Bassetlaw – A Community of Care and Support

OUR VISION

Better care for the frail & elderly, More & better care & support at home and in places nearby, A high quality local Hospital with 7 day working, easy access, and essential services like a 24 hour Emergency Department, and consultant-led maternity unit, Same day local care, with access to the right health care professional, More support for independent living with enhanced sheltered housing choices, Patients with a mental health condition to receive an excellent service, Care homes to be an integral part of our local community.

Reduction in potential years of life lost (PYLL) from causes to health care.

Health-related quality of life for people with long-term conditions.

Composite measure on emergency admissions.

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation

Patient experience of hospital care.

Composite indicator comprised if i) GP Services ii) GP Out of Hours

Hospital deaths attributable to problems in care.

GOALS	PROJECTS
Urgent Care • Improved model of same day care in Retford and Worksop. • Improved model of same day care for villages. • Improved care out of hours.	• Increased capacity in primary urgent services. • Joint working to sustain A&E service. • Review of out of hours model.
Care for Elderly in community • Improved intermediate care. • New model of community based geriatric care (inc. Care Homes). • Primary Care Teams co-ordinating person centred care.	• Primary care integrated led team-working. • Developing community geriatric service. • Identification and care planning for most vulnerable. Responsible lead clinician • Improved communications and records sharing. • Improved access to intermediate care services. • Telehealth wider use of assistive technology
Care Homes • New enhanced range of accommodation for older people. • Quality assurance framework across nursing and residential sector. • Alternative short-term service in care home setting. • New support living arrangements shared links and respite.	• Develop a care home quality dashboard/transparent quality assurance. • Care plans for patients with medical input. • Pharmacy and community service input. • Enhanced dementia nurse specialist access. • Develop alternatives to care homes where appropriate
Mental Health Services. • Improved link between physical and mental health services. • Increase emphasis on prevention and early intervention • Increased integration with primary care teams.	• 24 hour access to mental health services in A&E. • Identification and care plans for frequent users and vulnerable patients. • Integration and record sharing with primary care. • Improve focus with mental health problems and increased physical illness risk.
Supporting People after acute illness. • Independence & Re-ablement unit • Re-ablement pathways • Community based assessment	• Enhanced early senior review and discharge planning with early involvement of patients and social care team. • Improved access to intermediate care and alternatives to acute hospital beds. • Communication around delayed discharges and identification of barriers. • Discharge to assess model. • Care plans for vulnerable patients and clearer community input to ATC and A&E.

Delivering Transformational Service Models

- Developing joint responsibility for care and support
- Integrated delivery around the person.
- Organisations working across boundaries.
- Professions working together in teams.
- Resources openly shared and pooled.

Underpinned by:

- Increase in 7 day services in Community and Primary Care and in Hospital
- Clinically-led philosophy.
- Relentless focus on quality, safety and patient experience.

Planned Outcomes

- Improved access to services for people with urgent problems, including clear information and alternatives to face to face appointment where appropriate.
- Improved community services built around the primary care team and caring for more people in their own homes.
- Improved care home quality, more clinical input, co-ordinated care and transparency.
- Improved access to mental health services focusing on urgent problems, vulnerable patients and integration with primary healthcare teams.
- Improved discharge processes focusing on early senior review, access to alternative services and appropriate care planning.

Shared Values

- Trust each other
- Collaborate for the patient and service user.
- Be transparent
- Share resources
- Invest our time.
- Talk to local people and our staff.
- Build long term solutions.
- Quality and safety come first.
- Our community is more important than any one organisation.
- Share skills Provide leadership
- Encourage people to innovate.

Overseen through the following governance arrangements

- Shared system leadership group overseeing implementation of the improvement interventions is achieved through our Integrated Care Board
- Individual organisations leading on specific projects
- Agreed program management
- Financial framework and principles under development.