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Yorkshire Partnership
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SWYPFT

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With **all of us** in mind.

The vision for Barnsley

South West Yorkshire Partnership NHS Foundation Trust

How the PCN will impact and how SWYPFT will support these plans

Covering

- Our overall offer
- The development of community services
- The development of mental health services
  - Community mental health services
  - Older people's mental health services

With **all of us** in mind.

The shared vision

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An integrated joined up health and care system where the people of Barnsley experience continuity of care.

Patients and their families are supported and empowered by what feels like "one team", each delivering their part without duplication.

A shift in focus on treating patients with health problems to supporting the community to remain healthy in the first instance.

Integrated care that delivers the best value for the Barnsley pound.

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Our communities

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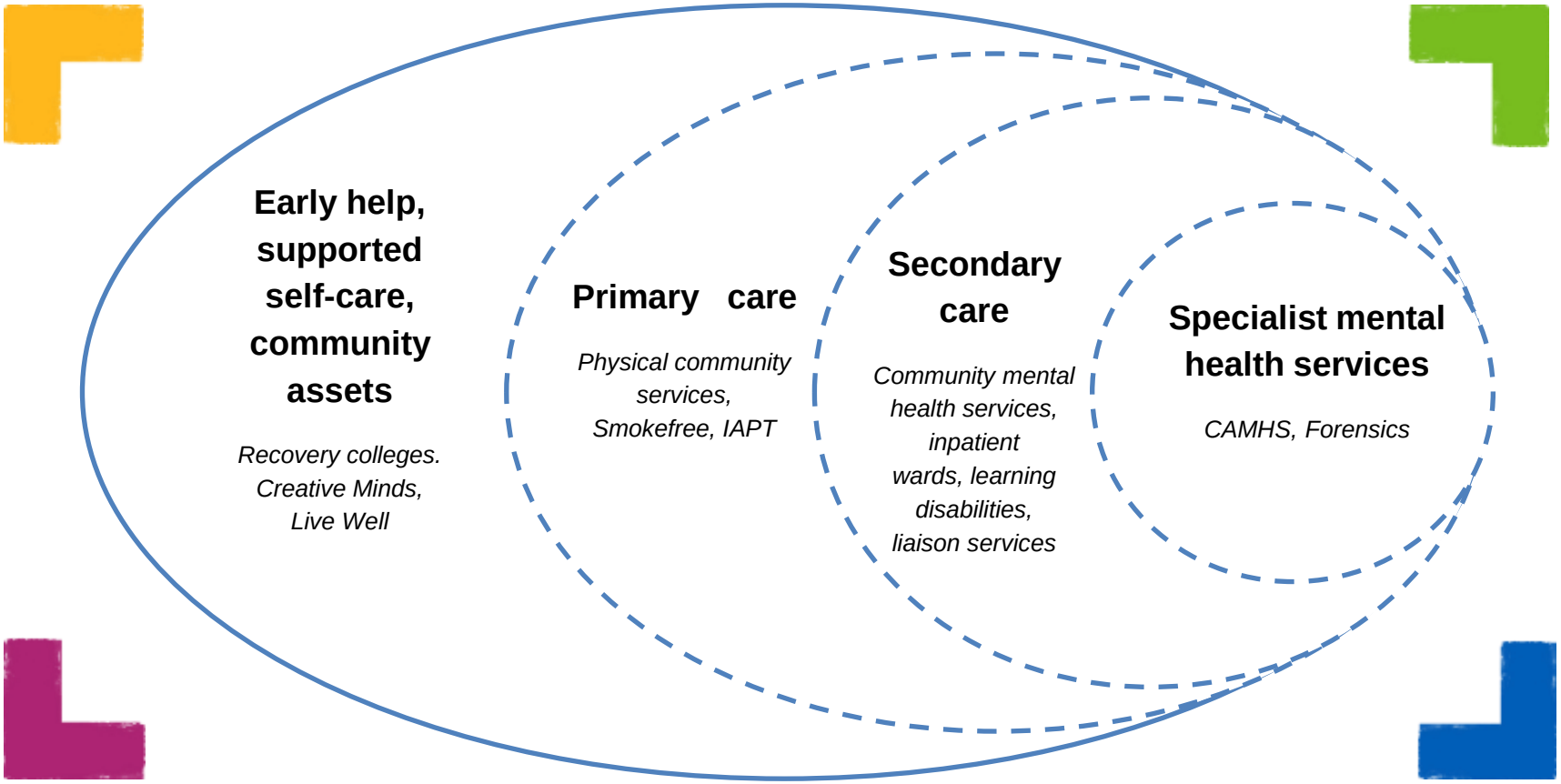

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The development of community services

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Neighbourhood teams and other services provided by SWYPFT in Barnsley: Physical health services

Services currently outside the scope of the neighbourhood teams specification provided by SWYPFT for Barnsley registered population

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Service	Delivery Model
Neuro Rehabilitation Inpatient unit	Based at Kendray Site
Tier three Weight Management Service	Delivered in community venues
Smoke Stop Barnsley	Delivered in community venues
Child Health Information System	Based at Cudworth
School Vaccination & Immunisation team	Via schools and other community venues
Children's Therapy Services : SALT, OT, Physio , Audiology	Delivered in community venues
Paediatric Epilepsy Service	Delivered in community venues

Services in the scope of neighbourhood teams & phasing in the specification

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Phase 1 (April to July 2020)	Phase 2 (by March 2021)
Neighbourhood nursing service	Memory assessment service
End of life	Speech and language therapy
Wound management and tissue viability service	Podiatry
Parkinson's disease	Dietetics
Continence and urology	Stroke
Heart failure	Musculoskeletal (MSK)
Epilepsy liaison	Cardiac rehabilitation
Intermediate care	Pulmonary rehabilitation
Occupational therapy	
Domiciliary physiotherapy including Falls	
Community home loans	
Equipment and adaptations	

What will neighbourhood teams do?

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- Work in integrated multi disciplinary teams, including primary care
- Be everybody's business, reducing multiple internal referrals.
- Have a clear set of commonly agreed response times which are based on clinical need (routine, urgent, etc.)
- Map to patient need using a population health management approach to planning
- Include organisational workforce development
- Focus on patient reported outcome measures, as opposed to the 'number of contacts' included in current contracts.
- Introduce one single point of access and clinical assessment for community services.
- Be supported by shared care records, one patient record that multiple teams can view and update

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General Community staff proposed alignment

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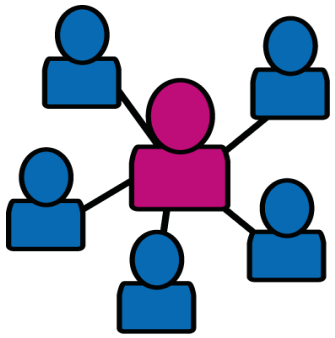
Neighbourhood Team Delivery Model

Supra PCN Level

Management & Operational Support
Professional Leadership
Patient Safety & Governance
SPA
EOL Clinical lead & EOL Educators (System wide all partners)
IMC Clinical Lead (System wide all partners)

Neighbourhood Networks x 6

Maintaining Patients in optimum health in their place of residence
Supporting Patient in their last month's/ days of life
Early Supported Discharge from tertiary and secondary care



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General community staff proposed alignment

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Neighbourhood Core Team

Advanced Practitioners

Community Matron (B8a)

Clinical Nurse Specialist Palliative Care (MacMillan)(B7)

ACPN (B7)

Extended Scope AHP (B8 & B7)

Enhanced Practitioners

DN Sister/Charge Nurses (B6)

Nurses & AHP's (B6)

Core Practitioners

Nurses & AHP's (Band 5)

Foundation Practitioners

HCA's, Support Assistants, Rehab assistants, phlebotomy (B 2 to B 4)

Admin & Clerical (B3 & B2)

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Progress On mobilisation

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- Mobilisation plan will run from October 2019 to March 2020 including any HR change processes for staff
- Programme Board in the CCG established chaired by Nic Balac, Dr Ghani and James Barker members for PCN
- Partnership Mobilisation group established chaired by Gill Stansfield James Barker PCN member
- Clinical reference group established to revisit pathways, new ways of working etc, would any clinical directors or GPs like to join?
- Task groups established including for
  - SPA : Multi agency led by Nic Balac & Jayne Sivakumar
  - Estate: scoping current staff bases and looking at hubs in each neighbourhood
  - IM&T: scoping interoperability , shared care records and SystmOne changes
  - Workforce : resources required, changes required, skills required, gap analysis

Care being taken not to destabilise current service offer whilst improving and changing to new model of working

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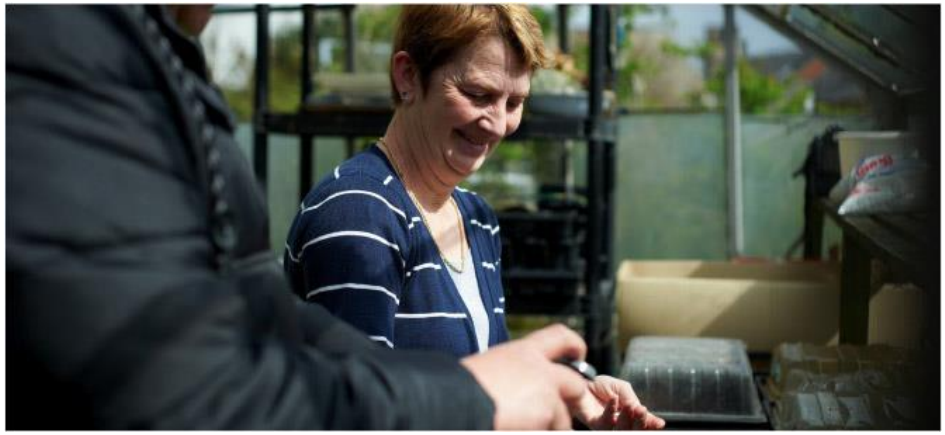
The development of mental health services in support of the primary care networks



Community mental health services

Older People's mental health services

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Community mental health

Current service and access points

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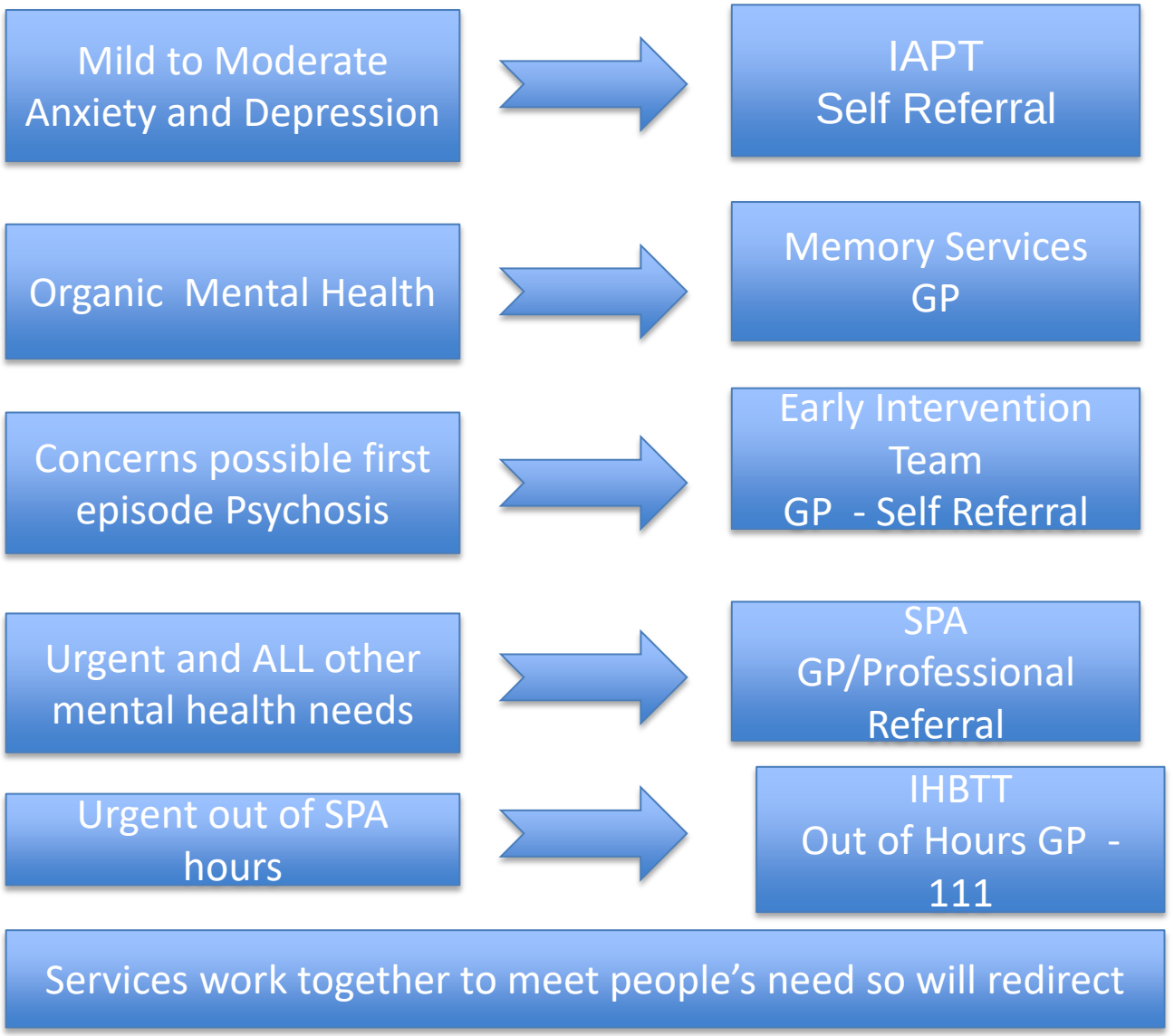
- Same business unit - managers & clinicians meet regularly
- Local work instructions to ensure smooth pathways
- Ensure clients don't get lost between services via internal transfer – minimise passing around
- Have well developed pathways with other nursing services, social services & third sector providers - ongoing development



How we work

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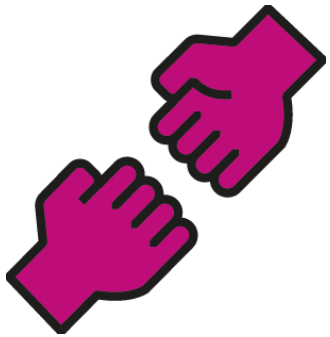
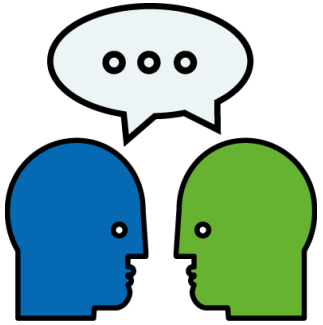
Treatment

- We provide time limited treatment
- In line with NICE guidance
- Aiming for clients to develop skills to manage own mental health and be more resilient
- Requires motivation and engagement from client
- We signpost people to other services for those who need help for non mental needs

Duty system

- SPA and IAPT
- Receive phones call from wide range of clients and carers
- Manned by qualified staff
- Maintains people in community
- Flexibility about appointments
- Signposts
- Provides psychoeducation and information





Our links to neighbourhoods & networks

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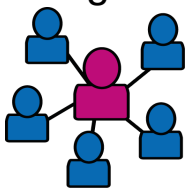
Now

- Core and IAPT have staff working in all neighbourhoods, providing sessions in GP surgeries and neighbourhood bases
- Assessments by SPA and IAPT are provided more centrally for risk management reasons and to provide a quicker response
- Mental Health Representatives attend neighbourhood meetings and Integrated Wellbeing Teams



In the future we want to work with you to

- Build-in mental health wellbeing as a health promotion and prevention step - before we go to treatment (more of creative minds offer, and recovery colleges as well as other VCS providers)
- Continue to provide a collaborative but wide range of mental health services
- Further links with the clinical networks. We can promote increased discussions between GPs and Consultant Psychiatrists as well as other members of the multi-disciplinary team
- Aim to minimise the impact on clinical services yet maximise relationships
- Identify and clarify the aims of pathways and ensure the right services are linking with the right clinical networks to be most effective
- Ensure clients receive the most effective least intrusive treatments

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Our Partnerships which are necessary at a neighbourhood level

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So we can succeed we need to work in partnership with others across the whole system. For community mental health services this includes:

- Working with our volunteers to co-produce and co-deliver Recovery College Courses, and creative, cultural and community activities through Creative Minds
- Working closely with Substance Misuse and Alcohol services
- Ensuring we work together to provide Talking Therapies for Long Term Conditions
- Link with colleagues in the third sector services in areas such as bereavement, domestic abuse, sexual abuse
- Work in partnership with “My Best Life” to support the development of Social Prescribing across Barnsley

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Our stepped care model for older people and those with complex needs

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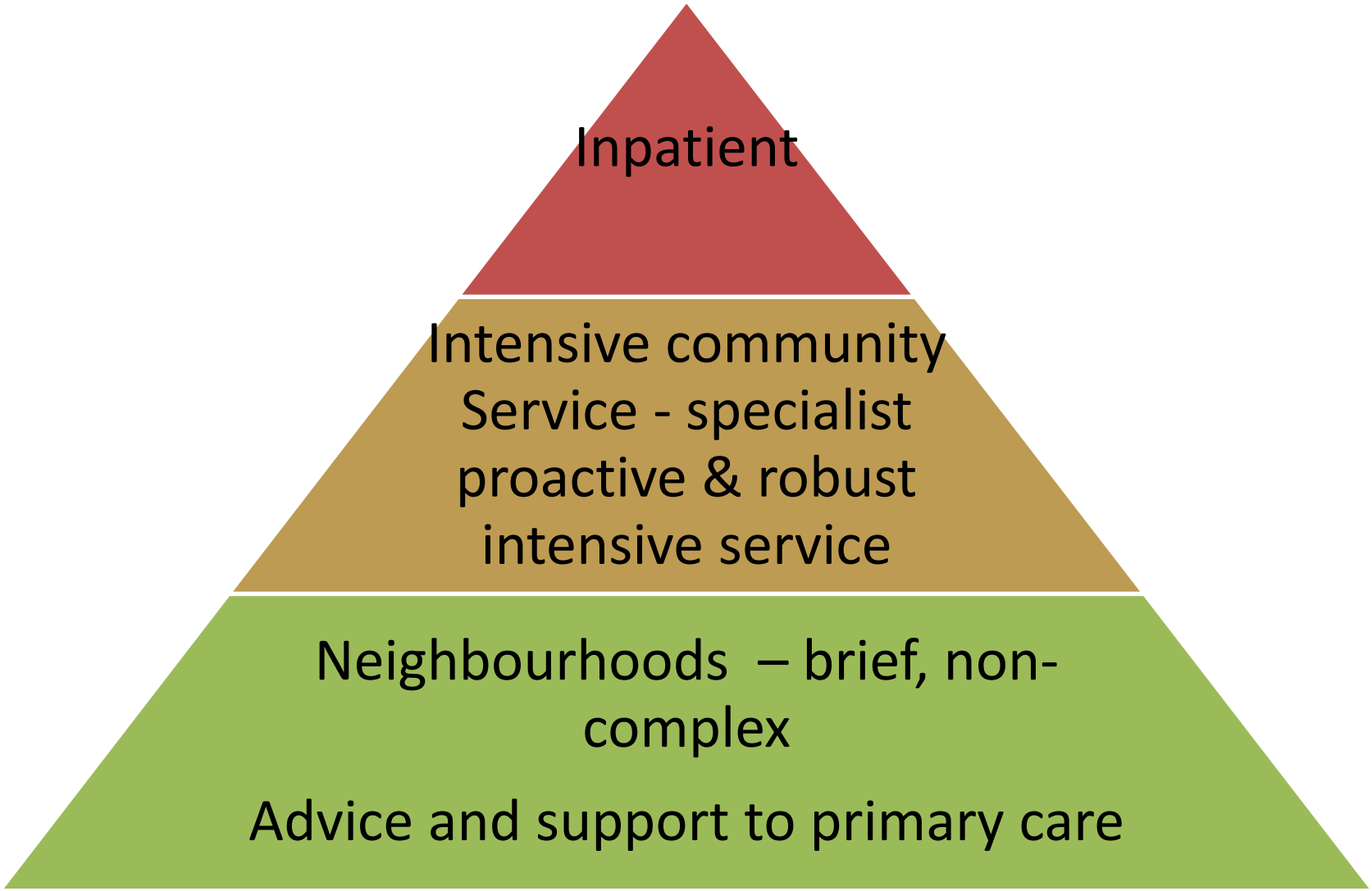

Older people's mental health – the Barnsley stepped care model

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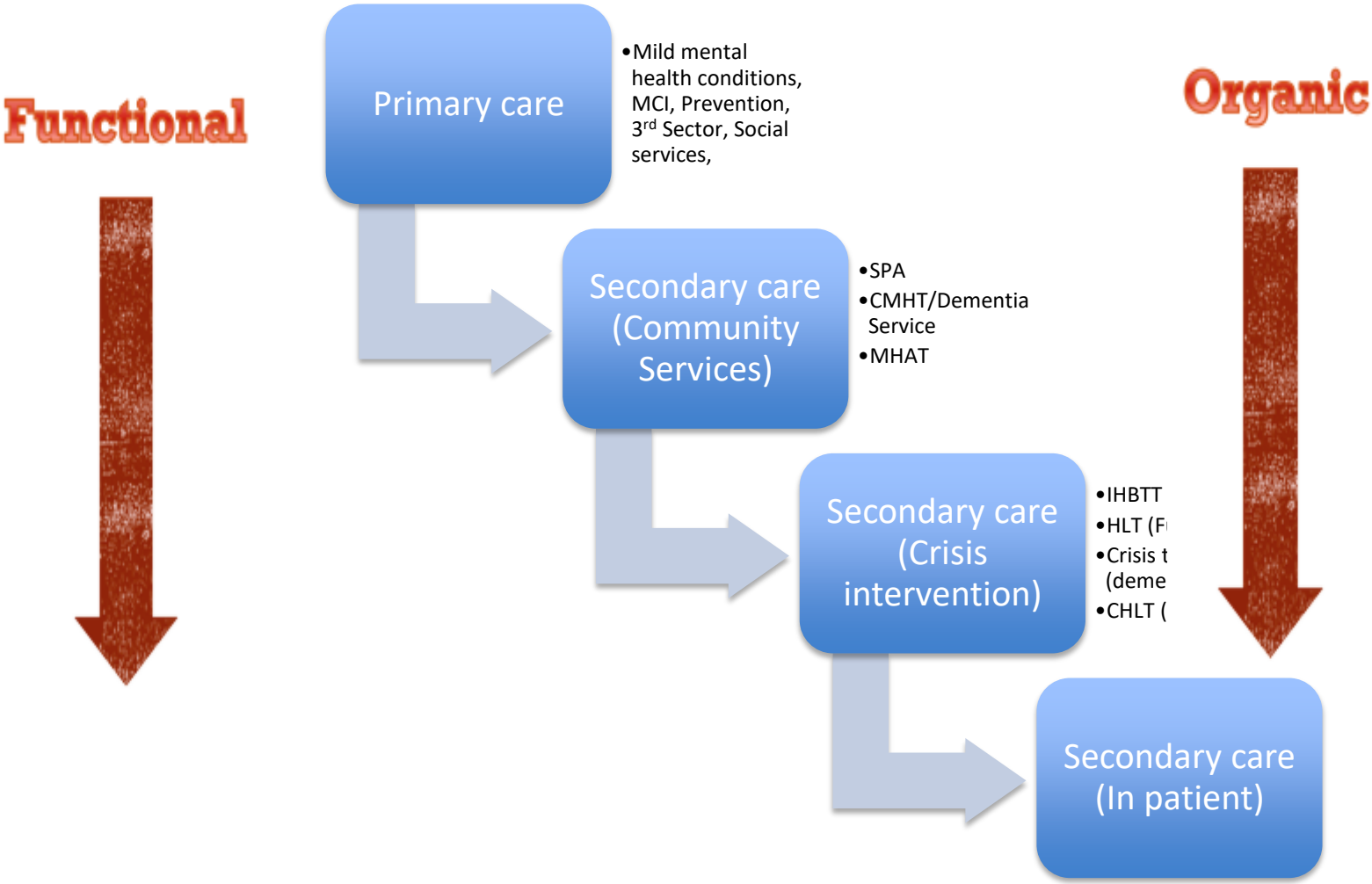

Dementia services – service offer

NICE Dementia Quality Standards (June 19)

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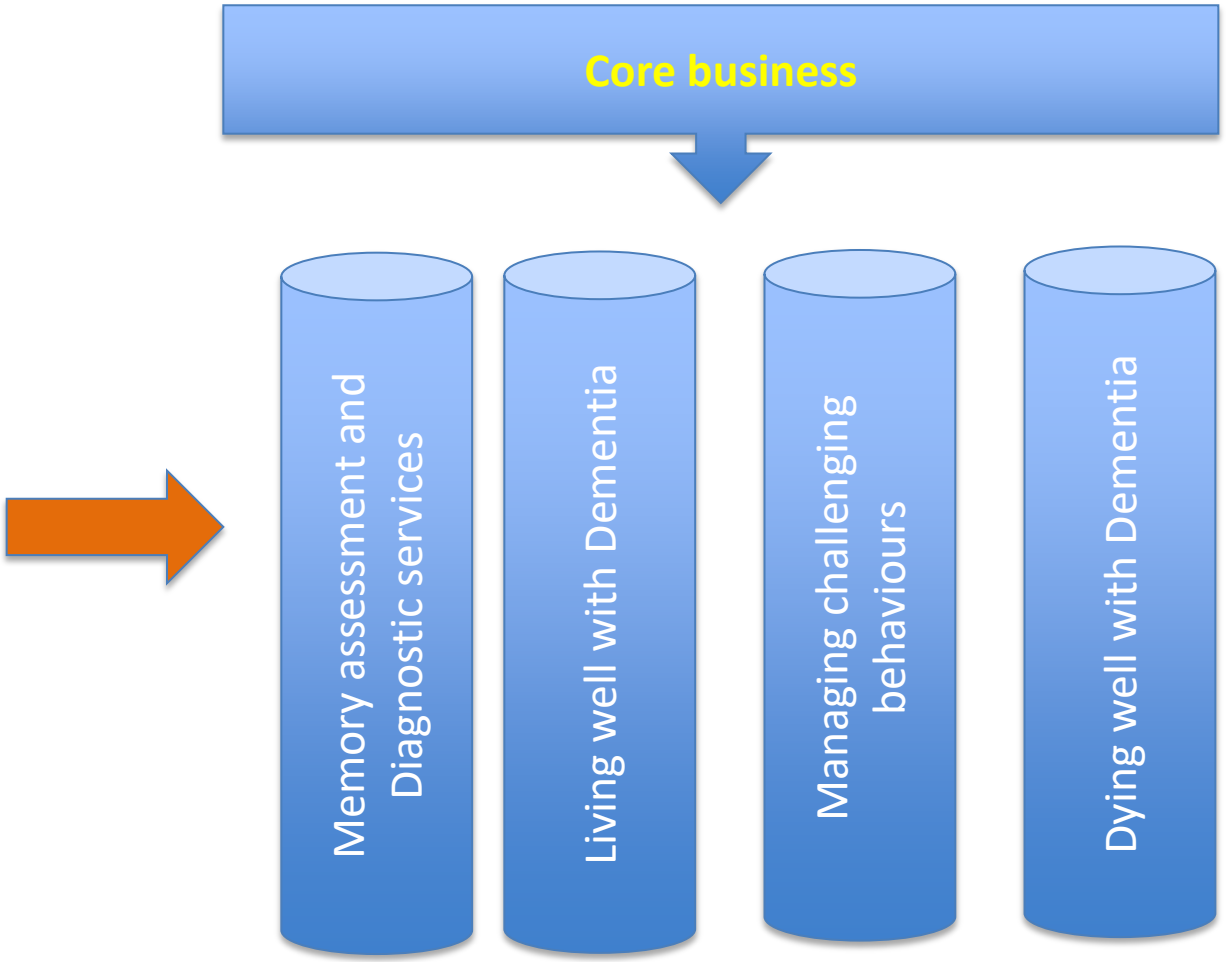
1. Raising awareness – health promotion interventions
2. Diagnosis
3. Advance care planning
4. Coordinating care
5. Activities to promote wellbeing
6. Managing distress
7. Supporting carers



How we work together

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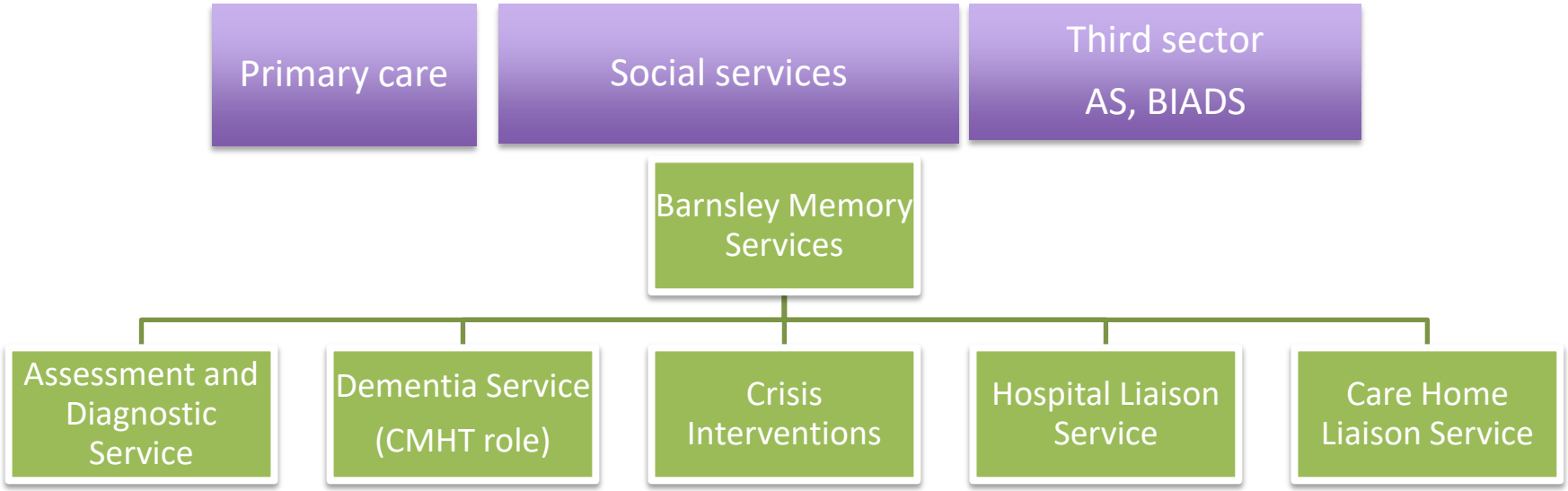

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TRIO pathway/functions from pre-diagnosis to end of Life

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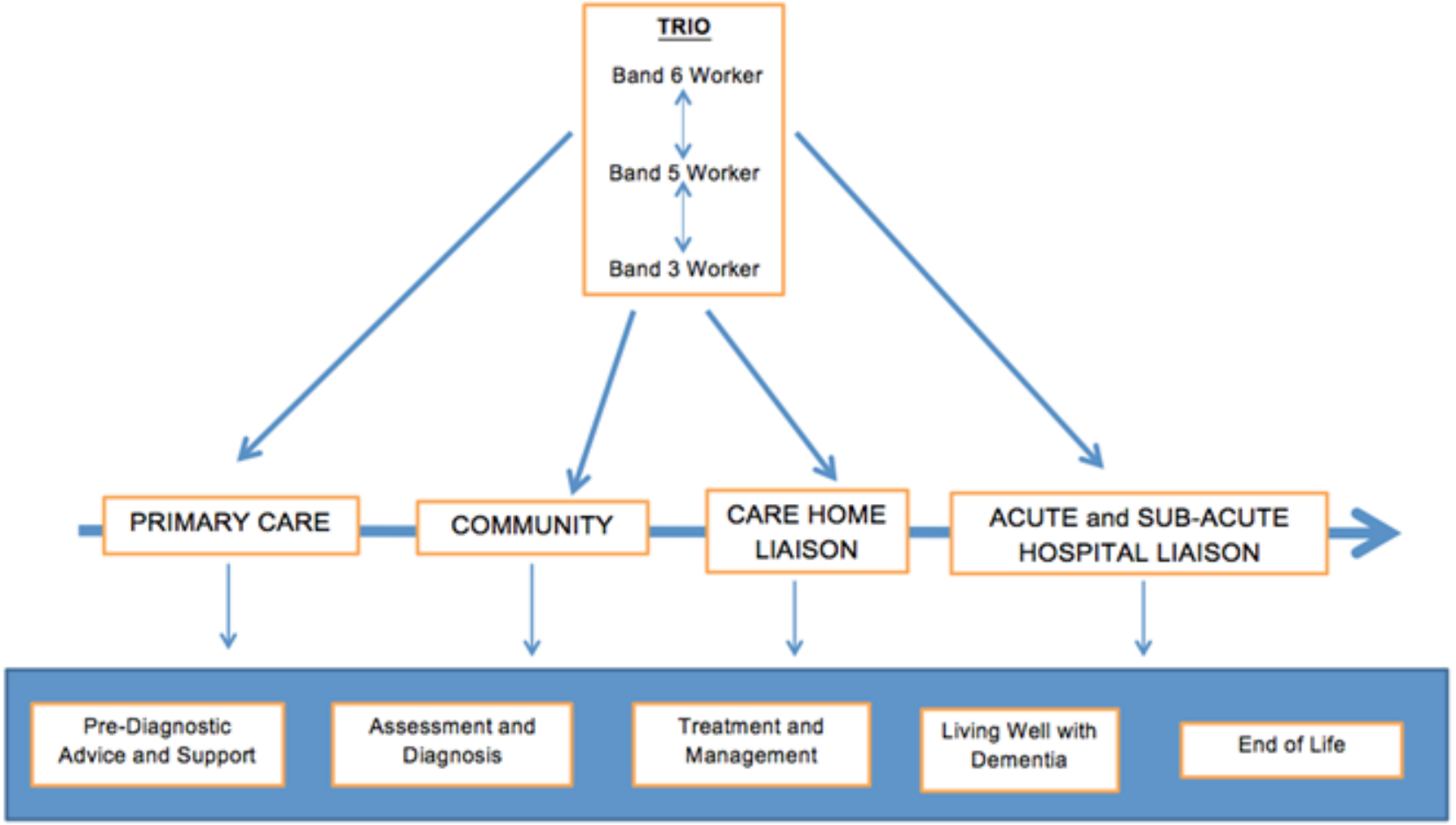

“Hub and Spoke” model integration with primary care

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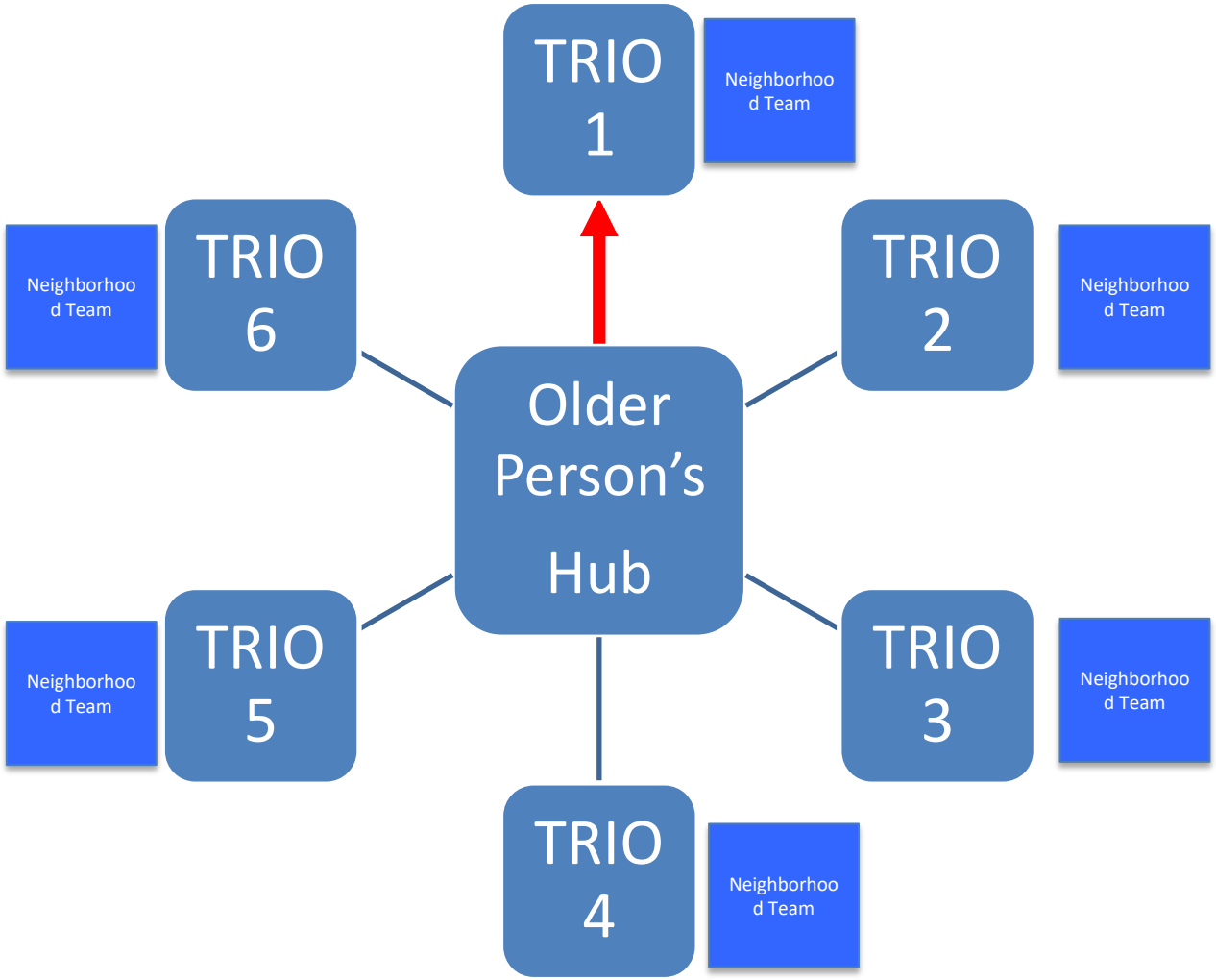

Summary and Conclusions

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We look forward to working even closer with you for the benefit of the people of Barnsley

With **all of us** in mind.