Appendix Two – MLCO New Care Models case studies

Examples and case studies of work taking place across Manchester Local Care Organisation services - February 2019

1. Joint working through Integrated Neighbourhood Teams is better coordinating services

Manchester Local Care Organisation's Didsbury East and West, Burnage and Chorlton Park Integrated Neighbourhood Team (INT) has been an early implementer of our new model of neighbourhood working across the city.

The neighbourhood's social work and district nursing teams have been working together from their hub at Withington Community Hospital in West Didsbury since November 2018. It will be one of the 12 hubs across the city.

The biggest single difference staff are reporting is the better exchange of information on a daily basis. Teams now work together and can immediately share information and take action. A great example was the district nurses going out to elderly service user who had a high level of dementia and mobility issues. They sadly found that their main carer and spouse, also elderly, had been diagnosed with cancer with a poor prognosis. The carer couldn't provide the care they previously had done and 24-hour care was going to be needed.

When a nursing needs assessment is requested by a social worker that process can traditionally take days, or even weeks. In this case, because the teams are now co-located, the nurses let the social work team know straight away of their concerns. The case was discussed in the district nurse huddle that day and the INT team was able to get the social care and nursing needs assessments completed in a day and the right care in place a couple of days later.

It's a simple example of an outcome of the teams being able to talk to each other on the spot about cases, but one that made a massive difference to the service user.

2. High Impact Primary Care wrapping care around the most vulnerable service users

High Impact Primary Care High Impact Primary Care (HIPC) is a service that provides care and support to people with complex health and care needs. The HIPC teams are led by a GP, working alongside a nurse, social worker, wellbeing adviser and pharmacist.

Mrs H is a service user with multiple issues including alcohol dependency, hearing and sight impairment, anxiety, 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 and her alcoholism had created a strained relationship with her children so she had no contact with her grandchildren.

The High Impact Primary Care (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.

Mrs H 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.

Manchester Community Response stories

3. South Crisis Response - preventing hospital admission

The South Manchester Crisis Response team launched in December 2019 and provide a crisis service to hospital (A&E and other urgent care units such as the clinical decisions unit), GPs and social care - allowing them to refer to the team and prevent people from needing to be admitted or sent to hospital.

Instead of going to A&E, Mr B was seen at home by one of our physiotherapists as part of the service. Up to 72 hours of care can be provided by the team who then refer on to other services.

Mr B's wife was very complimentary of the service they received, which prevented a possible 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'.

4. Central Crisis Response - taking cases from paramedics and providing care at home

The Central Manchester Crisis Response team launched in November 2018 and provide a service where NWAS paramedics attending 'amber pathway' 999 calls can call the crisis team in to see the patient rather than take them to A&E. The crisis team attend suitable calls and provide up to 72 hours of care.

Feedback collected from one of the service users said: "My experience with the crisis team has been outstanding. The team has been utterly professional, compassionate and helpful throughout my interaction with them. I appreciated being able to undertake various health checks in my home, blood tests and various physical examinations without having to go to A&E. They also contacted my GP surgery so I could collect my prescriptions sooner rather than later.

"I'd recommend the service. It's put my mind at rest and given me a clearer diagnosis of what the problem has been. The assessments have been done promptly and the team's engagement with my GP has been invaluable. I feel I have been extremely fortunate to be cared for by the team and I am extremely grateful for it."

5. Discharge to Assess - taking assessments into the community

Discharge to Assess provides a service that allows community teams to carry out assessments in the community rather than delay hospital discharge.

Mrs W was discharged home and was assessed by the Discharge to Assess 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.

Case studies collected from Manchester Local Care Organisation service users and anonymised. For further information or to use these elsewhere please contact chris.horner1@nhs.net