Ensuring Patients are Receiving the “RightCare” in Barnsley

Sue Wing, Deputy Director South West Yorkshire Partnership
Katie Roebuck, Acting Head of Commissioning & Transformation, Barnsley Clinical Commissioning Group
Jacqui Howarth, Service Manager, RightCare Barnsley
Interdependence with other services/providers

Strategic Objectives
a) Reduce emergency admissions
b) Support early discharge from hospital
c) Reduce emergency re-admissions

Rightcare Centre

- Intermediate Care
- Community Nursing
- Community Specialist Services
- Yorkshire Ambulance Service
- Hospital where appropriate
- Others unknown?
- Specialist Services e.g. Sheffield Teaching Hospital Foundation Trust
- Clinical Decision Unit
- Rapid Access Clinics
- Ambulatory Care - AMAC
MR SMITH’S EXPERIENCE (2014)

Mr Smith
- Born 27/10/34
- COPD
- Heart Failure
- Council tenant
- Ex-miner

Over the last 3 years...
6 - different agencies involved (GP, Acute Trust, Community Matron, Care Navigation Service, Independent Living at Home Service, Social Worker).
22 - different teams or professionals gave input.
128 - acute/sub-acute beds days consumed.
28 - assessments received.

_Wife (also has history of heart problems)_

_Daughter (x 2)_

_Son (x 1)_

_Grandchildren (x 5)_
RightCare Barnsley
Collaboration

- The Alliance is a partner Board, led by the Clinical Commissioning Group.
I could tell you......

• Reducing Pressure
• Increasing Safety
• Saving money and sanity
Mr Smith's Story Today

Mr Smith & his family and carer network are enabled to become more resilient in self managed care

Mr Smith's condition is well managed

- 1 point of access for a referral from varying agencies
- 1 assessment process, which includes assessing for resilience and opportunity for self managed/directed care
- 1 Care Plan, used and accessible across the spectrum of services
- A well defined and agreed visiting schedule tailored to Mr Smith's needs
- Operating framework that enables a structured approach to care level, that enables escalation and de-escalation of Mr Smith's changing needs
- 1 key worker/care co-ordinator
- Reduced LOS on LTC family of services caseloads i.e. from 2 years to 6 months

Mr Smith is able to remain at home and be at lower risk of admission to secondary care
Right care, Right time, Right place

- Relationships
- Resilience
- Revolutionising
• Thank you for attending
• Any Questions?!?