Welcome

This is an outline of all Wandsworth community adult health services (WCAHS).

Information about making referrals is on our website:
https://www.clch.nhs.uk/health-professionals/wandsworth

Contents

How to refer

Making a high quality referral that includes all key clinical information will help to improve your patients' experience and make their clinical treatments more effective.

To ensure all referrals are of the highest quality, we have tailored the referral process to meet the specific needs of our services and service users, and we process all referrals through our single point of access (SPA).

SPA contact details

8am-8pm (Mondays to Fridays) and 8am-5pm (Saturdays, Sundays and bank holidays). You can send referrals via email / EMIS at any time and they will be actioned when the SPA is next open.

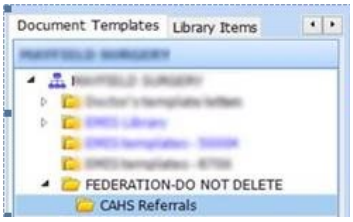
Referral line:	0333 300 2350
Patient line:	0333 300 0950
Email:	clcht.wandsworthspa@nhs.net
E-fax:	0300 008 2137
Post:	PO Box 130, Morden, SM4 9EF

Full details of how to refer to individual services are provided on our website: https://www.clch.nhs.uk/health-professionals/wandsworth

We are constantly aiming to improve the services that we provide and welcome any feedback on our referral process.

Referral forms

Wandsworth GPs should refer via EMIS managed referrals – please make sure you select the most up-to-date referral form by selecting from the following folder. You can check progress of your referral by accessing the patient's record on community EMIS.



Other referrers should use the referral form provided and send by fax /email to the SPA. Please note that we will be phasing out faxes as per the NHS plan to stop their use by 31/3/2020.

You are advised to call and check for safe receipt of your referral if it's clinically urgent or concerning.

Please contact the SPA if you are unsure of which referral form to use.

Care home in-reach team

Overview

Wandsworth care home in-reach team helps reduce avoidable emergency admissions to hospital. They comprise a team of advanced nurse practitioners and nurses who provide a 2-hour rapid response to residents living in one of the 14* Wandsworth care homes, for urgent referrals and 4 day response for routine referral. The team also acts as a unified point of access to other healthcare pathways. A care home pharmacist has been introduced to the team from 2018/19.

**Meadbank cover was also provided until 31 August 2019 and is subject to review for ongoing funding.*

Objective

The team work with care home staff to identify and case find new referrals and help the care home staff develop their skills and confidence to manage patients to reduce avoidable emergency admissions. The key functions delivered are:

1. **Rapid assessment and intervention in care homes** for residents with an urgent physical health, mental health or social needs **within two hours of referral** (Monday to Friday 8am-5pm, last referral 3pm, available for advice until 5pm).
2. **Proactive and preventative care** within 72 hours/three working days for routine referrals (Monday to Friday 8am-5pm, last referral 3pm, available for advice until 5pm).
3. **Training, education and mentoring support** for staff employed in care homes (Monday to Friday 8am-5pm).
4. **Investigation monitoring and support** functions (Monday to Friday 8am-5pm).

An appropriate care pathway has also been published for use by LAS.

A **care home pharmacist** works alongside the core care home team. Key areas of service delivery include:

- Prioritisation of medication reviews for care home residents as per national and locally developed guidance on targeted medication reviews.
- All medication reviews will be patient centred with medicines optimisation embedded within them. Any changes will be documented and communicated clearly for all relevant health and social care professionals and with residents/carer where appropriate.

Other activities undertaken include:

- pharmaceutical advice to GPs/healthcare professionals for care home residents
- planned and ad hoc training for care home staff to upskill them and prevent medication incidents
- review of medication policies where appropriate
- review of medication waste.

Inclusion criteria

For new patients:

- over 18 years of age
- registered with a Wandsworth GP
- living in one of the 14* Wandsworth care homes listed below:

• Lyle House	• Sherwood Grange
• Duchesne House	• Ashmead Care Centre
• Signature	• Heritage Centre
• George Potter House	• The Pines
• Nightingale House	• Rosedene
• Ronald Gibson House	• Bhakti Shyma Care Centre
• Trinity Court	• *Meadbank *(cover is currently provided until end August 2019 and is subject to review for ongoing funding)*
• Richard Cusden	

Examples of patient categories accepted

The team will consider referrals typically from the following groups following a clinical discussion.

Urethral and suprapubic catheters

- Blocked catheter (if patient is not in severe pain).
- Catheter has come out.
- Urine leaking from insertion area.
- Insertion area is sore, swollen, red or tender.
- Noticeable change in urine colour and smell.
- Blood in urine (light haematuria).

End of life care

- Pain and symptom management including breathlessness, nausea, and agitation.
- Assessment for equipment.
- Work with palliative care services.

Central venous access

- Need health information relating to a resident's condition.

Exclusion criteria

Examples of patient categories not accepted

- Acutely unstable patients requiring hospital admission e.g. chest pain, stroke.
- Where it is clear that even with support the patient would be unsafe to remain in the care home.
- Patients with acutely unstable mental health diagnosis.

Referral details

Age range Over 18 years of age	**Is patient self-referral available?** No	**Are home visits available?** Patients will be seen in Wandsworth care homes
Service contact Referral line: 0333 300 2350 Patient line: 0333 300 0950 Email: clcht.wandsworthspa@nhs.net E-fax: 0300 008 2137 Post: PO Box 130, Morden, SM4 9EF	**Is transport provided?** N/A	**How to refer** See page 3 How to refer **Clinical discussion or LAS ACP referral only**: 07990 353 463 *or* 07990 353 036

Complex care

Overview

The complex care service supports a multi-disciplinary platform to deliver home based care for those patients identified as the most vulnerable adults registered with a Wandsworth GP, their families and carers.

Objective

A key component is facilitating partnership working with other providers through the coordination of effective multidisciplinary team (MDT) meetings. Patient care is overseen by a key worker and is delivered by a core team which includes:

- a WCAHS GP
- the patient's own registered GP (for enhanced care pathway - ECP)
- geriatrician
- community matrons
- pharmacist
- social workers
- community nurses
- specialist nurses
- community therapists
- mental health nurses
- a voluntary sector co-ordinator, who will form part of the core WCAHS team.

Patients accepted will fall into one of two categories:

1. **Patients identified by primary care as part of the enhanced care pathway** (ECP) register (500) using a predictive risk modelling tool. These patients are considered to be the most complex patients who are at the greatest risk of attendance to A&E or non-elective hospital admission.

2. **Patients that have been identified as "complex".** Complex is defined by the service as two or more health and/or social uncontrolled conditions.

All patients will have a personalised care plan developed by the multidisciplinary team. The personalised plan may include an escalation plan to direct patients and/or their carers what to do in an emergency situation and when there is deterioration in the patient's condition.

The complex care service is open to receive referrals Monday to Friday (excluding bank holidays) 9am-5pm.

Urgent referrals will be assessed within 24 hours and routine referrals within five working days.

Enhanced care pathway patients are referred by the primary care GP following completion of a **care plan** and a **comprehensive geriatric assessment**.

Inclusion criteria

For new patients:

- over 18 years of age
- registered with a Wandsworth GP

Exclusion criteria

- Patients under 18 years
- Patients resident in a nursing home

Referral details

Age range Over 18 years of age	**Is patient self-referral available?** No	**Are home visits available?** Yes
Service contact Referral line: 0333 300 2350 Patient line: 0333 300 0950 Email: clcht.wandsworthspa@nhs.net E-fax: 0300 008 2137 Post: PO Box 130, Morden, SM4 9EF	**Is transport provided?** No	**How to refer** See page 3 How to refer

Community nursing

Overview

The community nursing service comprises a workforce of community nurses and health care support workers. The service provides nursing assessments, care and treatment to housebound patients with a physical health care need within their local communities, including the patients' home or residential care settings. The service supports and encourages people with disabilities and long-term conditions to live independent lives.

Objective

The community nursing service provides nursing care for adult patients (over the age of 16 years) who are housebound due to a short or long-term condition and are unable to access nursing services in their GP practice. Care can be delivered over a 24 hour period, 7 days a week, including bank holidays. Patients can be referred for:

- rapid assessments 4 hour response. An appropriate care pathway (ACP) is available to LAS (see pathway)
- urgent assessments (within 24 hours)
- routine assessments (within 72 hours)
- planned reviews (within 28 days).

Inclusion criteria

- Housebound patients.
- Registered with a Wandsworth GP.
- Over 16 years of age.
- A specific nursing need.

Examples of categories of patients accepted include:

General nursing	**Urethral and suprapubic catheters**	**End of life care**	**Surgical wound care**
Standard health checks directed by GP – pulse, BP, wright and blood sugars	Blocked catheter (if patient is not in severe pain)	Pain management	Remove clips and sutures
Phlebotomy services	Catheter has come out	Assessment for equipment	Change drainage systems
Annual flu jabs	Reduced urine output	Work with palliative care services	Pack cavity wounds & Prescribe dressings
Doppler	Urine leaking from insertion area		
Spirometry	Insertion area is sore, swollen, red or tender		
Administration IV antibiotics	Noticeable change in urine colour and smell		
Insulin administration	Blood in urine (light haematuria)		
Vitamin B12 injections			

Exclusion criteria

If a patient can easily access care within a clinical environment, we recommend that the patient is not referred to community nursing.

Examples include:

- registered with out-of-borough GP
- non-housebound patients
- nursing home patients – consider referral to the care home in-reach team
- severe pain associated with catheter; frank haematuria; paraphimosis
- infection or suspected sepsis
- chest pain or stroke
- unstable patients requiring hospital admission
- patients with acutely unstable mental health diagnosis.

Referral details

Age range Over 16 years of age	**Is patient self-referral available?** No	**Are home visits available?** Yes
Service contact Referral line: 0333 300 2350 Patient line: 0333 300 0950 Email: clcht.wandsworthspa@nhs.net E-fax: 0300 008 2137 Post: PO Box 130, Morden, SM4 9EF	**Is transport provided?** No	**How to refer** See page 3 How to refer

Continence service

Overview

The continence service provides care to adults with complex continence issues over the age of 16 years. The service comprises a small team of specialist nurses, providing a comprehensive range of interventions that enables individuals to become self-caring and independent, or to adapt and modify their lifestyles to enable them to adjust to increasing dependence. The service initiates and reviews interventions, supports patients and acts as an information resource for the multidisciplinary team.

Objective

The service offers education programmes to healthcare professionals. The service sees housebound patients and residents in nursing and residential homes. Continence products will only be supplied where a continence assessment has been carried out within the agreed guidelines.

The main aim is to promote good continence practice, and help patients gain control of continence using pads as a last resort by:

- assessing continence needs for complex patients. Routine continence assessments for house bound patients are carried out by the community nurses
- advise pelvic floor exercises for early onset of stress incontinence and bladder training for urge/overactive bladder
- discourage “just in case padding” to focus on improving symptoms
- assess level of hydration and type of fluid consumed during the course of the day, which may contribute to urgency
- provision of access to toileting facilities, which can assist patients in gaining control of continence
- explore other continence aid to prevent retention
- if problems such as a UTI or a need for secondary care referral are identified then a referral will be made back to the GP
- as a last resort assessment for level of incontinence will be completed with provision of appropriate containment products.

Inclusion criteria

For new patients:

- over 16 years of age
- registered with a Wandsworth GP
- a specific continence need.

Exclusion criteria

Patients under 16 years in which case they must be referred to the care of the enuresis service (please see enuresis information)

Referral details

Age range Over 16 years of age	**Is patient self-referral available?** Patients can self-refer if they have previously been known to the team.	**Are home visits available?** Housebound patients are seen by district nurses in the first instance.
Service contact Referral line: 0333 300 2350 Patient line: 0333 300 0950 Email: clcht.wandsworthspa@nhs.net E-fax: 0300 008 2137 Post: PO Box 130, Morden, SM4 9EF	**Is transport provided?** No	**How to refer** See page 3 How to refer

Diabetes service

Overview

The community diabetes service consists of a team of specialist nurses and a dietitian that work across primary care, community settings and secondary care. Patients with type 2 diabetes in Wandsworth have the opportunity to access multidisciplinary clinics managed by the diabetes team in the community.

The overall aims of the service are to:

- improve the health outcomes of people diagnosed with diabetes mellitus
- improve the quality and cost-effectiveness of diabetes services in NHS Wandsworth.
- reduce the use of secondary care services for diabetes management.
- improve the systematic care of people living with diabetes in Wandsworth.
- provide an enhanced diabetes service in primary care closer to people's homes.
- ensure a year-on-year reduction in mortality and morbidity from diabetes and its complications.

Objective

The aim of the diabetes service is to improve access to high quality expert diabetes care and to reduce health inequalities for Wandsworth patients with diabetes. To provide holistic support to patients and carers, in order to empower them to self-manage their condition and maintain an independent lifestyle.

The objectives of the service are to:

- Provide evidence based health promotion and education in the management of diabetes to health care workers including GPs, practice nurses and community based nurses.
- Provide timely access to multi-disciplinary specialist clinical expertise in the management of diabetes in primary care and the community.
- Provide an outreach service to patients who are housebound or in the care environment.
- Promote self-management skills to diabetes patients, including the initiation and maintenance of insulin regimens.
- Avoid unnecessary admissions and readmissions, and to support the early discharge of patients from secondary care.
- Ensure patients are offered self-management education (e.g. DESMOND) and a plan is agreed with them to improve self-management of their condition.
- Ensure patients are offered appropriate lifestyle advice and referral to expert patient programmes.
- Ensure all diabetes patients have a personalised care plan.
- To support patients in the complex case management function with multiple co-morbidities.

Inclusion criteria

- Over 16 years of age.
- Registered with a Wandsworth GP.
- The patient must have a clear diagnosis of type 2 diabetes.

Diabetes specialist nursing criteria:

- non-acute symptoms of hypo/hyperglycaemia
- routine insulin start
- GLP-1 injectable start
- deteriorating glycaemic control, on maximum OHA, HbA1C > 58 mmol/mol
- review/change of treatment regimen.

Diabetes specialist dietitian criteria:

Type 2 diabetes only, with one or more of the following:

- Hba1c > 75mmol/mol and on two or more medications (combination of metformin, sulphonylurea, DPP4, SGLT2)
- Hba1c >58mmol/mol and on insulin or if considering insulin.

This may include the following patients:

- those with multiple co-morbidities
- those with raised lipids despite intervention
- those with complications of diabetes e.g. CKD 1-3, retinopathy or previous MI/stroke
- housebound patients requiring home visits.

Ideally, all patients should have received structured education e.g. DESMOND as part of the NICE guidelines before referral to a diabetes specialist dietitian.

Diabetes DESMOND programme

All referrals to DESMOND in Wandsworth should now be sent to the diabetes book and learn service: https://diabetesbooking.co.uk/health-care-professionals

Exclusion criteria

- People with severe and/or unstable complications of diabetes, or with new symptoms or complications that require immediate medical attention
- Pregnant women with a diagnosis of established or gestational diabetes should be referred to Tier 4 services at local acute trusts.

Referral details

Age range Over 16 years of age	**Is patient self-referral available?** Patients can self-refer if they have previously been known to the team.	**Are home visits available?** Yes
Service contact Referral line: 0333 300 2350 Patient line: 0333 300 0950 Email: clcht.wandsworthspa@nhs.net E-fax: 0300 008 2137 Post: PO Box 130, Morden, SM4 9EF	**Is transport provided?** No	**How to refer** See page 3 How to refer

End of life care

Overview

The priority for care for patients nearing the end of their life (and their carers/families) should be, wherever possible, to provide excellent holistic care that prevents unnecessary admission to hospital, particularly if the preference of the patient is to be cared for at home.

In Wandsworth, it is considered that the identification of patients and provision of excellent end of life care is *"everyone's business"*. All WCAHS teams will support end of life care (EoLC) as appropriate.

EoLC patients and their carers/families that are known to WCAHS will have a member of the team identified as the **patient's key worker** and, as such, they have a key role in ensuring the provision of the best care to meet the patient's needs, wishes and preferences.

Objective

The service is delivered by the community nurses and there is also an **end of life care co-ordinator** who supports the delivery of care.

The main areas for all the teams are:

Identification

Taking joint responsibility (as part of the wider MDT caring for the patient) for ensuring that any patient who might be considered to fall within the definition of EoLC (i.e. their condition has changed/deteriorated) are identified in a timely way, are discussed with the patient's GP/MDT and placed on the GP practice "supportive care register" as early as possible, and appropriately flagged on provider systems.

Care planning/advance care planning

Taking appropriate joint responsibility (as part of the wider MDT caring for the patient) for ensuring that people approaching the end of life are offered comprehensive holistic assessments incorporating their wishes and advanced care planning through a comprehensive care plan in response to their changing needs and preferences. This will include:

- preferred place of care and death
- DNACPR/allow a natural death
- any wishes or preferences in relation to their care.

Communication

Identified EoLC patients are included in the weekly WCAHS MDTs in the four localities to facilitate discussion around the patients' holistic needs:

- WCAHS staff attend at GP practice gold standard framework (GSF) meetings
- utilise agreed EoLC system-wide communication mechanisms (e.g. **Co-ordinate my Care** and the **Yellow Communication Book**) to support timely and effective communication and coordination of individual patient care, across all care providers.
- Maximise opportunities for cross-provider communications in relation to patient care, including allowing agency carers, as part of the integrated team caring for patients, to add information to any community nursing notes held at the patient's house and for WCAHS team members to communicate changes required to care agency care plans.

Direct care

Provision of good practice end of life care for all patients including:

- Referral of identified EoLC patients to the Wandsworth EoLC co-ordination service at the earliest opportunity (with consent) to ensure the patient and those looking after them can benefit from the co-ordination services provided as soon as they are required. This service is described later in this spec.
- Rapid response (within 4 hours) to any referral/visit or contact request in relation to an identified end of life care patient;
- Sensitively addressing any anxieties of EoLC patients and family members/carers
- Accessing additional levels of support from the wider EoLC system when required. This might include a referral to specialist palliative care, requesting planned/respite night visits from Marie Curie, ensuring continuing care applications are made etc.;
- Ensuring that applications for continuing healthcare (including fast-track applications) for EoLC patients are made in a timely way using agreed processes. Fast-track applications should be completed and submitted within 24 hours of the patient being identified/assessed as requiring a fast-track care package;
- Where necessary, ensuring the availability of EoLC medication, both anticipatory and as required.
- Facilitating provision of appropriate equipment to meet the patient's needs.
- Undertake a carer's assessment for carer/families of EoLC patients to provide support.

Education

WCAHS team members will access relevant EoLC education to enable a skilled and knowledgeable workforce in relation to good practice EoLC. This will include syringe pump training and medications used in EoLC, plus completing syringe pump competency assessment; essential communications skills training (Sage & Thyme and having important/sensitive conversations); and introduction to principles of advance care planning.

Inclusion criteria

For new patients:

- over 16 years of age
- registered with a Wandsworth GP.

Exclusion criteria

- See community nursing

Referral details

Age range Over 16 years of age	**Is patient self-referral available?** Patients can self-refer if they have previously been known to the team.	**Are home visits available?** Housebound patients are seen by district nurses in the first instance.
Service contact Referral line: 0333 300 2350 Patient line: 0333 300 0950 Email: clcht.wandsworthspa@nhs.net E-fax: 0300 008 2137 Post: PO Box 130, Morden, SM4 9EF	**Is transport provided?** No	**How to refer** See page 3 How to refer

Facilitated and supported discharge service

Overview

The facilitated and supported discharge (FSD) service comprises a team of registered nurses and a support worker. They aim to ensure that discharges from acute settings happen in a safe, timely and effective manner. The service provides an in-reach element to the acute providers serving Wandsworth registered patients as well as to step-up and step-down bedded facilities such as those provided at Ronald Gibson house and Queen Mary's hospital.

Objective

The service provides a proactive response, to identify hospital admissions within 24 hours, wherever this is possible, through close collaborative work with the ward staff, discharge coordinators, WCAHS key workers and through making use of admissions data where provided by acute trusts. The team attends, or dials into, scheduled discharge meetings with the acute providers and will represent WCAHS services at any requested discharge planning or best interest events in order to help facilitated community discharge plans.

As well as providing assistance with planning discharge destination and times, FSD can order community equipment to facilitate safe discharges and will provide a follow up service for up to 2 weeks for patients after discharge to ensure patients are settled at home and managing, making onward referrals to appropriate health and social care teams if needed or provide a bridge until their scheduled nursing services resume or equipment is delivered. At times this input can be extended depended on the needs of individual patients.

The service operates from 8am-6pm, 7 days a week. Referrals can be made via the Wandsworth single point of access (SPA) for any adult (over 16 years of age) registered with a Wandsworth GP by any health, social care or voluntary sector worker.

The FSD team work closely with WCAHS colleagues to alert them to patient admissions and/or discharges, provide a conduit for information regarding plans for care and any changes to these.

Inclusion criteria

For new patients:

- over 18 years of age
- registered with a Wandsworth GP.

Exclusion criteria

- See community nursing.

Referral details

Age range Over 18 years of age	**Is patient self-referral available?** Patients can self-refer if they have previously been known to the team.	**Are home visits available?**
Service contact Referral line: 0333 300 2350 Patient line: 0333 300 0950 Email: clcht.wandsworthspa@nhs.net E-fax: 0300 008 2137 Post: PO Box 130, Morden, SM4 9EF	**Is transport provided?** No	**How to refer** See page 3 How to refer Referrals may also be generated by FSD staff case finding/ identifying patients from ward visits, discharge meetings or from admissions data supplied.

Heart failure service

Overview

The heart failure service comprises a team of specialist nurses that provides evidence-based treatment for patients with heart failure. The services provides an interface between primary care, community and secondary services to ensure patient care is coordinated and specialist input accessed as required. This includes monitoring of the condition, behavioural modification, health promotion, specialist care to improve quality of life by slowing disease progression and improving symptoms to reduce mortality, preventing re-admission to hospital and improving palliative care provisions for patients and carers.

Objective

To provide evidence based treatment for patients with heart failure by taking an active role in titration of heart failure medication to optimum doses and by providing education and support for other healthcare professionals involved in the care of these patients to share their expertise.

Patients are seen in their own homes and following assessment (and if indicated) will be provided with Telehealth equipment (subject to available kit) to support the self-management of their condition at home. Patients can also be seen in nurse-led clinics.

Priority 1 Patients whose heart failure is decompensating and are at risk of admission will be assessed within one working day of referral.

Priority 2 Patients referred following an acute episode resulting in hospital admission discharged will be assessed within five working days or telephoned with a follow-up call.

Priority 3 Patients referred for initial management following diagnosis will be assessed within two weeks unless they fall into the categories above.

Inclusion criteria

- Over 1 years of age
- Registered with a Wandsworth GP
- A diagnosis of heart failure

Exclusion criteria

- Patients with no evidence of heart failure on echocardiogram.
- Patients who **have not** had a diagnostic echocardiogram.
- Patients requiring inpatient care.
- If input is required a from paediatrician or paediatric nurse, requests will be made for support until the patient is 18 years old.

Referral details

Age range Over 18 years of age	**Is patient self-referral available?** Patients can self-refer if they have previously been known to the team.	**Are home visits available?** Yes
Service contact Referral line: 0333 300 2350 Patient line: 0333 300 0950 Email: clcht.wandsworthspa@nhs.net E-fax: 0300 008 2137 Post: PO Box 130, Morden, SM4 9EF	**Is transport provided?** No	**How to refer** See page 3 How to refer

Maximising independence team

Overview

The maximising independence service comprises a team of allied health profession therapists (including occupational therapists, physiotherapists and speech and language therapists) and rehabilitation support workers.

The team provides rehabilitation and enablement support for to those at risk of admission to hospital, those being discharged from an acute health setting, and to patients whose independence and wellbeing could be optimised by therapy intervention.

Objective

The service is designed to improve a patient's mobility and independence with activities of daily living in their own homes, and identify further rehabilitation and/or social support as required. A therapist will undertake a detailed assessment of rehabilitation needs and develop a personal rehabilitation plan in agreement with the patient, for example: mobility; stair practice; personal care; and meal preparation.

The service operates from 8am-6pm, 7 days a week with new patient assessments offered Monday to Friday. Urgent referrals accepted will usually have a clinical triage call within one working day and then a follow up visit within three working days as required. Routine referrals are assessed within 15 working days.

The team works in conjunction with colleagues in health, social care and the voluntary sector to ensure a holistic service to cover any health or social care needs that are identified. In particular the team works closely with the Quickstart and FSD WCAHS services and London Borough of Wandsworth social care's KITE service.

Inclusion criteria

- Over 16 years of age.
- Registered with a Wandsworth GP.
- Medically stable.
- Short term rehabilitation needs and goals and currently housebound.
- Patients are able to participate in a personal rehabilitation programme, are motivated to regain their independence, and are able to achieve their goals within 2-6 weeks.

Exclusion criteria

- Patients who are not medically stable.
- Patients who are unable to or unmotivated to engage with rehabilitation.
- Clients who require respite/social services step down support.
- We do not provide respite or convalescence care.

Referral details

Age range Over 16 years of age	**Is patient self-referral available?** Yes	**Are home visits available?** This is a home based service
Service contact Referral line: 0333 300 2350 Patient line: 0333 300 0950 Email: clcht.wandsworthspa@nhs.net E-fax: 0300 008 2137 Post: PO Box 130, Morden, SM4 9EF	**Is transport provided?** No	**How to refer** See page 3 How to refer

Phlebotomy

Overview

WCAHS provides phlebotomy services for patients on the WCAHS caseload and will also offer phlebotomy services for GPs who require bloods for patients who are housebound but not on the WCAHS caseload that are referred from primary care.

Objective

Referrals for phlebotomy requests can be made in line with the following response times:

- **Urgent** (1 working day)
- **Non urgent** (5 working days)
- **Routine** (20 working days)

Inclusion criteria

- Over 16 years of age
- Registered with a Wandsworth GP

Exclusion criteria

- Non-housebound patients

Referral details

Age range Over 16 years of age	**Is patient self-referral available?** No	**Are home visits available?** Yes
Service contact Referral line: 0333 300 2350 Patient line: 0333 300 0950 Email: clcht.wandsworthspa@nhs.net E-fax: 0300 008 2137 Post: PO Box 130, Morden, SM4 9EF	**Is transport provided?** No	**How to refer** See page 3 How to refer

Quick start service

Overview

The quick start service comprises a team of health support workers/carers that provide support to those at risk of admission to hospital in the absence of a rapid start of home care support.

Other assistance may be provided to bridge a gap where temporary care packages are needed, for example, where a regular family member/carer is unavailable for a short period, or to facilitate a discharge back into the community.

Objective

The care provided usually comprises between one to four visits a day. Without a social care package in place these patients would otherwise be admitted to hospital due to an overriding social care need. Visits can be provided for up to a 7-day period, after which a handover is made to a social services-funded team or private provider if ongoing assistance is required.

The service operates 8am-10pm, 7 days a week. Packages will aim to be set up within four working hours unless there is agreement to start beyond this time frame.

The team works in conjunction with colleagues in therapy and nursing services to cover any health needs that are identified. Patients may be signposted to other services such as Wandsworth Age UK as required.

Inclusion criteria

- Over 16 years of age.
- Registered with a Wandsworth GP.
- Patients requiring single-handed care only.

Exclusion criteria

- Patients requiring double handed care or more.

Referral details

Age range Over 16 years of age	**Is patient self-referral available?** No	**Are home visits available?** Yes
Service contact Referral line: 0333 300 2350 Patient line: 0333 300 0950 Email: clcht.wandsworthspa@nhs.net E-fax: 0300 008 2137 Post: PO Box 130, Morden, SM4 9EF	**Is transport provided?** No	**How to refer** See page 3 How to refer

Respiratory service

Overview

The respiratory service comprises a team of specialist nurses and a support worker who specialise in the treatment and management of adults with diagnosed or suspected chronic respiratory disease within the community. This includes monitoring and behavioural modification/health promotion and specialist care.

Objective

The service aims to manage patients with respiratory disease more effectively in the primary care and community setting, working closely with other health professionals to reduce unnecessary hospital admissions. The respiratory service offers clinical support, management, education, and advice to patients and their families. Patients can be seen in a range of settings including their own homes, clinics and GP practices.

Urgent referral: patients with exacerbation of their respiratory condition, patients at risk of admission and/or patients receiving end of life care support will be responded to within four working hours

A **non-urgent routine referral** will be assessed within five working days.

Inclusion criteria

- Over 16 years of age.
- Registered with a Wandsworth GP.
- Patients with a diagnosis of chronic respiratory disease (e.g. COPD, chronic asthma, bronchiectasis).

Exclusion criteria

- Patients who do not have a known chronic respiratory disease diagnosis.
- If input is required from a Paediatrician or paediatric nurse, requests will be made for support until the patient is 18 years old.

Referral details

Age range Over 18 years of age	**Is patient self-referral available?** Patients can self-refer if they have previously been known to the team.	**Are home visits available?** Yes
Service contact Referral line: 0333 300 2350 Patient line: 0333 300 0950 Email: clcht.wandsworthspa@nhs.net E-fax: 0300 008 2137 Post: PO Box 130, Morden, SM4 9EF	**Is transport provided?** No	**How to refer** See page 3 How to refer

Tissue viability service

Overview

The tissue viability service (TVS) comprises a team of specialist nurses who provide specialist assessment and patient care to enable optimisation of evidence based treatment and healing rates for wound management (including pressure ulceration and leg ulcers), effective management of pain and prevention of infection and other wound complications. In addition, TVS aims to provide wound management in order to prevent acute admission. Wound management includes specialist compression bandaging

Objective

To educate all community nursing staff to be able to prevent tissue viability issues and to be able to manage patients when tissue viability has been compromised. To provide an expert resource to manage highly complex patients with compromised tissue viability and wounds. Patients can be seen in a range of settings including their own homes, nursing and residential homes and GP practices. The service is provided Monday to Friday, 9am-5pm (excluding bank holidays).

Urgent referrals are responded to within 48 working hours, routine within five working days.

Inclusion criteria

- Over 16 years of age.
- Registered with a Wandsworth GP.
- Patients who have a complex non-healing wound.

Exclusion criteria

- Referrals for specialist dermatology advice.

Referral details

Age range Over 16 years of age	**Is patient self-referral available?** Patients can self-refer if they have previously been known to the team.	**Are home visits available?** Yes
Service contact Referral line: 0333 300 2350 Patient line: 0333 300 0950 Email: clcht.wandsworthspa@nhs.net E-fax: 0300 008 2137 Post: PO Box 130, Morden, SM4 9EF	**Is transport provided?** No	**How to refer** See page 3 How to refer