Addressing the National Crisis… One Step Ahead

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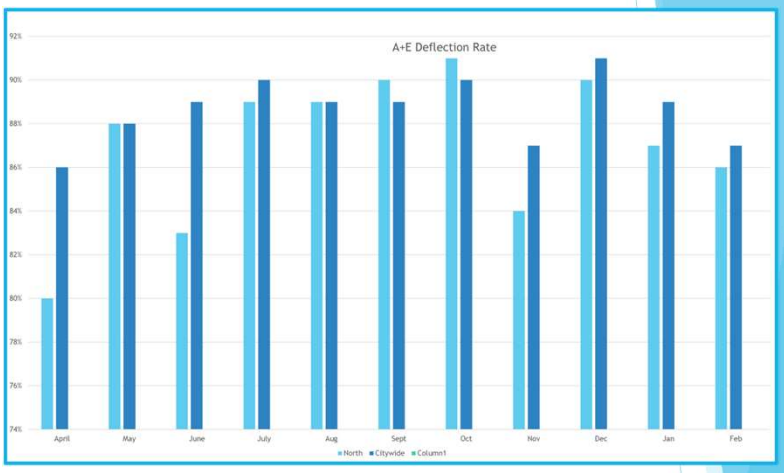
North Manchester Crisis Response

The Crisis Response Service, established in 2013, was the first *non-medical* team to formulate pathways with Northwest Ambulance Service (NWAS), GP's and A&E to avoid unnecessary hospital admission. The service provides clinical management and therapeutic support to patients in their own place of residence. The integrated and multi-disciplinary ACP led service has rapidly expanded and developed further subsystems pathways, including the Acute Home Visiting Service (AHVS), Reactive Care Home Service (RCH), ED frailty direct, 111 A-traumatic lower back pain and MSK upper and lower limb Pathway.

Aims/ Objectives

- ✓Working collaboratively to provide Advanced Practice led urgent care with primary and secondary care, community services and NWAS.
- ✓To avoid unnecessary hospital admission, providing rapid and comprehensive clinical assessments and implementing robust management plans to ensure patient safety and medical stability in their usual place of residence (1–2-hour response)
- ✓Empowering care home staff from two local PCN's to refer directly into RCH service, providing formal education to all care home staff to enable prompt identification of the deteriorating patient.
- ✓Working closely with local HEI's to support training of ACP's and provide clinical educator support for MSc ACP programmes.



Guidance in 2022 tasked all Integrated Care Services with evidencing urgent 2-hour community response for patients. The Crisis team were in a privileged position to act as pioneers for this, resulting in a city-wide Crisis model being established across Manchester and more recently Trafford.

Results/ Outcomes

- **90% A&E deflection rate for Crisis referrals (approximately 60-80 referrals per week)**
- **30% increase in hospital avoidance for RCH referrals.**
- **Increased credibility with all referrers from Primary Care, Urgent care teams and community colleagues allowing safe governance, managing increased levels of acuity in the community.**
- **Strong links with HEI's to ensure evidence based clinical interventions.**
- **Most vulnerable patients being able to access high quality clinical intervention in their own place of residence.**
- **Frequently reviewing, adapting and forecasting the projected needs of our complex and at times very frail and vulnerable patients with a fluid inclusive model of service delivery.**
- **Further investment to work with our acute colleagues to develop, implement and support new Hospital at Home and Virtual Ward models of care to further enhance the service offer, improve patient experience and support our urgent care teams.**

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Conclusion

We have developed a highly skilled highly motivated workforce across our services who are capable of innovative service and experiencing enhancing projects which are in line with the needs of our patient population.

We will continue to work with our key stakeholders and partners to ensure fair and equitable access to all our services and maintain an open and honest approach to dealing with any issues as they arise.

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