Appendix One – MCR and what it means for residents

Crisis Response

Mr B was seen at home by one of our physiotherapists as part of the community element of the new South Manchester **community crisis response service** which provides a crisis service to hospital, primary care and social care referrals. Mr B's wife was very complimentary of the service they received, which prevented a hospital admission, and stated 'the crisis response service has done more for Mr B in 72 hours than any other service has done in 3 years'.

Discharge to Assess

Mrs W was discharged home and was assessed by the team on day of discharge with the family present on assessment. During assessment Mrs W was identified as a high falls risk. She had a pendant alarm but has not pressed the alarm when she has fallen previously and has had six hospital admissions in the last year. The team arranged for a falls sensor which was delivered the same day. Following the family leaving, Mrs W fell and the falls sensor alerted the alarm company and the family so the right care could be provided immediately. The family thanked the team for their support and also for arranging the sensor so promptly.

High Impact Primary Care/Manchester Case Management

Mrs H is a service user with multiple issues including alcohol dependency, epilepsy, hearing and sight impairment, anxiety and depression and multiple long-term health conditions. She had started detox several times but not completed the courses and had cancelled multiple social care packages – putting herself at risk of harm and self-neglect. She attended A&E almost every day. Her alcoholism had created a strained relationship with her children and she had no contact with her grandchildren.

The HIPC team provided weekly support and developed a plan with Mrs H. They accompanied her to hearing and eye tests, arranged counselling and alcohol service support and organised attendance at social interaction groups to pursue her interest in drawing.

With the support of the team, Mrs H's drinking has significantly reduced and she has agreed to go to residential detox. She now has a hearing aid that has greatly improved her communication and has had support from pharmacy to improve how she uses her inhaler to control breathlessness; and the HIPC GP to prescribe a nebuliser to reduce anxiety. She is now much more willing to work with agencies and her attendance at A&E has reduced from once every day to around once every three weeks. Family relationships have improved greatly and her children and grandchildren now come to visit.