Our service offer

Barnsley Business Delivery Unit
Welcome to our brochure for the Barnsley Business Delivery Unit (BDU) of South West Yorkshire Partnership NHS Foundation Trust (SWYPFT).

• The Barnsley borough has a population of approximately 226,300 people. The population aged 65 and over has increased as a proportion of the total population, from 16.3% in 2002 to 16.7% in 2009, which is the same change as the England average.

• Barnsley is ranked 43rd most deprived local authority out of 354 by Index of Multiple Deprivation (2007).

• Approximately 10,000 elderly people in Barnsley live in the 20% most income deprived areas in England.

• 23.6% of Barnsley’s children aged under 16 years are currently living in poverty.

• Life expectancy in Barnsley is lower than the England average, with 1.9 years less for men (76.4 men) and 2.2 years less for women (80.1 women).

• The largest diseases that contribute to our gap in life expectancy compared to the England average are cardiovascular disease, cancer and respiratory diseases.

Many of the inequalities in health that we see in Barnsley are a preventable consequence of the lives people lead and the choices they make. Lifestyle choices and behaviours are often limited by the socio-environmental context in which people live.

Services need to understand how the wider determinants of health impact on lifestyle choices that people make. Supporting people to be in control and to make long term healthy lifestyle choices requires good engagement with service users and carers and an integrated approach across agencies. Many services are vital in responding to ill-health and disability, both in regard to short term crises and management of long term conditions. Equally, there are services that are preventative or that support the improvement or protection of health.

The service offer provided by the Barnsley BDU of SWYPFT attempts to emphasise the need for an approach to make sure that all services recognise the holistic needs of their clients, and that this approach supports people to be in control. The SWYPFT approach is also consistent with the aim highlighted in the JSNA for a more strategic, joined up, long term and community focused approach to commissioning and providing services.

Contact details
If you would like to discuss any issues relating to our services or our service offer, please contact:

Sean Rayner
Transition Director
sean.rayner@swyt.nhs.uk
01266 434041

There are also other contact details throughout this document if you would like to find out more about particular services.
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About the Trust

We are an NHS foundation trust, providing a range of community, mental health and learning disability services to the people of Barnsley, Calderdale, Kirklees and Wakefield. We also provide some specialist medium secure services to the whole of Yorkshire and the Humber.

As a partnership foundation trust we pride ourselves on working with others to provide an integrated service that is fully focussed around the needs of the person using our service.

Our mission statement is to help people to “live life to the full” and therefore we place particular focus on increasing our understanding of the lives of people who use our services. We then use this understanding as a basis for designing our input around their personal needs. We actively seek partnership working to help the wider system respond to the challenges we all face.

People who use our services have vastly different lifestyles in terms of social circumstances, wealth, housing, employment, where they live, their age, gender, sexual orientation, ethnicity, religion, culture and physical and mental abilities. We aim to make sure that services are designed and managed, as far as possible, to respect and value difference, creating environments where everyone feels respected and safe.

The Trust is increasingly a community based organisation. Recent developments have continued to reduce bed based services and increase provision in the community meaning that, at present, 98% of our contacts with people who use our services is in the community.

In order to deliver effective services our Trust is structured into Business Delivery Units (BDUs). The BDU that covers your services is the Barnsley BDU.

The Barnsley BDU has a degree of autonomy in the delivery of services, so it can be responsive and flexible to meet to the needs of your area, therefore keeping Barnsley services for Barnsley people.

The BDUs are supported by a headquarters function – our Quality Academy - which provides the governance framework, specialist expertise and oversight to the BDUs.

As a result of the government initiative ‘Transforming Community Services’ we have recently welcomed a range of additional NHS services to the Trust which has built on our traditional base of providing mental health and learning disability services. This means that all local mental health and community health services transferred to the Trust in the Barnsley district.

Barnsley services

We currently provide the following services for the people of Barnsley:

- **Mental health services**
  - Wellbeing pathway
  - Recovery pathway
  - Acute services

- **Community health services**
  - Services for people with long-term conditions
  - Children’s services
  - Primary care and preventative services
  - Inpatient and community rehabilitation services

The future

These are exciting and challenging times. The context in which we are working both nationally and locally is changing.
The Government has consulted on a major NHS reorganisation and a new commissioning landscape is emerging. This is in the context of an unprecedented pressure on financial resources along with demographic and social changes that increase demand for services.

Responding to meet the health and wellbeing needs of people in Barnsley is complex. We know that for some the picture is improving but for many it is not. We are using the findings from the Barnsley Joint Strategic Needs Assessment to target our services better at people in a way that reflects their level of need. This will support a reduction in the differences in health and wellbeing between groups of people and between different areas. This is not a quick fix but an ongoing, long term process which requires our partnership approach with commissioners, local organisations, local people, their families and their communities.

The range and coverage of services provided by the Trust has altered significantly in the past year. We directly provide and work with other organisations to develop and deliver integrated physical and mental health support for people. We are working towards the achievement of better outcomes for people that include improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours such as smoking and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation. To meet these challenges we need to redesign our services and continue to demonstrate value for money. Each year we achieve a minimum of 4% efficiency saving; this may increase in light of the 2012/13 operating framework. We are also able to utilise the freedoms of being an NHS Foundation Trust to generate surplus that we reinvest to enhance our service offer for local people. This includes improvements in our estate, the use of new technology such as telehealth, supporting service innovation and in improving access to services.

We understand that we need to be clearer about what we provide and how much it costs. To do this we have been working on the Care Pathways and Packages project to clarify and cost our mental health services in a way that helps people who use, commission and provide services.

If you would like more information about the Change Lab approach or would like to get involved please contact Kathryn Winterburn on 01924 327472

This new approach to describing our service offer will help us:
- Explain to commissioners what we provide and how much it costs and prepare for payment by results for mental health services.
- Ensure the delivery of the most effective packages of care to meet needs.
- Demonstrate the outcomes we are achieving for individuals and local populations.
- To plan and ensure that we have the most effective and efficient workforce, estate and information technology to meet people’s needs.

This description of our current service offer is only the first step as we know that radical changes are required to meet the challenges in future years.

We are working with the University of Leeds Centre for Innovation in Health Management to do this in a different way; not a traditional set of service reviews, but through the innovative Change Lab approach that really engages with stakeholders in a process of co-creation.

The core question that we are seeking to answer is: **How can we work more creatively with people in our communities to live life to the full?**

The change lab approach started in June 2011. There have been three workshops in which participants from a wide range of agencies and service users worked together to identify potential new services and ways of working over the next two years. The outcome from the workshops identified a number of possible “prototype” areas that will test these new ways of working over the next few months. These prototypes will inform and enhance our offer of services in this district in the future.

The prototype areas we are working on include:
- Service improvement and innovation
- Increasing the involvement of service users in commissioning and service improvement
- Engaging with staff
- Integrating dementia services
- Developing service user led evaluation of services
- Using creative approaches to boost wellbeing
- Using patient experience stories to further develop therapeutic services
- Developing a framework for wellbeing with better service integration
Background

Mental health services in Barnsley have been consistently moving toward a recovery based model over recent years. We aim to always offer the least restrictive alternative and our structures reflect this, with the majority of our services and resources being based and delivered in the community. The service has continued to reduce the number of bed based services we provide, to work toward our aim of delivering care closer to home for the majority of our service users. We recognise the importance of retaining and maintaining social systems and networks to support people with their recovery. We offer a flexible, accessible service that aims to deliver individualised care in partnership with our service users and their families.

Our services are fully integrated with our social services colleagues and our community teams have health and social care staff working together with service users to deliver the best possible care.

Services are currently delivered through teams that are organised into business units, each with a dedicated manager.

The business units are:

- **Acute services** – inpatient services, intensive home based treatment
- **Community services** – Community Mental Health Teams (CMHTs)
- **Specialist services** – Recovery services, assertive outreach team, early intervention team, criminal justice and substance misuse services

Who uses our services?

Any one of us, our friends or family may need to use mental health or community health services. So it’s important they are as good as they can be and are easy to access.

Mental health is just like physical health. It can be good or bad, lead to problems that last for a few weeks or ones that need to be managed over a lifetime.

People experience problems with their mental health at different times in their lives. Many of these people manage their problems with the support of family, friends and their family GP. Sometimes, people need extra help. In these cases, individuals will be given a referral to our services.

GPs are the people who most often refer people to our services. We have worked hard with GPs in the Barnsley area to make this as easy and quick as possible.

The majority of our referrals come into our Community Mental Health Teams (CMHTs) and the Improving Access to Psychological Therapies (IAPT) team. Individuals are usually assessed within 14 days although if needed can be seen more rapidly.

Sometimes it is necessary for somebody to be seen urgently, for instance if they are in crisis. The intensive home based therapy team will carry out an assessment within 4 hours and ensure that the person is treated in the least restrictive environment to assist in their recovery.
What types of services do people use?

Many people have common mental health difficulties. Some of these may have started recently, such as depression, anxiety and reactions to significant things that have happened in their lives. Others may be more severe and complex and the person may have had difficulties for some time. Some of these more severe and persistent problems may have developed after a particular trauma, for example if an individual suffered abuse as a child. People with common mental health difficulties will usually be seen in the wellbeing/community therapy pathway.

Some people have more complex problems, such as bipolar disorder or psychotic illnesses. People may experience these problems over longer periods of time and may need more ongoing support. They will usually be seen within the recovery/care management pathway.

Sometimes mental health problems can feel overwhelming, and a person may need extra support from acute services. Intensive home based treatment can be provided in a range of settings and offers an alternative to admission to hospital. For people who are in a particularly acute or vulnerable stage of their illness, inpatient services provide care in a safe and therapeutic environment where restriction is minimised as much as possible.

What is a pathway?

A pathway is how the NHS describes the way an individual will receive care from services: it is also a way of grouping services together.

It describes the journey an individual takes from their referral to our services through to their recovery or to where they are managing their condition as effectively as possible.

By describing it as a pathway it makes sure the focus remains on the person, rather than the contribution of each specialty or caring function independently.

Depending on the nature of the problem, some people may only have input from one or two professionals throughout the pathway, whilst others may have several different types of teams and professionals supporting them.

Whatever pathway people follow, care planning and co-ordination will be at the heart of the services they receive.
Where do we provide our services?

We provide care in a wide variety of settings. Sometimes we come to people’s own homes to see them, but often it’s better to offer the service in a particular setting – one that offers peace and privacy and where we can also run groups. People will go to different buildings depending on the service they need to use and also where they live.

Sometimes people may need extra support. The Intensive Home Treatment Team can rapidly assess a person’s needs and help them set up a more intensive care plan.

This could involve additional support in the community or, if a person needs to be supported in a very safe environment, they may need to spend a short time in one of our inpatient units.
Moorland Court on Gawber Road in Barnsley provides day services that offer a range of activity based services and opportunities such as confidence building, social skills, personal and domestic skills and support with housing, finance, education and employment.

Littleworth Court in Lundwood has consulting rooms as well as providing a base for the Central Community Mental Health Team (CMHT).

Lundwood Health Centre has consulting rooms as well as providing a base for the North CMHT.

Wombwell Clinic has consulting rooms as well as providing a base for the Dearne CMHT and the South CMHT.

Darfield Clinic provides a base for the older adults CMHT.

Cudworth Health Centre has consulting rooms as well as providing a base for the mental health access team.

Stairfoot Clinic has consulting rooms as well as providing a base for the early intervention team.

Community buildings – we work from a variety of buildings in the community at different times. For example, we run outpatient clinics at the Worsborough Lift Building.
Who provides our services?

The Trust employs dedicated and skilled staff from a great variety of professions and disciplines. Individuals will have contact with different staff depending on what service they are using and what support they need. Clinical staff are well supported by a number of non-clinical support and administrative staff. Staff who work in Barnsley mental health services include:

**Clinical psychologists** aim to reduce psychological distress and enhance and promote psychological wellbeing. Psychologists work with people, either individually or in groups, assessing their needs and providing therapies based on psychological theories and research.

**Dietitians** are skilled in the assessment and treatment of people’s nutritional needs and eating behaviours. They enable people to make informed choices about the food they eat. This may be to help manage a condition or to maintain a healthy eating pattern. They also work with families and carers.

**Nurses** use holistic assessment and care planning and they are skilled in psychosocial interventions. They can also administer medication. Nurses in both the community and in hospital settings help people develop skills to maximise their potential and promote recovery.

**Occupational therapists** work with people to support them to do the things they need, want and have to do in their everyday lives. This is done through assessment and the use of activity to enhance wellbeing or to improve skills. They also look at what can be changed in a person’s physical or social environment to enhance participation.

**Pharmacists** use their expertise in medicines to provide advice and support to help people achieve the best outcomes from their use of medicines. They are specialists in medicines use, with expertise in both the use of medicines and the barriers that people face when prescribed medicines, and are available to both professionals and service users to help provide expert support. The Trust has a dedicated medicines information line that can be reached on med.information@swyt.nhs.uk or 01924 32 7619. There is further information available via www.choiceandmedication.org/swyp.

**Physiotherapists** view movement as central to health and wellbeing. They aim to identify and make the most of movement ability by health promotion, preventive advice, treatment and rehabilitation.
Social workers work within the multi disciplinary teams across the Trust and local authority. They carry out holistic assessment, therapeutic interventions, care planning and risk management in line with the Care Programme Approach (CPA). In addition, a number of social workers have undertaken addition training enabling them to perform legal duties under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Support staff help mental health professionals deliver care plans and they add great value to how we deliver care. Their support may include engagement activities, advice, creative activities, advocacy, rehabilitation, community participation and support in personal and health care.

Psychiatrists are medically qualified doctors. They are skilled in the assessment and diagnosis of mental health problems. They can prescribe medication as well as recommend other forms of treatment.

Psychological wellbeing practitioners support people through guided self-help and education to raise their awareness of anxiety and depression and ways to manage their wellbeing.

Psychotherapists help people overcome psychological and emotional issues, addressing their thoughts, feelings and behaviours. They help bring a new understanding to emotional and relationship problems which helps to reduce symptoms and alleviate distress. This includes art psychotherapists and dance and movement psychotherapists.
Wellbeing/community therapy pathway

Who uses these services?
People may have a range of common mental health difficulties, such as anxiety and depression.

Some of these difficulties may have come on fairly recently, be fairly mild and the person may not have experienced this kind of problem before.

However, some may be more severe and complex and the person may have had difficulties for some time. This is particularly the case with:
- Severe anxiety
- Depression
- Obsessive-compulsive problems
- Eating disorders
- Self harm

Some of these more persistent problems may have developed after a particular trauma, for example if an individual suffered abuse as a child.

What support does this pathway offer?
People experiencing common mental health problems will usually be seen by staff from our improving access to psychological therapies team or by staff from the community mental health teams.

The mental health access team
(which includes Barnsley’s Improving Access to Psychological Therapies (IAPT) programme) provides signposting, assessment and a range of NICE recommended treatments for people experiencing mild to moderate anxiety and depression. We offer Stresspac (a five-session psycho-education group), a computerised Cognitive Behaviour Therapy (CBT) package for depression, self help, guided self help, counselling, CBT, an agoraphobia package, eye movement desensitisation and reprocessing and a range of groups for people who have problems with depression or low self esteem, or who have experienced sexual abuse. We also provide an improving access to psychological therapies service for Barnsley College.

The team accepts referrals from individuals or any health professional. Please contact 01226 707600 and ask to speak to the duty worker for more information or to make a referral.

Community Mental Health Teams (CMHTs)
provide a range of interventions aimed at reducing psychological distress and optimising psychological wellbeing. They work in partnership with service users, their carers and families and offer a number of treatment choices including medication, psychosocial interventions, occupational therapy, psychotherapy and psychology.

Where can you get more information?
Telephone: 01226 707600
Liz Holdsworth – Manager
liz.holdsworth@swyt.nhs.uk
Linda Matthews – Clinical lead
linda.matthews@swyt.nhs.uk
James Barnes – Team leader
james.barnes@swyt.nhs.uk
Since coming into contact with the team at Cudworth, I have been treated with the utmost respect by all members of the team. During the time I had with my psychological wellbeing practitioner I always felt that control of the intensity and speed of my therapy was mine. Without the help and dedication of the people at Cudworth I know that in my case I would not have the quality of life that I currently have. Thank you all.

What do we help people to achieve?
- Confidence about managing their mental health
- Significant reduction in symptoms or distress
- Increased self-esteem and a stronger sense of identity
- Ability to cope with life responsibilities, including education and employment
- Ability to maintain satisfying relationships and social networks
- Ability to manage physical wellbeing

How do people move on from this pathway?
People may be discharged from one part of the pathway and carry on getting help from another part.

When someone is completely discharged from the pathway, they will have a plan for relapse prevention if they need it.

Many people remain in contact with community groups, become involved in further education or training or return to paid employment.

Groups and support networks that people often link to from this pathway include:
- Voluntary organisations
- Community groups
- Local arts organisations
- Advocacy services
- Befriending/mentoring services
- Carer support services
- Health groups
- Housing organisations
Recovery/care management pathway

Who uses these services?
This pathway provides care for people who have severe or long term mental health difficulties which impact significantly on their ability to manage their everyday life without additional support.

Sometimes this group of individuals are more vulnerable to abuse or exploitation and may have had several admissions to hospital.

Whilst some individuals work collaboratively with staff to develop a care package which meets their personal needs others may find it difficult to maintain contact with services.

Within the pathway, we aim to:
- Reduce the length of time that people go without diagnosis or treatment
- Assist individuals on their personal recovery journey
- Reduce the stigma linked to mental illness
- Help people develop and find opportunities for personal fulfilment

What support does this pathway offer?
People with more complex problems will usually be seen by staff from our community mental health teams or one of the specialist teams such as early intervention, assertive outreach or the recovery team.

Community Mental Health Teams (CMHTs) provide a range of interventions aimed at reducing psychological distress and optimising psychological wellbeing. They work in partnership with service users, their carers and families and offer a number of treatment choices including medication, psychosocial interventions, occupational therapy, psychotherapy and psychology.

The early intervention team provides care for people experiencing psychosis for the first time. These people are usually between 14 and 35 years old. The service can be accessed 7 days a week. The team works with people’s strengths and focuses on social inclusion and promoting independence. The team may work with people and their carers for up to three years, with the aim of:
- Reducing the impact of psychotic experiences on social functioning
- Reducing the risk of people developing life-long mental health problems by reducing the risk of repeated relapse
- Helping people to maintain social networks, employment and education by working in a hopeful and optimistic way and maximising their potential to achieve life goals

“Before I attended the carers’ group I felt alone and not able to cope with my daughter's illness. Since attending the group it has changed my life. I have been able to meet people in similar circumstances. I have found it uplifting, extremely helpful and supportive.”
These may include:

- Managing their mental health
- Looking after themselves
- Recovering social networks
- Rebuilding self-esteem

The care offered to an individual is planned with them and is tailored to their needs. Care is comprehensively reviewed and evaluated at least once a year.

Individuals will learn how to manage or prevent a relapse in their mental health, and how to reduce risks to themselves and others. They will receive psychological support and medication to manage their symptoms over time.

Depending on individual need, people may be offered:

- Support with coping and confidence skills
- Healthy living advice, including nutritional and weight management
- Help with managing accommodation needs

What do we help people to achieve?

- Ability to manage their mental health, with support where needed
- Ability to look after themselves, their finances and their home
- Satisfying relationships and social networks
- Greater personal resilience
- Involvement in meaningful activity, including education and employment
- Improved self-esteem and more optimism towards the future
- Better ability to trust others and accept support
- Greater involvement in their own communities
- Better management of risk
Today I attended a care programme approach meeting to discuss the transfer of my son’s care from the assertive outreach team to the recovery team – a good sign that his condition has improved so much in the five years since his involvement with the team began. I feel that his recovery and improved health is due to the dedication, efficiency and effectiveness of the team approach. As soon as my son was referred to the team he has benefited from the knowledge and experience they have. When a relapse occurred the team intensified their services and provided the extra support to help him during this period. Apart from the obvious support, the team have been helping in supporting my son with daily living activities, budgeting, helping him to access voluntary employment and participating in group activities. All of this has helped him to improve his confidence and lead a more normal life.

Recovery/care management pathway

Where can you get more information?
Jane Taylor
Recovery and wellbeing team
01226 770712

Janette Hawkins
Assertive outreach
01226 434198

Joanne Tandy
Early intervention service
01226 323970

Lesley Birchall
Criminal justice liaison team
01226 785723

Janet Dacre, Moorland Court
01226 730433

Jill Jinks
Business unit manager, specialist mental health services
01226 434245

How do people move on from the pathway?
The pathway is based on the recovery model. We work with people to achieve their best possible wellbeing and independence.

Some people will, following regular reviews, be discharged completely from our services. Other people may need longer term support from us. When people are managing well, the intensity of their care will be gradually stepped down.

Whenever someone is discharged, we always make sure that if they need help in the future, it will be available rapidly. This includes agreeing a relapse prevention plan with them.

Many people remain in contact with community groups, become involved in further education or training or return to paid employment.

The community groups and support networks that people use include:

- Voluntary organisations
- Community groups
- Local arts organisations
- Advocacy services
- Befriending/mentoring services
- Carer support services
- Health groups
- Housing organisations

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Janet Dacre, Moorland Court
01226 730433

Jill Jinks
Business unit manager, specialist mental health services
01226 434245
I used to work in the fashion design industry until I became ill. This was a hard time in my life. I was diagnosed with schizophrenia and spent a year in hospital. When I came out of hospital I moved in supported living and began to get help from the recovery team. They were fantastic at supporting me to have the skills I need to be well.

I was offered a personal budget and had support to write a plan for how I was going to use the budget to help me meet my assessed needs. At first I used the budget to purchase some support from an agency, which helped me to regain some of my confidence. I’ve now had a personal budget for a few years. It helps me to feel happy again and gives me confidence to move forwards. It feels different because previously I had services organised for me.

As I am now on the road to recovery, my budget has reduced. I have updated my plan myself and this has given me the opportunity to talk about what I want for the future. The opportunity to be creative is very important to me and is something that keeps me well. I now receive a little support and a one-off payment which I use to help me to buy equipment to make jewellery. I hope that eventually I will be able to teach other people how to make jewellery to give something back. My goal is to have my own jewellery business and be financially self-supporting, and the recovery team is helping me with this.

Without the support that I have I would still be wondering where my life is going, but now I have hopes for the future. I would definitely recommend considering a personal budget – you can really make it work for you in a way that I didn’t know was possible. I feel lucky that I have been able to get back some of the life I have lost.

I want to tell you about how physical activity has changed my life. I used to sit in my bedroom with my mind full of things but not getting anywhere. There were a thousand voices telling me not to go and one voice telling me to go and I chose the one which changed my life.

I have been playing football for three years now. I have travelled to Holland and Germany and various places. All it took was to trust in the staff, especially our coach. I can look at how far I have come from sitting in my bedroom for six years to going out every day playing sports.

Going shopping, travelling and living my life again with my mental health and physical activity has improved my confidence and wellbeing and I know it has helped my mental health. All it took was the fight or flight to get involved in activities, and I thank our coach for supporting me in everything physically and mentally.
Acute services

Who uses our services?
Sometimes mental health problems can feel overwhelming, and a person may need extra support. A person with any mental health problem may experience a crisis and may need specialist support to maintain their wellbeing, recovery or safety.

We try to make the experience for service users as therapeutic and comfortable as possible whilst acknowledging that people who are in need of this part of the mental health service are at their most vulnerable and likely to be very distressed.

What support does this pathway offer?
The intensive home treatment team will carry out an assessment within four hours and ensure that the person is treated in the least restrictive environment to assist in their personal recovery. This could involve support from the team over a few days or even weeks. The team offers an alternative to hospital admission by providing intensive support to people and their carers in their own home.

If the person needs to be supported in a very safe environment, they may need to spend a short time in our inpatient unit. They will be admitted following an assessment by the Home Based Therapy Team who may stay in contact with them and assist them to return home as early as possible. Good co-ordination of the person’s care will ensure that they get the right level of care that is person-centred and is proportional to their needs.

We aim to create and maintain a safe, supportive and therapeutic environment where we can support people’s physical, emotional and mental wellbeing during an acute episode of mental illness.

What do we help people to achieve?
We aim to help people to achieve a rapid resolution of the crisis that they are experiencing and to swiftly regain a quality of life that is acceptable to themselves, their carers and their community.

How do people move on from this pathway?
The rapid improvement programme discussion group highlighted timely discharges from the acute adult inpatient services as the main focus for quality improvement in patient care. Alongside the work of the rapid improvement programme, the intensive home based treatment team identified the positive impact of improved communication and seamless working with inpatient services on reducing the length of admission and improving the quality of the patient journey by clearly identifying the reasons and objectives for the admission.

Where can you get more information?

Trish Ware  
Intensive home based treatment team  
01226 434683

Donna Shaw, Beamshaw Ward  
01226 434715

Mick Oldham, Clark Ward  
01226 434713

Dianne MacCauley, Willow Ward  
01226 434726
How the acute pathway has helped

Andrew suffers from a serious psychotic illness and was regularly admitted to hospital, detained under the Mental Health Act. Andrew and his family had a very negative view of mental health services – very often the police had to be involved in transferring him to hospital. Andrew did not understand his illness very well and had not engaged well with community mental health services.

In 2002, Andrew was offered intensive home based treatment as an alternative to hospital. His family were reluctant to accept this, but the team explained to them that it could be a way of preventing a lengthy hospital stay. The episode of home treatment worked very well. Andrew was able to stay at home and began to engage with services and begin to do some basic relapse prevention work with them. In the past 9 years he has only needed to come back into hospital once.

Kind-heartedness, politeness and the wanting to help attitude of staff has been the main impact on getting better.
Community health services

In Barnsley, we provide a wide range of community health services which includes:

- Services for people with long term conditions
- Services for children and families
- Primary care and preventative services
- Inpatient and community rehabilitation services

Who provides these services?
The Trust employs dedicated and skilled staff from a great variety of professions and disciplines. Individuals will have contact with different staff depending on what services they are using and what support they need.

Clinical staff are well supported by a number of non-clinical support and administrative staff. Staff who work in Barnsley community health services include:

- District nurses
- Health visitors
- Macmillan nurses
- Marie Curie nurses
- Physiotherapists
- Occupational therapists
- Podiatrists
- Speech and language therapists
- Community matrons
- Healthy lifestyle advisors

Where do we provide our services?
We provide our services at a variety of locations, including:

- Mount Vernon Hospital
- Barnsley Hospital NHS Foundation Trust
- Health centres
- Children centres
- Leisure centres
- GP surgeries
The long term conditions business unit has a number of specialist community nursing services. These are commissioned by NHS Barnsley to help support and care for the people of Barnsley who have a long term condition, or multiple long term conditions.

These services are constantly involved in a wide variety of on-going projects ranging from virtual wards with GP practices to telehealth schemes. Through these projects we are working collaboratively with local commissioners and well-renowned multi-national organisations from the private sector, striving to sustain and improve the existing quality healthcare services provided within this business unit.

Our services have strong, well established working links with a variety of local organisations including Barnsley Hospital NHS Foundation Trust, Sheffield Teaching Hospitals, Barnsley Council and Barnsley Hospice.

Our business unit is operationally structured to ensure all community healthcare services are led and managed by a business manager and where appropriate a professional lead nurse, who in-turn reports to the deputy director of operations.
District nursing service

The district nursing service supports the management of housebound clients, who are High Intensity Users (HIU) in conjunction with other nursing services.

The service is provided at a variety of locations across the Barnsley community and is delivered 365 days a year between 8.30am and 5.30pm. The rapid response service (see Inpatient and community rehabilitation services section) provides an out of hour’s service from 5.30pm to 8.30am.

Our service offer and objectives

- Assess, plan and implement high quality individualised care with on-going monitoring.
- Promote a co-ordinated approach to home care and hospital discharge that facilitates a seamless service leading to improved health outcomes.
- Reduce the incidence of hospital admission and readmission by supporting and educating both clients and carers who suffer from a long term condition.
- Promote evidence based approach to care delivery which ensures the most effective use of resources in order to improve the quality of patient care.
- Chronic disease and medicine management for housebound patients.
- Provision of terminal and palliative care to support the End of Life agenda, enabling patients to die in their preferred place of care.
- Education and teaching to promote self care and accept limitations.
- Participating in the rehabilitation of patients following surgery, disability, accident or illness events.
- Monitoring of patient’s medication regimes eg. anticoagulation.
- Prescribe medication and undertake medicines analysis and review.
- Supporting patients (and their carers where appropriate) to create and implement self management plans.

Referral criteria

- The patient is housebound or has complex health needs.
- Patients must have a physical or psychological health care need.
- Patients should be registered with a Barnsley GP.

In a recent survey:

- 99% of patients rated the service as either excellent or good.
- 91% said they were listened to carefully by their district nurse.
- 84% said they had enough time to discuss any concerns with the district nurse.

Where can you get more information?
Ruth Donoghue - 01226 433268 ruth.donoghue@swyt.nhs.uk
The community matron service provides case management in a primary and community setting for people with complex long term conditions and high intensity users.

The service is provided at a variety of locations across the Barnsley community and is delivered 365 days a year between 8.30am and 5.30pm. The rapid response service (see inpatient and community rehabilitation services section) provides an out of hour’s service from 5.30pm to 8.30am.

**Our service offer and objectives**

- Identify all patients from either primary or secondary care data sources who have or have the potential to be High Intensity User’s (HIU) of health care resources including those from residential and nursing homes.
- Identify those patients currently in hospital beds who could, by pro-active management of their condition be discharged back into primary care or home.
- Have named key workers within the service responsible for those identified as at risk or being HIU’s of resources.
- Provide a comprehensive assessment of health and social care needs of all patients.
- Undertake full medicines management analysis and an ongoing medicine review for each patient.
- Develop and implement an integrated and personalised care plan covering the health and social care needs of the individual.
- Provide an integrated approach with health and social care colleagues to support these patients at home.
- Provide case management in primary and community settings for people with complex long term conditions and high intensity needs.
- Maintain a specific number of HIU’s under the care of a community matron.

**Referral criteria**

- Diagnosed with 3 or more long term conditions
  
  or

- Diagnosed with one long term condition with either high A&E contacts, complex medication regimes and enhanced care package from social care.

**In a recent survey:**

- 100% of patients said they had enough time to discuss any concerns with the community matron.
- 100% rated the service as either excellent or good.
- 91% said the community matron had helped them stay in their own home when previously they would have been admitted to hospital.

**Where can you get more information?**

Ruth Donoghue - 01226 433268

ruth.donoghue@swyt.nhs.uk
The tissue viability service provides specialist advice treatment and therapies to primary, secondary and private nursing home patients with compromised skin, in line with our wound care policy and NICE guidance.

The service is provided at a variety of locations across the Barnsley community including in the patient’s home, in GP practices and health centres. The service is delivered Monday - Friday between 8.30am and 5.30pm (excluding bank holidays).

Our service offer and objectives
- Improve quality of life for clients by improving symptoms or managing deterioration.
- Promote a patient centred approach liaising with other nursing services as appropriate.
- Reduce length of inpatient stay by providing wound care and therapies to enable management of wounds in a community setting.
- Provide education to both clinical services and service users.
- Ensure that patients will receive treatment in the most appropriate setting using evidence based practices to improve patient outcomes.
- Where possible restore or maintain tissue viability to reduce amputations, ulcerations and infections and maintain the integrity of the skin.
- Promote healing by providing wound care products, pressure relieving equipment, and plans of care to optimise skin integrity.
- Provide specialist therapies to promote the healing process.

Referral criteria
- A wound assessment chart must have been commenced by a Nurse.
- At least one product from the wound care formulary should have been tried.
- Barnsley registered patient.
- Must be at least 16 years of age.

In a recent survey:
- 100% of patients rated the service as either excellent or good
- 100% said they would be more than happy to access the service again if required.
- 100% said they were happy with the consultation.

Where can you get more information?
Lynne Hepworth, 01226 433215 lynne.hepworth@swyt.nhs.uk
Cardiac and pulmonary rehabilitation service

Cardiac and pulmonary rehabilitation is the process by which patients, in partnership with a multidisciplinary team of healthcare professionals, are encouraged and supported to achieve and maintain optimal physical and psychological health.

The service is provided at the Dorothy Hyman Sports Centre in Barnsley, Monday - Friday between 8.30am and 5.30pm (excluding bank holidays).

Our service offer and objectives

- Assessing service users (there is need to ensure treatment is optimised before the start of pulmonary rehabilitation).
- Cardio protective drug therapy and implantable devices.
- Long term management strategy.
- Physical activity and exercise.
- Educational sessions.

Referral criteria

- Had a myocardial infarction (STEMI/non STEMI) and coronary revascularisation.
- Unstable or stable angina heart failure and post enhanced external counterpulsation therapy (EECP).
- MRC Dyspnoea Scale of 3 or above and who consider themselves functionally disabled by their disease. Patients having recently undergone a bullectomy or Lung Volume Reduction surgery should also be included.
- ST-Segment Elevated Myocardial Infarction (STEMI)/non STEMI/and post surgical patients.
- Stable angina if they have limiting symptoms.
- ACS who have been assessed as suitable for the programme.
- Chronic heart failure if they have limiting symptoms.
- Enhanced External Counter Pulssation (EECP).
- Respiratory conditions.

In a recent survey:

- 98% of patients said the service lived up to their expectations.
- 98% said they had benefited from their appointment.
- 95% said they felt involved in decisions regarding their treatment and potential next steps.

Where can you get more information?

Jill Young - 01226 719783
jill.young@swyt.nhs.uk
Palliative care services (Macmillan and Marie Curie)

The palliative care service is made up of two teams of frontline clinicians – the Macmillan team and the Marie Curie team. Palliative care services are delivered to people who have an advanced progressive illness. The service base is the Birdwell Medical Centre and the service is delivered throughout the community, 7 days a week between 9am and 5pm.

Our service offer and objectives
• Affirm life and regard dying as a normal process.
• Provide relief from pain and other distressing symptoms.
• Offer a support system to help the family cope during the patient’s illness and in their own bereavement.
• Deliver expert, high quality, responsive care to patients with complex issues.
• Provide information to ensure that patients, families and carers experience the optimal quality of life.
• Offer practical, emotional and psychological support for patients and their carers and family, particularly as the end of life draws near.
• Ensure care packages are created and tailored to meet the individualised needs of patients and their carers/families, enabling them to be supported in their choice to be cared for at home.
• Ensures care packages are tailored to meet the individualised needs of patients and their carers/families, enabling them to be supported in their choice to be cared for at home.
• Give ‘hands-on’ practical assistance such as personal cares, hygiene needs, washing, dressing, making meals and drinks - a key part of this service is the provision of a friendly, reassuring presence.
• Discuss fears and worries with patients/carers in the safe environment of their own home.

Referral criteria
• Uncontrolled, complicated multifaceted symptoms or short term specialised needs.
• Over the age of 18 years.
• Emotional or behavioural difficulties relating to the illness, as well as requests for euthanasia.

In a recent survey:
• 90% of patients said they felt they could cope better after seeing their health professional.
• 90% of patients rated the service as either excellent or good.
• 90% of patients said that after seeing their health professional they understood their medical conditions better.

Where can you get more information?
Andrea Dauris - 01226 433580
andrea.dauris@swyt.nhs.uk
End of Life service

The purpose of the End of Life (EoL) service is to plan, develop and coordinate systems whilst providing clinical leadership to frontline clinicians eg. GP practices, care homes etc. The service base is the Monk Bretton Medical Centre and the service is delivered Monday to Friday, 9am to 5pm.

Our service offer and objectives

- Raise awareness of the need for equitable EoL care and for all service providers and staff to recognise their contribution and engage with delivery of high quality EoL care.
- Ensure that services developed are culturally sensitive and meet the needs of groups that might otherwise be marginalised.
- Increase the number of deaths in a person’s preferred place.
- Ensure local services are developed in line with best evidenced based practice and national and regional directives.
- Opportunity for all patients to have an individualised care plan and key worker.
- Easily accessed support and services for patients and carers.
- Timely discharges for patients to be in their preferred place of care and reducing length of hospital stay.
- Reduction of stress, anxiety and strain for patient and carer, promoting well being and health of carers.
- Increased number of patients dying in their own home, if this is their wish.
- Patients and carers have the opportunity to discuss personal needs and wishes.

Where can you get more information?
Janet Owen - 01226 433558, janet.owen@swyt.nhs.uk

Referral criteria

- Diagnosed with 3 or more long term conditions or
- Diagnosed with one long term condition with either high A&E contacts, complex medication regimes and enhanced care package from social care.
Heart failure service

Heart failure is a complex syndrome that can result from any structural or functional cardiac disorder that impairs the pumping action of the heart.

The team base is the Apollo Court Medical Centre and the service is delivered Monday to Friday from 8.30am to 5.30pm (excluding bank holidays).

Our service offer and objectives

- Specialist assessment, treatment and management of service users with heart failure.
- Collaborative working with other professional staff and service users to ensure the development of patient pathways, which address specific aspects of heart failure care.
- High quality specialist education for health and social care professionals and support workers.
- Education and support to service users and their families/carers in one to one sessions.
- Provides service users with access to, and advice on, the use of assisted technologies such as tele-monitoring.
- People are empowered to make informed choices and manage their condition.
- People can attain better health outcomes and improve their quality of life because they understand the condition its complications and treatment regimes.
- Avoid unnecessary hospital admission by ensuring they have optimum symptom control and re-stabilisation of the condition when they experience a sudden deterioration in symptom control.
- Service users are given opportunities to become involved in service development.
- Improve quality of life by improving symptoms or managing deterioration.

Referral criteria

All patients that have diagnosed heart failure via an Echocardiogram.

Where can you get more information?

Jayne Jukes - 01226 209881  
jayne.jukes@swyt.nhs.uk or mandy.houghton@swyt.nhs.uk
The service offers a flexible pathway to accommodate for times when people need additional support to deal with changing life events. We work in partnership with people who use our service and their families to determine what level of support they require. When people are managing well their contact with the service may be less frequent.

Some individuals will require on-going review of medication alongside shared care arrangements with their GP. Others will receive time limited interventions to support them to achieve specific goals. When people are discharged they are provided with information of how to access support in the future should they need to.

Our service offer and objectives

- Specialist assessment treatment and management of service users.
- High quality education for health and social care professionals, support workers and service users/carers.
- A resource that healthcare, social care professionals and support workers can access.
- Apomorphine management; initiation of treatment regimen, providing instruction to individual and their carer on injection technique and management of Apo-Go continuous infusion pump.
- 12-week exercise programme for recently diagnosed patients or those in later stages of the condition.
- Optimum symptom control and restabilisation of systems during crisis situations including acute psychosis/frequent falls/infections/carer strain or sudden deterioration in symptom control.
- Ensuring patients are supported in obtaining appropriate treatment/therapies according to their personal needs.
- Annual review, or sooner, according to individual need to provide anticipatory care, medication review and signposting to therapies.

Referral criteria

A diagnosis of Parkinson’s, Parkinsonism, Multiple System Atrophy, Progressive Supra Nuclear Palsy, Lewy Body Dementia, Parkinson’s Disease Dementia, Vascular Parkinsonism and Calcification Basal Ganglia.

Where can you get more information?
Sue Slater - 01226 209885
sue.slater@swyt.nhs.uk
Diabetes service

Diabetes Mellitus is associated with significant morbidity and early mortality. The associated complications include cardiovascular disease, stroke, blindness, renal failure and lower limb amputation.

The team base is the Apollo Court Medical Centre and the service is delivered Monday to Friday from 8.30am to 5.30pm (excluding bank holidays)

Our service offer and objectives

- Specialist assessment, treatment and management of people with diabetes mellitus.
- Education and support to service users and their families/carers in one to one or group sessions.
- High quality specialist education for health and social care professionals and support workers.

- Patients are empowered to make informed choices and manage their diabetes by adjusting their own treatment on a day to day basis and during crisis situations.
- Attain better health outcomes and improve their quality of life because they understand the condition its complications and treatment regimes.
- Avoid unnecessary hospital admission by ensuring they have optimum symptom control and re-stabilisation of the condition when they experience a sudden deterioration in symptom control.
- Service users are given opportunities to become involved in service development.
- Improve quality of life for clients by improving symptoms or managing deterioration.

Referral criteria

- Newly diagnosed Type 1 patients.
- Require education having been diagnosed with Type 2.
- Are insulin dependant with specific problems relating to their diabetes control.
- On insulin with difficult to control diabetes requiring change in the type of insulin regime.
- Pregnant women with Type 1, gestational diabetes or impaired glucose tolerance.

Where can you get more information?
Sue Jones - 01226 209884
sue.jones@swyt.nhs.uk
Adult epilepsy service

Epilepsy is the most common, serious neurological condition, characterised by a tendency to have seizures and is associated with significant morbidity and mortality. It may be associated with a range of other conditions. The prognosis is favourable and up to 60-70% of patients can become seizure free with optimal management.

The team base is the Hoyland Medical Centre and the service is delivered Monday to Friday from 8.30am to 5.30pm (excluding bank holidays).

Our service offer and objectives

- All patients with epilepsy have a safe and correct diagnosis.
- All patients with a diagnosis of epilepsy have access to either a consultant led or specialist epilepsy nurse clinic, for appropriate review of diagnosis and treatments, ongoing support and management.
- The service acts as a care navigator for patients with epilepsy.
- Diagnosed epilepsy patients become seizure free/minimise seizures.
- Support minimisation of the adverse effects of epilepsy on a patient's life and promote safety.
- Provide information on healthy and safe lifestyles in respect of epilepsy.
- Improve transition of service users between child and adult epilepsy services.
- Provide consistent pre-conceptual and pregnancy care.
- Ensure inclusion of patients and carers in the management of their condition.

Where can you get more information?
Andy Pilley - 01226 355892
andy.pilley@swyt.nhs.uk

Referral criteria

- Over the age of 16 years.
- Suspected to be suffering from epilepsy.
- Diagnosed with epilepsy.
Continence and urology service

Incontinence is defined as ‘the voluntary or inappropriate passing of urine and/or faeces that has an impact on social functioning or hygiene. It also includes nocturnal enuresis (bedwetting)’ (Good Practice in Incontinence Service, DH 2000).

The team base is the Lundwood Medical Centre and the service is delivered Monday to Friday from 8.30am to 5.30pm (excluding bank holidays)

Our service offer and objectives

• Specialist assessment, treatment and management of service users with faecal and/or urinary incontinence.
• Collaborative working with other professional staff and service users to ensure the development of patient pathways, which address specific aspects of continence care.
• A resource for healthcare professionals in the pursuit of therapeutic continence care delivery.
• High quality specialist education for health and social care professionals, support workers and patients/carers.
• Attain better health outcomes and improve service users quality of life because they understand the condition, its complications and treatment regimes.
• Avoid unnecessary hospital admission by ensuring they have optimum symptom control and re-stabilisation of the condition when they experience a sudden deterioration in symptom control.
• All patients with urinary continence problems will have received an initial assessment performed by a qualified nurse in accordance with DH guidelines (2000).
• Improve quality of life for patients by improving symptoms or managing deterioration.

Referral criteria

• Bladder or bowel dysfunction irrespective of cause.

Where can you get more information?

Gill Smith - 01226 433517
gill.smith@swyt.nhs.uk
Chronic Obstructive Pulmonary Disease (COPD) service

The COPD service relates to service users who have a Chronic Obstructive Disease such as Asthma, Bronchietasis, Lung Cancer etc.

The team base is the Oaks Park Medical Centre and the service is delivered Monday to Friday from 8.30am to 5.30pm (excluding bank holidays)

Our service offer and objectives

- Specialist assessment, treatment and management to service users.
- High quality specialist education for health and social care professionals, support workers and patients/carers.
- The service provides service users with access to, and advice on, the use of assisted technologies such as tele-monitoring.
- Patients are empowered to make informed choices and manage their COPD.
- Attain better health outcomes and improve their quality of life because they understand the condition its complications and treatment regimes.
- Avoid unnecessary hospital admission by ensuring they have optimum symptom control and re-stabilisation of the condition when they experience a sudden deterioration in symptom control.
- Improve quality of life for clients by improving symptoms or managing deterioration.

Referral criteria

- Patient needs to be on a COPD register and a Barnsley registered patient.

Where can you get more information?

01226 729880
Telehealth Care service

Telehealth Care is an enabler to improving the quality of life of people in Barnsley, complementing more traditional service delivery and offering choice and control. The service supports people to be active participants in their care enabling them to achieve their optimum level of health and wellbeing and maintain their independence for as long as they are able.

The service is currently provided at a variety of locations across the Barnsley community and it is delivered Monday to Friday between 9.00am and 5.00pm.

**Our service offer and objectives**

An integrated range of services including:

**Care navigation** - Patients that access the telehealthcare service receive advice, information and support in order to identify unmet needs. The nurse care navigator signposts the patient to the most appropriate service/s to assist the on-going self-management of the patient’s long term condition.

**Health coaching** - Nurse care navigators deliver motivational interviewing via telephone and behaviour change techniques to patients to facilitate greater self care. Long term condition patients with complex needs access the service via participating GP surgeries using a risk stratification tool developed by the service.

**Telehealth monitoring** - This is the method of delivering health-related services and information remotely via telecommunications technology. Patients that receive a telehealth intervention are selected using a risk stratification tool, or following a referral from their GP or specialist nursing service already involved in their care. A telehealth unit is installed in the patient’s home and the patient completes a session each day, including the self reporting of vital sign readings. This data, and information about physical symptoms, health knowledge and health behaviours, is transmitted daily to the Telehealth Care service and is monitored by nurse care navigators and monitored to identify clinical trends.

**Post crisis support** - Patients access the service upon discharge from secondary care. Nurse care navigators contact the patient on discharge to discuss the reason for admission and offer telephone support to reduce the chance of the patient being readmitted.

**Referral criteria**

- The patient must be over 18-years old.
- Must be registered with a Barnsley GP.
- Require supported discharge package.
- Need help with motivation and confidence.
- Need help/support in accessing services (advocacy).
- Need regular telephonic support to comply with advice/treatment.
- Need more information regarding their condition to become more self-managing.
- Have modifiable risk factors.
- Require monitoring i.e. vital signs, medication.

Where can you get more information?

Paul Hughes - 01226 433281
paul.hughes@swyt.nhs.uk
Children’s services

We provide a range of community health services for children. Wherever possible, we provide these services in partnership, working collaboratively with parents and families as well as with other local health and social care providers.

Objectives are achieved by adopting collaborative working arrangements with parents, families and local health and social care providers, such as:

- General Practitioners
- Midwives
- Family Nurse Programme (FNP)
- Social workers
- Public health specialist nurses
- School nursing services
- Community paediatricians
- Children’s centres
- Child and Adolescent Mental Health Services (CAMHS)
- Housing associations

These services are constantly involved in a wide variety of on-going projects ranging from virtual wards with GP practices to telehealth schemes. Through these projects we are working collaboratively with local commissioners and well-renowned multi-national organisations from the private sector, striving to sustain and improve the existing quality healthcare services provided within this business unit.

Our services have strong, well established working links with a variety of local organisations including Barnsley Hospital NHS Foundation Trust, Sheffield Teaching Hospitals and Barnsley Council children’s services.

Our business unit is operationally structured to ensure all community healthcare services are led and managed by a business manager and where appropriate a professional lead nurse, who in-turn reports to the deputy director of operations.
Health visiting service

The health visiting service provides a universal service to children and their families, with a specific focus towards the safeguarding and development of children aged 0-5. This includes a range of screening development checks and Public Health Related Outcome Measures (PROMs) to support healthy lifestyles choices, whilst addressing any health concerns and improving health outcomes.

The service is provided at a variety of locations across the Barnsley community and is delivered Monday to Friday between 9am and 5pm (excluding bank holidays) but remains flexible to meet patient needs.

Our service offer and objectives

- Assess the health needs of children and families, involving the client/carer in the process.
- Delivers The Healthy Child programme for children aged between 0-5 years.
- Monitor the health and development of children between 0-5 years, involving the family in promoting optimum health and development of all children.
- Intervene to protect vulnerable children and adults eg. child protection and/or domestic violence.
- Working collaboratively with other agencies, statutory and voluntary, to meet local and national targets in order to improve and reduce health inequalities.
- Promote good health in early years to reduce health inequalities, implementing the public health/health protection agenda across Barnsley.
- The service works in partnership with other agencies across Barnsley resulting in positive achievements eg. BFI Stage 2.
- Working towards the national health visiting implementation plan.
- Support early intervention to identify and address the needs of children and families.
- The service includes a paediatric liaison health visitor, whose role is to review all paediatric A&E attendances, ensuring all relevant services are informed, whilst identifying clinical risks in the management of vulnerable children and families.
- Provides safe transition for children aged 5 years to the school nursing service.
- The service has close working partnership with the Family Nurse Partnership (FNP) service.

Referral criteria

All families with children aged 0-5 years that are either registered with a Barnsley GP or reside in Barnsley, are offered the healthy child programme which is delivered by the health visiting service.

In a recent survey:

- Out of 167 parents/carers who were audited when attending a child health clinic 97% agreed that they were able to ask questions and 74% stated that they felt informed when they left the clinic.

Where can you get more information?
Marie Shelley - 01226 433268
marie.shelley@swyt.nhs.uk
Safeguarding children service

The safeguarding children service is not a frontline service but provides a high quality and accessible training programme along with supervision and support to the health visiting service and other frontline healthcare services.

The service is provided at a variety of locations across the Barnsley community and is delivered Monday to Friday between 9am and 5pm (excluding bank holidays).

Our service offer and objectives

- Provide a high quality, accessible and approachable service thus empowering staff to safeguard children.
- Ensure that the Trust and partner organisations have the services of experts in safeguarding children to ensure compliance with government legislation and national healthcare guidance.
- Ensure staff are able to recognise risk of abuse and act efficiently to minimise the risk to children experiencing harm and promote their wellbeing.
- Ensure that children living within the boundaries of Barnsley are supported and their health needs met safely in an efficient and timely manner.
- Ensure the wider health community is aware of local procedures and protocols.
- Provide supervision and support for health staff who are actively involved in child safeguarding.
- Provide training sessions for all new members of staff in the Barnsley Business Delivery Unit.

Where can you get more information?

Julie Fleetwood, 01226 434005
julie.fleetwood@swyt.nhs.uk
Paediatric epilepsy service

The paediatric epilepsy specialist nursing service is designed to support paediatric patients diagnosed with epilepsy. The team base is the Hoyland Medical Centre and the service is delivered Monday to Friday between 9am and 5pm (excluding bank holidays).

Our service offer and objectives

- Reduce sudden and unexpected paediatric epilepsy related deaths.
- Ensure inclusion of patients and carers in the management of their condition and in care planning, by providing relevant information and support and promotion of self management/care.
- Provide information on healthy and safe lifestyles in respect of epilepsy.
- Provide a robust care pathway for children with epilepsy.
- Ensure that children with epilepsy in early years settings eg. nurseries, schools have individualised care plans.
- Provide education and awareness training sessions where appropriate.
- Delivers a paediatric epilepsy specialist nurse led clinic.
- Consult with paediatric liaison and the paediatric wards in secondary care relating to children who have been admitted with epilepsy symptoms.
- Ensures all children in Barnsley with epilepsy can have access to a paediatric epilepsy specialist nurse service.
- Advise and support GP practices who have children with epilepsy on their registers.
- Provide a telephone advice line.
- Support transitional arrangements from paediatric to adult epilepsy services.

Referral criteria

- Registered Barnsley patients.
- Under 16 years of age.
- Diagnosed with epilepsy.

Where can you get more information?
Phil McNulty - 01226 436591
phil.mcnulty@swyt.nhs.uk
Paediatric audiology service

The paediatric audiology specialist service is designed to support paediatric patients with hearing problems.

The team base is the New Street Health Centre and the service is delivered Monday to Friday between 9am and 5pm (excluding bank holidays).

Our service offer and objectives

- Full hearing assessment available for all children from birth – 18 years.
- All children are seen and screened no longer than 2 weeks after referral.
- The service consists of specialist paediatric audiologists.
- Provide a telephone advice line.
- Transitional arrangements from paediatric to adult audiology services.
- The service is supported by consultants from secondary care.
- School screening service for all reception aged children.
- Four screening clinics held per week.
- Follow-up service available.
- Issues paediatric hearings aids.

Referral criteria

- Under 16 years of age.
- Suspected hearing problems.

In a recent survey:

- 100% of patients said they were given the opportunity to ask questions.
- 95% said that staff instructed them about what would happen during the test.
- 95% said they would be happy to visit the clinic again.

Where can you get more information?
Stuart Hinchliffe - 01226 433165
stuart.hinchliffe@swyt.nhs.uk
The aims of the primary care and preventative services business unit are to:

- Promote wellbeing and independence to service users across the Barnsley borough.
- Support people to live full lives in their local community.
- Provide support to help prevent long term illness.
- Deliver a holistic approach to health and wellbeing.
- Deliver early interventions to prevent illnesses associated with lifestyle choices.
- Provide evidence-based, cost effective interventions.
- Offer professional specialist skills to help deliver a joint approach to deliver a ‘needs’ led service.
- Contribute to the wider public health agenda.
- Prevent deterioration.
- Deliver services in primary care to avoid hospital admissions in acute care.
- Prevent illness, injury and disability wherever possible.
- Provide support to maintain health and wellbeing.
- Promote self care so patients can take control of their health and wellbeing.
- Provide a range of behaviour change techniques and brief interventions to support health behaviour change.

All services have strong, well established working links with a variety of local organisations including other NHS providers in Barnsley, Sheffield Teaching Hospitals as well as Barnsley Council, Barnsley College and voluntary organisations.

The primary care and preventative business unit is operationally structured to ensure all community healthcare services within the business unit are led and managed by a business manager and where appropriate a professional clinical lead, who in turn reports to the deputy director of operations.
The contraception and sexual health service provides a range of specialist treatment, information and advice through evidence-based practice aimed at improving outcomes for patients accessing the service.

The team base is at Queens Road and the service also works in Barnsley College, health centres, youth centres and schools. The service is delivered Monday - Saturday (excluding bank holidays) with some early morning and late night provision and a range of appointments and drop in clinics available.

**Our service offer and objectives**

- Provides the full range of contraceptive methods and Sexually Transmitted Infection (STI) screening (including treatment and partner notification).
- Provides counselling (including psychosexual counselling), pregnancy testing, advice and support, referral for termination of pregnancy, cervical screening, increased condom provision through the C-Card scheme and health and lifestyle assessments.
- Contributes to training and continuing professional development of other primary care colleagues in relation to sexual health.
- Works alongside other partners (Barnsley College, school nursing, youth services, addiction) to improve the sexual health of clients through increased provision in Barnsley.
- Delivers a Health and Wellbeing Centre within Barnsley College providing a holistic range of health and wellbeing services to students and staff.
- Delivering the Chlamydia screening programme ensuring screening is embedded into the working practices of all core services involved in the delivery of contraception and sexual health services.
- Increases knowledge of contraception and sexual health services through a variety of initiatives and participates in a range of health promotion events.
- Improves access for young people in line with ‘You’re welcome’ standards.
- Aims to reduce the number of under-18 year’s conceptions in line with national targets
- Provides services that are people-centred, comprehensive and accessible.

**Referral criteria**

- Accepts self referral or referrals from a range of sources including GPs, midwives, health visitors and school nurses.
- Patients should be registered with a Barnsley GP.
- Any young person under the age of 16 will be assessed under the Fraser guidelines for their ability to consent.

**In a recent survey:**

- 94% of patients said that they were very satisfied with the advice given.
- 88% said that booking their appointment had been easy.

“There are drop-ins all the time so it’s alright really. I think knowing that no-one else is going to find out and that it’s confidential is really important. That they’re not going to go running around saying what you’ve been here for.”

**Where can you get more information?**

Sue Dymock - 01226 249949
sue.dymock@swyt.nhs.uk
Barnsley and Sheffield stop smoking service

Smoking is one of the most significant contributing factors to low life expectancy, health inequalities and ill health, particularly cancer and coronary heart disease. Smoking is one of the biggest causes of preventable ill health and premature death in Barnsley and is the single greatest cause of inequalities in health.

The team base is Eldon Street and the service is open Monday to Friday (excluding bank holidays) 9.30am to 4.30pm with late nights (7pm opening) on Tuesday and Wednesday, and Saturday mornings from 9.30am – 1pm.

We also provide this service in Sheffield from the team base at Charles Street.

Our service offer and objectives

- Provides high quality clinical smoking cessation services to the local population through a variety of service providers.
- Supports other local providers of smoking cessation e.g. GPs/ pharmacies, offering high quality evidence based support.
- Supports the work of NHS Barnsley’s Tobacco Control Programme and contributes to reducing smoking prevalence across Barnsley.
- Provides an evidence based programme of stop smoking interventions in a range of settings
- Delivers a range of evidence based training programmes to health professionals and the wider community
- Offers behavioural support from an adviser who has had training and receives supervision that complies with the ‘Standard for Training in Smoking Cessation Treatments’ and its updates.
- Provides information and provision of recommended stop smoking medications, Varenicline (Champix), Bupropion (Zyban) and nicotine replacement therapy (NRT) via an NRT voucher scheme.
- Offers an incentive scheme for clients with a successful 4-week quit vouchers for a 12-week membership at Barnsley Premier Leisure or Slimming World.
- Provides a series of follow up sessions throughout the course of a clients quit attempt for up to 12 weeks or until the client has finished their stop smoking medication course.
• Offers CO2 monitoring and other health/lifestyle checks at each visit (e.g. BMI, weight monitoring etc).
• Increases the likelihood of a successful quit attempt and reduces the likelihood of relapse
• Improves health and financial benefits for clients who are successful in their quit attempt
• Supports clients in making an informed choice regarding available, evidence based treatment options.

Where can you get more information?

**Barnsley team:**
Zoe Styring - 01226 737077
zoe.styring@swyt.nhs.uk

**Sheffield team:**
Claire Holden - 0800 068 4490
claire.holden@nhs.net

**Referral criteria**

There are no upper or lower age restrictions applied within the service.

The service recognises that it can take several attempts to successfully quit smoking; clients are re-accepted on relapse if required.

In a recent survey:
• 99% of patients said that they had benefited from the service
• 90% stated that the information and advice given by staff during their appointment had been helpful
• 91% of service users would recommend the service to other users who wish to stop smoking

“Passing the stop smoking service one day I thought ‘what have I got to lose, I’ll see what they’ve got to offer’. This has got to be one of the best off the cuff decisions I’ve made in a long while. The initial consultation was friendly, informative, and as the initial weekly meetings continued, very supportive.”
Community equipment service

The community equipment service provides equipment for all service users, both adults and children, with the overall aim of providing equipment when and where needed to support community care and promote the independence and dignity of service users.

The service is based at Grange Lane Industrial Estate and is open 8.30am - 4.30pm Monday to Friday, with some out of hours provision for repair/maintenance of specific equipment.

Our service offer and objectives

- Works in partnership with individuals, families and multi-agency networks to prioritise identified personal health needs and plan evidence based approaches.
- Provides community equipment such as commodes, wheelchairs, beds, specialist mattresses, mobility aids etc throughout the Barnsley borough.
- Fits/assembles equipment within a service user’s home (however other items require a care professional to complete the installation and demonstrate correct/safe use).
- Undertakes in-house servicing and maintenance of equipment.
- Provides PAT testing of equipment.
- Is responsive in meeting the national Key Performance Indicator (KPI) target for equipment delivery (currently 90% of prescribed equipment to be delivered within 7 working days).
- Supports service users to be independent, reducing the need for intensive care packages and rehabilitation.
- Provides the equipment required to support earlier admissions from hospital and aid recovery within own environment.
- Provides equipment that will enable service users to be supported in their own home and enable them to live there safely.
- Ensure timely delivery of clean equipment, with full instructions, advice and support to use the equipment safely.

Referral criteria

The service is provided to all service users that are a resident in the Barnsley area or registered with a Barnsley GP.

Equipment is issued to service users following an assessment by a qualified health or social care professional or for specific items self-referral is accepted.

Criteria for referral will include facilitating timely discharge from hospital, preventing unnecessary admission to hospital, supporting the end of life care pathway to enable people to die at home and assisting people to remain safe and independent in the community.

In a recent survey:

- 93% of patients were satisfied with the service provided.
- 84% stated that the store provided all the items they were expecting.

Where can you get more information?

Wayne Bendelow - 01226 320990
wayne.bendelow@swyt.nhs.uk
The health integration team aims to facilitate the integration of increasing numbers of overseas arrivals into mainstream health services and address evident inequalities in health and wellbeing. The team has responsibility for newly arrived asylum seekers residing in Barnsley, asylum seekers under the age of 18 without family (health triage and health education), refugees, migrant workers and immigrants within the local community.

The team base is Sheffield Road and the service is delivered Monday - Friday between 9am - 5pm. Ad hoc appointments are undertaken to see clients in hospital or as a domiciliary visit by referral from consultant etc.

Our service offer and objectives

- Provides health education sessions for unaccompanied asylum seeker minors (16-18yrs) eg. sexual health, healthy eating, topical illness.
- Offers a drop in facility for unaccompanied minors, triaging and treatment of minor ailments.
- Completes initial health assessments on newly arrived asylum seekers followed by prompt screening as required (e.g. TB, Hepatitis etc).
- Offers early detection, diagnosis and treatment of health problems.
- Treats minor ailments and encourages appropriate use of health services.
- Liaises with UK Borders, the Department of Health, housing teams etc in relation to asylum seekers.
- Works in partnership with a local GP practice who provide overall medical cover to this client group.
- Provides support and an education resource for GPs, other health professionals (consultants, nurses, social workers, and education staff) and the voluntary sector in the form of presentations/study days on working with asylum seekers and interpreters.
- Improves quality of life for clients by improving symptoms, improving mental wellbeing/self esteem and improving relationships between these clients and health professionals.
- Reduces the number of clients requiring referral to secondary care.
- Reduces the risk of undiagnosed health issues in high risk groups (e.g. communicable diseases etc)

Referral criteria

This service is available for any resident within the borough of Barnsley and will provide advice, support and advocacy both in the acute and primary sector.

There are high referral rates from the indigenous population, ethnic minorities, migrant workers and travellers (both adults and children).

In a recent survey:

- 96% of patients were satisfied with the information they were given.
- 100% said they had enough time to discuss their concerns with the health professional.
- 93% felt that they had benefited from their appointment.

Where can you get more information?

Helen Taber - 01226 731686
helen.taber@swyt.nhs.uk
Tuberculosis (TB) service

Tuberculosis (TB) is a micro bacterial disease which can affect a number of different organs in the body. This is a notifiable disease that is subject to government regulation (Public Health (Tuberculosis) Act 1921) that specifies that the number of cases in the United Kingdom are recorded and closely monitored by the Health Protection Agency (HPA) in order to ensure control and identify outbreaks. This monitoring also assesses risk to the population as a whole. Demographic trends by the HPA show that the incidence of TB is increasing regionally and nationally.

The team base is Sheffield Road and the service is delivered Monday - Friday between 9am - 5pm. Ad hoc appointments are undertaken to see clients in hospital or as a domiciliary visit by referral from consultant etc.

Our service offer and objectives

- The Tuberculosis service is currently integrated within the health integration team and provides screening, advice as well as a contact tracing service for clients who are identified as at risk or have TB. The service is currently piloting T-spot testing.
- Provides access to a high quality, easily accessible TB control and prevention service.
- Provides an integrated TB clinic twice monthly within Barnsley Hospital in conjunction with the consultant respiratory specialist.
- Liaises with the respiratory and paediatric consultants responsible for TB patients within Barnsley.
- Supports patients on treatment for TB, through visitation, dietary advice, medication advice and specific public health advice on treatment management.
- Offers emotional support for family and carers of patients on TB treatment.
- Provides a contact tracing service i.e. the tracing of recent contacts of clients identified with TB in order to ensure that screening is undertaken by referring to the respiratory consultant who manages the TB clinics.
- Gives advice to other professional agencies i.e. GPs, social workers, housing providers, UK Borders Agency, pharmacists and voluntary organisations.
- Liaises with other TB nurses nationally in order to ensure continuity of treatment and to ensure that close contacts receive screening.
- Oversees mantoux testing and symptom screening within a local induction centre for asylum seekers.
- Aims to increase awareness of TB and how to reduce the risk of outbreaks and manage TB.

Referral criteria

The referral criteria for the TB service is for any client who:

- Has commenced treatment for suspected TB
- Has had prolonged contact with an individual who has been diagnosed with active TB
- Newly arrived people from countries with a TB rate of more than 40/1000 per population.

In a recent survey:

- 96% of people said they would recommend the service to others.
- 92% said answers to their questions were explained in a way that they could understand.

Where can you get more information?

Helen Taber - 01226 731686
helen.taber@swyt.nhs.uk
Integrated weight management service (Barnsley Change4life)

Obesity is a major risk factor for many chronic diseases, including type 2 diabetes, hypertension and cardiovascular disease. Barnsley Change4life provides the residents of Barnsley, who are overweight or obese, with person-centred advice, help and support to achieve and maintain a healthy weight. The service is based at Eldon Street and is delivered Monday - Friday 9am – 4.30pm with some evening provision for group sessions.

Our service offer and objectives

- Provides community based and evidence-based weight management services for adults and children through a range of one-to-one and group sessions.
- Aims to reduce the number of people who are overweight and obese and increase the number of people who maintain or increase their weight loss.
- Provides a robust triage and assessment service covering a range of health and wellbeing related behaviours and issues.
- Provides specialist evidence-based dietary, physical activity, psychological and medical assessment and support, where required, for adults accessing the service.
- Assesses and identifies the need for pharmacological interventions such as Orlistat.
- Provides a planned programme of support to pregnant women accessing the service.
- Provides an evidence based programme for children and young people via the MEND (Mind, Exercise, Nutrition Do it) programme.
- Provides a range of support options for patients accessing the service including telephone support, motivational text messages and internet/email support.
- Refers to specialist physical activity and nutrition services where required e.g. exercise on referral, community dietetics team etc.
- Offers training and support to health providers helping them to raise the issue of overweight/obesity with their client group.
- Contributes to the wider health promotion agenda by aiming to; increase life expectancy, reduce CVD and cancer mortality rates, and reduce obesity in school aged children.

Referral criteria

The service is for all those who are registered with a Barnsley GP and who meet the following criteria:

- Children under the age of 18 (with parent/carer engagement and support) and their families where one or more children ≥ 91st centile.
- Adults aged 18 years or over with a BMI ≥ 30 with co-morbidities
- Adults aged 18 years or over with a BMI ≥ 40
- Pregnant women with a booking appointment BMI of 30+

The service will accept self referrals, GP, healthcare professionals and other health/lifestyle providers (eg. health trainers) referrals.

Where can you get more information?
Zoe Styring - 01226 737060 zoe.styring@swyt.nhs.uk
Equipment, adaptations and sensory impairment service

The equipment, adaptations and sensory impairment service work in partnership with other agencies to offer a quality service to assist in enabling the people of Barnsley with a physical and/or sensory disability to live as independently as possible in their own homes.

The service is based at Gateway Plaza and is delivered Monday – Thursday 9am - 5pm (excluding bank holidays) and Friday 9am - 4.30pm.

Our service offer and objectives
- Provides assessment and recommendation of specialist equipment to increase or maintain independence with daily living tasks.
- Demonstrates and provides training on the use of specialist equipment to service users and their carers.
- Undertakes moving and handling assessments for people with complex mobility needs.
- Provides recommendations for and advice on rehousing, advice on availability of practical help within the home and offers emotional support and counselling.
- Provides rehabilitation programmes to improve occupational performance and offers mobility training for people with visual impairment.
- Offers recommendation of further treatment or rehabilitation to increase or maintain independence with daily living tasks.
- Provides assessment and recommendation for adaptations to the home (major or minor) and advice on funding these adaptations.
- Provides specialist advice to social services, housing services, users and carers, health colleagues, voluntary and independent sectors on disability, special housing needs and the relevant legal and funding issues.
- Assist people with a physical and/or sensory disability to live as independently as possible by giving advice on available options, rehabilitation and support.
- Provides the most appropriate solution to people's needs by taking into account individual circumstances, available resources and clearly defined eligibility criteria.

Referral criteria
The person with the disability would normally be a permanent resident of Barnsley and have long term needs (over six months and there is no prospect of significant improvement).

The person must be substantially and permanently disabled as stated in Section 29(1) of the National Assistance Act 1948 and further defined in the Chronically Sick and Disabled Persons Act 1970, Disability Discrimination Act 1995, and for adaptations as defined in the Housing Grants, Construction and Regeneration Act 1996.

When assessment by this service is not appropriate:
- If the person with the disability is in Barnsley on a temporary basis.
- The person does not have a long term permanent disability or requires a surgical appliance.
- Mobility rehabilitation is needed - this requires physiotherapy.
- Assessment for permanent adaptations when the person with the disability is receiving treatment or rehabilitation and their condition is likely to improve.

In a recent survey:
- 79% of people said that the equipment and/or alteration provided by the service had improved their quality of life.
- 93% said they were satisfied with the service received.

Where can you get more information?
Michelle Sargesson
01226 775800
michelle.sargesson@swyt.nhs.uk
The purpose of Enable (equipment information and demonstration centre) is to promote independent living through the timely provision of information and advice about a broad range of equipment and assistive technology. This may include supporting people to undertake their own assessment and arrange their own equipment provision. The centre is also used to provide training for staff and raise awareness of the potential for assistive technology to facilitate independent living and meet assessed and eligible needs.

The centre is based at Wellington House and is open 9am - 4pm, Monday to Friday.

**Our service offer and objectives**

- Accessible venue where disabled people or elderly frail people, their family, friends and carers will be able to view, test or try a range of equipment for daily living.
- Support to assist people to undertake self assessment of their equipment needs. This includes, where appropriate introducing people to the use of IT to support self assessment.
- Appropriate advice and information to people who wish to purchase their own equipment. Provides a training resource for a range of staff that assess for equipment provision including equipment for people with sensory loss and equipment provided under the broad heading of telecare. Telecare devices are incorporated into the various areas and connection to Central Call system is operational for demonstration purposes.
- A venue for people with a visual impairment to receive information, advice and awareness raising. The program will include information about eye conditions, welfare benefits, daily living skills, mobility and I.T. skills.
- A venue for the demonstration of a range of telecare/assistive technology products including products for people with sensory loss.

**Referral criteria**

There are no formal eligibility criteria for access to Enable – anyone can access the service for assistance.

**Where can you get more information?**

Elaine Meehan, 01226 787855
enablebarnsley@barnsley.gov.uk
The musculoskeletal service aims to provide a high quality service for adults (over the age of 16 or 14-16 year olds who are deemed competent and choose to be seen in an adult service) who have spinal, peripheral joint, soft tissue or neuromuscular problems of an acute or long term presentation.

The service is divided into three main areas, the Clinical Assessment Service (CAS), the Musculoskeletal Assessment and Treatment Service (MSK) and the Physiotherapy Musculoskeletal Service.

The service is based at Mount Vernon Hospital and the Keresforth Centre. Clinics are held at a number of locations throughout Barnsley. The service is delivered Monday - Friday between 8.30am and 5.30pm (excluding bank holidays) with some evening provision for physiotherapy.

Our service offer and objectives
• CAS screens and triages musculoskeletal referrals to determine the most appropriate outcome for patients. Patients may be booked into a range of services in primary or secondary care following the triage processes.
• CAS offers patients requiring referral to secondary care (where appropriate) choice of provider along with information required to make an informed choice.
• The MSK service offers a range of treatment options from a team of physiotherapy extended scope practitioners and GP’s with a Special Interest (GPSI). Treatment options include; joint or spinal injection, referral for diagnostics (MRI, X-ray, Bloods etc), prescribing of medication, specialist physiotherapy techniques for complex conditions and advice regarding self management.
• The MSK physiotherapy service assesses and treats patients with a wide range of acute and
A 42 year old gentleman self refers into the service with back pain. He is telephoned by the physiotherapist who discusses his symptoms and advises him regarding exercise. The gentleman continues to be telephoned regularly by the physiotherapist and given reassurance and advice to progress exercises and mobility gradually. Once his pain is much improved, he is able to attend clinic and is referred into a group exercise class to prevent his back pain recurring. He completes a 6 week course of exercise and reports back that his back has never felt so good.

Referral criteria

The CAS is commissioned to screen non-urgent musculoskeletal problems that are referred for investigation and management.

The MSK physiotherapy service has criteria for both urgent/acute and routine/chronic referrals. Referrals are screened against the criteria by a senior physiotherapist before being accepted into the service.

Detailed information regarding referral criteria can be provided on request.

In a recent survey:

- 97% of patients said they were involved in decision making about their treatment.
- 98% felt that they had benefited from their appointment.
- 100% rated the service as very good/good.

Where can you get more information?

Helen Walker - 01226 435702, helen.walker3@swyt.nhs.uk
The domiciliary service predominantly provides assessment and treatment for people who are unable to attend an outpatient facility or where a home environment is more beneficial to the patients treatment programme.

The service is based at the New Street Health Centre and is delivered Monday - Friday between 9am and 5pm (excluding bank holidays).

**Our service offer and objectives**

- The service aims to improve/maintain the person’s ability to self manage their disability, increase their independence and safety, maximise their function and enable them to continue to live in the place of their choice.
- Provides respiratory clinics for advice and self management of mild to moderate diagnosed respiratory conditions and a ‘drop in’ clinic for advice and provision of specific walking aids and crutches.
- Provides treatment in the most appropriate setting for the patient. This includes their own home, residential and nursing homes. The respiratory clinics are held at Thurnscoe and Worsborough Health Centres. The mobility clinic is held at New Street Clinic and Enable Barnsley.

**Where can you get more information?**

***Di Dillon, 01226 433179***

di.dillon@swyt.nhs.uk

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**Referral criteria**

Available to patients registered with a Barnsley GP and people who live within the Barnsley borough who are registered with an out of area GP.

The services are only accessible for patients over the age of 16 (or 19 for patients with special needs).

The respiratory clinic will not see patients that:

- Are oxygen dependent
- Are normally housebound or have co-existing morbidities which would make attendance at such a clinic extremely difficult
- Require manual treatment techniques or require pulmonary rehabilitation.
- Have had previous physiotherapy for their respiratory condition in the past twelve months

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George underwent a right total hip replacement. On discharge the community domiciliary physiotherapy service carried out an assessment of his function, pain and joint movement within his 1st week at home. They advised on exercises he could undertake and assessed his current walking aids. As he progressed, George moved onto a walking stick and was referred to podiatry to be fitted with an orthotic to help his mobility.
Community podiatry service

Barnsley community podiatry services provide a service for the assessment, diagnosis and management of problems of the foot and lower limb based upon clinical need, as well as providing health promotion and education to patients and other health professionals/carers, on good foot health.

The service is based at the New Street Health Centre and clinics are held at a variety of locations. The service is delivered Monday - Friday between 8.30am and 5.30pm (excluding bank holidays).

Our service offer and objectives
Provides a wide range of integrated care pathways which enable provision of the best individually tailored service for the patients in our care.

- **General care and advice** - People with general callus and corn problems can be seen and assessed to determine if the problems are treatable with pressure relieving insoles/orthoses or debridement.
- **Foot assessment** - Providing specialist foot care advice and preventative assessment for the high risk foot.
- **Nail surgery** – Including treatment and surgical removal for in-growing toenails, thickened toenails and involuted or abruptly curved nails.
- **Biomechanics assessment** – For patients with poor mechanics of the foot and lower limb. Offering podiatric assessment of their foot and lower limb structure and gait analysis. Treatment is provided utilizing corrective foot insoles/orthoses and/or exercise advice to help alleviate the problem.
- **Wound care** - Providing care for any foot wounds whether it is due to an underlying medical condition eg. diabetes, rheumatoid arthritis, trauma or infection. A specialist podiatric wound team provide detailed assessment and care planning of patients with foot wounds and as well as wound healing dressings, provide pressure relieving insoles/orthotics.
- **Specialised diabetes care** - Podiatry is provided as part of the multidisciplinary team based at the Diabetes Centre at Barnsley Hospital. There are also specialist clinics based at Worsbrough LIFT twice a week and a domiciliary service provided by the Diabetes Lead Podiatrist when required to meet individual need.
- Reduces amputation, ulcerations and infections through restoration/maintenance of tissue viability.
- Improves joint problems, mobility/independence.
- Reduces pain and increases ability to undertake activities and improves quality of life by improving symptoms or slowing deterioration.

Referral criteria

- Available to patients registered with a Barnsley GP and people who live within the Barnsley borough who are registered with an out of area GP.
- The service is available to any age group (including children) who have a podiatric need or gait abnormality.
- Exclusions to the service are for podiatric foot surgery.
Helen was referred to the service for knee pain which was restricting her sports activity. She had a biomechanic assessment of her gait and joint mobility in her foot and lower leg and was diagnosed with a knee problem. The podiatry team prescribed, manufactured and fitted orthotic insoles to help her posture/pain and referred her to physiotherapy for exercises to strengthen her muscles. With exercise and orthotic intervention the problem resolved.

In a recent survey:
• 98% rated their overall experience of the service as very good/good
• 96% said the clinician was knowledgeable regarding their condition.
• 98% felt they had been treated with dignity and respect.

Where can you get more information?
Bob Senior - 01226 433173
bob.senior@swyt.nhs.uk
Adult domiciliary occupational therapy service

The adult domiciliary occupational therapy team provide a service to adults (16+) in a community setting. The focus of this service is rehabilitation programmes for adults primarily with long term disabilities who would benefit from goal-centred community intervention. The team deals with both cognitive and physical issues.

The service is based at the New Street Health Centre and is delivered Monday - Friday between 9am and 5pm (excluding bank holidays).

Our service offer and objectives
- Provides physical and cognitive rehabilitation programmes aiming to maintain function and independence.
- Provides fatigue management advice and support.
- Offers upper limb neurological splinting
- Provides support, advice and review to enable self management.
- Offers ongoing assessment, intervention and support for patients with a diagnosis of Motor Neurone Disease.
- High quality service provision via links with other areas of service including GPs, specialist nursing teams, equipment and adaptation, tissue viability, district nurses etc.
- Encouraging people to self manage their condition, maximise their function and maintain their independence through identifying and treating underlying impairment and providing training and practice in specific activities.
- Provides the service in the most appropriate setting to meet the patient’s rehabilitation goals. Including the patient’s own home, community venues, clinic settings and the work place.

Referral criteria
- Adults with a physical disability who have a rehabilitation goal that does not require inpatient rehabilitation
- Self referral and health and social care referral accepted.

Where can you get more information?
Di Dillon, 01226 433179
di.dillon@swyt.nhs.uk
The speech and language therapy service provides specialist assessment, diagnosis and management to patients in the Barnsley area who have feeding and/or swallowing difficulties (dysphagia) and who need assessment in their own homes/care homes.

**Our service offer and objectives**

- Assessment is carried out by speech and language therapists using food and drinks to establish if there are any swallow reflex problems. Adjustments are made to positioning, textures of diet or thickness of fluids as required and recommendations are made for continued oral feeding where possible. Patients are reassessed and reviewed as required.
- Specialist care is provided to patients with feeding or swallowing difficulties associated with a number of different causes, eg. dementia, COPD, stroke, general decline.
- Provides training, education and advice to other health professionals where required.
- Aims to improve the quality of life for patients by managing their symptoms or slowing deterioration where possible.
- Reduces hospital admissions by prompt assessment/treatment prior to deterioration or worsening symptoms.
- Helps patients stay in their own home/care home by consistent, effective management.
- Maintains oral feeding in patients.

**Referral criteria**

The service is provided to all service users that are a resident in the Barnsley area or registered with a Barnsley GP.

Equipment is issued to service users following an assessment by a qualified health or social care professional or for specific items self referral is accepted.

Criteria for referral will include facilitating timely discharge from hospital, preventing unnecessary admission to hospital, supporting the end of life care pathway to enable people to die at home and assisting people to remain safe and independent in the community.

**Where can you get more information?**

Deborah McLeod - 01226 432377
Deborah.mcleod@swyt.nhs.uk
Falls and osteoporosis services

Falls represent a significant public health challenge, with incidence increasing at about 2% per annum. Increased rates of falling, and the severity of the consequences, are associated with growing older and the rising rate of falls is expected to continue as the population ages.

The service is based at Mount Vernon Hospital and is delivered Monday - Friday between 9am and 5pm (excluding bank holidays).

Our service offer and objectives

- Offers specialist assessment, treatment, DXA scanning, medication advice and training to patients in a community environment.
- Aims to prevent falls occurring, where possible, by training staff in the use of the Falls Risk Assessment Tool (FRAT) and implementing measures to minimise the impact of a fall and to offer advice and appropriate management techniques for those who have already fallen.
- Provides timely and comprehensive assessment for acute fallers and those at risk of falling.
- Responds to a first fracture to prevent a second.
- Provide comprehensive case identification preventing frailty, promoting bone health and reducing accidents – through encouraging physical activity and healthy lifestyle, and reducing unnecessary environmental hazards.
- Supports GPs in the identification and management of osteoporosis (via DXA), which, in turn, minimises the impact of falls on the patient.
- Provides a comprehensive person-centred assessment for patients who require skilled, clinical and therapeutic interventions.
- Offers access to appropriate specialist advice for clinicians with regard to osteoporosis.
- Offers health education and evidence-based information to patients and their relatives/carers in order that patients can prevent falls occurring, or minimise the effect of a fall.
- Encourages all patients to take an interest in, and responsibility for their own health.
- Provides falls prevention equipment including hip protectors.
- Delivers mandatory falls / osteoporosis training to staff across the Trust and ad hoc training to other clinical areas.
- Runs Rapid Access Clinic with specialist therapy support and coordinate exercise groups in a variety of community settings.

Where can you get more information?

Jan Kitchen, 01226 433360
jan.kitchen@swyt.nhs.uk
I'm 72 now, and when I had a nasty fall recently and broke my ankle I lost all confidence about going outdoors. Someone from the falls service came to see me. They found that when I stood up, my blood pressure dropped. My balance was not so good, and some of my muscles were quite weak.

Almost straight away, they sorted out some equipment for my home to make me safer. They put grab rails at my front door and in my bathroom and fitted a second stair rail so that I had something to hold on to on each side going up and down stairs. They gave me a walking stick as well.

They were so thorough - they spoke to my GP about my blood pressure, and he changed my medication as well as starting me on some medication to make my bones stronger. They taught me exercises to do at home and how to use my walking stick properly. I have also joined a healthy bone class.

I feel that I've got my life back now. I'm back to my old social life, going out with my husband to do the shopping and visit our family. My balance is so much better and I am really pleased with the outcomes of the home exercise programme – I make sure to do my exercises every day. I also enjoy attending the healthy bones classes, not only for the exercises but also it's a bit of a social occasion!

Referral criteria

Services are provided to adults (aged 18 years +) with complex needs, who are registered with a Barnsley GP and are at risk of falls and/or Osteoporosis

- **Falls** - Adults with complex and multi-factorial medical and social issues relating to falls risk and requiring specialist falls management and intervention.
- **Osteoporosis** - Adults over 21 (Scanning Regulations 2000 [IR(ME)R 2000]) requiring Osteoporosis diagnosis, management and intervention.
Older people’s psychological service

The purpose of the service is to provide effective, safe and personalised provision of psychological services throughout Barnsley for people with a range of mental health problems relating to later life issues, contexts and diagnoses.

The service also extends to younger people facing issues commonly found in later life, or at the end of life, and to younger people facing diagnoses that are life changing such as stroke, dementia and the conditions for which people are referred to the Community Respite and Rehabilitation Unit (CRRU) such as head injury and neurological conditions.

The service is based at the Keresforth Centre and is delivered Monday - Friday, 9am to 5pm (excluding bank holidays) across a number of services.

Our service offer and objectives

- Providing psychological services to older people with functional mental health problems.
- Undertaking neurological assessment for people with memory problems to support early diagnosis, producing effective care plans and identifying and meeting the needs of the person as the illness develops.
- Undertaking psychological screening for patients referred to the stroke unit at Mount Vernon Hospital and assessing psychological involvement on a case by case basis. Assessing mood and adjustment, identifying the nature and degree of cognitive impairment, undertaking individual and group based interventions to promote psychological adjustment, cognitive rehabilitation, and an increased awareness of and ability to manage post stroke issues. Providing ongoing psychological intervention following discharge from the stroke unit.
- Providing assessment and intervention for patients referred to CRRU in relation to cognitive decline and psychological functioning. Psychological involvement is developed on a case by case basis according to individual need, and may be required both at inpatient and outreach stage to aid the rehabilitation process.
- Providing psychological provision to people with life limiting illness or palliative care needs and their carers including neuropsychological assessment, therapeutic work, and consultation.

Referral criteria

- Available to patients registered with a Barnsley GP.
- Patients who have already had a stroke or who have not been an inpatient are unable to access the service and have to be referred through the general mental health services route.
- All patients under the care of CRRU are eligible for psychological work where appropriate.
- Referrals relating to people within palliative care services and the Hospice are discussed on a case by case basis.

Where can you get more information?
Lyn Sutcliffe - 01226 433452
lyn.sutcliffe@swyt.nhs.uk
Inpatient and community rehabilitation services

The services within the inpatient and community rehabilitation business unit aim to prevent unnecessary acute hospital admission and facilitate acute hospital discharge, while promoting greater independence, choice and wellbeing for the patient. We provide a comprehensive range of rehabilitation, advice, support and care services, from within inpatient ward settings, community clinic sites and within the patient home.

The aim of inpatient and community rehabilitation services is to enable:

• Faster recovery from illness
• Improved quality of life, including making a positive contribution
• People to reach their potential and independence
• People staying in their own homes for as long as possible
• Early intervention in stroke rehabilitation, ensuring that in the short-term people's nutrition and hydration needs are met and that further risk factors are identified
• Reduction in long-term disability, including provision of appropriate health promotion and education
• Adjustment to diagnosis and risk of reoccurrence of the condition for people who are living with a stroke
• Improved levels of mobility for people who have had problems with falls
• People to be more able to manage their own health
• People and their families to be supported in continuing care, palliative care and meeting end of life needs
• Support the early diagnosis of dementia illness

Our services have well established links with other community services, local organisations and voluntary/independent groups such as The Stroke Association, Barnsley Hospice, Headway UK, Alzheimer’s Society, carer networks etc.
Our service offer and objectives
The service is flexible and responsive to the changing needs of patients, preventing unnecessary hospital admission, supporting timely discharge and enabling patients to regain sufficient physical function and confidence to return safely to their home.

- Improved quality of life, by ensuring people receive and obtain the appropriate treatment and clinical interventions according to their condition and individual needs.
- Optimum potential and independence, achieved through community inpatient rehabilitation.
- Reduction in long-term disability following active rehabilitation programmes and clinical intervention.
- Access to community older people’s rehabilitation and neurological physiotherapy outpatient service.
- Rehabilitation for patients whose recovery may be limited eg. palliative/end of life care.
- Higher level of mobility for people at risk of falls.

Where can you get more information?
Diane Collinson - 01226 433209 diane.collinson@swyt.nhs.uk or julie.bowser@swyt.nhs.uk

Referral criteria
- This service is predominantly for older people (55 years and above), although there may be circumstances where the needs of a younger adult are best met via inpatient rehabilitation, following discussion and subsequent agreement with the receiving consultant.
- The patient no longer requires acute care, but requires multidisciplinary rehabilitation and has the ability to participate in rehabilitation programmes. In addition the patient would benefit from one or more of the following:
  - Frequent nursing intervention over the 24 hour period eg. wound management, monitoring of vital signs, intravenous infusions, subcutaneous fluids, syringe drivers, bed rest for unstable fractures, NG feeds, PEG feeds
  - Medical support, eg. medication review and subsequent alteration to treatment regimes eg. sliding scale insulin, medication titration
  - On-site therapy intervention (physiotherapy, occupational therapy, speech and language therapy or dietician)
  - Complex multi-disciplinary assessment for future care
  - The patient meets level 5 (complex care needs) or level 6 (end of life) of the NHS Continuing Care criteria.

In a recent survey:
- 99% of patients said they were treated with respect and compassion
- 97% thought that meals were of a good standard
- 97% said they felt their dignity was maintained at all times
Outpatient adult neurological physiotherapy service

The outpatient adult neurological physiotherapy service at Mount Vernon Hospital provides specialist rehabilitation for people with neurological conditions. The service supports people to manage their own condition and offers specialist therapeutic interventions to maximise mobility, functional levels and thereby improve their quality of life. The outpatient service operates Monday, Wednesday and Thursday 8.30am – 4.30pm

Our service offer and objectives
The service offers an individual comprehensive clinical assessment and therapeutic programme of care, which includes the diagnosis, treatment, rehabilitation, secondary prevention and ongoing support to the patient.

In addition, an adult neuro-rehabilitation service is available for people discharged from hospital but who still require on-going therapeutic interventions in a community setting to maximise their rehabilitation potential.

- Higher level of mobility for patients following a falls risk assessment.
- Improved quality of life, ensuring people receive and obtain the appropriate treatment and clinical and therapeutic interventions according to their condition and individual needs.
- Reduction in long-term disability following active rehabilitation programmes and clinical interventions.
- Greater patient concordance, better health outcomes and improved understanding through comprehensive clinical assessment.
- Improved ability for patients to self-manage their condition.

If treated promptly for a symptom(s)/problem of that condition the service will:
- Prevent admission to hospital (eg. relapse in MS, sudden severe deterioration in condition but not due to a medical problem, post CVI treated in a home).
- Facilitate early discharge home from hospital, locality centre or intermediate care team allowing seamless pathway of care (eg. post CVA, but not TIA, post neuro-surgery).
- Prevent injury if unsafe mobilising and if patient is falling regularly. Falls must not be due to a medical problem eg. UTI, postural hypotension, side effects of medication.
- Reduce neuropathic pain when so severe it compromises daily function (eg. shoulder pain due to neurological impairment).
- Undertake physiotherapy intervention following Botulinum injections.

Referral criteria
This service is for:
- People with a long term neurological condition whose functional abilities have significantly changed recently (ie. within 1 month) and have rehabilitation potential
- Patients with a newly diagnosed neurological problem who are currently stable but require physiotherapy advice and education for self-management of their condition (and have not had physiotherapy before for this reason)

Where can you get more information?
Di Dillon - 01226 433209
di.dillon@swyt.nhs.uk
or julie.bowser@swyt.nhs.uk
Mount Vernon hospital: stroke unit

The stroke unit at Mount Vernon Hospital provides a borough wide community rehabilitation service, which enables people who have had a stroke access to a service specialising in stroke and rehabilitation. People referred to the stroke service benefit from early assessment and identification of the level of functional impairment, with access to prompt investigation, identification of cerebral risk factors and referral to specialist services.

Our service offer and objectives

A modified approach is taken to the rehabilitation process via continuous integrated assessment, review and programmes of care in order to identify goals and support early discharge.

In addition specialist clinical and therapeutic interventions for those patients whose recovery maybe limited and for those who may need palliative/end of life care or continuing care is provided.

As well as the active and intensive rehabilitation provided by the stroke rehabilitation unit, support is provided for stroke patients who require longer-term stroke management at a slower pace and intensity, based upon individual need and assessment. Patients benefit from being clinically managed in an environment conductive to their individual needs, in a variety of settings and placements with an aim to maximise their potential.

- Improved quality of life and independence, by ensuring people receive and obtain the appropriate treatment and clinical and therapeutic interventions according to their condition and individual needs.
- Reduction in long-term disability following active rehabilitation programmes and clinical interventions.
- Adjustment to diagnosis and reoccurrence of the condition, for patients following and living with a stroke, through advice, support, counselling and education.
- Improved understanding of the complexities of living with a stroke, following discharge from in-patient care in to the community including life after stroke and signposting.
- Supporting individuals and family members in continuing care, palliative care and end of life needs, following a stroke.

Referral criteria

The unit provides intervention for patients (18 years +) with a newly diagnosed Cerebral Vascular Incident (CVI) who are able to cope with active rehabilitation.

Patients with a significant pre-morbid medical or physical conditions, which would impact on the ability to engage in intensive/active programmes of therapy eg. dementia, cardiac problems, chronic arthritis, respiratory problems would be eligible for referral to ‘slow stream’ rehabilitation.

The stroke unit will also provide care for patients diagnosed with a terminal illness and are likely to require rehabilitation to improve their quality of life albeit for a limited time period.

Where can you get more information?

Ian Slater - 01226 433209
ian.slater@swyt.nhs.uk or julie.bowser@swyt.nhs.uk
Martin is 80 and was admitted to the unit for rehabilitation following his stroke. During his admission input was given by the full multi-disciplinary team. Both Patricia and Martin were involved in goal setting, self medication programme and monitoring of nutritional and hydration needs. Lots of information was given in the relative’s clinic and at ward level.

As Martin’s condition improved, a review meeting and later a discharge meeting, were arranged with Martin and his family to discuss the support network needed to maintain, support and improve his independence in his own environment.

Services were provided by Hospital at Home and four calls daily social care package. Following the 6-8 week stroke community review by the stroke co-ordinator and social worker, Martin was independently mobile and had minimal assistance with daily living activities.

Both Patricia and Martin were managing well and did not require a further care package. It was stressed that they had life-long contact from stroke services if required.

During the visit, Patricia said,

“I felt it was like family and I had no concerns leaving my husband and I could get ready for his discharge. All my concerns and anxieties were addressed and nothing was ever too much trouble. There was always a kind face and somebody to talk to. I thought my husband would have to be looked after in a residential home and we would have to be apart after 61 years of marriage, but he is back on his feet and we are together in our own home.”

In a recent survey:

- 95% of patients rated their experience of the Stroke Unit as excellent/very good
- 96% said they were reassured by the care and attention received by the therapists
The community rehabilitation and respite unit (CRRU) works to provide care, assessment and intervention for brain injury and neurological conditions eg. traumatic and/or acquired brain injury, multiple sclerosis, Parkinson’s disease, progressive supranuclear palsy and spinal cord injury.

The unit is currently based at The Keresforth Centre, and will move to new premises at Kendray Hospital from 1 April 2012.

**Our service offer and objectives**
The service provides inpatient and outreach services using a multidisciplinary team to provide ongoing advice and support to people in order to increase independence and reach full potential.

This involves a co-ordinated approach from a number of health and social care staff and supports people in a seamless move back into the community.

The service identifies the level of functional and cognitive impairment, provides access to prompt investigation and therapeutic intervention and supports patients and carers through the rehabilitation process.

Key target outcomes for the service are:
- Improved health and well-being
- Increase in choice and control
- Making a positive contribution
- Economic wellbeing
- Freedom from discrimination and harassment
- Improved quality of life

**Referral criteria**
This service is for any individual aged 17 years and over with a neurological condition including acquired brain injury, living in Barnsley and requiring:
- Inpatient admission for rehabilitation or SMART assessment
- Community rehabilitation including vocational rehabilitation
- Psychological assessment
- Education and family support
- Palliative neurological rehabilitation

Where can you get more information?
Anne Massey - 01226 433444
anne.massey@swyt.nhs.uk
or julie.bowser@swyt.nhs.uk

In a recent survey:
- 100% of patients felt comfortable talking to staff if they had any worries or anxieties
- 92% were kept fully informed fully of their condition and treatment throughout their stay
- 100% said nurses responded in a timely manner
Intermediate care provision

The intermediate care service provides short-term support to adults at a time of illness, crisis or significant disruption in people’s lives. It promotes independence by avoiding unnecessary admission to hospital or long-term care and also helps to speed discharge from hospital.

Our service offer and objectives
Intermediate care is a ‘bridge’ between hospital and independent living and aims to stabilise and improve levels of independence and wellbeing to a point where either support is no longer needed or, the person can be offered other appropriate services/care.

The intermediate care provision encompasses:-

**Rapid response service** operates on a 24/7 basis offering an alternative to hospital admission.

The team undertake intervention outside of service hours for district nursing, urology, other specialist nurses, home enteral feeding and palliative care.

People are supported in their own home, nursing home etc. according to need and level of dependency.

**The Hospital at Home** service provides rehabilitation to medically stable residents in their own home and residential care.

The team provides specialist community therapy assessment and treatment to improve health and independence.

In addition it offers rehabilitation to enable earlier discharge from hospital.

- Provides screening for rehabilitation/reablement potential and assessment of need /risk.
- Promotes faster recovery from illness and prevent unnecessary re-admission to hospital.
- Supports timely discharge following an acute hospital admission by provision of rapid screening and assessment of ongoing need and reablement potential.
- Prevents premature admission to long-term residential care through effective screening and assessment of rehabilitation/reablement potential.
- Promotes the use of assistive technologies within the home to support independence and wellbeing.
- Provides signposting and advice where appropriate and to support the prevention agenda.
- Promotes wellbeing and independence - people are supported more effectively to self manage their conditions while living in the community.

Referral criteria
We provide community care services to individual adults with needs varying form physical, sensory, learning or cognitive disability.

Where can you get more information?
Ruth Donoghue
01226 433268
ruth.donoghue@swyt.nhs.uk
Dementia services provide a single point of access, for the assessment, diagnosis and treatment of people with memory problems in line with the NHS national dementia strategy. The service is based at Kendray Hospital and operates from Monday to Friday, 8am to 8pm.

**Our service offer and objectives**

Problems with memory are not necessarily linked to dementia. Infections, intoxication and depression are some of the conditions that impact on what people remember.

Staff in the dementia service work closely with GPs and colleagues from the Barnsley Hospital NHS Foundation Trust, providing a single point of access for referrals. They carry out detailed assessments to uncover the underlying causes of memory problems. In cases where an individual does have dementia, they may be helped by medication that slows the progress of the illness.

The team is led by a matron and a nurse consultant who offer expert clinical input and guidance.

Senior community dementia workers offer diagnostic assessment incorporating risk, ongoing evaluation and review of people’s needs to enable people to maintain their optimum independence at home. When people are first diagnosed, we offer education and information to them and to their carers to help them make plans for the future.

They are supported by community dementia workers who provide further support in the later stages of illness, act as liaison to nursing and residential homes and navigate people through the range of support services available.

Dementia support workers help people to live as well as possible with their dementia illness in their own communities.

In times of crisis, the service will support the rapid response team to help to maintain people in their own homes. They also arrange for people to be admitted to short stay settings where needed.

**Our aims are to:**

- Help people maintain a strong sense of self.
- Enable people to cope with the emotional response to the diagnosis of dementia, including managing stress, anxiety and depression.
- Help people maintain relationships and social networks.
- Allow people to maintain employment for as long as possible for younger people with dementia.
- Gain practical coping strategies to manage problems of memory loss.
- Guidance and information to help people make choices and retain independence.
- Enable people to continue to look after themselves, their finances and home with support where needed.
- Management of risk while living life to the full.
- Forward planning to ensure that care is delivered in the way that they want.

Where can you get more information?

**Philippa Slevin**
01226 434246
philippa.slevin@swyt.nhs.uk
Referral criteria

- The dementia service is available for all people over the age of 18 years where a diagnosis of dementia is uncertain or required.

- The person with a diagnosis is presenting with a complex, (multiple components of cognitive dysfunction) presentation. This may be where there are considerable behavioural and psychological needs/risks to the extent that they significantly affect the level of independent functioning of the client or the carer.

- Safety issues have been identified and the client is believed to be at risk of harm or abuse, or at significant risk within their environment as a direct result of their cognitive decline.

- Treatment is to be considered for the assessment and prescribing of Acetyl cholinesterase inhibiting medications.

- There is a dual diagnosis and advice and/or treatment is required regarding their ongoing management plan.
Dementia service

Alice is a ninety four year old lady who was referred to the dementia service for assessment, treatment and support. Alice was cared for at home by her daughter Mary, who required advice regarding help from social services and ongoing support in caring for her mum.

Whilst awaiting memory assessment, Mary and her mum were offered the services of the dementia care navigator. Alice had suffered a number of falls at home which resulted in admission to hospital. This coupled with her diagnosed dementia illness eventually led to a period of respite care and then to residential care. The memory team has supported them both in coming to terms with the illness, making decisions for future cares and supporting the process through the acute care services, continuing care and social care service. The memory team remains involved in carer support to Mary and the provision of treatment to Alice through the memory clinic.

"An excellent service, no grumbles, I do not know what I would do without it. People with dementia are lost and lonely and need support. It is good to know you are not alone, I wish every one could have this service knowing there is someone to contact. I tell my friends what a marvellous service the memory team is."

In a recent survey:

- 82% of patients rated the service excellent/very good

- 95% said that their memory nurse organises the care and services they receive well

- 100% said they could contact the memory nurse if they had a problem