The Pennine Acute Hospitals NHS
NHS Trust

North Manchester Integrated Neighbourhood Care (NMINC)

Keyworker

OPERATIONAL MANUAL

Contents

1. Background and Pathway

Introduction

The UK population is ageing and increasingly people are living longer with complex, long term conditions. In order to respond to this better, we need to transform the way that care has traditionally been provided and bring health, social and other support together.

In North Manchester, we have been implementing an integrated way of working known as NMINC – North Manchester Integrated Neighbourhood Care. We have designed a new pathway to provide a more pro-active approach to supporting people who are likely to be admitted to hospital in the near future, and have established multidisciplinary teams to work together to improve care delivery.

This document is intended to support the activity of keyworkers, using a pathway approach. The pathway ensures that patients (or clients as they are known in social care) have a single, coordinated plan that will help improve their health, wellbeing and ability to live with their conditions.

The NMINC approach is based on three 'drivers that were identified by the national 'QIPP Long Term Conditions programme':

1. Having a systematic approach to selecting people at risk of future admission to hospital. (Combined Predictive Model/ Risk Stratification Score.)
2. Developing integrated health and social care teams, organised around local neighbourhoods, who offer proactive support
3. Implementing a systematic approach to supporting people to self-care.
   International evidence suggests that we need to implement all three of these to have the greatest chance of making a difference.

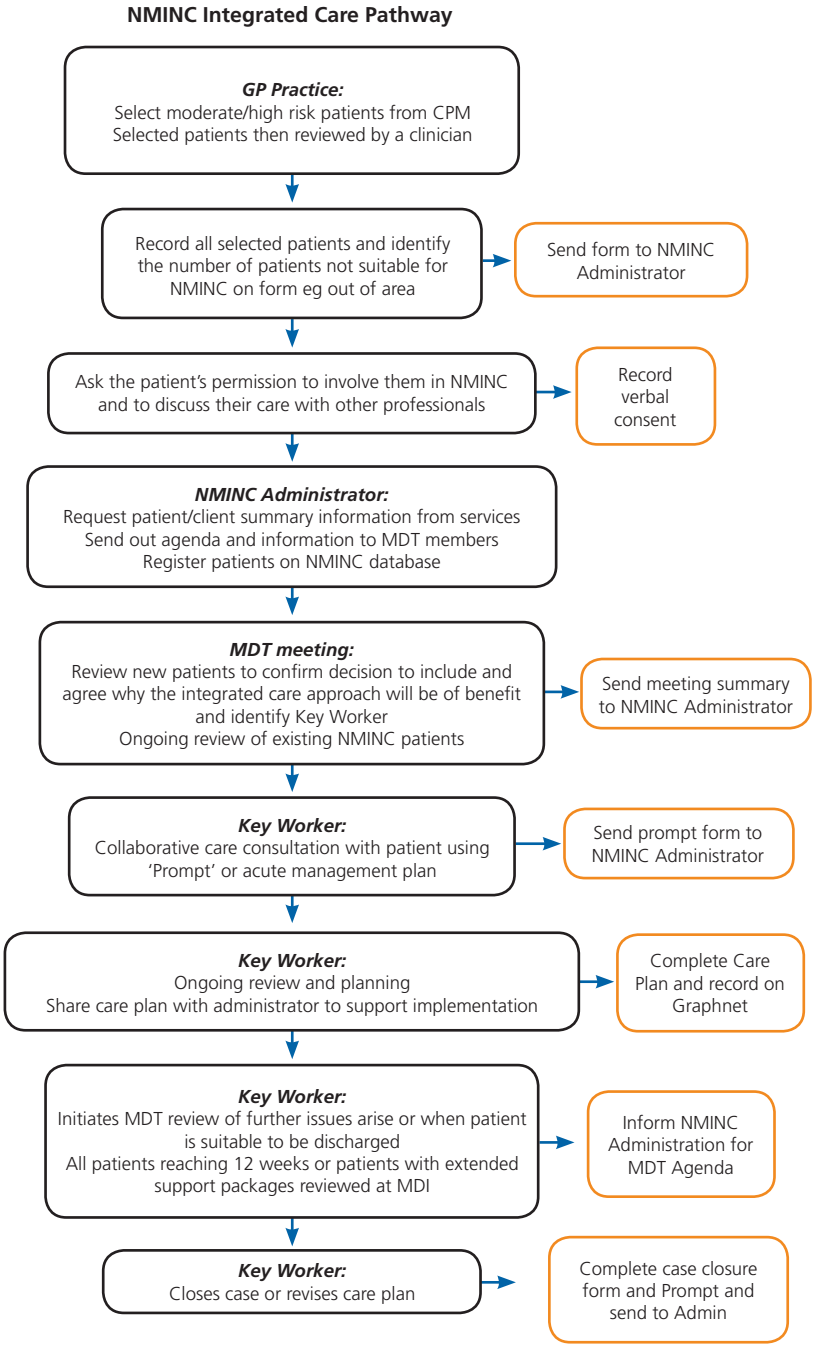
The NMINC approach can be summarised as follows:

- A person-centred pathway and support package, delivered over 12 weeks, produced in collaboration with the patient and managed by a 'Key Worker' who is identified from the 'core' team.
- A 'core' team of GP, Practice Nurse, District Nurse, Active Case Manager and Social Worker.
- Regular identification of adults who are at high or moderate risk of future admission to hospital (based on the 'risk stratification' tool).
- As inclusive as possible e.g. people who are acutely ill, who have now stabilised.
- Services organised around the GP practice and GP as the lead professional.
- Regular team meetings to plan care and problem solve.
- A Key Worker coordinates care and works collaboratively with the patient to agree and implement actions or goals around issue that are **important to them**.
- Includes other relevant services and support based on patient/client priorities and needs including support to self-care and access to local resources.

What we hope to achieve:

- Better outcomes for patients/clients and families including less dependence on urgent and emergency services and improved access to relevant support in the community
- High quality support and care provided in a joined up way by the right person or people and designed to improve health, wellbeing and to improve independence
- Improved joint working between different professionals – better understanding of roles, increased sharing of knowledge and better management of expectations between teams and services
- More efficient and focused use of resources.

The NMINC Pathway.



The pathway has four main elements.

i) selection of patients
ii) multidisciplinary team meetings
iii) care planning and review
iv) case closure

Refer to Appendix 1 for a more detailed account on the Pathway and NMINC Model.

2. Combined Predictive model (CPM)/ Risk Stratification Score (RSS)

2.1 what is CPM?

In North Manchester, we are using the combined predictive model (CPM) as a risk tool to look at future risk of admission to hospital. The tool uses a statistical algorithm to assign a score for future risk of admission to the entire CCG population. It then groups people into four categories of risk: very high, high, moderate and low.

Such tools are known not to be highly accurate but they are more effective than clinical opinion alone. In NMINC, we agreed that the tool is a 'good enough' way of working gradually and systematically through the population to identify people who may benefit from the support offered in NMINC. The critical next step, clinical opinion, is essential in deciding whether someone should or should not be offered the service.

We have also decided to focus on all of the population at risk of admission. Appendix 1 provides a more detailed synopsis of the NMINC model..

2.2 Risk Stratification Tool - User Guide for GP practices

Contents

Introduction

The risk stratification tool uses the Combined Predictive Model (CPM) to stratify patients by their risk of emergency admission to hospital.

The tool calculates a patients risk using inpatient, outpatient and A&E information from secondary care as well data from GP clinical systems collected via the Secure Data Extraction (SDE) System.

If primary care data is not available the risk score is calculated using secondary care data alone.

GP Practices can use the tool to identify patients by their risk score.

Accessing the tool

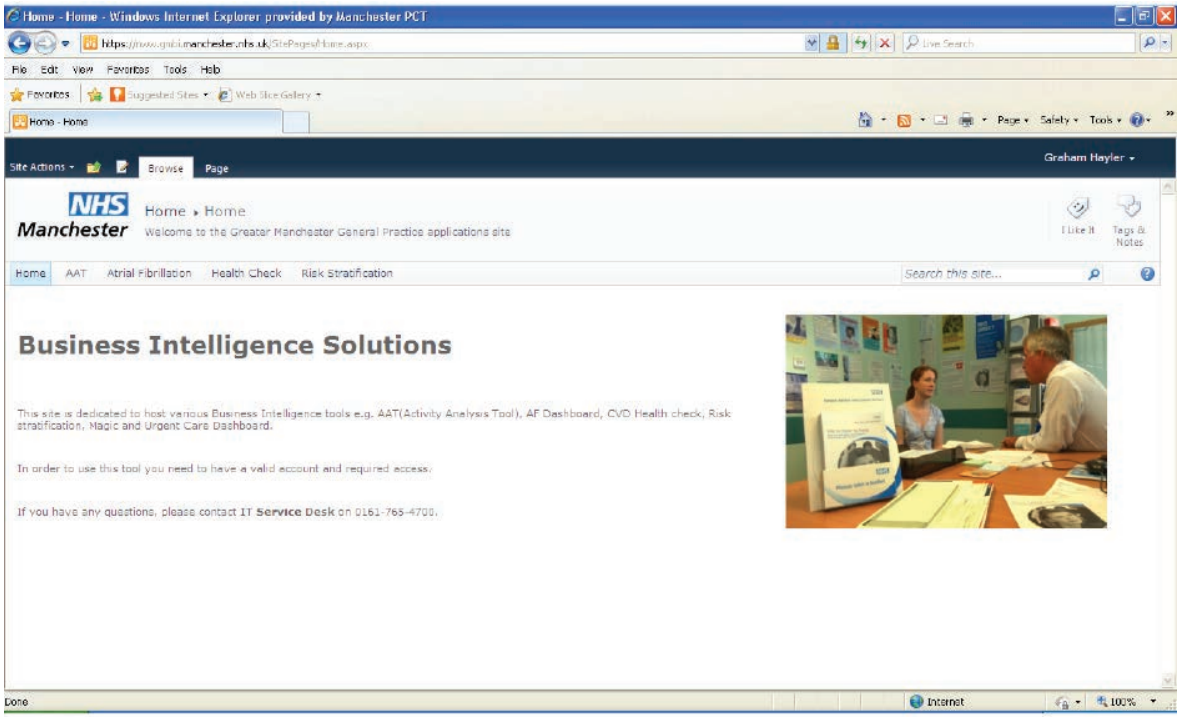
All users should have received a user name and password from Frank Sheridan (IT Services). If you need a user account please contact your CCG Information Analyst listed at the end of this paper.

Users will access the tool via the following link:-

https://nww.gmbi.manchester.nhs.uk/SitePages/Home.aspx

Users will be presented with the following log in screen:-

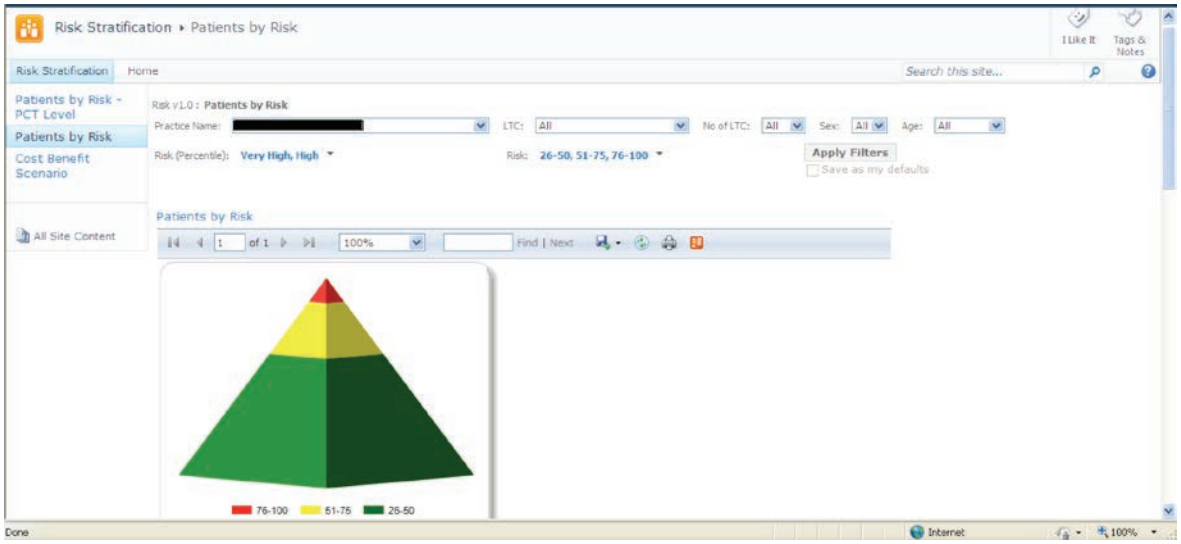
On entering the system the main menu will be displayed:-



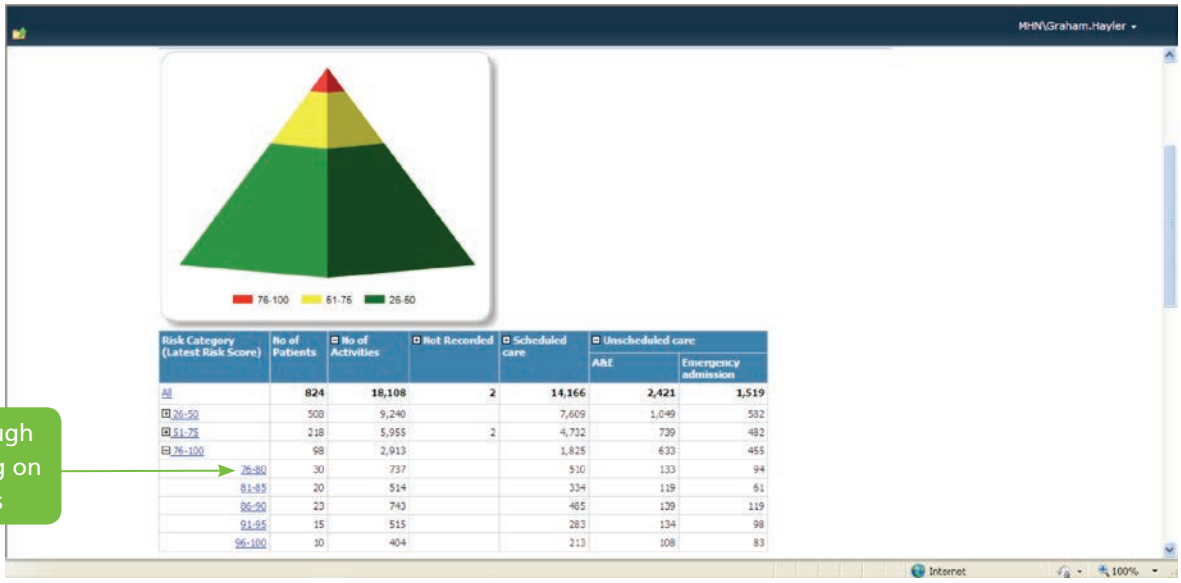
Users need to click on the Risk Stratification link to enter the application

Reports

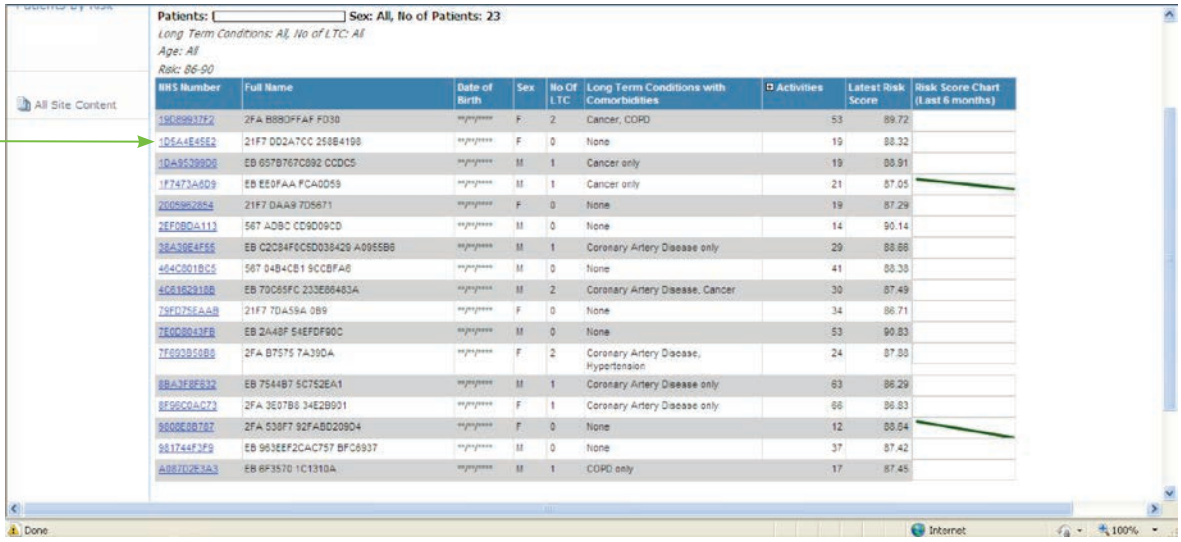
The default report (shown below) will be displayed when entering the system. The user has the Ability to filter the results by Long Term Condition, Number of Long Term Conditions, Gender, Age and Risk Band.



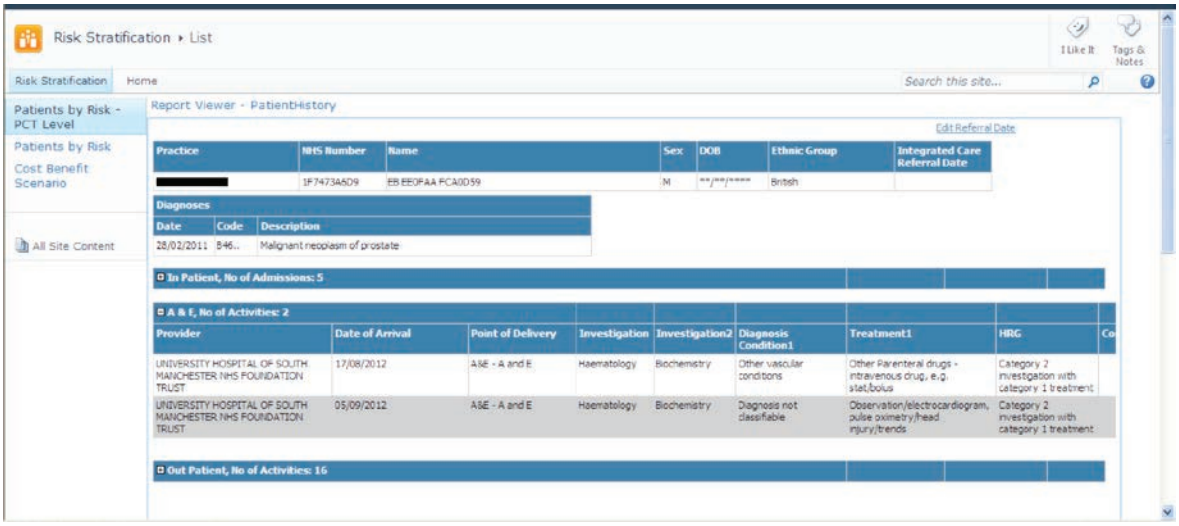
GP Practices can view patient identifiable information by clicking on the blue hyperlinks within the table view below:-



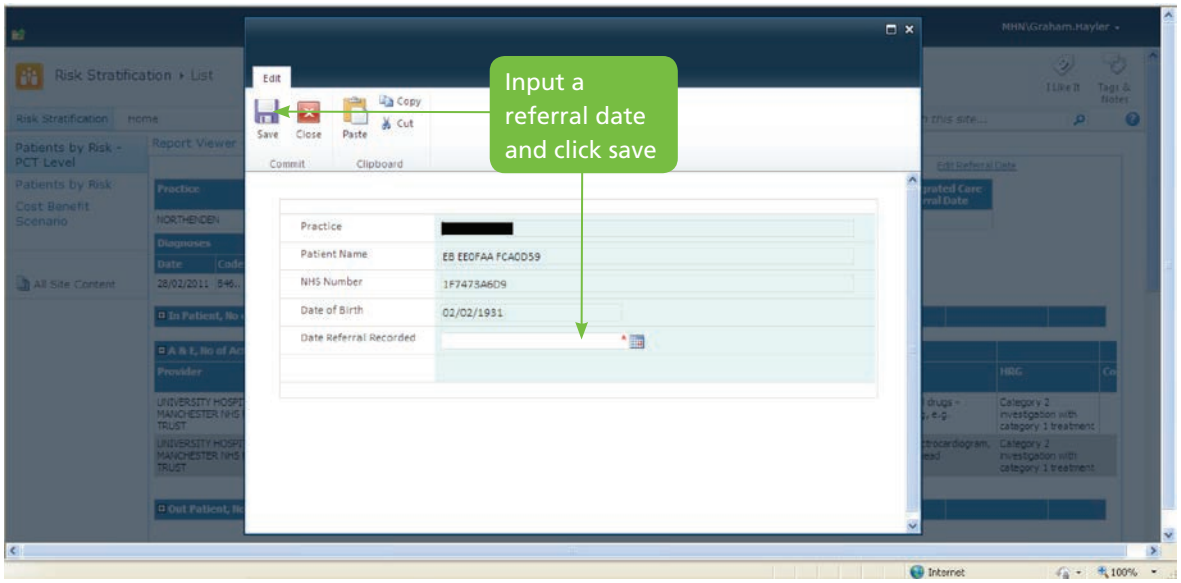
Drill through by clicking on hyperlinks



A patient's history can also be viewed:-



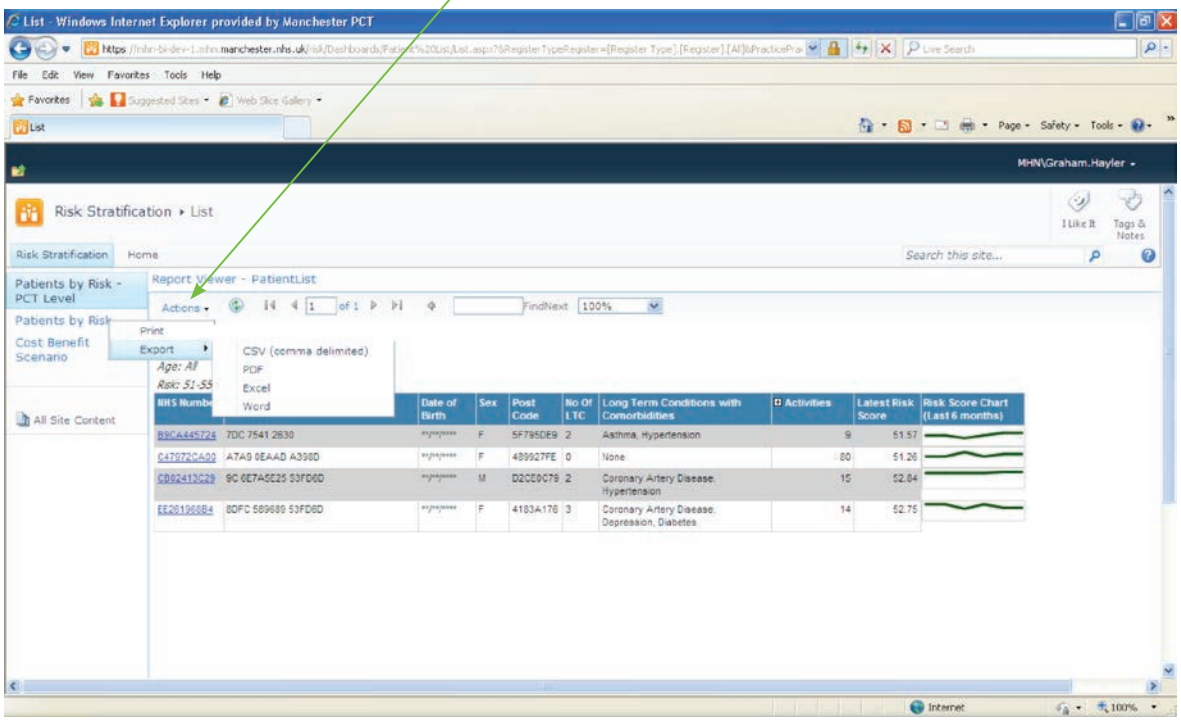
You can record if a patient has been referred to the Integrated Care Team



Printing patient lists

You can print patient lists by firstly clicking on the 'Actions' button and then selecting 'Export'. When you select export the list can then be displayed in PDF, Excel and Word for printing.

Important: when you select 'Actions' **do not select the 'print' option**, select 'export' and then print the list from the PDF, Excel or Word document that you have exported.



Further assistance

If you require any assistance please contact your CCG Analyst:- Patrick.Godfrey@nhs.net

3. Consent

3.1 Why do we need to obtain Consent?

The Integrated Neighbourhood Care Teams consists of Health and Social care members. It is the mix of local authority with health services that demands consent to be sought before sharing information. This is essential for new patients to be discussed at the MDT.

Following is the consent process for NMINC patients from point of selection to discharge.

3.2 Instructions for the Consent Process

1) Clinician to review the selected patients from the CPM list and select appropriate patients for NMINC.

   Clinicians can also select other patients they deem suitable for the NMINC process. In this instance the practice should supply the risk stratification score.

2) The Practice MUST obtain' verbal' consent from the patients. Guidance on verbal consent follows.

3) Community Practitioners may refer into the NMINC process, see Section 4.3.4. The referrer is responsible for obtaining the patients consent on initial contact and written consent on the first visit.

4) Verbal and written consent should be recorded on the 'Initial Case Selection Practice List' a copy follows this guidance. (Also in the MDT Admin Pack Appendix 2).

5) When completed this list is sent by the practice to the NMINC Admin Support Team **7 working days before** the planned MDT. This allows sufficient time for the health and social practitioners to gather relevant historical information.

6) The Keyworker will then obtain 'written' consent on the initial visit. Using the 'Consent to Share Health and Social Care Information.' A copy follows this instruction (for guidance see section 6.2.2).

7) The written consent is necessary for the Graphnet care-plan to be published by the Practice. The Keyworker should take the consent form to the NMINC Admin support team. The NMNC admin support team will then scan the consent document and send to the relevant Practice by a secure email account to a secure email account. This consent should be returned to the patient's home.

8) A Copy of the consent will be kept in the patients records within the home. If the keyworker is practice based then the consent should be kept with the patients records.

9) The consent form is archived with the patient's notes following discharge.

3.3 Getting verbal consent

Think about who does this – an unexpected call from someone a patient doesn't know will probably increase the number of 'no thanks'.

The 'preamble' will also be important and needs to connect with the person's current experience with their health care. For example, 'Doctor..... asked me to give you a quick call after your appointment last week, she wanted me to ask if you would be part of something we're trying in our practice.'

Then something like:

'We are trying out a new way of working to improve the support we give you to manage your health. To do this we are working collaboratively with our nursing and social care colleagues to better coordinate your care.

Would you be willing to allow us to meet and discuss your details with them to see if you would benefit from this new approach?

Do you mind if there is an observer at these meetings, who will help us in managing this new way of working?

or

'We'd like to have a more co-ordinated approach that improves the support we give you to manage your health. To do this we need to work with our district nursing and social care colleagues.

Would you be willing to allow us meet and discuss support for your health with them, to see if there could be benefits for you?

As part of this, is it ok if there are project workers at these meetings, who are helping us look at how well we are doing a way of working?'

3.4 Case Study Consent

Patient case studies are essential for the evaluation, improvement and development of services. Case studies need to be collected regularly by all the services in the NMINC core team, at least 1per service per month. The keyworker should discuss this with the patient and gain consent when nearing the patients discharge. Case studies require a specific consent form that can be seen in Appendix 4

Initial Case Selection Practice List

Practice name: .... Date: ....

NHS Number	Name	D.O.B

CPM Risk Score	GP	Confirmation of verbal consent (please tick)	Date of consent
		☐	

NHS Number	Name	D.O.B

CPM Risk Score	GP	Confirmation of verbal consent (please tick)	Date of consent
		☐	

NHS Number	Name	D.O.B

CPM Risk Score	GP	Confirmation of verbal consent (please tick)	Date of consent
		☐	

NHS Number	Name	D.O.B

CPM Risk Score	GP	Confirmation of verbal consent (please tick)	Date of consent
		☐	

NHS Number	Name	D.O.B

CPM Risk Score	GP	Confirmation of verbal consent (please tick)	Date of consent
		☐	

NHS Number	Name	D.O.B

CPM Risk Score	GP	Confirmation of verbal consent (please tick)	Date of consent
		☐	

NHS Number	Name	D.O.B

CPM Risk Score	GP	Confirmation of verbal consent (please tick)	Date of consent
		☐	

Consent to share health and social care information

To be completed by the customer and retained by GP / Keyworker, to be uploaded into shared electronic record

Integrated Neighbourhood Care Teams are being developed across North Manchester to ensure that patients and carers have better access to the right care, in the right place, at the right time.

The teams will bring together a range of health and social care professionals, including GPs, Social Workers and District Nurses who will work together to help to keep you healthy and well.

Information about your needs and support will be put onto a secure, shared computer system, which can be accessed by all the teams that provide health and social care to you. Only those people directly involved in your care will be allowed to look at this record and information. This will include GPs, A&E and hospital teams, Community health and Social Care Workers, and the Ambulance Service. Health and Care teams and their employers may also use this information to help plan, manage, design and monitor the services they provide and this may shared with those who commission their services.

The shared record will enable the people providing care to have the right information to help in making decisions, including knowing what you would like to be done in an emergency. It will also reduce the need for people to keep repeating information so that support can be provided more quickly and efficiently.

Information will only be held and accessed in this system if you have given your consent. Consent can be withdrawn at any time

Signed

I have had the opportunity to discuss and understand the nature of consent I am being asked for and am now happy to give my explicit consent that my personal health and social care information can be held in an electronic shared record and that the indicated information may be discussed by my practice integrated care team for use in improving my support and for the purposes above.

I confirm that all information given by myself is accurate and correct at time of submission.

This request for personal data is subject to the provisions of the Data Protection Act 1998, the Human Rights Act 1998, and the Common Law Duty of Confidentiality.

Name:

Signed: Date:

Name and role of person taking consent:

Name:

Signed: Date:

4. MDT (Multidisciplinary Team Meeting)

4.1 Members of the MDT /Core team.

- GP.
- Practice Nurse.
- Administrator.
- District Nurse.
- Social Care Worker.
- Active case Manager.

4.2 Roles and Responsibilities.

- GP Chairing the MDT: The GP is responsible for facilitating the MDT and ensuring everyone is listened to.
- The members of the MDT are responsible for identifying the best placed keyworker. Based on the health and social care indicators for self-care.
- The members of the MDT should share the relevant, historical information from their own profession, which may contribute to the future care plan. Or identify reasons the person is not suitable for the NMINC.
- The members of the MDT should share evidence based practice from their own profession that may contribute to the person's care plan.
- The members contribute their understanding of what is important to the person in terms of their health and wellbeing.
- The members of the MDT should discuss each person collaboratively to help develop the best outcome for the person's care plan.
- The members of the MDT are responsible for feeding back significant events such as hospital admission and deterioration in health.
- All MDT members involved with the person's care should input information on to the 'Record of Involvement' section to Graphnet.

4.3 Guidance for the MDT Process.

4.3.1 New Patients:

The clinician should screen the selected persons to ascertain if the person is suitable for NMINC before the MDT.

The Practice should obtain verbal consent (see section for consent process 3.2).This should be documented on the 'Initial case selection' document (See Appendix 2)

Each person should be discussed collaboratively by the MDT team.

A Keyworker should be allocated within 3 working days.

A tentative agenda for possible self-care should be established, based on the MDT member's discussions.

A member of the MDT should document discussions taken place at the MDT and the Keyworker allocated (Role and Name). Refer to the 'Integrated Neighbourhood Care Team Meeting Record.' In Appendix 2.

4.3.2 Review of the NMINC Patient:

Each person that has been allocated to a keyworker should be considered for a review, although they may not need to be reviewed at each meeting. (Significant events, Referrals to specialist services and how they engage with the patient, current plan of self-care, crisis plan and discharge plan should be considered at the review.)

The review should be documented on the 'Existing cases reviewed at this meeting' Appendix 2.

4.3.3 Discharge of the NMINC Patient.

The Keyworker should plan for a discharge from around 6 weeks. This should be with the patient so that they may plan to continue with their current and crisis plan.

The keyworker should work with the MDT and discuss discharge at the review, when appropriate. This will assist with a timely discharge.

The discharge should be feedback at the MDT and documented on the 'Existing cases considered for discharge at this meeting.' Appendix 2.

Cases that are running over the 12 weeks should be documented on the 'Existing cases open for more than 12 week's with an action plan to resolve when appropriate. Appendix 2.

4.3.4 Community Referrals into the NMINC.

A clinician or practitioner may refer into the NMINC process. (This could be from an existing service referral).

The person should obtain verbal or written consent from the patient to be referred into the NMINC. (See Section 6.2.2 and 3.2).

The referrer should supply patient details to the NMINC Admin team. The Admin Team can then ensure that the patient is listed on the 'Initial Case Selection Practice' list, with consent clearly documented. (Appendix 2).

The Admin team should obtain the CPM score from the Practice and document.

The patient would then be discussed at the MDT under the NMINC.

The referrer does not need to wait for the MDT to start visits but can feedback into the next MDT.

5. The Keyworker

Roles and responsibilities.

- The Keyworker should make the initial contact with the patient and arrange the first consultation. This should be achieved within 5 working days from allocation.
- The Keyworker should be the point of contact for the person. (The patient's contact with the Keyworker does not necessarily need to take place in the patient's home. It could be in the practice for example with the Practice Nurse or GP).
- The Keyworker should explain and obtain written consent. See section 3.2 and 6.2.2. This is essential for the Graphnet care-plan to be published.
- The Keyworker is responsible for developing the shared agenda and resulting care plan over a recommended period of 12 weeks. This should include what is important to the patient and agreed goals towards enabling self-care.
- The keyworker is responsible for feeding back information to the MDT, for example, consultations with the patient, their outcomes, agreed management/current plans and crisis plans to the MDT. This should include carers and relatives. This will constitute a review at the MDT.
- **The keyworker is responsible for feeding back significant events, such as hospital admissions, deterioration in health, medication changes, symptom changes and so on. The Keyworker MUST inform the practice and not presume that the information will be reviewed through graphnet.**
- The keyworker is responsible for working collaboratively with specialist services and other disciplines to achieve the patient's goals, including co-ordination of services where this is required.
- The Keyworker is responsible for planning the discharge for the person in collaboration with the person and the MDT. Discharge plans should be mentioned within earlier reviews.
- The Keyworker is responsible for sending a discharge summary to the GP and attaching a copy to the patients notes, within 3 working days.

6. Records

This is the order for the NMINC Patient records. This is the paper version of graphnet. This will change with the start of Graphnet. GP practices may choose not to use the support worker care plan. The next section explains how to complete these documents.

The NMINC patient Record Pack can be printed from Appendix 3

1. My Care Plan Front Cover.
2. Consent Form.
3. Prompt: NMINC Prompt for Keyworkers.
4. Prompt: Screening for other issues – Admission.
5. Prompt: Assess ment of Activation – Admission.
6. Prompt. Screening for other issues – Discharge.
7. Prompt. Assessment of Activation – Discharge.
8. Practice Integrated Care team - Record of Involvement. Graphnet.
9. Practice Integrated care Team - Integrated Care Plan. Graphnet.
10. Current Plan. Graphnet.
11. Crisis Plan. Graphnet.
12. Background information.
13. NMINC Support Worker Care Plan/Action Plan.
14. NMINC Support Worker Care Plan/ Clinical Monitoring Record.
15. Comments Sheet.
16. Monitoring Form
17. Case Study Consent Form.

6.2 Guidance for Completing a NMINC Patient Record.

This describes how to complete the patient record pack, as above (See Appendix 3).

6.2.1 My Care Plan Front Cover: Self-explanatory.

6.2.2 Consent Form: Obtaining written consent. (Also see consent section 3.2)

The Keyworker should explain the content of the consent form and that obtaining written consent is essential for sharing information about the patient to other members of the NMINC team. The Keyworker should highlight that this includes health and social care workers. The keyworker should obtain the patients name, signature and date of signing

6.2.3 Prompt 1: NMINC Prompt for Keyworkers.

This form is designed to support an initial conversation with the patient and perhaps their carer(s). The aims of this conversation are to help the person to understand what NMINC is, what being involved in it might mean to them and to understand their current situation better. This information will help the multidisciplinary team to develop a plan that reflects **what is important to the patient as well as what the MDT wants to happen**.

Self-management support training is available which will help to support you in doing this. Please speak to your manager for information. Refer to Section 10 for course details.

We would like to capture any issues for carers at the same time as understanding the patient's needs and strengths and what is important to them in their daily life.

We would like to know a bit more about their current health and sense of wellbeing, and to understand what is important for them in their daily life.

6.2.4 Prompt 2: Screening for other issues: Admission.

Each of these areas are likely to affect the patient in some way. Try to explore what sorts of issues they have in each, why they are happening and how often. The aim is to have an exploratory conversation with the person. The area's identified in the prompt are for things to explore and enquire about, rather than a list of questions being asked.

For medicines: we don't need to capture all of the medicines the patient is taking, it is more of a general discussion about how their medicines are affecting them or if they have any issues with them.

Depression/anxiety and mental wellbeing: you may wish to screen for suicidal thoughts if you think it fits with what you are hearing.

Scoring: please ask the patient to score how much the issue affects them, where 1 is not much, and 5 is severely. When you have been through all of the issues, please ask them to rank the problems – 1 is the biggest issue and 5 is the least important issue to them.

Anything else: Capture anything else that comes up in conversation that is important for the patient.

6.2.5 Prompt 3: Assessment of Activation – Admission.

This is self-explanatory. Questions to be asked and answered using the scoring from 'strongly disagree to strongly agree.'

The completed prompt (parts 2 and 3) will be used for NMINC evaluation. It is imperative it is completed by the keyworker on the initial visit and at the point of discharge and returned to the NMINC Admin Support Team.

6.2.6 Practice Integrated Care team - Record of Involvement. Graphnet.

All members of the MDT that are involved with the patient should complete the relevant section to their profession.

6.2.7 Practice Integrated care Team - Integrated Care Plan. Graphnet.

About Me:

Provide a concise summary of the person. This may include what is important to them, what do they feel is the main concern, who they live with, whether they have any support from others, what they like to do, any particular dislikes.

Capacity:

Record whether you had any concerns about whether the person had capacity at the time of assessment by stating yes or no. You should presume capacity unless there are reasons to suspect otherwise.

If you did have concerns, record what concerns you had and any actions you took or intend to take, this may include, discussion with GP or carer, mental capacity assessment, intention to return to review in 1 week.

6.2.8 Current Plan. Graphnet

This is the area of the plan focussed on PREVENTATIVE care planning, therefore how to promote a person's health and wellbeing.

The paper form gives 3 sets of 'Risk' entries. Unlimited numbers of 'Risk' entries may be made however, and if so another page should be added so that more entries can be recorded. You have the option to add another risk on Graphnet.

'**Risk**', '**Area of Need**', '**Responsibility**' and '**Task**' - all have drop down boxes from which one choice should be made. If none of the options apply there is a free text 'other' choice which can be made in all these fields apart from 'Risk'.

Goal - This is a short description of what the person wants to achieve, e.g. To feel more confident when I move around, to know who to contact if I need help in a health emergency, or be able to go on holiday in a few month's time.

Expected Outcome - This is a short description of what is expected to be achieved, e.g. To be able to walk confidently with a walking frame within my home, to have a list of phone numbers for emergencies.

Date of review - Each entry should have a review date inputted, this will be the date at which the team / keyworker would expect to review the individual need or group of needs to monitor progress.

End of Life Plan- This is to state if discussions around end of life have been approached and what supporting documentation is in place. Such as, Advanced Care Plan, Preferred Place of Care.

6.2.9 Crisis Plan. Graphnet

This is the area of the plan focussed on CRISIS care planning. What to do when things go wrong, or an emergency situation occurs. The paper form gives 3 entries. However unlimited numbers of entries can be made and so another page should be added sow that more entries can be recorded. You have the option to add another crisis plan on Graphnet.

Presenting state/clinical parameter - this is a free text description of what a usual or expected emergency situation may look like. This may include reflection on previous emergencies, signs and symptoms, issues of importance to the person or areas the professional team identify.

Action – This is a free text description of what actions are taken when the presenting state/clinical parameter occurs e.g. Actions to be taken by the person themselves, or by those caring for them and may include: Instructions on people to be contacted, medication to be taken, guidance on what the person responds well to.

Patient consent to share record – Yes or No response required. All people going through the NMINC should have consented and this section confirms that.

Plan created date - This is the date the keyworker completed the care plan.

Plan review date – This is the date the keyworker will review the care plan with the person.

6.2.9a Background information

The background information is supplied with each patient's record to help Keyworkers complete the care plans. Paper form or Graphnet.

6.3 Guidance for Managing Patient Records.

6.3.1 Before the Keyworker visit

NMINC Admin Support will send 'Acknowledgement letter' to the Patient with an 'Integrated Leaflet' (This can be found in the Admin Operational Manual).

NMINC Admin Support will supply the Keyworker with a Patient Record Pack. (Appendix 3).

When graphnet is live then records section 6.2.6 to 6.2.9 will be on graphnet.

6.3.2 Initial Contact: (first visit). In the absence of an episode of ill health

The Keyworker should obtain written consent, (Refer to Consent Section 3.2 and 6.2.2).

The Keyworker should have an initial conversation with the person exploring the person's understanding of why they have been referred; it may help to explain the integrated leaflet in simple language. The Keyworker should supply their name and contact details on the back of the leaflet.

Keyworker should complete the Admission part of the Prompt: 'Screening for other issues',' Assessment of Activation','NMINC prompt for Keyworkers' (These documents are in the patients record pack.) For more information regarding the Prompt refer to Sections 6.2.3, 6.2.4, and 6.2.5, and 7).

The Keyworker will need to take the written consent to the NMINC admin support team in order for graphnet to be published by the Practice see section 3.2 point 7.

6.3.3 Initial Assessment: (Second and subsequent visits).

The Keyworker should assess the patient's health literacy, and adapt the delivery of care appropriately. This will assist the patient achieving an increase in self-care behaviours. For more information on health literacy refer to Appendix 6

The Keyworker should open discussion's that allows the patient to identify what is important to them and what are the main concerns. The completed prompt will help with this.

The Keyworker and Patient/carer/relatives collaboratively agree on a care plan that will support the person to increase and make changes in the way they self-care. For more information on enabling self-care refer to Appendix 7.

The care plan will include the 'Graphnet – Record of Involvement',' Graphnet- Integrated Care Plan',' Graphnet - The Current Plan',' Graphnet - The Crisis Plan'.

The Keyworker should visit the patient for a period of approximately 12 weeks or 12 face to face contacts. The keyworker should inform the patient they will be working with them for a period of 3 months.

The Keyworker should refer to, and collaborate with appropriate specialist services and supporting community resources. This will enable the best disease management within self-care, that is centred on the patient's health and social care needs. A selection of specialist teams can be seen in Appendix 5.

All services involved should input on the Graphnet.

The Keyworker and the Patient should sign the care plan documentation.

The Keyworker should ensure that the patient receives a copy of the care plan (Graphnet).

The Keyworker should discuss developments in the care plan at the MDT review. (Refer to Guidance for the MDT Process).

The keyworker and patient should work together towards a timely discharge, from approximately 6 weeks. Aiming to discharge at 12 weeks

The patient should have the right care plan in place to enable the patient to self-manage their health and social care needs.

The care plan should detail how the patient can prevent deterioration in health (See Current plan section 6.2.8.)

The care plan should detail the 'clinical parameters' or signs and symptoms, that may indicate the patient deteriorating into crisis. This should describe the 'actions' the patient needs to take in order to prevent severity, and what to do when reaching crisis. (See Crisis plan section 6.2.9).

Following discharge the keyworker should inform the NMINC Admin Team and supply a copy of the prompts, care plan and consent form.

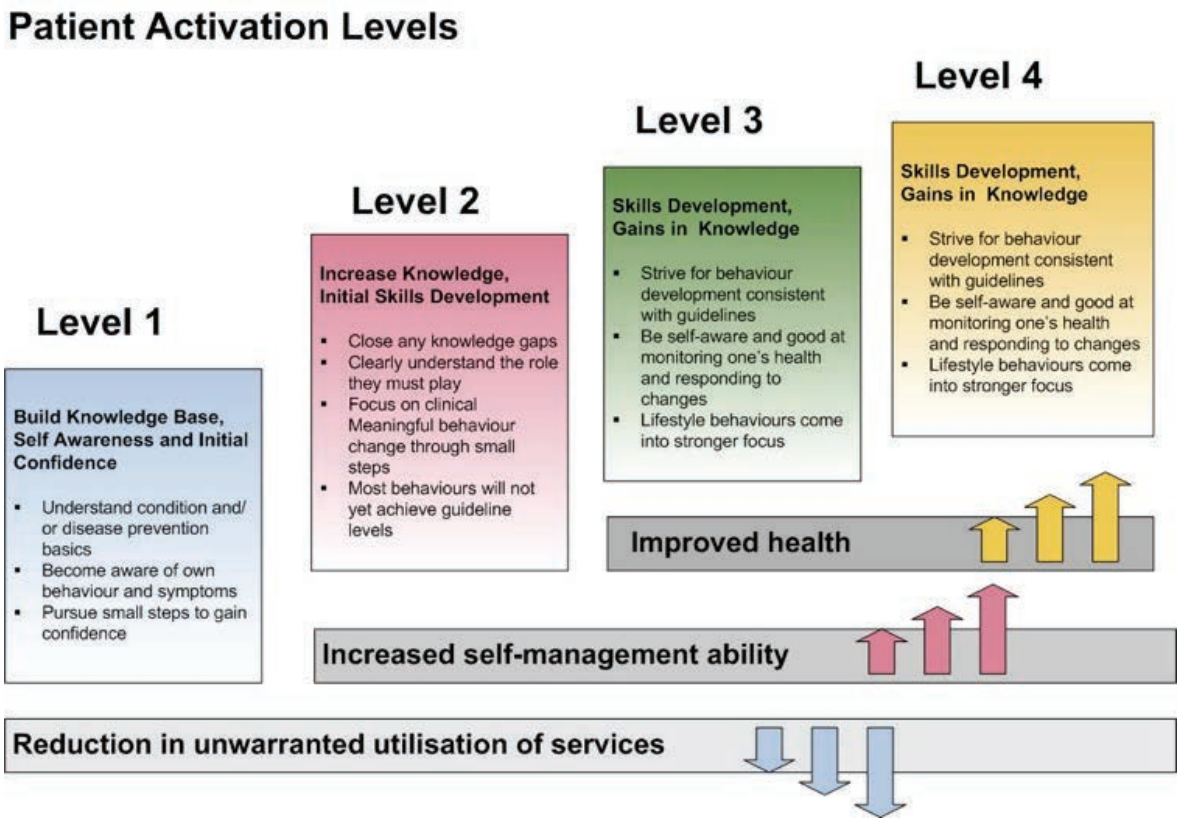
7. The Prompt

The Prompt consists of 3 parts see section 6.2.3, 6.2.4, 6.2.5. The prompt refers to the PAM, below describes why the prompt will help with beginning a relationship with the person that will support their self-management.

Patient Activation

The Patient Activation Measure® (PAM®) assessment gauges the knowledge, skills and confidence essential to managing one's own health and healthcare. Individuals that measure high on this assessment typically understand the importance of taking a pro-active role in managing their health and have the skills and confidence to do so.

The PAM assessment segments people into one of four progressively higher activation levels. Each level addresses a broad array of self-care behaviours and offers deep insight into the characteristics that drive health activation, including attitudes, motivators, behaviours, and outcomes



Without a systematic way to assess patient capabilities for self-management, coaching often takes a one-size fits all approach that pursues evidence based self-management objectives for all participants. Tailoring support to activation levels recognizes that individuals possess differing levels of knowledge, skill and confidence in managing their health.

In North Manchester the Patient Activation Measure is being trialled in a number of ways to improve the delivery of health care, including:

- a metric to assess the degree to which patients are prepared and able to self-manage
- to tailor support and education to help them increase in activation
- to track the impact of interventions and tailored support on increasing patient activation levels

Further information http://www.insigniahealth.com/solutions/patient-activation-measure

8. Graphnet

The Graphnet interface may change. You will be notified of any changes.
Practice Integrated Care Teams Record Pilot – Setting up Patients with Integrated Care Plans by GP Practices in the Graphnet System

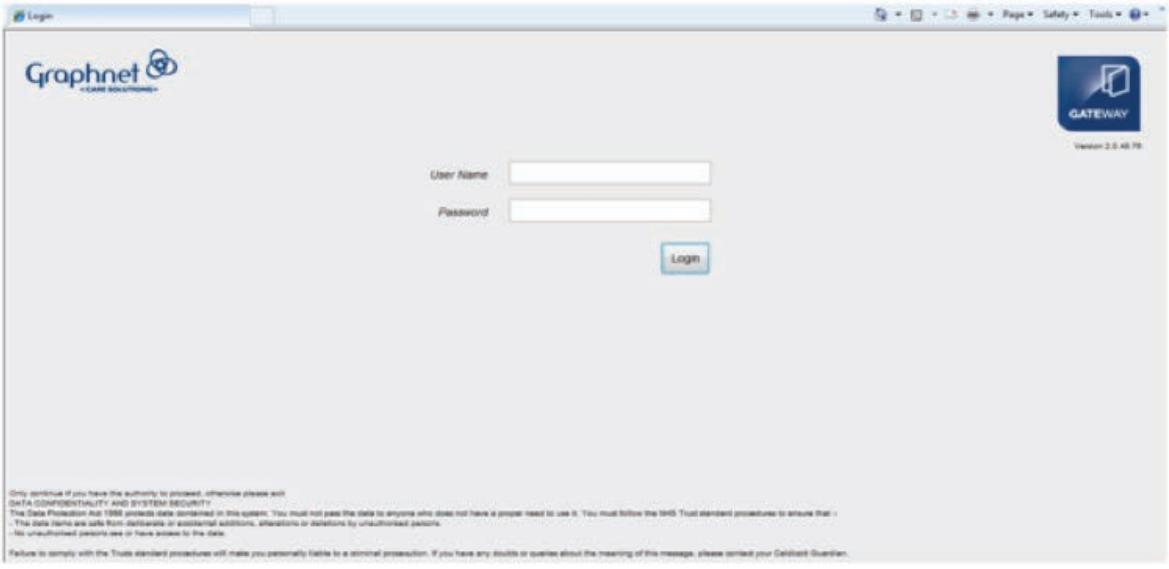
Step 1 - Identify Patient and Log on to the Graphnet site

Initially the GP will be using a Risk Stratification List of patients within the Practice. The GP or keyworker will contact the patient and discuss the benefit of going onto a care plan for their condition and well being. This may be face-to-face (at the practice or at home) or over the telephone. At this discussion, the patient will be asked to give their consent. This is essential for the process to continue.

With this consent, the GP or keyworker will then log onto the system. They will be able to see all the patients in their practice but none outside it.

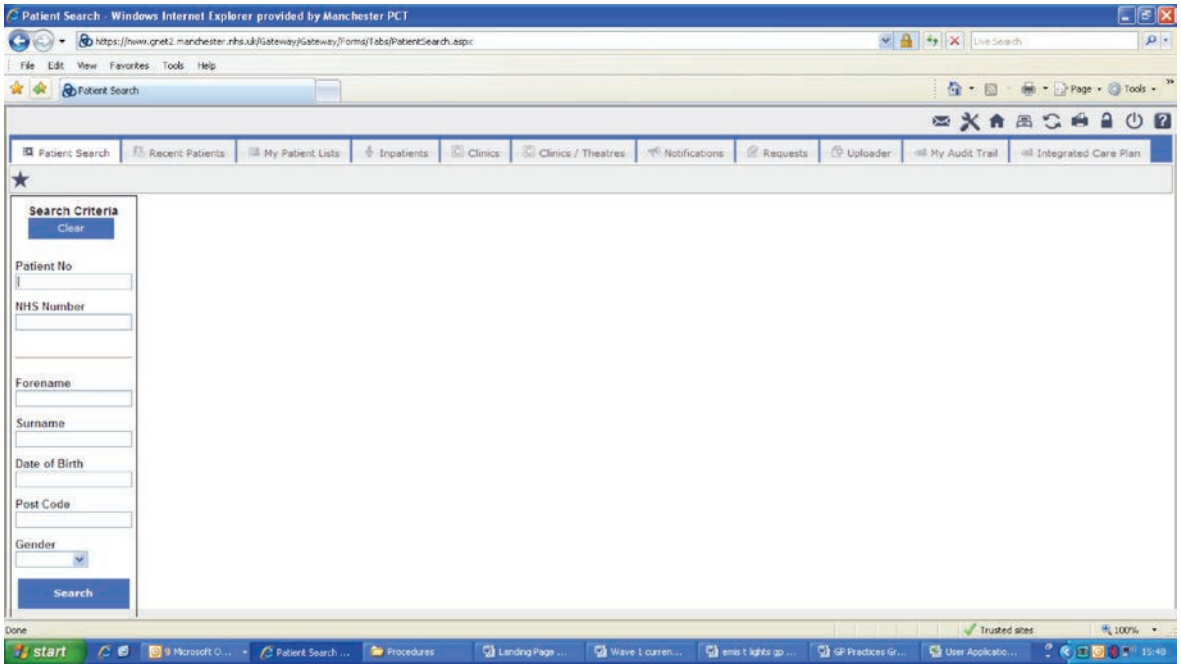
The site address is:

https://nww.gnet2.manchester.nhs.uk/Gateway

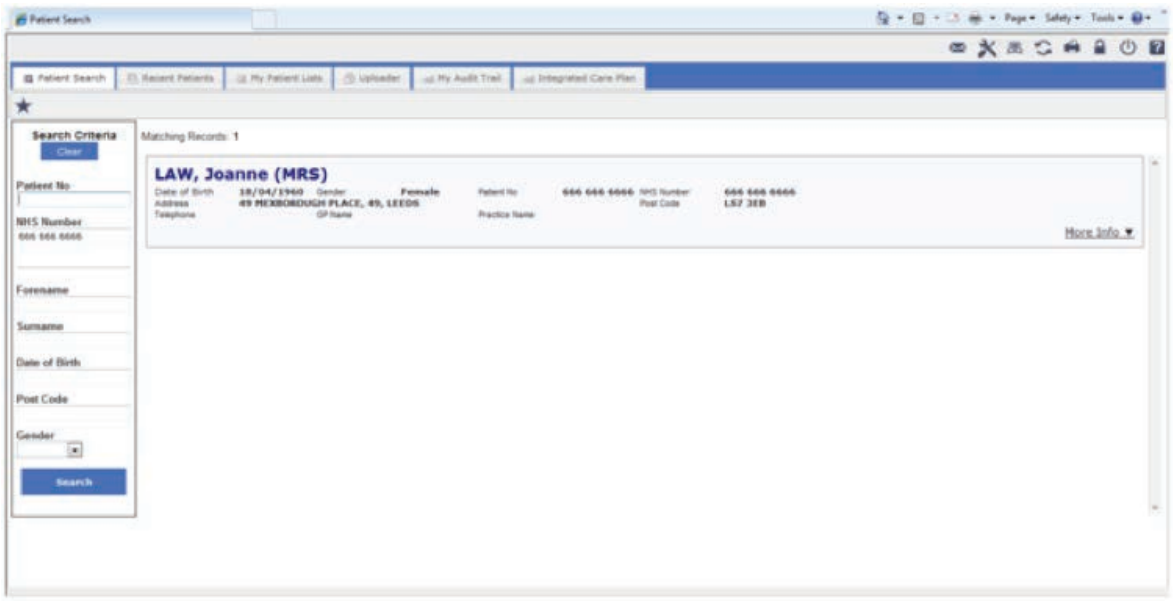


Step 2 - Search for the Patient and access the Patient Record

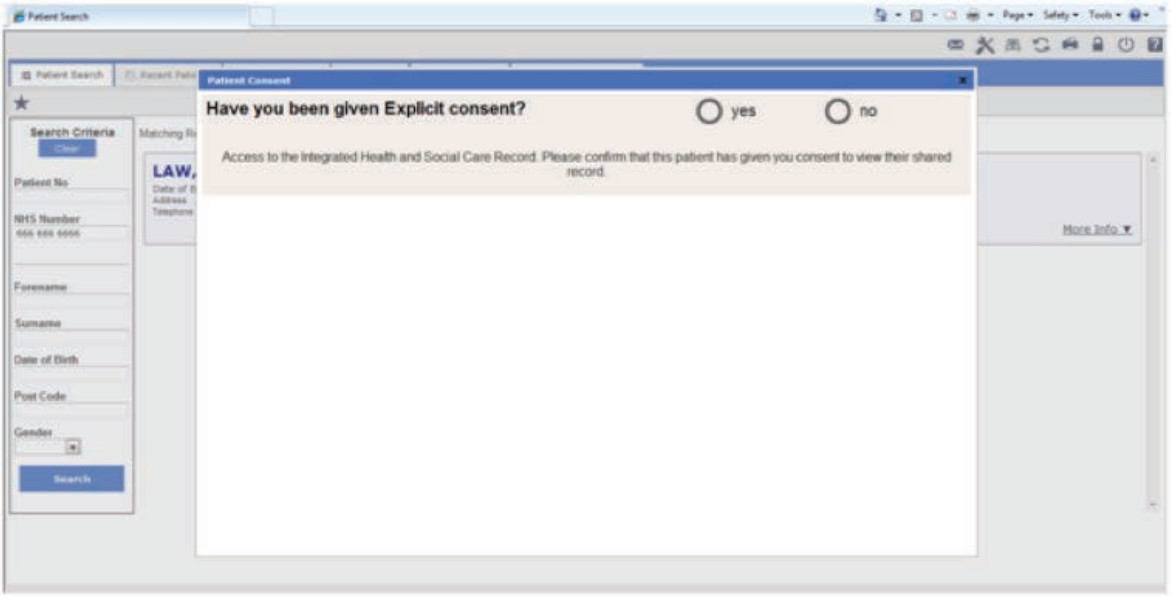
When you first log on, you will be presenting with the following screen to search your patent / practice list. You will have access to all the patients in your practice. Only the GP practice users have access to all the GP practice registered patients data as data controller.



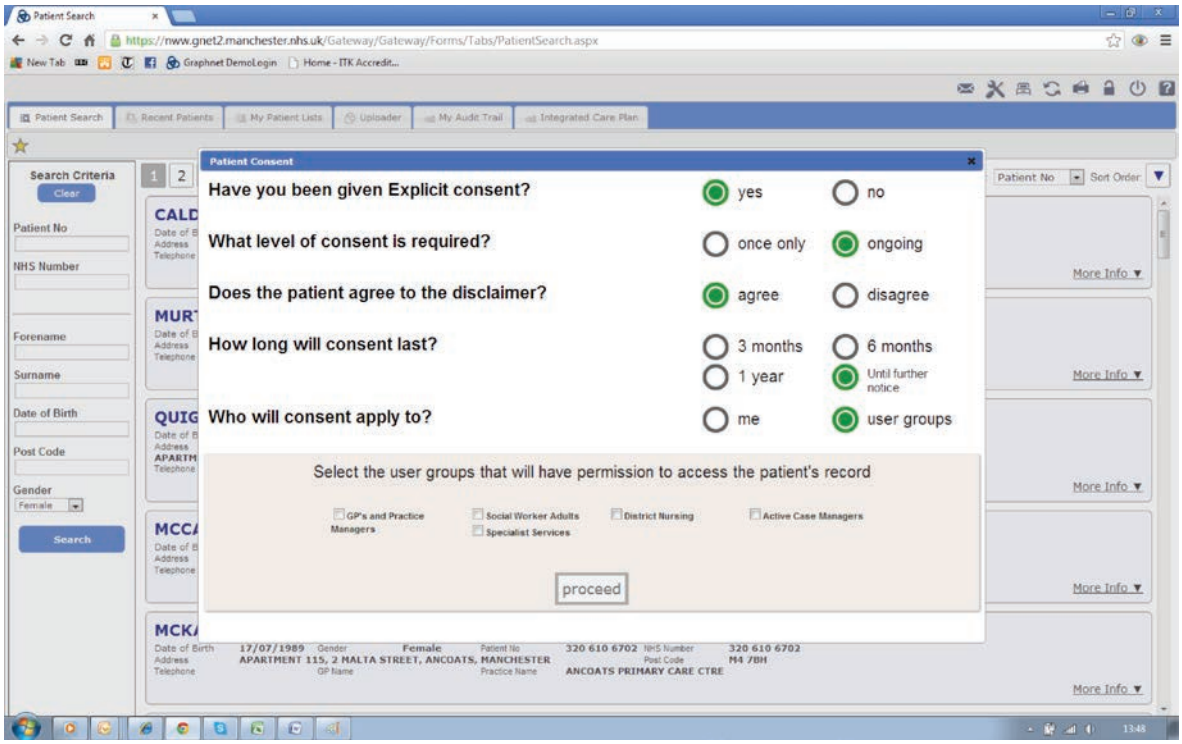
- Search by name or by NHS number to verify it is the correct patient.
- Double clicking on the patient name panel opens the record.



The system will now ask you about Consent:

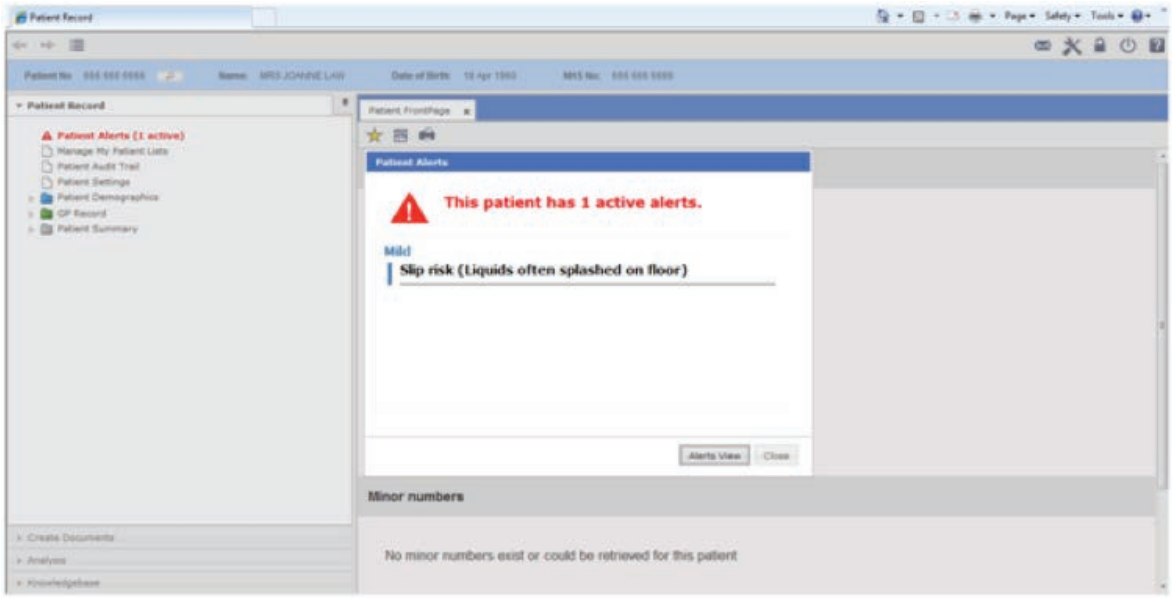


- if you have been given consent to access to record – ***click 'yes'***
- what level of consent is required – ***click 'ongoing'***
- Does the patient agree to the disclaimer? – If yes – ***then print the disclaimer before clicking 'agree'***
- How long will the consent last? – ***click 'until further notice'***
- Who will the consent apply to? – ***click on each of the groups listed – ACM, District & Community Nursing , Social Workers, Specialist Services***



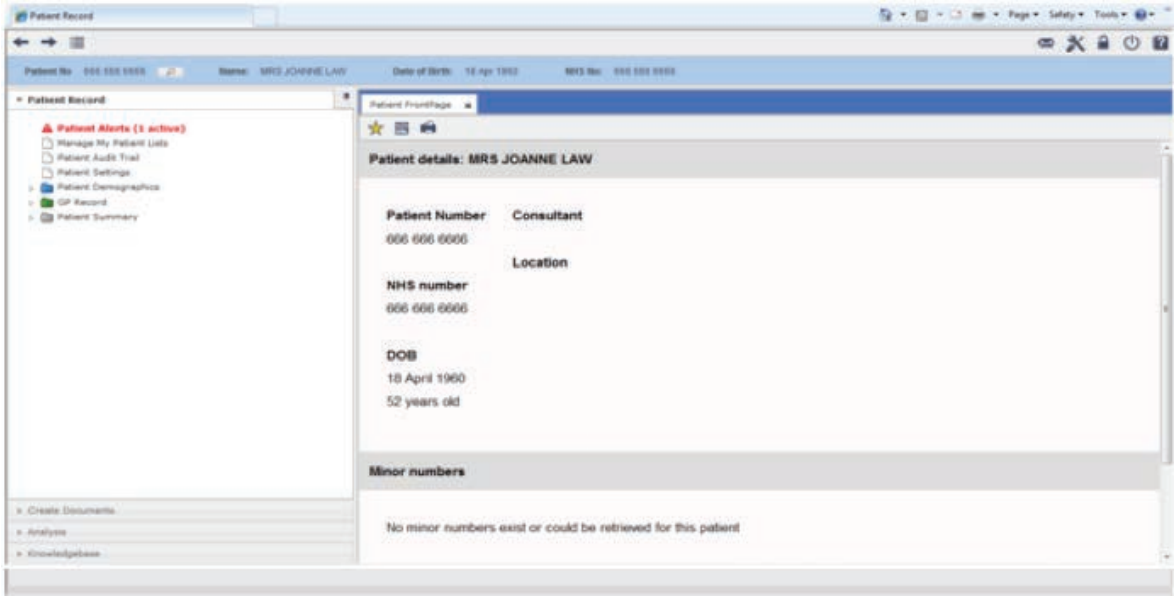
- ***click proceed***, and you will arrive at the main record

If the patient has alerts – not just medical but environment etc, these will appear for you to read and then close the window



Step 3 - Create Integrated Care Plan Document and confirm Consent for PICT

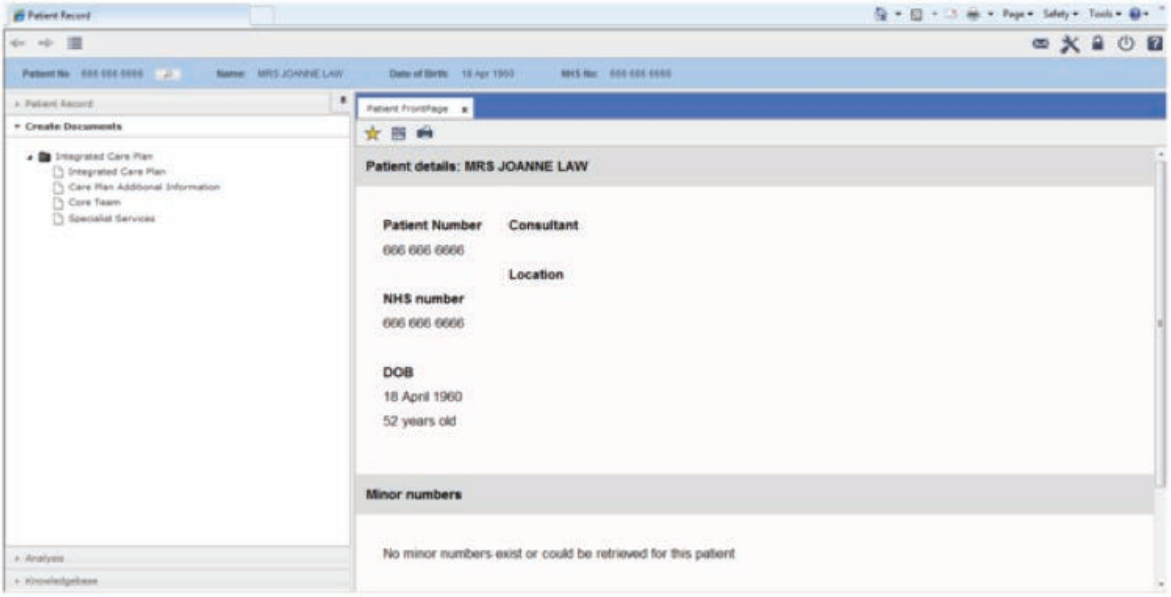
Once you have clicked into the patient record you will see on the left side of the record a tree folder structure.



If there is a folder named integrated care plan – the patient already has been set up in the system

If there is not a folder in the tree - they need a care plan and each of the sections of the care plan generating

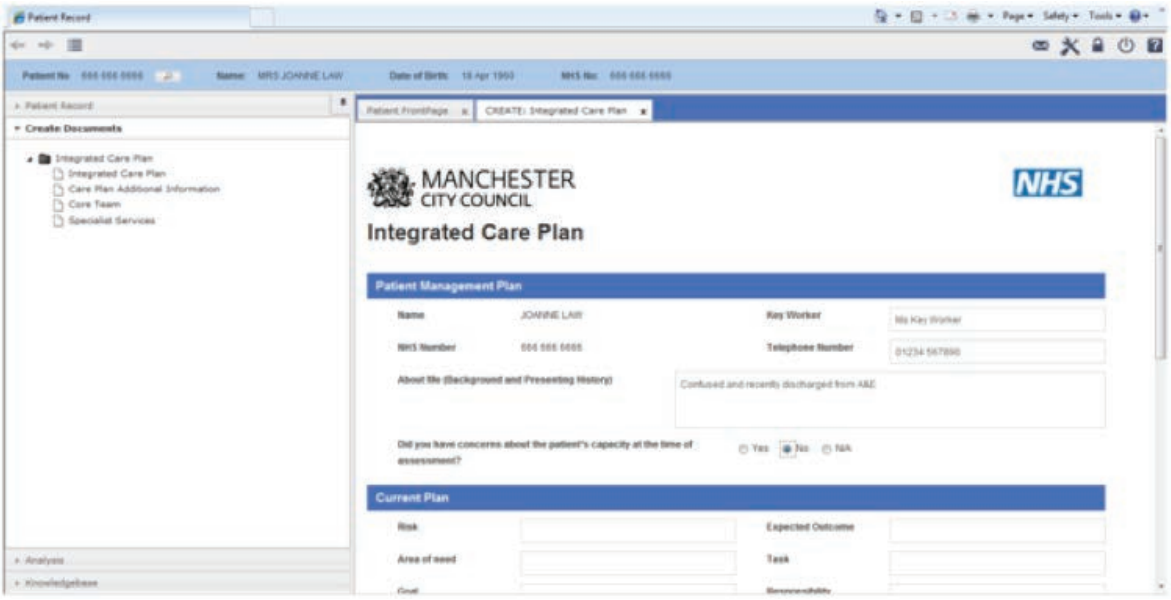
- please click on **create documents** at the bottom on the page on the left



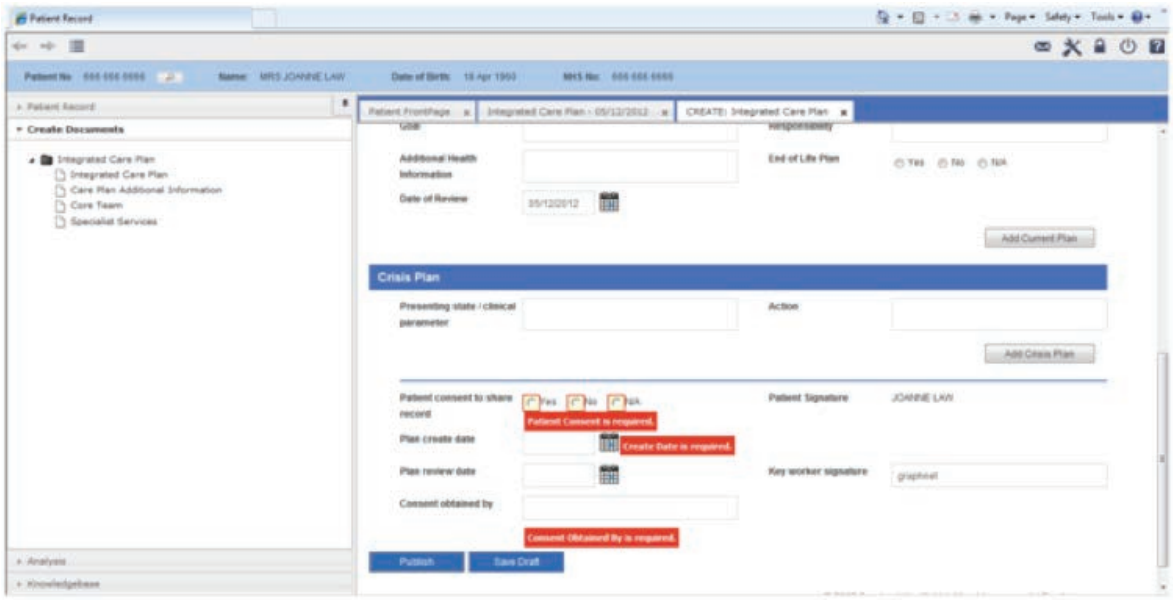
- click on the **integrated care plan folder**

A number of folders or document section will now be listed.

- You need to click on the **Integrated Care Plan document** first and record the patient consent to joining the Practice Integrated Care Team approach and the start of the care Plan itself



- Scroll down the record to where it says patient consent to share



- Click **yes**

  It will come up with today's date automatically

  Ignore the review date for now

- Consent obtained by – type in here the GP's name who obtained consent
- You **must** now click on **publish**

This will enable it to be seen by the integrated care team and completed by the relevant team member. If the team member to complete this is the GP – please complete all the relevant section.

You must always Publish to save and share the document

Step 4 - Create Remaining Care Plan Documents

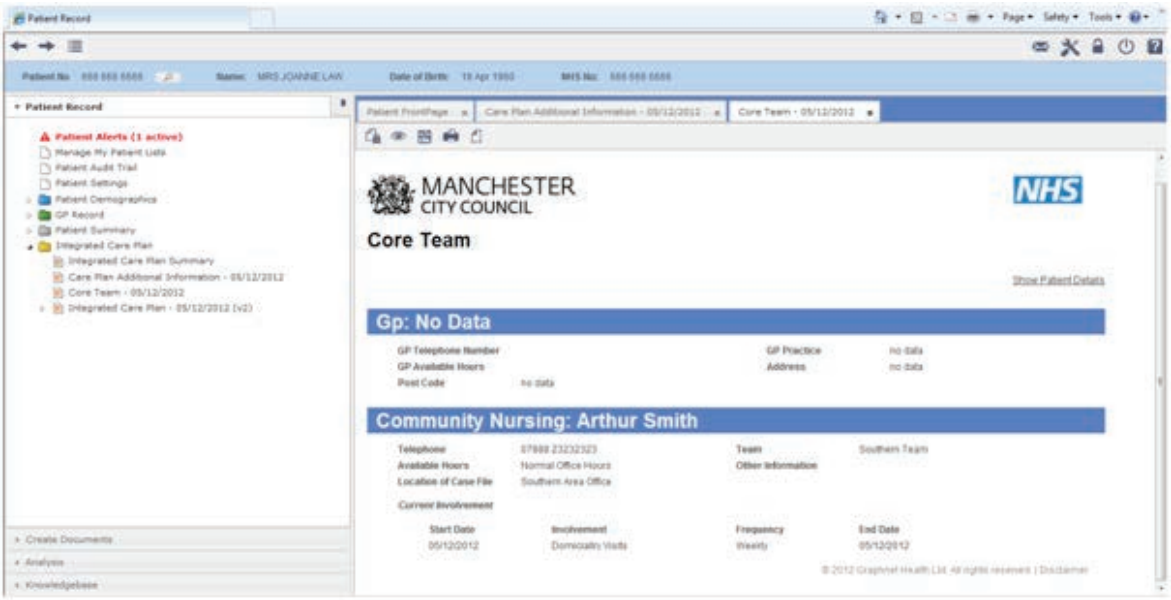
- You must now click on the other documents in the list to start all the care plan documents off, and let them be seen by the integrated care team
- Click on and each section of the Care Plan documents or sections to create them for the rest of the PICT to access:
  - Care Plan Additional Information
  - Core Team
  - Specialist Services
- Just Scroll down and click on Publish in each section

  Once you have done this for each of the documents in the tree they can appear to the rest of the Team

  Now check the main patient record

- Click on the patient record – top left of page above create documents

  The integrated Care plan will now be a yellow coloured folder in the tree of patient records and available for other members of the Integrated Care Team to complete from wherever their work base is.



You can only create 1 care plan and section of the Care Plan.

A Care Plan summary will now also appear in the document tree as shown above

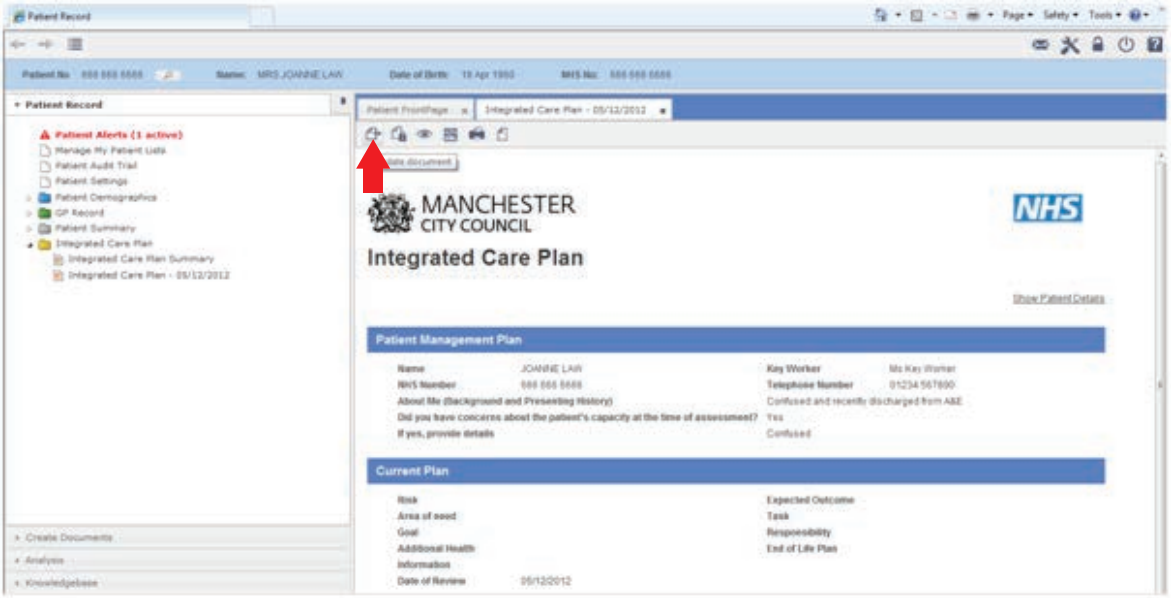
You can now search for your next patient , add some details to one of the sections of the care plan , or log off the system

Step 5 - Editing and Updating the Care Plan Sections

The only part of the patient record that is editable is the Integrated Care Plan. All other information is view only.

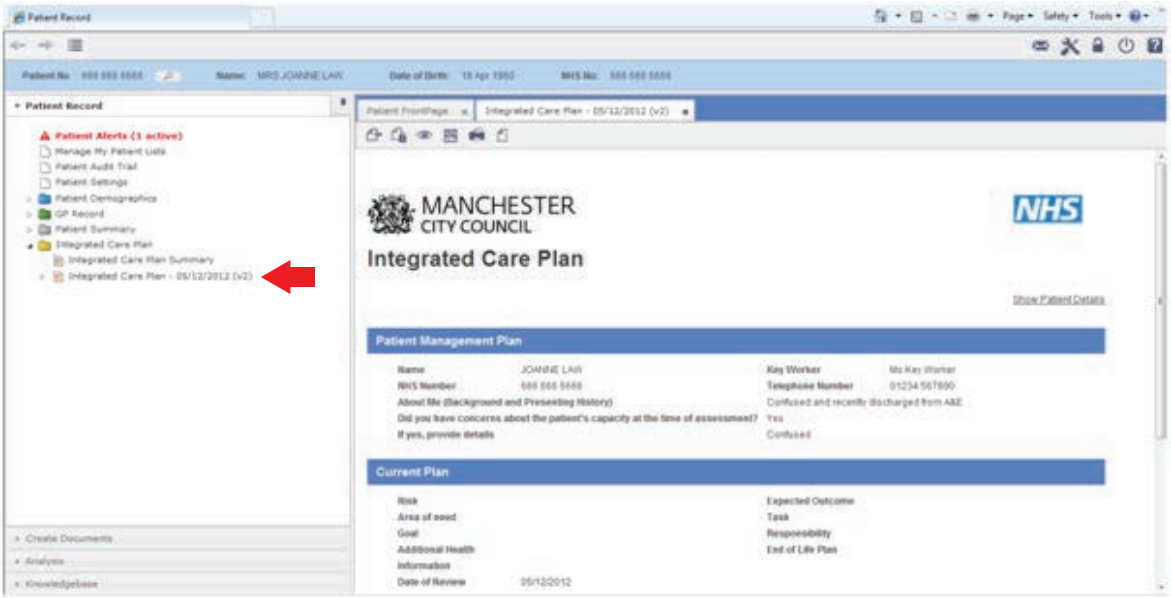
Once you have clicked into the patient record you will see on the left side of the record a tree folder structure.

Any section of the care plan / form can be updated by clicking the icon below (red arrow ⬅). If you roll the cursor over the icon (as with any icon in the system) an explanatory note appears (i.e. Update Document below).



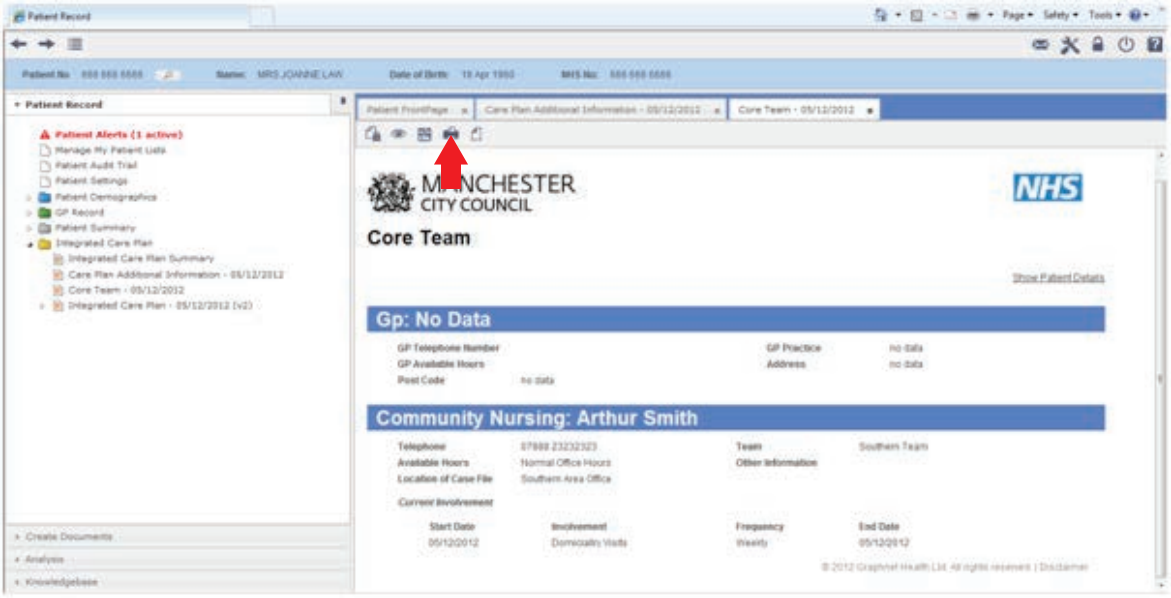
Make your additions to the section and to save those changes you much click Publish once you have updated the section of the Care Plan

On publishing the updated form a version number will appear in the document tree (i.e. v2 below - see red arrow). All changes and updates are tracked – so you know instantly when it was last updated

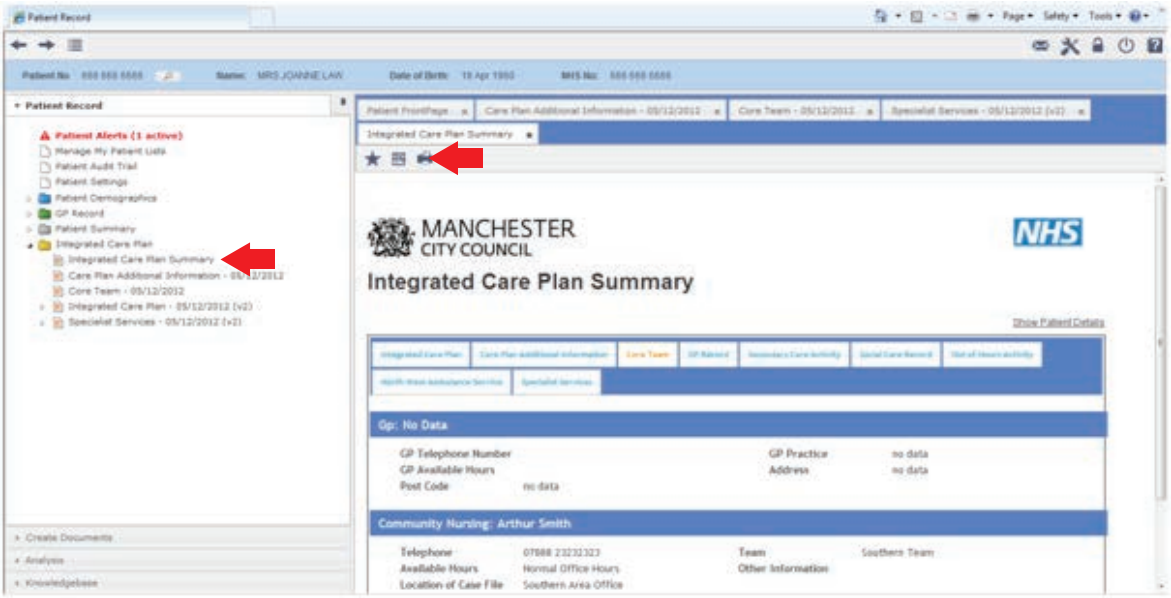


Step 6 - Printing a Section or the Whole of the Integrated Care Plan

You can print a hard copy of any sub-section of the care plan clicking by the print button as shown by the red arrow below:

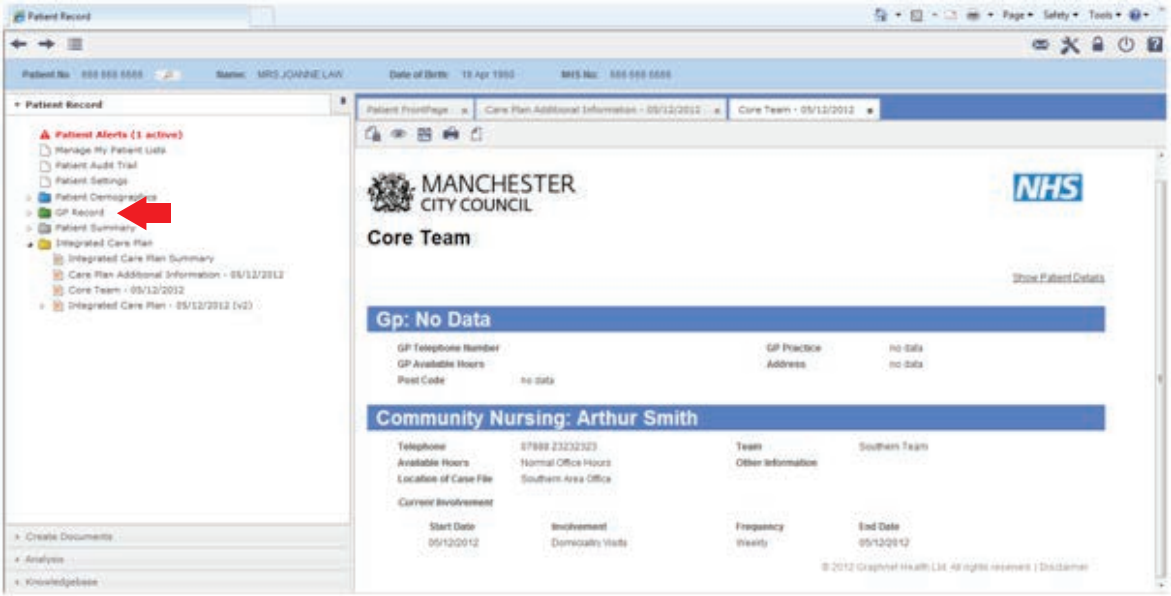


You can print the full care plan and any data within it by firstly viewing the Care Plan Summary in the Document tree on the left, and then clicking the print button as shown below:

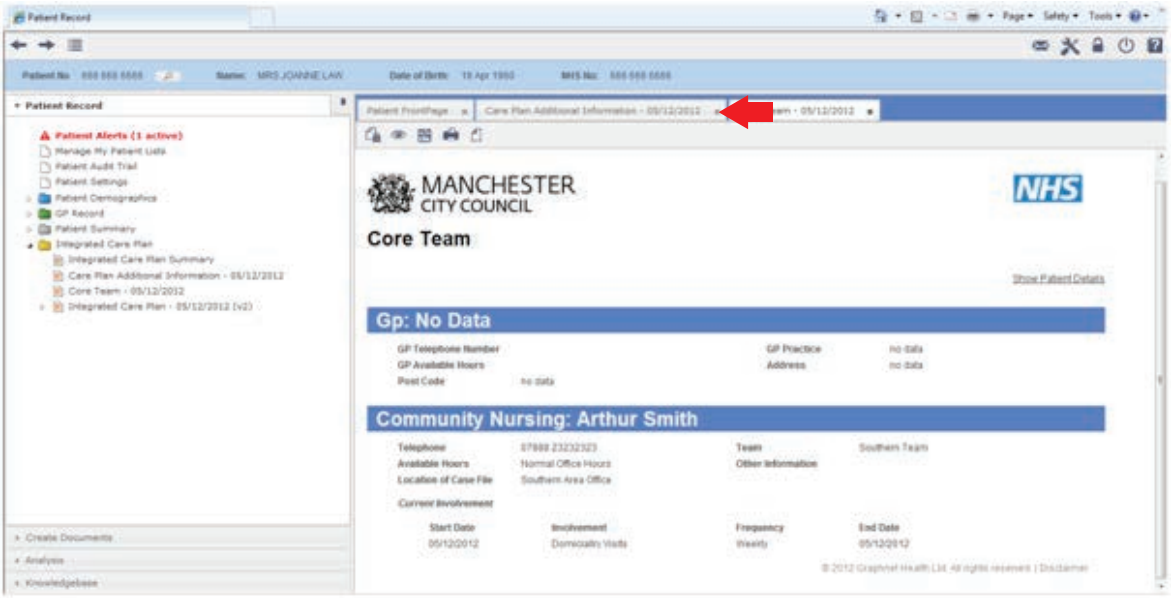


Step 7 - Opening and Closing the Sections of the Patient Record

You can look at the different data feeds in the patient record in the document tree on the left. The GP record will open out to multiple sub-folders or sections the same at the Integrated Care Plan, if you click in the folder below



Keep an eye on the number of windows you open up. To close a section of the patient record, simply click on the cross as shown below.



Where to go for help?

If you are having problems or think you may have made an error, please contact:

IT Training

IT Education, Training & Development - 0161 765 6038/6042

Ann-Marie Shields – ann-marie.shields@manchetser.nhs.uk

Nia Pendleton-Watkins – 07581 164 967, nia.pendleton-watkins@manchester.nhs.uk

PICT support - NHS-MAN.PICT@nhs.net

- Software/System Support by the Helpdesk Team 0161765 4700 which covers the hours from 08:00 to 20:30 Monday to Thursday, 08:00 to 17:30 on Fridays, 08:00 to 13:00 on Saturdays. General system queries can be to the Manchester PCT help desk and will be escalated from here.

9. Training

MDT Members.	Enabling Self-care Training for MDT Members
	Introduction to CPM – Briefing for GPs and MDT Members
	Introduction to Graphnet for MDT Members
Managers.	Introduction to NMINC for Managers
Administrator.	Introduction to NMINC for Administrators
	Introduction to Graphnet for Administrators

NMINC, working in partnership with;

The Pennine Acute Hospitals NHS
NHS Trust

NHS
North Manchester
Clinical Commissioning Group

Manchester Mental Health NHS
and Social Care Trust

MANCHESTER
CITY COUNCIL

To book places on any of the following please email to NMINC.Training@pat.nhs.uk for an application form.

For further information on the training and development provided by the Health & Wellbeing Service see:
http://goodhealth-manchester.nhs.uk

Enabling Self-care Training for MDT Members

Who should attend?

This course is designed for practitioners in health and social care who are working directly with patients who are involved in the North Manchester Integrated Neighbourhood Care Programme.

Course Aims:

- Understanding of self-care, how it works and potential benefits
- Skills in hosting helpful conversations with people about self care
- Ability to use simple tools and approaches for supporting change with people
- Become more confident in offering tailored advice and support to people to achieve lifestyle change and improved mental wellbeing

Venue:

Health & Wellbeing Service, Victoria Mill, Miles Platting, Manchester, M40 7LJ

Training Organisation:

Health & Wellbeing Service, Manchester Mental Health & Social Care Trust

Introduction to CPM – Briefing for GPs and MDT Members

Who should attend?

This course is designed for practitioners in health and social care who are involved in the North Manchester Integrated Neighbourhood Care programme. The course is designed to explain the use of the CPM risk stratification tool.

Course Aims:

- Ability to effectively use CPM for risk stratification and identifying patients for integrated care planning via the Multi-Disciplinary Team.

Venue:

Education Centre, Floor 2 - Trust Headquarters, North Manchester General Hospital

Training delivered by:

North Manchester Clinical Commissioning Group

Introduction to Graphnet for MDT Members

Who should attend?

This is designed for practitioners in health and social care who are involved in the North Manchester Integrated Neighbourhood Care Programme. The course is designed to explain how Graphnet works as a piece of software and how NMINC recording will be done using Graphnet.

Course Aims:

- Describe what Graphnet is and how it works
- Describe how NMINC care planning will be recorded on Graphnet
- Use of Graphnet for data sharing and care planning

Venue:

Education Centre, Floor 2 - Trust Headquarters, North Manchester General Hospital

Training Organisation:

North Manchester Clinical Commissioning Group

Introduction to NMINC for Managers

Who should attend?

This is aimed at mangers, supervisors, team leaders etc in the health and social care sector who support and direct the work of MDT practiotioners involved in the North Manchester Intergrated Neighbourhood Care (NMINC) project

Course Aims:

- Describe the concept
- Describe the MDT process.
- Describe MDT member roles.
- Describe "key worker" role
- Describe NMINC aims and expected outcomes
- Describe the NMINC evaluation framework and the theory of change that underpins it.
- Describe the knowledge and skills needed by MDT members.
- Describe the managers role in supporting / supervising their staff

Training Support:

- Access e learning 'Introduction to NMINC' Learning and development dept.
- NMINC operational manual - Managers Reference Guide. You can access this on the NMINC website.

Introduction to NMINC for Administrators

Who should attend?

This course is aimed at administrators who support NMINC MDT members and the NMINC core project team and describes the NMINC concept, the model and the process.

Course Aims:

- Describe the concept, including self care
- Describe the MDT process
- List the practice based MDTs responsible for supporting NMINC
- Describe the role of the administrator in the process
- Describe the role of other MDT members
- Describe the "key worker" role

Training Support:

- Access e learning 'Introduction to NMINC' Learning and development dept.
- NMINC operational manual - Managers Reference Guide. You can access this on the NMINC website.

Introduction to Graphnet for Administrators

Who should attend?

This course is aimed at administrators who support NMINC MDT members and the NMINC core project team. The course is designed to brief administrators on how Graphnet works as a piece of software and how NMINC recording will be done using Graphnet. The session will provide a demonstration of Graphnet and the opportunity to practice the use of the software.

Course Aims:

- Describe what Graphnet is and how it works
- Describe how NMINC care planning will be recorded on Graphnet
- How to input data into to Graphnet

Venue:

Education Centre, Trust Headquarters, Floor 2, North Manchester General Hospital

Training Organisation:

North Manchester Clinical Commissioning Group

10. Additional sources of support

http://goodhealth-manchester.nhs.uk

This link leads you to the new training website produced by Manchester Mental Health and Social Care trust.

http://www.manchestercommunitycentral.org/reducing-social-isolation-loneliness-grant-funding

This link leads you to a list of the voluntary sector projects funded by the three Manchester CCGs to reduce social isolation and loneliness among older people.

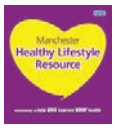
http://www.manchester.nhs.uk/clinicalcommissioninggroups/nminc.html

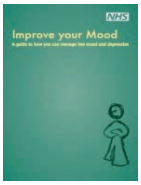
This link leads you to the NMINC Toolkit on the Manchester CCG website.

Links for further information about Self Care

NHS Choices – Your Health Your Choice	http://www.nhs.uk/Pages/HomePage.aspx
Self Care Toolkit	http://webarchive.nationalarchives.gov.uk/20130107105354/ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_087300.pdf
Self Care Forum	http://www.selfcareforum.org/
Self Care Connect	http://www.selfcareconnect.co.uk/
The Pain Toolkit	http://www.paintoolkit.org/
Know your Own Health	http://kyoh.org/The-self-management-ecosystem/
Choose Well Manchester	http://www.choosewellmanchester.org.uk

11. Directory for Additional Sources of Support

Name & Type of Resource & Date Produced	What is it?	Who Produced it and how is it accessed?	Who is it suitable for?	What can it help with?
RESOURCE PACKS				
Manchester Healthy Lifestyle Resource 2013 	A5 hardback folder, split into sections on different aspects of healthy lifestyle. Contains information as well as tools (e.g. activity diaries, action plans)	Produced by the Manchester Health and Wellbeing Service. Copies distributed through training courses and are available from Victoria Mill.	Staff supporting the public to make lifestyle changes	• Food & nutrition • Physical activity • Living smoke free • Disease prevention • Mental health and wellbeing • Healthy Living
Manchester Community Health Trainers Resource Pack 2012 	A5 hardback folder, split into sections on different elements of lifestyle and behaviour change. Practical, with images and clear presentation of information.	Produced by the Manchester Health and Wellbeing Service. Resource shared with individuals using the Community Health Trainers Service. Distributed by individual Health Trainers.	For the public wanting to make lifestyle changes	• Food & nutrition • Physical activity • Living smoke free • Drinking less alcohol • Mental health and wellbeing • Making and maintaining change
DIRECTORIES OF SERVICES				
Directory of North Manchester's Social Care Support Services 2014	A4 paper directory of services for focusing on Social Care Support Services that may be able to supplement a customer's care plan.	Produced by Manchester City Council. See document below  North Manchester Directory	This is a resource for staff to pass on information. Not designed to be given out to customers.	• Befriending • Carers support • Lunch clubs • Education and employment support • Practical support
Zest Activities Guide. Winter 2013-2014 	Groups and activities guide for improving wellbeing (organised by local area)	Zest is North and East Manchester's Healthy Living Project working with local people, communities and organisations to improve health and well-being. Produced, supplied and regularly updated by Zest. For copies ring 234 3715. Further information can be accessed via Facebook www.facebook.com/ZestManchester and twitter at www.twitter.com/ZestManchester or via www.tinyurl.com/ZestManchester	For the public wanting to take part in local activities	• Physical activity (Zumba, yoga, dancing, tai chi) • Relaxation • Drop in groups
Zest What's On Guides for GP Practice	Directory of what's available in specific GP practice areas.	Supplied and distributed by Zest. Practice copy of this resource is held by individual practice managers.	For practitioners to be able to signpost the public what is available in the local community	Social groups and activities, Work clubs, services for individuals and carers, drop in groups.

Name & Type of Resource & Date Produced	What is it?	Who Produced it and how is it accessed?	Who is it suitable for?	What can it help with?
MENTAL HEALTH & WELLBEING LITTLE BOOKS				
The Living Life to the Full (5 areas) Booklets	These brief and accessible guides address a range of common problems with key points to help resolve them, based in cognitive behavioural (CBT) approaches. Lots of the books are structured as workbooks. Example below  	The Living Life To The Full series has been developed and written by Written by Chris Williams www.llttf.com. Copies of the Living Life To The Full range are also available from www.llttfshop.com or read samples online at www.fiveareasonline.com These booklets are available to those working in Manchester and are supplied by the Manchester Health and Wellbeing Service. Stocks are held at Victoria Mill, Ground Floor, Miles Platting, Manchester M40 7LJ.	For the general public. Ideally to be used with a practitioner as supported self help	**Guides covering topics such as:** **Why do I feel so bad?** Provides insight into the vicious circle that maintains distressing thoughts and behaviours **How to fix almost everything**. A four step plan to making a start on your problems when you are feeling low. **Why does everything always go wrong?** How to beat bad thoughts that cause bad feelings **I'm not good enough**. How to overcome low confidence. **I feel so bad I can't go on**. How to deal with suicidal feelings. **10 things to make yourself happier straight away.** Simple activities to improve wellbeing. **Reclaim Your Life** (from illness, disability, pain or fatigue)
Manchester developed guides	Designed for people with specific issues around low mood, anxiety, sleep problems.  	This range are designed and produced by the Public Mental Health Team (Health and Wellbeing Service) in conjunction with Psychological services at MMHSCT. These booklets are supplied free to those working in Manchester by the Manchester Health and Wellbeing Service.	For the general public. Ideally to be used with a practitioner as supported self help	**Improve Your Mood**, a guide to managing low mood and depression. **Distress to De-stress collection**: ● **From Distress to De-stress**, a guide to dealing with stress and anxiety, especially the physical effects. ● **Unwind your Mind**, a guide to managing anxiety and worry, especially persistent and difficult thoughts. ● **Relaxation CD** **Sleep well – a guide to a better night's sleep** **Work and Mental Health**, a guide to managing work whilst you have a mental health problem

Name & Type of Resource & Date Produced	What is it?	Who Produced it and how is it accessed?	Who is it suitable for?	What can it help with?
Dementia Guides	Information on dementia and support available	Locally produced booklets and national information from the Alzheimer's Society All mental health booklets are supplied. See order form  Mental health guides order form		**Dementia information** : ● The dementia guide, living well after diagnosis ● Help cards, your communication tool ● Dementia. If you're worried, see your doctor ● Worried about your memory? ● 5 things you should know about dementia ● Dementia friendly community ● A guide to dementia ● Worried someone close to you is losing their memory?
Health Information Leaflets and Resources	Information leaflets, posters, teaching packs models, DVD's and books on a number of health promotion topics.	Health and Wellbeing Service developed and nationally produced. Limited stocks can be accessed via the Health and Wellbeing Service at Victoria Mill, Ground Floor, Miles Platting, Manchester M40 7LJ. The Health Information and Resources Library hold a wide range of resources. Based at 1st Floor, Fallow field Library, M14 7FB. Tel : 248 1769 http://www.mhsc.nhs.uk/services/library-services	Resources available for staff	● Stopping Smoking leaflets / resources ● Food & Mood ● Physical Activity and Mood ● Living with a long term physical health condition ● Drink Smart Guide ● Looking after your heart ● Cancer screening
COURSES FOR PRACTITIONERS Face to face courses for practitioners who want to develop their approach to supported self-management/enabling self-care				
Enabling Self Care	1 day course for practitioners, supporting them to enable self-care with patients and customers.	NMINC workers – by application to emma.kyte@pat.nhs.uk Tailored courses for practices – contact jackie.kilbane@mhsc.nhs.uk Health and Wellbeing Service course - by application via www.goodhealth-manchester.nhs.uk/training	Courses for practitioners	● Understanding self-care. ● Supporting conversations about self-care. ● Using behaviour change approaches. ● Signposting for self-care.
Connect 5: Mental Health in Everyday Practice	Training course from half a day to the full 2.5 days	Courses developed and delivered by Health and Wellbeing Service - by application below - http://www.goodhealth-manchester.nhs.uk/training/	Courses for practitioners	Help practitioners to better understand mental health, mental wellbeing. Learn about services, techniques and resources that enable people to help them. Develop the skills and confidence to work with people with poor mental health and wellbeing.
Emotional Aspects of Consultations	2 x 2 hour workshops for clinical staff. Equips staff to recognise and respond to the emotions that can have an impact on a person's ability to manage their long term health condition.	Emotional aspects of consultations is available on request by contacting Teresa.czajka@mhsc.nhs.uk		

Name & Type of Resource & Date Produced	What is it?	Who Produced it and how is it accessed?	Who is it suitable for?	What can it help with?
COURSES FOR THE PUBLIC				
BOOST (emotional resilience) course	A free 6 week course to improve wellbeing. Learn skills to cope with life's ups and downs. 2 hours a week. Held across local venues across Manchester.	Developed by the Health and Wellbeing Service/ Self Help Services. Open courses for the public delivered by Self Help Services. Tailored courses delivered by Health and Wellbeing Service and partners. For more information and to apply for open courses visit http://www.selfhelpservices.org.uk/shs_condition/self-esteem/#emotional-resilience-course	Anyone 16 and over (general public)	Understanding feelings and emotions, understanding unhelpful thinking styles, managing stress, how to communicate needs, building self-esteem and assertiveness, how to build wellbeing.
Expert Patient programme: **Staying well with a long term health condition**	2.5 hour course, held over 6 weeks at local venues across Manchester.	Part of UHSM. Referral by phone on 0161 371 2105  EPP referral form	General public who want to learn how to manage their long term condition	• Information and support for managing one or more long term health conditions. • Increasing confidence in dealing with health problems. • Support for healthier lifestyles.
Self Help Groups and courses	Support groups and courses for people experiencing anxiety, depression, low self-esteem, substance misuse.	A range of services offered by Self Help Services, a local mental health provider. Aimed at people with poor mental and wellbeing. Accessed via 0161 226 3871 or email admin@selfhelpservices.org.uk See the full list of all courses and groups available on their website http://www.selfhelpservices.org.uk/	General public	**"Beating the blues"** a self-help computer programme for people affected by depression, anxiety. **"Breaking Free":** 12 week online therapy for help in overcoming drug and/or alcohol abuse and provides tools to improve mental health. **Self-esteem and assertiveness**: to increase levels of self-esteem by encouraging changes in thinking and behaviour.
Condition specific support groups **2014**	Local condition specific support groups	 Condition support groups in Manchester	People living with long term conditions	Support groups available for people living with long term conditions such as lung, stroke and heart conditions

Name & Type of Resource & Date Produced	What is it?	Who Produced it and how is it accessed?	Who is it suitable for?	What can it help with?
WEB BASED RESOURCES				
Zest Google	Health and social activity information available via Google drive	Zest – Up to date leaflets promoting services available from www.tinyurl.com/ZestManchester	Members of the public	Information leaflets about resources in North and East Manchester relating to: Cooking & growing, Children's centres, Mental health services Local activities, Over 50's.
Mental Health in Manchester (MHIM) website	A website for people who want to know more about mental health and where to get help and support for problems.	Designed and updated by the public mental health team at the Health and Wellbeing Service. Accessed via link below: http://www.mhim.org.uk/	Primarily for the public but also useful for staff wanting to download guides and find information.	• Staying well and options for self help • Getting help and support for problems • Downloadable relaxation exercises and self-help guides (as above) • Information in different languages
Getting Manchester Moving website	Web site for those interested in becoming more physically active. Also includes activities going on in Manchester.	Updated by the Health and Wellbeing Service http://www.gettingmanchestermoving.nhs.uk/	Members of the public	• Physical activities available across Manchester • Health advice – healthy eating, physical activity. Groups – over 50's, men and women only groups
My Manchester Services	On line directory of services and opportunities that can improve an individual's health and wellbeing	Part of the Manchester city council website. Access by clicking on the link below http://mymanchesterservices.manchester.gov.uk *NB check resources as some listings out of date*	For the public and professionals who work to support people in the city.	Information relating to welfare rights, employment, transport, carers services, social activities, information prescriptions for long term conditions and more
Manchester Zoom	Directory with over 200 social and support groups across the city	Managed by Manchester City council. Accessed via http://www.manchesterzoom.com/	For the public who want to socialise and get support	Groups relating to learning opportunities, health and fitness, community groups, arts and creativity, support groups.
Manchester Community Central	Directory of Voluntary and Community Groups	Created by and updated by MACC http://www.manchestercommunitycentral.org/whats-happening-manchester/directory	For the public who want to engage in social and community activities	Volunteering opportunities, social groups, support with employment and training, arts, culture, sport and recreation.
Choose Well	Basic advice on self-care and what to do if feeling unwell. Translation facility on website makes this accessible for non-English speakers	NHS site http://www.choosewellmanchester.org.uk/self-care/self-care-information-for-adults	For the public so they can chose the correct action when unwell	• First aid advice, • Online symptom checker, • When to use Accident and Emergency, • Finding pharmacies, a dentist • Registering with a GP etc.

12. Useful contacts

Integrated Neighbourhood Care Teams - Support Network

PAHT Community Services Implementation lead	**Victoria Thorne** Victoria.thorne@pat.nhs.uk **Sharon. Lord** Sharon.lord@pat.nhs.uk 0161 202 5578 07772 710321
MCC Social Work and Adult Social Care	**Anne Nicholas** anne.nicholas@manchester.gov.uk 07960 985378
CCG General Practice	**Helen Speed** helenspeed@nhs.net 0161 219 9414 07776 323350
Project General Process Project Matters	**Joan Collins** joan.collins@manchester.gov.uk 07939 995260

Appendix 1

The NMINC Pathway

This section provides a guide to the NMINC Pathway. See Section 1 for the pathway diagram.

The Pathway has four main elements to it:

i) selection of patients
ii) multidisciplinary team meetings
iii) care planning and review
iv) case closure.

Selection of patients

We are looking for people who are at increasing risk of admission to hospital or residential care who we think might benefit from coordinated and proactive support.

Each GP Practice uses a tool called the 'Combined Predictive Model' (CPM) regularly to generate a list of patients who are at what is known as 'moderate' and 'high' risk of admission to hospital. They select a suitable number for each monthly multidisciplinary meeting (MDT). Most hold their meetings once a month.

MDTs can other patients, such as those that fall into the 'very high' risk category however we do not expect them to be on the NMINC caseload. They can be referred to other services such as Intermediate Care or Active Case Management.

Each practice decides its own approach to selecting from the available list of patients. This might be working from the highest scores downwards, or taking patients with a mix of scores. Choosing people with a range of scores might help to share the work across different disciplines in the team because the patients will probably have different types of need. It can also be useful to think about people who are not 'coping' or who don't have much in the way of social support.

The list of selected patient is reviewed by the core team to decide whether there is a reason not to include them. This may be that they are under 18, are currently in hospital or already have a coordinated care plan in place. Selection is inclusive as possible as the NMINC approach and working with others in the MDT may open up options that have not been possible previously.

Each practice keeps track of who has been considered and excluded or selected.

At this point, the Practice approaches the patient to ask their permission to include them in NMINC and to ensure they have verbal consent to share information about them in the MDT meeting. This is critical because we are working with, and therefore sharing information with, Social Care staff that is outside the NHS.

The first conversation is important it explains how the approach might help. We have developed a suggested script for this See section 3.3. The Practice decides who is best to get in touch with patients. We have found that some patients are concerned about social care staff being involved, and need reassuring that they will be fully involved in deciding what support might help them and what services are part of it.

The Practice notes when verbal consent has been given.

Team meetings

Practice holds at least one NMINC MDT meeting each month.

A NMINC Administrator is based in each neighbourhood and is available to organise MDT meetings.

Each month, Practices notify the Administrator of the new patients who are to be discussed. Administrators may also have been asked to include other patients on the agenda for the meeting.

The NMINC model and approach in detail

The model that we are implementing has been designed using the current evidence on multimorbidity, integrated care and tools for risk stratification.

This manual will replace the NMINC operational toolkit.

Background to the model

The common theme for the group of people we are aiming to work with is that they are living with 'multimorbidity'. This is defined as the presence of more than one long term disorder[2]. More people have two conditions than one condition, so most people with a chronic condition have multimorbidity. On average a person with Chronic Obstructive Pulmonary Disease (COPD) will have 3.9 conditions[4].

Absolute numbers of people with multimorbidity are higher in those under 65 years[5]. In North Manchester the average age of people at very high risk of admission to hospital is 64 and those of high risk is 62.

People with multimorbidity are more likely to die prematurely than those with single conditions, more likely to be admitted to hospital and have longer stay. They have poorer quality of life, have loss of physical functioning; more like to be receiving multiple drugs with the consequent difficulties of adherence, and are more likely to experience depression[6].

People with multiple conditions (multimorbidity) are more likely to die prematurely than those with single conditions, more likely to be admitted to hospital and have longer stay. In North Manchester, the average age of the cohort of people at highest risk of emergency admission is 64.

Managing multimorbidity

Disease management guidelines and pathways tend to be organised around single disease entities. A US review of guidelines for COPD, type 2 diabetes, osteoporosis, hypertension, and osteoarthritis showed that only one of the five explicitly acknowledged potential comorbidity, and recommendations were sometimes contradictory and suggested a drug and self-care schedule that would be unfeasible for many patients[2].

Guthrie et. al. cross-referenced recommended drug treatments for a single patient and demonstrated cautions, relative contraindications and recommendations for lifestyle and self-care that overlapped. It demonstrated a need to organise care around the patient rather than conditions, and take account of multiple conditions and psychosocial issues at the same time.

GPs are primarily responsible for the medical and wider management of these patients, supported by a range of professionals. Care coordination is problematic. The UK performs poorly internationally on care coordination with almost one third of people experiencing problems (test results not available at appointment, receiving conflicting information from health care professionals, tests ordered that have already been done). It also performs poorly on medical errors for this group with one quarter experiencing problems (medical mistake, lab test error, wrong dose/ medication)[7]. Medical complexity and multiple medication are major contributors to harm in primary care (Health Foundation, 2011)[8].

Patient perspectives

Patient's want the following from their care:
'My care is planned with people who work together to understand me and my carer(s), put me in control, coordinate and deliver services to achieve my best outcomes' (National Voices Campaign).

The aspects of care that correlate most closely with good patient experience are relational – patients want to be listened to, get good explanations from professionals, have their questions answered, to share in decisions, and to be treated with empathy and compassion[9].

People with multimorbidity say that they are looking for care that combines knowledge of the patient/service user/carer as a person and knowledge of the relevant condition(s) and all options to treat, manage and minimise them, including knowledge of all available support services[10].

Designing interventions to improve outcomes for patients with multimorbidity

A systematic review of interventions for people in primary care and community settings targeting multimorbidity showed that there was limited research in this area6. Interventions evaluated tend to be of two types – organisational e.g. case management or patient oriented e.g. drug adjustment. The evidence suggests that interventions targeted either at specific combinations of common conditions or at specific problems for people with multiple conditions may be more effective.

The Chronic Care Model assumes activated patients with the skills, knowledge and motivation to participate as active members of the health care team[11]. Hibbard et al. have developed a scale that reflects a developmental model of activation and have demonstrated that increased patient activation leads to improved health behaviours[12].

The Health Foundations' Co-Creating Health Programme has demonstrated improved outcomes for patients[13]. In particular, the evidence suggests that proactively supporting self-management can:

- have a positive impact on clinical outcomes;
- reduce crisis and unplanned admissions;
- reduce visits to health services by up to 80%;
- improve physical activity;
- lead to better adherence to medication; and
- continue to have an impact over the long-term

This indicates a multifaceted approach. Designing complex interventions requires a systematic approach that addresses the context for the intervention, a clear definition of the problem and understanding of how the intervention is likely to work[14].

NMINC model of care

International evidence from the national Long Term Conditions 'QIPP' programme suggests that that three drivers are most likely to reduce emergency admissions, which is often a poor outcome for patients. These are:

- Identification of people at increased risk of admission using a predictive model
- Neighbourhood multidisciplinary teams
- Supported self-management

Our strategy in NMINC is to target people who are likely to become at very high risk of admission in the next 2-3 years. We think that this will allow us to work with them now to improve their situation and increase their self-care skills and to reduce their likelihood of being admitted. We have designed a pathway to case manage people using a time-limited, structured intervention based on an approach that takes account of physical health, emotional wellbeing and social needs.

This approach sits within a wider programme of work at city level to determine the models of care, pathways and outcomes for thematic groups across the population.

North Manchester CCG is using the combined predictive model (CPM) as a risk stratification tool to determine future risk of admission to hospital.

The tool uses an algorithm to stratify the entire CCG population into four categories of risk of admission to hospital at any point in time: very high, high, moderate and low. Intervention to reduce avoidable emergency admissions has frequently focused on those people at very high risk of admission however the basis of North Manchester's approach is working with people who are most likely to become very high intensity users in the next 1-3 years. This offers greater potential for reduction in bed days and the population is more likely to be amenable to developing self-management skills.

As there is a dearth of high quality evidence on what works in reducing avoidable admissions, we have developed an intervention that is both organisational and patient oriented. We have used an approach that is person-centred to ensure that we build plans around what is important to the patient, and have identified a number of key issues that the evidence suggests are most likely to present problems for the patient. A key worker will liaise with the patient and use a collaborative approach and link to a multidisciplinary team that will propose a care plan to provide time-limited support to support the patient in developing their skills for self-care and improve their mental wellbeing and social situation.

A pathway and a 'Prompt' for Key Workers have been developed. See Section 1 and 7.

We will be using the 10-item Patient Activation Measure (PAM) to track changes in activation in the target population, and also tracking changes in the patient's view of the scale and extent to which key issues are a problem for them (mobility, depression/anxiety, pain, medicines), and utilisation of services. We will also be looking at the development of team working.

This model is still in development and will be expanded as a stepped model of care incorporating services and activities that will support the needs of the cohort of patients as we learn more about them.

Appendix 2

NMINC MDT Admin Pack

INITIAL CASE SELECTION PRACTICE LIST

Practice name: Date:

NHS Number	Name	D.O.B	CPM Risk Score	GP	Confirmation of verbal consent (please tick)	Date of consent

INTEGRATED NEIGHBOURHOOD CARE TEAM - MEETING RECORD

Practice name:

Date:

Present:

New Cases selected and discussed at this meeting

Name	Key Worker Allocated	Confirmation of verbal consent (please tick)	Initial action points

EXISTING CASES REVIEWED AT THIS MEETING

Name	Confirm writen consent obtained(Y/N)	Confirm care plan in place (Y/N)	Review decisions	Actions following review

EXISTING CASES CONSIDERED FOR DISCHARGE AT THIS MEETING

Name	Agreed for discharge? Y/N	Any further Actions

EXISTING CASES OPEN FOR MORE THAN 12 WEEKS

Name	Key Worker	Care Plan in place? Y/N	Estimated timescale of discharge	Issues to resolve and agreed actions

NMINC Patient Record Pack

NORTH MANCHESTER INTEGRATED CARE TEAM
PATIENT FRONTSHEET

1.	Date		
2.	Doctor		
3.	Client Name		
4.	Contact Number		
5.	NHS No		
6.	D.O.B.		
7.	Address		
8.	Next of Kin	Name	Relationship
		Contact Number:	
9.	Lives Alone	Yes	No
10.	Sex	Male ☐ Female ☐	
11.	Ethnicity		
12.	Language		
13.	Religion		
14.	Risk Score		

CONSENT TO SHARE HEALTH AND SOCIAL CARE INFORMATION

To be completed by the customer and retained by GP / Keyworker, to be uploaded into shared electronic record

Integrated Neighbourhood Care Teams are being developed across North Manchester to ensure that patients and carers have better access to the right care, in the right place, at the right time.

The teams will bring together a range of health and social care professionals, including GPs, Social Workers and District Nurses who will work together to help to keep you healthy and well.

Information about your needs and support will be put onto a secure, shared computer system, which can be accessed by all the teams that provide health and social care to you. Only those people directly involved in your care will be allowed to look at this record and information. This will include GPs, A&E and hospital teams, Community health and Social Care Workers, and the Ambulance Service. Health and Care teams and their employers may also use this information to help plan, manage, design and monitor the services they provide and this may shared with those who commission their services.

The shared record will enable the people providing care to have the right information to help in making decisions, including knowing what you would like to be done in an emergency. It will also reduce the need for people to keep repeating information so that support can be provided more quickly and efficiently.

Information will only be held and accessed in this system if you have given your consent. Consent can be withdrawn at any time

Signed

I have had the opportunity to discuss and understand the nature of consent I am being asked for and am now happy to give my explicit consent that my personal health and social care information can be held in an electronic shared record and that the indicated information may be discussed by my practice integrated care team for use in improving my support and for the purposes above.

I confirm that all information given by myself is accurate and correct at time of submission.

This request for personal data is subject to the provisions of the Data Protection Act 1998, the Human Rights Act 1998, and the Common Law Duty of Confidentiality.

Name:			
Signed:		Date:	

Name and role of person taking consent:

Name:			
Signed:		Date:	

NMINC PROMPT FOR KEY WORKERS

Name: ..... Date: .....

NHS number: .....

Theme	Note
Summary of Patient Goals/Priorities: *How are things going?*	Use 'agenda setting techniques'
Overview of Social Situation: *Who else supports or looks after you? Do you get out and see other people?*	Check if a carer Social networks and support (general) Social care and other agencies (formal) Any 'assets' to build on?
Dementia: *Have you/has the patient been more forgetful in the past 12 months to the extent that it has significantly affected your/their daily life?*	Yes or No
Activation: *This is a questionnaire that will help with understanding you and how you find it living with your health conditions.*	Use questionnaire provided
Family or carer's needs/priorities: *Linked to previous discussion about who supports or looks after the patient.*	

ADMISSION ON

Name: ..... Date: .....

NHS number: .....

Screening for other issues		Rating (1-5)	Relative importance (1-5)
Mobility:	What?		
	Why?		
	When?		
Medicines	What?		
	Why?		
	When?		
Depression/Anxiety	What?		
	Why?		
	When?		
Pain	What?		
	Why?		
	When?		
Anything else?			

DISCHARGE ON

Name: ..... Date: .....

NHS number: .....

Screening for other issues		Rating (1-5)	Relative importance (1-5)
Mobility:	What?		
	Why?		
	When?		
Medicines	What?		
	Why?		
	When?		
Depression/Anxiety	What?		
	Why?		
	When?		
Pain	What?		
	Why?		
	When?		
Anything else?			

ASSESSMENT OF ACTIVATION - ON **ADMISSION**

Name: ..... Date: .....

NHS number: .....

	Strongly disagree	Disagree	Agree	Strongly Agree
I am the person who is responsible for managing my health condition				
Taking an active role in my own health care is the most important factor in determining my health and ability to function				
I am confident that I can take actions that will help prevent or minimise some symptoms or problems associated with my health conditions.				
I know what each of my prescribed medications do				
I am confident that I can tell a doctor concerns I have even when he or she does not ask				
I am confident that I can follow through on medical treatments I need to do at home				
I understand the nature and causes of my health condition				
I know the different medical treatment options available for my health conditions				

ASSESSMENT OF ACTIVATION - ON **DISCHARGE**

Name: ..... Date: .....

NHS number: .....

	Strongly disagree	Disagree	Agree	Strongly Agree
I am the person who is responsible for managing my health condition				
Taking an active role in my own health care is the most important factor in determining my health and ability to function				
I am confident that I can take actions that will help prevent or minimise some symptoms or problems associated with my health conditions.				
I know what each of my prescribed medications do				
I am confident that I can tell a doctor concerns I have even when he or she does not ask				
I am confident that I can follow through on medical treatments I need to do at home				
I understand the nature and causes of my health condition				
I know the different medical treatment options available for my health conditions				

NHS No		Name		DOB	/ /

PRACTICE INTEGRATED CARE TEAM - RECORD OF INVOLVEMENT

GP **GP Practice** **Address** **Postcode** **Telephone**	

Practice Nurse

Name		Telephone	
Available hours		OOH Telephone	

Current Involvement

Start date	Involvement	Frequency	End date

Active Case Management

Name		Team	
Available hours		Telephone	
Location of case file		OOH Telephone	

Current Involvement

Start date	Involvement	Frequency	End date

District Nurse

Name		Team	
Available hours		Telephone	
Location of case file		OOH Telephone	

Current Involvement

Start date	Involvement	Frequency	End date

Social Work Adults

Name		Team	
Available hours		Telephone	

Current Involvement

Start date	Involvement	Frequency	End date

Community Nursing / Specialist Team

Name		Team	
Available hours		Telephone	

Current Involvement

Start date	Involvement	Frequency	End date

PRACTICE INTEGRATED CARE TEAM INTEGRATED CARE PLAN

Name	
NHS Number	
DOB	

Key worker	
Patient Telephone Number	

About Me (Background and Presenting History)

Did you have concerns about the patients capacity at the time of assessment?	
If yes, provide details	

CURRENT PLAN	

Risk	
Area of need	
Goal	
Expected Outcome	
Task	
Responsibility	
Date of Review	
Risk	
Area of need	
Goal	
Expected Outcome	
Task	
Responsibility	
Date of Review	
Risk	
Area of need	
Goal	
Expected Outcome	
Task	
Responsibility	
Date of Review	

End of life plan	

CRISIS PLAN

Presenting state / clinical parameter	Action

Patient consent to share record		
Plan create date		
Plan review date		
Consent obtained by		

Patient signature	
Key worker signature	

Form Guidance / Definitions

The following areas of the form will have 'drop down boxes' with the listed choice of entries. Please use one of these when completing this form.

For all of these fields apart from 'Risk' there is a free text box entry.

When using free text please keep this concise and clear.

Risk

- Of admission
- Care home placement
- Unplanned attendance at hosp
- Extended hospital stay

Area of need

- Personal care
- Eating and drinking,
- Practical aspects of daily living,
- Safety and security,
- Community involvement,
- Work and Education,
- Health education
- Emotional wellbeing,
- Dependents,
- Carers,
- Financial wellbeing,
- My home,
- Equipment,
- Medication,
- Continence,
- Falls,
- Weight management,
- Alcohol
- Drug use,
- Smoking,
- Mobility,
- Physical activity
- Mental Health
- Other - free text

Responsibility

- Self
- Family - with prompt box for free text entry for name
- Friend - with prompt box for free text entry for name
- GP
- District Nurse
- Active Case Manager
- Paid Carer
- Unpaid Carer
- Social Worker
- Specialist - free text
- Other – free text

Task

- Keyworker support
- Referral to health care provider,
- Referral to social care provider,
- Referral to other source,
- Referral to community / voluntary group
- Other - free text

Background Information

About Me

Provide a concise summary of the person. This may include what is important to them, who they live with, whether they have any support from others, what they like to do, and any particular dislikes.

Capacity

Record whether you had any concerns about whether the person had capacity at the time of assessment by stating yes or no.

If you did have concerns record what concerns you had and any actions you took or intend to take, this may include e.g. discussion with GP or carer, mental capacity assessment, intention to return to review in 1 week.

Current Plan

This is the part of the plan focussed on PREVENTATIVE care planning, therefore how to promote a person's health and wellbeing. The paper form gives 3 sets of 'Risk' entries. Unlimited numbers of 'Risk' entries may be made however, and if so another page should be added so that more entries can be recorded.

As stated above **'Risk'**, **'Area of Need'**, **'Responsibility'** and **'Task'** all have drop down boxes from which one choice should be made. If none of the options apply there is a free text 'other' choice which can be made in all these fields apart from 'Risk'.

Goal - This is a short description of what the person wants to achieve, e.g. To feel more confident when I move around, to know who to contact if I need help in a health emergency

Expected Outcome - This is a short description of what is expected to be achieved, e.g. To be able to walk confidently with walking frame within home, To have a list of phone numbers of emergency contacts

Date of review - Each entry should have a review date inputted, this will be the date at which the team / keyworker would expect to review the individual need or group of needs to monitor progress.

Crisis Plan

This is the area of the plan focussed on CRISIS care planning, that is what to do when things go wrong, or an emergency situation occurs.

The paper form gives 2 entries. However unlimited numbers of entries can be made, and if so another page should be added so that more entries can be recorded.

Presenting state / clinical parameter - This is a free text description of what a usual or expected emergency situation may look like. This may include reflection on previous emergencies, issues of importance to the person or areas the professional team identify. Like

actions to be taken by the person themselves or by those caring for them and may include e.g. Instructions on people to be contacted, medication to be taken, guidance on what the person responds well to.

Patient consent to share record - Yes or No selection to be made, in effect all people going through the PICT process should have consented to their records being shared, and this selection should confirm that.

Plan created date - This is the date the care plan has been completed.

Plan review date - This is the date the keyworker will review the care plan with the person.

Consent obtained by - Record the name and profession of the person who has gathered written consent

North Manchester Integrated Neighbourhood Care (NMINC)

Support Worker Care Plan

Clinic Monitoring Record for ( )

Name……..

Date of Birth ……. Date ……..

NHS Number ……. Review date …….

Date:						
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11 Other Issue arose						
Signature:						

Name of assessor ……..

Designation …….

A – Satisfactory, no action
B – Variance noted, action taken

C – Not monitored
/ - Not applicable

Organisation: (Record details of variance on contact summary)

Keyworker Signature …….. Page No ……..

North Manchester Integrated Neighbourhood Care (NMINC)

Support Worker Care Plan

Action Plan ( ) -

Name……..

Date of Birth ……. Date …….

NHS Number …… Review date ……..

Health Need:	Goals:
Actions:	Notes:

Name of assessor …….. Action Plan discussed with individual: Yes ☐ No ☐

Designation ……. Individual agrees to Action Plan: Yes ☐ No ☐

Organisation: Individual/

Representative signature

Keyworker Signature…….. Page No ……

Community Nursing Service

Comments Sheet

Name……Page No ……..

Address……

Date	Comments	Signature

Date	Comments	Signature

For admin use only	
Db	

REFERRALS
NMINC MONITORING FORM
(***Must be completed for every patient referred to the NMINC service***)

1A- PATIENT & REFERRAL DETAILS

PATIENT NAME DATE OF BIRTH	ADDRESS	NHS NO.
NEIGHBOURHOOD 1 ☐ 2 ☐ 3 ☐ 4 ☐	CPM Score: ……. Low ☐ Moderate ☐ High ☐ V High ☐	ETHNICITY White ☐ Mixed / Multiple ethnic groups ☐ Asian / Asian British ☐ Black / African / Caribbean / Black British ☐ Other ethnic group ☐

1B-SOURCE OF REFERRAL to KEYWORKER.

REFERRER: MDT ☐ From Health Care Professional/service ☐ Other ☐	PROFESSION:	CONTACT NO:
REFERRAL REASON;	CONSENT OBTAINED; Yes ☐ Date: No ☐ Verbal ☐ Date: Name:…….. Written ☐ Date: Name:……..	
HAS THIS PATIENT BEEN DISCHARGED FROM HOSPITAL /RESPITE WITHIN THE LAST 30 DAYS? Yes ☐ No ☐ Unsure ☐ REASON:	ACCEPTED FOR NMINC INTERVENTION; Yes ☐ No ☐ Patient Declined ☐ Other please Specify;	
ALLOCATED TO KEYWORKER Within 3 working days of referral; Yes ☐ No ☐ Date allocated; Team Member:- Social care ☐ G.P. ☐ Advanced Nurse Practitioner ☐ Active Case Management ☐ District Nurse ☐ Practice Nurse ☐ Other please Specify:	PATIENT CONTACTED WITHIN 5 WORKING DAYS; Yes ☐ No ☐ Reason ☐ Date contacted: First Visit date:	

***Email to NMINC neighbourhood admin within 72 hours of completing ***

For admin use only	
Db	

2. ASSESSMENT
NMINC MONITORING FORM
(*Must be completed for every patient referred to the NMINC service*)

2A- ASSESSMENT

PATIENT NAME DATE OF BIRTH	ADDRESS	NHS NO. Keyworker:

FIRST CONTACT DETAILS **DOCUMENTATION GIVEN AT FIRST VISIT** **1**-PAM Tool ☐ **2**-Info Booklet contact details ☐ **3**-Consent form ☐	**SECOND VISIT ARRANGED YES** ☐ **DATE;……..** **DECLINED** ☐ **FULL ASSESSMENT REQUIRED AT NEXT VISIT** Y / N *(IF YES clock starts at next visit start of care planning)* **(if no full assessment, pass to admin at this point)**
SECOND VISIT (CLOCK STARTS) **INTEGRATED CARE PLANNING** **NMINC PROMPTS FOR KEYWORKERS DISCUSSED WITH PATIENT** **Yes** ☐ **No** ☐ **PAM Score:……**	**REASON WHY NO FULL ASSESSMENT WAS UNDERTAKEN** **Admitted to hospital** ☐ **Inappropriate Referral** ☐ **Assessment Declined** ☐ **Referred to Another Keyworker** ☐ **Patient deceased** ☐ **Referred to other** ☐

2B-12 WEEKS OR 12 VISITS EVALUATION (which ever comes first)

(please tick appropriate box) **PATIENT DISCHARGED FROM CASELOAD < 12 WEEKS** ☐ **PATIENT ON CASELOAD FOR >12 WEEKS** ☐ **PATIENT ON CASELOAD FOR > 12 FACE TO FACE KEYWORKER VISITS** ☐	**IFMORE THAN 12WEEKS/12 FACE TO FACE VISITS** **ONGOING INTERVENTIONS DISCUSSED & AGREED AT MDT OR WITH PROFESSIONAL LEAD** **Yes** ☐ **DATE;** **Next review date:** **No** ☐
ADMITTED TO HOSPITAL, residential/nursing care Yes ☐ **No** ☐ **No: Of Admissions whilst on Caseload……..** **No; Of Bed days Occupied whilst on Caseload…….**	

***Email to NMINC neighbourhood admin within 72 hours of completing ***

For admin use only	
Db	

3. DISCHARGE
NIMINC MONITORING FORM

(*Must be completed for every patient referred to the NMINC service*)

PATIENT NAME: ..... **DOB:** ..... **NHS No:** .....

3A- SERVICE DISCHARGE DETAILS

DATE OF DISCHARGE	DISCHARGE LETTER COMPLETED No ☐ Yes ☐ DATE;
AT LAST VISIT PAM Tool ☐ PAM Score on Discharge ☐ Patient Questionnaire Given ☐	REASON FOR ONGOING MANAGEMENT UNDER CASELOAD PLEASE SPECIFY;

3B –PATIENT OUTCOME

LENGTH OF STAY ON CASELOAD;		
Patient at Home with No further Action	☐	
Reablement	☐	
Intermediate Care Home Care Pathway	☐	
Admitted to temporary Residential / nursing Accommodation (Respite)	☐	
Admitted to long Term Residential / NursingCare	☐	
Admitted to Intermediate Care Bed	☐	
Admitted to Hospital	☐	
Discharged back to Primary Care Management	☐	
Patient Deceased	☐	
Transferred to Other	☐	Please **Specify:**

3C- COST OF CARE PACKAGE / SPOT PURCHASE BED: (Social Care Use)
COMMISSIONED ACTIVTIY: LENGTH OF STAY AND COST
DETAILS:

3D- EQUIPMENT (assessed by appropriate specialist, put in place)

EQUIPMENT	PROVIDED	EQUIPMENT	PROVIDED
Commode		High chair	
Raised Toilet Seat / SIZE		Walking Stick	
Free Standing Toilet Frame		Fischer Stick	
Scandia Toilet Frame		Walking Frame / SIZE	
Perching Stool		Crutches / SIZE	
Kitchen trolley		Hoist	
Bed lever		Profiling bed	
Helping hand		Mattress	
Sock aid/ dressing aid		Cushion	
Bed raiser / blocks		Wheelchair	
Bath seat / Board		OTHER	

PATIENT NAME: ..... **DOB:** ..... **NHS No:** .....

3E-ONWARD REFERRALS

Reablement	☐	**District Nurse**	☐
Falls Team	☐	**Palliative Care**	☐
Domiciliary ITC	☐	**Mental Health Services**	☐
Community PHYSIO	☐	**Active Case management**	☐
Community Occupational Therapy	☐	**Health Trainer**	☐
MEAP	☐	**Telehealth**	☐
Care support at Home	☐	**Expert Patient Programme**	☐
Social Care	☐		

Other ☐ Please **Specify;**

3F- MANDATORY FEED BACK

WHAT HAS / HAS NOT WORKED WELL? Include any gaps (THIS SECTION MUST BE COMPLETED)

3G-TEAM MEMBER WHO COMPLETED DISCHARGE OF PATIENT
ALL PAPER WORK FULLY COMPLETED AND SIGNED

NAME: …… **DESIGNATION:** ……

***Email to NMINC admin for processing WITHIN 72HOUR OF DISCHARGE

Case Study Consent Form

PATIENT STORY/CASE STUDY CONSENT FORM 1 of 2

This form is to give my agreement to:

- The telling of my experience of the North Manchester Integrated Neighbourhood Care team in a patient story.

  Yes ☐ No ☐ *(tick as appropriate)*

- The use of information about and relating to my care from the North Manchester Integrated Neighbourhood Care team in a case study.

  Yes ☐ No ☐ *(tick as appropriate)*

I understand a patient story could be digitally recorded and/or typed into a narrative and will be kept indefinitely. I understand that all or some sections or quotes from my patient story or any of my information used for a case study may be used and shared with The Integrated Neighbourhood Care team, their employers (e.g. The Trust/NHS, Manchester City Council, GP surgery) and those who commission their services (e.g. Clinical Commissioning Group) for the following purposes.

☐ Improving, managing and developing services
☐ Staff Newsletter/ Press releases
☐ Presentations
☐ Reports
☐ Website content
☐ Leaflets / Brochures/ Posters

I understand I can change my mind after telling my story, or agreeing to my information being used in a case study, at any time without giving a reason, and this will not affect in any way any future care that I or my relatives may need.

Sometimes patient stories and case studies are shared and the name and age of the person are given. Please tick one of the options below:

Patient Story

☐ I am willing to have my first name and age known.

☐ I am not willing to have my first name and age known.

Case Study

☐ I am willing to have my first name and age known.

☐ I am not willing to have my first name and age known.

I understand that the Integrated Neighbourhood team might need to contact me again about my story/case study and I am happy for them to do so.

Yes ☐ No ☐ *(tick as appropriate)*

PATIENT STORY/CASE STUDY CONSENT FORM 2 of 2

Patient story

I agree to the telling of my experience of the North Manchester Integrated Neighbourhood Care team in a patient story. The purpose has been fully explained to me and I am happy to tell my story and for it to be used for the purposes above.

Patient's signature:

Name (PRINT):

Date:

D.O.B:

Signature of person taking the story:

Name (PRINT):

Date:

Job Title:

Telephone:

Email:

Case study

I agree to the use of information about and relating to my care from the North Manchester Integrated Neighbourhood Care team in a case study. The purpose has been fully explained to me and I am happy for this to be used for the purposes above.

Patient's signature:

Name (PRINT):

Date:

D.O.B:

Signature of person taking the story:

Name (PRINT):

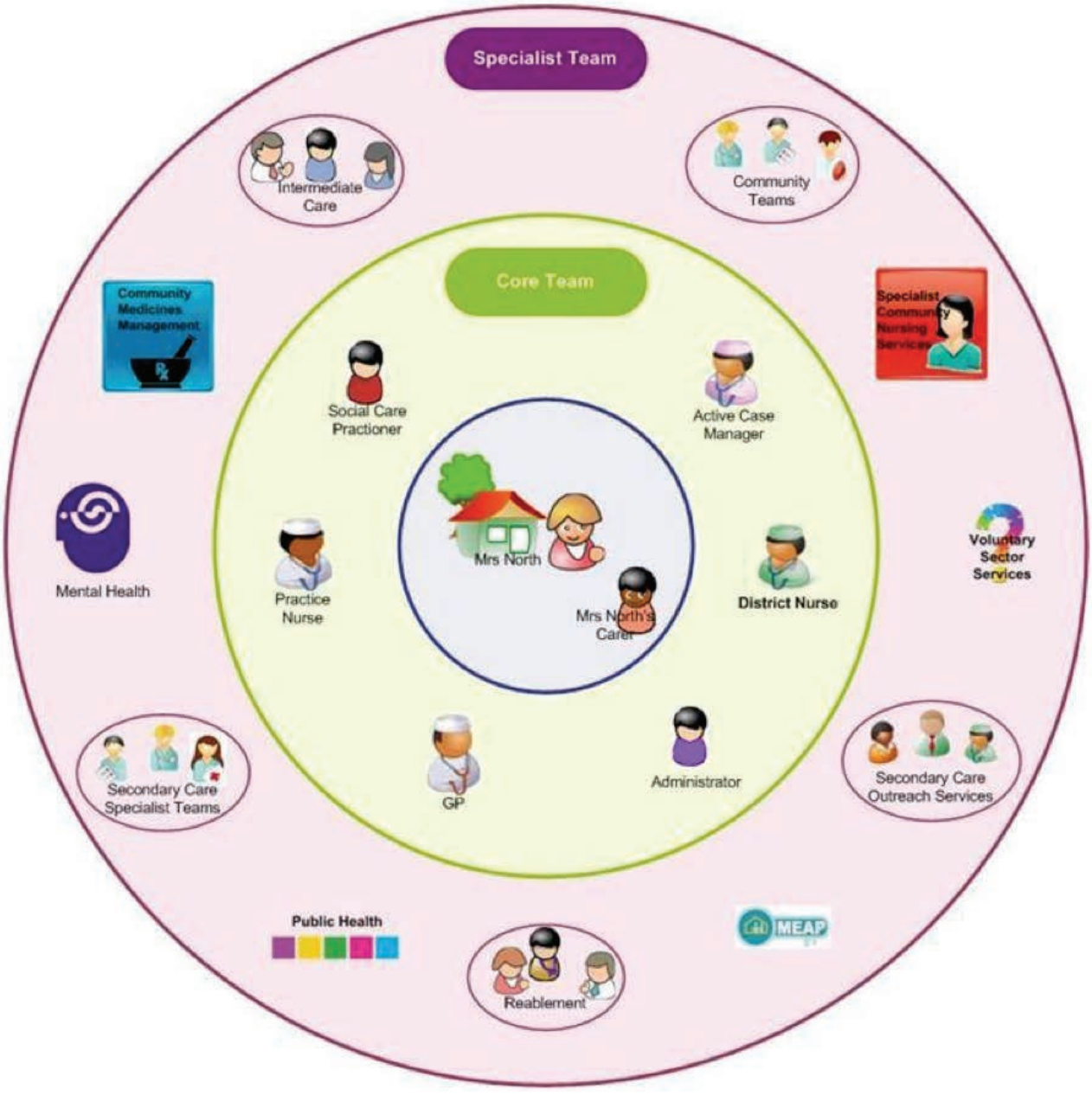
Date:

Job Title:

Telephone:

Email:

NMINC Core and Specialist Team



Appendix 6

Health Literacy

Health Literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Health literacy is not simply the ability to read. It requires a complex group of reading, listening, analytical, and decision-making skills, and the ability to apply these skills to health situations. For example, it includes the ability to understand instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex health care systems.

The lack of health literacy affects all segments of the population, although it is disproportionate in certain demographic groups, such as the elderly, ethnic minorities, recent immigrants and persons with low general literacy. Learning disabilities and the cognitive decline in older adults will also impact a person's health literacy level.

If a patient does not understand the implications of their diagnosis and the importance of prevention and treatment plans, or cannot access health care services because of communications problems, an untoward event may occur. Health literacy issues and ineffective communications place patients at greater risk of visits to A&E and admission to hospital. Over the last decade there have been a number of studies that have shown;

- People with low health literacy have a lower likelihood of getting flu shots, understanding medical labels and instructions, and a greater likelihood of taking medicines incorrectly compared with adults with higher health literacy.
- Individuals with limited health literacy reported poorer health status and were less likely to use preventative care
- Individuals with low levels of health literacy are more likely to be hospitalized and have bad disease outcomes
- Inpatient spending increases for patients with limited health literacy

Identifying patients at risk due to low health literacy is productive. The move toward "patient-centred" care as part of an overall effort to improve the quality of care and reducing costs means there needs to be more effective communication between people and the health and social care professionals that work with them. By identifying people with low health literacy it allows health and social care professionals to identify more effective ways of communicating key information and engaging with the patient. Patients with better understanding of their situation are more able to engage with decision making and planning their support.

Tools that may help with Low Health Literacy

Remove the barriers	Check if they need an interpreter or if they want a family member, friend or advocate with them. Check if there is any physical impairment that may affect communication e.g. hearing impairment Allow enough time
Slow down.	Communication can be improved by speaking slowly, and by spending just a small amount of additional time with each person. ● Use orienting statements: "First I will ask you some questions what has been happening, and then you can show me how you are managing with the stairs." ● Ask person if they have any concerns that have not been addressed. ● Ask patients to explain their understanding of their medical problems or treatments. ● Encourage patients to ask questions. ● Sit rather than stand. ● Listen rather than speak. These behaviours can further create an impression that you are focused on the patient, and patients may respond to these behaviours by perceiving that you have spent more time with them than you actually have
Use plain, language	You should always seek to use plain, language when speaking to patients. Words that professionals use in their day-to-day conversations with colleagues may be unfamiliar to the majority of our patients. A good approach is to explain things to patients in language that you might use when talking to your grandmother. I.e. conversational language. Conversational language creates opportunities for dialogue between the professional and patient, rather than limiting communication to a monologue by the professional.
Show or draw pictures	Visual images can improve the patient's recall of ideas. The saying that "a picture is worth a thousand words" is particularly true when communicating with patients who may have trouble understanding medical concepts delivered in words. It has long been known that visual images are remembered better than letters and words.
Limit the amount of information provided and repeat it.	Information is best remembered when it is given in small pieces that are pertinent to the tasks at hand. This does not mean you should withhold important information. Rather, it means that you should focus your communication on the one or the few most important things a patient needs to know at the time of the visit. The principle behind this approach is that advice is remembered better, and patients are more likely to act on it, when the advice is given in small pieces and is relevant to the patient's current needs or situation. Repetition further enhances recall. After discussing the key information with a patient, this information should be reviewed and repeated, because repetition is the key to learning and memory.

Use the "teach-back" technique	Confirm that patients understand by asking them to repeat back your instructions. It involves asking patients to explain or demonstrate what they have been told In using the teach-back technique, clinicians take responsibility for adequate teaching. If patients cannot explain or demonstrate what they should do, clinicians must assume that they did not provide patients with an adequate explanation or understandable instructions. The result should be new efforts to ensure that patients learn what they need to know. And, of course, it is important not to appear rushed, annoyed, or bored during these efforts—your affect must agree with your words. Research indicates that the teach-back technique is effective, not just for improving patients' understanding, but also for improving outcomes. ● Do not ask a patient, "Do you understand?" ● Instead, ask patients to explain or demonstrate how they will undertake a recommended treatment or intervention. ● If the patient does not explain correctly, assume that you have not provided adequate teaching and reteach the information using alternate approaches.
Create a shame-free environment: Encourage questions	Make patients feel comfortable asking questions. It is essential to create a shame-free environment in which patients feel comfortable asking questions about what they do not understand. Without such an environment, many patients, even those with well-developed literacy skills, may feign understanding material to avoid seeming "stupid" or annoying One simple strategy to encourage questions is to let patients know that "many people have difficulty reading and understanding the medical information I give them, so please feel comfortable asking questions if there's something you don't understand." Make certain to follow up on this by answering any questions your patient may have. Another strategy is to ask patients during the visit if they would like a family member or friend to be with them during discussions about diagnoses and options for treatment. Research shows that patients with limited health literacy often seek the assistance of family or friends after visits with health and social care professionals in interpreting what they have been told. By offering this opportunity in a routine, non-judgmental way, they will feel comfortable bringing others into the meeting.
Use patient friendly written material	The readability of consent forms and patient education hand-outs is important. The basic principles for creating patient friendly written materials involve attention to ● The depth and detail of the content. Have 2 or 3 key messages, don't overload the reader ● The complexity of the text itself. Keep the text simple. ● The format in which the material is prepared Text and structure of your document can make it more readable. Use clear fonts and use headings to separate information. ● User testing. Have someone, preferably a patient or non-health or social care staff read what you have written before distributing.

Behaviours and responses that may indicate limited literacy

Behaviours

- Forms that are incomplete or inaccurately completed
- Frequently missed appointments
- Noncompliance with medication regimens
- Lack of follow-through with laboratory tests, imaging tests, or referrals to consultants
- Patients say they are taking their medication, but laboratory tests or physiological parameters do not change in the expected fashion

Responses to receiving written information

- "I forgot my glasses. I'll read this when I get home."
- "I forgot my glasses. Can you read this to me?"
- "Let me bring this home so I can discuss it with my children."

Responses to questions about medication regimens

- Unable to name medications
- Unable to explain what medications are for
- Unable to explain timing of medication administration

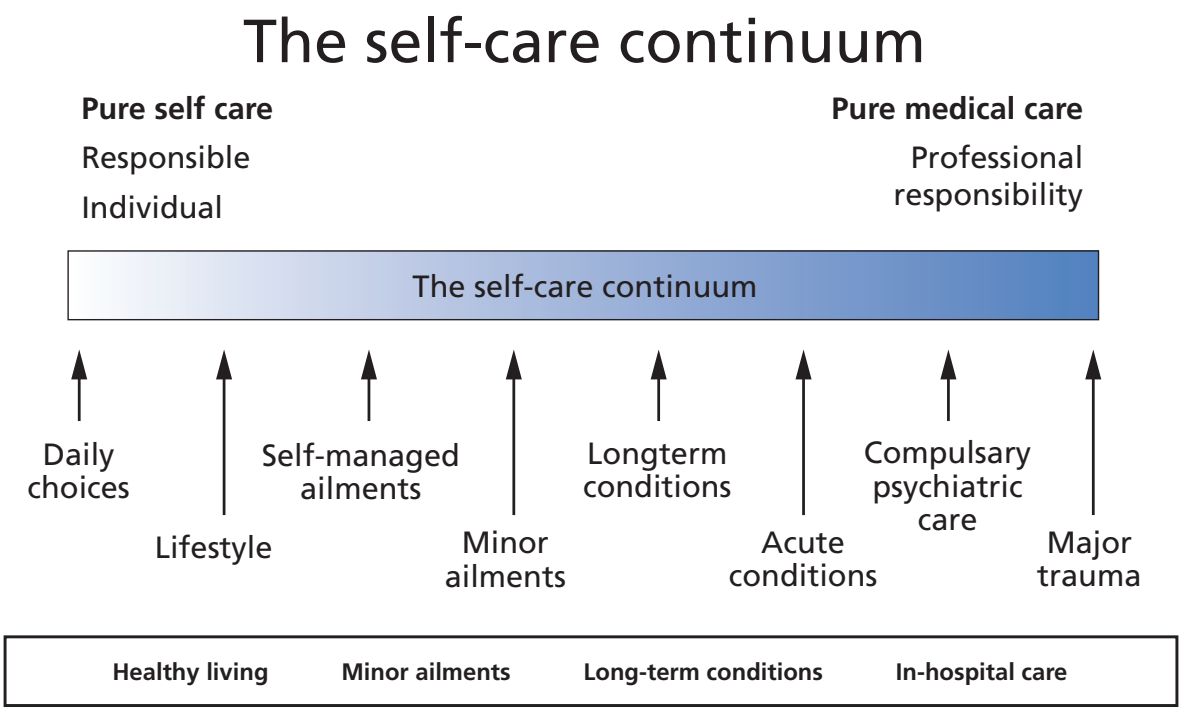
Appendix 7

Enabling Self-Care

Self-care is what patients do to look after their own health and wellbeing. Enabling self-care is what workers do to try to maximise self-care with a person. It covers every aspect of living a healthy life, from brushing our teeth to looking after ourselves when recovering from illness. This includes: staying fit and healthy, both physically and mentally; taking action to prevent illness and accidents; the better use of medicines; treatment of minor ailments and better care of long term conditions. Self-care includes both self-care and self-management. For people living with a long term condition, self-care can bring independence, self-worth and the ability to lead a life that's as near normal as possible.

All the evidence shows that proactively managing a long term condition is better than reacting to it. The best care management programmes involve:

- multi-disciplinary teams
- supported self-care and self-management
- The education of patients and carers.



The continuum above illustrates the sliding scale of self-care in the UK, starting with the individual responsibility people take in making daily choices about their lifestyle, such as brushing their teeth, eating healthily or choosing to do exercise. Moving slightly further along the scale, people can often self-manage the symptoms of minor ailments, for example by using over-the-counter medicines. At the opposite end of the scale is major trauma where responsibility for care is entirely in the hands of the healthcare professionals, until the start of recovery when self-care can emerge again. Around 80% of all care in the UK is self-care. The majority of people feel comfortable managing everyday minor ailments like coughs and colds themselves; particularly when they feel confident in recognising the symptoms and have successfully treated using an over-the-counter (OTC) medicine before.

Research shows that people often abandon self-care earlier than they need to, typically seeking the advice of a doctor within a period of 4-7 days. The main reasons for this are:

- Lack of confidence in understanding the normal progress of symptoms (e.g. a cold can last up to 14 days)
- The perceived severity and duration of symptoms
- Reassurance that nothing more serious is wrong
- A prescription to 'cure' the illness, even though the same medicine may be available over-the-counter

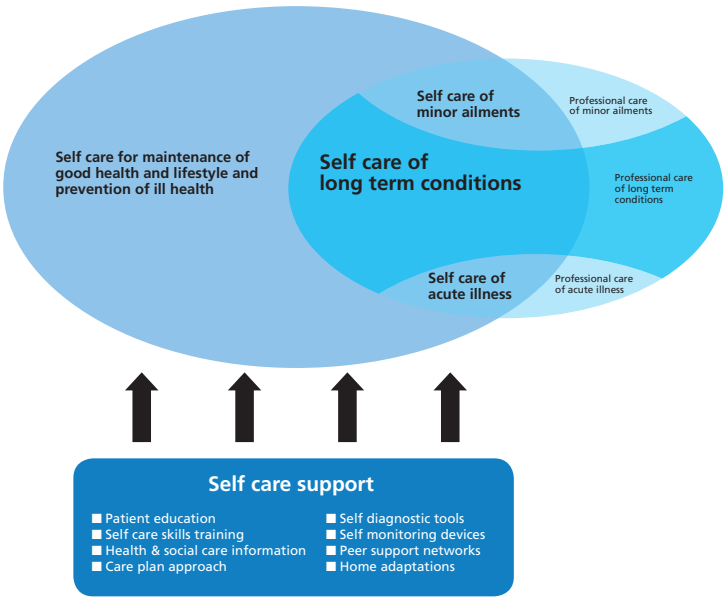
Changing behaviour

Often just simple changes aimed at meeting the needs of local communities can be very effective at encouraging increased self-care. These include giving patients the information they need to care for minor ailments, signposting people to the appropriate local services and outreach work to provide health advice in non-traditional settings such as pubs and job centres.

In the GP consultation itself, involving patients in their care through shared decision making has also proved to be a successful approach. Practitioner needs to use communication skills to reflect back to the person what is important to them, their ideas about change and to effectively support self-care.

Here are structured tools and approaches for supporting behaviour changes (with a huge evidence base). There is an introduction to these included in the Enabling Self-care training. Practitioners can also access free courses on behaviour change via www.goodhealth-manchester.nhs.uk/training

Supporting self care across the whole system



The Benefits of Self Care

Empowering people with the confidence and information to look after them when they can, and visit the GP when they need to, gives people greater control of their own health and encourages healthy behaviours that help prevent ill health in the long-term. In many cases people can self-manage their minor ailments, reducing the number of GP consultations and enabling GPs to focus on caring for higher risk patients, such as those with co-morbidities, the very young and elderly, managing long-term conditions and providing new services.

More cost-effective use of stretched NHS resources allows money to be spent where it's most needed and improve health outcomes. Furthermore, increased personal responsibility around healthcare helps improve people's health and wellbeing and better manage long-term conditions when they do develop. This will ultimately ensure the long-term sustainability of the NHS.

Improving quality of life. Being able to self-manage symptoms such as cough, fever and minor aches and pains improves people's quality of life - which is often all they want and need. Research shows that better self-care, for example, improves sleep and reduces disability from headache. This also makes people feel more positive and confident about their own abilities to take control of their lives and improves their feelings of self-worth. By supporting people in this way there can be the added advantage of making sure that people know when they must see a healthcare professional and avoid late detection of serious diseases, which is particularly pertinent for men, who are more prone to presenting later.

Improving disease outcomes People with long-term conditions that can recognise when their condition is worsening and what to do when that happens face less risk of suffering serious complications. Early and appropriate early self-care interventions (such as stepping up treatment in worsening asthma, using 'rescue packs' containing antibiotics and steroids for exacerbations of chronic obstructive pulmonary disease (COPD), or adjusting insulin doses in poorly controlled diabetes) can prevent potentially serious complications. There is good evidence that better self-care reduces hospital admissions and disability.

Why better self-care is good for people

Self-care is about health decisions that people make for themselves and their families to get and stay fit – both physically and mentally. This includes taking care of minor ailments as well as avoiding health hazards, such as smoking or drinking too much alcohol. But better self-care also includes exercising and eating well to prevent illness in the future. So being able to self-care directly benefits individuals, their families and society. Advantages of better self-diagnosis and self-care include:

- **Saving people time and money** - Having to take a day off work or organise child care to see a GP or other health professional for a health problem can make life difficult for people. By being able to self-diagnose and self-care appropriately, people can often save themselves a lot of time and hassle. Self-care is suitable for both self-limiting as well as long term conditions, such as diabetes, depression, hypertension or back pain. Pharmacists are an excellent resource to help with self-care too.
- **Giving individuals a feeling of control -** Like tackling simple computing problems, changing a fuse for a plug, looking after your bike or performing simple car maintenance tasks with just a little basic knowledge and confidence, there's no reason why people can't safely diagnose and treat many common medical problems themselves. Enabling people to learn what to do and where to find trusted information rather than going – and waiting to see – a health professional for every health problem can feel liberating. It also increases people's resilience and gives a feeling of 'being in control'.
- **Reducing anxiety** - Not knowing what a symptom may mean and what to do about it can make people feel anxious. And so deciding whether to seek medical help or not can be challenging. In these situations, being able to self-diagnose appropriately and manage certain health symptoms is greatly reassuring – as is being confident about deciding when it's best to seek medical help. For long term conditions, having care pathways and care plans developed in conjunction with a clinician can further enhance this so that people know what they can do to help themselves and when to seek help.

How We Deliver Self Care

Our role in delivering Self Care is a support role. Self-care support falls into the following four categories:

- **Information**
  Information is crucial for people with long term conditions - advice on how to access health and social care services as well as broader advice on voluntary services, housing and education. By directing people to the right information, we can help them feel more in control of their condition.
- **Skills and training**
  The Integrated Neighbourhood Care Teams have a pivotal role in giving people the skills to take control of their own long term conditions. You can encourage people to attend training courses such as the Expert Patient Programme. A confident, well-informed patient is not a threat to professional practices. In most cases the person knows more about living with their condition than anyone else.

- **Tools and devices**
  The Integrated Neighbourhood Care Teams need to be aware of the resources and technology that can be used to self-manage long term conditions. These interventions can make a significant impact on a person's quality of life.

  Pharmacies have a specific role in providing self-care support. The community pharmacy contract puts pharmacists at the centre of promoting self-care interventions for people with minor ailments and long term conditions. With an increasing availability of medicines over the counter (e.g. statins), pharmacists have a responsibility to ensure that people are given advice on the correct use of their medicines.

- **Support networks**
  if you involve people in their needs assessment, you can put the individual or their carer at the centre of an integrated package of care. This can improve quality of life, improve services and patient satisfaction. A support group can help someone live independently.

Common Core Principles to Support Self Care

The 'Common Core Principles to Support Self Care' aim to help health and social care services give people control over, and responsibility for, their own health and well-being, working in partnership with health and social care professionals. Consistent with the personalisation agenda they put people at the centre of the planning process, and recognise that they are best placed to understand their own needs and how to meet them. The principles are described in terms of competence, the context in which it lays the expected behaviours and underpinning knowledge.

	Principle	Context
1	Ensure individuals are able to make informed choices to manage their self-care needs	The worker's practice is informed by the principles of respect, dignity, choice and independence for individuals. It encourages and supports individuals to make decisions based on the experience of their needs and enhanced by appropriate professional support and guidance. Practice is based on a shift of values from professionals knowing best to them supporting and empowering individuals to be in control of their needs
2	Communicate effectively to enable individuals to assess their needs, and develop and gain confidence to self-care	Using communication and relationship skills which encourage and support individuals to work with professionals to identify strengths and abilities as well as areas for development, and to find solutions together building on existing skills
3	Support and enable individuals to access appropriate information to manage their self-care needs	Encouraging and supporting individuals in accessing appropriate information, and where possible provides the relevant and evidence based information in an appropriate manner, providing sufficient choice/ options
4	Support and enable individuals to develop skills in self care	Facilitating access to appropriate training and self-care skills development in order to develop and support individuals' confidence and competence to self-care. Also delivering support to individuals in developing self-care/ self-management skills.
5	Support and enable individuals to use technology to support self-care	Ensuring appropriate equipment and devices are discussed and when appropriate puts individuals in touch with the relevant agency from where they can procure the item(s), and where possible provides the relevant tools and devices. Also engaging with individuals to support and enable the use of technology.
6	Advise individuals how to access support networks and participate in the planning, development and evaluation of services	Advising individuals about participation in support networks both to receive from and give support to others. Promoting and encouraging involvement of individuals in the planning, development and evaluation of services they receive, and supports them to organise care packages to meet their self-care needs.
7	Support and enable risk management and risk taking to maximise independence and choice.	Encouraging and supporting individuals to make choices about how to live their lives and manage any identified risks. Promoting choice and independence while supporting individuals to manage risks proportionately and realistically.

Providing understandable and easily accessible information that will

- Enable people to:
  - assess their own condition
  - know what is 'normal' for their condition
  - know when, where and how to get further help and advice.
- Helping people to understand why it's so important they take their medicines and how to do so.
- Enabling people to recognise and monitor their symptoms.
- Allowing people to undertake strategies to aid their recovery.
- Enabling people to book routine tests as and when they need them, rather than requiring them to go to a GP for 'permission'.
- Supporting people to have the confidence and skills to better deal with their condition.
- Involving people in interpreting results so they understand what action needs to be taken and why.

Appendix 8

Useful information for health related issues.

BLOOD PRESSURE = BP

DEFINITION When your heart beats, it pumps blood around the body to give it the energy and oxygen it needs. As it moves it pushes against the sides of the blood vessels, the strength of this is your blood pressure.

HTN = HYPERTENSION = high blood pressure
Blood pressure is high if it is over 140/90, consistently over a matter of weeks, it puts extra strain on the heart and could lead to heart attack or stroke.

HYPOTENSION - low blood pressure

POSTURAL DROP - A sudden drop in blood pressure when standing up or getting out of bed, causing dizzy spells and increased risk of falls

Things to look out for

HIGH headaches, nosebleeds, dizzy spells but often no signs at all
LOW dizzy spells, increased risk of falls.

CANCER

DEFINITION Abnormal cells divide without control and are able to invade other tissues. There are more than 100 types of cancer.
Benign tumours - not cancerous
Malignant tumours - are cancerous

Things to look out for

Persistent cough, unusual lumps, abnormal bleeding, skin changes among others.

MACMILLAN, 0161 202 8920 (Manchester) 0161 621 7177 (Oldham) for pts with a diagnosis of cancer or any long term condition which is symptomatic. Anyone can refer in.

MARIE CURIE 0800 634 4520 freephone number
Marie Curie provide care for terminally ill patients in their own homes or in Hospices. Will sit overnight with patients.

COMPLEMENTARY THERAPIES 0161 291 2912 Neil Cliffe Centre,
outreach therapy, massage, aromatherapy, reflexology etc (no charge) for people in their own homes with any long term condition..

COPD (Chronic Obstructive Pulmonary Disease)

DEFINITION Umbrella term for any irreversible lung disease e.g. bronchitis, emphysema. Usually caused by smoking but can be environmental factors. (1 in 8 admissions are due to COPD)

SYMPTOMS CAN BE - cough, breathlessness (SOB), wheeze, increased sputum production, increased chest infections. Occasionally weight loss, tiredness, ankle swelling.

Things to look out for

All the above and repeated chest infections, smokers, certain industries such as cotton mills, cleaners, machinist, anything with dust, dust, fibres and/or chemicals.

Useful services

ARAS – 0161 720 4709 - Gp referral

PULMONARY REHAB – 0161 720 4709- REFER THROUGH ARAS TEAM

BREATHE EASY GROUP – Heathfield Resource Unit, Heathfield street, Newton Heath.
2nd Wednesday of the month 1-3pm • Contact; Dot 0161 273 4709, Shirley 0161 684 9573 or Joy 0161 202 0845.

OTHER ORGANISATIONS
British lung foundation www.lunguk.org
www.goldcopd.com

DEMENTIA

DEFINITION A syndrome associated with an ongoing decline of the brain and its abilities. There are many different kinds of dementia for instance, Alzheimers, Korsakoffs (usually associated with heavy drinking), Vascular usually caused by strokes.

Things to look out for

Struggling to remember recent events, finding it difficult to follow conversations, repeating themselves or losing the thread of the conversation, confusion even in familiar environments, forgetting names.

Useful services

ADMIRAL NURSES – 0161 901 7411. For families of people who have a formal diagnosis of dementia. They help families learn how to deal with the changing behaviours of dementia.

DIABETES

DEFINITION Insulin helps your body use glucose to provide energy.

IDDM = TYPE 1 = Insulin Dependent Diabetes Mellitus
Can develop at any age but usually before 40. The body does not produce insulin therefore it tries to get its energy from somewhere else and breaks down stores of fat and protein causing weight loss.

NIDDM =TYPE 2 = None Insulin Dependent Diabetes Mellitus
The body produces some, but not enough insulin.

Usually occurs in over 40's, (but can be any age) overweight, little physical activity, Asian, African or Caribbean descent.

Things to look out for

Genital itching, decrease in weight, increased thirst, extreme tiredness, blurred vision, infections that take a long time to heal, increased urination particularly at night.

If not effectively controlled can lead to serious health issues, heart attack, stroke, erectile dysfunction, amputation, blindness and kidney disease.

Useful services

Diabetic Specialist Nurse 07816169559/ 0161 741 2049

www.Diabetes.co.uk 0845 120 2960

Dietician 0161 205 4796

Podiatry 0161 861 2412

Foot Protection Team 0161 861 2400

Community Nutritian Service 0161 205 4796

DESMOND (Education course for professionals, patients and carers) 0161 622 9162/ 01706261896 can self refer.

HEART FAILURE

DEFINTION the heart becomes too stiff or weak to beat properly. Can be controlled with medication.

- CCF=Congestive Cardiac Failure
- CABG= Coronary Artery Bypass Graft= bypass
- IHD—Ischaemic Heart Disease
- AF= Atrial Fibrillation= irregular heartbeat
- MI=myocardial infarction= heart attack
- LVSD= Left Ventricular Systolic Dysfunction
- HFPEF= Heart Failure with Preserved Ejection Fraction

Things to look out for

Symptoms can include, tiredness, SOB (short of breath), weight loss, persistant cough, tachycardia (rapid heart rate), oedema (swelling caused by fluid).

Useful services

Heartfailurematters.org

British heart foundation - Bhf.org.uk

Heart failure specialist nurse, Janet Mills-Cook 0161 922 3923

STROKE

DEFINITION Interruption of blood supply to the brain cutting off the supply of oxygen and nutrients.

CVA = cerebral vascular accident

TIA = transient ischaemic attack (mini stroke)

Things to look out for

Confusion, slurred speech, difficulty walking, loss of balance or co ordination, severe headaches, fainting, weakness of limbs or face on one side.

Useful services

STROKE TEAM 0161 681 0940 offers rehab, physio, speech and language therapy.

OTHER USEFUL SERVICES AND PHONE NUMBER

ACTIVE CASE MANAGEMENT - 0161 202 8799
ARAS- 0161 720 4709
ADMIRAL NURSES - 0161 882 2053
AGE CONCERN – 07939 109 538 OR 0161 205 3851
BEFRIENDING SERVICE- 0161 850 1645
BLUE BADGE PARKING - 0161 277 5919
CRISIS POINT - 0161 225 9500
CRISIS RESPONSE - 0161 741 2008
COMMUNITY SUPPORT SERVICE - 0161 235 6900
COMMUNITY NUTRITION & DIETICIAN - 0161 205 4796
CARE AND REPAIR - 0161 872 5500
DIABETIC SPECIALIST NURSE – 0161 741 2000
DISABILITY LIVING - 0161 607 8200
DESMOND - 0161 622 9162 OR 01706 261 896
EQUIPMENT AND ADAPTATIONS- 0161 227 3280
EXPERT PATIENT- 0161 371 2105
EYE TEST (VISIONCALL - 0845 050 1831 OR 0161 370 1805
FALLS PREVENTION TEAM- 0161 230 1840
FOOT HOT LINE- 0161 861 2460
GADDUM BEFRIENDING SERVICE - 0161 214 3939
HEALTH TRAINERS - 0161 882 2583
HEART HELPLINE- 03003303311
HENNESSY HOUSE - 0161 834 0276
HOME OXYGEN ASSESSMENT SERVICE - 0161 922 3175

INTERMEDIATE CARE- 0161 291 7671
JANET MILLS-COOK (HEART FAILURE SPECIALIST NURSE) - 0161 922 3923
MACMILLAN - 0161 202 8920
MENTAL HEALTH FOR NORTH - 0161 277 1170
NEBULISER SERVICE - 0161 720 2425
NORTH MANCHESTER BREATHE EASY - 0161 684 9573
OUTREACH COMPLEMENTARY THERAPIES (NEIL CLIFFE CENTRE) - 0161 291 2912
OCCUPATIONAL THERAPY- 0161 946 9439
PALLIATIVE CARE SERVICES - 0161 720 2814
PHYSICAL ACTIVITY REFERRAL SERVICE - 0161 230 1857
PHYSIOTHERAPY- 0161 720 5982
PODIATRY- 0161 861 2412
PULMONARY REHAB – 0161 720 4709
SOCIAL SERVICES – 0161 255 8250
SALT- 0161 720 2232
SMOKING CESSATION SERVICE- 0161 205 5998
STROKE TEAM- 0161 681 0940
SOCIAL WORKERS - 0161 234 5127
TISSUE VIABILITY NURSE, MICHELLE PROUDMAN - 07811 123 932
WHEELCHAIR SERVICES - 0161 330 1446
WEIGHT MANAGEMENT SERVICE - 0161 209 9973

Appendix 9

Useful information about Manchester City Council

The first point of call for accessing City Council services is via the City Council website:

http://www.manchester.gov.uk

There are also some telephone numbers available if you do not have access to the internet:

Social Care Contact Centre	0161 234 5001
Council Tax	0161 234 5002
Benefits (inc. Housing Benefit)	0161 234 5003

For existing customers in receipt of services:

North Manchester Adult Social Care (18yrs and over, with mainly physical disability,)
0161 234 4596 (duty officer's phone)
FAX 0161 274 7300

North Manchester Primary Assessment Team;
0161 234 5184 (duty officer.)

North Manchester Reablement Team:
0161 234 4621

North Manchester Learning Disability Social Work Team:
0161 861 2958

North Manchester Mental Health Teams:
These have a number of bases – information can be found at; http://www.mhsc.nhs.uk/about-the-trust.aspx

Adult Social Care structure

The first point of contact for all new customers with social care needs is via Manchester Contact Centre

Primary Assessment Teams (PAT.) receive all referrals for customers needing a community care assessment for equipment, or physical support with care needs. This includes the provision of

- small equipment, e.g. seats, raised toilets, bath seats etc, Reablement
- Reablement a service offering up to 6 weeks free intervention and ongoing assessment of need.
- Services to meet long term care needs such as long-term care package , or Cash Individual Budget
- Most customers are required to make a financial contribution towards the cost of their care support. This is based on their income.

Types of support

Individual Budget

Virtual Budget: The service is arranged by the council and provided by an agency. Any issues that arise are dealt with by the social worker or primary Assessor. The person pays their contribution to the City Council.

Cash Budget: The customer is given a budget which is paid into a special account by the council every 4 weeks. The money is used to purchase the support they need. They can use it to commission an agency to support them, to employ their own Personal Assistants, to buy appropriate equipment, or a mixture of these.

The person needs to be able to manage their own budget or to have someone who can support them to do so. The council can fund an accountancy service to assist the person to manage their budget.

The person must pay their contribution into the Individual Budget account to ensure they have sufficient funds.

Individual Service Fund: If the customer does not want to use the Council's Locality Provider care agency they can ask for an Individual Service Fund or ISF to be set up. With this type of support the customer must negotiate their own care with the agency and be able to deal with any issues regarding the provision of support. They must also pay their contribution directly to the agency.

Carer Respite: When the customer is cared for by an unpaid carer the carer can ask for an assessment of their needs. Sometimes this results in the allocation of a respite budget. This budget can be used to provide care for the customer to give the carer a break. It can be used for both care in a care home or for additional community support such as day care services or sitting service. A respite budget is an amount of money that they can use over the course of the year. The current customer contribution to the cost of respite in a care home is £124.40 per week.

Terminology; Formal carer; someone paid to care using monies from Social care or NHS, (not including Carer Allowance from DWP.)

Informal carer; unpaid carer (is still classed as unpaid if claiming Carer Allowance from DWP.)

Domestic services: The council will only fund domestic assistance in exceptional circumstances such as where the person would be at serious risk to their health and wellbeing.

Daycare: There are only 3 council run daycare centres in Manchester. In North Manchester there is Heathfields in Newton Heath. There are some privately run daycare centres. These charge varying rates. Families can Google daycare services in Manchester.

Carers

See City Council website – social services page for carer services.

Carers are entitled to a carer assessment annually. They can also access a Carer Individual Budget to help them to pay for a break for themselves or for items that help them to continue in their role as a carer.

They can also access the Carer's emergency card and emergency plan – in the event of anything happening to them it will alert others that they are a carer and allows immediate support to be provided for a 48hr period until Social Care workers or family/friends can arrange further support.

General information

On the council website, the following services are listed under Social Care - http://www.manchester.gov.uk/socialservices includes:

- Housing support workers,
- Homelessness prevention,
- Carer advice,
- Community alarm,
- Blue Badges,
- Help with debt

Housing Support workers

Set up and run your home well

We can turn on your gas, electricity and water, find furniture, sort out bills, help you manage money and claim benefits.

Make the most of your neighbourhood

We'll show you local shops, services and leisure facilities, and help you look for jobs, training or courses.

Get in touch with extra help

We can set up expert advice on things like debt or mental health problems; and get in touch with organisations for you.

To get this service you will probably:

- have difficulty with everyday tasks or domestic affairs; or
- find it hard to keep to your tenancy agreement; or
- feel vulnerable because of crime or disorder; or
- be socially isolated because of illness or bereavement.

We help you get on your feet and live independently, so after a time you won't need us any more! But you can always come back if you need help in the future.

There is a button on the appropriate council webpage - http://www.manchester.gov.uk/info/100007/homes_and_property/968/supported_housing - to allow direct referral.

Alternative sources of information on services in Manchester

To find voluntary services, social activities and all kinds of services available in Manchester you can Google; mymanchesterservices.

This is a website which allows you to search for services by a person's postcode and will list services nearest first. (Please note that due to the large amount of information on the site that the information can become outdated and it is worth checking before you give it to a patient.)

Pets

If a person is taken into hospital or care in an emergency then the first responsibility regarding pets is to find if there is anyone – family, friend, neighbour etc – who can feed and water the pet until the owner returns.

Only if this has been exhausted then a referral can be made to Social Care, via the website or the Contact Centre no. above as there is a duty to ensure that the pets are looked after.

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