Since 2014, key stakeholders across Newcastle and Gateshead have developed a strong partnership approach to deliver better care. The Better Care Fund has acted as a catalyst for integration of services, teams and professions across health, social care, public and third sectors. As we move into our next integration and Better Care Fund plan, we recognise that our 'alliance' way of working underpins our wider ambitions to provide real integrated care to our residents.

Through effective joint working between health & social care commissioners we are now able, more effectively to:

- Understand local need & plan effectively;
- Jointly commission health and care services;
- Jointly monitor health & care services;
- Understand the data and review effectiveness of our interventions.

Importantly though we acknowledge that despite our approach, our health and care system has and still continues to face a range of challenges, and managing transfers is a complex task, for which there is no single answer or quick fix.

The Gateshead health care system has though worked collaboratively to implement the High Impact Change Model which has resulted in a reduction in unnecessary admissions and rapid and supported discharges to the most appropriate place for recovery rather than extended lengths of stay in an acute hospital bed. Specifically we can now demonstrate:

- Shorter lengths of stay when patients are admitted;
- Fewer patients waiting to be discharged when their acute care is complete; and
- Reductions in Delayed Transfers of Care (DToC) when compared to the original baseline figure.

In order to achieve this, there have been a number of system-wide improvements which have been implemented that have improved patient flow throughout all parts of the system which include being able to pro-actively manage transitions through the provision of timely and accurate information, good communication between hospital and primary care physicians, integrated working between health and care staff (acute and community based) and a single point of co-ordination.

Importantly the system has also moved beyond small-scale projects implemented initially to ensure delivery of the 8 Changes in the HICM (and as described in previous BCF submissions) and adopted comprehensive and mainstreamed admission avoidance and supported discharge programmes influenced by multiple evidence-based strategies and as part of a long term strategic commitment to integrating service provision between all key stakeholders.

Going forward our approach will be aligned not only to further embedding and enhancing the core components of the HICM but will also pro-actively target and support people with chronic, long-term conditions and the rapidly increasing frail, elderly population living within the Borough. Indeed as the vast majority of our emergency admissions result from acute exacerbations of one or more long-term conditions or is frailty related, we will focus on the proactive management of people through improved, comprehensive and standardised care planning. We will also better integrate community health and care teams as well as work closely with the

third and independent sector so that when an admission is necessary, patients can be transferred from an inpatient environment to a community setting with no delays and are able to continue their rehabilitation therapy at home (or normal place of residence) with the same intensity and expertise that they would receive in hospital. The evidence collected as a result of the CCGs participation in the Care Home Vanguard programme will also be used to deliver the components that have had the highest impact on the resident's quality of care to all of our Care Homes and join up primary, community and secondary, social care to residents of care and nursing homes, via a range of in reach services.

In developing our future plans we have reviewed and measured the success of existing services implemented as part of the of the High Impact Change Model and will continue to embed and then further improve these services, focussing on:

- Enhancing out of hospital health & care services –integrated around the individual;
- Joining up approaches to self-care and management of long term conditions and frailty in the community;
- Joining up our approach to assessment & care planning – proactive support to assist people in managing conditions and care;
- Increasing primary care MDT working and proactive interventions;
- Integrated Rapid Response services in the community, with dedicated clinical and social care support.