STOCKPORT'S NEIGHBOURHOOD TEAMS

CASE STUDIES

NHS Pennine Care NHS Foundation Trust

STOCKPORT METROPOLITAN BOROUGH COUNCIL

NHS Stockport NHS Foundation Trust

VIADUCT CARE CIC

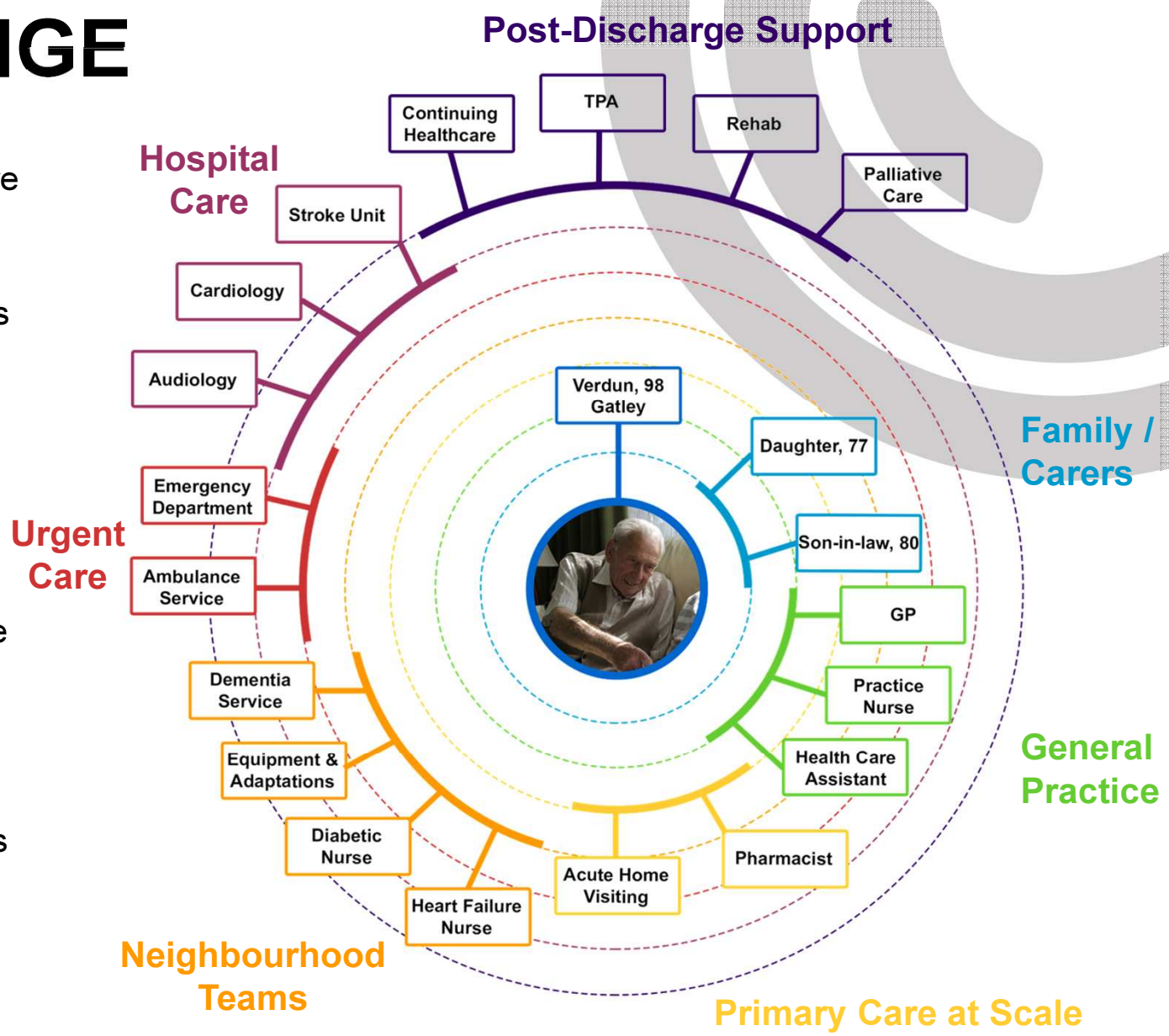
NHS Stockport Clinical Commissioning Group

CASE FOR CHANGE

Stockport's demographics mean that there are more and more people with complex care needs.

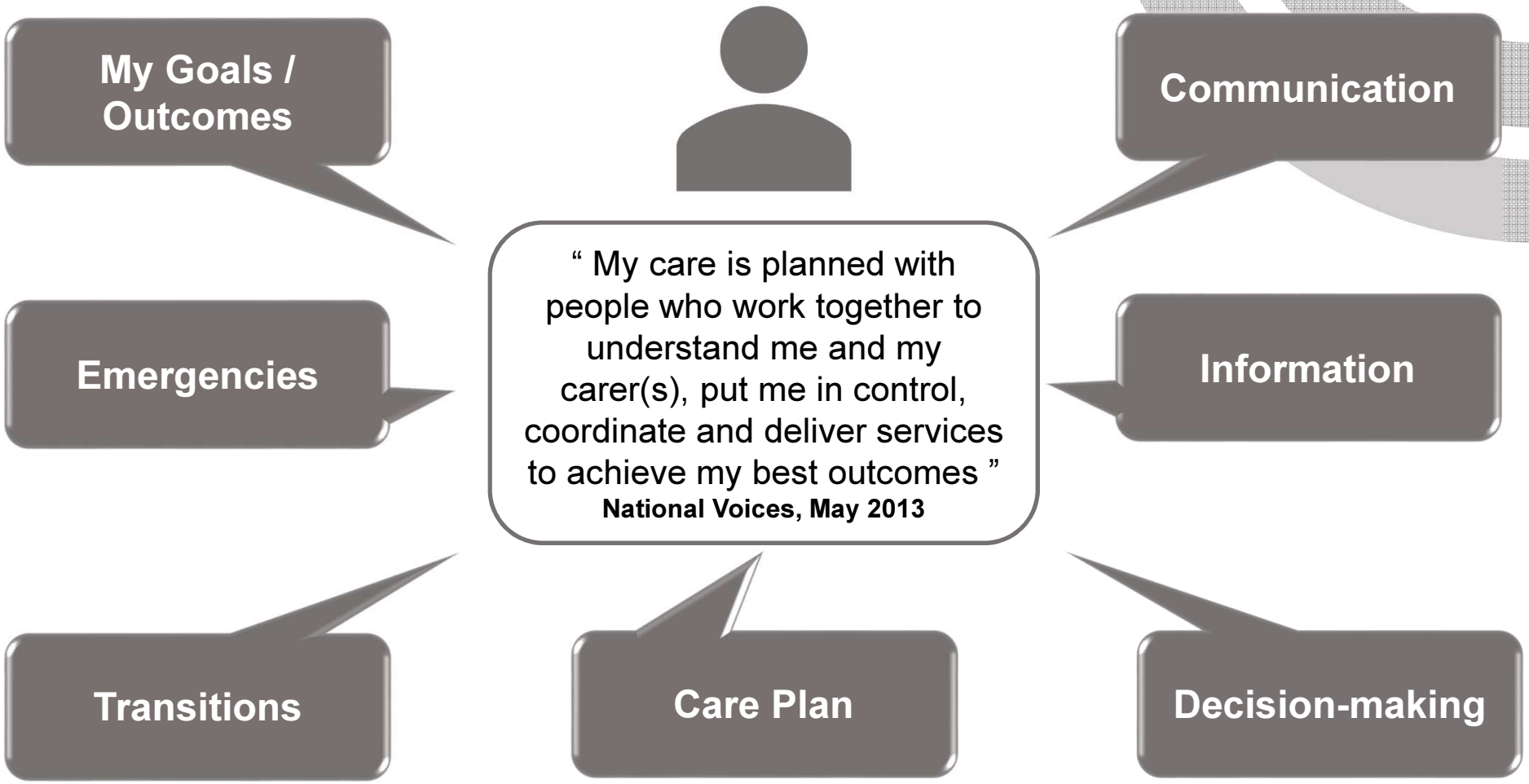
This patient example highlights the problems of the current system:

- patient has 16 sets of care records
- has to repeat history to over 18 different care professionals
- family (with own healthcare issues) managing appointments with 11 separate organisations
- no single plan
- constantly waiting for referrals
- repeat diagnostics at many appointments
- conflicting advice / medication
- over-hospitalisation (wanted to be at home)
- lack of control over own care.



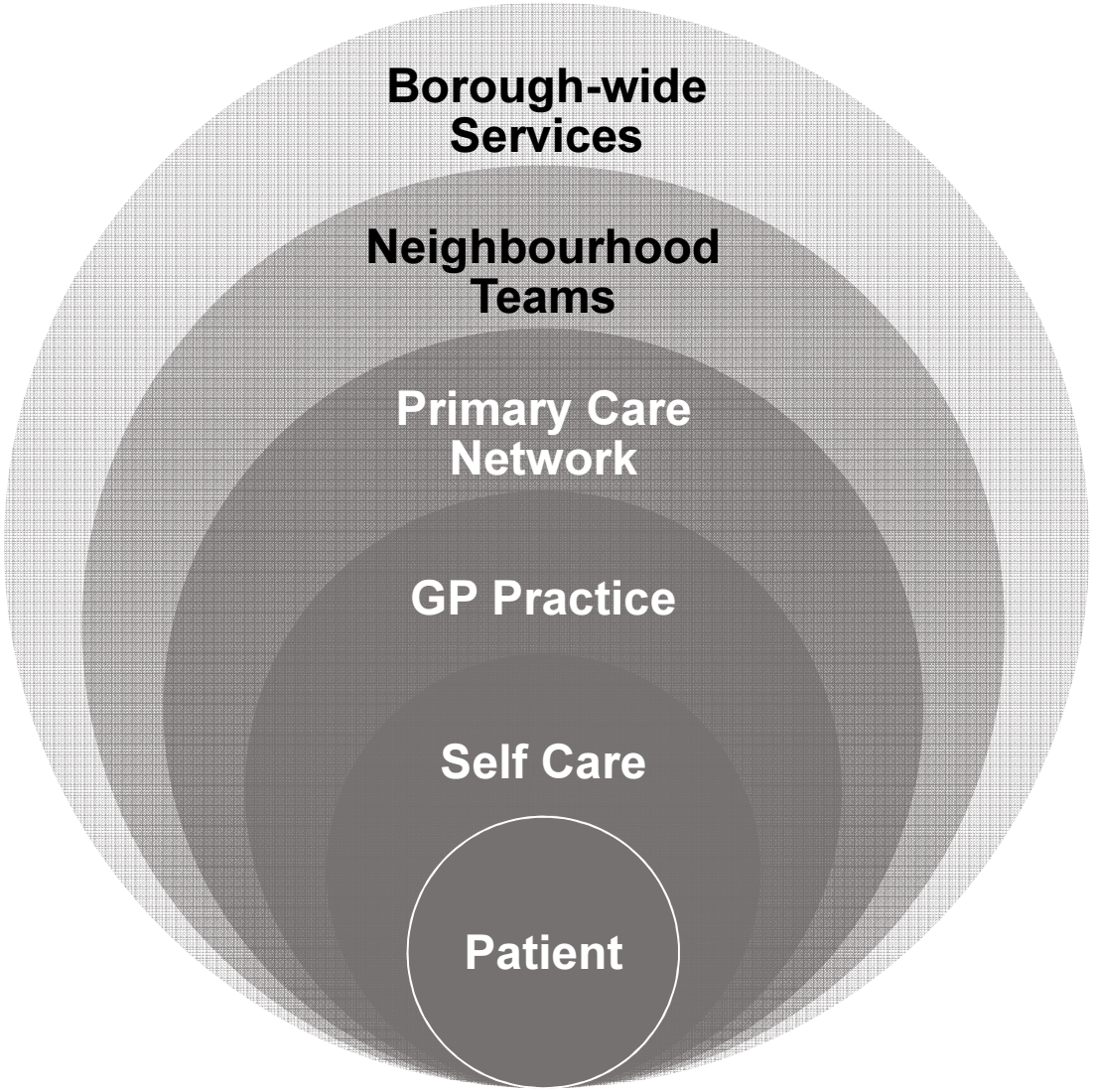
PERSON-CENTRED COORDINATED CARE

The aim of Stockport's neighbourhood model of care is to provide high quality care and support that is personalised, joined up and coordinated around the individual, supporting them to remain independent and manage their conditions outside of hospital.

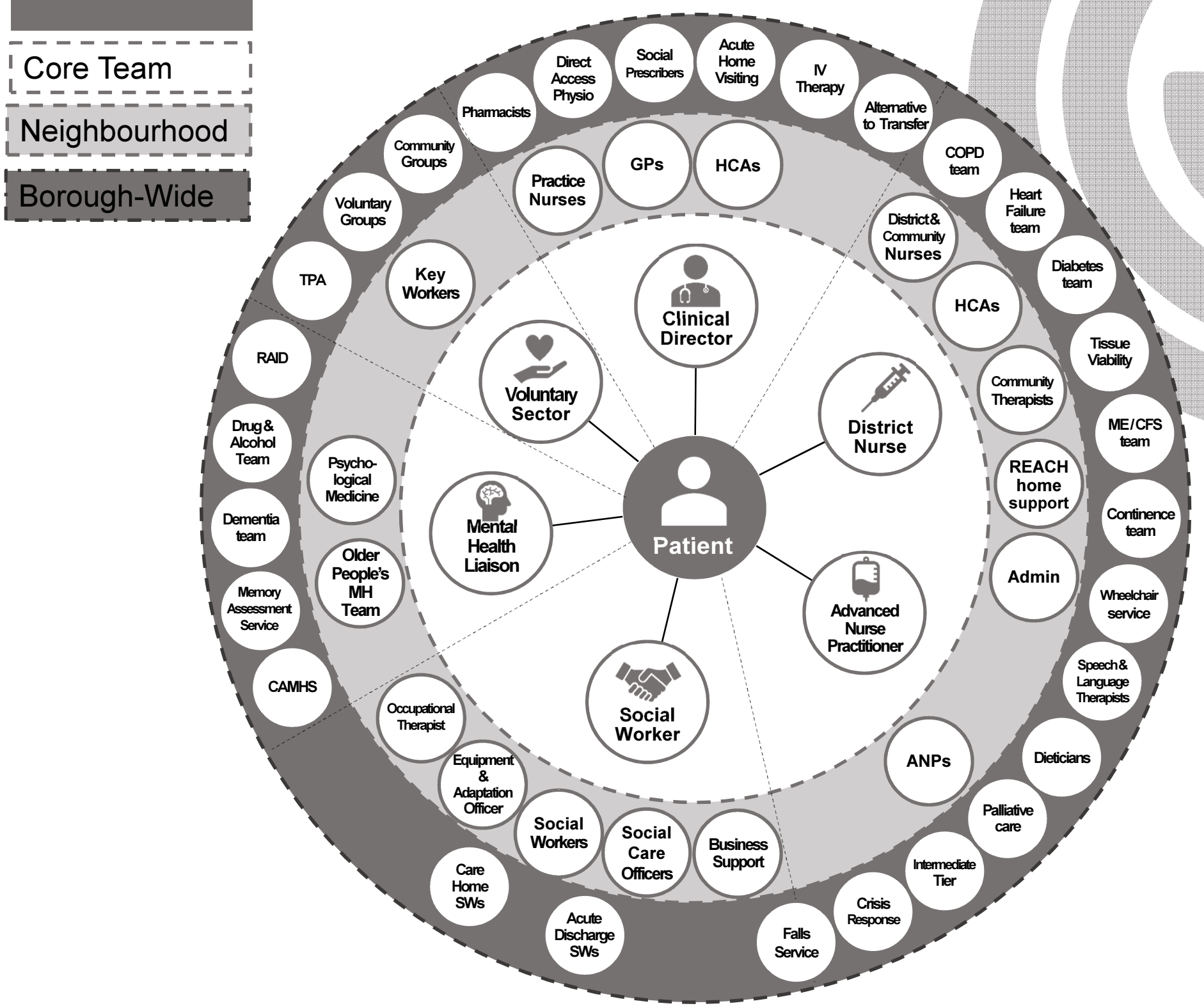


MODEL OF CARE

- Stockport's model of care puts patients and carers at the heart, with holistic, coordinated out-of-hospital care wrapped around their needs
- Advice and guidance is provided to support self-care
- GP Practices serve as the main gateway to services
- Practices work together in 7 Primary Care Networks, providing 7 day services and clinical leadership to multi-disciplinary teams
- Through the GP Federation, PCNs deliver *Primary Care At Scale* services, including navigation and signposting, social prescribing, psychological medicines, pharmacy support and direct access physio
- Dedicated community healthcare, mental health, adult social care and voluntary sector teams are aligned to neighbourhoods, supporting enhanced case management through multi-disciplinary teams
- These teams link into specialist services at a borough-wide level to provide crisis response, intermediate care, palliative care and support for a range of specialisms.



NEIGHBOURHOOD TEAMS - OUT OF HOSPITAL CARE



CASE STUDIES

AND TESTIMONIALS FROM FRONTLINE PROFESSIONALS

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CASE STUDIES – KEN'S STORY

Lisa Lainton
Head of Borough Wide Services – Integrated Care

Ken's Story

- Type 2 diabetes
- Profound neuropathy (loss of feeling), previous foot surgery
- Presented with a new diabetic foot ulcer with osteo-myelitis (bone infection)
- Use of observations (NEWS2) to ensure patient wasn't presenting with sepsis
- Identified as requiring Enhanced case management (ECM)
- Referred to Mastercall Out-patient Intravenous Antibiotic team

Ken's Goals

- To keep independent
- Wound care plan
- Infection management plan
- Get walking again

Ken's Plan

- Foot ulcers managed by Podiatry High Risk Foot team
- IV antibiotics via Mastercall
- Offloading via orthotist
- Pressure plate study
- Patient education re early identification of a 'crisis'
- Crisis Response team self-referral contacts

Ken's Outcomes

- Admission avoidance - Ken was managed successfully in the community
- ECM allowed for self referral to Crisis response if appropriate
- Collaborative care coordination
  - High Risk Foot team
  - Diabetes team
  - Mastercall IV team
  - Orthotics
- Foot ulcer now healed - working with Orthotics team to provide suitable footwear / offloading to improve mobility / self management

CASE STUDIES – COLLABORATIVE WORKING

Lisa Lainton
Head of Borough Wide Services – Integrated Care

- Male aged 69 years with diagnosis of COPD.
- Main symptoms: breathlessness, anxiety and reduced functional capacity.
- Reluctant to engage with community teams or psychological support.
- Frequent admissions: 2018-2019.
- Seen by COPD team and ECM created February 2019.
- Reduced admission rate since ECM in place.
- Referred to ANP for assessment of wider health needs.
- ECM updated by ANP. Reduced level of anxiety for the patient with ECM and teams' support.
- Ongoing collaborative management of functional capacity and low BMI.
- No admissions since December 2018.
- Last ED presentation was February 2019.

CASE STUDY

CARINA SCHOFIELD, DISTRICT NURSE, VICTORIA NEIGHBOURHOOD
LOUISE CARTER, SOCIAL WORKER, VICTORIA NEIGHBOURHOOD

The Victoria Team's District Nursing and Social Care team leads met with a social worker from the Integrated Transfer Team based at Stepping Hill Hospital to trial the revised care plan as a means of managing care for a shared patient.

The patient was a younger man with a range of chronic conditions, well known to the District Nursing team and the Foundation Trust for frequent support with leg ulcers, skin integrity and bariatric support requirements.

"Having a complete and up to date plan, shared on a common platform, makes nursing or therapy assessments quicker and easier, as the baseline is already done and it will speed up equipment and adaptations reviews if they already know what is in the home.**"**

"Using a frailty score that explains the individual's baseline will help prevent admissions by allowing paramedics to understand if a patient has deteriorated or if the level of frailty they see is normal for the individual.**"**

"Including more detailed information on the individual's living arrangements (equipment, carers, type of housing, whether they live alone, up stairs etc) will really help hospital and social work teams to discharge people from hospital. In this specific case, it helped improve support to the individual - by recording that the individual was in Extra Care Housing, the multi-disciplinary Team knew that he would be eligible for the red bag service for medicines transfer.**"**

JOANNE RHODES, SOCIAL WORKER, INTEGRATED TRANSFER TEAM, SFT

CASE STUDIES

DR VIREN MEHTA
GP, CHEADLE

Multi-Disciplinary Team meetings are a vital way of ensuring we are able to work collaboratively, share information and ensure joint decision making for our most vulnerable children and adults.

We now have the capacity to run virtual neighbourhood meetings, making it easier to get wide involvement without the hassle of finding rooms, parking, or travel time.

DENISE MONKS, SENIOR SOCIAL CARE SERVICE MANAGER, WEST NEIGHBOURHOODS

Social workers don't always get to know when people on their case load have been in hospital, so being able to see that information on the shared record is really beneficial to our teams.

Once the new Liquid Logic system is embedded at the Council it will be even easier, as social workers can go straight into the record from there in one click, without additional log-ins or passwords.

CASE STUDIES

DR BECKY LOCKE, GP, HEATON MOOR, CLINICAL DIRECTOR, HEATONS PCN

During the current COVID crisis, GPs are calling care homes almost daily to check in on vulnerable patients.

Having access to a virtual dashboard for our care home patients would allow us to know if a patient is deteriorating or showing COVID symptoms and to target scarce GP resources for the most vulnerable people under our care.

Goals of Care plans have been rolled out across almost all of Stockport FT's services over the past 15 months and it has been greatly successful.

We have to date in excess of 1,700 plans and our services have worked tirelessly to embed these. All of our plans have been registered on the NWAS ERRIS system and a hard copy is kept in a yellow folder within the patient's home.

As a result, our teams have expedited discharges and even prevented hospital admissions in the first place by getting the individual's carer to contact the Crisis Response Team, as opposed to calling 999.

LISA LAINTON, HEAD OF BOROUGH WIDE SERVICES, INTEGRATED CARE

CASE STUDIES

CHRIS HEAD, SENIOR SOCIAL CARE MANAGER, WEST NEIGHBOURHOODS

We all see the benefit of bringing together the teams of professionals supporting the same individual, but practically it can be difficult. A Social Worker might have to spend hours ringing round services to find the best support options for someone they support.

Having a clear overview of the service offer across the system and who you can contact for your neighbourhood is real bonus.

JANE COLLINGS, ADVANCED NURSE PRACTITIONER, TAME VALLEY

This revised care plan gives a clear structure to manage a patient who is an increased risk of hospital admission

It guides the professional to outline a personalised plan for non-escalation and appropriate care within primary care if at all possible

It is a useful guide for carers (formal and family) and encourages selfcare and the patient to understand their own condition better and recognise triggers that may indicate deterioration

It also gives guidance to paramedics when they need to make time critical decisions.

It is a useful tool but is also dependent on comprehensive completion by the professional and regular review.

CASE STUDIES

DR JAMES HIGGINS, GP, BRINNINGTON

We have been working in Stockport for a number of years to really embed integrated working across neighbourhood teams to wrap care around individuals with complex needs.

Updated shared records with live care plan section is the game changer we've been waiting for regarding effective multi-agency care planning.

The Goals of Care plans were updated with the frontline staff who actually use them in practice to make sure them as useful as possible.

We added in Activities of Daily Living measures (ADLs) so that staff in the hospital reading the care plan get a good understanding of the individual's baseline.

This helps expedite discharges as they are not trying to get a patient up to a level of health they haven't been at for a long time.

It also helps with discharge planning if you already know from the care plan what equipment and adaptations the individual has at home.

NICKY MAKEPEACE, ADVANCED NURSE PRACTITIONER, VICTORIA