Health Overview & Scrutiny Committee **12 March 2014**

Report of Rachel Potts, Chief Operating Officer, NHS Vale of York Clinical Commissioning Group

Urgent Care and Winter Pressures Money Update

Commenced November 2013:

Integrated hospital/community team; this team has been provided with additional funding to continue to support individuals outside of a hospital setting until March 2014. The scheme is being evaluated to understand the impact of this additional team over and above the core community nursing service.

Commenced December 2013:

Emergency Department workforce; additional funding has been committed to support the hospital to provide additional Registrars and senior nurses to work in the Emergency Department (ED) during the winter period. The aim is to enable more people to be discharged from ED following senior clinical review and decision making. ED report a positive change in the way communication is taking place and attributes this to influence of clinical educator post. Changes in senior nursing have also given them more a more autonomous role and the addition of senior cover at evenings and weekends, and additional SpR support from 8pm-6am, has also been seen to improve turnaround speeds. York Teaching Hospitals NHS Foundation Trust (YTHFT) report they are currently on track to achieve the 95% 4-hour ED target for February 2014 and possibly Q4.

Emergency Care Practitioners; an additional three members of staff from the Yorkshire Ambulance Service have been employed to work alongside regular ambulance crews to attend falls, faints and minor injuries. This service aims to see and treat individuals in the home or at the scene instead of conveyance to hospital. Similar pilots in our locality have shown a 50% reduction in conveyance to the ED for minor call outs. This scheme has been ongoing since 02/12, 268 tasks up to end December. 238 in VoY area, 14 in East Riding. 35% not conveyed during December 2013 and 44% in January 2014; reducing ED attendance, admission and discharge planning requirements. This scheme will continue to be supported under the Better Care Fund.

Extension of the Rapid Access and Treatment Service; into the early evening; the joint hospital and social care team has received additional funding to increase the hours of support available. This will help to ensure that packages of care are put into place as quickly as possible to prevent unnecessary admission to health and/or social care beds. Additional social care staff commenced in December 2013 and additional Physiotherapy and Occupational Therapy staff joined from February 2014. The team work to discharge patients up to 8pm and therefore have been able to send more patients home and reduce the number of tea-time admissions.

Additional social work posts; additional hours funded to support the main reablement teams during the winter period and optimise the number of individuals supported. This simply provides additional social care capacity to manage the discharge of patients.

The CCG are awaiting a full dataset for both of the above projects from City of York Council. Representatives were meeting w/c 3 March to discuss.

Homeless support worker; this project is providing funding for a support worker for the three busiest evenings of the week within the Emergency Department. The support worker works with staff to identify homeless patients who have no medical need and transfer them to the ArcLight centre for support. This project commenced on the 23/12 and during the first 5 weeks 14 unique patients were supported out of ED, into ArcLight and then onward referred to supporting agencies. There has been excellent staff and patient feedback to this scheme.

Block and spot purchase of step-up and step-down beds; this project increases the bed capacity available for patients to be transferred to if they require step up, or step down support from the acute hospital. This capacity aims to ensure that individuals do not remain in hospital beds when they may be appropriately supported in other settings, and hence which maintain patient flow across the health and social care system. There have been some difficulties in finding beds in the private care homes to use for this project. More work will be done around delayed transfers of care over the next six months to provide more robust plans prior to winter 14-15.

Commenced January 2014:

Hospice At Home; this project is providing additional weekend and evening support to individuals on an end of life pathway to enable them to die at home when at the end of their life, if this is their place of choosing. The Hospice@Home scheme has recorded 34 interventions in January and so far analysed the data of 21 of these patients. 14/21 of these patients died in their place of choosing. More analysis of the data is underway to understand the impact on hospital beds alongside quality of care for patients, and once an impact assessment is completed it is possible that this initiative may continue to be supported under the Better Care Fund.

Patient Transport; funds have been allocated for additional discharge support by Age UK to ensure elderly patients can be discharged in a timely way. The scheme provides transport home at times when other patient transport services are not available. If required, help can also be provided when individuals get home and carer support can be provided overnight to support individuals. This service has been well received; data shows a good spread of areas within the hospital using the service and they received 38 referrals in the first 19 days of operation. Further data around the service response times and impact at weekends has been requested from Age UK.

Equipment; additional funding over the winter period to ensure that there are no delayed discharges due to lack of availability of equipment, including items such as beds (30), mattresses (40) and hoists (4). The direct impact is difficult to measure, however there will be a staff survey and review of data around speed of provision at the end of the quarter.

The CCG have requested and are awaiting an interim dataset to assess the relevance of the equipment on patient discharge.

Yet to commence

Care Homes Support Project; this project is currently being developed with partners to be implemented in the near future as one of the integrated hub schemes for the Better Care Fund. It aims to support care homes in the management of vulnerable patients and prevent unnecessary admissions to hospital or to other escalation beds. Where individuals need to be admitted for elements of their care, the scheme will aim to support discharge at the earliest appropriate opportunity. This pilot project will be extended beyond the winter pressure funding to enable it to be implemented and tested fully.

Community Single Point of Access; this project will set up a single point of access for health and social care professionals to call for referral or advice. The initial pilot is being developed in partnership with Yorkshire Ambulance Service NHS111 service and will be sustained beyond the winter pressure funding to enable testing of the model on improved pathways of care. This project responds to one of the key issues identified by the community in recent engagement events run by the CCG for a single point of access to services. This scheme will commence during March 2014, with the CCG agreeing support for a 6 month trial; to test its function as an enabler for other projects.

Projects halted

Phlebotomy Outreach Services; this project did not commence. YTHFT have informed the CCG they are putting together a fuller business plan for a more sustainable service which will be part of the Trust service redesign plans.

Abbreviations

CCG – Clinical Commissioning Group

ED – Emergency Department

SpR - Specialist Registrar

VoY – Vale of York

YTHFT – York Teaching Hospitals NHS Foundation Trust.