The Integrated Community Service (Community Matron/Case Manager, District Nurses and Podiatry team) will:

- accept referrals from the public, Social Services, Secondary Services, AHP and HCPs via the Single Point of Access team, or out of hours services
- provide health care at home for the sick and vulnerable patient with complex health and social needs
- support and facilitate health education in the management of long term conditions and complex health needs
- work in partnership with GPs, carers, patients and their families using a multidisciplinary approach
- provide end of life care at home

The Integrated Team aim to:

- provide a quality and efficient service for clients in the community
- reduce the need for unnecessary A&E and hospital admissions
- continuity of health and social care post hospital admission
- facilitate and support health education for clients and carers in the community
- signpost to appropriate services and health professionals

Inclusion criteria:

- 16+ Greenwich resident
- Housebound (exception: post op care, catheter care, palliative/complex health/social needs)

Exclusion criteria:

- Nursing homes
- Not housebound and able to attend GP surgery

Joint Emergency Team (JET)
Available 7.30am – 8.30pm, seven days a week Tel: 020 8836 5031/020 8836 6000, Bleep 930

JET will:

- respond to situations where vulnerable adults require urgent intervention within 24 hours of referral
- consider options for re-ablement/rehabilitation via Intermediate Care
- act as a gatekeeper to Intermediate Care beds – prioritising appropriateness of referral and capacity of the units.

The team aims to:

- prevent unnecessary A&E attendances and hospital admissions
- facilitate timely discharges from AMU

Inclusion criteria:

- identify alternative care pathways and provide crisis intervention in the community.

Exclusion criteria:

- 18+, a Greenwich resident or registered with a Greenwich GP
- Medically stable
- Safe to be supported in the community

Exclusion criteria:

- Active substance misuse
- Respite care
- Mental health as a primary diagnosis
- Alzheimer’s/Dementia (looked at on an individual basis).

Lower Limb Service (Integrated Complex Wound Care Team)
Available Monday to Friday 9am – 5pm Tel: 020 8305 3038

The ICWCT aims to:

- prevent hospital admission for patients with cellulitis of the lower limb
- provide a preventative care pathway for those who are at risk of developing cellulitis of the lower limb e.g. those with oedema, lymphoedema, chronic skin conditions, leg ulcers.
- facilitate early discharge from AMU for those patients with cellulitis of the lower limb

Inclusion criteria:

- 18+ and registered with a Greenwich GP
- Patients with cellulitis of the lower limb of class 1 or 2

<table>
<thead>
<tr>
<th>Class III</th>
<th>Class IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant systemic upset e.g. acute confusion, tachycardia. Tachypnoea and hypotension</td>
<td>Sepsis syndrome</td>
</tr>
<tr>
<td>Or Unstable co-morbidities which might interfere with response to therapy</td>
<td>Or Severe life threatening infection e.g. necrotising fasciitis</td>
</tr>
</tbody>
</table>

Exclusion criteria:

- Patients with cellulitis elsewhere on body.
- Those with class 3 or 4 cellulitis

<table>
<thead>
<tr>
<th>Class</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>No signs of systemic toxicity And No uncontrolled co-morbidities</td>
</tr>
<tr>
<td>II</td>
<td>Systemically ill Or Systemically well but with co-morbidities e.g. PVD, venous insufficiency, morbid obesity</td>
</tr>
</tbody>
</table>

Class III

Class IV

Significant systemic upset e.g. acute confusion, tachycardia. Tachypnoea and hypotension

Or Unstable co-morbidities which might interfere with response to therapy

Or Severe life threatening infection e.g. necrotising fasciitis

Class

Significant systemic upset e.g. acute confusion, tachycardia. Tachypnoea and hypotension

Or Unstable co-morbidities which might interfere with response to therapy

Or Severe life threatening infection e.g. necrotising fasciitis
<table>
<thead>
<tr>
<th><strong>Chronic Obstructive Pulmonary Disease (COPD) Team</strong></th>
<th><strong>Out of hours service available 7am – 7pm, seven days a week via 07843 641 906</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Available Monday to Friday 9am – 5pm</td>
<td></td>
</tr>
<tr>
<td>Tel: 020 8319 5381</td>
<td></td>
</tr>
<tr>
<td><strong>The COPD team aims to:</strong></td>
<td><strong>The COPD team is able to:</strong></td>
</tr>
<tr>
<td>• prevent unnecessary A&amp;E attendances and hospital admissions</td>
<td>• offer nebulisers on short term loan</td>
</tr>
<tr>
<td>• facilitate timely discharges from AMU and other acute wards</td>
<td>• organise home oxygen within a 4 hour window</td>
</tr>
<tr>
<td>• provide crisis intervention in the community to those patients exacerbating</td>
<td>• offer support at home as home visits or telephone support for as long as required</td>
</tr>
<tr>
<td>• support patients post discharge to prevent unnecessary re admission</td>
<td>• liaise with GP to provide appropriate medication</td>
</tr>
<tr>
<td>• enable patients to be as active as possible by providing pulmonary rehabilitation</td>
<td></td>
</tr>
<tr>
<td><strong>Falls Prevention Team</strong></td>
<td><strong>Referral - via Information Contact Officers:</strong></td>
</tr>
<tr>
<td>Available Monday to Friday, 8.30am – 5.30pm</td>
<td>Tel: 020 8921 2304 Fax: 020 8921 3392</td>
</tr>
<tr>
<td>Tel: 020 8836 8630/1 (for enquiries)</td>
<td></td>
</tr>
<tr>
<td><strong>The Falls Team will:</strong></td>
<td><strong>Inclusion criteria:</strong></td>
</tr>
<tr>
<td>• provide a range of specialist multidisciplinary assessments and facilitate patients to access further assessments and services as part of the falls and bone health care pathway.</td>
<td>• 18+, registered with a Greenwich GP</td>
</tr>
<tr>
<td>• provide rehabilitation and interventions to promote engagement in activities and prevent/manage falls.</td>
<td>• Known diagnosis of COPD</td>
</tr>
<tr>
<td>• provide equipment, orthotics and advice and information.</td>
<td>• Patients with FEV1&lt;50% +/- MRC 3 or above</td>
</tr>
<tr>
<td>• request medication reviews via community Pharmacy</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes Service</strong></td>
<td><strong>Inclusion criteria:</strong></td>
</tr>
<tr>
<td>Available Monday to Friday 9am – 5pm Tel: 020 3260 5104</td>
<td>• work collaboratively with the Consultant in the Falls clinic.</td>
</tr>
<tr>
<td><strong>The Diabetes Specialist Team will:</strong></td>
<td>• prevent unnecessary A&amp;E attendances and hospital admissions</td>
</tr>
<tr>
<td>• accept referrals from GPs, community nurses, other LTC specialist teams and consultant diabetologists.</td>
<td>• facilitate timely discharges from AMU for patients who are experiencing falls</td>
</tr>
<tr>
<td><strong>The team aims to:</strong></td>
<td><strong>Exclusion criteria:</strong></td>
</tr>
<tr>
<td>• ensure that the Quality standard for diabetes in adults (March 2011) is met</td>
<td>• Children and Young people under 18 years</td>
</tr>
<tr>
<td>• ensure continuity of care for patients with Type 2 diabetes enabling a clear care plan to be implemented in the most appropriate setting. Housebound patients to receive home based care, all other patients to attend a clinic.</td>
<td>• Type 1 diabetes</td>
</tr>
<tr>
<td>• work in partnership with other LTC teams for those patients with co-morbidities reduce admissions to hospital of patients</td>
<td>• Pregnancy</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Heart Failure Service</strong></td>
<td></td>
</tr>
<tr>
<td>Available Monday to Friday 9am – 5pm Tel: 020 3260 5237</td>
<td></td>
</tr>
<tr>
<td><strong>The Heart Failure Team will:</strong></td>
<td><strong>Inclusion criteria:</strong></td>
</tr>
<tr>
<td>• accept referrals from GPs, physicians/heart failure nurses in secondary and tertiary care</td>
<td>• 18+ and registered with a Greenwich GP</td>
</tr>
<tr>
<td>• see patients who have been hospitalised with heart failure within two weeks of discharge and undertake a comprehensive assessment, including social support.</td>
<td>• Diagnosed Type 2 diabetes - on maximum tolerated OHAs, or insulin, or GLP-1 mimic and an HbA1c above 58mmol/mol (7.5%)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The team aims to:</strong></td>
<td><strong>Exclusion criteria:</strong></td>
</tr>
<tr>
<td>• ensure that the Chronic Heart Failure quality standard (NICE 2011) is met.</td>
<td>• Children and Young people under 18 years</td>
</tr>
<tr>
<td>• ensure continuity of care for patients with heart failure enabling a clear management plan to be implemented in the most appropriate setting. Housebound patients to receive home based care, all other patients to attend a clinic.</td>
<td>• Type 1 diabetes</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>