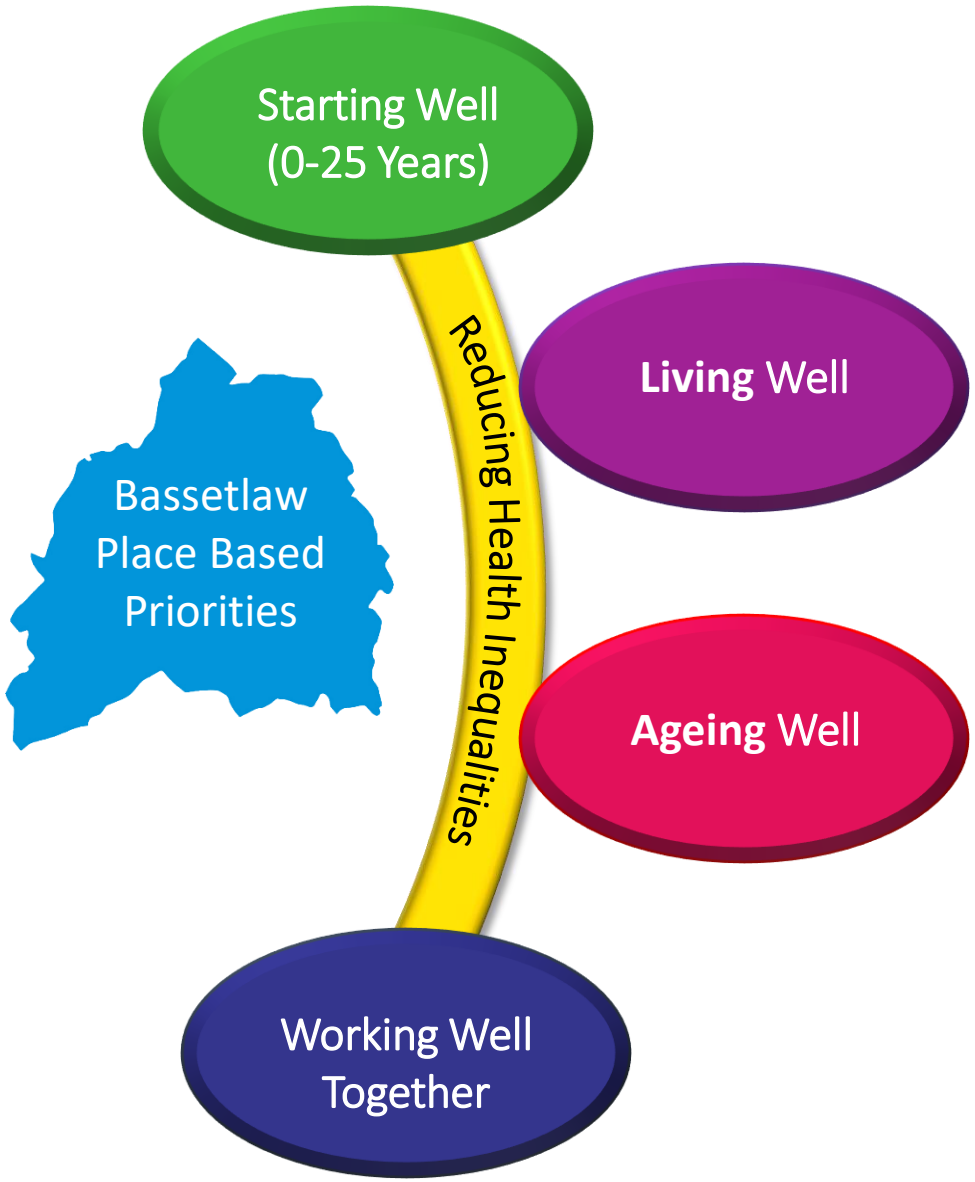

DRAFT in Development

Bassetlaw Place- Based Partnership Plan 2025/26

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Bassetlaw PBP – All Age Vaccinations and Immunisations Programme

Clinical Lead	Operational Lead (s)	Improvement Lead	Analyst Lead
Gemma Bird/ Dr Kumar	Mark Campbell Keeley Azar	Helen Azar /Leanne Monger	Helen Woods

Priority	All Age Vaccs and Imms Programme
Programme Summary	To implement initiatives across all 3 Bassetlaw PCNs and work in conjunction with DBTH and local partners to promote the uptake of vaccinations for Bassetlaw residents
Aim	To increase awareness and uptake of vaccinations in Bassetlaw To increase the uptake percentage of flu and RSV vaccinations in targeted groups in Bassetlaw
What we will achieve (benefits)	2% increase across targeted vaccination groups Flu vaccinations for at risk 18–64-year-olds – baseline 44.1% (March 25) Flu vaccinations for 2-3 years olds – baseline 41.1% (March 25) Flu vaccinations for pregnant patients – baseline 29.4% (March 25) RSV vaccinations for pregnant patients – baseline 18.9% (March 25) MMR 2nd Dose 5-year-olds – baseline 87.3% (March 25) Pneumoccocal 65years+ baseline 55.6% (March 25) maintain for PCNs over baseline Maintain Covid vaccinations % for eligible patients – baseline 53.3% (March 25)
Key deliverables	Promotion of vaccine clinics/flu fayres across Bassetlaw PCNs Working in conjunction with DBTH to increase opportunistic vaccinations in secondary care particularly with pregnant patients Promotion of vaccination training for Bassetlaw PC and VCSE colleagues to further spread awareness of vaccines Work with local community groups/employers to promote vaccination uptake
Measures of success (outcomes)	Increase in flu vaccinations for at risk 18–64-year-olds, 2-3 years olds and pregnant patients Increase in RSV vaccinations for pregnant patients Increase in number of children fully vaccinated against MMR Maintain eligible patients with Covid booster Reductions in winter pressures on primary/secondary care due to respiratory illnesses

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Partnership

Key -Status
On track
Off Track recoverable
Off Track at Risk

Delivery Plan – Bassetlaw Place Based Partnership All Age Vaccs and Imms Programme

Output	Milestone	Due Date	Status	Lead	Partnership Support
Staff trained on RSPH Encouraging Vaccination Uptake course	Promotion of RSPH training to wider partners – aim to get a representative from each practice trained	March 26		Mark Campbell Keeley Azar	All partners to support with sharing comms, County Council
Flu Unvaccinated at risk 18–64-year-olds identified through case finding Out of hours/weekend appointments offered and promoted Unvaccinated 2–3-year-olds identified through case finding Out of hours/weekend appointments offered and promoted Pregnant patients offered opportunistic flu vaccine in secondary care	Flu Fayres and clinics held and promoted in PCNs throughout Autumn/Winter months Unvaccinated patients identified through primary care – monthly report for babies under 60 months Patients contacted to book for their vaccine – PCNs use 2 letters with a follow up phone call for children. Adults receive a link to book after 2 letters Home visits to care homes/housebound patients DNAs followed up and recontacted to book with SMS reminders for planned clinics Collaboration with DBTH to promote flu vaccine and update on progress – discuss opportunities for vaccines in secondary care e.g. on discharge or in waiting rooms Collaboration with local employers/sports teams to promote – B&Q, Worksop Town FC	March 26		PCNs Mark Campbell Keeley Azar	PCNs, Practices, Care Homes, Childcare settings, County Council (CAMIV group)
RSV Pregnant patients offered opportunistic RSV vaccine in secondary care	Promotion of information – new vaccine and people may not be familiar Collaboration with DBTH to promote RSV vaccine to pregnant patients and update on progress Unvaccinated patients identified through primary care - eHealthscope Patients contacted to book for their vaccine	March 26		DBHT Mark Campbell Keeley Azar	DBTH, PCNs, Practices
MMR Unvaccinated 5+ year olds identified through case finding Out of hours/weekend appointments offered and promoted	Comms promotion to combat misinformation around this vaccine Monthly CHIS dashboard used to identify children with an incomplete vaccination record PCNs to have protected slots for childhood vaccinations and offer weekend and evening bookable slots Patients/parents contacted to book for their vaccine DNAs followed up and recontacted to book	March 26		PCNs Mark Campbell Keeley Azar	PCNs, Practices, Childcare settings, County Council (CAMIV group)

Bassetlaw
Place-Based
Partnership

Key -Status
On track
Off Track recoverable
Off Track at Risk

Delivery Plan – Bassetlaw Place Based Partnership All Age Vaccs and Imms Programme

Output	Milestone	Due Date	Status	Lead	Partnership Support
Covid Eligible patients identified and contacted Out of hours/weekend appointments offered and promoted	Promotion of information around the Covid vaccine Eligible patients contacted to book Covid vaccine offered alongside flu	March 26		Mark Campbell Keeley Azar	PCNs, Practices
Pneumococcal vaccine	**TBC with Kumar**				

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Partnership

Output/Activity

			2025/6				2026/7			
All Age Vaccs and Imms Programme										
Outcome Measures	Responsible Project Lead	Target	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
% of at risk 18-64 year olds vaccinated for flu	Mark Campbell Keeley Azar	46%				46%				
% of 2-3 year olds vaccinated for flu	Gemma Bird Mark Campbell Keeley Azar	43%				43%				
% of pregnant patients vaccinated for flu	Mark Campbell Keeley Azar	31%				31%				
% of pregnant patients vaccinated for RSV	Mark Campbell Keeley Azar	21%				21%				
% of eligible patients receiving the Covid vaccine	Mark Campbell Keeley Azar	53%				53%				
% eligible patients receiving the Pneumoccocal vaccine	TBC									
% of 5+ year-olds with MMR 2nd Dose	Mark Campbell Keeley Azar	89%				89%				

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Bassetlaw PBP –Start Well Programme NHS/ICB Place Led Initiatives

Clinical Lead	Operational Lead	Improvement Lead	Analyst Lead
Dr Kumar	Keeley Azar	Helen Azar /Leanne Monger	Helen Woods

Priority	Start Well Programme
Programme Summary	Ongoing management of Start Well Integrated Neighbourhood Team working together to reduce health inequalities and support children and young people's overall health and wellbeing. Targeted interventions reduce health inequalities across Core 20 populations and inclusion health groups.
Aim	• Deliver INT in core 20 areas • Reduce CYP ED attendances and admissions related to mental ill health • Reduced perveance of CYP self-harm, anxiety and depression and reduced risk of suicide • Stabilise the rising rates of obese and overweight CYP. • Reduce CYP weight related illness and disease prevalence • Reduction in ED attendance and admissions related to asthma. • Increase uptake of Childhood Vaccinations and Immunisations
What we will achieve (benefits)	• Reduction in Emergency admissions related to asthma • Increase % CYP annual asthma review completed • Reduction of CYP BMI • Reduction in CYP ED attendances and admissions related to mental ill health, self-harm and suicide risk.
Key deliverables	• Proactive case finding of CYP with respiratory conditions targeted intervention delivery • Proactive case finding to reduce childhood obesity and targeted intervention delivery • Proactive case finding to improve CYP's mental health and targeted intervention delivery
Measures of success (outcomes)	• 450 CYP offered stage 1 interventions via INT • Reduction in attendances and admissions from 2019/20 baseline • Increase uptake of Childhood Vaccinations and Immunisations • Collaborative working across BPBP partners, including Family Hubs to develop and implement 'Best Start' community-based approaches to outreach into communities

Bassetlaw
Place-Based
Partnership

Key -Status	
	On track
	Off Track recoverable
	Off Track at Risk

Delivery Plan – Bassetlaw Place Based Partnership Start Well Programme NHS/ICB Place Led Initiatives

Output	Milestone	Due Date	Status	Lead	Partnership Support
Ongoing management of INT with delivery partners	Fully embed across PBP, INT case supervision and MDT established	Q1-4 25/6		Keeley Azar	VCSE, PCN, Practices
Recovery action plan complete	ABL all targets being met	Q1		Keeley Azar	VCSE, PCN, Practices
Stage 1 and 2 reviews and inventions delivered focused on obesity	Care Co-Ordinator identifies those people within cohort. Care Co-Ordinator invites individuals for reviews within PCN and with delivery partners- ABL	March 26		Keeley Azar Care Co-Ordinator ABL	VCSE, PCN, Practices
Stage 1 and 2 reviews and inventions delivered focused on mental health and wellbeing	Care Co-Ordinator identifies those people within cohort. Care Co-Ordinator invites individuals for reviews within PCN and with delivery partners-Talkzone	March 26		Keeley Azar Care Co-Ordinator Talkzone	VCSE, PCN, Practices
Increased engagement with Moving on Asthma (MOA) digital tool	Proactive case finding of CYP with asthma condition. Weekly text messages with video links and support send for 8 weeks. INT delivery partners signpost and support CYP to engagement in MOA tool	Q1-4 25/6		Keeley Azar	VCSE, PCN, Practices
Roll out of MECC + Building Blocks approaches embed culture across INW and partners	BCVS deliver MECC + Building Blocks training to PBP	Q2 2025		BCVS/ Helen Azar	VCSE, PCN, Practices
	MECC + Building Blocks training offered & taken up across partnership.	March 26		Keeley Azar	VCSE, BDC, DBHFT, ICB, NHT, EMAS, NCC

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Place-Based
Partnership

Output/Activity

			2025/6				2026/7			
Start Well Programme										
Outcome Measures	Responsible Project Lead	Target	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CYP offered a stage 1 holistic needs review focussed on obesity	Keeley Azar	199	50	100	150	199				
CYP engaged in stage 2 targeted interventions focussed on obesity	Keeley Azar	131	30	60	90	131				
% of CYP engaged stage 2 obesity support demonstrate increased score by 3 or more on person- centred goal-based intervention plans	Keeley Azar	70%	17%	35%	53%	70%				
CYP maintain or reduce their BMI z score at completion of an intervention at 6 months	Keeley Azar	30%	7%	14%	21%	30%				
CYP offered a stage 1 holistic needs review focussed on Mental Health	Keeley Azar	251	60	120	180	251				
CYP contacted and offered a stage 2 holistic needs review focussed on Mental Health	Keeley Azar	166	40	80	120	166				
% of CYP engaged in stage 2 Mental Health Support demonstrate increased score by 3 or more on person- centred goal-based intervention plans	Keeley Azar	70%	17%	35%	53%	70%				
% increase of CYP at risk of asthma attacks contacted and signposted to digital recourse	Keeley Azar	40%	10%	10%	10%	40%				
% increase in CYP annual asthma reviews completed (2029/20 baseline)	Keeley Azar	5%	1%	2.5%	3.5%	5%				
% reduction in ED attendance and admissions related to asthma (2029/20 baseline)	Keeley Azar	10%	2.5%	5%	7.5%	10%				

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Bassetlaw Place-Based Partnership –Starting Well

What we will contribute to
Bassetlaw Obesity Forum
Family Hub Networks
Promoting healthier lifestyles for children & families (healthy eating, weight and moving more) Move More in May PBP campaign
Best Start Strategy Delivery
Bassetlaw Children and Young Peoples Mental Health & Suicide Prevention Alliance- Action Plan produced for in-year initiatives Peace of Mind resource
Supporting Positive Activities for children & young people (feeling safe and raising aspirations)- Bassetlaw CYP Network
North Notts Skills and Employment Board- employment and volunteering opportunities
CYP Core20Plus5 initiatives e.g. Investing in Communities Programme
Delivery and management of VCSE Services- ICB Community Investments

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Bassetlaw PBP – Living Well Programme NHS/ICB Place Led Initiatives

Clinical Lead	Operational Lead (s)	Improvement Lead	Analyst Lead
Dr Kumar	Mark Campbell Keeley Azar	Helen Azar /Leanne Monger	Helen Woods

Priority	Living Well Programme
Programme Summary	Ongoing Living Well Integrated Neighbourhood Team working together to support LTC, Severe Multiple disadvantage (SMD). Targeted interventions reduce health inequalities across Core 20 populations and inclusion health groups.
Aim	Promote Long term conditions/chronic disease management and increase the number of people receiving LD health checks and cancer screenings
What we will achieve (benefits)	• Earlier identification/ management of disease • Increase in referral/signposting to preventative services • Increase healthy choice initiatives across partners • Increase in % of LD patients receiving APHC • Increase in % of SMI patients receiving APHC • Decrease in presentation at primary/secondary care due to holistic INT support
Key deliverables	• Proactive case finding of patients identified as diagnosed with LTC specified • Patients offered holistic review to prevent development of comorbidities and improve self-management from outset of diagnosis reducing reliance on primary/secondary care services. • LD Health checks in L12M at 85% • SMI Health checks in L12M at 75%
Measures of success (outcomes)	• 400 people with LTC diagnosis in previous 12 months offered a clinical/holistic review. • Patients' health and wellbeing addressed proactively through SPLW providing personalised care and intervention plans • Increase % of eligible patients receive their cancer screening – cervical, breast, bowel • 85% of LD patients complete APHC • 75% of SMI patients complete APHC

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Place-Based
Partnership

Key -Status
On track
Off Track recoverable
Off Track at Risk

Delivery Plan – Bassetlaw Place Based Partnership Living Well Programme NHS/ICB Place Led Initiatives

Output	Milestone	Due Date	Status	Lead	Partnership Support
Adults with LTC/ SMD and lonely will benefit from clinical/ holistic review of needs and well-being.	Care Co-Ordinator identifies those people within cohort. Care Co-Ordinator invites individuals for reviews within PCN and with delivery partners – CANNs/BCVS Follow up review	March 26		Care Co-Ordinators PCNs CANNs/BCVS	PCNs, Practices, VCSE Sector
Targeted work focused on Adults living in decile 1 & 2 IMD with LTC/ SMD and lonely will benefit from clinical/ holistic review of needs and well-being	Care Co-Ordinator identifies those people within cohort. Care Co-Ordinator invites individuals for reviews within PCN and with delivery partners – CANNs/BCVS Follow up review	March 26		Care Co-Ordinators PCNs CANNs/BCVS	PCNs, Practices, VCSE Sector
85% of LD patients complete APHC	Care Co-Ordinator identifies those people within cohort. Collaborative working with NHT Health Improvement workers MECC with VCSE partners	March 26		Mark Campbell Keeley Azar	PCNs, Practices, NHT, VCSE Sector
75% of SMI patients complete APHC	Care Co-Ordinator identifies those people within cohort. Collaborative working with NHT Health Improvement workers MECC with VCSE partners	March 26		Mark Campbell Keeley Azar	PCNs, Practices, NHT, VCSE Sector
Roll out of MECC + Building Blocks approaches embed culture across INW and partners	BCVS deliver MECC + Building Blocks training to PBP	Q2 2025		BCVS Helen Azar	VCSE, PCN, Practices
	MECC + Building Blocks training offered & taken up across partnership.	March 26		Mark Campbell Keeley Azar	VCSE, BDC, DBHFT, ICB, NHT, EMAS, NCC
Cancer screening promotion and initiatives to increase timely presentation	Work with cancer champions to promote screening clinics Focused screening clinics to target low uptake demographics e.g. eastern European community Promotion of cancer awareness through PCNs and VCSE – Aurora Cancer Services Continuation of Bassetlaw Cancer Alliance to carry out the Bassetlaw Cancer Plan	March 26		PCN cancer champions Aurora Cancer Services Mark Campbell	VCSE, BDC, DBHFT, ICB, SYBCA

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Partnership

Output/Activity

			2025/6				2026/7			
Living Well Programme										
Outcome Measures	Responsible Project Lead	Target	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
400 people with LTC diagnosis in previous 12M invited to a review to support and promote wellbeing i.e. personalised care intervention and signposting.	Mark Campbell Keeley Azar	400	100	200	300	400				
75% of people n SMI register will have received an annual physical health check	Mark Campbell Keeley Azar	75%				75%				
85% of all people aged 14 and over on LD register will be offered an annual health check. (Baseline 87.6% - March 2025)	Mark Campbell Keeley Azar	85%				85%				
Min 10% increase in signposting from health and care professionals to delivery partners (2019/20 baseline)	Mark Campbell Keeley Azar	10%				10%				
Increase % of eligible patients receiving breast cancer screening (Baseline - 70.6% 23/24)	Mark Campbell Keeley Azar	75%	71%	72%	73%	75%				
Increase % of eligible 25-49yrs patients receiving cervical cancer screening (Baseline – 72.7% 23/24)	Mark Campbell Keeley Azar	75%	72%	73%	74%	75%				
Increase % of eligible 50-64yrs patients receiving cervical cancer screening (Baseline – 77.2% 23/24)	Mark Campbell Keeley Azar	78%	77%	77%	78%	78%				
Increase % of eligible patients receiving bowel cancer screening (Baseline - 74.3% 23/24)	Mark Campbell Keeley Azar	75%	72%	73%	74%	75%				

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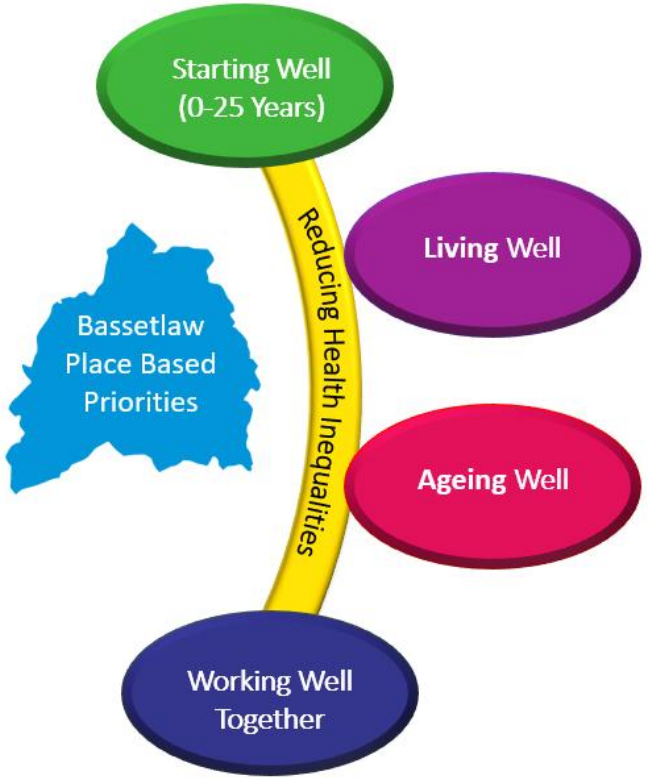
Bassetlaw PBP –Living Well

What we will contribute to
Bassetlaw Cancer Alliance, Timely Presentation Programmes of work, C the Signs
Lung Cancer Screening Programme
Cost of living partner initiatives
Bassetlaw Adult Mental Health Alliance & Suicide Prevention Action Plan and in-year initiatives
Stop Smoking Programme initiatives and campaigns- BPBP Tobacco Control Plan
Bassetlaw Focus on Farmers
Adult weight management, alcohol reduction and physical activity- Move More In May
North Notts Skills and Employment Board- employment and volunteering opportunities
Adult Core20Plus5 initiatives e.g. Investing in Communities Programme, Bassetlaw Thriving Communities Strategy
Tackling Loneliness Collaborative and PBP initiatives to reduce in social isolation and loneliness
Embed the Building Blocks of Health
Communications and public engagement awareness campaigns supported by all partners
Delivery and management of VCSE Services- ICB Community Investments



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Bassetlaw PBP – Ageing Well Programme NHS/ICB Place Led Initiatives

Clinical Lead	Operational Lead	Improvement Lead	Analyst Lead
Dr Kumar	Mark Campbell	Helen Azar /Leanne Monger	Helen Woods

Priority	Ageing Well Programme
Programme Summary	Ongoing Ageing Well Integrated Neighbourhood Team working together to support frailty, social isolation and/or loneliness. Targeted interventions reduce health inequalities across Core 20 populations and inclusion health groups.
Aim	• To reduce avoidable emergency admissions to hospital and support older adults (65yrs+) to live well and independently at home. • To reduce risk of readmission for older adults admitted as an emergency
What we will achieve (benefits)	• 300 people invited to have a clinical review by PCN Care Coordinator • Min 3% reduction in ED attendances for those living in IMD decile 1 & 2 and living in fuel poverty, 65yrs or older living with severe/moderate frailty and loneliness • Min 3% increase in 65+ years older adults engaging in NHS health check (2019/20 baseline). • Min 3% reduction in readmissions for 65+years older adults (2019/20 baseline).
Key deliverables	• Proactive case finding those living in IMD decile 1 & 2 and living in fuel poverty, 65yrs or older living with severe/moderate frailty and loneliness (estimated 410 people) • MECC & 'nudge the odds' interventions delivered across core Place partners • Min 200 of defined cohort have Comprehensive Geriatric Assessment completed (all NHS partners) • Min 300 people receive holistic interventions and support to promote well being i.e. personalised care intervention and signposting.
Measures of success (outcomes)	• Min 10% increase in signposting from health and care professionals to identified preventative services (2019/20 baseline) • Min 100 people assessed and report an increased improvement in patient reported four measures of personal wellbeing

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Place-Based
Partnership

Key -Status
On track
Off Track recoverable
Off Track at Risk

Delivery Plan – Bassetlaw Place Based Partnership Ageing Well Programme NHS/ICB Place Led Initiatives

Output	Milestone	Due Date	Status	Lead	Partnership Support
People aged over 65 with severe to moderate frailty and lonely will benefit from clinical/ holistic review of needs and well-being.	Care Co-Ordinator identifies those people within cohort. Care Co-Ordinator invites individuals for clinical review.	March 26		Care Co-Ordinators PCNs	PCN, Practice, NHT
Targeted work focused on People aged over 65 with severe to moderate frailty and lonely will benefit from clinical/ holistic review of needs and well-being.	Care Co-Ordinator identifies those people within cohort. Care Co-Ordinator invites individuals for clinical review.	March 26		PCN INT	PCN, Practice, NHT
Those from defined cohort have CGA completed to identify treatable health concerns and delivery of care supporting improved well being.	Comprehensive Geriatric Assessment completed and coded on clinical systems (from defined cohort)	March 26		PCN INT	All NHS partners.
Roll out of MECC + Building Blocks approaches embed culture across INW and partners	BCVS deliver MECC + Building Blocks training to PBP	Q2 2025		Helen Azar BCVS	VCSE, PCN, Practices
	MECC + Building Blocks training offered & taken up across partnership.	March 26		Mark Campbell/ Keeley Azar	VCSE, BDC, DBHFT, ICB, NHT, EMAS, NCC
People are supported to receive/access holistic interventions to improve well being and remain well.	Social prescribers & Care Co-ordinators support defined cohort with personalised support offer. Ageing Well MDTs completed	March 26		PCNs/ BCVS	All partners

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Output/Activity

			2025/6				2026/7			
Ageing Well Programme										
Outcome Measures	Responsible Project Lead	Target	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Overall outcome measure aligned to Programme 1 also included in trajectory here.										
Reduction in ED attendances following falls	Mark Campbell	3%	3%	3%	3%	3%				
Reduction in Emergency admissions following falls	Mark Campbell	3%	3%	3%	3%	3%				
Reduction in readmission of over 65years (2019/20 baseline)	Mark Campbell	5%	2%	3%	4%	5%				
300 people invited to clinical review/ holistic review to support and promote health and well being i.e. personalised care intervention and signposting.	Mark Campbell	300	75	75	75	300				
Comprehensive geriatric assessment completed (from defined cohort)	Mark Campbell	300	75	75	75	300				
MECC training uptake improved across all partners	Mark Campbell	100	60	75	85	100				
Min 10% increase in signposting from health and care professionals to identified preventative services (2019/20 baseline)	Mark Campbell	10%				10%				
Min 100 people assessed and report an increased improvement in patient reported four measures of personal wellbeing	Mark Campbell	100	40	60	80	100				

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Bassetlaw PBP –Ageing Well

What we will contribute to
PCN Frailty Hubs
Bassetlaw Cancer Alliance, Timely Presentation Programmes of work, C the Signs
Cost of living partner initiatives
Lung Cancer Screening Programme
Tackling Loneliness Collaborative and PBP initiatives to reduce in social isolation and loneliness
Bassetlaw Focus on Farmers
Digital requirements for care records
Adult Core20Plus5 initiatives Investing in Communities Programme
Embed the Building Blocks of Health
Delivery and management of VCSE Services- ICB Community Investments

Bassetlaw PBP – Proactive Care Home Management

Clinical Lead	Operational Lead	Improvement Lead	Analyst Lead
Dr Kumar	TBC	Helen Azar /Leanne Monger	Helen Woods

Priority	Proactive Care Home Management
Programme Summary	Partners coming at together at Place to improve quality of care within Care Homes to support proactive management of residents to improve their health and wellbeing. Key partners NHCT, PCNs, BPL, DBTH (discharge team), Care Homes.
Aim	• Review all patients to ensure appropriate recording on End Of Life register. Include in MDT discussions going forward. • Improve advance care planning for people residing in a Care Home through the increased use of ReSPECT form. • To reduce avoidable ED attendances and emergency admissions through proactive falls prevention
What we will achieve (benefits)	• Increase number of people in care homes on End of Life register from 35.6% to 40%. Increased target by 10% from previous 2025/6 plan • Increase number of people in care homes with a fully completed ReSPECT from 67.8% to 80% • Increase in people living within a Care Home who have had a falls assessment in the last 12 months from 78.50% to 85%. Increased target of 15% from previous 2025/6 plan • Increase number of people receiving structured medication review from 60% to 70% • Increase number of Care Home residents aged 18+ with PPoD recorded from 56% to 60%.
Key deliverables	• Prioritisation of proactive case finding Care home residents not on End of Life Register reviewed (excl. LD homes) (PCN staff) • Proactive Case finding Care Home residents without a ReSPECT form reviewed (PCN staff) • Proactive Case finding of Care Home residents not had a fall assessment reviewed (PCN/NHCT) • GP/Pharmacist Supported structured medication reviews (PCN staff)
Measures of success (outcomes)	• 3% Reduction in ED attendances following falls • 3% Reduction in Emergency admissions following falls • Qualitatively measured improvement in completion of advance care planning in Care homes (data completeness) • Min 5.7% increase in frailty/EoL patients having a personalised care plan/RESPECT plan

Bassetlaw
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Partnership

Key -Status
On track
Off Track recoverable
Off Track at Risk

Delivery Plan – Bassetlaw Place Based Partnership Proactive Care Home Management

Output	Milestone	Due Date	Status	Lead	Partnership Support
85% of Residents have a personalised care plan including completion of Respect form in place where appropriate. Improved advance care planning for people residing in a Care Home.	Care Co-ordinator identifies those people not on EOL register living in care home. PCN reviews patients (65+) via MDT to ascertain whether they would be more appropriately supported through EOL register. ReSPECT forms completed. Include in MDT discussions going forward. All patients reviewed to ensure appropriate recording on End Of Life register.	March 2026		Care Co-ordinators PCNs	PCN, Practice, Care Homes, NHT
80% of residents have completed falls assessment in previous 12 months. Reduction in ED attendances following falls. Reduction in Emergency admissions following falls.	Care Co-Ordinator identifies those without fall assessment in last 6 month living in Care home. Practice/PCN/NHT workforce complete falls assessment. PCN team code completion of fall assessment. Care Home receive training on fall prevention.	March 2026		Care Co-ordinators PCNs	PCN, NHT. Care Home
70% of residents have completed structured medication review	Care Cordinator identifies those without structured medication review. PCN/Practice workforce undertake structured medication review PCN team code structured medication review completion.	March 2026		Care Co-ordinators PCNs	PCN, Practice

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Output/Activity

			2025/6				2026/7			
Proactive Care Home Management										
Outcome Measures	Responsible Project Lead	Target	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Care Co-ordinator identifies those people without EOL register living in care home PCN reviews patients (65+) via MDT to ascertain whether they would be more appropriately supported through EOL register	Care Co-ordinators PCNs	40%				40%				
ReSPECT forms completed	PCNs	80%				80%				
PCN team code completion of fall assessment	PCNs	80%				85%				
PCN team code structured medication review completion.	PCNs	70%				70%				
Care Home residents aged 18+ with PPoD recorded	PCNs	60%				60%				
Reduction in ED attendances following falls	PCNs	3%	3%	3%	3%	3%				
Reduction in Emergency admissions following falls	PCNs	3%	3%	3%	3%	3%				
Qualitative Audit of completed ReSPECT forms undertaken which shows improve in quality of ReSPECT forms. (Timed audit to allow for winter pressures)	Quality Team	20% random review	0	0	0	20%				