

1.18.8 South Home Visits

How will you flexibly manage surges in demand for home visits, specifically in rural locations, to ensure that the consultation at their residence starts within the specified disposition timeframe.

(Maximum Word Count 750)

Words used = 749

1.18.8.1-Experience

Vocare has successfully managed home-visit demand on its existing Staffordshire-wide contract for 8 years. Reviewing demand patterns compared to our other home-visiting services shows Staffordshire does not widely and is perhaps comparable when corrected for factors such as age, socio-economic profile and multi-morbidity.

Demand can be categorised into care-home settings, palliative care and unmet needs including acute/chronic illness and long-term physical/social needs. Palliative-care visits (a large proportion), can take up to 90 minutes, along with residential/nursing homes. Most activity is weekends and late evenings.

a)-Productivity factors

Mental health, end-of-life and multi-morbidity are categories where routine home-visit duration can significantly differ. Ambulance response times and distances travelled also affect duration. Burton involves extensive travelling distances from the current bases, but will be mitigated by a Centre in that area.

We factor in such variables for rotas and, being a long-standing provider, we have the capability to meet this demand through contingency plans coupled with operating from rural locations over the core periods for increased local access. Video consultations will assist in enhancing access.

b)-Skill mix

Multiskilled clinical teams have improved ability to meet home-visit demand as more people are on shift. Effective triage (by WMAS NHS-111) and complete skill matrix mapping will help us plan rotas with skill mixes to meet expected demand. We have good experience of using Urgent Care Practitioners on home visits (supported by GPs/ANPs) with only a limited pool of tasks they cannot undertake e.g. mental-health assessment and end-of-life medication (they can see end-of-life patients for acute need e.g. UTIs).

Our team operates under a robust clinical-governance system that enables us to deliver efficient and safe care to patients.

1.18.8.2-Managing demand variations

a)-Staffing

We create rotas with varying skill mix that account for demand variation and foreseeable peaks and then fill them. Historical activity data informs our rotas and shift-pattern plans.

Some staff are on a 'Tri Role' on a shift, covering remote consultations, home visits and centre visits as needed to support fluctuations.

b)-Clinical prioritisation

We are used to working with a well-established clinical priority system that allocates patient to appropriate priorities on clinical need. On the new contract, the WMAS NHS-111 service will undertake allocation.

Home-Visit Despatchers will manage this disposition's queue, assigning patients to clinicians on shift according to clinical competency, current location and availability. They may also reassign cases where clinicians remain longer than expected with patients or quickly become available. They will have full access to our fleet-management system so will be aware of expected arrival times and issues to keep patients fully informed.

However, NHS-111 will pass calls from the prisons to our specialist contractor Gables Offender Healthcare to triage into remote/face-to-face consultations (prison visit).

c)-Local relationships

We have built collaborative relationships with Staffordshire care homes and GP surgeries that result in bidirectional constructive communication to meet patients' home-visit needs. Despite no formal forum for managing high-intensity users, we identify and manage them via our Clinical Services Manager working in partnership with GP practices and other services.

d)-Contingency plans

In addition to the above-mentioned 'Tri Role' workforce, contingencies include shift extensions, recalling off-duty staff, secondment from other contracts and involvement of senior clinical staff.

e)-Equipment

Due to rural locations of some home visits and adverse winter weather, our fleet includes 4x4 vehicles.

1.18.8.3-Managing surge

Being a large organisation with a national footprint, Vocare can share resources to meet surge exceeding local contingency plans. We have local and national on-call teams with overview of our wider services to identify how we can best manage surge.

1.18.8

South Home Visits

During surges, we can pull resource from our national CAS or other services to take over remote consultations thus releasing local clinicians for home/centre visits.

Since the pandemic, we experience surges from Covid-19 media stories that trigger NHS-111 surge followed by home-visit surge. In usual times, surge can be triggered by e.g. scabies outbreaks in care homes, local festivals and community disturbances.

Prison disturbances can also trigger unexpected in prison-visit demand e.g. during the riots in HMP Birmingham, activity surged in Staffordshire prisons as people were transferred out to other Establishments with little to no medication or transfer of medical records due to the evolving situation.

We manage surges:

- In line with Vocare's EPRR arrangements, rated fully compliant by NHSE & CCG.
- Using proven escalation plans with defined triggers and actions to be taken.
- With support for staff via operational/medical on-call functions 24/7.
- By taking a system approach to partnership working; we are part of the UEC board and system tactical coordination group for health.