EPUT Integrated and Specialist Community Services
South-East Essex

Service description summary reference guide

2020/21

Updated: November 2020
If you require **urgent** access please call:

0333 015 3481

This single number replaces:

- **Intermediate Care** (previously Single Point of Referral [SPOR])
- **Urgent Community Response Team (SWIFT)**
- **District Nurse Liaison**
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### Nurse-led Services

#### Community Heart Failure Service

**Criteria for referral:**
A confirmed diagnosis of heart failure on recent echocardiogram; which shows either a reduced left ventricular ejection fraction lower than 40% (HFrEF) or heart failure with preserved left ventricular function (HFpEF) and are symptomatic due to fluid overload.

Patient Management includes:
- Providing specialist evidenced based treatment, management, advice and support for adults 18 years and over with a confirmed diagnosis of heart failure.
- Education, advice and support.
- General assessment and review.
- Titration of prognostic medications used in management of heart failure.
- Advice and management of worsening symptoms.
- Management of resistant fluid overload.
- Management of End Stage Disease.
- Referral for consideration of device therapy.
- Referral to other services if required.
- Telephone helpline service for advice and information.
- Self-referral back into service for review following discharge if symptoms deteriorate.

**IV Diuretic**
Referrals for this service are only accepted from local GP’S, the Cardiology Team at SUHFT and the Community Heart Failure Service. This service is to facilitate early discharge from SUHFT, unnecessary hospital admissions and palliative management for those patients who remain fluid overloaded and symptomatic despite maximum oral diuretic therapies.

If following assessment by a heart failure nurse specialist independent prescriber, it is considered appropriate and safe for the patient to be managed in the community the treatment will be delivered in the patient’s home.

Management meetings with the Consultant Cardiologist at SUHFT take place weekly for advice and support as required on patient management.

<table>
<thead>
<tr>
<th>Referral Route: Heart Failure Service</th>
</tr>
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<tbody>
<tr>
<td>Tel: 01702 482841</td>
</tr>
<tr>
<td>Referrals to this service are accepted on receipt of a completed referral form e-mailed to: <a href="mailto:epunft.se.heartfailure@nhs.net">epunft.se.heartfailure@nhs.net</a></td>
</tr>
</tbody>
</table>

| IV Diuretics |
| Referrals to this service via telephone |
| Tel: 07580 398380 |
| Call to confirm that capacity is available. If accepted a completed referral form e-mailed to: epunft.se.heartfailure@nhs.net |

#### Continence Advisory Service (Adults)

**Criteria for referral:**
All patients, who have bladder or bowel symptoms, who would benefit from a specialist assessment, treatment (cure, improvement or containment).

The service will:
- Provide specialist evidence based treatment, management, advice and support for adults with a bladder or bowel dysfunction.
- Reduce the incidence of incontinence through effective, evidence-based treatment and education.

Clean intermittent self-catheterisation.
- Urethral structure therapy.
- Bowel management.
- Fluid intake and dietary advice.
- Anticholinergic medication or appliance in collaboration with medical colleagues.

<table>
<thead>
<tr>
<th>Referral Route:</th>
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<tr>
<td>Referrals can be sent via post, fax, secure email, or via electronic referral.</td>
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<tr>
<td>Email: <a href="mailto:continence.referrals@nhs.net">continence.referrals@nhs.net</a></td>
</tr>
<tr>
<td>Tel: 01702 372014</td>
</tr>
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</table>
### Diabetes Integrated Service

**Criteria for referral:**
The Community Diabetes service is an integrated nurse led service that facilitates self-management, enabling people with diabetes to make the necessary adjustments to remain well, reducing mortality, morbidity and the need for hospitalisation.

The service also provides care to patients in nursing and residential care homes.

**Referral Route:**
Tel: 01702 548094  
Email: Diabetes.one@nhs.net  
Patient Line: 01702 543404  
Patient Advice Line: 01702 543405

### Specialist Community Nursing Teams

#### District Nursing
The service supports patients who are housebound only (i.e. patients who cannot get to the GP/or clinic). All patients will receive a holistic assessment and review of needs on referral to the service. Care will be delivered by an appropriate practitioner; this can include non-registered nursing staff acting on delegated authority.

Operates between 08:00 – 22:00 365 days per year

**Referral Route:**
Electronic referrals are accepted via SystmOne  
(under Integrated Adult Services)  
Email referrals can be sent to:  
districtnurse.liaison@nhs.net  
Professionals number: 0333 015 3481  
Patient number: 0333 015 3481

#### District Nursing Night Service
This is a crisis response service only and responds to nursing needs of patients who are housebound; planned interventions are not accepted to this service as it reduces the responsiveness to crisis calls.

Operates between 21:00 – 08:00 365 days per year

**Referral Route:**
Tel: 0333 015 3481

#### Community Respiratory Nursing

**Criteria for referral:**
Criteria for Community Respiratory Nurse Specialist:
- COPD which has been confirmed by Spirometry Assessment
- Interstitial Lung Disease (ILD)
- Pulmonary Fibrosis
- Bronchiectasis
- Non-Interstitial Pneumonia
- 1 or more exacerbations of COPD within the last year.

Exclusion Criteria for Community Respiratory Nurse Specialist:
- Asthma
- Lung Cancer

**Referral Route:**
Tel: 0333 015 3481  
Mobile number: 07710 929672  
The contact number is available 7 days a week 08:00 – 22:00hrs.

#### Home Oxygen Service

**Criteria for referral:**
The service provides assessment for and provision of oxygen for patients in their own homes. It is also clinic based with spirometry to help diagnose and monitor certain lung conditions. The service uses arterial and capillary blood gases to measure suitability for and levels of oxygen required, and prescribe for long term and ambulatory oxygen requirements.

Referrals are accepted from acute hospitals, GPs, Community Respiratory Nurses, Palliative Care Nurses and other health professionals.

**Referral Route:**
Tel: 01702 372040  
Email: epunft.oxygen.spirometryteam@nhs.uk
professionals.

Inclusion Criteria for Home Oxygen Service
- Patients with an SpO2 of <93% on air (at rest) on more than 2 occasions
- Clinical diagnosis
- Optimum clinical management
- Completed pulmonary rehabilitation course prior to assessment
- Clinically stable for 8 weeks pre-assessment

Exclusion Criteria for Home Oxygen Service
- Children (under 16 years old)
- Patients with an SpO2 of >93% on air (at rest)

Operates between 08:00 – 17:00hrs 365 days per year

### Spirometry Service Provision:

**Criteria for referral:**
Patients registered with a CPR or Southend GP practice.

Exclusion Criteria for Spirometry Service
- If below 5 cm aneurism
- 6 weeks post Pneumothorax
- 6 weeks post eye surgery
- Less than 6 weeks post chest/abdominal surgery
- Known or suspected lung TB
- Recent vomiting/diarrhoea
- Haemoptysis
- Under 6 weeks MI
- Clear of antibiotics and steroids 6 weeks

### Integrated Palliative Care Service and Register

**Criteria for referral:**
This is a comprehensive offer for palliative care that includes:

a) Register Management
b) Palliative Care Services

Criteria is to provide specialist support to patients with palliative care needs, determining an appropriate plan of care and ensuring all appropriate partners are involved as the patient continues through their palliative disease/condition progression. All patients will have a holistic assessment (PEPSI COLA) on initial assessment or when deemed appropriate by the clinician. Symptom control is a key part of the role of the SPCNs; they also ensure patients and relatives are fully supported in decisions regarding their care and the choices they need to make as they approach the end of life.

Operates: Palliative Care Service 08:00 – 19:00 365 days per year
Register 08:30 – 16:30 Monday – Friday

### Tuberculosis (TB) Service

**Criteria for referral:**
The service provides diagnostic, treatment and screening services across South, Mid and West Essex. All tuberculosis patients are cared for by a multidisciplinary team whether seen as inpatients or in outpatients. This involves; the TB nurses, the chest consultants, infectious disease consultant, HIV services, paediatricians, microbiologists, infection control, physiotherapist, radiologists and Public Health England (PHE).

**Referral Route:**
Tel: 01702 546251
GP’s are advised to ring the service and additionally send a fax through with the patient’s details, including NHS number and contact number and reason for referral.

**Email referrals to:**
districtnurse.liaison@nhs.net

A completed referral form is required.

Tel: 0333 015 3481
Wound Care Service

Leg Ulcer Service
Criteria for referral:
The Leg Ulcer Service provides holistic assessment and treatment of leg ulceration for mobile service users, delivered at Clinics across the South East Locality. Focus is also given to the prevention of leg ulcers and reducing recurrence with provision of a “well leg” service.

The service is available to anyone mobile over the age of 18 and consents to treatment and meets the following criteria:

- Have an active leg ulcer that has not healed within four weeks of treatment; or;
- The service user has existing co-morbidities that increase the risk of leg ulcer deterioration, such as diabetes, connective tissue disease, significant venous disease or peripheral vascular disease.

Referral Route:
Leg Ulcer
Tel: 01702 372021

Please use the Leg Ulcer referral form which can be provided by contacting the service.

Tissue Viability Service
Criteria for referral:
The purpose of the Tissue Viability Service is to be proactive in the prevention of pressure ulcers and tissue damage.

The following wounds should be referred to the service:

- All Grade 3 and 4 pressure ulcers.
- Static wounds where there is no obvious improvement in wound condition after four weeks of treatment. This should be based on accurate wound measurements.
- Sudden deterioration of wounds despite appropriate management strategies (see Wound Management guidelines/Pressure ulcer management guidelines/Leg Ulcer Management guidelines).
- House bound patients with lower leg wounds that do not respond to current treatment within four-six weeks (complete assessment including Doppler and application of compression has been performed if applicable).
- Complex wounds such as fungating, malignant wounds, or wounds requiring larval therapy or TNP therapy.

There is no service provision for lower limb, chronic oedema or lymphoedema.

Referral Route:
Tissue Viability Service
Tel: 01702 372004

Pressure Relieving Equipment Service
Criteria for referral:
The Pressure Relieving Equipment Service is responsible for co-ordinating and arranging the provision of pressure relieving equipment to service users in the community following assessment and equipment request form completion, by community and secondary care health professionals.

The service will provide pressure relieving equipment such as specialist beds, mattresses and cushions for short term use (up to 6 months or longer if a full review is undertaken on a 10 weekly cycle or as determined by need) to adults in the community where health need is identified.

Referral Route:
Pressure Relieving Equipment Service
Tel: 01702 372004
Email: pressure.relieving@nhs.net
## Intermediate Care

### Care Coordination Service

**Criteria for referral:**

This is a population health service aimed at improving the coordination of health and social care services to support our most vulnerable, living with frailty or multiple or complex needs - to maintain optimum levels of independence and well-being, through provision of effective and coordinated services. It carries three essential components:

- a) Risk Stratification
- b) Assessing and care planning (including MDT as required)
- c) Case Management

Referrals will be accepted via secure email; setting out patient’s name, date of birth, NHS number and reason for referral.

<table>
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<tr>
<th>Referral route:</th>
<th>Castlepoint, Rayleigh &amp; Rochford.</th>
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<tbody>
<tr>
<td>Via</td>
<td>SystmOne</td>
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<tr>
<td>Email</td>
<td><a href="mailto:care.coordinationteam@nhs.net">care.coordinationteam@nhs.net</a></td>
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<tr>
<td>Tel</td>
<td>01702 538241 (CP&amp;R)</td>
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### Collaborative Care (Discharge Support) – CPR

**Criteria for referral:**

The Collaborative Care Team is a health based domiciliary rehabilitation team operating across the Castlepoint and Rochford area. To provide care and rehabilitation packages in peoples own homes to facilitate discharge from hospital or prevent unnecessary hospital admission. New admissions are accepted between 10:00-20:00 hrs daily.

- **Age range:** 16 yrs and over
- **Service provision:** 08:00 to 22:00 7 days per week 365 days per year

People 16 yrs or over who require rehabilitation following a stroke, a neurological event or un-stable fractures. Crisis referrals can be made for people experiencing an episode of ill health that require short term intervention to prevent admission to hospital.

**Referral Route:** Referral is via the Single Point of Referral (SPOR) and while there is a referral form used primarily by the hospital, GP’s are able to provide information over the phone.

<table>
<thead>
<tr>
<th><a href="mailto:spor.referrals@nhs.net">spor.referrals@nhs.net</a> or Tel</th>
<th>0333 015 3481</th>
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<tbody>
<tr>
<td>Out of hours referrals:</td>
<td>Tel: 07813 023277</td>
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### Community Stroke Team (Discharge Support)

**Criteria for referral:**

The Community Stroke Service will support stroke survivors who live and are registered with a GP in Southend, Rochford, Rayleigh and Castlepoint; and their families/carers post discharge from hospital after an acute episode of care following a stroke for up to 6 months.

The service aims to provide support and advice to stroke survivors and their families to help them feel less isolated and have a contact point for further information. On-going OT will be provided by the specialist therapists.

The service provides education and training to patients, carers and local inpatient rehabilitation centres to enable them to manage the stroke specific needs our client group. The team carries out the recommended 6 month review post stroke.

**Referral Route:**

<table>
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<th>Tel</th>
<th>01702 372055</th>
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<tbody>
<tr>
<td>Email</td>
<td><a href="mailto:communitystroke@nhs.net">communitystroke@nhs.net</a></td>
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### Complex Intervention Service - CIS (previously START) – Discharge Support

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<th>Criteria for referral:</th>
<th>Referral Route:</th>
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<tr>
<td>The Complex Intervention Service (CIS) previously START is a joint health and social care based domiciliary rehabilitation/reablement team operating across the Southend area. Their remit is to provide packages in peoples own homes to facilitate discharge from hospital or prevent unnecessary hospital admission.</td>
<td>Referral is via the Single Point of Referral (SPOR) and while there is a referral form used primarily by the hospital, GP’s are able to provide this information by telephone.</td>
</tr>
<tr>
<td><strong>Age range:</strong> 18 yrs and over</td>
<td><a href="mailto:spor.referrals@nhs.net">spor.referrals@nhs.net</a></td>
</tr>
<tr>
<td><strong>Service provision:</strong> 07:00 to 23:00 7 days per week 365 days per year</td>
<td>Tel: 0333 015 3481</td>
</tr>
<tr>
<td><strong>Criteria:</strong> For the health remit of the team this includes people with a rehabilitation need following stroke, neurological event or un-stable fractures. However please note this team also provides a general social reablement service, targeting those with complex care needs.</td>
<td>Out of hours referrals: 07967 614370</td>
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### Cumberlege Intermediate Care Centre (CICC) – Inpatient Unit

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<td>Cumberlege Intermediate Care Centre is a 22 bedded short-term rehabilitation unit based in Rochford for residents who live in the Southend CCG geographical area, or stroke patients from both Southend and Castlepoint/Rochford CCG areas. Patient care is led by a multidisciplinary team including Nursing Staff, Physiotherapists, Occupational Therapists, Rehab Assistants and social workers. The referral criteria includes:</td>
<td>Referral is via the Single Point of Referral (SPOR) and while there is a referral form used primarily by the hospital, GP’s are able to provide this information by telephone. Community referrals will need written confirmation from the GP prior to admission to confirm that the patient is medically stable &amp; able to participate in a rehab programme.</td>
</tr>
<tr>
<td>• 18yrs or over</td>
<td><a href="mailto:spor.referrals@nhs.net">spor.referrals@nhs.net</a> or</td>
</tr>
<tr>
<td>• Rehabilitation needs that cannot be provided in the patient’s own home.</td>
<td>Tel: 0333 015 3481</td>
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<tr>
<td>• Medically fit and able to participate in a rehabilitation programme.</td>
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<td>• Willingness and motivation to participate.</td>
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### Discharge to Assess (SPOR)

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<th>Criteria for referral:</th>
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<td>The Single Point of Referral (SPOR) is a multidisciplinary team providing a professional facing referral management function. Referrals are accepted from professional across both health and social care allowing easy access to a range of intermediate care services and onward referral to the wider health and social care system, without the need for a detailed knowledge of these individual services. In addition this service provides a multidisciplinary assessment service to identify individual patient needs, to support the prevention of further decline. This will include both the avoidance of unnecessary hospital/care home admission and the facilitation of hospital discharge. However this does not cover the delivery of these services; these are delivered through a range of health and social care commissioned and directly provided services.</td>
<td>Referrals are made via the Single Point of Referral (SPOR) and while there is a referral form used primarily by the hospital, GP's are able to provide this information by telephone.</td>
</tr>
<tr>
<td><strong>Referral Route:</strong></td>
<td>Electronic referral to</td>
</tr>
<tr>
<td>Referrals are made via the Single Point of Referral (SPOR) and while there is a referral form used primarily by the hospital, GP's are able to provide this information by telephone.</td>
<td><a href="mailto:spor.referrals@nhs.net">spor.referrals@nhs.net</a> or</td>
</tr>
<tr>
<td>Tel: 0333 015 3481</td>
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## Stroke Early Supported Discharge

**Criteria for referral:**
The service is a stroke specific rehabilitation service including OT, Physio, SLT, Psychology and nurses for patients leaving hospital following a new diagnosis of a stroke (both Hemorrhagic and Ischaemic Strokes). Patients will live and be registered with a GP in Southend, Rochford, Rayleigh and Castlepoint. The service will deliver 45 minutes of required therapies 5 days a week for up to 6 weeks; in accordance with individual care plans and provide a first face to face contact within one working day of discharge.

The stroke survivor must also meet the following criteria:

- New stroke diagnosis and discharge from Acute Hospital
- Medically Stable
- Safe to be managed at home in in a Residential/Nursing Home
- Ongoing Rehab Needs
- Patient Consent

### Urgent Community Response Team - SWIFT

**Criteria for referral:**
This is our community crisis response service (response time 2 hours). SWIFT is a community admission avoidance team that will help patients stay at home when they are feeling unwell rather than be transferred to hospital. The SWIFT service will provide specialist nurse-led care in patients own homes. They will visit patients within two hours of receiving a referral from a healthcare professional to stabilise their immediate health needs. Same day occupational therapy assessment and provision of equipment is available for falls patients to avoid hospital admission.

Inclusion criteria (this list is not exhaustive and we would encourage you to call and discuss each case individually):
- Respiratory Tract Infection
- UTI
- Cellulitis
- Exacerbations of COPD and heart failure
- Dehydration
- Frailty
- Falls requiring urgent OT assessment
- Urgent bloods to guide diagnosis

Exclusion criteria:
- Prime social needs
- Under 18 years of age
- Acute medical emergency
- Asthma
- Falls with LOC, suspected fractures
- Management of behavioural and/or psychological symptoms of dementia
- Mental health needs
- Nursing home residents

**Service Provision:** 08:00 – 22:00hrs 7 days a week
**Age Range:** 18 years and over

### Referral Route:
**SWIFT**
- **Tel:** 07773 478400
- **Email:** communitystroketeam@nhs.net

**UCRT Paramedics**
- **Tel:** 01702 372025

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**Referral Route:**
- **Tel:** 0333 015 3481
- **Referrals being received and accepted from 7 days a week:**
  - **08:00 – 20:00hrs.**
- **Patient No:** 0333 015 3481

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## Specialist Services

### Occupational Therapy Team

**Criteria for referral:**
The Occupational Therapy Team accepts referrals for adults (18+) who have a health or medical condition that affects their ability to live independently at home and/or which significantly affects their quality of life. The team works with patients in their own homes and addresses long and short term health needs. The aim of our service is to maximise independence in performing activities of daily living; to promote dignity and independence, prevent unnecessary admissions to hospital and support discharges.

**Referral Route:**
Email: epunft.duty@nhs.net
Tel: 01702 442128
Unit 8 The Forum
Coopers Way
Temple Farm Industrial Estate
Southend-on-Sea
Essex SS2 5TE

### Podiatric Surgery

**Criteria for referral:**
The scope of practice covered by Podiatric Surgery comprises of all surgical procedures for the correction of deformity; the reduction in pain and improvement of function of the foot and associated structures. In reality this includes such conditions as: hammer toes, claw toes, bunions, tailors bunions, metatarsalgia, flat foot, hypermobility and nail procedures for those who are unsuitable for chemical matricectomy - effective short-term intervention e.g. nail surgery.

**Service provision:** 09:00 to 12:20 - 13:30 to 17:00 Monday to Friday.

**Referral Route:**
Email: epunft.podiatry.service@nhs.net
Tel: 01702 538141

### Podiatry Service

**Criteria for referral:**
The Commissioners have determined the categories of patients who should be granted access to the service, and those categories are:
- People of any age who have diabetes.
- People of any age who have a systemic medical condition, which may render their limbs at risk.
- Those who would benefit from clinically-effective short-term intervention e.g. nail surgery.
- Patients 12 years and over who require Biomechanics/Musculoskeletal.

In addition: Any patient accepted into the service for a course of treatment must have an assessed clinical podiatric need. Home visits are for bedbound patients.

We do not cut non-pathological toe nails, treat verrucae or issue shoes.

**Referral Route:**
The Podiatry Appointments Office
Essex Partnership University NHS Foundation Trust
Rochford Hospital,
Ashingdon House,
Rochford, Essex SS4 1RB
Tel: 01375 364465

For general enquiries and specific comments:
Tel: 01702 538150

### Speech and Language Service (Adult Community)

**Criteria for referral:**
The Adult Community Speech and Language Therapy Team will assist people aged 18 and over who have the following types of problems:
- Communication and/or swallowing difficulties associated with an acquired neurological condition (stroke, TBI, brain tumour etc.).
- Communication and/or swallowing difficulties associated with a progressive neurological condition (MND, Parkinson’s, Multiple Sclerosis etc.).
- Voice problems associated with a range of organic or functional disorders.
- Fluency disorders (stammering).
- Transgender Voice Re-alignment.

**Referral Route:**
Email: epunft.slt.adultreferrals@nhs.net
Tel: 01702 578613
Wheelchair Service – Special Seating and Mobility Team

Criteria for referral:
The South East Essex Wheelchair Service provides the following:
- Manual wheelchairs (self-propelling or transit)
- Indoor/Outdoor powered wheelchairs;

General Criteria for provision of all equipment:
- Required for a minimum of 6 months – no short term loan available
- Be in regular use by patient or supported by friends/relatives or carer (regular use is defined as minimum of four times a week).
- Do not provide transit chairs into residential or nursing home
- Do not provide electric scooters or powered wheelchairs for outdoor only use.

Referral Route:
Email: southendwheelchair.service@nhs.net
Tel: 01702 442145
Please complete the Wheelchair Service referral form which can be requested from the service.

Children’s Services

Asthma / Allergy Service

Criteria for referral:
The Asthma & Allergy service provides:
- Assessment
- Advice
- Support
- Care plans
- Asthma, eczema and allergies training for patients and families

Our team works in partnership with parents, carers and health professionals in caring for children with asthma and allergies. We encourage families to become active participants in their child’s assessment and treatment.

Service Provision: 08:30 – 16:30 Monday to Friday
Age range: up to 16 Years

Referral Route:
Referral is via telephone or email
Email: epunft.paediatric.asthmaallergy@nhs.net
Tel: 01702 372074

Behavioural Play Advisory Service (Jigsaws)

Criteria for referral:
This is a specialist home visiting service for children identified as having developmental delay in more than two areas of development. It is also for children with diagnosed syndromes or disabilities. The service offers a 6 - 12 week programme of play and developmental work on a one to one basis. The aim is to improve the play skills and attention span of children referred; and to support parents to develop strategies to manage sensory behaviours that their child/ren may display. Assessments made, with parents’ consent will be shared with paediatricians and education in support of possible EHCP or formal diagnosis. There is a sleep clinic which children can be referred to if criteria are met and the service will also support feeding issues in children who have safe swallow but previous enteral / Nasogastric feeding.

Age range: Birth to 5 years
Criteria: For children with known diagnosis or developmental delay.

Referral Route:
Referral is via electronic referral on SystmOne.
Email: epunft.jigsaws@nhs.net.
Tel: 01702 482863

Essex School Age and Community Immunisation Service

Criteria for referral:
The Essex School Age and Community Immunisation Services provides the Childhood Vaccination Programme to all children and young people who are:
- Attending school within Essex, Southend-on-Sea and Thurrock
- And/or are registered with a General Practice Essex, Southend and Thurrock
- And/or are resident in Essex, Southend and Thurrock

Referral Route:
Referral is via email: Epunft.SE-Immunisations@nhs.net
General Immunisation queries Tel: 01268 366606
Specialist Immunisation queries Tel: 01268 366605
## Family Nurse Partnership

### Criteria for referral:

The aim of the Family Nurse Partnership is to:
- Improve antenatal health
- Improve child health and development
- Improve economic self-sufficiency

The programme covers the six domains of personal health: environmental health, life course development, maternal role, family and friends and health and human services. The family nurses use programme guidelines, materials and practical activities to work with mums (as well as dads and wider family), on understanding their baby; making changes to their behaviour; developing emotionally and building positive relationships. The in-depth relationship the family nurses develop with their clients and their therapeutic communication skills enable them to connect with the motivations and 'hearts desires' that all first time parents have. In this way; they can guide their clients safely, through what is often a difficult life transition to becoming the parent they want to be for their new baby.

**Service Provision:** Hours of operation fit around the needs of mothers and fathers where possible but in the main are: 08.00 – 18.00, Monday to Friday.

**Age range:** Under 20 years

### Paediatric Community Nursing

### Criteria for referral:

The Paediatric Community Nursing Team (PCN Team) provides clinical nursing care for children that have complex and on-going health needs in the community. The team cares for children between the ages of 0 – 16 years that would need to return to hospital or their GP for their health care needs.

The service operates in partnership with the child and family to promote hospital avoidance, unnecessary hospital admission and facilitation of early discharge. This is encouraged by teaching and supporting children and their families to manage their conditions at home.

**Age range:** 0 – 16 Years

### Paediatric Continence

### Criteria for referral:

The children’s Continence Advisory Service provides specialist treatment; management; advice and support for children and young people with a bladder or bowel dysfunction. The service has overall responsibility for the assessment of children’s continence needs and the provision and supply of continence products.

**Service provision:** Monday to Friday 09:00 – 17:00

**Age range:** 4 – 17 years

### Paediatric Diabetes

### Criteria for referral:

The children’s Community Diabetes Service is a nurse led service that facilitates self/family-management, enabling children, young people and families living with diabetes to make the necessary adjustments to remain well; reducing mortality, morbidity and the need for hospitalisation. The Service provides community based care and support.

**Referral Route:**
- Referral is via Telephone: Tel: 01702 482866

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**Paediatric Community Nursing**

**Referral Route:**
- Referral is via Telephone: Tel: 01702 372076
  - On call mobile: 07966 792396
  - 07:00 – 23:00 hrs, Monday to Friday. (Outside of these hours the service operates an on call system 7 days a week, 365 days a year for urgent enquiries).

**Paediatric Continence**

**Referral Route:**
- Referral is via Email: epunft.paediatriccontinence@nhs.net
  - Tel: 01702 372073

**Paediatric Diabetes**

**Referral Route:**
- Tel: 01702 372017
  - Mobile: 07944 282466
  - Out of Hours – 01438 285000
for children, young people and families with a diagnosis of diabetes and works closely with secondary and primary care services to ensure that the Diabetes care pathway is implemented appropriately according to patient need.

**Service provision**: Monday – Friday 09:00 – 17:00 hrs
The service also offers an out of hours service to children and young people already on the case load.

### Paediatric Liaison

**Criteria for referral:**
The Paediatric Liaison service ensures that there is appropriate and timely information sharing between Secondary Care (primarily Southend University Hospital Foundation Trust – SUHFT) and EPUT Community Children’s Services and other community Children’s services providers in Southend, Castle Point and Rochford. Information includes children and mothers attending hospital for emergency/unplanned care, the maternity unit and for babies admitted to Neo-natal Intensive Care.

**Service Provision**: 08:00 to 16:00hrs Monday - Friday.

**Referral Route:**
Referral is via Email: epunft@paediatricliaison@nhs.net
Tel: 01268 366607

### Specialist Health Visitor for Children with Disabilities

**Criteria for referral:**
The Specialist Health Visitor works alongside paediatricians at Lighthouse Child Development Centre and the Behavioural Play Advisory Service (Jigsaws) offering support to families with complex and life limiting conditions. The Specialist Health Visitor will make assessments and plan care to ensure the children and their families have additional services and support in place. Sleep counselling is offered to families if needed. Help to obtain specialist equipment needed and referral to CWD if appropriate. The Specialist Health Visitor will liaison with other agencies involved in the care of the child/ren to ensure that holistic care is in place.

**Age range**: Birth to 5 years

**Criteria**: For children with additional needs

**Referral Route:**
SystmOne Electronic referral or task
Email: jay.walsh1@nhs.net
Tel: 07583 692625

### Specialist Health Visitor for Perinatal Mental Health – A Better Start (Southend)

**Criteria for referral:**
The aim is to provide extra support and build capacity for those families with low-moderate mental health needs that are primarily supported by primary care, universal services and the local community within the A Better Start wards in Southend.

The Specialist Health Visitors for Perinatal Mental Health work with the named Health Visitors and other community practitioners to provide additional support for parents adjusting emotionally to becoming parents from the antenatal period to around one year of the baby’s life.

This support may include joint visits and work alongside the named Health Visitor, additional supportive visits, invitation to group support (currently a 6 week group called Mindful Mums and Babies), and links to other suitable support networks.

The Specialist Health Visitor can also liaise with the local Perinatal Mental Health Team, who have a more specialist service for women with moderate to severe difficulties, for further support, and if necessary referral to this service.

The service also provides education, support and liaison with the wider workforce working in the Southend Borough Council area to support

**Referral Route:**
SystmOne electronic referral
Email: epunft.perinatalhvs@nhs.net
Tel: 01702 482862
Mobile No's:
07816 965420
07866 609752
families with low-moderate mental health needs during the perinatal period. 
Service Provision: This direct work is primarily with parents and families in the Better Start Wards of Southend.

**Age range:** Mothers (and their partners) who are pregnant or with an infant until around one year of age.

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**Specialist School Nursing**

**Criteria for referral:**
The Specialist School Nursing service provide ongoing support for children, young people and their families with additional and complex needs throughout their school lives from 3 to 19 years; within special and mainstream schools.

**Service provision:** Monday to Friday 09.00 – 17.00 (term time only).
Lead Specialist Nurse - Monday to Friday 09.00 till 17.00 (full time)

**Age range:** 3 – 19 Years

**Referral Route:**
Referral is via telephone
Tel: 01702 507102
Lynsey Payne
The Lighthouse Child Development Centre,
Snakes Lane,
Southend on Sea,
SS2 6XT

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**Speech and Language (Children)**

**Criteria for referral:**
The Speech and Language Therapy Service provides assessment, advice, direct and indirect interventions for patients with speech, language and communication disorders.
The Speech and Language Therapy Service considers the role of parents, carers and other significant people to be vital in maximising effective communication. Much work is therefore concerned with working to improve communicative ability by training and supporting those in the person’s communicative environment.

**Service Provision:** 09.00 to 17.00hrs Monday - Friday.

**Referral Route:**
Referral is via Email: slt.educationenquiries@nhs.net
Tel: 01702 578614

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If you require **urgent** access please call:

**0333 015 3481**

This single number replaces:

- **Intermediate Care** (previously Single Point of Referral [SPOR])
- **Urgent Community Response Team** (SWIFT)
- **District Nurse Liaison**
## Nurse-led Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Details</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Heart Failure Service</td>
<td><a href="mailto:epunft.se.heartfailure@nhs.net">epunft.se.heartfailure@nhs.net</a></td>
<td>01702 482841</td>
</tr>
<tr>
<td>Community Heart Failure IV Diuretics</td>
<td><a href="mailto:epunft.se.heartfailure@nhs.net">epunft.se.heartfailure@nhs.net</a></td>
<td>07580 398380</td>
</tr>
<tr>
<td>Continence Advisory Service (Adults)</td>
<td><a href="mailto:continence.referrals@nhs.net">continence.referrals@nhs.net</a></td>
<td>01702 372014</td>
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<tr>
<td>Diabetes Service</td>
<td><a href="mailto:Diabetes.one@nhs.net">Diabetes.one@nhs.net</a></td>
<td>01702 548094</td>
</tr>
<tr>
<td>District Nursing</td>
<td>[Via SystmOne districtnurse <a href="mailto:liaison@nhs.net">liaison@nhs.net</a>](mailto:Via SystmOne districtnurse <a href="mailto:liaison@nhs.net">liaison@nhs.net</a>)</td>
<td>0333 015 3481</td>
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<tr>
<td>District Nursing Night Service</td>
<td></td>
<td>0333 015 3481</td>
</tr>
<tr>
<td>Community Respiratory Service</td>
<td>The contact number is available 0800 – 2200 7 days a week.</td>
<td>0333 015 3481</td>
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<tr>
<td>Community Respiratory Service</td>
<td></td>
<td>07710 929672</td>
</tr>
<tr>
<td>Home Oxygen Service</td>
<td><a href="mailto:epunft.oxygen.spirometryteam@nhs.uk">epunft.oxygen.spirometryteam@nhs.uk</a></td>
<td>01702 372040</td>
</tr>
<tr>
<td>Spirometry Service Provision</td>
<td><a href="mailto:epunft.oxygen.spirometryteam@nhs.uk">epunft.oxygen.spirometryteam@nhs.uk</a></td>
<td>01702 372040</td>
</tr>
<tr>
<td>Integrated Palliative Care and Register</td>
<td>[Via SystmOne districtnurse <a href="mailto:liaison@nhs.net">liaison@nhs.net</a>](mailto:Via SystmOne districtnurse <a href="mailto:liaison@nhs.net">liaison@nhs.net</a>)</td>
<td>0333 015 3481</td>
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<tr>
<td>Tuberculosis (TB) Service</td>
<td></td>
<td>01702 546251</td>
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<tr>
<td>Wound Care Service</td>
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<tr>
<td>Wound Care Service</td>
<td>Leg Ulcer Service</td>
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<tr>
<td>Wound Care Service</td>
<td>Pressure Relieving Equipment Service</td>
<td>01702 372004</td>
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<tr>
<td>Wound Care Service</td>
<td>Tissue Viability Service</td>
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## Intermediate Care Services

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<tr>
<th>Service</th>
<th>Contact Details</th>
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<tbody>
<tr>
<td>Care Coordination Services CPR</td>
<td>[Via SystmOne <a href="mailto:care.coordinationteam@nhs.net">care.coordinationteam@nhs.net</a>](mailto:Via SystmOne <a href="mailto:care.coordinationteam@nhs.net">care.coordinationteam@nhs.net</a>)</td>
<td>01702 538241</td>
</tr>
<tr>
<td>Care Coordination Southend</td>
<td>[Via SystmOne Complexcare <a href="mailto:coordinationservice@nhs.net">coordinationservice@nhs.net</a>](mailto:Via SystmOne Complexcare <a href="mailto:coordinationservice@nhs.net">coordinationservice@nhs.net</a>)</td>
<td>01702 372060</td>
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<tr>
<td>Collaborative Care</td>
<td><a href="mailto:spor.referrals@nhs.net">spor.referrals@nhs.net</a></td>
<td>0333 015 3481</td>
</tr>
<tr>
<td>Community Stroke Team</td>
<td><a href="mailto:communitystroketeam@nhs.net">communitystroketeam@nhs.net</a></td>
<td>01702 372055</td>
</tr>
<tr>
<td>Complex Intervention Service (CIS) previously START</td>
<td><a href="mailto:spor.referrals@nhs.net">spor.referrals@nhs.net</a></td>
<td>0333 015 3481</td>
</tr>
<tr>
<td>Cumberlege Intermediate Care Centre (CICC)</td>
<td><a href="mailto:spor.referrals@nhs.net">spor.referrals@nhs.net</a></td>
<td>0333 015 3481</td>
</tr>
<tr>
<td>Discharge to Assess (SPOR)</td>
<td><a href="mailto:spor.referrals@nhs.net">spor.referrals@nhs.net</a></td>
<td>0333 015 3481</td>
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<tr>
<td>Early Supported Discharge Stroke</td>
<td><a href="mailto:communitystroketeam@nhs.net">communitystroketeam@nhs.net</a></td>
<td>07773 478400</td>
</tr>
<tr>
<td>Urgent Care Response Team - SWIFT</td>
<td></td>
<td>0333 015 3481</td>
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**Paramedics 01702 372025**
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<th>Service</th>
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<tbody>
<tr>
<td>Occupational Therapy Service</td>
<td><a href="mailto:epunft.duty@nhs.net">epunft.duty@nhs.net</a></td>
<td>01702 442128</td>
</tr>
<tr>
<td>Podiatric Surgery</td>
<td><a href="mailto:epunft.podiatry.service@nhs.net">epunft.podiatry.service@nhs.net</a></td>
<td>01702 538141</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>For general enquiries and specific comments: Tel: 01702 538150</td>
<td>01375 364465</td>
</tr>
<tr>
<td>Speech and Language Therapy (Adult)</td>
<td><a href="mailto:epunft.slt.adultreferrals@nhs.net">epunft.slt.adultreferrals@nhs.net</a></td>
<td>01702 578613</td>
</tr>
<tr>
<td>Wheelchair Service</td>
<td><a href="mailto:southendwheelchair.service@nhs.net">southendwheelchair.service@nhs.net</a></td>
<td>01702 442145</td>
</tr>
<tr>
<td>Asthma/Allergy</td>
<td><a href="mailto:epunft.paediatric.asthmaallergy@nhs.net">epunft.paediatric.asthmaallergy@nhs.net</a></td>
<td>01702 372074</td>
</tr>
<tr>
<td>Behavioural Play Advisory Service (Jigsaws)</td>
<td>Via SystmOne <a href="mailto:epunft.jigsaws@nhs.net">epunft.jigsaws@nhs.net</a></td>
<td>01702 482863</td>
</tr>
<tr>
<td>Essex School Age and Community Immunisation Service</td>
<td><a href="mailto:Epunft.SE-Immunisations@nhs.net">Epunft.SE-Immunisations@nhs.net</a></td>
<td>01268 366605</td>
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<tr>
<td>Family Nurse Partnership</td>
<td>Tel: 01702 482866</td>
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<tr>
<td>Paediatric Nursing</td>
<td>Tel: 01702 372076 On call mobile: 07966 792396</td>
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<td>Paediatric Continence</td>
<td><a href="mailto:epunft.paediatriccontinence@nhs.net">epunft.paediatriccontinence@nhs.net</a></td>
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<tr>
<td>Paediatric Diabetes</td>
<td>Tel: 01702 372017 Mob: 07944 282466 Out of Hours: Tel: 01438 285000</td>
<td></td>
</tr>
<tr>
<td>Paediatric Liaison</td>
<td>epunft@<a href="mailto:paediatricliaison@nhs.net">paediatricliaison@nhs.net</a></td>
<td>01268 366607</td>
</tr>
<tr>
<td>Specialist HV for Children with Disabilities</td>
<td>Via SystmOne <a href="mailto:jay.walsh1@nhs.net">jay.walsh1@nhs.net</a></td>
<td>07583 692625</td>
</tr>
<tr>
<td>Specialist School Nursing</td>
<td>Tel: 01702 507102</td>
<td></td>
</tr>
<tr>
<td>Specialist HV for Perinatal Mental Health – A Better Start (Southend)</td>
<td><a href="mailto:epunft.perintatalhvs@nhs.net">epunft.perintatalhvs@nhs.net</a></td>
<td>01702 482862</td>
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<tr>
<td>Mobile No's: 07816 965420 07866 609752</td>
<td>Tel: 01702 578614</td>
<td></td>
</tr>
<tr>
<td>Speech and Language</td>
<td><a href="mailto:slt.educationenquiries@nhs.net">slt.educationenquiries@nhs.net</a></td>
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