Barnsley Hospital NHS
NHS Foundation Trust

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

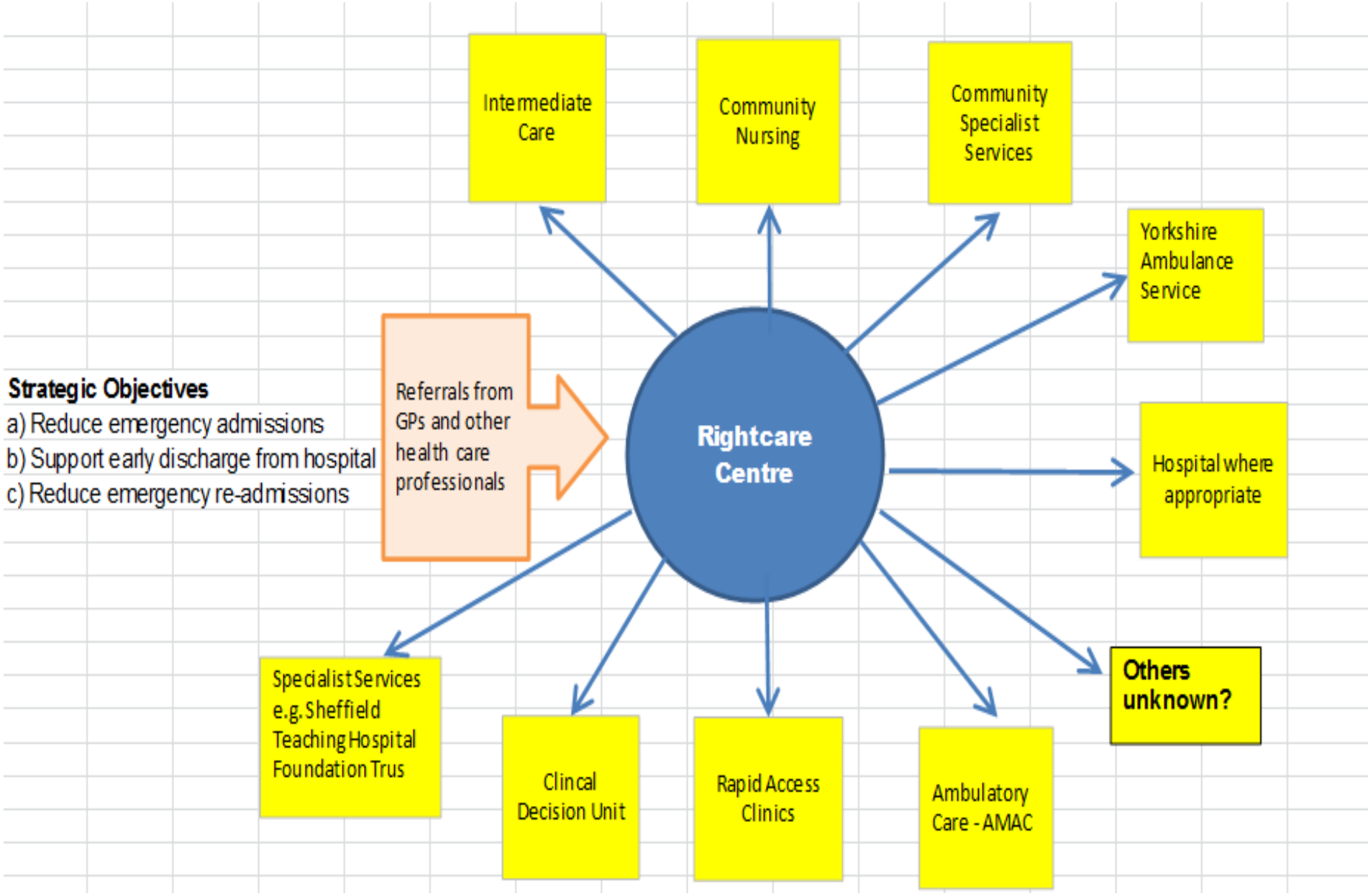
South West Yorkshire Partnership NHS
NHS Foundation Trust

RightCare
Barnsley

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



MR SMITH'S EXPERIENCE (2014)

Wife
(also has history of heart problems

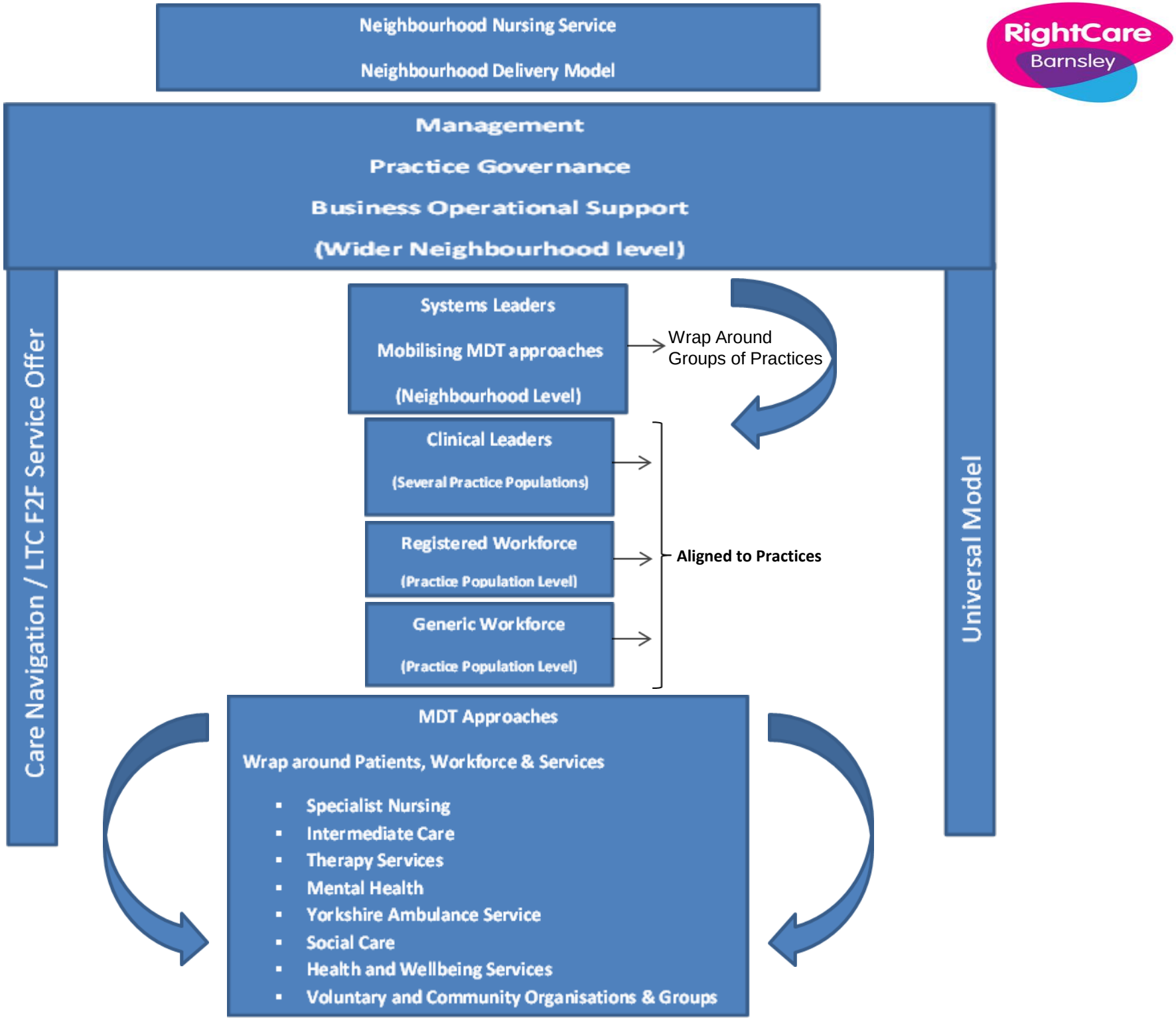
Daughter
(x 2)

Son (x 1)

Grand-children (x 5)

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.


Neighbourhood Nursing Service
Neighbourhood Delivery Model
RightCare
Barnsley
Management
Practice Governance
Business Operational Support
(Wider Neighbourhood level)
Care Navigation / LTC F2F Service Offer
Universal Model
Systems Leaders
Mobilising MDT approaches
(Neighbourhood Level)
Wrap Around
Groups of Practices
Clinical Leaders
(Several Practice Populations)
Registered Workforce
(Practice Population Level)
Generic Workforce
(Practice Population Level)
Aligned to Practices
MDT Approaches
Wrap around Patients, Workforce & Services
Specialist Nursing
Intermediate Care
Therapy Services
Mental Health
Yorkshire Ambulance Service
Social Care
Health and Wellbeing Services
Voluntary and Community Organisations & Groups

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

Beth

Mr Smith's Story Today

Mr Smith

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

Mr Smiths condition is well managed

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

- 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 Smiths needs
- Operating framework that enables a structured approach to care level , that enables escalation and de escalation of Mr Smiths changing needs
- 1 key worker/care co-ordinator
- Reduced LOS on LTC family of services caseloads i.e. from 2 years to 6 months

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Right care, Right time, Right place

- Relationships
- Resilience
- Revolutionising

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- Thank you for attending
- Any Questions?!?