TOGETHER
A HEALTHIER FUTURE

Blackburn with Darwen Integrated Neighbourhood Case Study

Background

Martin lived with his teenage son in a rented property within the local area. He worked 12 hour shifts in a factory which required him to stand up all day. He was experiencing breathlessness and felt generally unwell but continued to work due to financial reasons. He saw his **GP** who referred him to the **Pulmonary Rehab team**. Upon assessment, the **pulmonary rehab team** identified that Martin was very underweight. The **Pulmonary Rehab** team referred Martin into the INT weekly meeting.

Summary of Medical, Physical and Social Conditions

- **The Pulmonary rehab team** also referred Martin into the **Care Network Hub** for advice & guidance on benefit entitlements as he was struggling to work a full shift.
- Martin lived in private rented accommodation that had damp. Martin had been keeping the windows closed to retain the heat, which exacerbated Martins chest problems due to the condensation.
- Martin was incontinent of urine. He had discussions with his **GP** previously around the possible use of catheters for when he is at work.
- Martin was at high risk of pressure sores due to his reduced levels of activity so the oxygen nurses ordered a pressure cushion.
- Martin is generally low in mood, presents as anxious and regularly describes feelings of wanting to 'give up'.
- Martin is a heavy smoker

An Integrated Neighbourhood Team Approach

The INT Team supported the care co-ordinated between the below organisations as part of his care package:

Lancashire Fire & Rescue Service – A home fire safety check was completed and 3 smoke alarms where installed during the visit. The fire officer noticed that the property was very damp, in a poor state of repair and cluttered. A fire retardant throw was provided for his settee and a metal bin for his cigarette ends as Martin was smoking 40 cigarettes a day. The fire officer suggested assistance to help declutter Martin's home and suggested a referral to Adult Social Care to see what support they could provide.

VCF LSCFT LA CCG FED/GP ELHT

The **Complex Case Manager** (CCM) arranged to visit Martin, during the visit Martin explained that he is experiencing severe chest problems. The CCM discussed the case with the **COPD team** who witnessed Martins chest and breathing problems. Martin started to show signs of gaining weight. The CCM referred Martin for a full continence assessment. The CCM discussed the option of stopping smoking with Martin, the Wellbeing service offered to support him with this if he chose to stop or even cut down to a few a day.

The CCM also arranged for Martin to have a chest scan due to his worsening chest and breathing problems. The results came back as a diagnosis of lung cancer. Martin was referred to Royal Preston Hospital for surgery and was not fit to work.

AGE UK completed all his benefit applications and Martin started to receive P.I.P benefits. Martin also registered his interest for alternative housing.

Martins condition worsened; he needed ambulatory oxygen which the **oxygen team** were reluctant to put into his property due to heavy smoking.

AGE UK discussed with Martin the possibility of a referral to Adult Social Care to help support his case for new/alternative accommodation. Martin declined the assessment A housing application was completed and BwD Housing Needs fast tracked his application via AGE UK to enable him to start bidding on an alternative property that would be more suitable for him and his young son to live in.

East Lancashire Hospice at Home, visited Martin and offered hospice support, Martin declined as he just wanted to go back to work.

End of Life pathway and support

Martin had a hospital admission due to the exacerbation of COPD and was informed that his tumour was inoperable. The CCM started discussions with Martin about end of life care and resuscitation but he refused to engage in these discussions.

Martin experienced reduced appetite and the **dietician** prescribed supplements and a Social Worker was allocated but Martin declined carers visiting him.

East Lancashire Hospice visited Martin to discuss end of life care preferences. Martin stated that he wanted to stay at home and this would be his preferred place of care but would engage with Hospice at Home. The hospice agreed to visit Martin twice a week. Martin was experiencing very shallow breathing even though he was still on oxygen. As Martins condition deteriorated, the **District Nurses** completed the checklist for continuing health care funding.

Outcome

The Out of Hours nurses visited Martin and his symptoms where monitored and he was given medication. Martin was in his last moments of life. All his family were made aware of situation and were present at the time of Martins death.

The GP visited to confirm Martins death.

*Name has been change to protect anonymity.