Bassetlaw
A Community of Care and Support.

Vision	Better care for the frail and elderly	More and better care and support at home and in places nearby.	A high quality personal and efficient service from local doctors, nurses and other professionals, who they work for will not matter.	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
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 health care teams**	**Improved discharge processes focusing on early senior review, access to alternative services and appropriate care planning.**			
Program	**Urgent Care**	**Care for Elderly in Community**	**Care Homes**	**Mental Health Services**	**Supporting people after acute illness**			
Program Goals	• Improved model of same day care in Retford and Worksop • Improved model of same day care for villages. • Improved care out of hours.	• Improved intermediate care • New model of community based geriatric care (inc. Care Homes). • Primary Care Teams co-ordinating person centred care.	• 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.	• Improved link between physical and mental health services. • Increased emphasis on prevention and early intervention. • Increased integration with primary care teams.	• Independence & Re-ablement unit. • Re-ablement pathways. • Community based assessment.			
Supporting Projects	• Increased capacity in primary urgent services. • Joint working to sustain A&E service. • Review of our of hours model.	• Primary care led team-working • Developing community geriatric service. • Identification and care planning for most vulnerable. • Improved communications and records sharing. • Responsible clinician. • Improved access to intermediate care services.	• 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.	• 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.	• Enhanced early senior review an 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.			

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 comes first	Our community is more important than any one organisation.	Share Skills	Provide Leadership	Encourage people to innovate.

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