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.

Services:

1. Frailty Advice & Guidance Line
2. Frailty Crisis Response Hub
3. Community Response Team
4. Urgent Community Response Team
5. Virtual Frailty Ward
6. York Integrated Care Team
7. Adult Social Care Community Team
8. Adult Social Care Emergency Duty Team
9. Reablement (Adult Social Care Intensive Support Service)
10. Extra Discharge Support Service
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17. Immedicare Telemedicine Service
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23. Dementia Forward
24. Be Independent
25. Move the Masses
26. District Nursing
27. One team

Service name	Details of the service available
1.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 to Friday 9am – 8pm (increased hours during junior doctor strikes) • **Telephone/email contact:** 01904 928844
2.Frailty Crisis Response Hub	• **Name of service:** The York Frailty Crisis Hub is a new service for this Winter and is a fully integrated collaborative team from four different providers working together at Acomb Garth Community Centre to support and keep people that are vulnerable and frail safe in their homes whenever possible, whilst respecting people's wishes. • The team comprises:

	○ GP with a specialist interest in Frailty (provided by the York Integrated Community Team) ○ Social worker (provided by the Local Authority) ○ Social prescriber (provided by York Community and Voluntary Sector) ○ Community therapist (provided by the Community Response Team). • **How to make a referral:** referral is via the usual referral routes of the individual services that make up the hub and cases will be discussed in a multidisciplinary setting and may result in a collaborative response.
3.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
4.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
5.Virtual Frailty Ward	• **Name of service:** The Virtual Frailty Ward (VFW) is a Geriatrician-led service, delivered by York Hospital / CRT, and enables people to receive hospital-level care in their own home. • **Eligibility:** Frail and a requirement for hospital-level care that can be safely and effectively delivered by the FVW team in the person's own home. • **How to make a referral:** Patients are primarily identified by the teams at York Hospital, including RAFA/RATS/UCR/CRT. • **Opening hours:** 24/7 • **Telephone/email contact:** If you think a patient is suitable for the Virtual Frailty Ward, call CRT on 01904 721343.
6.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
7.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

8.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:** o Monday to Thursday: from 5.00pm to 8.30am o Weekends: from 4.30pm on Friday to 8.30am on Monday o Bank Holidays: 24 hours a day • **Telephone/email contact:** 0300 131 2131
9.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
10.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
11.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

12.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.
13.Frailty Clinic Assessment Service	• **Name of service:** Frailty assessment is a preventative service aimed at catching patients before they have falls or their condition deteriorates, as well as addressing chronic conditions and identifying any mental, social or physical health and memory concerns early. The aim is to reduce the number of hospital admissions by keeping patients healthy and safe at home for as long as possible. • **Eligibility:** It's for patients who are showing signs of frailty and at risk of deteriorating clinically in the months ahead. • **How to make a referral:** via Nimbuscare

	• **Opening hours:** Clinics take place at Acomb Garth Community Care Centre every Wednesday, from 9am to 1pm. • **Telephone/email contact** 01904 943 690, nimbuscare.operationalservices@nhs.net . For more information, please visit Nimbuscare website
14.Social Prescribing in York	• **Name of service:** 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. • **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.
15.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.

16.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: via** Nimbus care • **Opening hours:** Monday-Friday 8-8pm • **Telephone/email contact:** 01904 943 690, nimbuscare.operationalservices@nhs.net . to find out more please visit Nimbus care
17.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:** sam.varo@nhs.net 07593 382927- ICB lead for the service.
18. 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
19.Frailty Same Day	• **Name of service:** Frailty Same Day Emergency Care Located at York Hospital

Emergency Care (FSDEC)	• **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 • **Opening hours:** service available 7 days per week from 08:00, last routine referral is 15:00. • **Telephone/email contact:** 01904 726616
20.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.
21. St Leonard's Hospice @Home and Carer Support service	• **Name of service:** Services supported by Single Point of Coordination re: o York Hospital's Macmillan Community Palliative Care Clinical Nurse Specialist service o St Leonard's Hospice@Home service o St Leonard's Sunflower Wellbeing Hub o St Leonard's Carer Support service o St Leonard's Bereavement Support service (call our dedicated bereavement phone number 01904 777 760) o Marie Curie night sit referrals and allocations • **Eligibility:** The referral criteria to access Carer Support is essentially: o Patients must be 18 years of age or above and have a life limiting condition. o All referrals must be Fast Track funding eligible. o Patients must consent to a referral being made to the Carer Support Service or a Best Interests decision made on their behalf. o Patients must be registered and assigned to the District Nursing service. o 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
22. 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 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/
23. 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/
24.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
25. 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.
26. 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
27. 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.