Directory of Services to Support People to Stay Well in Their Communities Over the Winter – Information for Health and Care Professionals

The below table includes a directory of support services, aimed at supporting the public during the winter months, with a specific focus on community and frailty elements.

Health and care professionals can efficiently guide individuals towards the assistance they require, fostering a resilient and healthy community during the challenging winter season. This resource highlights the support available to York residents to navigate winter with confidence and ensuring that help is readily available when needed the most.

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Service name	Details of the service available

1.Adult Social Care Community Team	• **Name of service:** Adult social care is about providing personal and practical advice and support to adults who need help to live an enjoyable life as independently as possible.
	
	• **Eligibility:** In order to get support from City of York Council, you must –
	  ○ be aged 18 or over
	  ○ be living within the City of York Council Local Authority area
	  ○ have needs which are eligible for support based on the National Care Act eligibility criteria (2014)
	• **How to make a referral:** refer directly via Adult Social Care team
	
	• **Opening hours:** Monday -Thursday 9-5pm, 9-4.30pm on Fridays
	
	• **Telephone/email contact:** 01904 555111, Textphone: 07534 437804 adult.socialsupport@york.gov.uk
	• For more information please see guide attached:
	 
	A_quick_guide_to_Adult_Social_Care.pdf

2.Adult Social Care Emergency Duty Team	• **Names of Service**: Contact the Emergency Duty Team for an urgent social care assessment and support outside of normal office hours. They provide advice and guidance, and carry out urgent assessments of adults, young people and children.
	
	• **Eligibility:** All social care, housing and homelessness emergencies
	
	• **Opening hours:**
	  ○ Monday to Thursday: from 5.00pm to 8.30am
	  ○ Weekends: from 4.30pm on Friday to 8.30am on Monday
	  ○ Bank Holidays: 24 hours a day
	
	• **Telephone/email contact:** 0300 131 2131

3.Age UK Out and About Service	• **Name of service: Age UK Out and About Service** Providing support for 6-8 weeks post discharge, helping frail and elderly people to integrate back into their communities, reducing isolation and loneliness and admission avoidance.

	• **Eligibility:** frail and elderly people • **How to make a referral:** this service is free of charge. You can refer directly by calling Information and Advice service on 01904 634061. • **Opening hours:** 9:30- 3:30 pm Monday to Friday • **Telephone/email contact:** 01904 634061, firstcall@ageukyork.org.uk For more information please visit the website Age UK website
4.Asylum Seekers support	• **Name of service:** Asylum Seekers support to some of our most vulnerable patients and families with children, residing in Staycity. To proactively manage their care, the ICB has commissioned bespoke support via Nimbuscare which provides a specialist in-reach service to manage what are often complex needs for these people. • **Eligibility:** Asylum Seekers **How to make a referral:** Patients cannot be referred into this service – this service is solely for Staycity residents. • **Opening hours:** Monday-Friday 8-8pm • **Telephone/email contact:** 01904 943 690, nimbuscare.operationalservices@nhs.net . to find out more please visit Nimbus care
5.Be Independent	• **Name of service:** Be Independent helps citizens to live independently by bringing emergency care and specialist equipment to their home; services can play a key role in supporting their better health and care, and to maintain their own independence, in York. • **Eligibility:** anyone needed specialist equipment to live independently • **How to make a referral:** Be independent professional partners can refer customers here

	• **Opening hours:** General enquiries: 9.00am to 5.00pm, Monday to Friday
	
	• **Telephone/email contact** Telephone: 01904 645000, email: be.independent@york.gov.uk
	
	• Find out more about what Be Independent offers including:
	  ○ York Telecare Response Service
	  ○ Equipment Loan Service

6. Cardiac Prevention and Rehabilitation Team	• **Name of service:** Cardiac Prevention and rehabilitation Team Cardiac Rehabilitation is a service provided by clinical nurse specialists and a specialist physiotherapist following a diagnosis of a heart condition (acute or elective). Patients and their families are provided with up to date information and support to help with their recovery from both a physical and psychological perspective, with the overall aim of getting people back to 'normal' and reducing further heart complications in the future. • **Eligibility:** Post MI/ heart surgery/ TAVI / Stenting procedures • How to make a referral: email yhs-tr.crehab@nhs.net • **Opening hours:** 08.00-16.00 • **Telephone/email contact:** 01904 725821 (Monday to Friday, excluding bank holidays)
7. Community Diagnostic Centres	• **Name of service:** The new Community Diagnostic Centre (CDC) at Askham Bar Community Care Centre, York, and offers a range of services to help diagnose life-threatening conditions, such as cancer and heart problems, more quickly. Provided in partnership between York and Scarborough Teaching Hospitals Foundation Trust and Nimbuscare, the CDC offers a broad range of diagnostics, including checks, scans and tests which patients can be referred to by their GP. Askham Bar is providing: 1. CT – mobile 2. MRI – mobile

3. Dexa
4. NOUS
5. ECHO
6. **Phlebotomy (via Nimbuscare)**
7. **Spirometry / Feno (via Nimbuscare)**
8. **ECG (via Nimbuscare**)
9. **ABPM (via Nimbuscare**)
10. Holter Fitting and monitoring

How to make a referral:

IMAGING

- **Trust referrals:** For all imaging from primary care, refer as usual electronically and the Trust will allocate to the main site or CDC, dependent on the information provided in the referral. and the closest suitable site to the patient's home address (unless requested otherwise). Please put in up-to-date contact details for the patient. Results will be returned electronically to the surgery of the referring clinician.

- **Nimbuscare Provided Modalities**: via email to nimbuscare.cdc@nhs.net Referral information should include: Referral Modality, NHS Number and preferred contact number for patient. Results will be sent back via S1 or EMIS to the patient's registered GP practice.

PHLEBOTOMY at Askham Bar.

- This service is for all patients that require blood testing. GP requires to complete the form on ICE send it to the patient. There is no need to collect blood forms in advance. An appointment can then be booked at the CDC by calling 01904 943690. Service hours are Monday to Friday 8:00-18:00.

Opening times

The centre is open Monday to Friday between 8am to 6pm.
CT scanning is also available on Saturdays between 8am to mid-day.

For more information about CDCs please see:

20240917_CDC Comms Document.do

8.Community Response Team	• **Name of service:** The York Community Response Team (CRT) is a large multi-disciplinary health care team consisting of nurses, therapists, and support workers. The team provide assessment, short term intervention, rehabilitation, reablement and recovery, supporting both discharge and admission avoidance. • The same team also delivers Urgent Community Response (care with 2 hours) and supports the Frailty Virtual Ward, however the CRT element is typically care provided within 1-2 days for a period of around 6 weeks. • **Eligibility:** Patients 18 years and over, within their own home environment (including care homes), registered with a York GP (except Pocklington). • **How to make a referral:** Call the CRT telephone number below • **Opening hours:** 8am – 8pm, 7 days per week, 365 days per year • **Telephone/email contact:** 01904 721343 / 07943876398
9. Continence Advisory Service: Selby and York	• **Name of service: Continence Advisory Service: Selby and York:** ○ Comprises of a team of nurses and physiotherapists who are specialists in the treatment and management of bladder and bowel conditions including urinary incontinence and bowel incontinence. ○ Aim is to treat and cure bladder and bowel dysfunction where possible. When all possible improvement has been achieved the team aims to manage any residual problems as best as possible to maintain each individual's comfort and dignity. ○ The team provides training for community based health and social care staff to broaden and maintain knowledge of continence care; for people in their own homes and in residential care. ○ The team, also acts as a resource for queries and specialist information regarding continence for all health and social care staff within North Yorkshire and York and the East Coast.

	• **Eligibility:** provide services for adults and older people across North Yorkshire running accessible clinics in local areas and providing home visits when required. • **How to make a referral:** Referral is open in most localities, although a letter if preferred from a GP outlining the person's symptoms and previous medical history. Patients may be referred from their GP or other health professional. Continence assessment and reassessment documents can be found here. • **Opening hours:** service operates Monday to Friday 8.30am - 5.00pm (excluding public holidays) • **Telephone/email contact: Telephone: 01904 721200**
10. Dementia Forward	• **Name of service:** Dementia Forward (DF) is the leading dementia charity for York and North Yorkshire that provide support, advice and information to anybody affected by dementia across the county, and have developed a comprehensive range of services; all with people living with dementia at their heart. • **Eligibility:** people living with dementia • **How to make a referral:** via DF service • **Opening hours:** Mon-Fri 9am-4pm • **Telephone/email contact:** helpline on 03300 578592 or by email to info@dementiaforward.org.uk more info on website: https://www.dementiaforward.org.uk/
11. District Nursing	• **Name of service:** District nurses supporting patients living in their own homes, including residential care homes and meet the definition of housebound are able to access the service. Housebound is an individual who is unable to leave their home environment due to a physical or psychological illness. An individual is not housebound if they are able to leave their home environment with minimal assistance from other e.g. family, friends or Carers to attend the Doctor, Dentist, Hairdresser or leisure venues.

	• **Eligibility:** Each patient will be individually assessed to determine their eligibility for home nursing visits by a qualified community nurse". This decision is based on individual needs and clinical judgement. Care needs typically addressed by the district nursing team include:
	  ○ end of life/ palliative care
	  ○ wound care/leg ulcer management
	  ○ catheter management
	  ○ administration of medication.
	  ○ Care of Hickman/PICC lines and discontinuation of chemo pumps
	  ○ This list is not exhaustive, referrals will be triaged, refers will be advised if patients are not suitable for the district nursing service
	• **How to make a referral:** via DN team
	
	• **Opening hours:** 24 hour service accessed via single point of access
	
	• **Telephone/email contact:** 01904 721000

12.Extra Discharge Support Service	• **Name of service:** Age UK Home From Hospital: A free service enabling older people to be more confident and comfortable at home after their hospital stay, support for up to six weeks for older people in York when they leave hospital. • **Eligibility:** those aged 60 or over who live in the York area and who have either: • Been in A&E • Had a day procedure • Had a hospital stay • Have CYC reablement support. Unable to offer support for • those aged under 60 with some complex long term care needs. • **How to make a referral:** refer directly via Age UK • **Opening hours:** Monday - Friday 9:30-3:30pm • **Telephone/email contact:** 01904 726191, ageukyork@ageukyork.org.uk

13. Frailty Advice & Guidance Line	• **Name of service:** The Frailty Advice & Guidance line is ran by a GP with a specialist interest in Frailty working the in the Frailty Crisis Response Hub (see below), and is available to the whole system to offer advice and guidance for frail patients experiencing a crisis in the community in order to support admission avoidance. • **Eligibility:** **Inclusion Criteria:** o Living in own home or residential/care setting with frailty (Rockwood Score of 5 or more prior to acute illness) **Exclusion Criteria:** o Patients requiring acute pathways, eg. PPCI, Stroke, #NOF etc. (*unless YAS clinician feels conveyance is not in the patient's best interests – refer to Advance Care Plan*) o Patients experiencing a mental health crisis requiring assessment by a specialist mental health team o Patients needing acute/complex diagnostics and clinical intervention in hospital • **How to make a referral:** Call YICT team and ask for the Frailty Advice & Guidance Line • **Opening hours: Monday – Friday 8am – 8pm and Sat and Sun 10am – 6pm** • **Telephone/email contact:** 01904 928844
14.Frailty Same Day Emergency Care (FSDEC)	• **Name of service:** Frailty Same Day Emergency Care Located at York Hospital • **Eligibility:** services available to all patients in the York area who fit the following criteria: o Patient is 75 yrs or older AND has a Clinical Frailty Score (CFS) of 5 or more o Patients are likely to be able to return to their usual place of residence same day following assessment o Patient is presenting with a medical condition that cannot be managed in the community NEWS2 is 4 or less and less than 3 in any one parameter.

	Examples of suitable conditions include (but not limited to) UTI, confusion, falls, COPD, heart failure, syncope, cardiac arrhythmia, anaemia, urinary retention, dementia, Parkinson's, low-risk chest pain (now pain free and no ECG changes). Patients ***should not*** be referred to FSDEC if outside of the above criteria or; -Infection risk (e.g, Covid, Flu, D&V) -Suspected #NOF or undiagnosed fracture -Trauma related problems including head injury -Patients requiring specialist pathways (e.g. PPCI, Stroke, red Flag Sepsis, Vascular, Major Trauma)Sepsis, • **How to make a referral:** via the service, call to discuss if unsure of suitability. **Last referral must reach the unit before 5pm, 7 days per week.** • **Opening hours:** Mon – Sun, 8am – 4pm • **Telephone/email contact:** 01904 725199
15. Heart Failure Virtual Ward	**Name of service:** Heart Failure Virtual Ward **Eligibility:** • Patients must have a confirmed diagnose of Heart Failure (HFpEF/ HFrEF) on echocardiogram or cardiac MRI (CMR) scan • Patient has evidence of decompensated heart failure requiring diuresis. • Patient must be registered with a Vale of York GP. • Patient must be 18 years and older and consent to the referral. **How to make a referral:** By email: yhs-tr.heartfailurenursesyork@nhs.net By telephone call: 01904 721344 **Opening hours:** • Monday to Friday 8am to 5pm **Telephone/email contact:** • As above

16. Heart Failure Nursing Services York and Selby	• **Name of service: York and Selby Heart failure nursing services:** The specialist heart failure team are involved with the care of patients with heart failure in both the hospital and community settings, from the time of diagnosis of this condition. • **Eligibility:** ○ **Rapid Access Clinic** – urgent review of any deteriorating heart failure patient with the option to offer IV diuretics to prevent hospital admission ○ **Community clinic –** face to face clinic reviews to optimise management of heart failure with EF <45% until stable ○ **Home visiting –** face to face reviews of housebound patients with an EF <45% • **How to make a referral:** Referrals are accepted from cardiologists, GPs, district or practice nurses. Once a referral is received the team will telephone the patient to make the appointment. Nurses can visit patients in their home or invite them to a clinic setting of their choice. • **Opening hours: Monday – Friday 9:00-17:00** • **Telephone/email contact:** ○ **Health care professionals:**01904 721344 ○ **Patients with EF < 45%:** Urgent 01904 721445 Non urgent 01904 721200 ○ **Patients with EF >45%:** 01904 721445 **The patient advice line closes at 15:30**
17.Health Navigator	• **Name of service**: **Health Navigator:** Health coaching for individuals with long term conditions to provide additional support, to individuals to manage their conditions and stay well. • **Eligibility:** This programme is **currently open to patients registered with Haxby Group Practice, Priory Medical Group, and York Medical Group,** although referrals from

	other York practices may be considered. Typical patient profiles include those with 2+ LTCs that may include: diabetes, respiratory conditions, cardiovascular diseases, and anxiety/depression. • **Exclusion criteria**: Under 18s, Primary diagnosis of an acute mental health issues, cognitive impairment, end of life, homelessness. • **How to make a referral:** Professional referrals accepted only via email. • **Opening hours:** Standard office hours, 09:00-17:00, excluding bank holidays. • **Telephone/email contact:** for general queries only info@hn-company.co.uk Please do send patient identifiable information to this address.
18. Home Oxygen and review service (not an acute service)	• **Name of service:** Home Oxygen and review service (not an acute service) • **Eligibility:** All non-smoking (includes vapes/e-cig) defined as smoke free for a minimum of 12 weeks registered with a GP in the Vale of York who met the BTS criteria for Home Oxygen. • **How to make a referral:** Referrals which have been completed fully including all the mandatory investigation are accepted via GPs (referral forms are available of the Vale of York RSS website). Palliative care team and Consultants**.** • **Opening hours:** 08:30-16:30 Monday to Friday (excluding Bank holidays) • **Telephone/email contact:** 01904 726448 or e-mail yhs-tr.yorkrespiratorynurses@nhs.net
19. Immedicare Telemedicine Service	• **Name of service:** Available to 31 nominated older adults and LD/MH care homes in York, the Immedicare service aims to support response to deterioration early and help keep care home residents within their place of residence, preventing hospital conveyance and calls to other services. • Able to support with all urgent care contacts, with the most frequent calls received for falls, suspected UTI's, chest infections, skin complaints and medication issues. The team provides video-assessment, supervision, advice and guidance,

	and can support staff while awaiting an ambulance, and can perform virtual verification of death where appropriate and issue prescriptions. • **Eligibility:** Care home residents within nominated homes**.** • **How to make a referral:** Homes provided with a secure clinical laptop to access a remote consultation. Staff are encouraged to call as soon as they are concerned about a resident/notice deterioration. • **Opening hours:** 24/7, 365 days a year • **For further information please contact:** **Email:** hnyicb-voy.yorkplacequalitynursingteam@nhs.net **Phone:** 07593 382927- ICB lead for the service.
20. Local Area Coordinators	• **Name of service:** Local Area Coordinators work with individuals and families of all ages and abilities. They help raise awareness of available resources within the local community. • **Eligibility:** support people with a wide range of issues. • **How to make a referral** This directory contains contact details of all Local Area Coordinators working within local communities in York LACDirectory • **Opening hours:** Monday-Friday 9-5pm • **Telephone/email contact: via** LACDirectory If your area isn't covered by a Local Area Coordinator, contact our Community Facilitator.
21. Long Covid Service	• **Name of service: Long Covid Service** ○ Providing practical support and advice to patients with Long Covid and ongoing post viral symptoms, aiming to give patients the skills to self-manage their symptoms. ○ Via telephone, Living with Covid Recovery app and F2F appointments.

	○ The team is Consultant led, with in-house specialist Occupational Therapists providing support with fatigue management, cognitive issues and vocational rehabilitation, specialist Physiotherapists supporting patients with breathlessness management and return to activity, a dedicated Psychologist and strong links with Talking Therapies to support emotional wellbeing. ○ Patients have an initial holistic assessment by specialist nurses, are enrolled onto Living with Covid Recovery app, offered on-line Group Education/self-management sessions to give an overview of Long Covid symptoms and management. Onward specialist referrals following completion of the group sessions. **Eligibility:** ○ Referrals accepted from York, Selby, Scarborough, Whitby and Ryedale GPs. Referrals from other local HCPs following discussion. ○ Over 16yrs, with ongoing post viral symptoms for 12wks or more following infection. ○ Other causes for symptoms must be ruled out prior to referral by relevant blood tests, CXR and ECG as appropriate. ○ Patients should complete the C-19 YRS screening tool prior to referral. **How to make a referral:** Via Choose and Book, professional letter **Opening hours:** 09.00-17.00 Mon - Fri **Telephone/email contact:** Office No. 01904 721506 Email: yhs-tr.longcovidmdt@nhs.net
22. Medical Same Day Emergency Care (MSDEC)- **York Hospital**	• **Name of service: Medical SDEC** is the provision of same day care for emergency patients who would otherwise be admitted to hospital. Under this care model, patients presenting at hospital with a suspected medical condition not suitable for referral elsewhere when in the community can be rapidly assessed, diagnosed, and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.

	Consider Medical SDEC first, no pathways, using the standardised exclusion criteria below. • **Eligibility** **Inclusion criteria:** o NEWS score <5 and/or 3 in one parameter, and age 18+ o A medical condition is the primary working impression (ie. no trauma/surgical/urology/ENT problems etc.) o All medical patients will be considered for SDEC unless meeting exclusion criteria o All GP/Primary Care referrals which meet criteria o See below for additional criteria for patients with chest pain **Exclusion criteria:** o Not suitable for management via primary care or community pathway o Trauma/surgical/gynae presentations o NEWS2 score ≥5 and/or 3 in any one parameter o Acute mental health crisis o Intoxicated (alcohol/drugs) o Requires isolation o New oxygen requirement o Active bleeding o Requires specialist pathway (stroke, STEMI, vascular etc.) o Confirmed diagnosis where admission is required **CHEST PAIN EXCLUSIONS** o Sudden onset of severe or ongoing pain o Acute ecg changes o Pain occurring with minimum exertion o Pain lasting longer than 15 mins o Nausea/vomiting/sweating/syncope o Pain radiating to left arm/jaw/back • **How to make a referral:** o In-hours, if patient meets criteria, bring patient straight to Medical SDEC - no phone call o Out-of-hours, call unit to discuss/agree referral before conveying o Medical SDEC is located at Second Floor, Junction 5 at YDH

	○ If patient has any infective symptoms that require isolation, but otherwise meets criteria, call to discuss ○ If conveying directly to the unit, please record in ePR under Clinical Outcome > Meets criteria for hospital conveyance > SDEC York Medical > Accepted ○ If SDEC then decline to accept patient at point of handover, amend ePR Clinical Outcome screen to say referral Declined and add notes in comment section • **Opening hours:** **5 days a week** (Monday – Friday) ○ 08.00-18.00: phone call not required*, unless IPC risk ○ 18.00-08.00: call ahead to discuss/agree referral **2 days a week** (Saturday-Sunday) ○ 09:00 – 15:00 phone call not required*, unless IPC risk ○ 15.00-09.00: call ahead to discuss/agree referral York SDEC now located at Ward 24, Junction 5, 2nd floor • **Telephone/email contact:** ○ SDEC Direct Line: 01904 726024 (to call first before bed managers) ○ Bed Manager: 01904 725986 ○ SDEC Consultant: 01904 721247 York Hospital - Medical Same Day Em
23. Mental health support /other support	• **Crisis Line – York (TEWV):** a free phone line, open 24 hours a day, 7 days a week. For all ages, offering support for anyone in a mental health emergency. 0800 0516 171 • **The Haven:** offers out of hours mental health support to anyone aged 16 or over. Monday to Friday 6pm-10pm and Weekends 12pm -10pm. 30 Clarence Street, York, YO31 7EW • **Ways to Wellbeing:** Connecting people to local community support to make them feel better, phone number: 01904 621133, Option 4 email waystowellbeing@yorkcvs.org.uk. Mon - Fri 9am - 4.30pm

	• **York Carers Centre:** an independent charity to ensure unpaid carers throughout York have access to confidential information, advice and support, phone number 01904715490 enquiries@yorkcarerscentre.co.uk .The telephone lines are open Monday to Friday 9.30am to 4.30pm (4pm on a Friday) for information and advice. Free evening Advice Line on Wednesdays from 5 to 8pm on main number: 01904 715 490. • **Live Well York:** an information and advice community website for adults and families. They have a page signposting to health and wellbeing support in York. www.livewellyork.co.uk • **Qwell**: a safe and confidential space online to share experiences and gain emotional wellbeing and mental health support from users and qualified professionals. https://www.qwell.io/
24. Move the Masses	• **Name of service:** Move the Masses is a charity which aims to create healthy communities by enabling people to improve their wellbeing through exercise. One of their most well known projects is called Move Mates, which sees volunteer walking buddies pair up with people who do not have the confidence to go out of their home by themselves. • **Eligibility:** people who do not have the confidence to go out of their home by themselves. • **How to make a referral:** via Move the Masses team • **Opening hours:** Monday - Friday 9-5pm • **Telephone/email contact hello@movethemasses.org.uk Call 01904 373017** • Further information on the activities offered by them can be found here.
25. One Team	• **Name of service:** The One Team is multi-provider collaboration that meets daily to collaborate in the provision of support to enable patients to be discharged to their own homes. The team consists of CRT, YICT, Reablement and

	Social Care, Domiciliary Care Providers, voluntary care services supporting discharge and the York Hospital Discharge Team. • **Eligibility:** Inpatient at York Hospital suitable for discharge to home with support. • **How to make a referral:** N/A – all suitable patients at York Hospital reviewed routinely.
26. Pharmacy First	**Name of service:** The Pharmacy First service builds on the NHS Community Pharmacy Consultation Service (CPCS) which has run since October 2019. The service enables patients to be referred (not signposted) into community pharmacy for a minor illness or an urgent repeat medicine supply. The new Pharmacy First service, launched 31 January 2024, enhances what was CPCS and introduces a third element to the service – 'Clinical Pathways', which enables community pharmacies to complete episodes of care for 7 common conditions following defined clinical pathways. • Pharmacy First 7 common conditions: • Uncomplicated UTI – women 16-64 years • Shingles – 18 years and over • Impetigo – 1 year and over • Infected Insect Bites – 1 year and over • Sinusitis – 12 years and over • Sore Throat – 5 years and over • Acute Otitis Media – 1 to 17 years Further information, patient group directions and protocols can be found at Community Pharmacy advanced service specification: NHS Pharmacy First Service When a patient visits a community pharmacy with one of these conditions, the pharmacist will offer the patient advice, treatment or refer the patient to a GP or other healthcare professional if needed. Guidance on escalation is found within Annex D shared by the ICB. If you require a copy, please contact: hnyicb-ny.pharmacycontracts@nhs.net. • Pharmacy First referrals for minor illness (previously Community Pharmacist Consultation Service (CPCS)). • Pharmacy First urgent repeat medicines supply service.

Eligibility:

- The Clinical Pathways element of Pharmacy First (7 common conditions) can be accessed by the age ranges listed above and further information can be found at Community Pharmacy advanced service specification: NHS Pharmacy First Service and appendix 1 Aide-Memorie for Pharmacy First.

- Minor Illness referrals for Pharmacy First can be accessed by patients over 1 year old. Further information can be found in Appendix 2 which includes what conditions are suitable for referral.

- Urgent Repeat Medicines Supply for Pharmacy First is for patients who need urgent access to their repeat medication outside of their GP practice opening times and bank holidays. This does NOT include Controlled Drugs.

How to make a referral:

- Clinical Pathways Pharmacy First (7 common conditions) are accessed by a digital referral from a GP practice or NHS 111 or a patient visiting a participating community pharmacy with one of the 7 common conditions e.g. via PharmRefer.

- Minor Illness Pharmacy First referrals are accessed by a digital referral from a GP practice or NHS 111. A digital referral is required to access this service as outlined in the Community Pharmacy advanced service specification: NHS Pharmacy First Service- e.g. via PharmRefer.

For both the Clinical Pathways and Minor Illness elements of Pharmacy First, a digital referral needs to be sent to the community pharmacy of the patients' choice. A digital referral means a patient can be treated for either the minor illness pathway OR the clinical pathway. This reduces the chance of the patient being escalated back to their GP practice as two pathways can be explored under a digital referral. If the patient is with a SystmOne practice, please see Appendix 3 for how a referral is made. If the patient is with an EMIS practice, please see Appendix 4 for how a referral is made.

- Urgent Repeat Medicines Supply Pharmacy First is accessed by a patient contacting NHS 111 outside the opening hours of

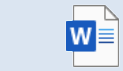
	their GP practice and bank holidays. This does NOT include Controlled Drugs. **Opening hours:** • Clinical Pathways Pharmacy First (7 common conditions): Community pharmacy opening hours are available on Find a Pharmacy • Minor Illness Pharmacy First referrals: A digital referral for this service is available when the patient's GP practice is open or contacting NHS 111. A consultation with a pharmacist is available when the community pharmacy is open. • Urgent Repeat Medicines Supply Pharmacy First: NHS 111 **Telephone/email contact:** • Contact details for a community pharmacy can be found at Find a Pharmacy. • Contact details for a GP practice can be found on their website. • NHS 111 Appendix 1: Pharmacy First - Aide Memoire.pdf Appendix 2: Minor Illness Conditions.pdf Appendix 3: HNY%20Pharmacy%20First%20Referral%2 Appendix 4: HNY%20Pharmacy%20First%20Referral%2
27. Practitioners Guide to Carers Support in York	• Practitioners Guide To Carers Support in York One document with all the headline information that Health teams need to identify, support and signpost carers in York.
28. Rapid Assessment Therapy (RATS)	• **Name of service:** (RATS) Rapid Assessment Therapy team are a group of occupational therapists' physiotherapists and social workers who work within ED and cover the frailty FSDEC and urgent care centre. • **Eligibility:** The RATS team focus is admission avoidance rapid assessment and discharge. They are able to access support services and step-up patients in the local area via CRT, IPU or

	temporary respite. They have greater access to these services than other therapy teams in the acute setting. • **How to make a referral:** They team take referrals from each area via a morning and afternoon handover but can also screen and see patients who are frail or have mobility issues • **Opening hours:** The RATS team operate on a 7 days service 8:00 till 20:00 cover. • **Telephone/email contact:** To contact any members of the RATS team for advice or to handover patients who have attended ED, you can contact on 01904 726656.
29.Reablement (Adult Social Care Intensive Support Service)	• **Name of service:** Reablement can help people who need support with daily activities because, for different reasons, they are finding it more difficult to do them. • Often provided when a person is discharged from hospital and needs support to get back to their usual level of independence ('step-down'), or when they have experienced a stressor event in the community and require support for a time-limited period to get back to their baseline ('step-up'). • **Eligibility:** The service is for anyone over the age of 18 who is eligible for social care support and who would benefit from a period of reablement. It is not suitable for people who already have a long term care provider or people who have a serious illness which requires specialist care and pain support (palliative care). • **How to make a referral:** refer directly via Adult Social Care • **Opening hours:** Monday-Friday 9-5pm • **Telephone/email contact:** Adult Social Care on 01904 555111 adult.socialsupport@york.gov.uk, **emergency outside office hours**, or at the weekend contact Emergency Duty Team for advice on 0845 0349417. • For more information please see guide attached:

	 Reablement_print_artwork_file.pdf
30.Social Prescribing in York	• **Name of service: Social Prescribing** is a term which means linking people to non-medical sources of support to improve people's health and wellbeing. Social Prescribers are not Support Workers, Counsellors, Social Care or Mental Health Workers – they support patients to connect with these services **Primary Care Link Workers** are part of the Social Prescribing Team at York CVS. The Primary Care Link Workers are Social Prescribers based in GP surgeries across York, working alongside individuals to get to know them, and ultimately help them improve their health and wellbeing. • **Eligibility:** people with social issue, (e.g. loneliness, isolation, financial problems), social prescribing helps provide individuals with an alternative to medical intervention. The team supports people aged 18+ living in the area served by City of York Council. • **How to make a referral:** via GP practice or self-referrals. • **Opening hours:** Monday-Friday 9-5pm • **Telephone/email contact: 01904 437911** More information on the York CVS website.
31. St Leonard's Hospice @Home and Carer Support service	• **Name of service:** Services supported by Single Point of Coordination re: ○ York Hospital's Macmillan Community Palliative Care Clinical Nurse Specialist service ○ St Leonard's Hospice@Home service ○ St Leonard's Sunflower Wellbeing Hub ○ St Leonard's Carer Support service ○ St Leonard's Bereavement Support service (call our dedicated bereavement phone number 01904 777 760) ○ Marie Curie night sit referrals and allocations • **Eligibility:** The referral criteria to access Carer Support is essentially:

	○ Patients must be 18 years of age or above and have a life limiting condition. ○ All referrals must be Fast Track funding eligible. ○ Patients must consent to a referral being made to the Carer Support Service or a Best Interests decision made on their behalf. ○ Patients must be registered and assigned to the District Nursing service. ○ All patients must have a carer in need of a break, whom otherwise would not be able to get out due to their caring responsibilities. • **How to make a referral:** via Single Point of Coordination team • **Opening hours:** The service operates daily from 8.00am until midnight. The **Hospice@Home service** is extending from 8am – 12mn to a full 27/7 service from January 2024 to enable us to care for more patients in their own homes. This is a responsive service that prevents admission to hospital but also enables rapid discharge home to die if patients are identified in ED. Contact with SPOC to co-ordinate support as an alternative to 999 is crucial. • **Telephone/email contact** A single point of co-ordination for end of life and palliative care advice and support, phone number 01904 777 770. Access to the Hospice@Home Leaflet and Referral Criteria: Hospice@Home - St Leonard's Hospice (stleonardshospice.org.uk)  Referral Criteria for H@H.docx
32. TEWV: **Multi-disciplinary team (MDT)**	**Name of service: Multi-disciplinary team (MDT) meetings:** • MDT meetings have been created to allow professionals from a wide range of services to come together to discuss and meet their client's needs. • The meetings cover a variety of physical, mental and bio-psychosocial needs. This can help tailor and formulate a plan

	to meet someone's overall needs, rather than a specific need in isolation. • By professionals coming together to discuss cases they can identify what treatment / approach would be most effective and often discover new and alternative approaches. • The meetings can also ensure multiple needs are met at one time, it's a coordinated response with clients being referred to the right service at the right time rather than waiting for referrals to other services further down the line or discovering an initial referral wasn't appropriate. • Meetings are held twice monthly, diary slots offered. For more information contact tewv.transformationnyy@nhs.net.
33.TEWV: Menta Health services for young people and adults	**Menta Health services for young people and adults available from TEWV:** 1. Home - York and Selby Talking Therapies 2. Acute hospital liaison service in North Yorkshire - Tees Esk and Wear Valley NHS Foundation Trust 3. Community learning disability service in the Vale of York for adults - Tees Esk and Wear Valley NHS Foundation Trust 4. Community mental health services for older people in York and Selby - Tees Esk and Wear Valley NHS Foundation Trust 5. Community mental health services in the Vale of York for older people - Tees Esk and Wear Valley NHS Foundation Trust 6. Early intervention in psychosis service in York and Selby for young people and adults - Tees Esk and Wear Valley NHS Foundation Trust 7. Outreach recovery service for adults in York and Selby - Tees Esk and Wear Valley NHS Foundation Trust 8. Individual Placement and Support (IPS) service for adults - Tees Esk and Wear Valley NHS Foundation Trust

	9. Crisis resolution and intensive home treatment service (CRHT), Trustwide, for people aged over 16 years old - Tees Esk and Wear Valley NHS Foundation Trust
34. TEWV: First Contact Mental Health Practitioners	• **Name of service:** The First Contact Mental Health Practitioner Team (FCMHP) is a multi-disciplinary health care team consisting of nurses, occupational therapists, and social workers. The team provide assessment, short term intervention, and appropriate signposting within Primary Care. The Team are based across North Yorkshire and York, and have practitioners based in GP Practices. • **Eligibility:** Patients that are not currently under a Secondary Mental Health Team that are needing support for their Mental Health. • **How to make a referral**: Contact your local GP Practice to book an appointment with the FCMHP. • **Opening hours:** Vary depending on local GP Practice. • **Telephone/email contact:** Local GP Practice Number, pleases see document attached  FCMHP Surgeries and Contact Informati
35. Urgent Community Response Team	• **Name of service:** The Urgent Community Response Team (UCR) provides urgent care to people in their homes (including care homes) to avoid hospital admissions, and care is typically provided within 2 hours. • Conditions typically referred to Urgent Community Response Teams include falls (with no apparent serious injury requiring hospital admission), reduced function/mobility/decompensation of frailty/confusion/delirium caused by a minor stressor event such as a UTI, cellulitis, chest infection.

	• **Eligibility:** Over the age of 18 experiencing a health or social care crisis that requires urgent treatment or support within 2 hours and can be safely delivered in the home setting. Patient's must be registered with a York GP to access this service. • **How to make a referral:** UCR referrals are made via the CRT single point of contact. This is a clinician-to-clinician triage conversation to establish suitability of referral for UCR service. • **Opening hours:** 8am – 8pm, 7 days per week, 365 days per year • **Telephone/email contact:** 01904 721343 / 07943876398
36.Virtual Frailty Ward	**Name of service:** The Virtual Frailty Ward (Hospital at Home) offers a safe community-based alternative to hospital for patients living with frailty. Patients will be overseen by a Consultant Geriatrician with daily monitoring, and treatments provided at home by a multidisciplinary team to enable patients to remain independent whilst recovering. **Referral inclusion criteria:** • Aged 65+ and in acute crisis or in need of early supported discharge • Rockwood score of 4 or more • Registered with a York GP • Can independently mobilise to the toilet • Can be safely managed at home **Referral exclusion criteria:** • Cannot be seriously injured • Not be in a mental health crisis • Cannot need end of life care. • **How to make a referral:** The ward take verbal referrals only as it is important to have a discussion with the referring clinician. This is to ensure the ward can meet the patients' needs both clinically and in a timely way.

	If you feel your patient meets the FVW criteria and would benefit from being cared for by the FVW team rather than being admitted to hospital, please call the Frailty Virtual Ward office on 01904 721483. The ward can accept referrals Monday to Friday between 8am and 4pm. For patients referred in the morning we will see the patient that afternoon, for patients received in the afternoon we will see the patients the next morning. Patients should consent to being referred to the FVW and should be safe to manage independently overnight. On acceptance to the ward, a pop up box will appear in the patient's Systmeone record to confirm the admission. • **Opening hours:** 24/7. Referrals accepted Monday to Friday between 9am and 4pm • **Telephone/email contact:** If you think a patient would benefit form care from the Virtual Frailty Ward, please call the Virtual Frailty Ward office on 01904 721483. The ward also welcomes any clinical queries.
37.York Integrated Care Team	• **Name of service:** The York Integrated Community Team (YICT) is a multi-disciplinary Anticipatory Care Team that provides an initial Comprehensive Geriatric Assessment and then regular reviews thereafter to ensure concerns identified are addressed early to prevent crisis situations. • An agile, holistic, empathetic & personalised response is at the core foundation of what YICT offer. YICT also provide an in-reach service to expediate and support discharges from York Hospital when capacity allows, and patients on the YICT caseload can get in touch with the team directly when in need of support. • **Eligibility:** The most frail and vulnerable residents in York. • **How to make a referral:** Refer directly via YICT team • **Opening hours:** YICT are available 8-9pm, 7 days a week to support patients coming from RATS in ED or as part of the In-reach service.

	• **Telephone/email contact:** 01904 928844, nimbuscare.yict@nhs.net
38. York Place Quality and Nursing Team- Care Provider Support	• **Name of service:** Care Provider Support, ICB Quality and Nursing Team. work as part of an integrated quality team alongside North Yorkshire Council and closely with other partner Local Authorities to promote delivery of high quality care. • Support delivery of best practice through React to Falls Prevention, React to Red, Identifying and Responding to Deteriorating Residents and Improving Hydration training programmes. Act as a link between health and social care services, leading workforce and leadership in the care sector and closer integration between services through digital enhancement. • **Eligibility:** quality improvement support to all care providers across North Yorkshire and York • **How to make a referral:** via York Place Quality Nursing Team • **Opening hours:** Monday-Friday 9-5pm • **Telephone/email contact** hnyicb-voy.yorkplacequalitynursingteam@nhs.net • Find out More About our Quality Assurance and Improvement Team- Working With Care Providers Across North Yorkshire and York • **MULTIDISCIPLINARY SUPPORT TO INDEPENDENT CARE PROVIDERS,** please see document for more details: QAIT offer June23 V4.docx