Lancaster Road, London, W11 1QG St Mary's Department of Child and Adolescent Psychiatry 17 Paddington Green , London, W2 1LQ Violet Melchett Clinic Child & Family Consultation Service, 30 Flood Walk, London, SW3 5RR

Service type	**Children's inpatient service**
About the service	Collingham Child and Family Centre have developed a unique model of care for children with a wide range of complex and severe mental health problems. The idea of inpatient care requires a huge leap of faith for the child, family and referring professional alike. We do not underestimate this process but truly believe that, for the small number of deeply troubled children and families whose lives have become strained beyond endurance, an inpatient admission may offer a real hope of respite, understanding and

	the possibility of change. Our highly experienced and dedicated multidisciplinary team is committed to offering the highest standards of care to help children and families regain their self-confidence. We will help identify solutions for hard to manage problems and steer a course towards optimism, newly realised potential and a positive future. Our wide range of services include: • Consultation to families and professionals • Day and inpatient interventions • Assessment –individual and family • Treatment –individual, group and family • School and community reintegration Our approach is holistic and solution-focussed and our multidisciplinary ethos aims to make each admission as short as possible. This approach enables each child and family to return to their community with greater strengths and the ability to sustain positive changes. We are also able to offer a number of training workshops to professional agencies working with children and families. These include: • The management of challenging behaviour • Solution focussed work with children and families • Working with translators • Child Protection
Eligibility criteria (who is the service for?	The service is available for children under the age of 13 suffering from complex mental health problems where community interventions are not appropriate or have been tried and not worked. The service also admits children where there are significant safety concerns resulting from a mental health problem
How can someone be referred?	To access the centre referrals must come via a community CAMHS team. The service accepts referrals via telephone, fax or email. For further information contact the Referral Coordinator on 020 7361 7940. The service does not accept self referrals.
Service times	The service is open 24 hours a day as it is a residential service from Monday to Friday. It is closed at weekends.
Choose and Book	NO
Service locations	Collingham Child and Family Centre 1 Beatrice Place, Marloes Road, London , W8 5LW Telephone: 0207 361 7940

Service type	**Education centres**
About the service	The Family Education Service provides help for children and their families via problems that children are showing in schools. The Family Education Centre runs an intensive, four mornings a week, multi-family programme for children who are presenting serious behavioural or emotional difficulties and who are frequently at risk of being excluded from their school. The Centre is staffed by experienced teachers who are also fully trained systemic psychotherapists. The Centre's approach is to work closely with groups of families in collaboration with each child's teachers in their own school in order to bring about rapid and sustained behavioural change and improved academic performance. The Family Education Centre has also developed an Early Intervention Service whereby Centre staff work directly on school sites to encourage better coordination of practice between CAMHS and schools. Their remit is to improve accessibility for children and families by setting up and running school-based multi family groups in partnership with school colleagues.
Eligibility criteria (who is the service for?	The service is available for children with complex behavioural problems or emotional problems which is affecting their education
How can someone be referred?	Referrals are accepted primarily from special education services The service does not accept self referrals and is an appointment only service
Service times	Monday to Friday mornings
Choose and Book	NO
Service locations	Marlborough Education Centre 38 Marlborough PlaceLondon NW8 0PJ

Community Physical Health – Camden

Service type	Foot Care
About the service	The Podiatry Service (Foot Care), provides assessment and treatment for Camden residents with foot related problems, with an emphasis on prevention and self management. Treatment is carried out in community clinics, hospital settings or, for those who are housebound, in the patient's own home. Assessment, treatment and advice are provided by a team of state registered practitioners and trained podiatry assistants.
Eligibility criteria (who is the service for?	• with no foot pathology and who only need toenail cutting. • who have a verruca. • who need custom shoes: we make orthotics but not custom shoes.
How can someone be referred?	If you are under 16 or over 60, or have a medical condition that places your feet at risk of ulceration and infection, you can complete a podiatry referral form which can be obtained from any Health Centre or GP Practice. **Referral route** Podiatry referral form to be sent via fax to 0207 485 5306 or posted to: Podiatry The Peckwater Centre 6 Peckwater Street London NW5 2UP If you are aged between 16 and 60 and meet the clinical criteria, a health care professional or GP must complete a podiatry referral form for you. This will be sent to The Peckwater Centre for clinical triage into the appropriate assessment clinic. If you require an emergency referral, e.g. acute pain, inflammation or infection, your GP or other health professional should contact the Podiatry Clinical Manager on 020 7685 5615.
Service times	Various
Choose and Book	No
Service locations	Foot Care - Belsize Priory HC 208 Belsize Road, London NW6 4DX Tel: 020 3317 3300

	Foot Care - Gospel Oak Health Centre 5 Lismore Circus, London NW5 4QF **Tel: 020 3317 3300** Foot Care - Hunter Street HC 8 Hunter Street, London WC1N 1BN **Tel: 020 3317 3300** Foot Care - Kentish Town Health Centre Bartholomew Rd, London, NW5 2AJ **Tel: 020 3317 3300** Foot Care - Spectrum Centre 6 Greenland Street, London NW1 0ND **Tel: 020 3317 3300** Foot Care - St Pancras Hospital 4 St Pancras Way, London NW1 0PE **Tel: 020 3317 3300**

Service type	**Wheelchair service**
About the service	The wheelchair service completes mobility, postural and pressure care assessments for adults and children with long-term disabilities. The service supplies a range of powered and manual wheelchairs, buggies and customized seating and provides a repair and maintenance service. The aim of the service is to increase the mobility and independence of people who need wheelchairs or customised seating.
Eligibility criteria (who is the service for?	Children and adults who live in Camden or Islington or are registered with a Camden or Islington GP who: • Have reduced mobility for more than 6 months (Exceptions are made for palliative care service users).
How can someone be referred?	You can be referred to the service by your GP or by another health professional – for example, a consultant, nurse, physiotherapist, occupational therapist or social worker. If you already use one of our wheelchairs but it no longer meets your needs, you can contact the team for a review. We offer free maintenance and repair for wheelchairs provided by the service.

	Referrals are accepted from: • GPs • Health and social care professionals The service is not suitable for people: • who require a wheelchair for short term use of less than 6 months • who are undergoing rehabilitation or who are not medically stable • who require outdoor only powered mobility • who are living in Nursing Home/ Residential Home and require a wheelchair for transit use only Referral route • Send a wheelchair referral form via fax to 020 7485 5306 • Email wheelchair referral form to candi.wheelchairservice@nhs.net
Service times	The service is open between 9am and 5pm daily.
Choose and Book	No
Service locations	Peckwater Centre 6 Peckwater Street, London NW5 2UP Tel: 020 3317 5400

Service type	**Palliative Care**
About the service	The Palliative Care Team provides specialist palliative and end of life care to residents of South Camden, North East Westminster, and Islington and to patients being cared for in University College London Hospital Trust (UCLH) and HCA Ltd, a private health care provider with inpatient units in UCLH, Harley Street and the Princess Grace Hospital. It comprises of three multi-disciplinary teams: Camden community team, Islington ELiPse community team, and the in-patient team Our palliative care service specialists include nurses, doctors, occupational therapists, physiotherapists, social workers/counsellors and assistant practitioners. We give telephone advice and see people in their homes regarding end of life issues, but also provide symptom control and support at other times of need, whether they have cancer or another progressive illness, such as heart failure, chronic respiratory diseases, neurological conditions and many more. We may even be involved for a short time when someone is first diagnosed with the condition, to help them in the

	process. As well as our community teams, we also have a hospital team of palliative care nurses and doctors caring for patients within St Pancras Hospital, University College London Hospitals (UCLH) and the HCA sites at Harley Street Clinic, Harley Street on T15 and Princess Grace Hospital. This provides good links with other professionals working in the community, local hospitals and hospices, and the paediatric community palliative care team (LifeForce).
Eligibility criteria (who is the service for?	Referrals are accepted from: • GPs • Acute Services • Community services • Patients and families (self referrals are accepted, we will always check with the GP or hospital consultant to check that our input is needed before accepting the referral)
How can someone be referred?	For community referrals, a North Central London Palliative Care Referral should be completed For inpatients contact: 020-3447-7140. Out of Hours, please call 0845 1555000 and ask the switchboard operator to air-call the palliative care team For patients in South Camden and North East Westminster please call 020 3447 7140 For patients in Islington please call 020 3317 5777 For inpatients please call 020 3447 7140
Service times	
Choose and Book	NO
Service locations	As well as our community teams, we also have a hospital team of palliative care nurses and doctors caring for patients within St Pancras Hospital, University College London Hospitals (UCLH) and the HCA sites at Harley Street Clinic, Harley Street on T15 and Princess Grace Hospital.

Service type	**St Pancras Rehabilitation Unit**
About the service	We provide inpatient rehabilitation services for people requiring: • Neurological Rehabilitation following a neurological event or where a relapse in a neurological condition has impacted on the individuals functional ability • Complex Rehabilitation where a significant health event has led to a deterioration in functioning • Disability management where therapy input can facilitate better self management of reduced function

	The multidisciplinary team provides a full range of medical and therapy input. The aim of the service is to enable patients to return home as independently as possible following a hospital stay, neurological event or deterioration in their condition
Eligibility criteria (who is the service for?	Patients registered with a Camden, Islington or City and Hackney GP who: • Require inpatient rehabilitation because rehabilitation/management cannot be provided in the home or an alternative facility. Referrals are accepted from • Health or social care professionals in residential or acute settings The service is not suitable for people • without rehabilitation potential • sectioned under the Mental Health Act or with severe mental health needs • requiring isolation for infection control reasons • who are medically unstable
How can someone be referred?	CNWL Camden Community Services referral centre: 0845 900 0684 2nd Floor, South Wing, St Pancras Hospital. NW1 0PE
Service times	Monday to Friday 9.00 – 17.00
Choose and Book	NO
Service locations	South Wing, St Pancras Hospital. NW1 0PE 0845 900 0684

Service type	**Rapid Response Services**
About the service	The Rapid Response Service provides advanced nursing care and/or urgent occupational therapy to people with immediate health or functional needs who would otherwise require an admission to hospital. We offer short-term intensive support including nursing and therapeutic assessments and social care for up to ten days after which we refer on to other appropriate services. Our aim is to offer safe care at home which enables people to avoid hospital admissions.
Eligibility criteria (who is the service for?	Adults over the age of 18 who live in Camden and are registered with a Camden GP who: • require immediate intervention to prevent a possible

	hospital admission **Referrals are accepted from:** • GPs and other health and social care staff including sheltered housing managers • Next of kin • London Ambulance Service • Acute services (if the patient is already at home we are not a discharging service), **The service is not suitable for people:** • who are medically unstable
How can someone be referred?	CNWL Camden Community Services referral centre: 0845 900 0684 2nd Floor, South Wing, St Pancras Hospital. NW1 0PE
Service times	Monday to Friday 9.00 – 17.00
Choose and Book	NO
Service locations	Patients homes 0845 900 0684

Service type	**Early Supported Discharge for Stroke in the community**
About the service	The Early Supported Discharge for Stroke team provides a multidisciplinary rehabilitation programme at home for people who have recently had a stroke. The six week (maximum) programmes we offer replicate the rehabilitation services offered by an acute stroke unit and allow medically fit people to return home within 72 hours of having a stroke. Our aim is to enable people to leave hospital early but still enable them to increase functional abilities, independence and the ability to self manage.
Eligibility criteria (who is the service for?	Adults over the age of 18 who live in Camden and are registered with a Camden GP who: • have had a confirmed diagnosis of new stroke and will benefit from rehabilitation • are medically fit for discharge or for whom risks associated with discharge home can be mitigated • able to transfer with assistance of one other person **Referrals are accepted from** • Hospital Therapists/Nurses • Consultants **The service is not suitable for people** • with naso gastric tubes or complex swallowing problems

	• with significant communication/cognitive impairments which means they are not safe at home even with three times a day care visits
How can someone be referred?	ESD phone, direct paperless referrals: 07747 461273 2nd Floor, South Wing, St Pancras Hospital. NW1 0PE
Service times	Monday to Friday 9.00 – 17.00
Choose and Book	NO
Service locations	Care in delivered in patients' homes

Service type	**Community Rehabilitation Services**
About the service	The Early Supported Discharge team supports early discharge of eligible patients from acute hospitals and inpatient intermediate care beds. It provides intervention from therapists and enabling carers within client's own home for 6 weeks. The team assists in multidisciplinary hospital discharge planning and provides advice on referrals for ongoing rehabilitation. Aims to prevent patient hospital re-admissions within 30 days of hospital discharge and reduce long term care costs Our disease management services include support for people with: • Strokes and other long term neurological conditions • Diabetes • Chest conditions such as chronic obstructive pulmonary disease • Heart conditions such as heart failure
Eligibility criteria (who is the service for?	Adults over the age of 18 who live in Camden and are registered with a Camden GP who: • require community based rehabilitation and intervention • Adults with deterioration in health and physical function (not predominantly mental health) for whom an episode of rehabilitation or advice is likely to be of benefit. • Adults whose needs are related to multiple pathologies or whose needs are related to illness which typically manifests itself in later life e.g. falls, Parkinson's Disease, orthopaedic trauma degenerative bone and joint disease.
How can someone be referred?	Referrals are accepted from: • Hospital Therapists/Nurse • Consultants • PACE Nurses and Therapists Referral route

	CNWL Camden Community Services referral centre: 0845 900 0684 The service is not suitable for: • Those without rehabilitation potential • Those who require an escort home only
Service times	Tel: 0845 900 0684, 2nd Floor, South Wing, St Pancras Hospital. NW1 0PE We are open Monday-Friday 9:00 - 17:00.
Choose and Book	NO
Service locations	Home or in a location of your choice within the borough of Camden.

Community Physical Health – Hillingdon

Service type	**Adult speech and language Therapy (SALT**
About the service	The Adult Speech and Language Therapy Service is provided to patients aged 16 years and over who present with a complex range of communication and/or swallowing problems, providing patients with an individual assessment and treatment plan. The service aims to provide accessible comprehensive assessment of communication and swallowing disorders and appropriate therapeutic interventions in patients aged sixteen years and over. Following assessment all patients are advised on their treatment plan. The service also works closely with the following groups: • Input to multi-disciplinary community service • Attendance at regular Motor Neurone Disease and Multiple Sclerosis meetings • Multi-disciplinary Parkinson's Disease group • Health Care Professionals and carers who undertake training provided by the SaLT Team • Input to Patient Information Groups • Training for other Health Care Professionals and Carers • Nurses and radiotherapy radiographers who undertake training provided by the SaLT team • Input to relevant Mount Vernon Cancer Network Study Days
Eligibility criteria (who is the service for?	The service accepts referrals from all patients registered with a Hillingdon GP and those patients who are resident within the borough but have a GP outside of the borough (except Ealing). The Adult SLT service is for patients of 16 years and over. There is no service provision for Adult non-fluency patients at present. The service accepts referrals from those who present with a complex range of communication and/or swallowing problems • stroke patients • those with progressive neurological disease • patients with head and neck cancer • those with pathological and functional voice disorders.
How can someone be referred?	Patients can be referred by any of the following: • Hospital Consultants (both in and out of Borough) • G.Ps • AHPs

	• Clinical Nurse Specialists • Rapid Response Team • Palliative Care Team • District Nurses • Self-referral The service operates an appointment only system. Referrals are received via correspondence, fax, NHS Mail, the Referral Centre, telephone and face-to-face contact in clinic.
Service times	The service operates Monday to Friday from 9am to 5pm, excluding bank holidays.
Choose and Book	NO
Service locations	Mount Vernon Hospital – Rickmansworth Road, Northwood, HA6 2RN Tel: 01923 844457 The Warren Health Centre – The Warren, Uxbridge Road, Hayes, UB4 0SF Tel: 01895 484838, Eastcote Health Centre – 2A Abbotsbury Gardens, Eastcote, HA5 1TG Tel: 01895 488701 Hillingdon Hospital – Elderly Day Unit, Pield Heath Road, Hillingdon, UB8 3NN Tel: 01895 279154 Civic Centre (Health and Sensory Team) Civic Centre High Street, Uxbridge, UB8 1UW Tel: 01895 558658 Community Domiciliary Service for housebound patients Tel: 01923 8444457

Service type	**Community Cardiac Rehabilitation Team**
About the service	The service provide a comprehensive rehabilitation programme providing weekly sessions of graded exercises, education, risk factor reduction and stress management as well as answers to frequently asked questions. The service aims to help those who have suffered a chronic acute cardiac event to recover, through the provision of guidance on making lifestyle changes to ensure better overall health.
Eligibility criteria (who is the service for?	The service accepts referrals for any patient over the age of 18 who has suffered an acute cardiac event
How can someone be referred?	The service accepts referrals from Hillingdon GP registered patients by: • Self referral

	• GP • Any health care professional The service offers an appointment only system.
Service times	Operating Hours are 3 days a week (Monday, Tuesday & Wednesday) from 8.30am to 4.30pm
Choose and Book	NO
Service locations	Hillingdon Hospital, Cardiac Rehabilitation Service, Pield Health Road, Hillingdon, UB8 3NN Tel: 07984 191315. Domiciliary visits will be at the patient's home address.

Service type	**Community Heart Failure Nursing**
About the service • A brief description of the service that is meaningful and understandable to all potential users.	The heart failure service provides specialist nursing advice and management of adult patients with a diagnosis of heart failure. The service aims to enhance the care of patients with a diagnosis of heart failure (LVSD), improving quality of life and ultimately preventing avoidable hospital admissions. The service achieves this by focusing on improving patient self-management, through education and support, working closely with GPs and Hospital consultants to help patients look after their heart health. The role of the service is to: • Promote independence and educate patients so they have a good understanding of their disease and symptoms. • Promote self-management to enable patients to achieve optimum health and quality of life. • Optimise research based treatments/medicines to prevent unnecessary admissions to hospital. • To arrange appropriate palliative care to ensure comfort and symptom control when at the end stages of the disease. • To organise, facilitate and deliver specialist study days/courses to multi professional groups, e.g. Community Matrons, District nurses, GP's etc. Once a referral has been accepted, contact with patient is made within 2 weeks or earlier if urgent. A full assessment will be performed and an evidence based care plan is agreed.
Eligibility criteria (who is the service for?	• Patients must have a diagnosis of left ventricular systolic dysfunction with objective evidence such as echocardiography or angiography. • Their main clinical problem is heart failure. • Patients must be under the care of a Hillingdon general practitioner (GP) • Patients must be willing to accept the added support of the

	service. • Discharged patients can also refer back into the service. **Exclusion criteria** • Patients with right sided heart failure. • Patients not registered with a Hillingdon GP • Patients who do not have a definitive diagnosis with echo evidence
How can someone be referred?	Referrals for the service are received from a variety of primary care settings which include GP's, District Nurses, Community Matrons, and secondary care, Cardiologists, Care of the Elderly, post discharge or from OPD clinics. Referrals are initially discussed with the Heart Failure nurses to ensure appropriateness and then information is faxed over to Oak Farm on 01895 484 811. Referrals are accepted from Healthcare professionals and Hillingdon GPs. The service operates appointments only by domiciliary visits or clinic based.
Service times	Monday to Friday, 8:30 – 4:30pm Tel: 01895 484810
Choose and Book	NO
Service locations • Please check locations as shown • Provide telephone numbers	Mount Vernon Hospital, Rickmansworth Road, Northwood, Middlesex HA6 2RN Tel: 01895 484810 Hesa Clinic, 52 Station Road, Hayes, Middlesex UB3 4DD Tel: 01895 484800 Uxbridge Health Centre, Chippendale Waye, Uxbridge, Middlesex UB8 1QJ Tel: 01895 488850

Service type	**Community Matron Service**
About the service	The Case Management Programme will provide a holistic (medical and psycho-social needs) approach to managing long-term conditions that is centred on primary care. The focus of the Community Matron will be on those who would benefit the most from the service by proactively providing individualised care planning and coordination. They will help the patient to understand their disease pathways and how to recognise early symptoms or changes in their health status. Community Matrons will work closely with the patient's GP and District Nursing service in the planning and delivery of

	care. Programme principles include: • Centred on primary care • Patient centred care • Assists to extend the GP's reach into the community • Empowers patients and family to take a more active role in their care decisions • Coordinates care in order to provide seamless care across the various health care providers • Focuses on methods to better manage medications • Helps identify additional services needed to support the patient in their home. • Supports the mental wellbeing of patients to enable them to participate in their care There are five primary functions of the Community Matron: 1. **Clinical** – Provides advanced skill and knowledge in managing long-term conditions which includes a level 3 medicine review 2. **Care coordination** – Helps to manage care across providers, supports timely and organised hospital discharge. Proactively addresses future care needs 3. **Communication** – Provides timely and ongoing GP, patient and family communications 4. **Coach** – Empowers the patient to self-care, assists with providing greater understanding to patients about their conditions 5. **Care champion** – Helps patient plan and achieve care preferences and goals
Eligibility criteria (who is the service for?	The service will see Hillingdon GP registered patients up to two miles over the London Borough of Hillingdon border with the exception of the Ealing Border which the service does not go into. The following describes a typical profile of a patient. The majority of patients are adults over 65 years and have at least 3 of the following criteria: • Diagnosed with 1 or more long term conditions which is unstable/unmanageable and highly impacts the patients daily life • 2 or more A&E visits or unplanned hospital admissions within the last 12 months • Is currently taking 8 or more medications • Cognitively impaired (MSE tool) • Recently bereaved (major loss within last 6 months) • Is a main caregiver for someone else • Have had a major change in treatment within the last 30

	days • Demonstrating difficulties with ADL's • Lives alone **Exclusion criteria** • Repeated non-concordance • Patient Choice • GP Choice • Staff safety compromised after exploring options • Threat of violence • Patient stable after moving to a LTC facility • Exhausted methods to influence patient behaviour
How can someone be referred?	General Practice identification or clinical judgement – GPs and HCPs can refer those patients who meet the referral criteria above. The service only accepts referrals from clinicians/HCPs. The service operates offering patients domiciliary visits at home by appointment.
Service times	Monday to Friday 9.00am to 5.00pm
Choose and Book	NO
Service locations	Ickenham Clinic, Community Close, Long Lane, Ickenham UB10 8RE Tel: 01895 488820

Service type	**Community Dental Service**
About the service	The Community Dental Service provides a range of specialised clinical dental treatments for people who cannot obtain such care within general dental services. Referrals for specialist services are accepted from dentists only. Dentists and other health and social care practitioners may refer for special care dentistry. Once the treatment has been provided, patients are referred back to their own Dental Practitioner unless they meet acceptance criteria for special care dentistry. . The acceptance criteria have evolved to ensure that the Service targets the types of patients requiring specialist care and advanced mandatory care to keep in line with new guidelines. The commissioners will be responsible for ensuring that GDPs are aware of the acceptance criteria. The services offered to patients are listed below: • Children and adults with moderate to severe learning difficulties • Children and adults with severe physical disabilities • Children and adults with complex medical needs

	• Children with complex dental needs • Adults advanced restorative needs (see acceptance criteria) • Screening in Special schools • Oral Health Promotion Oral health promotion role remains an important service provision within the Community DentaService (CDS)..The overall aim to work with other stakeholders to improve oral health in residents in Hillingdon. The specific aim is to inform people on how to look after their teeth and gums.
Eligibility criteria (who is the service for?	Patients must be registered with a Hillingdon GMP or if unregistered, resident in the borough. In addition, a service level agreement is in place to provide Harrow residents registered with a Harrow GMP for the following specialist treatment: • Endodontics • Periodontics
How can someone be referred?	Referrals for specialist services are accepted from dentists only. Dentists and other health and social care practitioners may refer for special care dentistry. The service offer an appointments only system.
Service times	Services operate from Monday to Friday from 8:30am to 5pm (excluding bank holidays). Emergency appointments are available for clients who are undergoing treatment.
Choose and Book	NO
Service locations	Ickenham Clinic, Community Close, Long Lane, Ickenham, UB10 8RE Tel: 01895 488 820 Uxbridge Health Centre, George Street, Uxbridge, UB8 1UB Tel: 01895 488 620

Service type	**Community Children's Nursing Team**
About the service	The service provides skilled nursing care and support for children with acute, chronic and complex needs in their own homes. It will play a key role in improving patient's quality of life and enabling them to remain in their own homes by offering care co-ordination and care giving. It aims to optimise health, prevent avoidable admission to hospital and facilitate early return home. The service will provide case management support for children with the most complex needs. They provide education and training for patients, their carers,

	statutory and voluntary organisations.
Eligibility criteria (who is the service for?	The service is offered to children with a health need who require nursing care at home and who are under the age of eighteen. **Exclusion criteria** • Mental health issues • Continence assessment if not on team caseload • Continuing care assessments of children not on caseload • Enuresis • Home Ventilation • Children resident in Hillingdon with a Cross Border GP
How can someone be referred?	The service holds an open referral system and referrals should be made by face to face contact, telephone, letter or fax to the service **Diabetes referrals** Any newly diagnosed diabetic patient can be referred into the service using the above method. Those patients being assessed by the specialist nurse at Hillingdon Hospital will be seen by the service once their condition is stable. The service will link closely and meet regularly with the hospital's specialist nurses, and will follow and implement the jointly agreed Paediatric Diabetes care pathway to ensure a seamless service for patients. **Paediatric Community Matron** All referrals for the Paediatric Community Matron should be made directly to the member of staff at the following contact details: Yiewsley Health Centre, 20 High Street, Yiewsley, UB7 7DP Tel: 01895 443 686
Service times	Monday to Friday (excluding bank holidays) 8.30-4.30pm The service operates a weekend and bank holiday service for patients currently on the caseload this operates from 8.30 – 4.30pm.
Choose and Book	NO
Service locations • Please check locations as shown • Provide telephone numbers	Laurel Lodge, Harlington Road, Hillingdon UB8 3HB Tel: 01895 488480 (Monday to Friday) 07534 266001 (Weekends and Bank Holidays only)

Service type	**District Nursing**
About the service	The District Nursing Service supports housebound patients by providing skilled nursing care in their own homes and/or other

	community settings, prevents hospital admission as appropriate, and aids in the safe early discharge of patients from hospital into the community, wherever possible. The District Nursing Services provides specialist assessments and development of individualised packages of care to enable patients to have treatment in the most appropriate environment. Clinics will be run for ambulatory wound care patients in three locations across the borough. The service is provided for patients whose wounds take longer than fifteen minutes to dress. Patients with complex wounds should be referred to the Tissue Viability service.
Eligibility criteria (who is the service for?	The service sees patients who meet the following criteria: • The GP is willing to accept responsibility for care. • The patient has a nursing need, is housebound and is unable to attend the surgery. • The environment is suitable in line with health and safety policies, for the provision of care. • Consent is obtained for assessment of nursing needs. • Access can be easily gained to the property and the patient will be at home when a visit is due to be made. • Over the age of 18 Please contact the District Nursing Team if you are unsure as to whether a potential referral meets these criteria. **Exclusion criteria** • Patient is not registered with a Hillingdon GP (with the exception of patients registered with an Ealing GP who live in LBH) • The patient is not housebound, except Ambulatory Wound Clinic patients • The patient does not have an on-going nursing need • The patient does not give consent • Urgent bloods • Routine bloods for patients not already on the District Nursing caseload
How can someone be referred?	The service runs an open referral system and new referrals should be made Monday to Friday 9am and 5pm via the referral centre, tel: 01895 486127, fax 01895 625268 Referrals to the out of hours Twilight team should be made as above however between, 5pm and 12.30am there is a message taking service available on 01895 234 001 or fax 01895674606 The service accepts self re-referrals.

	The service operates via domiciliary home visits patients are advised an estimated time for their visit, when requested a two hour window if offered. For the Wound Care Clinic patients will be given a set time appointment.
Service times	365 days a year 8.00am to 4.30pm (from July 2013 the service will be extending its operating hours to 8.00am to 6.00pm)
Choose and Book	NO
Service locations	Belmont Medical Centre, 53-57 Belmont Road, Uxbridge, Middlesex, UB8 1SD Tel: 01895 233211 Yiewsley Health Centre, 20 High Street, Yiewsley UB7 7DP Tel: 01895 488840 Oak Farm Health Centre, Long Lane, Hillingdon UB10 9PB Tel: 01895 484810 Eastcote Health Centre, Abbotsbury Gardens, Eastcote HA5 1TG Tel: 01895 488810 Ickenham Health Centre, Community Close, Long Lane, Ickenham UB10 8RE Tel: 01895 488820 Northwood Health Centre, Neal Close, Acre Way, Northwood HA6 1TH Tel: 01895 488830 Minet Clinic, Avondale Drive, Hayes UB3 3NR Cedar Brook – 11 Kingshill Close, Hayes, Middlesex UB4 8DD Tel: 01895 484850

Service type	**Community Paediatricians**
About the service	The Community Paediatrician Service undertakes multi-disciplinary assessments of children with additional needs/long term conditions to provide early diagnosis and interventions / monitoring up to the age of nineteen. The Community Paediatricians are a team of highly skilled clinicians who lead in the following areas: • Designated doctor and named doctor for child protection • Medical assessments for adoption and fostering for Children in Care • Immunisation co-ordinator • Designated doctor for Education
Eligibility criteria (who is the service for?	The service sees patients who are up to the age of nineteen and has one or more of the following conditions:

	• Children with developmental delay / long term conditions • Children with epilepsy • Children with cerebral palsy • Children with chromosomal disorders • Children with neuromuscular conditions • Children with developmental coordination disorder • Babies who are high risk neonatal (non specific) follow up • Under 5's with suspected ADHD **Exclusion criteria** The community paediatrician service does not provide a service to: Children age five and over with ADHD (NB in the interest of continuity of care, children diagnosed with ADHD and already under the community paediatrician service in 2006 will remain with the service rather than transfer to CFACS)
How can someone be referred?	Referrals to the service are made in writing either by using the referral form, the Common Assessment Framework or by letter. All referrals are screened. Referrals are accepted from Professionals from health, education or social services may refer into the service via the patient's GP. The service offers an appointments only system.
Service times	The services are provided 0900-1700 Monday to Friday excluding bank holidays. The community paediatrician service is part of a 24 hour on-call rota for Child Protection with Hillingdon Hospital Paediatricians.
Choose and Book	NO
Service locations	The Child Development Centre, Woodlands Centre, Hillingdon Hospital, Pield Heath Road, Hillingdon, UB8 3NN Tel: 01895 891800

Service type	**Community Rehabilitation Team**
About the service • A brief description of the service that is meaningful and understandable to all potential users.	The service provides therapy for people who are housebound and are unable to attend an Out-Patient department. This is primarily the frail housebound or those for whom the journey to a clinic setting would be too tiring or distressing, predominately the elderly or those with long term conditions. Following initial assessment the service will also include those who can get out, but the intervention is considered to be more relevant at home. It aims to help people who are experiencing mobility problems that are directly related to their home environment and their medical status. Provided are specific individually tailored rehabilitation programmes to patients in their homes to improve functional independence. It assists

	and promotes functional independence and self care, prevention of deterioration and prevention of unnecessary hospital admission. Specific individually tailored rehabilitation action plans are provided to patients in their homes to improve their overall health and quality of life, prevent deterioration and avoid unnecessary hospital admission. The service will support work to develop more integrated assessment and services models across health and social care partners, to improve the coordination of health and social care for people living in the community
Eligibility criteria (who is the service for?	The service will see GP registered patients up to two miles over the London Borough of Hillingdon Borough Boundary. The service is for adults, aged sixteen years and over, who are have limited mobility and/or unable to attend outpatient departments. Patients or households must not be a risk to a lone worker. **Exclusion criteria** • Mobile patients within the community • Under 16 years of age
How can someone be referred?	Referrals can be made by a GP or health professional to the centre. The service offers home visit appointments to patients
Service times	Monday to Friday 8.30am to 4.30pm (Excluding Bank holidays)
Choose and Book	NO
Service locations	Eastcote Health Centre, Abbotsbury Gardens, Eastcote HA5 1TG Tel: 01895 488810 (main reception)

Service type	**Bladder & Bowel Service (Continence)**
About the service	The aim of the Bladder and Bowel Service is to promote continence and provide a fully integrated service for the early identification, treatment and management of bladder dysfunction, with or without incontinence. The main remit of the service offers an advisory and educational role to other health professionals. The Continence Nurse Specialist will treat patients with complex continence conditions, whilst other patients are seen by the District Nursing services who receive support, advice and education from the Continence Nurse Specialist. Urinary incontinence (UI) is the involuntary leakage of urine and affects people of any age The severity varies and although

	rarely life threatening, it may significantly affect quality of life. Types of incontinence include stress, urge, mixed, overflow, functional and chronic retention of urine with or without incontinence. The service provides a range of high quality TENA disposable and washable containment incontinent products to patients. The distribution to patients in their own homes/residential homes is provided by NHS Supply Chain.
Eligibility criteria (who is the service for?	Those patients requiring maintenance of equipment will be seen by the District Nursing service. Children under the age of three years may be considered for entry to the service where it can be demonstrated that requirements are above the normal level due to medical / surgical intervention. Children suffering from enuresis should be referred to the School Nursing Enuresis Clinics. **Exclusion criteria** • Clients/patients with no bladder or bowel concerns. • Frank painless haematuria • Painful palpable bladder • Unexplored raised PSA • Clients making no contact for one year will be removed from pad delivery service • Clients/patients who cannot demonstrate a need for urinary leakage requiring at least one pad per day and do not suffer from night time incontinence or suffer faecal incontinence. • End of life patients (should be directly referred to District Nursing) The service will see Hillingdon GP registered patients living in the London Boroughs of Hillingdon and Harrow, and also West Hertfordshire PCT. They do not see patients in Ealing, Buckinghamshire, Hounslow or Berkshire
How can someone be referred?	The service accepts referrals from GPs, consultants, health care professionals and self referrals. Appointments are offered at clinics on an appointment basis only and for housebound patients domiciliary visits are arranged.
Service times	8.00am to 4.00pm Monday to Friday (excluding bank holidays)
Choose and Book	NO
Service locations	Alexandra Avenue Health and Social Care Centre, 275 Alexandra Avenue, Harrow, Middlesex HA2 9DX Belmont Health Centre, 516 Kenton Lane, Harrow, Middlesex HA3 7AE

	Laurel Lodge - Harlington Road, Hillingdon, Middlesex, UB8 3HB Tel: 01895 484870 Northwood Health Centre - Neal Close, Acre Waye, Northwood, Middlesex, HA6 1TH Tel: 01895 488830 Westmead Clinic, Westmead, South Ruislip, Middlesex, HA4 0TN Tel: 01895 488860

Service type	**Diabetes**
About the service	The Diabetes Service is delivered by Specialist Diabetes Nurses with the support of specialist GPs who review the more complex cases. The service accepts referrals for patients with complex or difficult to manage diabetes who require review for: • increasing HbA1c • carbohydrate counting • renal failure & acute infection • poly-pharmacy • psycho/social issues affecting self management • hypo awareness • pre-conceptual type II diabetic women requiring conversion to Insulin Clinic appointments are provided along with home support visits. The service also supports patients and carers with education and training in the management of diabetes.
Eligibility criteria (who is the service for?	The Specialist Nurses accept referrals for complex and difficult to manage adult diabetic patients who suffer from one of the following conditions. • Poor glucaemic control or unstable diabetes • Complications • Poly-pharmacy hypo unawareness • Counselling of women with type 2 diabetes planning pregnancy **Exclusion criteria** • The Diabetes Service based at the Hesa will only see adults over the age of 18 years of age. • All new type 1 diabetes should be referred initially to secondary care, after initiation of insulin in that setting they can be referred for education to the Hesa Diabetes Team.
How can someone be	Referrals should be preferably faxed directly to the Diabetes

referred?	Nursing Service on 01895 484776 using the Diabetes Referral form or the DESMOND referral form. All Provider Services Staff can refer via RIO but must contact the Diabetes Nursing Team to discuss the referral once they have completed the RIO referral form. Appointments are offered in a clinic setting and domiciliary visits are scheduled for housebound patients. No walk-in clinics are available.
Service times	Monday to Friday (8.00 am – 4.00pm) except Bank Holidays DESMOND course are scheduled on a monthly basis and patients are offered choice of time and place to attend these do include some Saturday and late afternoon sessions.
Choose and Book	NO (plans in place to transfer to CAB by end of 2013/14)
Service locations	HESA Primary Care Centre, 52 Station Road, Hayes, UB3 4DD Tel: 01895 484 800

Service type	**District Wheelchair Service**
About the service	This service provides a wheelchair assessment of appropriate equipment for clients with reduced or no mobility. The service ensures accessibility in the home environment and equipment issued is suitable wherever possible. The service reviews people with long term disabilities and replaces equipment due to change in clinical need or where equipment becomes obsolete or beyond economic repair. The service is run with a patient centred approach with patient choice and education emphasised through • Voucher Scheme where patients are able to purchase a wheelchair of their choice using a voucher allocated by the service • Hillingdon Wheelchair Users Group which meets monthly
Eligibility criteria (who is the service for? • Identify the relevant client base, especially any/all restrictions and exclusions that may apply.	The service runs an open referral process accepting referrals from all sources including self-referral. **Exclusion criteria** • Clients who are able to walk but for various reasons refuse to do so. • People living in a Residential or Nursing Home may have an individual assessment and individual prescription of equipment usually due to specialised needs, alternatively selected homes may have access to a range of pool wheelchairs of standard sizes which residents and their carers can use and further assessment will not be needed.

	Equipment Exclusion • Cushions will not be issued for static seating. • The wheelchair service does not provide any of the following: ▪ Power packs ▪ E-motion assisted rim systems ▪ Powered outdoor wheelchairs (EPOCs) except for Service Users on the EPIOC pathway or scooters ▪ Rain covers / sun shades or comfort items ▪ Hoists ▪ Ramps ▪ Transfer boards or aids
How can someone be referred?	Referrals should be made to the Hillingdon Independent Living Centre at the address provided above. Phone referrals will be accepted but completed referral forms are preferred. Patients are offered clinic appointments or for housebound patients domiciliary visit will be arranged.
Service times	8.00 – 4.00 pm Monday to Friday excluding bank holidays.
Choose and Book	NO
Service locations	Wood End Centre, Judge Heath Lane, Hayes, UB3 2PB Tel: 01895 484881 Harrow Wheelchair Assessment Centre, Unit 11 Waverley Industrial Estate, Hailsham Drive, Harrow HA1 4TR Telephone: 020 8427 2881

Service type	**Health Visiting**
About the service	The health visiting service is to promote the health of the whole community and specifically families with children under the age of five years old, the exception being children with additional needs who are seen up to the age of seven years old. One of the key aims of the service is to promote healthy lifestyles addressing concerns about physical, psychological and mental well being. The service also aims to readdress health inequalities within the London Borough of Hillingdon. Health Visitors key principles include the search for health needs, the stimulation of an awareness of health needs, the influence on policies affecting health and the facilitation of health-enhancing activities. The health visitor will contact the family to make an appointment for the new birth visit to take place within fourteen days of birth notification.
Eligibility criteria (who is	This service is an open referral system which sees children

the service for?	and families. Health Visiting is a universal service and therefore does not strictly require referrals; however new referrals may be received via: • Parents • GPs • Midwives • Family Nurse Partnership Nurses • School Nurses • Children's Centres • Children's Services • Other Health Visitors outside of Hillingdon PCT • Allied Health professionals • Acute Trust Staff • Community Paediatricians Following the initial assessments, the needs of the children and families are targeted. The assessment process using the domains of the Common Assessment Framework tool enable a holistic assessment to be undertaken, and individual client needs identified for appropriate and specific care packages. Delivery of care packages which are sensitive and target those in most need. Targeting services to reduce inequalities particularly for vulnerable children in need of safeguarding, disability and those from BME groups. **Exclusion criteria** • Families who are abusive / threatening in line with the Trust's no tolerance policy • Families not registered with a Hillingdon/Ealing GP
How can someone be referred?	Antenatal notification form from the Maternity Unit (THH) is sent to Child Health (Provider Services) and forwarded to the relevant HV team where it is allocated to a Health visitor. New Births notifications from the Maternity Unit (THH) is sent to Child Health (Provider Services) and forwarded to the relevant HV team where it is allocated to a Health visitor. Transfer in are received from clients / GP /A&E / Child Health. They are assessed and health needs identified. A&E attendances are received from the THH and forwarded to the HV teams. Assessment and follow up if required Merlins (F78s) forms are received from the police and forwarded to relevant HV teams for assessment and follow up. Post Natal Depression – HV to 'Way Forward Group' (facilitated by group of HVs)

	Severe Post Natal Depression referred to GP
Service times	Monday to Friday 8.30 – 4.30pm The service also offers some Saturday morning sessions at Children Centres
Choose and Book	NO
Service locations	Laurel Lodge, Harlington Road, Uxbridge UB8 3HD Tel: 01895 484870 Northwood HC, Neal Close, Northwood HA6 1TH Tel: 01895 488830 Westmead Clinic, Westmead, South Ruislip HA4 0TN Tel: 01895 4888860 Ickenham Clinic, Community Close, Ickenham UB8 8RE Tel: 01895 488820 Minet Clinic, Avondale Drive, Hayes UB3 3NR Tel: 01895 484830 Uxbridge Health Centre, Chippendale Way, Uxbridge UB8 1QJ Tel: 01895 488850 The Warren Health Centre, The Warren, Hayes UB4 0SF Tel: 01895 484840 Yiewsley Health Centre, 20 High Street, Yiewsley, UB7 7DP Tel: 01895 488840 Community Engagement Team, Hesa Centre, Station Road, Hayes, UB8 4DD Tel: 01895 484800

Service type	**Hillingdon Centre For Independent Living (HCIL)**
About the service	Hillingdon Independent Living Centre (HILC) is registered as a Disabled Living Centre with Assist UK, which is a network of national disabled living centres. It is one of nearly fifty centres nationally and works in partnership with Disablement Association Hillingdon (DASH). HILC is a jointly funded service with London Borough of Hillingdon (LBH). The service is a permanent exhibition of equipment and acts as an information and assessment centre for prescribers in both health and Social Services. Advice is also offered directly to service users wishing to purchase equipment privately, gain education and advice or wishing to link with voluntary agencies. The service assists in admission prevention and early discharge from the acute setting by offering training to

	hospital nurses, occupational therapists and physiotherapists enabling them to HILC works closely with other Provider Services teams to support them when ordering equipment for clients. It also links closely, and provides advice to Social Services and Hospital therapists. During 2008, the Provider arm has worked closely with LBH to redefine the service and to re-launch to service users. This model is currently being refined and will need to be reflected in the service specification once finalised.
Eligibility criteria (who is the service for?	Referrals are accepted for Hillingdon GP Registered Patients from clients or carers who require equipment information, trial of equipment or training in use and what to consider when buying equipment. **Exclusion criteria** Service Users living outside Hillingdon and not registered with a Hillingdon GP.
How can someone be referred?	Referrals can be from any stakeholder or self referral by Telephone or letter. All patients are seen on an appointment only basis. There is no such referral form but all requests are logged on the form below and processed by the service.
Service times	8.30- 4.15pm excluding bank holidays.
Choose and Book	NO
Service locations	Hillingdon Independent Living Centre, Wood End Centre, Judge Heath Lane, Hayes, Middlesex UB3 2PB Tel: 01895 484 880

Service type	**Looked After Children**
About the service • A brief description of the service that is meaningful and understandable to all potential users.	The responsibility of the Service for Children in Care extends nationally. The Children in Care Designated Doctor and Nurse organise and ensure that all Children in Care (who are the responsibility of the London Borough of Hillingdon) have their Health Assessments and also contribute to their Health Action Plans. The Children in Care team also provide a service to children residing in Hillingdon who are looked after by another Local Authority. The following services are provided either individually by team members or as part of a multi-disciplinary/multi-agency team: • Training - contributes and delivers multi agency training in line with Corporate Parenting work plan. Develop, offer

	and implement training to HCH staff, who work with children in care and their families. Training is also delivered to social workers, foster carers and staff/children in residential establishments. • Advice & Support to all staff • Audits (of service standards) are conducted to maintain a high quality service • Attendance if necessary at relevant looked after children reviews. • Attendance at the Corporate Parent Board and sub groups to contribute to inter agency working • Links and advice to Hospital Trusts and independent contractors and other agencies e.g. Social Services, Education, Police and Voluntary Services **Other work includes:** • Teenage pregnancy – sexual health of young people, sexual health outreach services. • Emotional wellbeing – Wellbeing project, CAMHS transition group, Self harm working group • Health assessment meetings – Service manager (LBH) meetings • Active involvement of young people – Youth council meetings, Kids in Care Awards group • Corporate Parenting Board • Adoption panel (as part of the community paediatrician role) • Fostering panel (as part of the community paediatrician role)
Eligibility criteria (who is the service for?	The referral criteria is in line with the 'Statutory Guidance on Promoting the Health and Well-being of Looked After Children', (DCSF/DH 2009). **Exclusion Criteria** The service is only available to children (under the age of 18) Children with disabilities may be seen up to their 19th birthday. We may be asked to review health needs of care leavers.
How can someone be referred?	Referrals can be made using the contact details (see below). Referrals are received from social services within and outside the CCG & Borough.
Service times	Monday to Friday between 9am and 5pm (excluding weekends and Bank Holidays).
Choose and Book	YES / NO
Service locations	The lead Nurse and main service is based at:

	Minet Clinic, Avondale Drive, Hayes, Middx UB3 3NR Tel: 01895 484940 The Designated Doctor for Looked after Children is based at the Child Development Centre. The Hillingdon Hospital, Pield Heath Road, Uxbridge, Middx UB8 3NN Tel: 01895 279370

Service type	**Paediatric Occupational Therapy**
About the service	The Paediatric Occupational Therapy service provides assessment of function, mobility, sensory processing, perception and development. The Occupational Therapy service focuses on assessing the daily functional impact of any impairment. It provides strategies in partnership with parents and children, to modify sensory processing difficulties, provide splinting and equipment to improve function, prevent deformity, control tone and encourage enablement of tasks. **Acquired Brain Injury (ABI)** Any child with an ABI at Hillingdon Hospital will be assessed by the service prior to discharge to ensure it is suitable for the child to be discharged into the community. Treatment of the child, for more than one session per week is excluded from this SLA agreement. If the service decides the child can be appropriately managed in the community then the service will seek approval of funding from Commissioning. One therapy session per week will be included in this SLA agreement. Any additional therapy will be charged on an hourly basis to commissioning.
Eligibility criteria (who is the service for? • Identify the relevant client base, especially any/all restrictions and exclusions that may apply.	The service sees children ages 0-16yrs and up to 19yrs for students in full time education who are registered with a Hillingdon GP and meet the criteria detailed below. • Children with Physical Disabilities (PD) and identified neuro dysfunction, e.g. Cerebral Palsy, Spina Bifida, Erb's palsy, muscular dystrophy, etc. • Children with Severe Learning Disabilities (SLD) with difficulties with postural motor or sensory function • Children with an uneven pattern of development, with obvious deficits in the following functions: ▪ Postural-motor function, e.g. weak muscle tone ▪ Sensory processing functions, e.g. sensory seeking behaviour, or hyper-reactivity to external stimuli, etc. ▪ Perceptual functions, e.g. poor visual

	discrimination and visual-spatial skills, etc. ▪ Motor-planning function, e.g. sequencing, spatial, mature hand grasp, etc. ▪ Gross and fine motor skills, e.g. balance, ball skills, mature hand grasp, etc. ▪ Activities of daily living, e.g. self-dressing, self-feeding, etc. ▪ These children may/may not have a diagnosis of autism, social and communication problems etc. The key is the presence of an uneven pattern of development ▪ Children with congenital abnormalities, which affect their development, e.g. limb deficiency. ▪ Children with more than one presenting impairment. **Exclusion criteria** • Children with an even pattern of development, though they could have mild to moderate grade learning disabilities. • Children with mild to moderate general development delay. • Autistic children without obvious deficits in sensory, perceptual and motor functions. • Children with only ONE presenting problem but without other concomitant deficits, e.g. ▪ Toileting ▪ Hypersensitivity ▪ Handwriting. • Children who present Primary emotional and behavioural difficulties not related to any underlying dysfunctions. • Children who present behavioural problems because of stress within the family dynamic. Babies and infants without clear needs of Occupational Therapy input. Decision on referral should be made at a later stage once the child's needs are clear, e.g. baby with Down's Syndrome
How can someone be referred?	The Paediatric Occupational Therapy Service accepts referrals from: • Consultant Paediatricians/ Medical doctors, Gps, Health Care Professionals. • The service operates an appointment only system in clinics and arranges domiciliary visits with parents and carers.
Service times	8.30-4.30 pm Monday to Friday excluding bank holidays

Choose and Book	NO
Service locations	The service is delivered at the Child Development Centre (CDC) and other community settings including client's homes, nurseries, schools, clinics and Children's Centres. Child Development Centre, The Woodlands Centre, Hillingdon Hospital, Pield Heath Road, Uxbridge, Middlesex UB8 3NN Tel: 01895 891211

Service type	**Paediatric Physiotherapy**
About the service • A brief description of the service that is meaningful and understandable to all potential users.	Paediatric Physiotherapy intervention aims to promote optimal motor functioning and to facilitate normal development. The service aim is to support each child to achieve their maximum potential as a valued member of society. The service aims to prevent secondary complications resulting from altered tone, spasticity and reduced mobility. This includes prevention of muscular and joint contractures, pressure relief, abnormal skeletal growth and respiratory complications. Effective intervention reduces the amount of hospital admissions and the need for hospital consultations. The service aims to promote self care and patient responsibility for their own condition. Integration into society in line with the patient's ability and independence is the ultimate aim of the service. **Acquired Brain Injury (ABI)** Any child with an ABI at Hillingdon Hospital will be assessed by the service prior to discharge to ensure it is suitable for the child to be discharged into the community. Treatment of the child, for more than one session per week is excluded from this SLA agreement. If the service decides the child can be appropriately managed in the community then the service will seek approval of funding from Commissioning. One therapy session per week will be included in this SLA agreement. Any additional therapy will be charged on an hourly basis to commissioning.
Eligibility criteria (who is the service for?	The service provides physiotherapy to children and adolescents aged eighteen years or under, or up to nineteen years of age if attending a special school located within the borough of Hillingdon and physiotherapy is listed under paragraph 3 of their Special Needs Educations statement The service attends to children who are registered with a GP

	in the borough of Hillingdon. Children registered with a GP in West Hertfordshire or Harrow but are resident in the Hillingdon borough are also eligible to access the service. Children who attend the listed schools, but are registered and/or resident outside the borough of Hillingdon are entitled to receive physiotherapy in their school, as long as physiotherapy has been listed under section three of their Statutory educational Statement. For these children physiotherapy additional physiotherapy outside their educational setting will need to be provided by their local service. **Exclusion Criteria** Children registered with a GP based outside the borough of Hillingdon are only legible to access the physiotherapy service under the following circumstances; Children are registered with a GP based in West Herefordshire or Harrow, but are resident in Hillingdon. Such patients are entitled to receive physiotherapy treatment by the service. Children who have physiotherapy recorded in their Special Needs Educational statement under section 3, and attend one of the above named special schools in the borough of Hillingdon. The service does not attend to children older than five years with musculoskeletal conditions. The service will not attend to patients who receive private physiotherapy as outlined in the guidelines of the Chartered Society of Physiotherapy (CSP).
How can someone be referred?	The children's physiotherapy service operates with an open referral system, e.g. all parties involved with a particular child can make a referral to the service. Families are always advised to contact their GP prior to self-referral. Referrals are only accepted in original written format and need to be directed to 'The Children's Physiotherapy service' at the Child Development Centre. The service operates an appointment only system and does organise domiciliary visits with parents and carers.
Service times	8.30 – 4.30pm Monday to Friday excluding bank holidays.
Choose and Book	NO
Service locations • Please check locations as	Child Development Centre, Hillingdon Hospital, The Furze, Pield Heath Road, Uxbridge UB8 3NN

shown • Provide telephone numbers	Tel: 01895 279 434 Northwood HC, Neal Close, Northwood HA6 1TH Tel: 01895 488830 Hesa Centre, Station Road, Hayes, UB8 4DD Tel: 01895 48480 Minet Clinic, Avondale Drive, Hayes UB3 3NR Tel: 01895 484830 Oak Farm Health Centre, Long Lane, Hillingdon UB10 9PB Tel: 01895 484810 The service also provides physiotherapy within the following educational settings: Coteford infant school, Coteford Junior school, Grangewood School and Moorcroft School. In these settings specific service entry criteria apply which are outlined further in this document. • The service attends home visits according to the criteria outlined in the 'Hillingdon Paediatric Physiotherapy service pathways' document. • The service offers a six-weekly joint clinic with the podiatry service at Minet Clinic

Service type	**Paediatric Speech and Language Therapy**
About the service • A brief description of the service that is meaningful and understandable to all potential users.	The service provides assessment, diagnosis and treatment for a range of feeding, swallowing and speech and language difficulties for children age 0 – 16 years (or up to 18 years if in full time education) and registered with a Hillingdon GP. Assessment and Therapy is delivered via the following teams: • Pre-School Special Needs Team; • Pre-School Clinic Team, (including the Pre-School Intensive Therapy Team) • Hearing Impairment Team • School Age Team (The service for Statemented Students is commissioned by the LA) Each team has defined referral criteria and packages of care and these are provided based on the clinical needs of each child as determined by the Speech and Language Therapist.
Eligibility criteria (who is the service for?	The agreement covers NHS activity for the Commissioner's registered population and other non registered people resident in Hillingdon. Eligibility for provided services varies from registration to residency on a service by service basis. **Exclusion criteria** All appropriate referrals will be offered an initial assessment

	appointment.
How can someone be referred?	The service operates an open referral system in line with Professional Guidelines (RCSLT). This means that referrals can be received from anyone concerned about a child's speech and language development (with parental consent) Referrals are typically received from GPs, early years practitioners, health visitors, paediatricians, audiology, parents, teachers of the deaf, education staff. All referrals must be made via the Central Referral and Messaging Service at Westmead Clinic using the SLT service Pre school/ School age referral forms or CAF.
Service times	8.30 – 4.30 pm Monday to Friday excluding bank holidays.
Choose and Book	NO
Service locations	

Service type	**Palliative Care Team**
About the service	The Palliative Care team is a group of Clinical Nurse Specialists who hold a caseload of patients with complex needs in the palliative phase of their life (both cancer and non-cancer related). The service provides expert and proactive advice and support in holistic symptom control management to patients, carers and families. The aim of the service is to provide adult patients registered with a Hillingdon GP who have specialist palliative care needs with fast and equitable access to palliative and supportive care services. The service works closely with other specialist and general teams to provide a high level of care to patients at all times. The Hillingdon Community Palliative Care Team is leading the implementation of The Gold Standard framework across the community health economy. As part of this initiative each patient is reviewed as a minimum on a monthly basis (increasing if their symptoms become unstable) with the relevant District Nurse and Community Matron teams to ensure a pro-active end of life plan is maintained and enables patient choice regarding location in the final stages of life.
Eligibility criteria (who is the service for?	The service is open to adult patients registered with a Hillingdon GP who have specialist palliative care needs. Exclusion criteria –those under the age of 18 **Exclusion criteria** The service will not see anyone under the age of 18
How can someone be	• Referrals can be from any health care professional working in acute hospitals, primary care,

referred?	residential/nursing homes, adult care services, self-referral, families or carers • Referrals: preferably by fax (01895 279452) using the referral form or but can also be made by telephone, in person and in writing. The service provided domiciliary visits to patients on the caseload, patients are contacted and given estimated time slots for visits.
Service times	8.30am to 4.30pm excluding bank holidays.
Choose and Book	NO
Service locations	The Furze, Hillingdon Hospital, Pield Heath Road, Uxbridge UB8 3NN Tel: 01895 279412

Service type	**Musculoskeletal (MSK) Physiotherapy**
About the service • A brief description of the service that is meaningful and understandable to all potential users.	This service provides musculoskeletal physiotherapy rehabilitation which specialises in solving, preventing, or ameliorating problems of movement, mobility, fitness, strength and stiffness, The aim of this intervention is to facilitate the patient's recovery according to their individual functional potential. Essential components of the service include: • Clinical assessment based on the principles of musculoskeletal physiotherapy to ascertain the patient's suitability for physiotherapy and physiotherapeutic diagnosis. • Development of a plan of care based on the assessment findings.
Eligibility criteria (who is the service for?	Referrals will be categorised as urgent or routine using the following guidelines. Providers will be expected to triage referrals and prioritise patients based on clinical need. URGENT: • Acute uncontrolled pain • Pain needing increasing dosages of medication • Severe disruption to lifestyle • A carer who is unable to care due to presenting condition • Soft tissue injury within 48 hours • New neurological changes ROUTINE: • Patient managing pain with medication • Disrupting family life/ work performance • Managing most daily functions

	• Chronic problem with no previous advice Patients who have already received physiotherapy for the same problem with minimal benefit, will be reassessed by a physiotherapist and further treatment given only if appropriate. Appointments will be made with the patient by the provider offering choice of appointment dates and alternative venues if original appointment is unsuitable. **Exclusion criteria** Problems requiring other special clinical expertise, or different treatment environments e.g. • Conditions requiring intensive rehabilitation e.g. head/ spinal injuries/amputation/acute multi-arthritis/primary neurology. • Respiratory conditions e.g. COAD/ asthma • Over riding mental health problems affecting perception/compliance (there are occasions when physiotherapists are working alone in a clinic) • Children under five years of age with musculoskeletal conditions are assessed and treated by the paediatric physiotherapy service at the Child Development Centre
How can someone be referred?	Referral to the service will be via a Hillingdon registered GP using a designated referral form, referrals are accepted from GPs and Health Care professionals only. The service invites patients to call and make their own appointment at a location of choice and also offers this service via Choose and Book. There is no option for walk-in.
Service times	Monday to Friday, 8:.30am to 4.30pm which includes two evening sessions, and also two Saturday sessions per month (excluding Bank Holidays)
Choose and Book	YES
Service locations	West Drayton Physiotherapy Centre - 145 Station Road, West Drayton, Middlesex UB7 7ND Tel: 01895 488870 Laurel Lodge Clinic, Harlington Road, Hillingdon, UB8 3HD Tel: 01895 484870 Uxbridge Health Centre, George Street, Uxbridge, UB8 1SD, Tel: 01895 488850 Eastcote Health Centre Abbotsbury Gardens, Eastcote, HA5 1TG, Tel: 01895 488810 Harefield Health Centre, Rickmansworth Road, Harefield, UB9 6JY

	Tel:01895 484860 Warren Medical Centre, The Warren, Uxbridge Road, UB4 0SF Tel: 01895 484840 Westmead Clinic, Westmead, South Ruislip, HA4 0TN Tel: 01895 488860

<table>
<tr><td>Service type</td><td>Rapid Response</td></tr>
<tr><td>About the service</td><td>Rapid Response Service is designed to provide a single point of access to contact when patients over eighteen years of age, registered with a Hillingdon GP, are experiencing a health crisis in the community and could be safely cared for in the community in lieu of hospitalisation.

It is a multi-disciplinary team that will assess and initiate services in order to support the patient, within two hours of referral. They work closely with the patient's GP, District nurses and other Community Health, Social and Voluntary services to identity the most appropriate and safe package of care.

The service will also provide a community phlebotomy service for housebound patients in their own homes.</td></tr>
<tr><td>Eligibility criteria (who is the service for?</td><td>The list below includes the types of patients who could be supported by Rapid Response:

<table>
<tr><td>Callers who might access the rapid Response Service might include:</td><td>The types of conditions that might require a Rapid Response might include:</td></tr>
<tr><td>• A&E departments
• A&E GPs
• Primary GP
• Emergency Care Practitioner
• Community Matrons/Case managers
• Voluntary & Social Care staff
• District Nurses/Palliative care staff
• Nursing home staff
• Ambulance Service
• Out of hours health care professionals</td><td>• Falls without apparent injuries
• UTI
• Respiratory tract infection
• Exacerbations of COPD
• Exacerbation of CHF
• Carer has become incapacitated
• Dehydration
• Cellulitis
• Emergent change in carer situation (major carer is unavailable)
• Unstable diabetes
• Patients at end of life
• Elderly frail patients who have become symptomatic</td></tr>
</table>
</td></tr>
</table>

	<table><tr><td></td><td>and are at risk of admission</td></tr></table> NB. this is not an exhaustive list – please contact the Rapid Response service to discuss any potentially appropriate patient **Community Phlebotomy** The Community Phlebotomy service will see patients: • over the age of eighteen years • willing to receive the service • registered with a Hillingdon G.P • living within the boundary or less than two miles over the boundary • not on the District Nursing caseload • not requiring urgent same day bloods, only routine bloods. If the patient is unwell and at risk of an avoidable admission the Rapid Response service should be contacted. **Exclusion Criteria** • Patients not registered with GP's in Hillingdon or who are registered with GP's who do not have a commissioning arrangement with Hillingdon Community Health. • Patients who require a social care assessment/package where the only need identified is a social care need which would be better addressed by a direct referral to duty social services. • Patients who are resident over 2 miles from the Hillingdon border. • Patients with a known psychiatric diagnosis whose needs are better met by a specialist mental health service. NB this is not an exhaustive list – please contact the Rapid Response service to discuss any potentially appropriate patient.
How can someone be referred?	New Referrals from HCPs only. All referrals should be made by phone contact on the number below; Referral Telephone Number – 018995 633546 A detailed referral document will be completed by the call handler/Advanced Assessment Nurse to ensure patient is appropriate for the service. **Referrals from A&E** If a patient presents at A&E who could be supported in their home environment (either patient's own home of care home) a senior A&E clinician (e.g. sister/charge nurse or registrar) will refer to Rapid Response duty nurse by phoning 01895

	633546 **Referrals from the Observation Ward** Rapid Response will be willing to take patients who have been transferred to the Observation ward if the admission tariff is not changed or a GP referral into the observation ward has been intercepted prior to admission.
Service times	09.00 to 00.30, 365 days a year for assessment, 08.00 to 21.00 for provision of care (assistance with activities of daily living).
Choose and Book	NO
Service locations	Ickenham Clinic, Community Close, Ickenham, UB10 8RE Tel: 01895 488 820

Service type	**Safeguarding Adults**
About the service	The role of the Safeguarding team is to encourage public and practitioner recognition of abuse and to facilitate policies and cultures that challenge abuse. The team work with partners in Social Care, Police, The Hillingdon Hospital, and The Voluntary Sector to ensure that all people in Hillingdon have the confidence, knowledge and support to take action to counter abuse. **Responsibilities** • To provide expertise in the field of safeguarding adults. • To act as the first point of contact for staff with queries regarding Safeguarding adults issues. • To be easily contactable and accessible for staff, partners, clients families or carers. • To lead on investigations of referrals of adult abuse including report writing, (related to HCH/CNWL services). • To provide supervision in relation to safeguarding adults investigations to clinical staff. • To ensure staff are supported where necessary when managing a Safeguarding adults case. • To attend all strategy meetings and case conferences to advise and support staff where necessary and to give an opinion. • To ensure that HCH/CNWL has awareness of national and local guidelines and utilises documents in the development of strategies. • To develop and implement plans which support compliance and evidence in line with the Care Quality Commission Essential Standards of Quality and Safety. • To work with all key agencies involved in Safeguarding adults. • To represent HCH/CNWL on the Local Safeguarding Adults

	Partnership Board and all relevant sub-groups. • To attend and contribute to the Safeguarding Committee as part of HCH • Attendance at the monthly Multi agency Risk Assessment Conference (MARAC) • To raise awareness through out-reach, visiting groups, societies and other organisations • To provide training for admin, clinical, and management staff. • To develop and write policies relating to Safeguarding and Dignity and contribute in the re-writing of London Borough of Hillingdon's Multi Agency Policy. • To review any relevant incident reports and investigate, building a picture of recurring problem areas and intervene where required. • To take part in Social Services investigations regarding HCH/CNWL patients or staff including report writing. • To lead on providing IMR/chronology as part of the Serious Case Review Process. • To develop and lead on the Safeguarding Adult Annual Audit Plan and ensure audit activity is carried out as planned to evidence effectiveness and to identify any potential gaps in service provision. • To lead on the dignity agenda for across HCH services; developing appropriate strategies and plans to improve patient experience and address any gaps in delivery. • To offer support and supervision to all staff involved with safeguarding adults cases or referral. • To undertake relevant Root Cause Analysis for any serious incidents requiring investigation including pressure ulcers acquired whilst under the care of HCH.
Eligibility criteria (who is the service for?	The Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse should always be followed where there is an allegation or suspicion that a vulnerable person is being or has been abused or where there is a potential for harm to other vulnerable people Vulnerable adult - a person over the age of eighteen who is or may be in need of Community Care Services by reason of mental or other disability, age or illness and is unable to take care of himself/herself or is unable to protect themselves against significant harm or serious exploitation (DoH 2000) Definition of abuse - Any act or failure to act which results in a significant breach of a vulnerable person's human rights, civil liberties, bodily integrity, dignity or general well being: whether intended or inadvertent; including sexual relationships or financial transactions to which a person has not or cannot validly consent, or which are deliberately

	exploitative (Council of Europe 2002) **Exclusion criteria** For anyone not registered with a Hillingdon GP the relevant PCT or Social Service would need to be contacted and the team will endeavour, where possible, to facilitate cross boundary safeguarding concerns.
How can someone be referred?	By telephone or faxed referral to the numbers detailed below. Concerns can be initially discussed with the team to support a decision as to whether or not onward referral to the Safeguarding Adults Team at LBH is required.
Service times	Monday to Friday 8-4pm excluding bank holidays
Choose and Book	NO
Service locations	Kirk House, 97-109 High Street, Yiewsley, Middlesex UB7 7HJ Tel: 01895 488241 or 01895 488242 Fax: 01895 488253 For urgent enquiries 07932 605993 or 07904 168690, Out of hours: there is a HCH senior manager on call 07958 331078.

Service type	**School Nursing**
About the service	School Nursing provides specialist nursing care, advice and support to school age children, young people and their families to enable achievement of optimal health and wellbeing. In 2009, the two 4 hour asthma nurse specialist posts were integrated within the School Nursing team who now provide this service across all Hillingdon Schools. The Asthma school nurses are part of the Hillingdon Children's Asthma Group and provide specialist advice to schools to ensure that children with asthma receive maximum support. The service is an integrated part of the school nursing service. The service will assist Commissioners in reviewing service provision to move towards an integrated children's service, aligned with the Healthy Child Programme and Healthcare for London Children and Young People's Pathway.
Eligibility criteria (who is the service for?	**School Nursing:** The core service is offered to all children aged 5-18 years attending a Hillingdon school **Asthma Nursing:** The team offer a universal service to all schools within the London Borough of Hillingdon. This includes all state primary and secondary schools, special schools and independent schools. **Exclusion Criteria** Home visits to children attending Hillingdon schools who live

	outside of the London Borough of Hillingdon
How can someone be referred?	Referral to core services can be face to face, telephone, fax, or letter from the client, carer, school, social services Referral to the Enuresis clinic is via the Gp or Hosp consultant only Referral from neonatal BCG is via parents / carers by making an appointment directly to the host clinic Seasons for Growth can be referred by parents, schools or school nurse Enuresis clinics offer patients scheduled appointments only.
Service times	Monday to Friday 9am to 5pm term time only with a limited service during school holidays targeting BCG/Enuresis clinics.
Choose and Book	NO
Service locations	Eastcote Health Centre, Abbotsbury Gardens, Eastcote, HA5 1TG Tel: 01895 488 810 Minet Clinic, Avondale Drive, Hayes, UB3 3NR Tel: 01895 484 830 Laurel Lodge, Harlington Road, Hillingdon, UB8 3HB Tel: 01895 484 870

Service type	**TB Nursing**
About the service	The TB Specialist Nurses work in partnership with the multi disciplinary team based at The Hillingdon Hospital. The purpose of the Team is to prevent, control and treat TB across the London Borough of Hillingdon. The Community based element of the service provides out break management, community support eg: following up patients during treatment for medicine adherence, side effects, symptoms, drug interactions. DOT Therapy and health promotion and awareness for patients and significant others eg. Family members in their home setting or within a community based clinic.
Eligibility criteria (who is the service for?	The service sees patients of all ages who have or have been exposed to TB, are suspected of having TB, are new entrants to the UK from countries where the incidence of TB in the population is >40 per 100,000.(present time only new entrants referred from port health (103) e.g. individuals with abnormal chest x-rays Referrals are accepted.
How can someone be referred?	The service is accessible via Hillingdon Hospital, GP's , practice nurses, Borough education establishments and all PCT services, mental health Trust, local authority services, care

	and residential homes, voluntary organisations, immigration detention/ removal centres (Harmondsworth & Colnbrooke) , Health Control Unit (Heathrow), HCW from other PCT's, HPA, self referral and the Mobile X-Ray Unit.
Service times	Monday to Friday 9am to 5pm excluding bank holidays.
Choose and Book	NO
Service locations	The Hillingdon Hospital. Hillingdon clinics. Education establishments in the London Borough of Hillingdon. Patient's homes or at appropriate locations suitable for effective service delivery. Tel: 01895 488228

Service type	**Tissue viability**
About the service	The tissue viability service is delivered both in the community and at a central clinic on the South Borough and has the following aims: • To assist health care professionals in the management of patients with complex wounds. The specialist team will undertake a full assessment, outlining a care programme with the patient and multidisciplinary team and suggest a treatment pathway. The service does not provide total management of care, but provides the specialist support to facilitate HCP's to deliver the appropriate management. The patient will be given a follow-up visit/appointment to assess progress. • To provide expert training to healthcare professionals in the assessment & management of complex wounds • To prevent inappropriate secondary care referrals - see pathway • Prevent inappropriate hospital admission • Facilitate early discharge from hospital. • Facilitate research and audit • Encourage and promote public health through education and facilitation • To facilitate a one stop multi-disciplinary team approach in the complex wound treatment centre (CWC), for patients with diabetic foot wounds.
Eligibility criteria (who is the service for? • Identify the relevant client base, especially any/all restrictions and exclusions that may apply.	**DOMICILLARY TISSUE VIABILITY SERVICE** • Patient must be registered with a Hillingdon GP • Patient is unable to attend the complex wound clinic. • Patient with non-healing wound present for + 4 weeks with no progression or a deteriorating wound despite following guidelines. • Support/advice required for complex tissue viability

	problems e.g. complicated by other medical conditions e.g. vascular, Diabetes, Heart failure, Renal Failure, Rheumatoid Arthritis or Deep fascia traumatic/surgical wounds where support/advice is required for management and possible advanced therapies such as TNP or EST therapy and/or advice whether to refer back to surgical team. • Request by patient • Equipment concerns e.g. Pressure relieving, VAC therapy advice/support • Education requirement for equipment or advanced therapies. • Referring HCP must be present for visit/assessment of patient • Patients with Diabetic foot ulcers (wounds below maleolus) should be referred to Podiatry as the first part of pathway since these patients require specialist podiatry assessment e.g. off-loading, debriding. Podiatry can then refer to Tissue Viability Service for advice/support regarding wound management if necessary. (See referral pathway below) **COMPLEX WOUND CLINIC** • Patient must be registered with a Hillingdon GP • Patient with non-healing wound present for + 4 weeks with no progression or a deteriorating wound despite following guidelines • Support/advice required for complex tissue viability problems e.g. complicated by other medical conditions e.g. vascular, Diabetes, Heart failure, Renal failure, Rheumatoid Arthritis, or Deep fascia traumatic/surgical wounds where support/advice is required for management and possible advanced therapies such as VAC therapy and/or advice whether to refer back to surgical team. • Request by patient • Equipment concerns e.g. Pressure relieving, VAC therapy advice/support • Patient must consent and be able to attend clinic and be able to weight bear. • Education requirement • For specialist support following discharge from acute care • For patients recruited/followed up as part of a research project. • Referring Practitioner must be able to attend complex wound treatment centre, following initial assessment for training in the on-going management of their patient if necessary.

	• Practitioner must be able to under-take shared care in the on-going management of their patient. • Patients with Diabetic foot ulcers (wounds below maleolus) should be referred to Podiatry as the first part of pathway since these patients require specialist podiatry assessment e.g. off-loading, debriding. Podiatry can then refer to Tissue Viability Service for advice/support regarding wound management if necessary. (See referral pathway) **Exclusion Criteria** • Patients without a wound • Patients with post operative pilonidal sinus wounds. If these patients are failing to heal/deteriorate they should be referred back to the Surgical Team since they usually require further surgical intervention and excision. • Patients who do not meet the referral/admission criteria.
How can someone be referred?	Fax Tissue viability referral form to Hesa Primary Care Centre 01895 486034 The service operates an appointment only system for clinics and domiciliary visits are delivered in patient homes by prior arrangement. Nursing Homes fax referral form to Harefield Health Centre 01895 484 861 or phone 01895 484 860 or 07946342196
Service times	Monday - Friday 8.30am -5pm excluding bank holidays.
Choose and Book	No
Service locations	Community including patients' homes, and Northwood & Pinner Community Unit. Complex Wound Clinic (CWC) Hesa Primary Care Centre, 52, Station Road Hayes Middlesex. The clinic has the use of four clinical rooms on the ground floor which has disabled access. Tel: 01895 485002 Nursing Homes

Service type	**Northwood and Pinner Community Unit**
About the service	Northwood and Pinner Community Unit (NPCU) is a twenty two bedded inpatient facility operated and managed by Provider Services. The unit is housed on the Mount Vernon hospital site within the medical block. The service provided has a long and locally cherished tradition, the original site having been donated by the local

	people It is a medically led service which offers a Multidisciplinary team approach including the services of an attached Physiotherapy, Pharmacist and Specialist Nurse, Activities Coordinator and Occupational Therapist input. Members of community teams such as Community Matrons, and Rapid Response work closely with the unit. Some of the benefits of this approach are: • Patients are familiar with staff • Discharges are well planned and facilitated • Community staff have direct access to non-acute inpatient beds The range of services on offer to inpatients mean that there is no specific stigma attached as it is a mixed age and diagnosis/treatment ward, as compared to a care of the elderly facility or a hospice. The first referrals for respite care must be made through the patients GP (subsequent respite care can be arranged directly by the patient or carer with NPCU).
Eligibility criteria (who is the service for? • Identify the relevant client base, especially any/all restrictions and exclusions that may apply.	**Criteria for admission for Intermediate care** • Be registered with a Hillingdon GP • Have a potential for rehabilitation • Eighteen years of age or over • Appropriate health needs that the Unit can manage • Assessed as medically stable, so their care can be managed outside an acute hospital setting • Assessed as having rehabilitation potential with the expectation of them returning to their own home • Assessed as having an MMSE (Mini Mental State Examination) score of 17 or above. Or MTS (Mental Health Score) of 7/10 although this is not always the deciding factor. **Criteria for admission for Respite care** • Be registered with a Hillingdon GP • Normally be cared for at home • Eighteen years of age or over • Require twenty four hour care with a nursing input • Medical cover provided by THH Care of the Elderly Team who is also responsible for Intermediate Care Patients • Assessed as medically stable, so their care can be managed outside an acute hospital setting • Have medication available for the length of their respite care (no dossette box) • Have resuscitation status confirmed

	• Appropriate health needs that the Unit can manage • There is potential for admission for clients assessed as eligible for NHS continuing care managed in a domiciliary setting **Exclusion criteria** We are unable to accept referrals for Intermediate care in these settings for: • Clients who have mental health problems which are reflected in wandering, disruptive or challenging behaviour • Clients requiring acute medical care We are unable to accept referrals for respite care in these settings for: • Clients that have mental health problems that are reflected in wandering, disruptive or challenging behaviour • Clients being discharged from an acute hospital setting • Clients requiring acute medical care • Clients who primarily require social or personal care, rather than medical or nursing care
How can someone be referred?	Any patient who is aged over eighteen and meets the referral criteria can be referred by any health or social care professional.
Service times	Twenty-four hours a day, seven days a week throughout the year.
Choose and Book	NO
Service locations	Northwood and Pinner Community Unit, Medical Block, Mount Vernon Hospital, Rickmansworth Road, Northwood, HA6 2RN Tel: 01923 844 226

Service type	**Podiatry**
About the service	Podiatry services core aim is to maintain tissue viability and improve foot function. Foot problems constitute a diverse group of different needs, where more than one condition may co-exist. The three main groups requiring foot care include: a) People with systemic disease, which puts the feet at risk (e.g. diabetics), b) Disabling foot conditions (e.g. arthritic conditions) and c) Basic foot care (e.g. inability to self care).

Eligibility criteria (who is the service for?	**Referral criteria and sources** Eligibility is prioritised to those with a known Medical and or Podiatric Risk factor, using a Triage model of care (See below). Each individual patient is given a short and long term treatment plan with patients falling into 4 main groups. Each individual patient is given a short and long term treatment plan with patients falling into 4 main groups. a) Intensive course of treatment leading to cure and discharge. E.g. nail surgery b) Short course of treatment leading to discharge. e.g. musculo-skeletal c) Surveillance and management of high risk patients who meet prioritisation criteria to prevent serious limb threatening complications e.g. Neuro/Ischaemic Diabetics. d) Routine maintenance for High risk patients who return for regular treatment e.g. Rheumatoid Patients. **Exclusion Criteria** Any patient not attending their scheduled appointment, without prior notification, more than two times will be discharged from the service. Diabetic patients covered by GP's through the LES or QOF.
How can someone be referred?	Referral to the service is by written referral using the Podiatry Application form, or via letter from a health care professional. The service offers patients appointments to attend clinic for housebound patients domiciliary visits are arranged. The service also offers patient choice through choose and book.
Service times	8.30am to 5.pm, Monday to Friday, excluding bank holidays
Choose and Book	YES
Service locations	Eastcote Health Centre Tel: 01895 48810 Harefield Health Centre Tel: 01895 484860 Hesa Primary Care Centre Tel: 01895 484800 Ickenham Clinic Tel: 01895 488820 Laurel Lodge Clinic Tel: 01895 484870 Minet Clinic Tel: 01895 484830 Uxbridge Health Centre Tel: 01895 488850

	Yiewsley Health Centre Tel: 01895 488840 Westmead Clinic Tel: 01895 488860

Service type	**EPIOC (Electronically Powered Indoors and Outdoor Chairs)**
About the service	The EPIOC Service will provide a comprehensive service for people of all ages with long-term mobility problems and associated postural needs in accordance with statutory requirements and standards of the NHS Plan, the NSF for Older People and the NSF for Long-term Neurological Conditions.
Eligibility criteria (who is the service for?	**Referral criteria and sources** This service will only see Hillingdon GP registered patients living in the London Borough of Hillingdon or neighbouring boroughs. **Exclusion criteria** Clients who are able to walk but for various reasons refuse to do so.
How can someone be referred?	The service runs an open referral process accepting referrals from all sources including self-referral Initial access to the service will be via one of the following routes: • referral from a health or social care professional, which may be by letter or initially by telephone • from a district wheelchair service.
Service times	Monday to Friday, from 8.15am to 4.15pm (excluding bank holidays)
Choose and Book	No
Service locations	Wood End Centre, Judge Heath Lane, Hayes, Middlesex UB3 2PB Tel: 01895 484 880

Community Physical Health – Milton Keynes

Service type	**The Acute Home Treatment Team (AHTT)**
About the service	The Acute Home Treatment Team is based at the Campbell centre and offers 24/7 support to people from 18 years upwards who are experiencing acute psychiatric distress, that without the intervention of the team, would require admission to hospital. The team is multidisciplinary in nature and offers a range of medical and psycho-social interventions. The Acute Home Treatment Team work in close collaboration with the Inpatient Service and Care Coordinators, with its main function as "Gate-Keepers" for all acute beds. All admissions to all inpatient beds must be gate kept through the Acute Home Treatment Team.
Eligibility criteria (who is the service for?	We offer 24/7 support to people from 18 years upwards at home, rather than in hospital. Our carers will visit individuals up to four times a week. If a patient gets very unwell, we'll be sure to find them a bed a hospital.
How can someone be referred?	Our patients come to us through the Mental Health Assessment Service. If they need a lot of support, then we will offer them help.
Service times	24/7
Choose and Book	NO
Service locations	Mental Health Assessment Service on 01908 605650 Senior Practitioner – Tamba Van Songa

Service type	**Assertive Outreach Team**
About the service	Community based service dealing with enduring psychotic illness. We work with clients who are difficult to engage, non-concordant with prescribed medication and who need help with social inclusion, activities of daily living and need motivation to attend activities.
Eligibility criteria (who is the service for?	The service is available to people over the age of 18 who are registered with a Milton Keynes General Practitioner (GP).
How can someone be referred?	You can be referred by any Recovery and Rehabilitation Team in Milton Keynes.
Service times	We work 9am to 5pm Monday through Friday. Weekends and Bank Holidays we work 10am to 6pm.
Choose and Book	NO

Service locations	Westcroft Health Centre, 1 Savill Lane, Westcroft, Milton Keynes MK4 4EN Telephone: 01908 340950 Fax: 01908 340989

Service type	**The Assessment and Short Term Intervention Team (ASTI)**
About the service	The Assessment and Short Term Intervention Team (ASTI) is a community based assessment and short-term intervention team which supports individuals aged 18 and over, who have a presentation of severe and /or enduring mental illness. On completion of the assessment, the Mental Health Practitioner may provide advice or information, introduce a care plan for support and/or, if the person's needs or more complex, refer to onward to the Memory Assessment Service, Recovery Teams or to the Dementia Service.
Eligibility criteria (who is the service for?	The ASTI service provides an ageless single point of access to the mental health service.
How can someone be referred?	Referrals are accepted from any individual experiencing severe and/or enduring mental health difficulties or who are having a mental health crisis. Their family and carers and any other partner referrer may refer e.g. GPs, primary care professionals, statutory and non statutory agencies. The team will provide services within a recovery framework.
Service times	The service operates from 8am – 7pm from Monday to Friday with a more limited service provided from 9am - 5pm on Saturday and Sunday. The ASTI team host the Approved Mental Health Practitioner service from Monday – Friday 9am – 5.30pm. Outside these hours the AMHPs service is provided by an out-of-hour rota until midnight and by standby until 9am the next day.
Choose and Book	NO
Service locations	Manager - Richard Morris Tel: 01908 605650

Service type	**Campbell Centre: Mental health inpatient unit**
About the service	The Campbell Centre is a 38-bedded acute inpatient unit predominately for working age adults who require a hospital admission when suffering from a mental health problem. It is staffed over a 24 hour period and the team consists of Nurses, Occupational Therapists, Doctors, Pharmacy staff and Domestics. A range of therapeutic activities are on offer both in groups and as individuals and support is also given to

	families with our family support service. There is access to the Citizens Advice Bureau and regular surgeries for both Housing and Carers. The Unit works closely with the Acute Home Treatment Team and all the other community based services to ensure a smooth transition between services.
Eligibility criteria (who is the service for?	The service is available to people over the age of 18 who are registered with a Milton Keynes General Practitioner (GP).
How can someone be referred?	Referrals are made via the Assessment and Short Term Intervention Team (ASTI), GP or Medical consultants.
Service times	24/7
Choose and Book	NO
Service locations	Campbell Centre, Milton Keynes Hospital, Eaglestone, Milton Keynes MK6 5NG

Service type	**Children with Complex Needs Team**
About the service	Our team comprises of six children's nurses, a number of nursery nurses and a service administrator. Our services provide assessment, care, case management and the provision of supplies to children with complex needs. We offer End of Life Care, respite care to relieve family members and carers and management of complex continence needs.
Eligibility criteria (who is the service for? • Identify the relevant client base, especially any/all restrictions and exclusions that may apply.	Our service is offered to children who are registered with a Milton Keynes GP or there is an agreement in place with a neighbouring PCT to provide the service. To use our service, individuals must be under 19 years of age, and one of the following three criteria: 1. Children with severe, unpredictable or complex medical conditions, including sickle cell disease and epilepsy, and/or disability or range of complex medical conditions that indicate a very high use of health care. 2. Children with life threatening or life limiting illnesses where it is expected that they will not reach adulthood. 3. Children whose long term or complex conditions make them medically unstable and requiring input from a health professional and/or regular hospital admissions. OR • Children who attend special schools in Milton Keynes who have complex epilepsy require medical supplies or have complex continence needs that require specialist

	input.
How can someone be referred?	Children can be referred into the service by a parent, or any professional who feels that the child meets the criteria. Following receipt of the referral form, an initial assessment will be carried out by one of the community paediatric nurses. Once accepted onto the team caseload, a key worker will be identified and they will visit the family at the earliest opportunity.
Service times	Our nurses are available Monday – Friday 09.00 – 17.00 A 24 hour Out of Hours service is available for eligible children.
Choose and Book	NO
Service locations	Milton Keynes Hospital, Trust Headquarters, Hospital Campus, Standing Way, Milton Keynes MK6 5NG Nicky Saunders, Service Administrator Tel: 01908 234792 Community Paediatric Matron Tel: 01908 660033 ext 2643 Community Paediatric Nurse Tel: 01908 660033 ext 2644 Community Paediatric Nurse, Redway School Tel: 01908 206410

Service type	**Continence Service**
About the service	Our team consists of one Continence Specialist Nurse (part time), one District Nursing Continence Specialist Nurse and one Administrator (part time). We offer continence assessments to people with bowel and bladder problems. Individuals will be invited to attend the continence clinic. For those who are housebound a domiciliary visit will be offered. Following the assessment we may offer treatment, advice, support and products/equipment where necessary. We will also refer you to other specialist services where appropriate. We operate the Milton Keynes Community Health Services (MKCHS) continence product home delivery service.
Eligibility criteria (who is the service for?	The service is available to people over the age of 18 who are registered with a Milton Keynes General Practitioner (GP).
How can someone be referred?	Individuals can be referred by any health care professional e.g. GP, Specialist Nurse, Practice Nurse, District Nurse, Carer

	providing they have given consent for the referral or can self refer. Referrals can be made by telephone (do not leave referral details on the answer phone, please leave brief message, name and telephone number and your call will be returned), fax or by letter.
Service times	Continence Specialist Nurses: Monday to Friday 8.30am to 4.30pm Continence Administration Office: Monday to Friday 9am to 2pm
Choose and Book	NO
Service locations • Please check locations as shown • Provide telephone numbers	Continence Service, Whalley Drive Clinic, Whalley Drive, Bletchley, MK3 6EN Telephone: 01908 650401 Text Relay users: 18001 01908 650401 Fax: 01908 650470 Email: marie.riding@mkchs.nhs.uk

Service type	**Dental Services**
About the service	Bucks Priority Dental Service employs dentists, dental nurses, dental therapists, oral health promoters, a dental diploma team and reception staff who will always aim to provide a high standard of care and service for patients.
Eligibility criteria (who is the service for?	Hertfordshire and the South Midlands and Thames Valley NHS Local Area Teams have agreed for BPDS to provide NHS services for Priority Patients, who live within their catchment area and who fit within the criteria listed below: • Adults and children with learning disabilities. • Adults and children with complex medical problems. • Adults and children with severe mental health problems. • Children with severe behavioural management problems. • Adults with very severe anxiety and dental phobias. Patients who fit the above criteria must also be unable to access their dental care from the General Dental Services. For patients who pay NHS charges there are three standard charges for all NHS dental treatment. Dental treatment is allocated to one of three bands and the charge varies according to which band the treatment you have is in. You will find posters in our waiting rooms which will show information about the cost of NHS treatment, or see the NHS website: www.nhs.uk **Specialised services** We also provide the following specialist services – where

	appropriate; treatment with sedation or general anaesthesia and home visits. All of our clinics are accessible to disabled patients but patients who require a ground floor surgery should initially try and obtain care with a general Dental Practitioner and only be referred to BPDS if there is no ground floor access within a reasonable distance. Some of the BPDS surgeries also have hoists for those who need help transferring to the dental chair.
How can someone be referred?	**Referral** If you require dental treatment you will need to be referred to our Service. This can be done by your GDP, GP, health or social care worker. Self-referrals will be accepted if it is not possible to obtain a referral from one of the other routes. **Reminders and recalls** At the end of your course of treatment, the BPDS dentist will discuss with you when you will need to have your next dental examination (which may not be with a Bucks PDS dentist). NHS dentists now follow guidelines issued by the National Institute for Health and Clinical Excellence (NICE). This means you will be advised to attend as often as is needed to keep your teeth and gums healthy and you may no longer need a check-up every six months. **Cancellations** If you are unable to keep your appointment please let us know as soon as possible (at least 24 hours notice) so that we can give the appointment to someone else. Missed appointments waste NHS time. If you miss more than 2 appointments, we may not be able to complete your treatment or offer you NHS care in the future and you may be referred back to your GDP. Referral Form BPDS Service Booklet For Information about the cost of NHS treatments see the NHS website You can get support with making a complaint from website.
Service times	Mon – Fri: 8.45am – 4.45pm (Closed for lunch 12.30pm – 1pm) Out of Hours care Mon – Fri: 6.30pm – 9.30pm Sat/Sun/Bank Hols: 9am – 5pm
Choose and Book	NO
Service locations	Eaglestone Dental Clinic, Eaglestone Health Centre, Standing Way, Milton Keynes MK6 5AZ

	Tel: 01908 694599 Shipley Court Dental Clinic, Shipley Court Health Centre, Marsh End Roadl, Newport Pagnell, Milton Keynes, MK16 8EA Tel: 01908 210874 (Part time clinic) Urgent Care Centre, MK Hospital Campus, Fleming Drive, Milton Keynes, MK6 5NG Tel: 01908 303034 (Part time clinic) Neath Hill Dental Clinic, 1 Tower Crescent, Neath Hill, Milton Keynes MK14 6JY Tel: 01908 695332 (Part time clinic) Brookside Dental Clinic, Station Way East, Aylesbury, Bucks HP20 2SR Tel: 0844 225 2411 Bedgrove Dental Clinic, Camborne Centre, Jansel Square Aylesbury, Bucks HP21 7ET Tel: 01296 395113 (Part time clinic) Buckingham Dental Clinic, Buckingham Hospital, High Street Buckingham MK18 1NU Tel: 01280 823693 (Part time clinic) Oakridge Dental Clinic, Oakridge Health Centre, 240 Desborough Road, High Wycombe, Bucks HP11 2QR Tel: 0844 225 2406 Amersham Dental Clinic, Amersham Health Centre, Chiltern Avenue, Amersham, Bucks, HP6 5AY Tel: 01494 434605 (Part time clinic) Marlow Dental Clinic, Marlow Health Centre, Glade Road, Marlow, Bucks SL7 1DJ Tel: 01628 471348 (Part time clinic) Clinic phone numbers in clinic details above. For Out of Hours Dental care, telephone NHS Direct on 111. If you would like to comment about any aspect of our service please contact: Mrs. Natalie Bell, Operational Manager Eaglestone Dental Clinic, Eaglestone Health Centre, Standing Way, Milton Keynes, MK6 5AZ Tel: 01908 209303

Service type	**Early Intervention in Psychosis Team – Mental Health**
About the service	The Early Intervention in Psychosis Team is made up of psychiatric nurses, an occupational therapist, a psychologist, a social worker and a psychiatrist. The aims of the Early Intervention in Psychosis 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.
Eligibility criteria (who is the service for?	The Early Intervention in Psychosis Team is a team of professionals who work with young people [14 - 35] in the borough of Milton Keynes who are in the early stages of a psychotic illness.
How can someone be referred?	Anyone who is concerned about someone they believe may be experiencing psychosis can contact us. This includes: • You • GPs • Parents • Friends • Relatives • Schools and colleges • Health or Social Care professionals • Probation services and police
Service times	Monday to Friday, 9am - 5pm
Choose and Book	NO
Service locations	1 Savill Lane, Westcroft Medical Centre, Westcroft, MK4 4EN You can telephone us on 01908 340950 begin_of_the_skype_highlighting or fax us on 01908 340989

Service type	**Equipment Loans Service**
About the service • A brief description of the service that is meaningful and understandable to all potential users.	Our team comprises of Technicians. The service provides equipment to help people with disabilities and health problems to return to or remain in their homes. The equipment provided will often play a crucial part in enabling people to live as independently as possible and to improve daily life. We offer a range of equipment, including: • Toileting aids • Bathing aids

	• Walking frames • Pressure relieving cushions • Mattresses • Profiling beds • Hoists • Specialised items to meet specific conditions When the individual no longer needs the equipment, it is then returned to the Equipment Loans Service.
Eligibility criteria (who is the service for?	Clients, their carers, relatives or friends involved in their care will be provided with training in the use of the equipment. This will generally be carried out by a follow up visit from a professional. Our service is provided to anyone registered with a Milton Keynes PCT GP and/or who lives within the boundaries of Milton Keynes Council and who has been assessed as meeting the need for equipment.
How can someone be referred?	Referrals for the provision of equipment are only accepted from professionals, e.g. • Occupational Therapists (OTs) • Community OTs • Physiotherapists • District Nurses • Social Workers • General Practitioners • Consultants
Service times	Monday – Friday 9am – 5pm
Choose and Book	NO
Service locations	Equipment Loans Service, Bletchley Therapy Unit, Whalley Drive, Bletchley, Milton Keynes MK3 6EN Enquiries: 01908 379450 Text Relay: 18001 01908 379450

Service type	**Home to Stay Team**
About the service	Our team has five skilled nurses one of which will be your key worker. We answer any questions you may have about your hospital discharge and any ongoing care that has been identified for you. On discharge you will be given our information leaflet and contact numbers for the service. Our team will support you and your carers for up to 30 days after discharge from leaving hospital. We are here to help you understand how to access the services you need to keep you well at home. We provide specialist personal reviews which highlight areas

	that require input from other services, such as, your doctor, district nurses, care providers and Milton Keynes Social Services. We will work with these services to allow you to regain as much independence as possible following you hospital discharge.
Eligibility criteria (who is the service for?	Our service is provided to people who live in Milton Keynes, registered with a Milton Keynes GP and have been recently discharged from hospital. Intermediate Care services provide a wide range of community rehabilitation and therapies in Milton Keynes for any person over the age of 18. Amongst these is the Rapid Assessment and Intervention Team.
How can someone be referred?	MKCHS Staff and patients can refer themselves by ringing 01908 826763.
Service times	Monday – Friday 9am – 7pm Weekends 9am – 4pm
Choose and Book	NO
Service locations	Home to Stay Team, Maple Unit, Milton Keynes Hospital NHS Foundation Trust, Eaglestone, Milton Keynes MK6 5LD Tel: 01908 826763 Text Relay: 18001 01908 826763 If, for any reason, you need help outside the Home to Stay Team hours, please contact: NHS Direct: 0845 4647 Urgent Care: 01908 201022

Service type	**Neurological Clinical Specialist Team (NCST)**
About the service	We are a community based team of NHS professionals with a wide range of clinical expertise and knowledge relating to neurological conditions, physical disabilities and rehabilitation. Our specialists include: • Brain Injury Clinical Specialist • Sapphire Nurse Specialist (Epilepsy) • Multiple Sclerosis Clinical Specialist • Multiple Sclerosis Specialist Nurse (Disease Modifying Treatment) • Parkinson's Disease Nurse Specialist • Stroke Clinical Specialist • Neurological* Conditions Clinical Specialist (*includes Motor Neurone Disease, Huntington's Disease and other neurological conditions). Our team provides a specialist service for adults with a neurological diagnosis. Each specialist aims to empower

	individuals, their carers and family through education and support and by giving them advice about their specific condition. We also educate and support other health care professionals, voluntary and statutory bodies caring for people with neurological conditions. The clinical specialist will support the individual for as long as their condition affects their health and wellbeing. The specialist's continued guidance will help the individual to adapt to and reach the goals they set with the specialist, enabling them to cope with/manage their condition independently.
Eligibility criteria (who is the service for?	Our team will provide support to anyone aged 18 and over, who has a neurological diagnosis and is registered with a Milton Keynes GP.
How can someone be referred?	Referrals can be made by anyone, but a diagnosis must have been confirmed beforehand.
Service times	Monday to Friday 9am to 5pm
Choose and Book	NO
Service locations	Milton Keynes Community Health Services, Bletchley Community Hospital, Whalley Drive, Bletchley, Milton Keynes MK3 6EN Brain Injury Clinical Specialist - (01908) 650423 Sapphire Nurse Specialist (Epilepsy) - (01908) 378229 Multiple Sclerosis Clinical Specialist - (01908) 650420 Multiple Sclerosis Specialist Nurse - (01908) 650409 Neurological* Conditions Clinical Specialist - (01908) 650419 Parkinson's Disease Nurse Specialist - (01908) 650425 Stroke Clinical Specialist - (01908) 650424 For general enquiries, please get in touch with our Team Administrator. Tel: (01908) 650447 Text Relay: 18001 01908 650447

Service type	**Occupational Therapy**
About the service	Our team comprises of Occupational Therapists, OT Assistants, Technicians and administration support.
Eligibility criteria (who is the service for?	We provide support to people with physical disabilities who are living in the community. By helping the individual with day-to-day living and assisting their carers, we aim to enable the individual to live as independently as possible and remain at home. Depending on the outcome of the Occupational Therapist's full assessment of the individual's needs, the OT may provide

	advice, equipment or make recommendations for changes to the individual's living environment or recommend re-housing.
How can someone be referred?	Our service is offered to individuals who are aged 18 and over, live in the Milton Keynes Unitary Authority area and have any of a wide range of long term physical disabilities. Some service users will also have underlying mental health issues. Individuals are assessed within their home and our service will be offered to those who have a critical or substantial need for help.
Service times	Office hours: weekdays 9am-5pm
Choose and Book	NO
Service locations	Bletchley Therapy Unit, Whalley Drive, Milton Keynes MK3 6EN Tel: 01908 372538 (office) 01908 253772 (referrals) Please note, we cannot take referrals on the office number

Service type	**The Older Person's Assessment Service**
About the service	TOPAS (The Older Person's Assessment Service) is a modern 20-bedded en-suite unit which comprises qualified psychiatric nurses and health care assistants, providing assessment and treatment predominately for older people with complex or acute mental health needs, enabling a return to independent living wherever possible.
Eligibility criteria (who is the service for?	The service is available to people over the age of 18 who are registered with a Milton Keynes General Practitioner (GP).
How can someone be referred?	Referrals are made via the Assessment and Short Term Intervention Team (ASTI), GP or Medical consultant.
Service times	24/7
Choose and Book	NO
Service locations	Modern Matron: Amanda Baxter Senior Practitioner: Sue Rodgers

Service type	**Paediatric Service**
About the service	Our team is comprised of community paediatricians, clinical psychologist and children's assessment service coordinator. Community Paediatricians are specialist children's doctors with training and expertise in developmental paediatrics and disability, social paediatrics (including child protection), educational paediatrics and public health for children.

	Our Community Paediatricians manage children who have long term problems which often require long-term follow up care. They offer a range of services, which include: • Services for children with disabilities and complex health needs • Services for looked after children and to support adoption process • Services to provide medical information for children undergoing an assessment of their special educational needs. • Services for children with neurodevelopmental concerns such as social and communication difficulties/ autistic spectrum/developmental delay / motor co-ordination difficulties • Safeguarding and protecting children
Eligibility criteria (who is the service for?	Our service is offered to children aged 16 and under and up to the age of 19 if the child attends a special school. Service users must also be registered with a Milton Keynes GP.
How can someone be referred?	Referrals for medical assessment are accepted from Milton Keynes GPs, health visitors, school nurses, allied health professionals (e.g. therapists) and other medical consultants (e.g. CAMHS). We do not accept self referrals.
Service times	Monday to Friday 9am – 5pm
Choose and Book	NO
Service locations	Community Paediatric Team, Trust Headquarters, The Hospital Campus, Standing Way, Eaglestone, Milton Keynes MK6 5NG Please speak to your GP, Health Visitor or School Nurse who will contact us on your behalf if appropriate

Service type	**Podiatry Services**
About the service	We are a free NHS podiatry service that is available to anyone living in Milton Keynes and surrounding rural areas. We provide treatments ranging from nail care to complex musculoskeletal conditions. Our podiatrists specialise in foot-related conditions that cause pain, particularly those that affect peoples' mobility. We offer a wide range of podiatry services including: • Removal of corns and callus • Cutting of problematic nails • Removal of in-growing nails

	• General footcare advice • Treatments for ulcers, and wounds • Advice and treatment of painful verrucae • Treatment for hip, knee heel or foot pain • Diabetic foot assessment and treatment • Assessment and provision of insoles or orthotics (custom made inserts that fit inside the shoe) if required • Advice on maintaining mobility and prevention of falls • Treatment of sports injuries • Assessment and treatment of painful and developmental lower limb conditions in children We aim to provide you with: • A local, friendly and reliable service • Easy access to services near to where you live or work • Appointments times that suit you • Care tailored to your need
Eligibility criteria (who is the service for?	The service is available to people over the age of 18 who are registered with a Milton Keynes General Practitioner (GP).
How can someone be referred?	Alternatively, you can complete a referral form and return it to us via email or in the post. The form is available from most GP surgeries or health centres or you can download one here. Your GP or another healthcare professional can also refer you to the service. The service details are available on Choose and Book. Anyone, of any age can access our services, just call us on 01908 650451 or 650450.
Service times	Weekdays: 8.45am – 5pm
Choose and Book	YES – indirect booking
Service locations	Bletchley Therapy Unit, Whalley Drive, Bletchley, Milton Keynes, MK3 6EN Cobbs Garden Surgery, West Street, Olney, MK46 5HR Eaglestone Health Centre, Standing Way, Eaglestone, Milton Keynes, MK6 5AZ Neath Hill Health Centre, Tower Crescent, Neath Hill, Milton Keynes, MK14 6JY Newport Pagnell Medical Centre, Queens Avenue, Newport Pagnell, MK16 8QT Wolverton Health Centre, Gloucester Road, Wolverton, Milton Keynes, MK12 5DF

Service type	**Rapid Assessment and Intervention Team (RAIT)**
About the service	The Rapid Assessment and Intervention Team (RAIT) can work with you towards reaching your own goals by helping you to maximise your functional abilities. Our aim is to assist you to remain as independent as possible within your own home, supporting early discharge from hospital and avoiding hospital admission. The Rapid Assessment and Intervention Team (RAIT) is a multi-disciplinary team of physiotherapists, occupational therapists, nurses, speech and language therapists, and rehabilitation assistants. Providing assessment, care planning and therapy to rehabilitate and promote independence in patients own homes or as close to home as possible. Your health professional will work with you and together agree on your personal goals help you to achieve them within a carefully planned therapeutic programme. This may last from one day to a maximum of six weeks. The service is short term and input can range from a one-off visit to a full 6-week therapeutic programme. Following referral a Nurse or Therapist will come to visit you. An assessment will be completed to identify your goals and needs. A plan of care will be discussed and agreed with you to achieve your goals. RAIT will support you as necessary and your progress will be reviewed at regular intervals. If, after the assessment we are not able to meet your needs; with your agreement, a referral will be made to a more appropriate service.
Eligibility criteria (who is the service for?	The service is available to people over the age of 18 who are registered with a Milton Keynes General Practitioner (GP).
How can someone be referred?	When a referral is received, from a healthcare professional to RAIT the appropriate healthcare professional will contact you and an appointment will be made to see you, preferably in your own home, at a mutually convenient time. The assessment will involve asking you questions and gathering further information on your physical abilities and social circumstances. We also take a history of your health status, medications and any recent illness should your doctor or district nurse feel you are unable to cope at home at the moment. This information is used to agree your key goals and how our team members can work with you to achieve these goals. Any health or social care professional, for example, doctor/GP, district nurse, therapist, Intermediate Care Team Leader, or any other community or hospital based professional. Referrals are made through Single Point of Access, Intermediate Care Services.

	RAIT also have access to rehabilitation beds in Windsor Intermediate Care Unit, Bletchley and Orchard House, Wolverton. These beds are available for people who are medically stable and do not require admission to Milton Keynes General Hospital. These facilities also provide 24 hour rehabilitation and reablement to support early discharge from hospital and allow people time to recover following an illness. A range of support is provided to maximise independence prior to discharge.
Service times	9am - 9pm Monday to Friday (Last referral 7pm) Tel: 01908 363070 9am - 5pm Saturday and Sunday (Last referral 3pm) Nurses only
Choose and Book	NO
Service locations	Rapid Assessment and Intervention Team (RAIT), Intermediate Care Services, Old Windsor Ward, Bletchley Community Hospital, Whalley Drive, Bletchley, Milton Keynes MK3 6EN

Service type	**School Nursing**
About the service	Our team comprises of a Team Leader, School Nurses, Registered Nurses, Health Assistants and Administrative support staff. The team has three bases accross the Milton Keynes area in Bletchley, Statonbury and Newport Pagnell. The work we do includes: • New entry screening (age 4-5 years) When your child starts school you will be asked for your consent to allow us to carry out vision, hearing, and growth screening. Should any problems be identified we can refer your child to a relevant specialist. • National Children's Measurement Programme (age 10-11 years) In school year 6 we will measure your child's height and weight as part of the National Children's Measurement Programme. You will be given the opportunity to opt out of this programme should you not wish your child to take part. • Immunisation Programmes HPV - During school year 8 (age 12-13 years) we will offer all girls the chance to be immunised against Human Papillomavirus (HPV). This immunisation has been shown to reduce the risk of developing cancer of the cervix. Diptheria, Tetanus & Polio - During school year 10 (age 14-15 years) we will offer all children immunisation against Diptheria, Tetanus & Polio as part of their recommended childhood immunisation schedule.

	BCG - BCG vaccination offers protection against the disease called Tuberculosis. In line with current government guidelines this immunisation is now provided via a targeted service. When your child starts school (reception) and in school year 9 (age 13-14 years) you will receive a screening form to complete relating BCG immunisation. **Enuresis (Bedwetting) Service** We offer an Enuresis support service to all children (aged between 7-16 years) who reside in Milton Keynes or who are registered with Milton Keynes based GP practice. A referral can be made to this service via a relevant health care professional (i.e GP. Health Visitor, or Paediatrician). Parents are welcome to self refer their child by contacting their school nurse team. Further information relating to Enuresis can be found on the Education and Resources for Improving Childhood continence (ERIC) website.
Eligibility criteria (who is the service for?	Our team covers all mainstream schools in Milton Keynes and its surrounding areas. As a team we can offer advice and support on health issues that may affect your child's health or wellbeing. We also carry out annual programmes for health screening and immunisation. Confidential advice is available to both parents and children The service is available to children between the ages of 4 – 16 year olds who are registered with a Milton Keynes General Practitioner (GP) or at a Milton Keynes school.
How can someone be referred?	Referral can be made through Milton Keynes schools.
Service times	Milton Keynes schools times: 9am – 3.30pm
Choose and Book	NO
Service locations	Milton Keynes Schools

Service type	**Tissue Viability Service**
About the service	Tissue Viability services are provided by qualified nurses with specialist education and experience in this area. This service was developed to support practitioners, mainly district nursing, to plan and deliver optimum care to patients with complex wounds. The Tissue Viability nurses perform joint visits to patients with community staff, and provide an ongoing comprehensive education programme based on evidence and expert opinion for community and primary care staff, on all aspects of wound management. Highly skilled Specialist Nurse wound care assessment, this can

	include Doppler assessment for leg ulcer management and treatments and pressure ulcer risk assessment and treatment.
Eligibility criteria (who is the service for?	The majority of patients seen will have leg ulcers but the staff will also offer treatments for patients who have suffered burns, chronic sinuses, plastic surgery or similar problems related to skin integrity, such as venous eczema and varicose veins, chronic lower leg oedema and non-cancer related Lymphoedema. Our service is offered to individuals who are aged 18 and over, live in the Milton Keynes Unitary Authority area and have problems with acute or chronic wounds. Individuals can be seen in their own home, residential/nursing home, GP surgery, community inpatient units and the Chronic Wound Clinic.
How can someone be referred?	Referral through health professionals.
Service times	Office hours: Monday to Friday 9am to 5pm
Choose and Book	NO
Service locations	Tissue Viability Service**,** Willen Village Surgery, Beaufort Drive Willen MK15 9ET Tel: 01908 554582 (office and answer machine) Text Relay 18001 01908 554582

Service type	**Windsor intermediate Care Unit (WICU)**
About the service	A short-term programme of nursing and therapy for people who need a period of rehabilitation to enable them to regain functioning, independence and confidence to return safely to their own home. We aim to achieve a maximum length of stay of 21 days. Windsor Intermediate Care Unit is a nurse led unit. We have a contactable doctor between the hours of 9am to 5pm Monday to Friday and emergency cover outside of these times.
Eligibility criteria (who is the service for?	The service is available to people over the age of 18 who are registered with a Milton Keynes General Practitioner (GP).
How can someone be referred?	Referral can be made via a medical professional.
Service times	If you need to speak to a member of the health care team please call the unit between 9.30am to 12.00pm and 2pm to 5pm or to nursing staff after 6pm. These are the times that staff are more readily available and helps to protect patient meal times.

	Monday – Friday 3.00pm - 5.00pm 5.30pm - 9.00pm Protected meal times - 5.00pm - 5.30pm Saturday and Sunday 9.00am - 9.00pm Please do not visit during protected meal times: 12.15pm - 1.30pm 5.00pm - 5.30pm Please speak to the nurse in charge if you cannot visit between these times, but please be aware that visiting may not interrupt therapy programmes.
Choose and Book	NO
Service locations	Windsor Intermediate Care Unit, Dovecote Manor, Whalley Drive, Bletchley, Milton Keynes MK3 6EN Telephone: 01908 376415

Service type	**Dementia (Day) Services**
About the service	The community team is made up of health and social care staff who are generally known as Mental Health Practitioners. The allocation of a Mental Health Practitioner to a referral will depend on the complexity and special needs of the person being referred. Redwood Day Centre provides a range of activities for individuals and groups which encourage social interaction and provide carer respite for people who have moderate to severe dementia.
Eligibility criteria (who is the service for?	
How can someone be referred?	Referrals to the team can only be made via the Assessment and Short Term Intervention Team (see above) following assessment by the Mental Health Practitioner.
Service times	Monday to Saturday 9am to 5pm
Choose and Book	YES / NO
Service locations	Team Manager: Elaine Liburd

Service type	**Memory Assessment Support Service**
About the service	The service provides comprehensive psychiatric and neuro-psychological assessment to ascertain the cause of memory problems and arrive at a diagnosis. Following diagnosis the service offers support, education and information, group and individual sessions including cognitive stimulation therapy,

	memory strategies and CBT for carers.
Eligibility criteria (who is the service for?	The service is available to people over the age of 18 who are registered with a Milton Keynes General Practitioner (GP).
How can someone be referred?	Referrals are made via the Assessment and Short Term Intervention Team.
Service times	Monday – Friday 9am - 5pm
Choose and Book	YES / NO
Service locations	Cripps lodge Netherfield Milton Keynes

Service type	**Cherrywood House**
About the service	Cherrywood provides short-term (up to 1 year) residential rehabilitation to enable service users to return to independent living and to enable 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**.**
Eligibility criteria (who is the service for?	The target population for the rehabilitation service is people with severe and complex mental health problems aged 18 years and above who are eligible for secondary mental health services.
How can someone be referred?	To be admitted to the service a person will have been assessed as needing a period of intensive rehabilitation to enable them to redevelop skills around daily living before being able to live independently in the community. Referral to the rehabilitation service will be through the Bed Manager based at the Campbell Centre Appropriate referrals will include: • a person with severe and complex mental health needs who cannot be discharged from an acute ward but is unlikely to benefit further from an acute ward environment • a person requiring transition from a highly supported setting to a less supported placement; this includes people leaving forensic or secure services, people leaving out-of-area placements, or leaving residential care to live in the community • a person needing help in overcoming disabilities associated with severe and complex mental health problems that would benefit from a structured environment and intensive therapeutic programmes that are available on a rehabilitation service

	• assessment of, and engagement with, a person with severe and complex mental health problems who has become 'stuck' and non-progressive in their recovery
Service times	This is a 24 hour 7 days a week 365 days per year service provision.
Choose and Book	NO
Service locations	2 Gregories Drive, Wavendon Gate, Milton Keynes, MK7 7HL Virginia Richards Senior Practitioner Grace Beaman Charge Nurse 01908 282072 or by writing to the above address

Service type	**Adult Hearing Service**
About the service	• We will check the health of your ears using a light called an Otoscope • We will screen your hearing using a Siemens HearCheck Screener device which takes only a couple of minutes and is placed next to your ear • If you would benefit from a full test, we will arrange the full NHS hearing test for you • If you need hearing aids, we will fit the latest Siemens digital hearing aids available on the NHS in a range colours
Eligibility criteria (who is the service for?	If you have any concerns about the health of your ears or your hearing levels, are aged 16+ and registered with a Milton Keynes G.P – you can refer yourself to the service.
How can someone be referred?	Firstly you do NOT require a G.P. referral and no appointment is necessary to see us, you can just attend one of our Drop-in clinics across Milton Keynes.
Service times	Drop in clinics: • Every Wednesday: 9am – 12pm – Eaglestone Health Centre • 3rd Thursday of each month – 9am – 12pm – Wolverton Health Centre • 3rd Thursday of each month – 1.30pm – 3pm – Bletchley Therapy Unit on Whalley Drive Last Friday of each month – 12.00 – 3.00 – Newport Pagnell Medical Centre
Choose and Book	YES – indirect booking
Service locations	Drop in clinics at: • Eaglestone Health Centre The Hospital Campus, Sanding Way, Eaglestone, Milton KeynesMK6 5AZ • Wolverton Health Centre, Gloucester Rd, Wolverton, Milton Keynes, Buckinghamshire MK12 5DF • Bletchley Therapy Unit Whalley Drive, Bletchley, Milton

	Keynes, Buckinghamshire • Newport Pagnell Medical Centre Queens Avenue, Newport Pagnell, Buckinghamshire MK16 8QT Tel: 01908 209314

Service type	**Children and Adolescent Mental Health Services (CAMHS)**
About the service	Milton Keynes Specialist Child and Adolescent Mental Health Services (MK Sp CAMHS) is designed to support families and professionals who are concerned about children and young people who may be experiencing mental health difficulties. We work with families, children and young people who live in the Milton Keynes area, or who are registered with a Milton Keynes GP and who are causing a high level of concern owing to a significant change in the child/young person's mood or behaviour or experiencing mild, moderate or severe mental health difficulties.
Eligibility criteria (who is the service for?	Milton Keynes Specialist CAMHS provides support to children and young people up to their 18th birthday, their parents/carers and their families who: • Are causing a high level of concern to adults around them due to significant change in the child's/ young person's mood or behaviour • Reside within the Milton Keynes area or have a Milton Keynes PCT GP This Service is designed so that we can work with children, young people and/or families over a short or longer period of time if required. We work to meet the needs of the child, young person and their families using a range of psychological interventions. This may involve working with other agencies to ensure a consistent approach when meeting the needs of the community.
How can someone be referred?	You may refer to the service either by telephone on 01908 254375 / 01908 254357 via letter to Eaglestone addressed to: MK Sp CAMHS, Eaglestone Health Centre, Standing Way, Eaglestone, and Milton Keynes, MK6 5AZ. **New referrals:** All new referrals are discussed within regular team meetings. Urgent referrals are given priority appointments and non-urgent referrals are placed on a waiting list. Inappropriate referrals will be informed by letter as quickly as possible. Families will be allocated to the most appropriate professional based on the presenting information. Sometimes more than one professional may become involved. Any intervention

	offered will be discussed with you and your child/young person.
Service times	Monday – Friday: 9am – 5pm
Choose and Book	NO
Service locations	Telephone: 01908 254375 or 01908 254357 Written referrals: MK Sp CAMHS, Eaglestone Health Centre, The Hospital Campus, Standing Way, Eaglestone Milton Keynes MK6 5AZ Telephone: 01908 607501 Fax: 01908 209300

Service type	**Dermatology Service**
About the service	Team comprises of Dermatology Nurse Specialist, 2 part time Dermatology Nurses. Full time admin support. Clinical Assistant attends some clinics. See patients of all ages with a wide variety of Dermatological conditions.
Eligibility criteria (who is the service for?	Provide advice and support for the ongoing management of condition.
How can someone be referred?	Patients are referred to service by any member of the Multi-Disciplinary team.
Service times	Monday to Friday. Office hours.
Choose and Book	YES – indirect booking
Service locations	Community Dermatology Service, Shipley Court, Marsh End Road, Newport Pagnell MK16 8EA Tel: 01908 500092 Text Relay: 18001 01908 500092

Service type	**Diabetes Specialist Team**
About the service	The Diabetes Specialist Team supports the care provided by GPs and practice nurses and manages the care of those patients who have difficult to control or complicated diabetes.
Eligibility criteria (who is the service for?	The service is available to people over the age of 18 who are registered with a Milton Keynes General Practitioner (GP).
How can someone be referred?	Your GP, Practice Nurse or District Nurse will refer you to this service should you require this level of care.
Service times	Drop in clinics:

	• Diabetes clinic, diabetic foot clinic, retinal screening – Tuesday & Thursday 1.30am - 1pm • Adolescent clinic – 1st Tuesday of each month 8.30am – 1pm • Education sessions for newly diagnosed Type 2 diabetics – Wednesday pm • Joint Ante-natal and Dibetic clinic – Thursdays from 11.30am • Drop in session for diabetics who are planning a pregnancy or who are pregnant – Monday (except Bank Holiday) 12pm – 1pm • Diabetes Drop-in session – Last Monday of each month 5pm – 7pm (except Bank Holidays)
Choose and Book	NO
Service locations	The Maple Unit, Milton Keynes General Hospital, Eaglestone Milton Keynes MK6 5LD

Service type	**Early Stroke Rehabilitation Team (ESRT)**
About the service	Our team comprises of a Team Co-ordinator, Speech and Language Therapists, Social Workers, Physiotherapists, Rehabilitation Assistants, Occupational Therapists and Psychologists. We provide rehabilitation for stroke survivors in their own home. By helping you manage your day-today activities, such as, washing, dressing and cooking, and offering support to your family and/or carers, we aim to help you regain as much independence as possible following your stroke. You will see the team for varying amounts of time, depending on your needs. Our team may see you for a one-off visit or regular visits over a period of up to six weeks after hospital discharge.
Eligibility criteria (who is the service for?	The service is available to people over the age of 18 who are registered with a Milton Keynes General Practitioner (GP).
How can someone be referred?	Patients are referred into the service by their hospital consultant. If you need any more help at the end of 6 weeks, you will be referred to another service.
Service times	Monday – Friday 09.00am – 07.00pm Weekends 09.00am – 04.00pm
Choose and Book	NO
Service locations	ESRT Co-ordinator: Intermediate Care Services, Old Windsor Ward, Bletchley Community Hospital, Whalley Drive, Milton Keynes MK3 6EN

	Tel: 01908 363074 Text Relay: 18001 01908 363074

Service type	**Recovery teams**
About the service	The aim of the teams is to enable people with mental health needs to be able to choose to live safely in the community with the appropriate support in the least restrictive way. The Teams will operate within a recovery framework and will provide longer – term interventions and support for people with enduring mental health problems, their families and carers. The teams will also actively engage with carers. Service Users will be discharged back to Primary Care as soon as is practical, in line with least restrictive interventions. The team provides focused and person centred care over the longer term to enable individuals to remain supported within the community setting
Eligibility criteria (who is the service for?	The services are community based and support individuals with a functional mental illness. The services are available to people over the age of 18 who are registered with a Milton Keynes General Practitioner (GP).
How can someone be referred?	Referrals to the Recovery team are passed through a transfer mechanism from the Assessment and Short term Intervention team or another team within the Mental Health Service.
Service times	The service operates from 9am – 5pm (with some flexibility) from Monday to Friday and also operate a more limited service provided from 9am to 5pm at weekends.
Choose and Book	NO
Service locations	East Recovery Team Senior Practitioner – Kay Newman West Recovery Team Senior Practitioner – Jill Bailey

Service type	**Falls Service**
About the service	Our team comprises of therapists, management and administrative staff. Our service offers support to individuals aged over 65 years, who have fallen or at risk of falling. By working together with the service user and their carer, we will make decisions about the best way to reduce the risk of the person falling, raise awareness of risk factors for falling and make any necessary changes to their home to prevent the person from falling.

	Our service also works in partnership with AGE UK (Milton Keynes), as well as intermediate care service, social services and other primary care services e.g. district nurses and General Practitioners, South Central Ambulance Service, Home Alarm Service and Milton Keynes Hospital Foundation Trust.
Eligibility criteria (who is the service for?	Our service is provided to any person aged over 65 years, who is registered with a Milton Keynes GP and have fallen or at risk of falling.
How can someone be referred?	Referrals are accepted from health and social care professionals, people who have fallen or their family members.
Service times	The service will operate Monday to Friday 9am – 5pm excluding bank holidays.
Choose and Book	NO
Service locations	Milton Keynes Community Health Services, Whalley Drive, Bletchley, Milton Keynes MK3 6EN

Service type	**Family Nurse Partnership**
About the service	Our team comprises of specially trained family nurses. Our nurses will often have backgrounds in midwifery and health visiting and they receive supplementary training to equip them for their new role. The Family Nurse Partnership is a voluntary support programme for vulnerable first time mothers under the age of 17. If you are a young mother and feel that you and your family would benefit from the guidance and (insert word) of a specially trained family nurse, please get in touch. Your family nurse will visit on a regular basis from early pregnancy until age two. You'll build a trusting and supportive relationship with your nurse. She'll share lots of helpful information with you about pregnancy, giving birth and looking after babies and toddlers; you'll be able to rely on her to help you out with anything you find difficult; and she'll help you to plan for the future, too. You are the most important person in your baby's life and this programme will help you be the best parent you can.
Eligibility criteria (who is the service for?	This is offered to all first-time mothers under the age of 17, who live in the agreed catchment area.
How can someone be referred?	You may volunteer for our service if previous pregnancies ended in miscarriage, termination, still-birth or multiple births. You should volunteer as early in pregnancy as you can and recommend no later than the 28th week. If you plan to have your child adopted or you have had a

	previous live birth, then you may not volunteer. If you would like to receive our support, please get in touch with your Family Nurses Advisor at Netherfield – Tel: 01908 559195. If you would like to receive the help of a midwife, we will offer you the chance to get in contact with one.
Service times	Monday to Friday 9am to 5pm Can do flexible visits
Choose and Book	NO
Service locations	Neath Hill Health Centre, 17 Tower Crescent, Neath Hill Milton Keynes, Buckinghamshire Family nurses are based at: Hedgerows Children's Centre, Langland road, Netherfield Milton Keynes, MK6 4NH

Service type	**Health Visiting**
About the service	The service comprises of 16 teams who work across Milton Keynes. Our teams are based in GP practices, health centres, children's centres and are comprised of health visitors, health visitors in training, registered nurses and health assistants. All Health Visitors are Registered Nurses with an additional qualification as a Specialist Community Public Health Nurse. We offer a named health visiting team to all families across Milton Keynes with a child under the age of five. Our teams provide young baby clinics and health advice drop ins. These take place across Milton Keynes and offer an opportunity for parents to access health advice and support. The service aims to work in partnership with families and also with other local providers of services for children and families. In addition, the health visiting teams' link with school nursing once the child enters school. Health Visitors lead on the National Healthy Child Programme (birth to five years) and universally offer health reviews and support to families at home or in a community venue.
Eligibility criteria (who is the service for?	Every family in Milton Keynes, with young children, has access to a health visiting team which works in partnership with their GP and other members of the primary health care team.
How can someone be referred?	Families will have contact from their health visiting team during pregnancy, new birth contact (day 11 to 14) or on moving into Milton Keynes. Parents are also invited to bring their children to key health reviews and drop in clinics which are delivered by the health visiting team.

Service times	The service mainly operates from 9am to 5pm Monday to Friday but with the possibility of some flexibility in negotiation with the health visitor.
Choose and Book	NO
Service locations	

Service type	**Intermediate Care Team**
About the service	The service is available to people over the age of 18 years who are normally resident in Milton Keynes. Our service supports people to become as independent as possible by providing them with the opportunity to choose to remain in their own homes for as long as they feel able to. We aim to: assist people regaining former mobility; prevent deterioration in a long standing condition; work in partnership with users and informal carers; and provide opportunities for people to maintain, develop or reinstate social networks and reduce isolation.
Eligibility criteria (who is the service for?	The service is available to people over the age of 18 years who are normally resident in Milton Keynes.
How can someone be referred?	Referral can be made through a health professional.
Service times	Our service is available 24 hours a day throughout the year. The CQC Registered Manager and Duty Team Leader are available Monday – Friday 9am – 5pm
Choose and Book	NO
Service locations	Intermediate Care Services, Old Windsor Ward, Bletchley Community Hospital, Whalley Drive, Bletchley, Milton Keynes MK3 6EN Milton Keynes Community Health Services, Trust Headquarters, Hospital campus, Eaglestone, Milton Keynes MK6 5NG Intermediate Care Services Tel: 01908 363070 Text Relay: 18001 01908 363070 Milton Keynes Community Health Services Tel: 01908 243933 Text Relay: 18001 01908 243933

Service type	**The Early Intervention Team**

About the service	The aim of the Early Intervention Service is to provide an intensive care package that includes assessment, treatment and support of young people experiencing their first episode of psychosis in collaboration with their carers, relatives and friends. This aim will comprise the following components: • Early detection of symptoms and reduction in the length of time young people remain undiagnosed and treated • Reduction of stigma associated with psychosis, improve professional and lay awareness of symptoms of psychosis • Development and implementation of meaningful engagement strategies, providing evidence-based interventions and promote recovery during the early phase of illness • Increase stability in the lives of service users, facilitate development and provide opportunities for personal fulfilment • Facilitate a smooth, thoughtful and effective transfer of individuals between services.
Eligibility criteria (who is the service for?	Provide a user-centred service, support the principle of a seamless service that is available for those aged from 14 to 35 that effectively integrates child, adolescent and adult mental health services and works in partnership with primary care, education, social services, youth and other services
How can someone be referred?	Referral can be made through a health professional.
Service times	Weekdays: 9am – 5pm
Choose and Book	NO
Service locations	Team Manager – Tina Swain

Service type	**Long Term Conditions Team**
About the service	A manager, administrative care co-ordinator, four community matrons, a telehealth lead and four long term condition RGNs (Affiliated- community pulmonary rehab team and oxygen service). We offer a specialised service that provides personalised episodes of care to promote self management, independence and prevention where possible of emergency admission to hospital.
Eligibility criteria (who is the service for?	Telehealth can be offered to patients as part of their health management and triage for this is undertaken within the team.
How can someone be referred?	Self and professional referral of patients with long term conditions such as COPD, HF, CHD, Diabetes who are not managed elsewhere or who would benefit from education and

	support to self manage. Assessment will be made and a personalised care plan reached with the patient.
Service times	9am to 5pm every day
Choose and Book	NO
Service locations	Whalley Drive Clinic, Whalley Drive, Bletchley Tel: 01908 375874 Monday to Friday Text Relay: 18001 01908 375874 Monday to Friday Weekends and bank holidays 07771340168

Service type	**Mental Health Hospital Liaison Team**
About the service	The Mental Health Hospital Liaison Service is a new and exciting initiative. It is a dedicated nurse led service which offers integrated care for patients with comorbid physical and mental health problems as part of Milton Keynes Hospital Foundation Trust. The team is still under recruitment, but when fully operational will offer: A Senior Mental Health Liaison Practitioner/Team Leader, five Mental Health Liaison Practitioners and will be supported by a clinical psychologist (0.5 WTE).The team will have its own admin support and will be based on Ward 17. We are currently: • Leila Sharda Senior Mental Health Liaison Practitioner and Nurse Prescriber • Steve Pope Mental Health Liaison Practitioner • Heidi Pullen Mental Health Liaison Practitioner • Natalie Copestake our administrator
Eligibility criteria (who is the service for?	The team will provide enhanced access to assessment and intervention for people with mental health difficulties in the emergency department and across all hospital wards.
How can someone be referred?	The service is available to people over the age of 18 who are registered with a Milton Keynes General Practitioner (GP).
Service times	Monday to Friday: 7am - 8.30pm Saturday and Sunday: 9am - 5pm The team can be contacted via the hospital site managers.
Choose and Book	NO
Service locations	

Service type	**Neurological Rehabilitation Service**
About the service	We are a multidisciplinary team of NHS professionals including:

	• Physiotherapy • Occupational Therapy • Speech and language therapy • Psychology • Nursing Our service provides rehabilitation for people with neurological conditions or multiple diagnoses related to ageing. We aim to help people live as independently as possible in their home, work, social and community lives, helping them to understand, adjust to and manage their condition. We also offer support to the individual's family and carers. Before treatment begins, we will provide an opportunity for the service user to consider their individual needs with a member of staff and plan goals with the individual to meet their potential to achieve practical daily living skills. A time limited course of therapy sessions will be provided to meet these goals through out-patient appointments at our unit or, when needed, in the person's home.
Eligibility criteria (who is the service for?	Our service is provided to anyone aged 18 or over, who is registered with a Milton Keynes GP and would benefit from a specialist programme of active rehabilitation, treatment and carer support to enable them to live as independently as possible in their day-to-day life.
How can someone be referred?	Referrals may come from clinical and social care professionals.
Service times	Monday to Friday 8.30am – 5.00pm excluding Bank Holidays
Choose and Book	NO
Service locations	Bletchley Community Hospital, Whalley Drive, Bletchley, Milton Keynes, MK3 6EN Tel: 01908 379440 Text Relay: 18001 01908 379440

Service type	**Recovery and Rehab Team**
About the service	The Recovery and rehab Team is a large integrated health and social care team that operates across the city of Milton Keynes offering a range of interventions for individuals suffering from a sever and or enduring mental illness, predominantly a psychosis or serious mood disorder. The team is made up of Mental health specialist nurses, social workers, Occupational therapists and support workers. The treatment is recovery focused and aims to jointly work with individuals to meet their own potential and targets.
Eligibility criteria (who is the service for?	This service is open to clients from 18 yrs who have been assessed by the Access and short term intervention team and

	have met the criteria for longer term mental health involvement.
How can someone be referred?	Most referrals to the R+R team come from the Assess and short term intervention team. All people accessing this service will have met the threshold for longer term mental health intervention. Clients can re refer themselves for reassessment of need within 6 months of being discharged from the R+R service.
Service times	9.00am – 5.00pm Mon – Fri 01908 340967 Weekend duty system 09.00 – 17.00 01908 340950
Choose and Book	YES / NO
Service locations	Recovery and Rehab Team, 1 Savil Lane, Westcroft MK4 4EN Tel: 01908 340967

Community recovery service line

Service type	**Recovery Support Service**
About the service • A brief description of the service that is meaningful and understandable to all potential users.	The Recovery Support Service is a service for people living with a mental health condition. **Helping you live a full and satisfying life** The Recovery Support Service is based in Westminster. It provides support and a range of things to do to help you live your life the way you want to. We understand that at times people may want and need: • some company • support to be part of their community • to gain confidence • support to achieve changes • to develop existing skills and learn new ones • support to look after their physical as well as mental health We can help you in the following ways: • Socially-we offer drop-in sessions - These provide a welcoming, safe space where you can meet people and get support • One to One Support-to help you make the changes you want to make in your life. We can also help you decide what you want to achieve if you are not sure • Courses and Activities-we offer a range of courses supporting people to develop their skills. We run IT courses, cooking courses, supported gym sessions, a friendship course as well as art courses like pottery, mosaics and woodwork
Eligibility criteria (who is the service for?	The RSS is for people: Who are over 18 years at the point of referral and who are Westminster residents or have been accepted as Westminster adult services responsibility. Who have been assessed as eligible for social care (i.e. having substantial or critical needs – FACs assessment) and who have been through the personalisation process i.e. have an approved Personal Budget. Who are open to a Westminster recovery team and remain open to that team (or are transferred to an equivalent team) for the time they use the RSS People who are under the care of the Westminster Assessment & Brief Treatment teams would also be eligible

	for the service as long as they meet the first 4 points above and remain under the care of that team (or are transferred to a recovery team) for the period they use the RSS. People may also be referred by inpatient therapies teams at St Charles and the Gordon as long as they have been assessed as FACS eligible and have been through personalisation and are open to one of the teams as above. Any referral from inpatient therapies needs to be made in collaboration with person's care coordinator (or LPC)
How can someone be referred?	• People access the service following a referral from their Care Coordinator or lead professional • Care Coordinators may not be the referrer but they have to be in agreement with the referral and agree to complete the personalization process • We can't accept self referrals • We can arrange pre-referral meetings for those that wish to find out more about the service • We can arrange taster sessions to help people make decisions about how they want to spend their personal budget
Service times	1 St Mary's Terrace is our main site but we also offer courses and activities at 66 Lupus St on certain days as follows: **Monday** 9am-5pmThe Terrace **Tuesday** 9am-5pmThe Terrace and 5.15pm-8.15pm Drop-in at the Terrace **Wednesday** 9am-5pmThe Terrace and 4.15pm-7.15pm Drop-in at Lupus Street **Thursday** 9am-5pmThe Terrace and 2pm-4pm Art & Craft Drop-in at Lupus St **Friday** 9am-5pm The Terrace 2pm-4pmDrop-in at the Terrace **Saturday** 11.45am-3.15pmDrop-in at the Terrace **Sunday** 10.45am-2.15pm Drop-in at Lupus St The times above will change dependent of the needs of people using the service. We also some activities from community venues.
Choose and Book	NO

Service locations	Recovery Support Service 1 St Mary's Terrace (Main site-staffed Monday to Friday) London W2 1SU 020 7725 5100 66 Lupus St (Not staffed every day-see above) London SW1V 3EQ

Service type	**CNWL Recovery College**
About the service	Recovery describes your personal journey with mental health issues and the steps you take to rebuild and live a meaningful and satisfying life. The CNWL Recovery College offers students a range of courses, seminars and workshops which are co-designed and co-delivered by peer recovery trainers (these are people with lived experience of mental health issues) and mental health practitioners. The CNWL Recovery College aims to: • Offer support for people who use CNWL mental health services, and enable them to become experts in their own self-care. • Enable family, friends, carers and CNWL staff to better understand mental health conditions and support people in their personal recovery journeys.
Eligibility criteria (who is the service for?	Access to the Recovery College courses/workshops is available to: • Individuals who currently or have previously used services delivered by Central and North West London NHS Foundation Trust (CNWL) • their supporters (family, friends and carers) • CNWL staff (including Local Authority staff working within CNWL integrated services) • Individuals aged 16 and over (we hope to provide access for younger students in the future) • GPs who deliver services within the Trust's catchment area. • Carer support workers working in third sector organisations. • Current courses/workshops are provided free of charge; from January 2013 charges may apply to some courses for students who no longer use CNWL services or who are not employed by the Trust

	The courses/workshops are currently not available to: • Students on clinical placement within the Trust (e.g. nursing, occupational therapy, social work, medicine, psychology) • Staff not employed by CNWL • Members of the general public
How can someone be referred?	The enrolment process is through registration with the College. Registration forms are available in the College prospectus and on the Recovery College website, which is available to all. Forms may be completed manually or electronically. Anyone enrol onto courses themselves. All courses are open to CNWL staff, service users and their supporters (family, friends and carers). Students can attend timetabled courses publicised in the prospectus.
Service times	Currently 9am – 4.30pm Mon to Fri. Some evening sessions are available dependent on interest and venue availability.
Choose and Book	YES
Service locations	CNWL Recovery College Stephenson House, 75 Hampstead Road, London, NW1 2PL is the main hub but local venues are used across the Trust. recoverycollege.cnwl@nhs.net 020 3214 5686

Service type	**Community outreach**
About the service	Community outreach services support service users who experience symptoms of psychosis and who find it difficult to engage with services. They may have been involved with the criminal justice system or have complex difficulties. The service users that are referred to us will usually have had a history of admissions to hospital, possibly detained under the Mental Health Act and often encountered problems with medication treatments. The aims of this service are: • to work creatively to improve engagement • to reduce relapse by working collaboratively with service users to provide service-user-focused packages of care • to reduce likelihood and duration of admission to hospital • to improve social functioning • to promote stability in the lives of service users and their

	families • to work in an integrated manner with other statutory and non-statutory local services
Eligibility criteria (who is the service for?	Adults (aged over 18) The service is for those who have a primary diagnosis of severe and persistent major mental disorder associated with a high level of disability, multiple complex needs and who have difficulty maintaining lasting and consenting contact with services. Service user must have an allocated care coordinator directly linked to either the community recovery or early intervention in psychosis service
How can someone be referred?	Referrals to the community outreach team are made by professionals/clinicians who have had current or previous engagement with the service user. The service does not accept self – referrals or provide a walk in service Referrals are accepted directly into the team if a service user is known to an out of borough community outreach team and have recently taking up residency locally
Service times	The service is available Monday – Friday 9 am – 5pm
Choose and Book	NO
Service locations	Brent Assertive Outreach Team 15 Brondesbury Road Kilburn London NW6 6BX Tel: 020 8937 4601 Harrow Assertive Outreach Team Bentley House, 15-21 Headstone Drive, Harrow, Greater London, HA3 5QX Tel: 020 8424 7730 Westminster Community Outreach Team (CORT) 7A Woodfield Road, London, W9 3XZ Tel: 020 7266 9620

Service type	**Joint homelessness team**
About the service	The Joint Homelessness Team is a multi-disciplinary community mental health service that works with people who sleep rough in Westminster and who have a mental illness. The service users that are referred to us will usually have had a history of admissions to hospital, possibly detained under the Mental Health Act and may have arrived from other countries or elsewhere in the UK. T often encountered problems with medication treatments.

	The aims of this service are: • to work creatively to improve engagement • to reduce relapse by working collaboratively with service users to provide service-user-focused packages of care • to reduce likelihood and duration of admission to hospital • to improve social functioning • to promote stability in the lives of service users and their families • to work in an integrated manner with other statutory and non-statutory local services The Joint Assessment Service (JAS) is commissioned by Housing Options Service in Westminster to assess under Housing legislation people who present as homeless, and appear to be vulnerable in terms of their mental health. Service users of JAS may have been engaged with other mental health services in the past, but will have disengaged at the time of their referral, possibly as a result of homelessness. JAS will carry out a comprehensive assessment, the result of which will be a recommendation as to whether or not the service user meets the vulnerability threshold.
Eligibility criteria (who is the service for?	Anyone over 18 who is sleeping rough in Westminster, who has a mental illness and is unwilling or unable to access mainstream mental health services. JAS – Any single person aged 18 or over who has presented as Homeless at Westminster Housing Options Service, and appears to be vulnerable within the meaning of housing legislation as a result of their mental health.
How can someone be referred?	Service users will already be known to specialist mental health services who refer directly to community outreach teams. Mental health homelessness teams receive referrals from a range of sources working within street homelessness. The JHT work with people who are unwilling or unable to access mainstream services therefore we would not normally take self-referrals. Known patients would normally be seen by appointment but a duty worker is usually available to see someone if they turned up without an appointment. We see most of our referrals via regular outreach sessions either at day centres or on the street. JAS referrals are made exclusively via Housing Options by their caseworkers. The decision to refer is based upon the information provided by the homeless applicant. Service users referred are assessed by the JAS worker at

	Housing Options in Westminster.
Service times • Details of the times/days when the service is available.	JHT – The service operates usual office hours of 9-5 with a duty worker usually available during these hours. We also do regular early and late shifts on the streets in order to see people at their sleep site. JAS operates between Monday and Friday, 9-5.
Choose and Book	NO
Service locations	Joint Homelessness Team 190 Vauxhall Bridge Road, London, SW1V 1DX Tel: 020 7854 4206

Service type	**Community recovery teams**
About the service	Community recovery teams (previously known as community mental health teams) bring together a range of health care professionals who each have specialist skills who work with people living in the community who have complex and severe mental health problems. The services aims to deliver excellent integrated, recovery focused and evidence based health and social care. There is a range of professions within the integrated health and social care recovery teams, including psychiatrists, community psychiatric nurses (CPN), social workers and Approved Mental Health Professionals (AMHPs), psychologists, occupational therapists and pharmacists. Other members of the team include the team manager and administrators. Other staff such as peer support workers, mental health support workers, benefits workers, employment specialists, arts therapists and psychotherapists also work as part of the team. The aims of this service include: • 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 the team members understand the distress that goes with mental illness. They can all offer psychological support,

	encouragement and practical help to service users and their families/carers. Each team will have a base where they can see people. They will also work in a whole range of other places: GP surgeries, day centres, hostels and people's own homes, for example.
Eligibility criteria (who is the service for?	Adults (over 18) with complex mental health and social care needs, which require longer term multi- disciplinary interventions.
How can someone be referred?	Referrals to the recovery team can be made by other mental health professional within CNWL, primarily from the assessment and brief treatment (ABT) team and inpatient (acute) teams Referrals can be made by directly by GPs where a service user has previously been known to the team. The service does not accept self- referrals, not does it offer a walk-in service
Service times	Monday to Friday 9am-5pm
Choose and Book	NO
Service locations	Brent Community Recovery Team 15 Brondesbury Road , London, NW6 6BX Tel: 020 8937 4601 Harrow Community Recovery Team Atkins House, 19 Marshall Close, Harrow, Greater London, HA1 4DH Tel: 020 8422 9443 Hillingdon Community Recovery Team Mead House, Hayes End Road, Hillingdon, Greater London, UB4 8EW Tel: 01895 558270 North Kensington & Chelsea Community Recovery Team Pall Mall Centre, 151 Barlby Road, London , W10 6BS Tel: 020 8206 6915 North Westminster Community Recovery Team 7A Woodfield Road, London, W9 3XZ Tel: 020 7725 9746 South Kensington & Chelsea Community Recovery Team Chelsea Chambers, 262a Fulham Road, London, SW10 9EL Tel: 020 7349 6530 South Westminster Community Recovery Team 190 Vauxhall Bridge Road, London, SW1V 1DX Tel: 020 7854 4162

Service type	**Early intervention services**

About the service	Early intervention services work with people aged 14-35 experiencing their first episode of psychosis. Once referred, service users can remain with the team for three years. Psychosis is more common than you think. It can occur for any number of reasons, including a change of circumstance, increased stress or drug use. People are most likely to experience psychosis for the first time in their late teens to early thirties. Initially, people may feel that something isn't right, but can't quite identify what. They may become more withdrawn, experience loss of sleep or appetite, find it difficult to concentrate, feel suspicious or paranoid. Later signs might include strange behaviour, unusual beliefs or hallucinations. People can recover fully from psychosis: the most important thing is to get help early. The aims of this service include: • Early detection, assessment and effective treatment of symptoms • Reduce the duration of psychosis through improved access to services. • Optimistic views about recovery, focused interventions • Provide a wide range of psycho-social interventions and support • Provide support, education and intervention for family and carers • To work in partnership and establish links with a range of statutory and non-statutory services • Improve vocational and educational outcomes for people experiencing a first episode of psychosis
Eligibility criteria (who is the service for?	• Age between 14 – 35 years of age and resident of the borough • Identified as experiencing a first episode of any psychotic illness with a history of at least seven days of symptoms. • Kensington & Chelsea and Westminster – The team will only accept clients that have had less than six months of engagement with another service for psychosis. This encourages early referral to appropriate early intervention. • Harrow and Hillingdon – accept clients within a year of the onset of symptoms • The team are unable to accept clients who have a primary organic diagnosis. • Case by case discussion around clients referred whose primary problem is substance use, severe learning

	disability, or a primary diagnosis of personality disorder. Consultation and joint working will be considered.
How can someone be referred?	• Direct referral from the GP including primary care teams • A&E liaison service • Home treatment teams • Assessment and brief treatment teams • Inpatient units • Court diversion and youth offending teams • IAPT services • Currently the team does not have self referral or walk in facilities
Service times	**Kensington & Chelsea and Westminster Early Intervention Service:** Monday- Friday • 9am-5pm Monday, Tuesday Thursday and Friday • 9am-8pm Wednesday **Harrow and Hillingdon Early Intervention Service:** Monday to Friday • 8.30am -5pm Tuesday, Wednesday, Thursday and Friday • 8.30am- 7pm Monday Team offers flexibility around client and carers personal commitments so appointments outside of these times are possible.
Choose and Book	NO
Service locations	Brent Early Intervention Service Bell House, 145 High Road , Willesden, London, NW10 2SJ Harrow and Hillingdon Early Intervention Service Pembroke Centre, 90 Pembroke Road, Ruislip, London, HA4 8NQ Kensington & Chelsea and Westminster Early Intervention Service 1B Beatrice Place, Marloes Road, London, W8 5LW

Service type	**Personality disorder services**
About the service	People with a primary diagnosis of personality disorder are frequently unable to access the care they need from secondary mental health services and sometimes specialist services are designed to better meet their needs. The Waterview Centre aims to help people who have long-standing emotional and interpersonal problems resulting from personality disorder. People may have been given a formal diagnosis of personality disorder or have no clear diagnosis but significant problems related to their personality.

	The centre provides a service specifically designed for people with self-harming behaviour and chaotic or unstable relationships, especially those who have a history of using A&E or inpatient mental health services at times of crisis. It works with people with anxiety and depression and other non-psychotic mental illnesses, but not those with a primary diagnosis of schizophrenia or bipolar I. It also works with people who have harmful use of alcohol and drugs but not drug or alcohol dependency. **Treatment programme** The Waterview Centre offers an 18-month group-based treatment programme which includes individual sessions and group-based therapy. Our group programme includes mentalisation-based treatment and skills-based groups. Mentalisation-based treatment aims to help people develop a better understanding of their thoughts and feelings and the actions of others. Treatment focuses on the 'here and now' of difficulties in relationships and the powerful and sometimes confusing feelings that interaction with others can evoke. Awareness of attachment patterns of service users also guides our work, with thoughtful and active efforts made to engage and maintain contact with the service users. We aim to help people identify and verbalise their feelings and feeling states, to work towards secure relationships, to develop a stable identity and to develop constructive coping mechanisms. We aim to help each person achieve their own stated goals which may include a reduction in self-harming behaviours, admissions to hospital, and use of emergency services. Service users may be offered one or two groups a week depending on their needs. Group work aims to give service users the opportunity to consider relationships with others, explore perceptions and misunderstandings and transfer these skills into their daily life. **The assessment process** Group-based treatment can be challenging but can also help people realise that they are not alone and that other people with long-term problems can and do recover. There is also good evidence that group-based treatment combined with individual support is an effective approach to helping people who have personality disorder. Nonetheless, many people still find the idea of group-based treatment difficult. To address this, we have set up a 10-week series of introductory groups called the Group Awareness Programme (GAP). This enables us to further assess service users who have never engaged in a group, or who have

	expressed ambivalence around group work. It also gives people a chance to find out what it is like to be in a group without having to make a commitment to longer term treatment. Not all service users will need to access the GAP, and some of those that do may decide not to engage in the Waterview treatment programme and to access other appropriate services instead. Because we ask most people to try attending the GAP, the assessment process includes one-to-one meetings and an assessment group.
Eligibility criteria (who is the service for?	The Waterview Centre aims to help people who have long-standing emotional and interpersonal problems resulting from personality disorder. People may have been given a formal diagnosis of personality disorder or have no clear diagnosis but significant problems related to their personality. The centre provides a service specifically designed for people with self-harming behaviour and chaotic or unstable relationships, especially those who have a history of using A&E or inpatient mental health services at times of crisis. The service works with people with anxiety and depression and other non-psychotic mental illnesses, but not those with a primary diagnosis of schizophrenia or bipolar I. It also works with people who have harmful use of alcohol and drugs but not drug or alcohol dependency.
How can someone be referred?	Registered mental health professionals/teams can refer service users registered with a GP in Kensington & Chelsea and Westminster for treatment at the Waterview Centre. It does not accept referrals from primary care. No referral form. Criteria to be include in referral letter. Brief summary of need, risk assessment, Patient agreement to be referred to the service.
Service times	9am-5pm, Monday to Friday.
Choose and Book	NO
Service locations	Waterview Personality Disorder Service 7A Woodfield Road, London, W9 2NW Tel: 020 7266 9550

Service type	**Psychotherapy services**
About the service	Our psychotherapy services provide assessment and treatment to help people with complex difficulties, who are keen to understand themselves better. Assessment may be followed by any of the following

	treatments: **Individual psychotherapy:** A talking and listening treatment that uses the relationship between patient and therapist to identify and change (often hidden) patterns of thoughts and feelings that hamper the patient's emotional life. **Group psychotherapy:** As with individual therapy, but also benefiting from the relationship with and different perspectives from other group members, who have similar but distinct problems **Cognitive analytic therapy:** A therapy where unhelpful patterns of thinking and behaviour are thought about and mapped out on paper, paying careful attention to relationships and finding ways to break out of negative cycles. **Couples and Family therapy:** Sometimes a person's illness can act as a spokesperson for a family's difficulties. The therapy team works with the couple/whole family to draw on their strengths and overcome their shared difficulties.
Eligibility criteria (who is the service for?	Adults (over 18 years) who often have serious or longstanding difficulties they want to address. Typically, people have difficulties in their mood or in the way they relate to themselves or other people. They may already have received other medical or talking therapies. When the main problem is an active substance dependence, this should be addressed first before seeking a psychotherapy referral.
How can someone be referred?	All new patients, not currently receiving treatment from CNWL, are referred to the local Assessment and Brief Treatment Team (ABT). Patients can speak with their GP to request a referral to the ABT or self-refer to the ABT. Patients already receiving treatment from secondary care mental health services (CNWL) can be referred to us by the clinician treating them.
Service times	Usually 9-5 Monday-Friday, although some evening appointments are available in some locations.
Choose and Book	NO The Central London CCG is piloting a central computerised referral system for all psychological treatments, and KCW are participating in this. In Hillingdon, referred patients are invited to opt in by telephoning to say they want an appointment. They are given an appointment time when they phone.
Service locations	Brent Psychotherapy Service Roundwood Centre, Harlesden Road , London, NW10 3RY Tel: 020 8438 1770

	Harrow Psychotherapy Service Northwick Park Hospital, Watford Road, Harrow, Greater London, HA1 3UJ Tel: 020 869 3602 Westminster and Kensington & Chelsea (KCW) Psychotherapy Service The KCW Psychotherapy Service works from four sites: • Parkside Clinic, 63-65 Lancaster Road, London, W11 1QG • Gordon Hospital, Bloomberg Street, London SW1 V 2RH • 190 Vauxhall Bridge Road, London SW1V 1DX • 1 Nightingale Place, London SW10 9NG Tel: 020 8383 6132 Hillingdon Psychotherapy Service: This service operates from 3 sites: • Riverside Mental Health Unit, The Hillingdon Hospital, Uxbridge, Middx, UB8 3NN • Pembroke Centre, 20 Pembroke Road, Ruislip Manor, Middx, HA4 8NQ • Mead House, Hayes End Road, Hayes, Middx, UB4 8EW

Service type	**Psychotherapy services**
About the service	Our psychotherapy services provide assessment and treatment to help people with complex difficulties, who are keen to understand themselves better. Assessment may be followed by one of our two main treatment types: **Individual psychotherapy:** A talking and listening treatment that uses the relationship between patient and therapist to identify and change (often hidden) patterns of thoughts and feelings that hamper the patient's emotional life. **Group psychotherapy:** As with individual therapy, but also benefiting from the relationship with and different perspectives from other group members, who have similar but distinct problems. Some areas of the Trust also offer the following potential options: **Cognitive analytic therapy:** A therapy where unhelpful patterns of thinking and behaviour are thought about and mapped out on paper, paying careful attention to relationships and finding ways to break out of negative cycles. **Couples and Family therapy:** Sometimes a person's illness can act as a spokesperson for a family's difficulties. The therapy team works with the couple/whole family to draw on their

	strengths and overcome their shared difficulties.
Eligibility criteria (who is the service for?	Adults (over 18 years) who often have serious or longstanding difficulties they want to address. Typically, people have difficulties in their mood or in the way they relate to themselves or other people. They may already have received other medical or talking therapies. When the main problem is an active substance dependence, this should be addressed first before seeking a psychotherapy referral.
How can someone be referred?	All new patients, not currently receiving treatment from CNWL, are referred to the local Assessment and Brief Treatment Team (ABT). Patients can speak with their GP to request a referral to the ABT or self-refer to the ABT. Patients already receiving treatment from secondary care mental health services (CNWL) can be referred to us by the clinician treating them.
Service times	Usually 9-5 Monday-Friday, although some evening appointments are available in some locations.
Choose and Book	NO The Central London CCG is piloting a central computerised referral system for all psychological treatments, and KCW are participating in this. In Hillingdon, referred patients are invited to opt in by telephoning to say they want an appointment. They are given an appointment time when they phone.
Service locations	Brent Psychotherapy Service Roundwood Centre, Harlesden Road , London, NW10 3RY Tel: 020 8438 1770 Harrow Psychotherapy Service Northwick Park Hospital, Watford Road, Harrow, Greater London, HA1 3UJ Tel: 020 869 3602 Kensington & Chelsea and Westminster (KCW) Psychotherapy Service The KCW Psychotherapy Service works from four sites: 1. Parkside Clinic, 63-65 Lancaster Road, London, W11 1QG 2. Gordon Hospital, Bloomberg Street, London SW1 V 2RH 3. 190 Vauxhall Bridge Road, London SW1V 1DX 4. 1 Nightingale Place, London SW10 9NG Tel: 020 8383 6132 Hillingdon Psychotherapy Service: This service operates from three sites: 1. Riverside Mental Health Unit, The Hillingdon Hospital, Uxbridge UB8 3NN

	2. Pembroke Centre, 20 Pembroke Road, Ruislip Manor HA4 8NQ 3. Mead House, Hayes End Road, Hayes UB4 8EW

Eating disorders service line

Service type	**Outpatient eating disorder services**
About the service	The service provides specialist outpatient care for adult patients (16 years+) with a range of eating problems. The assessment team is psychiatry led and provides a comprehensive medical, social, psychiatric and psychological appraisal of the eating and related problems of the individual and their family/carers. The choice of treatment options offered is guided by an individualised case formulation and the evidence base. Interventions for outpatients, are usually delivered in the form of one session per week (reducing as the patient progresses), include: • Cognitive behavioural therapy • Cognitive analytic therapy • Family/systemic therapy • Supportive clinical management Given the nature of the eating disorders, motivational work is a key part of each of these treatments. Long-term outpatient treatment may be offered for those with chronic severe illness, where specialist treatment is necessary to maintain slow progress toward recovery or to prevent deterioration. We also offer family therapy for those that would benefit from this service. The number of sessions will depend on the therapeutic needs of each patient The liaison team provide a flexible model of care, individually tailored to the needs of patients who find it hard to engage, and who are struggling to manage medical or psychiatric risk safely. When necessary, the team work alongside professionals in primary and secondary care to manage care safely in the community, or to prepare for and facilitate admission to hospital. During treatment, responsibility for medical care and prescribing of any medication remain with the patient's GP, with access to specialist medical review at Vincent Square when required. We aim to maintain good liaison and consultation with other services involved in care throughout treatment and follow-up
Eligibility criteria (who is the service for?	The service accepts referrals of female and male patients (16+ years) suffering from anorexia nervosa (restricting and binge-purge subtypes), bulimia nervosa (purging and non-purging subtypes), binge eating disorder, and other forms of atypical

	eating disorder. The service cannot accept referrals of patients suffering from simple obesity in the absence of an eating disorder
How can someone be referred? • How do people access the service? • Is it only available for professionals/clinicians to refer to? • Can patients self refer? • Does the service provide a walk-in service or is it appointment only? • Please also provide an up-to-date referral form if relevant.	We accept referrals for local patients from the North West Sector Consortium, which includes Kensington & Chelsea, Westminster, Hounslow, Ealing and Hammersmith & Fulham to the Nightingale Place Service We accept referrals for local patients from Brent, Harrow and Hillingdon to our Northwick Park Satellite Service We also accept national referrals from any healthcare professional, subject to a cost per case contract being agreed with the relevant funder. Referrals are accepted from GP's, CMHT's and other appropriate services Referrals should be sent to Dr Frances Connan or Pamela Taft by Fax on: 020 3315 2280 Referrals need to contain core information, as detailed in the reference form accessible on www.cnwl.nhs.uk/vincent-square. If you are unsure about whether a referral is appropriate, or need urgent advice, you can talk to one of our liaison team members on: 020 3315 21049 Care Programme Approach (CPA) and risk assessment documentation should be enclosed when relevant. Making a referral is assumed to indicate a willingness to provide aftercare following discharge, if necessary. Urgent referrals will usually be assessed within two weeks, or sooner if clinically indicated, and routine referrals will be seen for assessment within a maximum of three months, but usually sooner. Prioritisation for treatment is determined at the assessment, according to clinical need. When need is urgent, treatment will be offered within two weeks, and immediately if necessary. For non-urgent patients, we aim to offer start of treatment within less than four months.
Service times	Mon – Fri 09:00 – 17:00
Choose and Book	NO
Service locations • Please check locations as shown • Provide telephone numbers	Harrow Outpatient Eating Disorder Service (Satellite Service) Northwick Park Mental Health Centre, Watford Road, Harrow, Greater London, HA1 3UJ Tel: 020 8869 5499 Fax: 020 8869 3027 Vincent Square Eating Disorder Services, 1 Nightingale Place, London , SW10 9NG

	Tel: 020 3315 2104 Fax: 020 3315 2280

Service type	**Inpatient and daypatient eating disorder services**
About the service	Inpatient treatment is provided for eating disorder patients at high medical or psychiatric risk and those who are motivated to make changes but have been unable to do so after an effective period of outpatient treatment. The service has 14 bedrooms for national patients with severe eating disorders. Of these, 12 are reserved for women and two for men. If admission is required, patients and their carers are offered the opportunity to visit the unit and to meet with inpatient staff for an introduction and preparation for admission. On admission a keyworker from the nursing team is allocated to each patient, and this keyworker will remain the same until discharge. They will meet weekly with the patient and coordinate their care. An initial Care Programme Approach meeting is organised soon after admission, to begin the process of discharge planning and liaison with relevant after care services. Care plans and length of stay at the unit is guided by individual need and not by fixed programmes of treatment. The inpatient treatment packages combine meals and nutritional support with more intensive medical, psychological and social care than can be provided by outpatient attendance. Care is delivered through a combination of group work, individual sessions, specialist psychotherapies and occupational therapy interventions within a framework of motivational enhancement. Ongoing day patient and outpatient treatment is recommended for at least one year following discharge from inpatient treatment. For the majority of patients this will be offered at Vincent Square, although for some patients it is sometimes more appropriate to transfer care to a local eating disorder service. Many of the components of the day treatment programme are accessible to both inpatients and day patients, in order to facilitate flexible and graduated movement between these two levels of care. Transitions between services (or components within a service), are associated with high risk of disengagement and relapse. Continuity of relationships with staff and peer group, structure of the programme and familiarity of the environment help to reduce the risk of disengagement or relapse at the time of transition from

	inpatient to day patient care. Transitions are graded, with periods of increasing home leave in preparation for discharge to day patient care. Timing of transition is determined by progress with weight gain during periods of home leave and not by fixed length of stay or body mass index (BMI) criteria. Thus, if a patient is able to continue to make progress with weight gain on leave, they will be able to continue care as a day patient, even if BMI remains low. Where geography precludes the use of day patient care, inpatient care is extended until there is evidence from periods of extended leave that progress is likely to continue with local outpatient care.
Eligibility criteria (who is the service for?	Inpatient treatment is provided for eating disorder patients at high medical or psychiatric risk and those who are motivated to make changes but have been unable to do so after an effective period of outpatient treatment. The service has 14 bedrooms. Of these, 12 are reserved for women and two for men.
How can someone be referred?	All national referrals accepted for Inpatient services We also accept non national referrals from any healthcare professional, subject to a cost per case contract being agreed with the relevant funder. Referrals should be sent to Dr Frances Connan or Pamela Taft by Fax on: 020 3315 2280 Referrals need to contain core information, as detailed in the reference form accessible on www.cnwl.nhs.uk/vincent-square. If you are unsure about whether a referral is appropriate, or need urgent advice, you can talk to one of our liaison team members on: 020 3315 21049 Care Programme Approach (CPA) and risk assessment documentation should be enclosed when relevant. Making a referral is assumed to indicate a willingness to provide aftercare following discharge, if necessary. Urgent referrals will usually be assessed within two weeks, or sooner if clinically indicated, and routine referrals will be seen for assessment within a maximum of three months, but usually sooner. Prioritisation for treatment is determined at the assessment, according to clinical need. When need is urgent, treatment will be offered within two weeks, and immediately if necessary. For non-urgent patients, we aim to offer start of treatment within less than four months.
Service times	In-patient service provides care 24 hours a day, 7 days a week.

	Day Patient Service (Long) 7 days a week, 08:00-19:00 Day Patient Service (Short) Mon-Fri, 09:30-16:00
Choose and Book	NO
Service locations	Vincent Square Eating Disorders Service 1 Nightingale Place, London , SW10 9NG Tel: 020 3315 2104 Fax: 020 3315 2280

Learning disabilities service line

Service type	**Autism Diagnostic Service**
About the service	The CNWL Autism Diagnostic Service offers specialist assessment services, taking referrals from Mental Health Teams and GPs. Autism Spectrum Conditions, including Asperger's Syndrome, can be difficult to identify in adults and people may go undiagnosed without specialist assessment. The Autism Diagnostic Team utilises specialist assessment tools following referral from mental health services or GPs across London with commissioner agreement to fund the assessment. The assessment identifies issues around social communication and interaction as well as repetitive and stereotypical behaviour, in order to achieve diagnostic clarity. A full feedback report is provided together with a follow-up session for families, along with recommendations for accessing local services. This service is based at The Kingswood Centre.
Eligibility criteria (who is the service for?	Adults (aged over 18), needing specialised diagnosis. Patients must not have a diagnosis of Learning Disability.
How can someone be referred?	Referrals can only be made by your GP or other Mental Health Practitioner. Patients cannot self-refer. All our appointments are scheduled in advance once funding approval has been provided by the referring borough's commissioner.
Service times	Clinic runs once a month on a Monday and appointments are booked in advance
Choose and Book	NO
Service locations	Autism Diagnostic Service The Kingswood Centre, 134 Honeypot Lane, Kingsbury, London, NW9 9QY

Service type	**Community learning disability services**
About the service	The Community Learning Disabilities Service is committed to providing support for people with complex or challenging behaviour in a community setting for Brent and Harrow. Our community health teams for people with a learning disability consist of multi-disciplinary staff teams made up of: community nurses, psychiatrists, psychologists, physiotherapists, occupational therapists, psycho-sexual therapist, loss and bereavement counsellor, speech therapists and a range of other support workers. We provide assessment and treatment to people in their choice of environment, whether that be in their

	own home or an alternative community setting such as a local clinic, school, college, day service, supported living, residential setting, care home or hospital. Liaison with Adult care services where placement breakdown is likely will ensure that consideration has been given to emergency respite – Intensive support specialists could carry out the necessary assessment and treatment in a respite setting as a way of minimising hospital admissions.
Eligibility criteria (who is the service for?	• Aged 18 years and over • Registered with a GP contracted to provide services by Brent or Harrow PCT • Diagnosis of Learning Disability • Presence of additional complex health need The definition of Learning Disability includes: • Significantly below average intellectual functioning (IQ < 70) • Impairments in socio adaptive functioning (e.g. communication, self care, home living, social functioning, use of community resources, self direction, academic skills, work, leisure, health & safety) • Onset before the age of 18 years Complex health needs include: • Complex and or multiple physical health problems / impairments requiring support to access appropriate health services • Severe challenging behaviour presenting risks to self or others, requiring specialist assessment and treatment • Complex mental health disorders/ developmental disorders which cannot be adequately addressed by mainstream psychiatric services
How can someone be referred?	Referrals can only be made by your GP or other Mental Health Practitioner. Patients cannot self refer. All referrals are discussed with the local healthcare teams and
Service times	Normal working week days (Monday to Friday) form 9.00 am to 5.00pm.
Choose and Book	NO
Service locations	Brent and Harrow Community Health Team (Learning Disabilities)The Kingswood Centre, 134 Honeypot Lane, Kingsbury, London, NW9 9QY Kensington & Chelsea Learning Disability Service 1-9 St Marks Road, Kensington and Chelsea, London, W11 1RG Lisson Grove 215 Lisson Grove, Westminster, London, NW8 8LW Riverside Centre Hillingdon Hospital, Pield Heath Road, Uxbridge, Greater London, UB8 3NN

	St Andrews House St Andrew's Court, 1-4 River Front, Enfield , Enfield, Greater London, EN1 3SY

Service type	**Court diversion and vulnerable offender services**
About the service	The aim of the service is to identify offenders with learning disabilities within the courts and the prisons, assess the extent of those needs and makes recommendations for more suitable interventions. **What we do** We offer specialist assessment and treatment for learning disabled offenders who have problems with: • Violent behaviour • Inappropriate sexual behaviour • Extreme challenging behaviour • Self injury • Dual diagnosis (learning disability and mental illness) • Autistic Spectrum Disorder **What we offer** Screening for individuals who may have learning disabilities and may benefit from further specialist assessments and intervention; • Make a recommendation, where appropriate, for formal psychological/psychiatric assessments and ensure that the offender receives the appropriate specialist service intervention; • Offer the Court alternatives to custody to support an offender with a learning disability, for example, access to specialist inpatient services at The Kingswood & The Seacole Centres, or signposting those individuals not eligible for custody to other community services that could appropriately address their needs; • Provide specialist multi-disciplinary treatment for vulnerable offenders such as nursing, psychotherapeutic intervention and reasonable adjustments such easy read documents; • Reduce the likelihood of re-offending. **Where we operate** The service is based at The Kingswood Centre with assessments being carried out in HMP Bronzefield, HMP Holloway as well as Hendon and Hammersmith Magistrate Courts.
Eligibility criteria (who is the service for?	Aged 18 years and over Diagnosis of Learning Disability (or suspected LD) Presence of additional complex health need

	Funding approval must be in place prior to any transfer into an in-patient bed.
How can someone be referred?	This service can be accessed by mental health professionals, probation, court, prison staff, police and solicitors who suspects that an offender may have a learning disability. Individuals can self-refer if they feel they would benefit from an assessment. Referrals can be made by contacting the following: Hammersmith Magistrates Court Criminal Justice Mental Health Team TEL: 020 8700-9384 Fax: 020 87009395 (Contacts: Nigel Baillie/Shirin Rusmaully) HMP Holloway Learning Disability Prison Practitioner: 020 7979-4534 Fax - 0207 979 4745 (Contact: Shona Ho) For HMP Bronzefield and Hendon Magistrates' Court Please contact: Salma Ali, Learning Disability Court Diversion Practitioner 020 8238-0900
Service times	Normal working week days (Monday to Friday) form 9.00 am to 5.00pm.
Choose and Book	NO
Service locations	Medico-Legal/Vulnerable Offender Services The Kingswood Centre, 134 Honeypot Lane, Kingsbury, London, NW9 9QY

Service type	**Inpatient learning disability assessment and treatment services**
About the service	Our inpatient learning disabilities assessment and treatment services provide highly specialised residential treatment and care for people with learning disabilities within a safe environment. We provide care to people aged over 18 that require assessment and treatment in a specialist learning disability hospital setting, including those with forensic needs and presenting with challenging behaviour. All service users and their families or carers are encouraged and supported throughout the assessment and treatment programme. Care is provided as part of the Care Programme Approach (CPA) and service users and their families or carers are seen as an integral part of the care process, and are encouraged to regularly attend and contribute to clinical team meetings and reviews, inpatient treatment planning and post-discharge planning. Kingswood Intensive Treatment Service provides individual and group therapy sessions to people admitted to the inpatient service. We will help plan and arrange care and support for adults with learning disabilities and their families or carers and provide a range of specialist services. Community teams also liaise with other specialist services to support someone in times of crisis to prevent them from coming into hospital or if they are

	at risk of their current placement breaking down. The service is founded on a person-centred approach based on the principles of 'Valuing People' which are rights, independence, choice and inclusion. We are committed to developing and supporting close links with service users' families, their existing and future community support networks. We endeavour to ensure the full participation of the service user as a valued and integral member of the wider community. Referrals are taken nationally, but the majority of referrals come from London and the surrounding areas. Pre-admission assessments are undertaken following a referral being received.
Eligibility criteria (who is the service for?	All service users with a Learning Disability and over the age of 18 years who are appropriate to the service as they have a mental health problem or challenging behaviour. Funding approval from the commissioning borough must be approved prior to any admission.
How can someone be referred?	We take national referrals to our assessment and treatment services. However most referrals are made within the London area, covering Brent, Barnet, Ealing, Enfield, Hammersmith & Fulham, Haringey, Harrow, Hillingdon, Hounslow, Kensington & Chelsea, Westminster and surrounding boroughs. Referrals need to be made by a professional and most commonly this will be a psychiatrist, care manager or care co-ordinator. Before assessment and treatment can be offered authorisation of funding from the relevant commissioner will be required, if the referral is for an inpatient bed or Autism diagnosis. Referrals for inpatients are typically planned although they may be affected at very short notice if required. We do not offer an emergency admission facility. The Kingswood and Seacole Centres are not designated “Places of Safety” under the Mental Health Act. To make a referral please contact: Central and North West London NHS Foundation Trust Learning Disabilities Service The Kingswood Centre 134 Honeypot Lane Kingsbury NW9 9QY Eileen Cassin, Business Process Manager: Tel: 020 8238 0962
Service times	All admissions are planned, our inpatient units are open 24 hours a day, 365 days a year. Office working week days (Monday to Friday) form 9.00 am to 5.00pm.

Choose and Book	NO
Service locations	The Kingswood Centre The Kingswood Centre, 134 Honeypot Lane, Kingsbury, London, NW9 9QY The Seacole Centre The Seacole Centre, Chase Farm Hospital SiteThe Ridgeway, Enfield, Middlesex EN2 8JL

Offender care service line

Service type	**Community Offender Health Services**
About the service	Community offender health services help bridge the gap between community health services and the Criminal Justice System. We deliver our community offender health services from local community-based teams and we service courts, police stations and probations teams. Our patients may have any number of complex health care issues and have a history of offending, or potential to commit a serious offence. Our services are essential to meet the specific needs of this unique patient population and aim to improve their wellbeing, reduce the likelihood of reoffending in future and promote their inclusion in local communities. Our services provide specialist interventions including advice and sign-posting to individuals and criminal justice agencies, specialist assessment and referral, individual and group interventions and risk management. We employ doctors, nurses, social workers, psychologists, support staff and administrators. Our staff work with a multitude or statutory and non-statutory agencies.
Eligibility criteria (who is the service for?	The eligibility criteria is different for each community service we provide: **Police Advice, Assessment, Liaison and Diversion Service.** • Individuals should usually be between the ages of 18 and 65. **Court Advice, Assessment, Liaison and Diversion Service.** • Individuals should usually be between the ages of 18 and 65. **Forensic Community Mental Health Service** • Individuals should usually be between the ages of 18 and 65. • The Responsible Commissioner is Inner North West London NHS CCG. • The individual will have a primary diagnosis of either a severe mental illness or severe personality disorder. • The individual may have a secondary diagnosis of substance misuse, and / or learning disability and /or personality disorder. • The primary mental disorder will have brought them into contact with the Criminal Justice system. • There will evidence of their risk to others, either because of seriousness of their actual offending towards others or exceptionally, the potential risk of such offending. • They will have been accepted by local Adult Services as requiring secondary care. • The individual will be subject to CPA. • Exceptions to these will criteria are considered on a case by case

	basis.
How can someone be referred?	The referral routes to our community offender health services are as follows: **Police Advice, Assessment, Liaison and Diversion Service** • Referrals are received from custody sergeants. • People in police custody are actively screened by our staff to identify people who may wish to or need to take up our service. • We will accept referrals from other services based in the police stations we serve e.g. drug service etc. • Patients cannot self-refer. **Court Advice, Assessment, Liaison and Diversion Service** • Referrals are received from Magistrates via Justices' Clerks. • People in court custody are actively screened by our staff to identify people who may wish to or need to take up our service. • We will accept referrals from other services based in the court we serve e.g. learning disability service. • Patients cannot self-refer. **Forensic Community Mental Health Service** • The majority of our referrals for our forensic community mental health services come from mental health services from within the local boroughs as well as from prison and NHS and private forensic inpatient hospitals. • Patients cannot self-refer to these services. • Only professionals / clinicians can refer to this service.
Service times	The details of the open times of our community offender health services are as follows: **Police Advice, Assessment, Liaison and Diversion Service.** • In Westminster Core services from Monday to Saturday 09:00 – 21:00. **Court Advice, Assessment, Liaison and Diversion Service.** • Core services operate Monday to Friday 08:00 – 16:00 excluding public holidays. **Forensic Community Mental Health Service** • Core services operate Monday to Friday 09:00 – 17:00 excluding public holidays. • A reduced service runs from 17:00 – 20:00 and from • A 24-hour on call system is provided by the service for the use of mental health professionals within Westminster and Kensington and Chelsea Forensic teams, in regards to users known to the service.

Choose and Book	The detail of where choose and book applies to community offender health services are as follows: **Police Advice, Assessment, Liaison and Diversion Service** • No **Court Advice, Assessment, Liaison and Diversion Service** • No **Forensic Community Mental Health Service** • Yes
Service locations	Central Criminal Court - Court Liaison and Diversion Service Old Bailey, Central Criminal Court, 15 Old Bailey, London, EC4M 7EH Telephone 020 7248 3277 Contact person: Charles DeLacy Hammersmith Magistrates' Court: Diversion Service Hammersmith Magistrates' Court, 181 Talgarth Road, London, W6 8DN Telephone 020 8700 9384 Contact person: Nigel Baille Harrow Forensic Community Service (FOCUS) Atkins House, 19 Marshall Close, Harrow, Greater London, HA1 4DH Telephone 020 8422 9443 Contact person: Brendan Shelley Hillingdon Health Assessment, Advice, Liaison and Diversion (HAALD) Service The Court House, Harefield Road, Uxbridge, Greater London, UB8 1PQ Telephone 01895 271183 Contact person: Linda Burgess Kensington and Chelsea Forensic Community Service (FOCUS) Pall Mall Centre , 150 Barlby Road, London, W10 6BS Telephone 020 8206 6430 Contact person: Sue Browning Westminster Forensic Community Service (FOCUS) Pall Mall Centre, 150 Barlby Road, London, W10 6BS Telephone 020 8206 6430 Contact person: Andy Crowther Westminster Police Liaison Service Pall Mall Centre, 150 Barlby Road, London, W10 6BS Telephone 020 8206 6430 Contact person: Andy Crowther

Service type	**Inpatient secure services**
About the service	These services provide specialist assessment, treatment and care to people who have or may have severe mental illness and complex needs and require an environment with enhanced security and safety. This ordinarily means they need to be detained under the Mental Health Act. The aim of our secure mental health inpatient service is one of care and treatment. Our service is for patients who display particularly challenging behaviour and who may have complex needs that cannot be effectively managed in mental health services. Patients who are admitted are encouraged to fully participate in their comprehensive and detailed treatment programme with a goal of planned rehabilitation and resettlement in the community. Treatments and therapies include: • Treatment of offending behaviour • Socialisation and rehabilitation into the community • Arts psychotherapy • Cognitive Behaviour Therapy • Practical support in developing / improving daily living skills • Pharmacotherapy
Eligibility criteria (who is the service for?	The eligibility criteria for our low secure inpatient service is as follows: • Adults only (aged over 18) • Requires assessment and treatment in a specialist low secure hospital setting, including those with forensic needs and presenting with challenging behaviour.
How can someone be referred?	The referral routes to our low secure inpatient services are as follows: • Referrals must be made to the Manager or Consultant Psychiatrist by a health care professional (usually a psychiatrist, care manager or care co-ordinator). • Patients cannot self-refer to this service. • Before the service can offer assessment and treatment we require authorisation of funding from the relevant commissioner or local authority, if the referral is for an inpatient bed in a low secure setting. • Once we receive a referral, we then undertake a pre-admission assessment.
Service times	As a low secure inpatient service, we provide care 24 hours a day, 7 days a week.
Choose and Book	N/A

Service locations • Please check locations as shown • Provide telephone numbers	Java House Forensic Step-down Rehabilitation Unit Park Royal Mental Health Centre, Central Way, off Acton Lane, London, NW10 7NS Telephone 0208 955 4517 Contact person: Jon Ruddock Tasman Ward Low Secure Unit Park Royal Mental Health Centre, Central Way, off Acton Lane, London, NW10 7NS, Telephone 0208 955 4517 Contact person: Jon Ruddock

Service type	**Prison and Immigration Removal Centre Services**
About the service	All prisoners / detainees are entitled to free healthcare. We deliver a range of healthcare services in prisons across London, Surrey, Kent, Hampshire and Buckinghamshire as well as to one immigration removal centre in Dover, Kent. We employ a range of healthcare professionals and support staff to deliver our services, including nurses and doctors, opticians, dentists, pharmacists, psychologists and substance misuse experts. We often work in partnership with other healthcare provider agencies. We do not provide non-essential health treatments to prisoners' e.g. specific dental treatments such as tooth whitening, breast implants etc.
Eligibility criteria (who is the service for?	In order to access the service, a service user must: • Be a serving prisoner / detainee of one of the prisons / Immigration Removal Centre listed below at the service locations. • Have been identified as likely to benefit from our healthcare services. We provide many different services in prison – primary care, mental health and substance misuse. Most services are accessed directly by prisoners. Specialist mental health services can only be accessed following a referral by another healthcare professional e.g. GP, primary care liaison mental health nurse. As a service provider we do not refuse to provide services to any individual without the prior written consent of the Commissioners. Such consent will only be given: (a) on grounds that to treat the person would expose our staff or others to serious risk; or (b) for other good cause, as evidenced).
How can someone be referred?	The referral routes to our prison health services are as follows: **Primary Care:**

	• Self-referral • From other healthcare professionals e.g. from Reception • From other prison agencies e.g. IMB **Substance Misuse:** • Self-referral • From other healthcare professionals e.g. from Reception • From other prison agencies e.g. IMB **Mental Health:** • Self-referral • From other healthcare professionals e.g. from substance misuse • From other prison staff e.g. wing officer
Service times	**Blantyre House and East Sutton Park** • Our substance misuse service provides a reduced service. **HMP Elmley** • Our substance misuse service operates 24 hours a day, 7 days a week. **HMP Swaleside** • Our substance misuse service operates 24 hours a day, 7 days a week. **HMP Standford Hill** • Our substance misuse service operates 24 hours a day, 7 days a week. **HMP Maidstone** • Our substance misuse service operates 24 hours a day, 7 days a week. **HMP Rochester** • Our substance misuse service operates 24 hours a day, 7 days a week. **Dover Immigration Removal Centre** • Our substance misuse service provides a clinic once each week with emergency call-out outside this slot. **HMP & YOI Bronzefield** • Our mental health in-reach service operates from Monday to Friday 09:00 – 17:00. • It does not provide a service on weekends or on Bank holidays. **HMP Wormwood Scrubs** • Our mental health in-reach service operates from Monday to

	Friday 09:00 – 17:00. • It does not provide a service on weekends or on Bank holidays. • Our mental health inpatient service operates 24 hours a day, 7 days a week. • Our substance misuse service operates 24 hours a day, 7 days a week. **HMP Winchester** • Our substance misuse service operates 24 hours a day, 7 days a week. **HMP & YOI Holloway** • Our core primary care service operates from Monday to Friday 09:00 – 17:00 with a reduced service all the time outside this period. • Our mental health in-reach service operates from Monday to Friday 09:00 – 17:00. • It does not provide a service on weekends or on Bank holidays. • Our mental health inpatient service operates 24 hours a day, 7 days a week. • Our substance misuse service operates 24 hours a day, 7 days a week.
Choose and Book	N/A
Service locations	Dover Immigration Removal Centre Substance Misuse Service Dover Immigration Removal Centre, The Citadel Western Heights, Dover, Kent, CT17 9DR Telephone: 01634 803061 Contact person: Sally-Ann Morris HMP & YOI Bronzefield Mental Health In-reach Service HMP & YOI Bronzefield, Woodthorpe Road, Ashford, Greater London, TW15 3JZ Telephone 01784 425690 Contact person: Carmel Carter HMP & YOI East Sutton Park Integrated Substance Misuse Service HMP & YOI East Sutton Park, Sutton Valence, Maidstone, Kent, ME17 3DF Telephone 01634 803061 Contact person: Sally-Ann Morris HMP & YOI Holloway Mental Health In-reach Service HMP & YOI Holloway, Parkhurst Road, London, N7 0NU Telephone 020 7979 4616 Contact person: Chrissy Reeves HMP & YOI Holloway Primary Care Services

	HMP & YOI Holloway, Parkhurst Road, London , N7 0NU Telephone 0207 979 4737 Contact person: Kathleen Jewson HMP & YOI Holloway Substance Misuse Services HMP & YOI Holloway, Parkhurst Road, London, N7 0NU Telephone 02079794514 Contact person: Gertrude Diala HMP Blantyre House HMP Blantyre House, Horden, Kent, TN17 2NH Telephone 01634 803061 Contact person: Sally-Ann Morris HMP Elmley Integrated Substance Misuse Service HMP Elmley, Church Road, East church, Kent, ME12 4DZ Telephone 01895 802079 Contact person: Fran James HMP Maidstone Integrated Substance Misuse Service HMP Maidstone, 36 County Road, Maidstone, Kent, ME14 1UZ Telephone 01634 803061 Contact person: Sally Morris HMP Standford Hill Integrated Substance Misuse Service HMP Standford Hill, Church Road, Sheerness, Kent, ME12 4AA Telephone 01895 802079 Contact person: Fran James HMP Swaleside Integrated Substance Misuse Service HMP Swaleside, Brabazon Road, Isle of Sheppey, Kent, ME12 4AX Telephone 01895 802079 Contact person: Fran James HMP Winchester Integrated Substance Misuse Service HMP Winchester, Romsey Road, Winchester, Hampshire, SO22 5DF Telephone 01962 723251 Contact person: Deborah Sanders HMP Woodhill HMP Woodhill, Tattenhoe Street, Milton Keynes, Buckinghamshire MK4 4DA Telephone 01908 722000 Contact person: Lesley Halford HMP Wormwood Scrubs Mental Health Services HMP Wormwood Scrubs, Du Cane Road, London, W12 0AE Telephone 020 8588 3382 Contact person: Maddie Ryan HMP Wormwood Scrubs Substance Misuse Services HMP Wormwood Scrubs, Du Cane Road, London W12 0AE Telephone 02085883214

	Contact person: Andrew Jere HMYOI Rochester Integrated Substance Misuse Service HMYOI Rochester, 1 Fort Road, Rochester, Kent ME1 3QS Telephone 01634 803061 Contact person: Sally-Ann Morris

Older people and healthy ageing service line

Service type	**Community mental health teams**
About the service	Most patients treated by the team will have short-term mental health issues and after a period of weeks or months they will be referred back to their GP when their condition has improved. A small minority, however, who need specialist care will remain with the team for a longer period for ongoing treatment, care and monitoring. Community Mental Health Teams (CMHTs) have three key functions: To give advice on the management of mental health problems to other professionals – in particular, providing advice to primary care, and making sure appropriate referrals are made. Providing treatment and care for those with severe mental health issues who can benefit from specialist interventions. Providing treatment and care for those with more complex needs. CMHTs have access to a range of specialist therapies within the range of services available to older people.
Eligibility criteria (who is the service for?	The CMHT welcomes referrals for those service users with mental health difficulties. The following represents our guide to referral criteria: People of any age with a primary dementia (this excludes traumatic brain injury and Korsakoff's) . People with mental disorder and significant physical illness or frailty which, contributes to, or complicates the management of their mental disorder. Exceptionally this may include people under 60. People with psychological or social difficulties related to the ageing process, or end of life issues, or who feel their needs may be best met by an older adults service. This would normally include people over the age of 70. The criteria above will be applied bearing in mind the person's choice about services.
How can someone be referred?	For people who haven't ever had any contact with one of our Community Mental Health Teams, referrals can be made by a GP, social services or other health professionals. However, if people have had previous contact with one of our CMHTs, they are welcome to ring their local team to discuss any difficulties or concerns they might have. The CMHTs will usually arrange to see people in their own homes

	by appointment and do not offer a walk-in service.
Service times	Monday to Friday, 9.00 am to 5.00 pm, excluding bank holidays. The Home Treatment Teams, which are integrated into the CMHTs in the boroughs of Kensington & Chelsea and Westminster, operate Monday to Friday, 8.30 am to 7.00 pm, and weekends and bank holidays, 9.00 am to 5.00 pm.
Choose and Book	No
Service locations	Brent Community Mental Health Team Belvedere House, Harlesden Road, Brent, London NW10 3RX. Tel. 020 8459 5020. Harrow Community Mental Health Team Bentley House, 15-21 Headstone Drive, Harrow, MiddlesexHA3 5QX. Tel. 020 8424 7728. Hillingdon Community Mental Health Team Woodland Centre, Hillingdon Hospital, Pield Heath Road, Uxbridge, Middlesex UB8 3NN. Tel. 01895 891104. Kensington & Chelsea Community Mental Health Team Nightingale House, St Charles Health & Wellbeing Centre, Exmoor Street, London W10 6DZ. Tel. 020 8206 7148. Westminster Community Mental Health Team 3rd Floor, 190 Vauxhall Bridge Road, London SW1V 1DX. Tel. 020 7854 4105.

Service type	**Continuing care services**
About the service	Continuing care means care provided over an extended period of time to a person with physical or mental health needs which have arisen as a result of disability, an accident or illness. Patients must be assessed for their eligibility for NHS continuing care. The Trust has two Continuing Care Services for older people who have advanced cognitive impairment or severe and enduring mental health needs. One is situated in Kensington & Chelsea (Beatrice Place) and the other in Westminster (Butterworth Centre). Staff are available 24 hours a day to provide support and advice to patients and their carers. Inpatient services have access to a range of specialist therapies within the Directorate. There is a varied programme of individual and group therapies and activities running throughout the week.
Eligibility criteria (who is the service for?	Residents admitted to the units must be eligible to receive care under the 'Continuing Care Eligibility Criteria for Elderly Mental Health', which is determined by the continuing care assessment process.

How can someone be referred?	Access is via the continuing care eligibility criteria set out by the Local Authority. People are unable to refer directly to continuing care services.
Service times	24 hours a day, 7 days a week.
Choose and Book	No
Service locations	Beatrice Place 3 Beatrice Place, Marloes Road, London W8 5LW Tel: 020 7361 7942 / 7943 Butterworth Centre Hospital of St John & Elizabeth, 36 Circus Road, London NW8 9SE Tel: 020 7078 3860

Service type	**Intermediate Care Services**
About the service	A joint mental health and physical health service which aims to bring a complete package of healthcare treatment under one team. There are currently two teams in the Directorate, operating in the boroughs of Westminster and Harrow. The intermediate care services provide intensive, targeted treatment to help patients recover at home rather than being admitted to hospital. In addition they also work with hospitals and mainstream services to support patients when they return home. The aim of these service is to promote and optimise wellbeing by addressing the following needs: • Physical health • Mental health • Communication • Cognitive rehabilitation • Psychosocial Intermediate care services have access to a range of specialist therapies from other older people's services in the Directorate.
Eligibility criteria (who is the service for?	**Inclusion Criteria** Stable medical condition: • When there is a clear evidence of change to pre-morbid functioning. • The patient has rehabilitation potential. • There is evidence that the patient is presenting with mental health problems/symptoms and/or confusional state which is secondary to their current health status and clearly impeding their rehabilitation. • The individual referred is willing and able to participate in a programme of rehabilitation. • The individual and/or family (where appropriate) are aware

	and happy for the referral to intermediate care services. **Exclusion Criteria** • The patient has suffered a dense stroke which requires functional rehabilitation. • The patient requires specialist neuro-rehabilitation.
How can someone be referred?	The team accepts referrals from GPs, Social Workers, Nurses and Rehabilitation staff. People who are currently receiving support for their health and care needs can ask their support worker to refer them to the Intermediate Care Team. Patients are able to self-refer to the services. The Intermediate Care Services will arrange to see people by appointment and do not offer a walk-in service.
Service times	**Westminster Intermediate Care Service** Monday to Friday, 8.30 am to 4.30 pm, excluding bank holidays. **Harrow Intermediate Care Service** Monday to Friday, 8.30 am to 4.30 pm, excluding bank holidays.
Choose and Book	No
Service locations	Westminster Intermediate Care Service 3rd Floor, 190 Vauxhall Bridge Road, London SW1V 1DX. Tel. 020 7854 4105. Harrow Intermediate Care Service Cedar Unit, Woodland Hall Care Home, Clamp Hill, Stanmore, Middlesex HA7 3BG. Tel. 020 8424 7728.

Service type	**Memory services**
About the service	Memory services provide assessment and diagnosis of dementia and provide ongoing support and information to people with memory problems and their carers. Memory services are specialist services for people of any age who may be experiencing memory difficulties, which includes early onset dementia. All our memory services have no upper or lower age limit so will assess and work with people of any age who may have or suspect they have memory problems. All teams have access to medical staff, specialist dementia nurses, occupational therapists, and psychologists. Most boroughs also have Admiral Nurses in their teams who specialise in supporting carers. Memory services offer a comprehensive assessment of an individual's memory, ensuring that if dementia is an issue a diagnosis is given as soon as possible. Once the diagnosis is given the services can help to support individuals in coming to terms

	with their diagnosis and provide useful strategies and treatments to help people minimise their memory difficulties. Our aim is to help people live independently and safely. People may need this service if they are: • Having difficulty remembering day-to-day things. • Starting to forget dates and appointments. • Getting in a muddle with finances, paying bills etc. • Finding that they are losing things around the house. • Finding it harder to remember names. • Having difficulty following conversations. • Carer is having difficulty coping. Any of these difficulties may result in anxiety, frustration, anger, high levels of stress and a feeling of isolation. The teams are there to help patients and carers to manage these feelings.
Eligibility criteria (who is the service for?	**Inclusion Criteria** • Symptoms consistent with suspected dementia rather than a physical or functional mental illness. • An existing diagnosis of dementia requiring further referral for assessment or treatment. • Any age • The person is a resident of a Borough served by CNWL (i.e. the area covered by Brent, Harrow, Hillingdon, Westminster, Kensington and Chelsea) • The person is medically stable i.e. does not require 24 hour monitoring by a medical team or an emergency mental health admission • The person has a 6 month history of memory impairment without physical a physical cause e.g. UTI. **Exclusion Criteria** • People with an existing diagnosis of dementia currently under the care of the Directorate's Community Mental Health Teams. • Those service users reporting memory problems following a traumatic brain injury will be redirected to specialist neurological services.
How can someone be referred?	Referral is appropriate when it is suspected that the memory loss is more than just minor, and/or the memory loss is suspected to be part of a wider picture of dementia which may require specialist intervention (e.g. pharmacological intervention). In the event that functional mental illness is found to be the cause of memory impairment, the patient will be transferred back to their GP or CMHT. People can be referred to memory services by their GP or

	directly via another specialist practitioner such as a neurologist or medical staff in another hospital. In the latter case, the Memory Service will inform the GP of the referral. Direct referral to the Memory Assessment Service will be taken from within the Directorate, from the General Practitioners, locality Social Services teams or any other health or social care professionals. Where people self referral further information will be requested from their GP. Memory Services will arrange to see people by appointment and do not offer a walk-in service.
Service times	Monday to Friday, 9.00 am to 5.00 pm, excluding bank holidays.
Choose and Book	No
Service locations	Brent Memory Services Park Royal Centre for Mental Health, Central Way (Off Acton Lane), London NW10 7NS. Tel. 020 8955 4415. Harrow Memory Services Bentley House, 15-21 Headstone Drive, Harrow, Middlesex HA3 5QX. Tel. 020 8424 7714. Hillingdon Memory Service Woodland Centre, Hillingdon Hospital, Pield Heath Road, Uxbridge, Middlesex UB8 3NN. Tel. 01895 279 970. Kensington & Chelsea Memory Service Westminster Memory Service 42 Westbourne Park Road, London W2 5PH. Tel. 020 3219 0910.

Service type	**Day Services**
About the service	Day services are open five days a week, with patients attending one to three days a week depending on their needs. These services are staffed by qualified mental health nurses, occupational therapists and support staff. There are also sessions arranged by medical staff and psychologists. The services can also help people access services provided by physiotherapy staff, dieticians and chiropodists. Services carry out an assessment of the individual's needs so a greater understanding of their mental health issues can be gained. A planned care programme is put in place which is reviewed regularly. The aim of these plans is to aid the patient in their recovery. Each service runs a therapeutic group programme to support people in maintaining independence in the community. Services also support early discharge from hospital and some provide respite to carers. In addition to this the services carry out

	outreach work, visiting the patients at home.
Eligibility criteria (who is the service for?	
How can someone be referred?	People are usually referred to Day Services by the Community Mental Health Team (CMHT) once the individual has been assessed. Referral can also be made by inpatient services. People cannot directly refer themselves to Day Services and we do not offer a walk-in service.
Service times	Monday to Friday, 9.00 am to 5.00 pm, excluding bank holidays.
Choose and Book	No
Service locations	Brent Day Services Belvedere House, Harlesden Road, London NW10 3RX. Tel. 020 8459 3562. Harrow Day Services Bentley House, 15-21 Headstone Drive, Harrow, Middlesex HA3 5QX. Tel. 0208 424 7765. Kensington & Chelsea Day Services Westminster Day Services Chamberlain Building, St Charles Health & Wellbeing Centre, Exmoor Street, London W10 6DZ. Tel. 020 8206 7113 / 7114.

Service type	**Inpatient Services**
About the service	Inpatient services provide a multidisciplinary assessment and treatment package involving the patient, relatives and carers from admission through to discharge. The care will take into account the needs of the patient as well as the relative and/or carer and will ensure that discharge planning reflects the needs of both. The wards are staffed by a range of specialist clinicians, who are involved in assessment planning, implementation and evaluation of nursing care. They are supported by psychologists, occupational therapists and, when required, physiotherapists. Nursing staff are available 24 hours a day to provide support and advice to patients and their carers. There is a varied programme of individual and group therapies and activities running throughout the week.
Eligibility criteria (who is the service for?	**Inclusion Criteria** • People of any age who have any primary cognitive disorder. • People who have mental disorders and who have significant physical illness (e.g. stroke, Parkinson's disease, severe IHD or COPD) or frailty.

	• People over 70 or approaching end-of-life.
How can someone be referred?	**Referral to inpatient services is by:** • Community-based services, for example, Community Mental Health Teams (CMHTs). • Psychiatric liaison services in acute hospitals - either A&E or wards. • Other inpatient units for older people. • Inpatient units for adults. • The Home Treatment Team (Kensington & Chelsea and Westminster boroughs only. • No specific referral form as referrals come via The Home Treatment Team.
Service times • Details of the times/days when the service is available.	24 hours a day, 7 days a week.
Choose and Book	No
Service locations • Please check locations as shown • Provide telephone numbers	Oak Tree Ward (Hillingdon) Woodland Centre, Hillingdon Hospital Pield Heath Road, Uxbridge, Middlesex UB8 3NN Tel: 01895 279393 Ellington Ward (Brent and Harrow) Northwick Park Hospital, Watford Road, Harrow, Middlesex HA1 3UJ Tel: 0208 869 2269/ 2268 Kershaw Ward (Kensington & Chelsea) Redwood Ward (Westminster) St Charles Health & Wellbeing Centre, Exmoor Street, London, W10 6DZ Tel: 020 8206 7220 (Kershaw Ward) Tel: 020 8206 7230 (Redwood Ward)

Service type	**Psychiatric Liaison Services**
About the service	Psychiatric liaison services for older people provide mental health assessment and treatment for people who are inpatients in hospital or for those who may present at an A&E department and be in need of a mental health assessment. Sometimes when people go into hospital for treatment for a physical illness they may also be feeling depressed, anxious or paranoid. They could be hearing voices or are forgetful and confused. If this is the case the ward staff may refer to the Psychiatric Liaison Service based locally at the acute hospital, usually linked closely with the A&E department. The teams are

	comprised of mental health clinicians who specialise in working with older people who have mental health concerns. If a referral is made, a specialist Doctor, Nurse, Occupational Therapist or Psychologist may come and assess the person's mental health needs on the acute ward. These professionals will make recommendations to improve the individual's mental health. These teams have easy access to other specialist mental health services such as inpatient mental health wards, Memory Services or Community Mental Health Teams where treatment can be continued at home or in the specialist ward. The team can support you whilst you are in the hospital ward and monitor how you are feeling or if any treatments recommended are effective. In addition to this, individuals may be brought by a family member / ambulance, or referred by a GP to A&E departments. Alternatively individuals could self-present at A&E. Within A&E, the same liaison service can assess, treat and make recommendations again to improve an individual's mental health, accessing the same services as outlined above.
Eligibility criteria (who is the service for?	People can be referred to Psychiatric Liaison Services by the hospital inpatient ward that is delivering their care or by the Accident and Emergency Department. The service will assess anyone who is referred, regardless of where the person lives, and they will ensure the appropriate follow up services are contacted.
How can someone be referred?	Referral is accepted from health and social care professionals within the hospital involved with the patients care. The Adult liaison team will see urgent referrals made out of hours. Alternatively, people can access psychiatric liaison services via presentation at the A&E Departments of the acute hospitals.
Service times	Monday to Friday, 9.00 am to 5.00 pm (for referrals to OPHA liaison staff). Access to psychiatric liaison services operates 24 hours a day, 7 days a week (via presentation at A&E Depts).
Choose and Book	No
Service locations	Psychiatric Liaison - Kensington & Chelsea Chelsea and Westminster Hospital, 369 Fulham Road, London SW10 9NH Tel: 020 3315 2432 Psychiatric Liaison - Westminster St Mary's Hospital, Praed Street, London W2 1NY Tel: 020 7854 4151

Psychological medicine service line

Service type	**A&E liaison**
About the service	When emergency care is needed, A&E is the area of the NHS that most people will turn to. Whilst people who have used mental health services before may know the different types of support available and how to access them, A&E is where most people will turn to when they need emergency care. People who attend A&E with urgent mental health or psychological needs may present with a range of problems including self-harm, delirium, behavioural disturbance, and alcohol and drug-related problems. Our services work closely with the general hospital staff within A&E departments and are available 24 hours a day, 365 days a year. Initially we provide comprehensive psychiatric and risk assessments and for those who need it, following assessment may refer or signpost people onto other services.
Eligibility criteria (who is the service for?	Open access – any member of the population can attend A&E
How can someone be referred?	Referrals are made to A&E liaison via the A&E department/ acute Trust staff Adults 16+
Service times	24/7, 365 days a year
Choose and Book	NO
Service locations	A&E Liaison, Chelsea and Westminster Hospital Chelsea and Westminster Hospital, Fulham Road, Fulham, London, SW10 9NH A&E Liaison, Hillingdon Hospital Hillingdon Hospital, Pield Heath Road, Hillingdon, London, UB8 3NN A&E Liaison, Northwick Park Hospital Northwick Park Hospital, Watford Road, Harrow, London, HA1 3UJ A&E Liaison, Central Middlesex Hospital Central Middlesex Hospital, Central Way, off Acton Lane, London, NW10 7NS A&E Liaison, St Mary's Hospital St Marys Hospital, Praed Street, Westminster, London, W2 1NY

Service type	**Clinical health psychology**
About the service	Clinical health psychologists usually work as part of team with

	other physical healthcare professionals. They provide psychological input directly to patients as well as providing consultation, supervision and training for other members of the general hospital team. Clinical health psychologists work in a wide range of areas including HIV/sexual health, diabetes, pain management, oncology, burns, respiratory medicine, bariatric surgery and weight management. The services focus on psychological problems that arise from physical illness or pre-existing psychological problems that complicate the management of the physical illness. They offer treatments such as cognitive behavioural therapy or motivational interviewing, to optimise coping, quality of life and physical healthcare treatment.
Eligibility criteria (who is the service for?	Services are aligned with acute Trust services e.g. gastroenterology according to local commissioning arrangements. Access is via the acute Trust team who refer on as appropriate. Working aged adults 17+
How can someone be referred?	Clinical health psychologists work closely with clinical teams staff to identify patients who require mental health support. Referrals are via acute Trust staff.
Service times	Mon-Fri 9-5pm
Choose and Book	NO
Service locations	Clinical Health Psychology, Central Middlesex Hospital Central Middlesex Hospital, Central Way, off Acton Lane, London, NW10 7NS Clinical Health Psychology, Chelsea and Westminster Hospital Chelsea and Westminster Hospital, 369 Fulham Road, London, SW10 9NH Clinical Health Psychology, Harefield Hospital Harefield Hospital, Hill End Road, Harefield, Greater London, UB9 6JH Clinical Health Psychology, Brompton Hospital Brompton Hospital, Sydney Street, London, SW3 6NP Clinical Health Psychology, Hillingdon Hospital Hillingdon Hospital, Pield Heath Road, Uxbridge, Greater London, UB8 3NN Clinical Health Psychology, Northwick Park Hospital Northwick Park Hospital, Watford Road, Harrow, Greater London, HA1 3UJ Clinical Health Psychology, St Marys Hospital St Marys Hospital, Praed Street, London, W2 1NY

Service type	**Liaison psychiatry**
About the service	Liaison psychiatry bridges the gap between physical and mental healthcare. Our services provide mental healthcare to people being treated for physical illness in general hospitals, whether they attend out-patient clinics or are admitted to inpatient wards. The co-occurrence of mental and physical health problems is common among these patients, often leading to poorer health outcomes, delayed discharges and increased use of healthcare resources. Our aim is to improve patient experience, quality and efficiency of service in the general hospitals by focusing on the significant number of patients that have mental health problems complicating their care and discharge. Some problems that may be referred to liaison psychiatry: • Psychological reactions to physical illness • Deliberate self-harm • Medically unexplained symptoms • Organic mental disorders - delirium and dementia • Alcohol and substance misuse • Mental illness related to childbirth • Diagnostic difficulties • Abnormal illness behaviour • Behavioural disturbance • Medico-legal decisions • Assessment of capacity to refuse medical treatment Our staff are based in some of London's largest general and specialist hospitals to help detect mental health problems early and provide the necessary support.
Eligibility criteria (who is the service for?	To anyone who is a patient with the acute Trusts that we provide services to. Adults 16+
How can someone be referred?	Referrals are made through the general hospital by a health professional.
Service times	24/7 365 days a year – generally urgent referrals out of hours and at weekends
Choose and Book	NO
Service locations	Liaison Psychiatry, Central Middlesex Hospital Central Middlesex Hospital Central Way, off Acton Lane Liaison Psychiatry, Chelsea and Westminster Hospital Chelsea and Westminster Hospital, 369 Fulham Road, London, SW10

	9NH Liaison Psychiatry, Harefield Hospital Harefield Hospital, Hill End Road, Harefield, Greater London, UB9 6JH Liaison Psychiatry, Hillingdon Hospital Hillingdon Hospital, Pield Heath Road, Uxbridge, Greater London, UB8 3NN Liaison Psychiatry, Northwick Park Hospital Northwick Park Hospital, Watford Road, Harrow, Greater London, HA1 3UJ Liaison Psychiatry, Royal Brompton Hospital Royal Brompton Hospital, Sydney Street, London, SW3 6NP Liaison Psychiatry, Royal Marsden Hospital Royal Marsden Hospital, Fulham Road, SW3 6JJ Liaison Psychiatry, St Marys HospitalSt Marys Hospital, Praed Street, London, W2 1NY

Rehabilitation service line

Service type	**Inpatient rehabilitation**
About the service	Inpatient rehabilitation is provided for people who have complex mental health needs. There are a range of services to meet different service user needs and levels of support. The services provide a homely environment for people with long-term mental health needs Multi-disciplinary teams support service users to develop the necessary skills for independent living, including practical skills, mental health management and being prepared psychologically. Service users and their relatives or carers are encouraged to work with staff to draw up a programme of care. The programme includes learning or relearning life skills, a range of group and individual therapies, managing mental health including medication, activities and access to leisure, education and employment opportunities in the community.
Eligibility criteria (who is the service for?	The service is for people who are already engaged with secondary mental health services, who have complex mental health needs and need intensive support to be able to move to more independent living.
How can someone be referred?	Applications are made by care co-ordinators, from commissioners or other mental health trusts. There is no self referral or walk-in service. There is a centralised referral process managed by the rehabilitation service line lead nurse.
Service times	24 hours a day throughout the year.
Choose and Book	NO
Service locations	2 Colham Green Road 2 Colham Green Road, Pield Heath Road , Hillingdon, London, UB8 3NN Bluebell Lodge 7a Woodfield Road, London, W9 3XZ Fairlight 27-29 Fairlight Avenue, Harlesden, London, NW10 8AL Horton Rehabilitation Service , 5 Haven Drive, Long Grove Road, Epsom, Surrey, KT19 7HA Horton Rushett House Horton , 5 Haven Drive, Long Grove Road, Epsom, Surrey, KT19 7HA Horton Cottages - Rose Horton , 5 Haven Drive, Long Grove Road, Epsom, Surrey, KT19 7HA Horton Cottages - Shrubbery Horton , 5 Haven Drive, Long

	Grove Road, Epsom, Surrey, KT19 7HA Horton Cottages - West Horton , 5 Haven Drive, Long Grove Road, Epsom, Surrey, KT19 7HA Horton Westfield House Horton , 5 Haven Drive, Long Grove Road, Epsom, Surrey, KT19 7HA Horton Villas - Ascot Horton , 5 Haven Drive, Long Grove Road, Epsom, Surrey , KT19 7HA Horton Villas - Birch Horton , 5 Haven Drive, Long Grove Road, Epsom, Surrey, KT19 7HA Kenton Ward Kingswood Centre, 134 Honeypot Lane, Kingsbury, London, NW9 9QY Rosedale Court 75-79 Greenford Road , Harrow, Greater London, HA1 3QF Roxbourne Complex & Annex 41 Rayners Lane, Harrow , Greater London, HA2 0UE

Service type	**Community rehabilitation services**
About the service	Community rehabilitation services provide care co-ordination and treatment from the multi-disciplinary team for service users in 24 hour rehabilitation units managed by the trust and other service providers. Community Rehabilitation units in Brent comprise independent flats or bedsits with some communal facilities and 24 hour staff support. Staff provide individual sessions to each service user to enable them to develop community living skills with the aim to move on to less supported accommodation within a year. The main focus is promoting independence.
Eligibility criteria (who is the service for?	The service is for people who are already engaged with secondary mental health services, who have complex mental health needs and need intensive support to be able to move to more independent living.
How can someone be referred?	Applications are made by care co-ordinators, from commissioners or other mental health trusts. There is no self referral or walk-in service. There is a centralised referral process managed by the rehabilitation service line lead nurse.
Service times	Mon – Fri, 9am-5pm
Choose and Book	NO
Service locations	Brent Community Rehabilitation Service, 15 Brondesbury Road, Kilburn, London, NW6 6BX Kensington & Chelsea and Westminster Community

	Rehabilitation Service, Sycamore Lodge, 7a Woodfield Road, W9 2NW Harrow and Hillingdon Community Rehabilitation Service, Mead House, Hayes End Road, Middlesex, UB4 8EW

Sexual health services

Service type	Chlamydia Screening
About the service	We offer free chlamydia screening (testing) to all men and women including young people
Eligibility criteria (who is the service for?)	All men and women including young people
How can someone be referred?	Chlamydia testing does not require booked appointments, examinations or blood tests. There are several options, simply choose the most convenient. 1. Walk in to any of the clinics at the times and locations listed below. You can take the Chlamydia test (self-administered) at the clinic and we'll discuss with you how you'd like us to contact you with the results. (*These clinics do not provide full STI testing so if you have symptoms of infection or want to have other tests, such as for gonorrhoea, syphilis or HIV tests, you need to attend a clinic providing full STI testing. You can also find information on our HIV Services. 2. Collect the self-test chlamydia pack from one of the pharmacies listed below. The Chlamydia test can be taken at home and you then post the pack to us. We will let you know your results by telephone. If you have a positive result (i.e. you have chlamydia), we will advise how to collect your antibiotics over the counter at a participating pharmacy. 3. Collect a self-test chlamydia pack from a participating GP (general practice). To find out if the service is available from a particular practice, just call our Helpline on Tel: 020 3317 5474/5475. 4. Order a test kit online. The kit will be sent to your home address (service only available to Camden residents). Visit www.urlife.org.uk for details.
Service times	**Uxbridge Health Centre Young peoples' clinic (under 25 only)** Monday 3:30pm – 5:30pm Saturday 11.00am – 2.00 pm **The Hesa Primary Care Centre Young peoples' clinic (under 25 only)** Tuesday 5.30pm – 7.30 pm **Yiewsley Health Centre Young peoples' clinic (under 25 only)** Friday 4.00pm – 6.00 pm **Finsbury Health Centre**

	Mon, Tue, Thurs 5.00pm – 6.30pm **Pulse N7,** Mon 12.00pm – 6.00pm Tue 12.00pm – 6.00pm Wed 12.00pm – 6.00pm Thurs 12.00pm – 6.00pm Fri 12.00pm – 5.00pm Sat 12.00pm – 2.15pm **Archway** Sexual health clinics, appointments preferred Mon: 9.00am – 6.15pm Tue: 9.00am – 6.15pm Wed: 9.00am – 6.15pm Thu: 9.00am – 6.15pm Fri: 9.00am – 6.15pm **Archway young peoples' walk in clinic (for people under 20)** Mon to Thu: 3.00pm – 4.30pm **Mortimer Market STI (STD) testing (appointments preferred)** Mon 9.00am – 6.00pm Tue 9.00am – 6.00pm Wed 1.00pm – 6.00pm Thu 9.00am – 6.00pm Fri 9.00am – 3.00pm
Choose and Book	YES
Service locations	**Finsbury Health Centre** Pine Street, London EC1R 0JH 020 7530 4200/4221 **Pulse N7** 164 Holloway Road, London N7 8DD 020 7527 1300 **Mortimer Market** Mortimer Market Centre, Off Tottenham Court Road, London WC1E 6JB **Uxbridge Health Centre** Chippendale Waye Uxbridge, UB8 1QJ Tel: 01895 - 488850 **The Hesa Primary Care Centre** 52 Station Road Hayes, UB3 4DD

	01895 – 484800 **The Archway Centre** 681 - 689 Holloway Road, London N19 5SE Telephone: 020 3317 5252 **Yiewsley Health Centre** High Street Yiewsley UB7 7DP Tel: 01895 - 488840

Service type	**Contraception & Related Services**
About the service	Appointment and walk in based contraceptive (family planning) clinics are available daily at Margaret Pyke Centre in central London. We also offer clinics from health centres across Camden, Brent, Hillingdon and Islington, usually on a walk-in basis. Evening and Saturday morning sessions are also available at some clinics. Emergency Contraception is available free from all the clinics listed. Implants and long acting contraception is also available at the clinics offered Consultant led clinics for complex contraception problems are available at Margaret Pyke and Archway which are available by referral either from the general clinics based at these sites or by GP referral. Services include: • Advice and provision of all reversible methods of contraception including intrauterine contraception and long-acting reversible contraception (LARC) • contraception including natural family planning • counselling and referral for male and female sterilisation • emergency contraception • pregnancy testing • referral for abortion • cervical screening (smear test) • chlamydia screening by self-taken sample for people under 25 • young people's sexual health clinics • advice about gynaecological issues including the menopause. pre-menstrual syndrome and menstrual problems

	• advice and referral for breast problems.
Eligibility criteria (who is the service for?	The service is open access and no referral is required
How can someone be referred?	Clinics are free and confidential. They are open-access which means that you do not need a referral from your GP. A full list of available clinics can be viewed below. Walk-in clinics are only able to see a limited number of patients. This varies according to the number of staff available. Clinics are run on a first come, first served basis - when demand for services is high, appointment slots are filled quickly.
Service times	**Pulse N7 (Under 21 only)** Mon: 12.00pm – 6.00pm Tue: 12.00pm – 6.00pm Wed: 12.00pm – 6.00pm Thurs: 12.00pm – 6.00pm Fri: 12.00pm – 5.00pm Sat: 12.00pm – 2.15pm **Belsize Priory Health Centre** Mon : 5.00pm – 6.30pm Wed: 5.00pm – 6.30pm Thurs: 1.45pm – 3.30pm Fri: 9.00am – 11.15am **Crowndale Health Centre** Mon: 5.00pm – 6.30pm Wed: 9.00am – 11.30am, 1.30pm – 3.30pm, 5.00pm – 6.30pm Thurs: 9.00am – 11.30am, 1.00pm – 3.00pm, 5.00pm – 6.30pm Sat: 9.00am – 10.30am **Finsbury Health Centre** Mon: 5.00pm – 6.30pm Tue: 9.00am – 11.15am, 5.00pm – 6.30pm Thurs: 5.00pm – 6.30pm **Hillside Primary Care Centre** Mon: 9.15am – 11.30am, 1.00pm – 3.30pm, 4.00pm – 6.00pm (walk-in for young people under 20) Tue: 1.00pm – 3.30pm Wed: 9.15am – 11.30am, 1.00pm – 3.30pm Thurs: 1.00pm – 3.30pm, 5.00pm – 7.00pm **Margaret Pyke Centre** Mon: 9.00am – 4.00pm, 5.00pm – 6.30pm Tue: 8.30am – 4.00pm, 5.00pm – 6.30pm Wed: 9.00am – 4.00pm, 5.00pm – 6.30pm Thurs: 9.00am – 4.00pm, 5.00pm – 6.30pm Fri: 8.00am – 4.00pm

	Wembley Centre for Health & Care Mon: 9.30am – 11.00am, 13:00 – 15:30 Tue: 9.30am – 11.30am, 5.00pm – 7.00pm Wed: 9.30am – 11.30am, 4.00pm – 6.00pm Thu: 9.30am – 11.30am Fri: 9.30am – 11.30am **Willesden Centre for Health & Care** Mon: 9.15am – 11.30am Tue: 4.00pm – 6.00pm Wed: 5.00pm – 7.00pm Thurs: 9.15am – 11.30am, 1.00pm – 3.30pm, 5.00pm – 7.00pm Fri: 9.15am – 11.30am, 1.00pm – 3.30pm **Uxbridge Health Centre Appointments only unless for emergency contraception** Mon: 12.30pm –2.30 pm Tues: 9.30am – 11.30am, 1.30pm – 3.30pm, 5.30pm – 7.30pm Wed: 9.00am – 11.30, 1.00pm – 3.30pm, 5.30pm – 7.30 pm Thu: 9.30am – 11.30am, 1.30pm – 3.30pm, 5.30pm – 7.30pm Fri: 9.30am – 11.30am, 1.30pm – 3.30pm Sat: 11.00am – 2.00pm **The Hesa Primary Care Centre** Tues: 5.30pm – 7.30pm Young peoples' clinic (under 25s only) Wed: 9.30am – 11.30am, 1.30pm – 3.30pm, 5.30pm – 7.30pm Fri: 1.30pm – 3.30pm **Yiewsley Health Centre** Wed: 5.30pm – 7.30pm Fri: 4.00pm – 6.00pm Young peoples' clinic (under 25s only) **Westmead Clinic** Fri: 5.30pm – 7.30pm **The Archway Centre for sexual and reproductive health Sexual Health & Contraceptive Service (appointment preferred)** Mon: 9.00am – 6.15pm Tue: 9.00am – 6.15pm Wed: 1.30pm – 6.15pm Thu: 9.00am – 7.15pm Fri: 9.00am – 3.15pm Sat: 9.00am – 11.15pm (contraception only) **Walk-in Rapid HIV Testing Service (no appointment necessary)** Mon: 9.00am – 6.15pm Tue: 9.00am – 6.15pm Wed: 1.30pm – 6.15pm Thu: 9.00am – 7.15pm Fri: 9.00am – 3.15pm

	Young person's walk-in service (under 20's no appointment necessary, spaces limited) Mon: 3.00pm – 4.30pm Tue: 3.00pm – 4.30pm Wed: 3.00pm – 4.30pm Thu: 3.00pm – 4.30pm	
Choose and Book	YES	
Service locations	Pulse N7	164 Holloway Road, London N7 8DD 020 7527 1300
	Belsize Priory HC	208 Belsize Road, London NW6 4DX 020 3317 5800
	Crowndale HC	59 Crowndale Road, London NW1 1TU 020 3317 2402
	Finsbury HC	Pine Street, London EC1R 0JH 020 7530 4200/4221
	Hillside Primary Care Centre	150 Hilltop Avenue Harlesden London NW10 8RY 0203 188 7363
	Margaret Pyke Centre	73 Charlotte Street, London 020 3317 3737
	Wembley Centre for Health & Care	116 Chaplin Road, Wembley, Middlesex HA0 4UZ 020 8795 6010
	Willesden Centre for Health & Care	Robson Avenue, Willesden Green, London NW10 3RY 020 8438 7085
	The Archway Centre for sexual and reproductive health	681 - 689 Holloway Road, London N19 5SE 020 3317 5252

	Uxbridge Health Centre Chippendale Waye Uxbridge, UB8 1QJ **Tel: 01895 - 488850** **The Hesa Primary Care Centre** 52 Station Road Hayes, UB3 4DD **01895 – 484800** **Yiewsley Health Centre** High Street Yiewsley UB7 7DP **Tel: 01895 - 488840** **Westmead Clinic** South Ruislip, HA4 0TN **Tel: 01895 – 488860**

Service type	**HIV Services**
About the service	The Bloomsbury Clinic at the Mortimer Market Centre in Central London offers a free and confidential outpatient service for people with HIV. **Services** • HIV treatment advice and follow-up including Walk-in Rapid HIV test • In-house specialist HIV pharmacy • Designated treatment, advice and support for patients starting or switching Anti-HIV medication (HAART) • Emergency clinic • Close collaboration with University College London Hospital (UCLH) to provide a range of specialist clinics such as neurology, renal, oncology, TB, antenatal and a family clinic at Great Ormond Street Hospital • Other specialist services include a teenage clinic for adolescents living with HIV, known as the TEAM Clinic, dietician, treament for facial lipoatrophy, HIV and hepatitis co-infection clinic • Inpatient services on ward T8 at UCLH • Sexual and reproductive health advice including sexual health screens and cervical smears

	• Health advisor and Psychology services • Patient representatives offering advocacy and peer support **Emergency Clinic** If you already attend the Bloomsbury Clinic and have an urgent problem that is HIV related then you can attend the clinic where the duty doctor will be available to assess you. If you are unsure whether your problem is HIV related or would like some advice, please telephone the nurses during the opening hours shown below on **(Tel) 020 3317 5100.** **Emergency out-of-hours advice:** Outside the clinic opening hours you can get urgent telephone advice via the UCLH switchboard on **(Tel) 0845 155 5000**. Please ask for the on-call HIV doctor. This number is available until 2100 daily.
Eligibility criteria (who is the service for?	All clients with a diagnosis of HIV.
How can someone be referred?	**New Appointments** If you are HIV positive and transferring your care to the Bloomsbury Clinic from another centre then please contact our appointment booking line on **(Tel) 020 3317 5143** and ask for a Transfer Nurse Appointment. If you have been newly diagnosed HIV positive at another centre and have not yet arranged any follow up care with any centre, you can register as a new patient at the Bloomsbury Clinic. You do not need to be referred to the clinic by a doctor or other healthcare professional. Health advisors in the male or female sexual health clinics at Mortimer Market Centre will arrange your first appointment with Bloomsbury Clinic. Please come to Mortimer Market Centre in the first instance and ask to speak to a health advisor, no appointment is necessary. For further advice, please call the Health Advisor Team on **(Tel) 020 3317 5100.**
Service times	**Monday 0930 - 1730** **Tuesday 0900 – 1730 La**te Clinic **1730 - 1920 *appt only** **Wednesday 1300 - 1630** **Thursday 0900 - 1730** **Friday 0900 – 1500** and Early morning bloods **0815 - 0900**

	Emergency Clinic (for Bloomsbury patients only) **Mon** **Tue** **Wed** **Thu** **Fri** **0900-1300** **0900 - 1300** **1300 - 1500** **0900 - 1300** **0900 - 1300** **Pharmacy Opening Hours** **Mon** **Tue** **Wed** **Thu** **Fri** **0930 - 1330** **1445 - 1700** **0930 - 1330** **1445 - 1700** **1330 - 1700** **0930 - 1330** **1445 - 1700** **0930 -1500**
Choose and Book	YES
Service locations	**Bloomsbury Clinic at Mortimer Market Centre** Mortimer Market Centre, off Capper Street, London WC1E 6JB Telephone: 020 3317 5100

Service type	**STI (STD) & HIV Tests**
About the service	Sexual health (GUM) clinics in Central and North London offering advice, testing and treatment of all sexually-transmitted infections (STI/STD/HIV tests). For locations, opening times and booking information visit the Mortimer Market Centre and Archway Centre clinic pages. Services at the clinics include: • STI (STD) testing and treatment for sexually transmitted infections. • walk-in rapid HIV testing (Limited spaces available) • information and advice on sexual health issues • Hepatitis A, B and C testing for people at risk • Hepatitis A and B vaccination for people at risk • free condoms and lube • emergency contraception • post-exposure prophylaxis (PEPSE) within 72 hours of sexual exposure to HIV • referral to clinical psychology for sexual health issues • Young Person's Clinic (**Archway Centre**) • Sexual health screening for People With Learning Disabilities (**The Bridge Service)**

Eligibility criteria (who is the service for?	This is an open access service with people can self refer to
How can someone be referred?	Most clinics are by appointment only and you can call or attend the clinic to book an STI (STD) or rapid HIV test. If you need urgent help, you can walk in to an STI clinic without an appointment and we will try to see you. However, if the clinic is busy you may be asked to book an appointment.
Service times	**Mortimer Market Centre** Mon 09:00 – 18:00, Tue 09:00 – 19:00 Wed 13:00 – 18:00 Thurs 09:00 – 18:00 Fri 09:00 – 15:00 **The Archway Centre** **Sexual Health & Contraceptive Service (appointment preferred)** Monday 09:00-18:15 Tuesday 09:00-18:15 Wednesday 13:30-18:15 Thursday 09:00-19:15 Friday 09:00-15:15 Saturday 09:00-11:15 (contraception only) **Walk-in Rapid HIV Testing Service (no appointment necessary)** Monday 09:00-18:15 Tuesday 09:00-18:15 Wednesday 13:30-18:15 Thursday 09:00-19:15 Friday 09:00-15:15 **Young person's walk-in service (under 20's no appointment necessary, spaces limited)** Monday 15:00-16:30 Tuesday 15:00-16:30 Wednesday 15:00-16:30 Thursday 15:00-16:30
Choose and Book	YES
Service locations	Mortimer Market Centre: Mortimer Market Centre, Off Tottenham Court Road, London WC1E 6JB, 020 3317 5100 The Archway Centre: 681 - 689 Holloway Road, London N19 5SE

	020 3317 5252