Directory of health services for staff working in care homes with nursing

Bristol Clinical Commissioning Group

Introduction

Welcome to the Care Home Directory. This directory is intended for the use of registered nurses working within care homes across Bristol.

The directory is a resource to signpost you to all the health and specialist services to access for residents. The directory provides a list of services available. It includes the contact details about each of the services and criteria for referral.

We hope this guide is helpful and will enable you to access services to support your residents.

Useful Websites

Bristol Clinical Commissioning Group
www.bristolccg.nhs.uk

Bristol Community Health
http://briscomhealth.org.uk

Bristol City Council
http://www.bristol.gov.uk

Personal Dementia Support for Bristol People
http://www.bristoldementiawellbeing.org

St Peters Hospice
http://www.stpetershospice.org.uk

Well Aware
A signposting and information service for health and wellbeing organisations and events
http://www.wellaware.org.uk

Please note: Paper copies of the referral forms are provided separately in a folder for ease of copying which is kept with this directory. Please choose which form(s) you need, make a copy and return it to the folder.

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BrisDoc Healthcare Services
(GP Out of Hours Professional Line)

What can the line be used for?

To refer patients to the GP Out of Hours Service or to seek medical advice from a GP/ advanced nurse practitioner/emergency care practitioner to support the care of patients in the home.

Available to:	All care homes with nursing
Who can call:	A registered nurse in the care home.
Line is available:	Weekdays 6.30pm-8am weekends and Bank Holidays Friday 6.30pm to Monday 8am (Out of hours period).
Telephone:	0117 244 9283

Please have available:

- Presenting complaint
- Previous medical history
- List of current medications
- Allergies known
- Baseline observations of: temperature, heart rate, blood pressure, respiratory rate, oxygen saturations (if you are able) and you may be asked for a Urinalysis if appropriate.

For futher guidance, go to:
http://www.brisdoc.co.uk/

Bowel and Bladder Care Service

The Bowel and Bladder Care Service provides assessments for those with bowel and bladder problems and can offer advice and support to patients in care homes and care homes with nursing in Bristol.

Referrals from:	Patients, families, carers and healthcare professionals.
Referrals by:	Phone, or alternatively, healthcare professionals can write a referral letter with a summary of the patient's care and post it to the address below.
Address:	Horfield Health Centre, Lockleaze Road, Horfield, Bristol, BS7 9RR
Telephone:	0117 373 7118
Fax:	0117 373 7113

The Continence Service works with individuals and organisations to:

- Promote healthy bladders and bowels
- Provide care and advice for people with bladder and bowel problems
- Improve people's quality of life and promote dignity and independence.

The Continence Service is led by nurses who provide patient assessments for those with bladder and bowel problems. This service also offers advice and support about patients with continence needs to healthcare staff in care homes with nursing across Bristol.

Patients, families, carers and healthcare professionals can make referrals directly to the Continence Service for an appointment. To make a referral please telephone the service directly on the above number. Healthcare professionals can alternatively write a letter of referral enclosing a summary of the patient's care and post it to them at the above address.

A summary of the patient's medical history and a medication list from their GP should be available at the appointment.

The service is for:

- people registered with a Bristol GP
- families, carers, healthcare staff and our own community healthcare teams who are working with adults and children and require advice and support for people's continence needs
- housebound patients who have bladder and bowel problems.

For further guidance, go to:
www.briscomhealth.org.uk/our-services/item/37-continence.html

Care Direct and Hospital Social Workers

Care Direct

Care Direct is part of the council and is the main way to contact adult care (social services). They provide information about care services, other types of support and welfare benefits. They can advise you and put you in touch with organisations and council services.

Referral from:	Self-referral
Referrals by:	Telephone or email
Telephone:	0117 922 2700 (8:30am to 5pm Monday to Friday - answerphone outside office hours).
Email:	adult.care@bristol.gov.uk

Care Direct provide information about care services, other types of support and welfare benefits. They can advise and put you in touch with organisations and council services. You should also contact them if you are concerned that a vulnerable adult is being abused.

They have a directory of residential and nursing homes in Bristol, North Somerset, South Gloucestershire and Bath and North East Somerset. They can also inform individuals about their eligibility criteria – how they work out if they can help people – and charges for services.

N.B. No drop-in service, please contact by phone or e-mail.

- Help to look after oneself at home
- Advice, aids and adaptations to help people continue living at home
- Support for carers
- Help after leaving hospital
- Support with meals
- Advice on benefits
- Direct payments – giving you money to buy the help you need
- Supported living schemes
- Advice about residential and nursing care, and extra care housing. Requests for a review for someone already receiving care in a care home (e.g. where their care needs have changed).

For further guidance, go to: https://www.bristol.gov.uk/social-care-health/form-contact-adult-care-services

Hospital Social Work teams

If a resident of a care home is in hospital then the Hospital Social Work team may need to be involved in ensuring a safe and timely discharge back to the Care Home. The wards will refer directly to the Hospital Social Work teams where this is required.

Telephone:	Southmead: 0117 414 4444 Bristol Royal infirmary: 0117 3427671
Fax:	0117 903 6688
Email:	adult.care@bristol.gov.uk
Address:	Bristol City Council, 100 Temple Street, Bristol City Council, BS1 6AN

Community Dental Service

The Community Dental Service (CDS) provides dental care for people who are unable to access treatment from a general dental practitioner (GDP) because of special needs, or disabilities.

Referrals from:	GDPs, GPs, other health care professionals, carers and relatives.
Referrals by:	Referral Form
Telephone:	Office 0117 342 4557
	The Dental Out of Hours Emergency Service (OOH) Telephone: 111
Fax:	0117 342 4890
Address:	PCDS Office, Bristol Dental Hospital, Lower Maudlin Street, Bristol BS1 2LY

The service is provided across Bristol, Bath and Weston and referrals are welcome from GDPs, GPs, other health care professionals, carers and relatives.

Home visits are available where patients are housebound, or where the disability is such that the individual would find it too difficult to visit a clinic, but this would be at the discretion of the service.

For referral forms and further information, go to: www.uhbristol.nhs. uk/patients-and-visitors/your-hospitals/ university-of-bristol-dental-hospital/ referral-guidelines-and-forms

The service is for people with:

- mobility problems
- learning difficulties
- dental phobia
- complex medical histories or are housebound.

Community Respiratory Service

The Community Respiratory Team (CRS) provides assessments and treatment for patients with COPD and other respiratory diseases and can offer advice and support to patients in care homes and care homes with nursing in Bristol.

Referrals from:	Acutely unwell patient - healthcare professional only. Planned care – patient, carer, Healthcare professional
Referrals by:	Acute service (prevention of admissions to hospital) SPA on 0117 9030202
Planned services – phone, letter of referral, email or fax (see below)	
Telephone:	0117 987 8335
Fax:	0117 878432
email:	copd.referral@nhs.net
Address:	Amelia Nutt Clinic, Queens Road, Bishopsworth, Bristol, BS13 8QA

The service is made up of four elements which specialise in:

- Acute service to support admission avoidance
- Early supported discharge from hospital
- Long term oxygen therapy
- Pulmonary rehab.

The CRS works with individuals and organisations to:

- Prevent unnecessary admission to hospital for patients with respiratory disease and prevent readmissions for those recently discharged from hospital
- Support development of self-care strategies for people with respiratory diseases
- Support optimal prescribing of medications including oxygen for patients in the community with respiratory disease
- Improve people's quality of life and promote dignity and independence.

The CRS is led by therapists and nurses who provide patient assessments for those with respiratory disease. There is access to a respiratory consultant for support of patients with complex needs. This service also offers advice and support about patients with respiratory disease, to healthcare staff in primary care and care homes with nursing across Bristol.

For referral forms and further information, go to: briscomhealth.org.uk/our-services/copd/

The service is for:

- people registered with a Bristol GP
- with a known respiratory diagnosis e.g. COPD (for hospital at home or pulmonary rehabilitation)
- people requiring assessment or support to manage home oxygen therapy (including those who never had a formal assessment)
- people able to attend a clinic to be assessed
- housebound patients.

Community Therapy

(Including occupational therapy and physiotherapy)

This service provides occupational and physiotherapy to help patients rehabilitate and self-manage their condition(s).

Referrals from:	Healthcare Professionals
Referrals by:	Referral Form Telephone: 0117 919 0290
Fax:	0117 919 0296
Address:	Knowle Clinic, Broadfield Road, Knowle, Bristol, BS4 2UH

This service provides occupational therapy and physiotherapy at a person's place of residence.

They help patients to rehabilitate and find self-management strategies in order to overcome the physical, psychological and social problems caused by their condition.

They do this by helping patients (and their carers) to engage in education, exercise, by providing equipment and using other therapy techniques.

Members of the team include:

- Occupational therapists
- Physiotherapists
- Rehabilitation assistants.

For referral forms and further information, go to: http://briscomhealth. org.uk/our-services/physiotherapy- musculoskeletal-outpatient-service-msk/

The service is for:

- people registered with a Bristol GP
- people who are unable to leave their place of residence
- people who require help in managing the effect of their long term condition(s), e.g.: have difficulty walking, daily activities such as washing or dressing
- Patients who have had a fall and require a multi-factorial assessment and intervention
- Rehabilitation programmes for people that have broken a bone (this includes people that have had joint replacement surgery such as a hip replacement) and people who have been in hospital and suffered deterioration in their walking or function
- management of long term conditions such as arthritis
- advice to carers e.g. manual handling
- pressure care advice involving seating or postural management.

Continuing Healthcare

The Health Assessment and Review Team (HART) and Bristol Clinical Commissioning Group are responsible for continuing healthcare (CHC). HART assess patients and make recommendations to the CHC panel on whether an individual is eligible. If so, they will receive a fully funded package of care. The team also manage funded nursing care applications. Bristol CCG is responsible for the commissioning of CHC.

Referrals from:	Healthcare Professionals who have completed CHC training.
HART:	0117 984 1501 Bristol Community Health: (the HART team) - hart.admin@nhs.net
CHC Commissioning	0117 900 2331
Email:	Bristol CCG: chcprogrammenhsbristol@nhs.net

If found eligible for CHC funding, the NHS will pay for healthcare (e.g. services provided by a community nurse or specialist therapist) and associated social care needs (e.g. personal care); eligible residents in a care home will have their board and accommodation paid for.

Eligibility is assessed on a six and 12 month basis; although initially there is a three month review during the first year of funding.

A ‘primary health need’ is assessed by looking at all of a resident’s care needs and relating them to four key indicators.

- Nature - characteristics and type of needs including the overall effect on the individual and the type of intervention that may be required.
- Complexity - how the individual’s needs present and interact including the level of skill required to treat and manage the care.
- Intensity - extent and severity of the individual’s needs and the support needed to meet them, (including the need for sustained/ongoing care).
- Unpredictability - relates to the difficulty to predict changes in an individual’s needs that might present challenges when managing them.

The first stage of the assessment process is the CHC checklist, this determines whether an individual meets the threshold for a full CHC assessment.

For further information and referral forms:

Continuing Healthcare
www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

Health, Assessment and Review Team
briscomhealth.org.uk/our-services/health-assessment-review-team-hart-continuing-healthcare-team-chc/

The service is for:

- people registered with a Bristol GP who require a CHC assessment
- Information regarding CHC fast track funding is overleaf.

Continuing Healthcare Fast Track tool

To enable immediate provision of a package of NHS continuing healthcare for a resident with a rapidly deteriorating condition.

If a patient is registered with a GP practice in Bristol, the Fast Track service is managed by Palliative Care Home Support
Telephone: 0117 982 8551
Fax: 0117 982 1458

To receive fast track funding, the individual must fulfil the following criterion:

He or she has a rapidly deteriorating condition and the condition may be entering a terminal phase. For the purposes of Fast Track eligibility this constitutes a primary health need. No other test is required.

Brief outline of reasons for the fast-tracking recommendation:
Please set out below the details of how your knowledge and evidence of the patient's needs mean that you consider that they fulfil the above criterion. This may include evidence from assessments, diagnosis, prognosis where these are available, together with details of both immediate and anticipated future needs and any deterioration that is present or expected.

When outlining reasons why a clinician considers that a person has a rapidly deteriorating condition that may be entering a terminal phase, the clinician should consider the following definition of a primary health need.

Primary health need arises where nursing or other health services required by the person are:
a) where the person is, or is to be, accommodated in a care home, more than incidental or ancillary to the provision of accommodation which a social services authority is, or would be but for the person's means, under a duty to provide; or
b) of a nature beyond which a social services authority whose primary responsibility is to provide social services could be expected to provide.

Continuing Healthcare Fast Track
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213140/NHS-CHC-Fast-Track-Pathway-tool.pdf

The service is for:
- patients who are rapidly deteriorating on a daily basis and have a prognosis three months or less
- All referred patients must be registered with a Bristol GP

Funded Nursing Care

NHS-funded nursing care (FNC) is care provided by a registered nurse, paid for by the NHS, for people who live in a care home. Services provided by a registered nurse can include planning, supervising and monitoring nursing and healthcare tasks, as well as direct nursing care.

Health Assessment and Review Team (HART)
Telephone: 0117 984 1501
Fax: 0117 984 1551
Email: hart.admin@nhs.net

An individual will be assessed for NHS continuing healthcare (see previous CHC information) and if found not eligible for CHC funding, they may be eligible for Funded Nursing Care.
The NHS make a payment directly to the care home to fund care provided by the registered nurses within the nursing home which is set at a standard rate nationally.

Individuals should receive NHS-funded nursing care if:

- They live in a care home registered to provide nursing care (or be planning to transfer to one)
- They don't qualify for NHS continuing healthcare but have been assessed as needing care from a registered nurse.

For further information, go to:

Continuing Healthcare
https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

Funded Nursing Care
https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

Dementia Wellbeing Service

The Dementia Wellbeing Service is a partnership between Alzheimer's Society and Devon Partnership NHS Trust, creating the Bristol Dementia Partnership. Since 1 April 2015, it has been responsible for delivering dementia services in Bristol. Every GP practice and care home with nursing in Bristol has a named dementia practitioner and each GP practice also has a named dementia navigator. They also provide the Care Home Liaison Service for care homes.

Referrals from:	Care homes with nursing can refer directly residents where they need support around dementia care or mental health issues.
Referrals by:	Referral Form
Access Point Telephone:	0117 904 5150
Email forms to:	dpn-tr.enquiriesBristolDementia@nhs.net
Website	www.bristoldementiawellbeing.org

If you are unable to get hold of your local HUB or your allocated practitioner or navigator, you may wish to call: The Dementia Wellbeing Service operates from three local HUBs, Monday-Friday 9am-5pm:

Local team numbers	North - Trinity Office Park T3, Filton Road, BS7 0DD Telephone: 0117 9513410 Fax: 0117 3013919 East - Brookland Hall, Conduit Place, BS2 9RU Telephone: 0117 9045150 Fax: 0117 904 5155 South - @Symes, Peterson Avenue, BS13 0BE Telephone: 0117 9473120 (Ext. 400) Fax: 0117 9473129

Or Access Point: Telephone: 0117 904 5151 (Monday-Friday 8am- 8pm, Saturday 9am-1pm, Bank Holidays 9am-5pm)

Alzheimer's Society National Dementia Helpline can provide information, support, guidance and signposting to other appropriate organisations. Telephone: 0300 222 1122. Open 9am-8pm Monday-Wednesday, 9am-5pm Thursday-Friday, 10am-4pm Saturday-Sunday.

The service also provides support from psychiatrists and psychology to support high quality prescribing and psychologically mindedness in how care is provided.

The service is for:

- people registered with a Bristol GP
- where the care home requires support to manage a resident's dementia care or mental health issues

For referral forms and further information, go to: dpn-tr.enquiriesbristoldementia@nhs.net

Dermatology Service

The Dermatology Service provides individuals with diagnosis, support, education and treatment planning. It also provides support to professionals caring for individuals with skin conditions.

Referrals from:	Healthcare Professionals, GPs, health visitors, community and practice nurses, podiatrists
Referrals by:	NHS Choose and Book, Fax: 0117 963 8707
Telephone	0117 944 9782 / 0117 944 9783 Monday-Friday 8.30am-5pm
Email:	BRCH.dermatology@nhs.net

For referral forms and further information, go to: www.briscomhealth. org.uk/our-services/item/50-dermatology. html

The service is for:
- people registered with a Bristol GP
- people diagnosed with a skin condition and where support, education and treatment planning is required.

Deprivation of Liberty Safeguards

Deprivation of Liberty Safeguards (DoLS) is a law that protects vulnerable adults in hospitals or care homes who might be deprived of their liberty.

Referral from:	Care Home
Referrals by:	Application Form
Telephone:	0117 903 6460
Email:	dols@bristol.gov.uk
Fax:	0117 903 6653
Address:	Bristol DoLS, Red House, Haggard Close, Withywood, Bristol, BS13 7SE

Deprivation of Liberty Safeguards (DoLS) is a law that protects vulnerable adults in hospitals or care homes who might be deprived of their liberty. This information is for both staff in hospitals and care homes who may need to apply for Deprivation of Liberty authorisation and for people directly affected by or concerned about these decisions.

Hospitals and care homes cannot deprive anybody of their liberty without formal deprivation of liberty authorisation and must apply for standard authorisation to deprive someone of their liberty to their relevant local authority or CCG. All requests for authorisation to NHS Bristol and Bristol City Council go through Bristol DoLS Service.

What is deprivation of liberty?

There is no simple definition of 'deprivation of liberty'. It depends on the circumstances of each individual case. Court judgements suggest factors to look for that can help identify deprivation of liberty:

- Someone resists being admitted to a place and they are restrained and or sedated so that they can be admitted.
- Staff have complete control over the care and movement of someone for a considerable time.
- The institution has decided that someone cannot be released into the care of others, or allowed to live somewhere else.
- Carers ask for someone to be discharged to their care and this is refused.
- Someone is not able to maintain social contacts because of restrictions placed on their seeing other people.
- Someone loses independence because they are under continuous supervision and control.

On their own, these factors do not mean there is a deprivation of liberty. However, the more factors present and the greater their impact, the more likely it is that a person is being deprived of their liberty.

The DoLS Code of Practice provides more information about how to identify a deprivation of liberty.

Applications for deprivation of liberty authorisation

There are two special terms used in the DoLS process:

- Hospitals and care homes are called ‘managing authorities’.
- The ‘supervisory body’ gives authorisation. This could be the CCG or a local authority.

Before making an application

Hospitals and care homes must consider options for delivering care or treatment that avoid deprivation of liberty altogether.

Making an application in cases that do not involve depriving a person of their liberty may place undue stress upon the person being assessed and on their families and carers. Please check with the Bristol DoLS service if you are not sure if the case involves deprivation of liberty.

Making an application

When deprivation of liberty is the least restrictive option and is in the best interest of the relevant person, the hospital or care home must apply for a standard authorisation of deprivation of liberty.

Applications should be made to the correct supervisory body. Bristol DoLS Interagency Policy and Procedures (link) contains some guidance on identifying the correct supervisory body. There are special arrangements for making applications to the supervisory bodies outside Bristol.

To make an application please use the appropriate standard DoLS form and send (fax or recorded delivery mail) together with all supporting evidence (care plan and risk management plan) to the DoLS Service.

Secure email

You can also apply by email to dols@bristol.gov.uk using SecureSend service. SecureSend will allow you to create a password to protect the confidential information in your email. Important: you must either send the password in a separate email or tell it over the phone once you have confirmed your email is safely received by DoLS Service. For help on using SecureSend go to How to use SecureSend on http://www.bristol.gov.uk/page/deprivation-liberty-safeguards

The supervisory body will perform six assessments in order to determine whether the deprivation of liberty can be authorised.

What if the application is authorised?

If the supervisory body authorises a deprivation of liberty, this will be for a limited time (up to maximum of 12 months) and the supervisory body will put conditions in place to ensure the person’s welfare.

The supervisory body will also appoint a representative for the person being deprived of their liberty. The representative's role is to provide support and to represent the person deprived of their liberty in all matters regarding authorisation and request a review of the authorisation where necessary.

The safeguards also ensure that the person deprived of their liberty and their family, carers and friends have a right to appeal against a decision in a court of law.

Review of authorisation

If circumstances change then the hospital or care home should apply for a review.

The person concerned, or their representative, can also request a review.

The supervisory body must also carry out a review when statutory review grounds are met.

For further information go to:
http://www.bristol.gov.uk/page/deprivation-liberty-safeguards

Diabetes and Nutrition Service

The Diabetes and Nutrition Service is an integrated community team of specialist community dietitians, Diabetes Specialist Nurses and structured diabetes education. The team provides three main services, diabetes education, diabetic specialist nurses and dietitians. Our dietetic provision is limited to those in the North and Inner City East areas of Bristol only and we do not provide a domicilally service.

Referral from:	Self-referrals and referrals from any healthcare professional to our diabetes education courses, for patients or their carers able to attend a course at a community venue. To access the Diabetes Specialist Nurses, Patients must be referred by a GP. Referrals to our dietitians can be made by any health care professional or self-referral for those that meet our criteria.
Referrals by:	Referral Form A (if patient has diabetes) Referral Form B for dietitian only if patient does not have diabetes.
Telephone:	0117 959 8970
Fax:	0117 959 8971
Email:	dans.bristol@nhs.net
Address:	Diabetes and Nutrition Service, John Milton Clinic, Crow Lane, Henbury, Bristol, BS10 7DP.

Diabetes education

We provide a range of free education courses around Bristol for people with Type 1 and Type 2 diabetes, to support them to learn more about their condition and how to manage it. For people unable to attend a course themselves, spaces are available for carers or a family member to attend in their place. http://briscomhealth.org.uk/diabetes-education-courses/

We have a wide range of patient information and resources available on our website, such as leaflets and video clips and packs, including resources translated into a variety of languages.

People who are newly diagnosed with Type 2 Diabetes should receive a copy of the Diabetes Information Pack (a purple coloured folder), along with a Diabetes Care Plan via their GP Surgery at the point of diagnosis, or shortly after. Alternatively, download a copy at: http://briscomhealth.org.uk/wp-content/uploads/2015/02/Main_pack-Large_font-Jan-2016-Final-PDF. pdf

Diabetes Specialist Nurses

Our Diabetes Specialist Nurses support GP practices across Bristol by developing health professionals' knowledge of diabetes through training, joint working and advice. They also provide study days, conferences and network meetings throughout the year for local healthcare professionals.

In addition to the education of healthcare professionals, the Diabetes Specialist Nurses carry a small caseload of local people with diabetes and complex issues, who have been referred by their GP and who require short term intensive support and education from the team.

Dietitians

Please note our dietitians only take referrals from patients registered to North and Inner City and East GP practices. Our dietitians provide nutritional advice to people in particular, diabetes, we also provide limited support and advice around irritable bowel syndrome, coeliac disease, food intolerances, anaemia, malnutrition and nutritional deficiencies. We are able to offer a limited number of telephone advice appointments for malnutrition, but do not provide a home visiting service.

Our dietitians are available to see patients who need dietary assessment and advice, in particular, but not exclusively, diabetes, who are able to attend a clinic and live in the north, inner city and east of Bristol. We accept self-referrals or referrals from any healthcare professional to this service. We do not provide a home visiting service. Contact us on the telephone number provided if you would like to self-refer. UHB Trust provides services to patients in the West and the South of the city.

For further information and referral forms, go to: http://briscomhealth.org.uk/ our-services/diabetes-nutrition-service/

There are resources, such as leaflets and video clips and packs, translated into a variety of languages on our website at: http://briscomhealth.org.uk/patients-and-carers/self-management-information-people-with-diabetes/
Free education courses: http://briscomhealth.org.uk/diabetes-education-courses/

Diabetes information pack for people newly diagnosed with Type 2 diabetes: http://briscomhealth.org.uk/wp-content/uploads/2015/02/Main_pack-Large_font-Jan-2016-Final-PDF.pdf

How to manage unintentional weight loss, poor appetite and malnutrition, as well as comprehensive information on Irritable Bowel Syndrome: http://briscomhealth.org.uk/videos/worried-poor-appetite-unintentional-weight-loss-malnutrition

The service is for:

- Bristol residents diagnosed with type 1 or Type 2 diabetes
- people who wish to learn more about their condition and how to manage it.
- patients registered to North and Inner City practices who need dietitian services.
- patients who need dietary advice on diabetes, support and advice around irritable bowel syndrome, coeliac disease, food intolerances, anaemia, malnutrition and nutritional deficiencies.

Falls Specialist Nurse

The falls specialist nurse (Bristol Community Health) provides non urgent comprehensive geriatric assessment for complex patients at risk of recurrent falls who have already been screened for any unstable medical problems. The nurse will then agree an action plan for further investigation or risk reduction with the patient and refer on to other services as necessary.

Referrals from	GP
Referrals by	Written referrals sent via fax
Fax	0117 919 0296
Falls Specialist Nurse	0117 919 0290
Address:	Knowle Clinic, Broadfield Road, Knowle, Bristol, BS4 2UH

Falls

A fall is "an event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness" - National Institute for Clinical Excellence (NICE) 2004

If an older person has fallen they should be screened for acute illness which may include a falls blood screen i.e. thyroid, full blood count, electrolytes, liver function tests, calcium, vitamin B12 and folate.

A multifactorial falls risk assessment should be completed for any resident who has a risk of falls and discussed with the GP before considering referral to the falls specialist nurse. This is central to communication with the GP and other staff and reduces duplication of assessment.

The root cause analysis form charts the timing, place and circumstances of falls for both individuals and all falls within the care home.

The service is for:

- Those registered with a Bristol GP
- Those experiencing falls who require comprehensive assessment by a falls specialist following assessment by the GP and care home.

For the multifactorial falls risk assessment and root cause analysis forms go to: http://briscomhealth.org.uk/our-services/falls-in-older-people/

For NICE Falls guidance, go to: https://www.nice.org.uk/guidance/cg161

Independent Mental Capacity Advocacy Service

The Independent Mental Capacity Advocacy Service (IMCA) provides independent safeguards for people who lack capacity to make certain significant decisions and who, at the time such decisions need to be made, have no-one else other than paid staff to support or represent them or to be consulted.

Applications from:	The registered manager of the care home
Referrals by:	Referral Form
Telephone:	0117 980 0371
Email:	imca@bristolmind.org.uk
Fax:	0117 927 6587

The purpose of the Independent Mental Capacity Advocacy Service is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions. The role of the Independent Mental Capacity Advocate (IMCA) is to work with and support people who lack capacity, and represent their views to those who are working out of their best interests.

More recently the Department of Health extended the Act through Regulations to cover two additional circumstances a) where a safeguarding adult's allegation has been made and b) in social care reviews.

This policy statement focuses on the first circumstance and aims to provide guidance on which eligible individuals receiving safeguarding adult's measures would most benefit from having the involvement of an IMCA and to ensure that the available resources are targeted to those in most need.

Who may need an IMCA in relation to safeguarding concerns?

In relation to safeguarding adult's cases, the regulations specify that local authorities and the NHS have powers to instruct an IMCA if the following requirements are met:

- where safeguarding measures are being put in place in relation to the protection of vulnerable adults from abuse; and
- where the person lacks capacity

In these circumstances the Local Authority or NHS body may instruct an IMCA to represent the person concerned if it is satisfied that it would be of benefit for the person to do so.

In safeguarding adult's cases (and no other cases) access to an IMCA is not restricted to people who have no one else to support or represent them. People who lack capacity who have family and friends can still have an IMCA to support them through the safeguarding process. The regulations equally apply to:

- a person who may have been abused
- a person who has been neglected and

- a person who is alleged to be the abuser

Where the qualifying criteria are met, it would be unlawful for the local authority or the NHS not to consider the exercise of their power to instruct an IMCA for safeguarding adult's cases. Assessing capacity in relation to safeguarding adults issues.

Someone is said to lack capacity if they are unable to make a particular decision. This inability must be caused by an impediment or disturbance of the mind or brain, whether temporary or permanent.

In order to make a decision, the person needs to be able to:

- Absorb basic information about the pros and cons of an issue.
- Retain the information for long enough to process it.
- Weigh up the pros and cons against their own value system and arrive at a decision.
- Communicate that decision.

To be eligible for the IMCA service a person must lack capacity in relation to a specific issue or decision in question, e.g: a person may not be able to absorb and weigh up the pros and cons of continuing to live with an abusive family member.

At what point in the process should an IMCA become involved?

Consideration should be given as to the most appropriate time to instruct an IMCA in safeguarding adult's cases. This will be dependent on the decisions to be made and the risks to those involved. In some cases it will be appropriate to involve an IMCA at the strategy discussion/meeting stage. This would need to happen for cases where the wishes/decisions made by the individual would have a significant impact on the investigative process or where immediate actions need to be taken to safeguard the individual prior to further investigation taking place.

In other cases, it may be more appropriate for an IMCA to become involved at the case conference/safeguarding planning stage so that they can provide input into the safeguarding protection plan. This would be more appropriate in cases where decisions need to be made as a result of findings of the investigation.

Where an IMCA has been involved at any stage of the safeguarding process, they should be invited to attend safeguarding adults meetings, as appropriate, including any subsequent reviews. The involvement of the IMCA should be reviewed once the specific decisions that prompted the referral have been resolved.

In some situations, a case may start out as a safeguarding adults case, where consideration is given whether or not to involve an IMCA under the set criteria – but may then become a case where the allegations or evidence give rise to the question of whether the person should be moved in their best interests. In these situations the case has become one where an IMCA must be involved if there is no one else appropriate to support and represent the person in this decision.

What are the criteria for referring someone to the IMCA Service?

The IMCA Service is a limited resource, therefore it is important that the use of IMCAS focuses on the cases where non IMCA arrangements are not robust enough to support the necessary decision making, and an external (IMCA) opinion will give a more defendable and more appropriate outcome. When the subject of the concern is already supported by an approved advocacy service, there should be no need to involve the IMCA Service.

In order to ensure that the IMCA Service is targeted to those in most need it is recommended that, in relation to safeguarding adults, referrals to the IMCA Service are made in cases where one of the following applies:

For someone who may have been abused or neglected

- Where there is a serious exposure to risk of:
  - death
  - serious physical injury or illness
  - serious deterioration in physical or mental health
  - serious emotional distress.
- Where a life changing decision is involved and consulting family or friends is compromised by the reasonable belief that they would not have the person's best interests at heart.
- Where there is a conflict of views between the decision makers regarding the best interests of the person.

For someone who is alleged to be the abuser

- Where a life changing decision is involved and consulting family or friends is compromised by the reasonable belief that they would not have the person's best interests at heart.
- Where there is a conflict of views between the decision makers regarding the best interests of the person.

Intermediate Care

Intermediate care services include:

- Rapid Response, who offer care for those who are suffering from acute episodes of illness. We will visit patients in their own home or place of residence for up to seven days.
- Community rehabilitation and re-ablement, who support patients in their own home or place of residence.
- Residential centres provide recovery and rehabilitation support for short periods of time.
- Hospital based teams provide a link with our Intermediate Care Services in the community and help to facilitate the discharge of patients from hospital care.

Referral from:	GPs, and health and social care professionals.
Referrals by:	Telephone
Telephone:	0117 903 0202 Single Point of Access (SPA) Lines are open 24 hours a day, 7 days a week.
Website	http://briscomhealth.org.uk/our-services/intermediate-care/

Our staff include:
- Advanced Nurse Practitioners
- Mental Health Nurses
- Nurses
- Occupational Therapists
- Pharmacists
- Physiotherapists
- Rehabilitation Workers
- Social Workers
- Speech and Language Therapists
- Support Workers.

What happens when I refer a patient?
1. Single Point of Access (SPA) administrator takes baseline information including name, address.
2. Contact and referrer details.
3. Case manager then triages / has further discussion with the referrer. A visit plan and clinically appropriate response time of visit will be agreed.
4. Case manager assesses and / or transfers patient to appropriate Rapid Response team.
5. Daily case review by the multi-disciplinary team.
6. Rapid Response team devises care plan and informs referrer of outcome.

The service is for:
- Bristol residents registered with a GP practice
- People over 16 years of age
- People who are physiologically stable and suitable for out of hospital care
- People who are agreeable to receiving care from Rapid Response
- Intravenous antibiotics for residents who are currently unwell or have a long term condition which is unstable and requires additional support from this team through this period of decompensation
- Where hospital admission is not required but the resident requires additional support from a multidiscipinary team.

Medicines Management in Care Homes

The Care Homes pharmacy technician can provide advice and support to the residents and staff within the Bristol area, in line with the Care Quality Commission's Essential Standards of Quality and Safety and the National Guidelines.

In addition to guidance on best practice and measures required to effectively and safely practice in medicines management, the Care Homes pharmacy technician will also provide help and advice in communications with prescribers and community pharmacists.

PA to the Medicines Management Team:
Telephone: 0117 900 3432

NHS Bristol Clinical Commissioning Group
South Plaza
Marlborough Street
Bristol BS1 3NX

Medicines Management Specialist Dietitian

Identifying and treating dehydration and malnutrition in your setting

Training on malnutrition/malnutrition Universal Screening Tool (MUST) is available for all staff. This can be delivered in your care home and covers the causes and consequences of dehydration and malnutrition, how to screen for malnutrition using MUST, and how to treat it, including a range of food first approaches.

A range of written resources are also available. Please contact The PA to the Medicines Management Team on the number below.

PA to the Medicines Management Team:
Telephone: 0117 900 3432

NHS Bristol Clinical Commissioning Group
South Plaza
Marlborough Street
Bristol BS1 3NX

Palliative Care Services

Bristol Care Coordination Centre (Coordinating end of life care)

The Bristol Care Coordination Centre service is provided by Bristol Community Health. The service provides co-ordination of care, some ordering of equipment (if needed urgently, in order to facilitate care) and signposting to other services, as needed.

Referral from:	Any clinician involved in patient care or management, with the permission of the patient or his/her representative.
Referrals by:	By telephone or fax. Also by email if both parties agree that this is supported by the Information Governance policies (generally nhs. net addresses are acceptable).
Telephone:	0117 982 8315 8am – 6pm Monday – Friday and 8 – 4pm on weekends and Bank Holidays.
Fax:	0117 3167690
Email:	bristolccc@nhs.net
Address:	Bristol Care Coordination Centre, Avonmouth Medical Centre, Collins Street, Avonmouth, Bristol, BS11 9JJ

What information is needed?

The information specified on the proforma, to include patient details, referrer details (and specified person to contact the next day, if referral is made out of hours), and details of any key worker, if known.

What happens outside the hours?

Any calls, whether for urgent need, advice, or for coordination referrals, will be taken by existing teams (BCH Out of Hours SPA and St Peter's Hospice Advice Line). Please use the main number, as above, as it will be transferred automatically to the Out of Hours SPA. Referrals for coordination taken after 6pm (or 4pm for weekends and Bank Holidays) will be followed up the next morning – please be sure to include details and availability of keyworker or relevant clinician for follow up call.

Which resources/services will be allocated by the Care Coordinators?

A plan of care will be comprise care from a range of services/teams, to include:

- Palliative Care Home Support Service (PCHS)
- Marie Curie
- Hospice@Home.

The service is a 'test and learn' project, and will be adjusted according to feedback from service users and referrers and other key stakeholders.

For further information go to:
www.briscomhealth.org.uk/our-services/Palliative-care-home-support

The service is for:

- Patients in the Bristol area
- patients with a life expectancy of three months, or less, and who require coordination of care.

St Peter’s Hospice Palliative Care Team

St Peter’s Hospice is a local charity providing care free of charge to patients with complicated needs towards the end of life, but nearly always needing relief from distressing symptoms or worries. They provide this care to the people of Bristol, South Gloucestershire, North Somerset and part of BANES.

Referral from:	Anyone can make a referral but usually patients are referred by a health or social care professional such as their GP, district nurse or Hospital Palliative Care Team.
Referrals by:	Referral form
Telephone	0117 915 9430 (24 hour advice line)
Address:	St Peter’s Hospice, Charlton Road, Brentry, Bristol, BS10 6NL

24 hour advice line

The advice line can be accessed by our healthcare professional colleagues in the community regardless of whether or not the patient they wish to discuss is known to St Peter’s Hospice. Patients known to the hospice or their carers may also call for advice. The advice needed may be medical, nursing or about general palliative care issues.

Governance

Calls for medical advice are always taken by a senior doctor i.e. a Specialist Registrar, Consultant or the Medical Director. We make a record of all calls including general or nursing queries. When the query is about an existing patient we update patients’ records accordingly.

The queries dealt with by nursing staff are reviewed by senior members of the medical team at least twice a week, and within the medical team we have a system of peer review for the advice given.

We can fax, e-mail or text complex advice if required. Responsibility remains with the clinician assessing the patient and detailed prescribing advice will only be given directly to the prescriber.

Referral Criteria and Process

Criteria

1. The service is available to people living within the catchment area that have incurable, life-limiting malignant or non-malignant disease. Most patients will have advanced progressive disease and the focus of care will have changed from curative to palliative. Some patients, who have complex specialist needs, may be referred at an earlier stage of their disease.
2. The patients will have complex problems associated with their disease, such as difficult physical symptoms and/or psychological, social or spiritual issues requiring Specialist Palliative Care Services.
3. The patients (or their advocate) and the patients’ GP must consent to the referral.
4. Patients may be referred for an urgent assessment by a Community Nurse Specialist or

a Hospice Doctor, and contact will be made with them within 2 working days. These patients must have been assessed by a healthcare professional in the previous 48hrs, and meet one or both of the following criteria:

- Particularly severe symptoms not readily responding to current management
- A rapidly deteriorating condition requiring specialist palliative care input

The Referral Process

1. A request for assessment can be made by any professional, but it must be made with the consent of the patient (or their advocate) and their GP.
2. Referrals should always be accompanied by a fully completed referral form and must include copies of recent hospital letters, scans and blood results and any other relevant information. Insufficient information will delay the initial assessment. If the referral is for Hospice at Home to provide 24 hour nursing care at the end of life please return the specific referral form for this service - Hospice at Home referral form (below).
3. It is essential that the referrer identifies the reason for the referral and current problems requiring specialist palliative care input.
4. Urgency of the referral should be specified according to the above criteria.
5. Referrals indicated as 'urgent' should be faxed to the Hospice and at the same time be accompanied by a telephone call from the referrer to a member of the Community Clinical Nurse Specialist Team (who will be working as the triage nurse) or the Senior Medical team. This is in order to provide immediate advice to the referrer. Following this telephone discussion with the referrer, if it is still deemed as urgent the patient will be contacted within 2 working days.
6. For referrals marked as routine patients will be contacted within 2 weeks.
7. Once a patient has been accepted by the Hospice services they will be contacted to let them know how the referral will be processed.
8. If, following assessment/management the patient no longer requires input from the Hospice they will be discharged from the service. Re-referral is welcomed but further information or another referral form may be requested, particularly if there has been no Hospice involvement for longer than 9 months.

Hospice Services

Patients can be referred for one of the following services:

Day Hospice

A patient can be referred to attend a therapeutic programme; one day a week for twelve weeks. Patients will be in a group environment with access to a specialist multidisciplinary team. The day will include relaxation as well as gentle physical exercise, and the opportunity to join in informal education sessions on relevant topics such as oral care, medicine management, and planning for the future. Patients who do not have their own transport but are able to get in and out of the car independently can have access to a volunteer driver. It is the referrer's responsibility to sort transport for those who may need more assistance. Patients will normally be discharged from Day Hospice after 12 weeks: back to the care of the referring Health Care Professional.

Patients can also be referred to the Fatigue and Breathlessness (FAB) Management

Programme run by the physiotherapy, occupational therapy and nursing team within Day Hospice. It runs over a 6 week period.

For either service; if the patient is using oxygen, a HOOF will need to be completed by the GP to ensure oxygen is delivered to St Peter's Hospice for use by the patient on their day of attendance at the Day Hospice.

Inpatient Unit

The Hospice Inpatient Unit beds at Brentry are used to offer short-term admission (usually up to 14 days), with the aim of supporting patients at times of acute and/or complex specialist palliative care needs. For patients with acute reversible conditions requiring urgent investigation or intensive medical management, hospital admission should be considered, depending on the informed choice of the patient or patient's advocate.

If a GP/DN/hospital palliative care team would like a current patient to be considered for admission they should contact the patient's Hospice Community Nurse Specialist or Day Hospice team to request this. If the patient concerned is not already known to the hospice it is essential to fax a full referral form and discuss the case with one of the senior doctors.

Routine requests for admission will be discussed at the next admission meeting (Daily: Monday to Friday). Emergency admissions can be arranged for the same day or out of hours if appropriate, depending on bed availability. Requests for urgent admission must be discussed with a senior hospice doctor who is available 24 hours for urgent advice.

For planned admissions if patients are using oxygen, a HOOF will need to be completed by the GP or referring hospital team to ensure oxygen is delivered to St Peter's for use by the patient during their inpatient stay.

For further information go to:
www.stpetershospice.org.uk/health-care-professionals/24-hour-advice-line/

Parkinson’s Nurse Specialist

Specialist Parkinson’s nurses are experienced registered general nurses with specialist experience, knowledge and skills in Parkinson’s. They offer information and advice to families of people with Parkinson’s and other health and social care professionals involved in a person’s care.

Referral from:	GP, consultant, or any healthcare professional involved in their care
Referrals by:	Parkinson’s Nurse Specialist referral form
Telephone (helpline):	0808 800 0303
Email:	pnsbristolsouth@nhs.net
Website:	parkinsons.org.uk
Address:	South Inner City & East Bristol, Specialist Community Neurology Service, Knowle Clinic, Broadfield Road, Bristol, BS4 2HU

Parkinson’s nurses provide valuable help in supporting people coming to terms with their Parkinson’s diagnosis. They can offer guidance on managing medication and make appropriate referrals on to other professionals such as speech and language therapists and physiotherapists. Parkinson’s nurses also train other health and social care professionals who are involved with Parkinson’s.

For further information go to:
www.briscomhealth.org.uk/our-services/parkinson-nurse-specialist/

The service is for:
- Patients in the Bristol area where information or specialist advice is required regarding a patient with Parkinson’s

Patient Advice and Liaison Service (CCG)

As a patient, carer, or relative sometimes you may need to turn to someone for help, advice and support. This is where Patient Advice and Liaison Service (PALS) comes in. PALS can act on your behalf when handling patient and family concerns, liaising with staff, managers and, where appropriate, relevant organisations to negotiate solutions. PALS can guide you through the different services available from the NHS. PALS can also help you get support from other local or national agencies for help and support with problems that are outside of the CCG PALS remit.

Telephone:	0117 947 4477
Freephone:	0800 073 0907
Email:	Sarah.jenkins@swcsu.nhs.uk
Address:	PALS, Suite 15, Corum 2, Corum Office Park, Crown Way, Warmley, Bristol, South Gloucestershire, BS30 8FJ

The service is free and confidential. Only in exceptional cases where your safety or that of others must be considered will PALS have to pass information on. PALS will always tell you if they have to do this.

PALS will always ask for your permission before personal information is discussed with others.

Bristol CCG is responsible for commissioning hospital, mental health, community and GP out-of-hours services. If you have a query, concern or compliment about these services, you are welcome to contact PALS.

You can also contact PALS if you have concerns about our commissioning decisions or the outcomes of our decisions.

Podiatry

The podiatry service provides comprehensive foot care treatment, advice and support.

Referrals from:	GP, district nurse
Referrals by:	Referral form
Telephone:	0117 919 0275 (Mon- Fri 8:30 – 5pm)
Address:	Podiatry Department, Knowle Clinic, Broadfield Road, Knowle, Bristol, BS4 2UH

The Podiatry Service provides comprehensive foot care for conditions affecting the foot and leg. In some circumstances, the service will offer courses of treatment for chronic medical conditions that affect foot health and / or a person's mobility.

They can provide podiatry services in community clinics but they also visit bed and chair bound patients. The treatment provided will be based on a risk assessment.

The care provided includes:

- immediate, short term and long term solutions to painful foot problems
- minor surgery using local anaesthetic
- prescribing aids to help with structural imbalances affecting the feet and legs
- screening for potential foot problems
- helpful advice on foot problems.

Patients must be referred into the Home Visit service by their GP. Therefore care home nurses should discuss referral with the resident's GP.

Please see the referral form at: http://briscomhealth.org.uk/our-services/podiatry/

The service is for patients who have:

- a medical condition or illness that may make it more difficult for damaged skin to heal, e.g. diabetes, rheumatoid arthritis or circulatory problems.
- a disability which causes foot pain and/or affects mobility.
- a painful foot condition which affects mobility, e.g. ingrown toenails.

Safeguarding

Safeguarding adults involves a range of additional measures taken to protect patients in the most vulnerable circumstances, patients that are currently defined within No Secrets as 'vulnerable adults'. This may be due to illness, impaired mental capacity, physical or learning disability or frailty brought about by age or other circumstance.

Referral from:	Anyone
Referrals by:	Safeguarding Adult Referral Form sent via fax or email.
Telephone:	0117 922 2700 8.30am to 5pm Monday to Friday (answerphone outside office hours)
Email:	adult.care@bristol.gov.uk
Fax:	0117 903 6688

There are seven stages to safeguarding:

Stage One: Raising an alert

Everyone has a responsibility for safeguarding adults. If you are raising a concern within an organisation, then the concern should be passed immediately to the person responsible for dealing with safeguarding alerts. If there is no organisation involved, the person raising the alert should contact Adult Social Care directly.

Stage Two: Making a referral

The decision to make a referral will normally be made by the person responsible for dealing with safeguarding. If there is no organisation providing services to the adult at risk, the person who is concerned can make a referral directly to Adult Social Care.

Stage Three: Strategy discussion or meeting

This is a multi-agency meeting convened and coordinated by the Safeguarding Adults Manager (SAM) in Adult Social Care, who will discuss the allegations with a range of professionals (usually including the police, where appropriate) to:

- Consider the wishes of the adult at risk.
- Agree whether an investigation will take place, and if so, how it should be conducted and by whom.
- Undertake risk assessment.
- Agree an interim protection plan.
- Make a clear record of the decisions.
- Record what information is shared.
- Agree an investigation plan with timescales.
- Agree a communication strategy.
- Consider whether a child (under 18 years) may also be at risk.
- Circulate decisions to all invitees within five days using the appropriate pro forma.

Stage Four: Investigation

The nature of the investigation is decided by those at the strategy meeting, who will also appoint an investigating officer. The purpose of the investigation is to:

- Establish the facts and contributing factors leading up to the referral.
- Identify and manage risk and ensure the safety of the individual and others.

If a mental capacity assessment is indicated, the meeting should also consider instructing an Independent Mental Capacity Advocate (IMCA). This may be appropriate where the person lacks other appropriate support to represent their interests.

Stage Five: Case conference and protection plan

The aim of a case conference is to:

- Consider the information contained in the investigating officer's report(s).
- Consider the evidence and, if substantiated, plan what action is indicated, or alternatively.
- Plan further action if the allegation is not substantiated.
- Plan further action if the investigation is inconclusive.
- Consider what legal or statutory action or redress is indicated.
- Make a decision about the levels of current risks and a judgement about any likely future risks.
- Agree a protection plan.
- Agree how the protection plan will be reviewed and monitored.

The protection plan, which will be overseen by a designated protection plan coordinator, focuses on minimising the risk of harm to the person at risk and developing strategies to enhance their resilience. This does not include actions taken against the person causing harm.

Stage Six: Review of the protection plan

The purpose of the review is to ensure that the actions agreed in the protection plan have been implemented and to decide whether further action is needed, including any service improvements.

Stage Seven: Closing the safeguarding adults process

The safeguarding adults process may be closed at any stage if it is agreed that an ongoing investigation is not needed or if the investigation has been completed and a protection plan has been agreed and put in place.

In most cases a decision to close the safeguarding adults process is taken at the case conference or at a protection plan review.

Further detailed information on the stages of the adult safeguarding process can be found in SCIE Report 39.

For referral forms and further information, go to: Multi - Agency Policy: https://www.bristol.gov.uk/documents/20182/33728/Bristol+Safeguarding+Adults+Policy2015.pdf Referral Form: https://www2.bristol.gov.uk/form/adult-care-and-health/report-suspected-abuse-safeguarding-adults-referral-form-professionals

Speech and Language Therapy Service

Speech and Language Therapists (SLT) assess and treat speech, language and communication problems in people of all ages to help them better communicate. They'll also work with people who have eating and swallowing problems.

Referral from:	GP (communication & oro-pharyngeal swallowing problems) Self-Referral (communication difficulties only)
Referrals by:	Please complete North Bristol NHS Trust Adult Speech and Language Therapy referral form and email to SLTContact@nbt.nhs.uk or Letter stating reason for referral, current problems, relevant medical history and any known risks, whether patient can attend as an outpatient and if transport is required
Telephone	Southmead: 0117 414 4011/12 or 0117 414 9467 Cossham: 0117 340 8525 or 0117 340 8526
Address:	Speech and Language Therapy Department, Gate 10 Level 6, Brunel Building, Southmead Hospital, BS10 5NB

Speech and Language Therapists covering adult, acute and rehabilitation services at North Bristol NHS Trust are based at Southmead and Cossham Hospitals. Most appointments are held in the outpatient departments. Please advise if transport / home visit is required.

This service does not accept referrals of adults with developmental language disorders, congenital deafness and those with social communication difficulties related to Autistic Spectrum Disorders.

Joint working is promoted with the Adult Learning Difficulty SLTs for their clients who may require access to specialist North Bristol NHS Trust SLT Services (e.g. stammering, video fluoroscopy).

Close links are maintained with SLTs working in the Bristol, North Somerset and South Gloucestershire areas. If the person requires multidisciplinary support please refer to the SLT in Bristol Community Health Partners. The SLT service for people with voice difficulties is based at University Hospitals Bristol NHS Foundation Trust.

Wound Care

The Wound Care service provides a comprehensive assessment of people who have non-healing wounds that are slow to heal and not progressing as they should.

Referral from:	Self-referrals, clinicians or GPs.
Referrals by:	Referral Form
Telephone	0117 919 0270 Monday - Friday 8.30am - 5pm excluding bank holidays
Fax:	0117 919 0370
Email:	wcs@nhs.net
Address:	Wound Care Service, Knowle Clinic, Broadfield Road, Knowle, Bristol, BS4 2UH

Patients can be seen in the clinic environment or in the patient's home if they are housebound.

An assessment is undertaken and treatment plan formulated which can then be followed by the practice nurse or community nurse who will undertake the care. Depending on the treatment plan, reviews of the care may be arranged to ensure that the wound is progressing as expected and to provide further advice.

Where there are wounds or oedema (swelling) on the lower limb, a Doppler assessment can be performed to assess the vascular status and to consider the use of compression therapy either using hosiery or bandaging.

A number of advanced wound treatments can be considered for challenging wounds and the necessary guidance and support would be provided to facilitate this.

For further information and referral forms, go to: http://briscomhealth.org.uk/ our-services/wound-care/

The service is for:

- patients registered with a Bristol GP
- patients who have non-healing wounds that are slow to heal and not progressing as they should
- advice and support.