Gateshead Better Care Fund Narrative Plan 2021/22

Health and Wellbeing Board

1. Gateshead Health & Wellbeing Board.

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

2. The Gateshead BCF Plan for 2021/22 is part of a wider programme of work to integrate health and care across Gateshead Place for the benefit of local people and their communities and therefore must not be seen as a stand-alone Plan. This broader programme of work is being driven by 'Gateshead Cares' i.e. Gateshead Place health and care system which is representative of:
    - NHS Newcastle Gateshead CCG
    - Gateshead Council
    - Gateshead Health NHS FT
    - The Newcastle upon Tyne Hospitals NHS FT
    - Cumbria, Northumberland, Tyne & Wear NHS FT
    - Community Based Care Health Ltd
    - Blue Stone Collaborative
    - VCS (via Connected Voice)

3. The programmes of work undertaken by Gateshead Cares partners are undertaken in collaboration with provider representatives across the health and care sector. This includes the adult care home model which encompasses older persons care homes, working age care homes, promoting independence centres and mental health specialist centres.

4. Our approach to the BCF Plan, building upon what is already in place for 2021/22 and arrangements for bringing the BCF Plan together have been discussed by the:
    - **Integrated Commissioning Group**, which includes representatives of commissioners and providers;
    - **Gateshead Cares System Board**, representative of the organisations listed under paragraph 1 above;
    - **Gateshead Health & Wellbeing Board**, representative of statutory and other partners at Gateshead Place
    - **Newcastle Gateshead CCG's Executive Committee**
    - **Gateshead Council's Corporate Management Team**

5. Our BCF Plan continues to be developed in collaboration with stakeholders across health and care, with review and refinement of schemes overseen by the NGCCG, Council and Gateshead Health Foundation Trust. The strong joint working arrangements across local system partners are well embedded and ensure that a whole system integrated approach to health and care in Gateshead is at the forefront when reviewing and developing our models of care and schemes that form part of the BCF.

6. We will continue to involve and collaborate with a wide range of partners in further developing our approach to integrated health and care for Gateshead Place in future years. This will also incorporate BCF Plans for future years beyond 2021/22.

Executive Summary

This should include:

- *Priorities for 2021-22*
- *Key changes since previous BCF plan*

7. We see the integration of health and care in Gateshead as an evolving journey where the BCF Plan is part of that journey and part of broader programmes of work to provide person centred, joined-up health and care to local people in a way that is responsive to their particular needs and is sustainable.

8. Our collective response as a system to the challenges presented by the pandemic has further strengthened our resolve in taking the next steps along that journey, building upon the strong foundations already in place and embedding learning from the pandemic.

9. Our approach to integration is informed by the Primacy of Place, which is a key underlying principle. This means that, as far as possible, integrated planning of services is undertaken at Gateshead Place and provision of services is as close to peoples' homes as possible.

10. The focus for the Gateshead Cares (our Health and Care System at Gateshead Place) continues to be to shift care upstream to prevent the levels of ill health our population experiences, to provide integrated and proactive care and support whereby ill health is managed earlier and more effectively. These approaches are crucial to reducing the need for high cost acute care and long term care packages thus improving health and wellbeing and managing cost in a sustainable way.

11. Our collective experience and response to the pandemic has further demonstrated the importance of working together to prevent and reduce admissions to hospital; to support safe, timely and effective discharge; to improve outcomes for people being discharged from hospital with a focus on 'home-first' and to ensure that addressing health inequality is embedded across our programmes of work.

Priorities for 2021-22

Our broad priorities for 2021/22 can be summarised as follows (with further detail provided under the section on our overall approach to integration):

- To build upon the strong foundations already in place across our local system in developing our approach to health and care integration.
- To support safe, timely and effective discharge from hospital and to progress a home-first approach.

- To develop an enhanced Integrated Commissioning and Placement function that supports the Hospital Discharge service to maximise same day discharges for hospital as well as supporting additional work around transforming local services.
- To support and work with providers of health and care across our local system in addressing the unique challenges presented by a combination of the pandemic, winter pressures and the implementation of recovery plans.
- To continue to develop new models of care to better meet the needs of local people in an integrated and sustainable way, whilst also addressing inequalities.
- To embed learning from the pandemic in developing our plans in future years and to enhance our resilience as a system.

Approach to setting Metrics for 2021/22

12. In developing our metrics for the BCF plan system partners from the CCG, Council and Gateshead Health FT have worked together to collectively review data sets and intelligence in order to agree and set realistic trajectories at a Gateshead system level.

13. Our approach has included reviewing health and social care activity, plans for hospital discharge and plans for reducing length of stay as they are key components which will contribute to the improvements agreed against BCF national metrics for hospital discharge.

14. In our discussions we have carefully considered what is causing delays to discharge and what actions are being taken through the BCF and wider implementation of the hospital discharge policy and links with the Ageing Well work programme, including achieving the 2 hour Urgent Community Response (UCR) target.

15. In developing or BCF plan and metrics, it is important that we ensure we are making the right connections to Ageing Well and Urgent Community Responses as Ageing Well is integral to delivery of the NHS Long Term Plan and NENC ICS ambitions to improve out-of-hospital care, reduce pressure on hospital services, give people more control over their health and more personalised care when they need it. The UCR is supporting improvement of the quality and capacity of care for people through delivery of crisis response care within two-hours and reablement care within two-days.

16. Across the Gateshead system we are currently gathering information and intelligence in relation to current services for the maturity matrix which will support the development of the 2hr UCR action plan; this will also build on the Ageing Well programme.

17. Although detailed narratives and progress against the High Impact Change Model have not been collected in 2021 we are cognisant that the model remains best practice, reinforces the Hospital Discharge Policy and is closely aligned with our BCF funding streams supporting hospital discharge and the implementation of ‘home first’. This has also been reviewed when developing our metrics.

18. We have also been mindful of the need to consider health inequalities and inequalities in access to services as part of this process.

19. The rational for the metrics set for 2021/22 are set out at Appendix 2.

Key changes since previous BCF plan

20. The previous BCF Plan (2020/21) was a continuation of the Plan approved for 2019/20 in line with government guidance and in recognition of the overarching need as a system to respond to the challenges presented by the pandemic.

21. At the time of submission of our BCF Plan for 2021/22, we will already have completed almost 8 months of the 2021/22 year period. Our submission, therefore, reflects both:
    - a continuation of the 'steady-state' that has served our local system well - continuing and building upon our schemes;
    - an eye to the future - setting the ground to enable us take forward our future aspirations together.

22. As in previous years, the Better Care Fund consists of a pooled budget created from three mandatory funding sources:
    - The CCG minimum contribution
    - Improved Better Care Fund (iBCF)
    - Disabled Facilities Grant (DFG)

23. Whilst the iBCF and DFG pools remain at the same level as in 2020/21, the CCG minimum contribution requirement has increased. The Gateshead specific figures are shown below, which in real terms is a 4.5% increase to the overall minimum CCG contribution:

Gateshead Better Care Fund Contributions		2020/21	2021/22	Increase in 21/22	
DFG		£2,111,149	£2,111,149	£0	
Minimum CCG Contribution		£16,950,796	£17,713,351	£762,555	4.5%
	NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£4,746,839	£4,933,892	£187,053	3.9%
	Adult Social Care services spend from the minimum CCG allocations	£6,661,430	£6,961,103	£299,674	4.5%
	Balance	£5,542,528	£5,818,356	£275,828	5.0%
iBCF		£11,051,841	£11,051,841	£0	
Winter Pressures Grant					
Additional LA Contribution		£0	£0	£0	
Additional CCG Contribution		£0	£0	£0	
Total		£30,113,786	£30,876,341	£762,555	

24. As in previous years, guidance allows CCG and Council contributions to be in excess of the nationally prescribed minimum contributions; however, in line with previous years, the pool has been matched to national expectations. Allocation of the 'growth' funding within the BCF pool against schemes has undergone a review, refresh and refine process to ensure that the funding is utilised in the most effective way to align with the Better Care Fund Metrics. This includes the development of an enhanced Integrated Commissioning and Placement function that support the Hospital Discharge Service to maximise same day discharges for hospital as well as supporting additional work around transforming local services.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

25. As has been mentioned, the BCF forms part of wider system working to integrate health and care which is being progressed by Gateshead Cares, our Health and Care System Board and is accountable to Gateshead's Health & Wellbeing Board.

26. Governance arrangements for developing our BCF Plan continues to be through the Integrated Commissioning Group which has responsibility for managing the BCF to support integrated working and ensure that the processes around the BCF are robust. Arrangements complement those for broader system working through the Gateshead Cares System Board with formal sign off of the BCF Plan through the Health and Wellbeing Board.

27. Progress in implementing our BCF Plan through template returns and end of year returns to NHSE/I are also reported to the Integrated Commissioning Group and Health & Wellbeing Board as required. The Integrated Commissioning Group reviews and monitors progress against our schemes and plans to meet the national conditions, as well as performance against key metrics linked to the BCF. It also oversees our BCF Section 75 agreement and its implementation.

Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including:

- *Joint priorities for 2021-22*
- *Approaches to joint/collaborative commissioning*
- *Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.*
- *How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21*

28. Our overall approach to integration is built upon a collective leadership approach which has stood Gateshead Place well during the pandemic and which saw the LGA produce a good practice guide on the work undertaken by Gateshead Cares: LGA Covid-19 Good Practice Case Study: Gateshead's collective leadership approach

29. A case study on Gateshead Cares collective leadership approach was also included within the 'Social Care State of the Nation report, The Future of Social Care: Turning Rhetoric into Reality', launched in July of this year.

Joint priorities for 2021-22

30. Our broad priorities for 2021/22 can be summarised as follows:
    - To build upon the strong foundations already in place across our local system in developing our approach to health and care integration.

- To support safe, timely and effective discharge from hospital and to progress a home-first approach.
- To develop an enhanced Integrated Commissioning and Placement function that supports the Hospital Discharge service to maximise same day discharges for hospital as well as supporting additional work around transforming local services.
- To support and work with providers of health and care across our local system in addressing the unique challenges presented by a combination of the pandemic, winter pressures and the implementation of recovery plans.
- To continue to develop new models of care to better meet the needs of local people in a way that is sustainable whilst also addressing inequalities.
- To embed learning from the pandemic in developing our plans in future years and to enhance our resilience as a system.

31. These priorities for 2021/22 are consistent with and complement the priorities that have been developed for the Integrated Gateshead Team at Appendix 1.

Approaches to joint/collaborative commissioning and overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care

32. Building upon the collective leadership approach that has been adopted and taken forward by Gateshead Cares, referred to above, the Gateshead System developed an Alliance Agreement in April 2021 building upon a MoU that had already been in place.

33. The Alliance Agreement has provided an opportunity for the Gateshead system to set its stall out, making the most of the relationships that have been developed at Place over a long period and looking to maximise benefits for the Gateshead population in the future. The Agreement is intended to facilitate further progress towards integrated commissioning and delivery of health and care services across Gateshead.

34. The Alliance Agreement differs from the existing MoU in a number of key respects:
    - It is a legally binding agreement;
    - It sets out details of work programme areas that partners are committed to take forward through the Agreement during 2021/22;
    - It formalises governance arrangements to support the delivery of those programmes;
    - It will be an evolving Agreement which will be reviewed and developed further on a regular basis i.e. it will be an iterative process;
    - Importantly, it provides a framework that the Gateshead system can use to build upon.

35. The Alliance Agreement covers:
    - Vision and core objectives of the Gateshead Health & Care System
    - Values and principles of joint working
    - Obligations and roles under the Agreement
    - Arrangements to review / vary the Agreement
    - Governance Arrangements
    - Programme Areas to be included within the Agreement

36. The Gateshead System's vision is derived from Gateshead's Health & Wellbeing Strategy 'Good jobs, homes, health and friends" and it supports Gateshead's Thrive agenda - 'Making Gateshead a place where everyone thrives'.

37. The Gateshead System has confirmed:
    - The importance of the primacy of 'Place' and subsidiarity principle, whereby decisions should be taken as close to communities as possible.
    - The need to focus on addressing health and other inequalities, which have been exacerbated by the pandemic.
    - The need to protect and to continue to develop relationships at Place.
    - The importance of Provider collaboration and mutual co-operation, rather than competition.

38. The core objectives of Gateshead Cares within the Alliance Agreement are to:
    (i) reduce levels of inequality through tackling the circumstances that lead to inequality;
    (ii) shift the balance of services from acute hospital care and crisis interventions to community support with a focus on prevention, early help and self-help, matched by appropriate resource levels;
    (iii) support the development of integrated care and treatment for people with complicated long-term health conditions, social problems or disabilities;
    (iv) create a joint planning and financial framework for managing the difficult decisions required to ensure effective, efficient and economically secure services, getting the most from the Gateshead £.

39. Gateshead System partners identified the following work programme areas for inclusion within the Agreement, subject to annual review and work plans have been developed for each area:

    (i) CYP Best Start in Life: SEND (including transition to adulthood)
    (ii) Older People: Older Persons Care Home Model (now broadened to Adult Care Home Model)
    (iii) Older People: Frailty (Strength & Balance)
    (iv) Mental Health Transformation
    (v) Development of PCNs

40. Other programmes of work to integrate health and care for the benefit of local people include:
    - 'People@ the Heart – programme of work focusing on people with multiple and complex needs
    - Community Services Review
    - Enablers of Integration – Workforce (e.g. Integrated Teams) and Digital (e.g. Digital Inclusion)

41. The BCF Plan therefore forms part of these broader work programmes to integrate health and care at a local level in Gateshead – it does not exist in a silo.

42. When agreeing how BCF funding is used we have also been cognisant of the need to ensure a continued alignment to wider plans, such as those funded through the NHS Long Term Plan, Hospital Discharge fund, Ageing Well, The 2hr Urgent Community Response (UCR) etc.

43. We are currently gathering information and intelligence in relation to current services for the 2 hr UCR maturity matrix which will support the development of the 2hr UCR action plan. We believe this will support priorities on enhancing out-of-hospital care; reducing pressure on hospital services; and supporting the collaborative working required to deliver the requirements of the hospital discharge operating model.

44. We are also focused on using the DFG to promote joined-up approaches to meeting people's needs to live in suitable housing so they can stay independent for longer as we know this can make a significant contribution to health and wellbeing and is a key part of our integration plans.

45. Our BCF plan highlights a number ways in which the Gateshead system is linked with the NENC ICS, and person centred health and care agenda, including through the Ageing Well and Population health and prevention workstreams of which we are active participants, and allows us to locally deliver the best outcomes for patients and service users.

46. We also have clear alignment between our BCF plan, UEC networks and A&E Delivery Boards in Gateshead, through our Associate Director for Transformation, System Resilience and EPRR - this is a joint post between NGCCG and the Council.

47. Other joint posts established to progress health and care integration include:
    - Director for the Gateshead System (NGCCG and the Council)
    - Associate Director for the Gateshead System (NGCCG and the Council)
    - Public Health Consultant (Gateshead Health FT, Council and NGCCG)

How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

48. Programmes and services funded by the BCF support the core objectives of Gateshead Cares set out above under the section on 'Approaches to joint/collaborative commissioning'. They are focused on shifting the balance of services towards community support with a focus on prevention, early help and self-help to avoid hospital admissions; developing integrated care and treatment for people with health and care needs; minimising the length of stay in acute settings and supporting home first discharge arrangements where feasible.

49. Our BCF schemes:
    - Reflect a continuation of the 'steady-state' that has served our local system well during the pandemic;
    - Provide a foundation that we will build upon to enable us to take forward our ambitions through integrated care models beyond the current 2021/22 year.

50. Allocation of the 'growth' funding within the BCF pool against schemes has undergone a review, refresh and refine process to ensure that the funding is utilised in the most effective way to align with the Better Care Fund Metrics**.** This includes the development of an enhanced Integrated Commissioning and Placement function that supports the Hospital Discharge service to maximise same day discharges for hospital alongside work to transform local services, consistent with our ambitions relating to the integration of health and social care.

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

51. Throughout the pandemic health and social care colleagues across partner organisations have worked seamlessly to manage the flow of people out of hospital, through reablement services and onto health and care assessment processes. The Council continues to prioritise services which support discharge, including reablement at home (PRIME) and bed based reablement (Promoting Independence Centres) with additional capacity from other services such as day centres. The discharge liaison and hospital social work functions are completely aligned in delivering the Discharge to Assess model, and then ensuring that people receive a timely assessment post discharge.

52. There are, however, significant pressures within the system, with the lack of home care capacity being one of the greatest concerns which has meant that a substantial number of people have had difficulty accessing home care services due to a lack of availability. The Gateshead Health and Care System is working jointly to identify potential solutions, but the issue is a deep rooted and endemic one in respect of the home care workforce, which the pandemic has worsened. Hospital discharges continue to be prioritised, and partners are proactively considering options in terms of the additional workforce funding granted; however, the temporary nature of the funding does present a challenge in itself. Since the recent announcement of additional workforce capacity funding, system partners have come together to agree the best utilisation of the funds, which will focus predominantly on retention of the existing workforce during the winter period.

53. Provision has been made within the BCF Plan for recurrent support for the Hospital Discharge Programme, including non-recurrent management over winter. The £626k scheme is a recurrent commitment to funding the Hospital Discharge Programme once the national funding ends in March 2022. During 2021/22, this funding will be used flexibly for non-recurrent winter support to care systems where required, whilst acting as the catalyst funding to put new schemes in place to support the HDP agenda so that once national support ends the Gateshead system has recurrent solutions in place.

54. We recognise the important role of informal and unpaid care in providing support to some of our most vulnerable residents. The care provided not only enhances the quality of life of those individuals but also helps to prevent unnecessary admission to

hospital. Informal carers need to be supported in their role accordingly in order to avoid negative impacts on their own health and wellbeing and their ability to fulfil this important role. Carer support is provided in a number of ways and assessments are undertaken to determine their needs. Health and care partners work together to provide appropriate care and support to enable a safe hospital discharge and involve carers as part of these arrangements.

55. To ensure that families and carers are supported on discharge, Age UK offer a telephone service for all patients discharged to identify any issues with ongoing care and to offer support, and Gateshead has recently introduced a new Carer Assessment process, delivered by Gateshead Carers Association, to improve uptake in Carer Assessment and Support.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

56. Gateshead Cares (Health and Care System) recognises the importance of the adaptations services that it delivers to support vulnerable people to remain in their own homes.

57. These services, which reach across all housing tenures, engage with individuals, their families and carers who need, or in the future may need, services and support to lead their lives and thrive. Ensuring that these services are delivering well is central to achieving effective delivery in health, social care, early intervention and prevention.

58. A strategic system wide review of Occupational Therapy services took place last year, this included the Disabled Facilities Grant and adaptations services. This review is ongoing and will be taken forward by a Senior Programme Manager.

59. Work has also been undertaken to align the infrastructure in relation to occupational therapy capacity with the available DFG resources. In addition, processes in relation to progressing adaptations works have been considered to remove unnecessary barriers and improve the pace at which adaptations can be undertaken.

60. A revised version of the Disabled facilities Grant (DFG) policy is now in place. This policy has provided an opportunity to make a real difference to the lives of vulnerable and disabled people in Gateshead by exercising greater flexibility in the use of DFG / BCF through the discretionary powers in the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO).

61. An options appraisal examining major and minor adaptations services in Gateshead is ongoing, to consider the structure, skills mix and delivery model of existing services and inform future decision making about the delivery of adaptations services. The development of a home improvement agency is being explored which will help develop cost and process efficiencies, whilst offering an improved and more extensive service to vulnerable people within Gateshead.

62. Embedded within the Council's housing strategy is the integration of health and housing within our strategic planning. Housing is a basic human need and good quality homes are essential to ensuring that residents have the best physical and mental health possible. A warm, dry home, free from hazards and with sufficient space is a positive contributor to health and wellbeing.

63. Conversely, poor housing and homelessness are key drivers of social exclusion and contribute to lower life expectancy and preventable causes of death. Each year 233 people per 100,000 in Gateshead die from causes considered to be preventable, compared to the England average of 185 per 100,000. There are three strategic themes: supply, standards and support.

64. Housing Support can help break the cycle of disadvantage and inequity. Support is provided in many ways and by a range of organisations including the Council and The Gateshead Housing Company, registered housing providers, the voluntary and community sector, and the NHS. The Council and its partners want to provide Gateshead residents with the right type of advice and support, that is proportionate, timely and at its heart promotes independence and equality.

65. The implementation of the new DFG policy, and the Occupational therapy and adaptations review activity together with the wider BCF spending plans are identified in the strategy as an enabler to helping people live independently and sustain their independence. The strategy also recognises the need to reduce avoidable hospital admissions and reduce delayed hospital discharges by ensuring people are able to access suitable accommodation and support in a timely way.

Equality and Health Inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

(i) Changes from previous BCF plan.
(ii) How these inequalities are being addressed through the BCF plan and services funded through this.
(iii) Inequality of outcomes related to the BCF national metrics.

66. Our BCF plan and broader plans at Gateshead Place take an integrated and holistic approach to the health and wellbeing of people in Gateshead, underpinned by the Gateshead Joint Strategic Needs Assessment (JSNA). This has enabled us to understand the key issues facing people within our communities and to identify key strategic priorities to improve their health and wellbeing.

67. Our integrated ways of working across the Gateshead system enables a place-based approach to health inequalities, including the wider determinants of health; work, housing, environment etc, and with partners working collaboratively to identify opportunities to address health inequalities:

- Work by public health colleagues to identify and analyse the main drivers of inequalities in health outcomes and access within communities.
- Developing plans which incorporate actions from partners to address the wider determinants of health.
- Ensuring plans include locally agreed targets to reduce health inequalities.
- Engaging with Voluntary, Community and Social Enterprise (VCSE) sector and local residents to ensure actions build connected and empowered communities.
- Using the Health Inequalities toolkit to support this work in the Acute Trust to prioritise patients.
- Ensuring that social care delivery is framed in the context of the Council's 'Thrive' agenda, which pledges to 'tackle inequality so people have a fair chance'.
- Utilising the Gateshead Local Index of Need (LIoN) data to inform service delivery.

68. Within Gateshead, we continue to develop risk stratification techniques, and person-centred care to identify at risk groups for our population. The continued building of relationships between primary and secondary care and the Council during the pandemic has further strengthened collaboration, developing closer working relationships across PCNs, including a focus on addressing inequalities, to help ensure that people with complex needs receive the support they need. Specific examples of population health management approaches include:

    - Colleagues across the Gateshead system have been involved in developing the Gateshead system outcomes framework, linking this to our inequalities agenda.
    - Developing metrics at PCN level to facilitate engagement with PCNs, including the development of PCN Heatmaps for them to incorporate both health data and indicators looking at the wider determinants of health. This will inform PCN planning to address inequalities.
    - Working with NECs to explore how Axiom can be linked to the outcomes framework to link datasets together at patient level to address inequalities.
    - The CCG is continuing to support our general practices to provide personalised care and support planning for people with long term conditions with a focus on patient preparation, shared decision making etc.
    - Ensuring that Community Health resources are aligned to effectively prioritise areas with high levels of inequality and bespoke, targeted roles introduced to support this.

69. Our experience of responding to the challenges posed by the pandemic demonstrated that communities that experience health and other inequalities were more adversely affected, not only in terms of their physical and mental health, but also its impact on their broader wellbeing and resilience.

70. This experience has enhanced our understanding of the impact of health inequalities within our communities. Poverty and health inequalities are sadly more apparent in our communities and we understand the direct impact that this has on poor health outcomes. We know that if we are to improve peoples' life chances, their opportunities and those of local communities, we need to work together in a different way building upon the assets within communities and taking a far broader view of opportunities to create the conditions where health and wellbeing is able to thrive.

71. Population health management will have a greater focus in the new NENC ICS and Gateshead Cares will work closely with wider system partners to establish population health intelligence to draw on this insight to support care redesign locally, building on existing expertise across the Place and system. Going forward this will be a key component of our approach to addressing health inequalities.

72. Impact assessments inform decisions on the type and nature of support provided, particularly to our most vulnerable residents and communities. BCF schemes have supported individuals with protected characteristics and supported work to reduce health inequalities. The introduction of Community Nurse Practitioners in all Older Person's Care Homes has ensured that this vulnerable group are supported effectively across Gateshead with robust multi-disciplinary plans to ensure that the care they receive is timely and appropriate, with 24/7 urgent support delivered at all Care Homes as an alternative to hospital admission.

73. Hospice @ Home has been introduced throughout Gateshead to provide end of life support. Part of this initiative is specifically focused on expanding the choices for end of life care to those whose geographical isolation, or social preferences have previously meant that this is a challenge.

74. The Nurse Clinical Educator posts have ensured that the quality of care throughout Care Homes is enhanced with the recent introduction of the Health Call scheme to work alongside this.

75. Although not directly related to BCF, we have the following examples of how the Gateshead system is enabling place-based approaches to health inequalities, including the wider determinants of health to identify opportunities to support the reduction in health inequalities:

    (i) Following the start of the pandemic where delivery of Annual Health Checks to those with a learning disability was significantly reduced, we focused on the delivery of this agenda to subsequently integrate the voice of people with LD working closely with NGCCG, third sector, Council and CNTW. This resulted in achieving an 82% uptake for patients on Learning Disabilities registers in Gateshead 20/21. We have also proactively provided care for people with additional needs, whose health risks and opportunities may otherwise be unrecognised and are ambitious to build on the successes to-date.

    (ii) The Gateshead Outer West PCN includes the communities of Chopwell, Rowlands Gill and Blaydon: areas that are within the 20% most deprived areas in England, according to the Index of Multiple Deprivation. Between 2019 and 2020, NGCCG undertook research to establish how these communities accessed their local GP services. We also asked the communities how they would prefer to access local GP services. The findings and recommendations were collated into a report: 'Exploring patients views of using digital solutions in GP practices'.

    244 patients shared their views alongside 13 stakeholder organisations who work with BAME, Carers, Children and Young People, Disabled People, Families,

LGBTQ+ People, Older People, People requiring support around drugs and alcohol and people requiring support around emotional wellbeing.

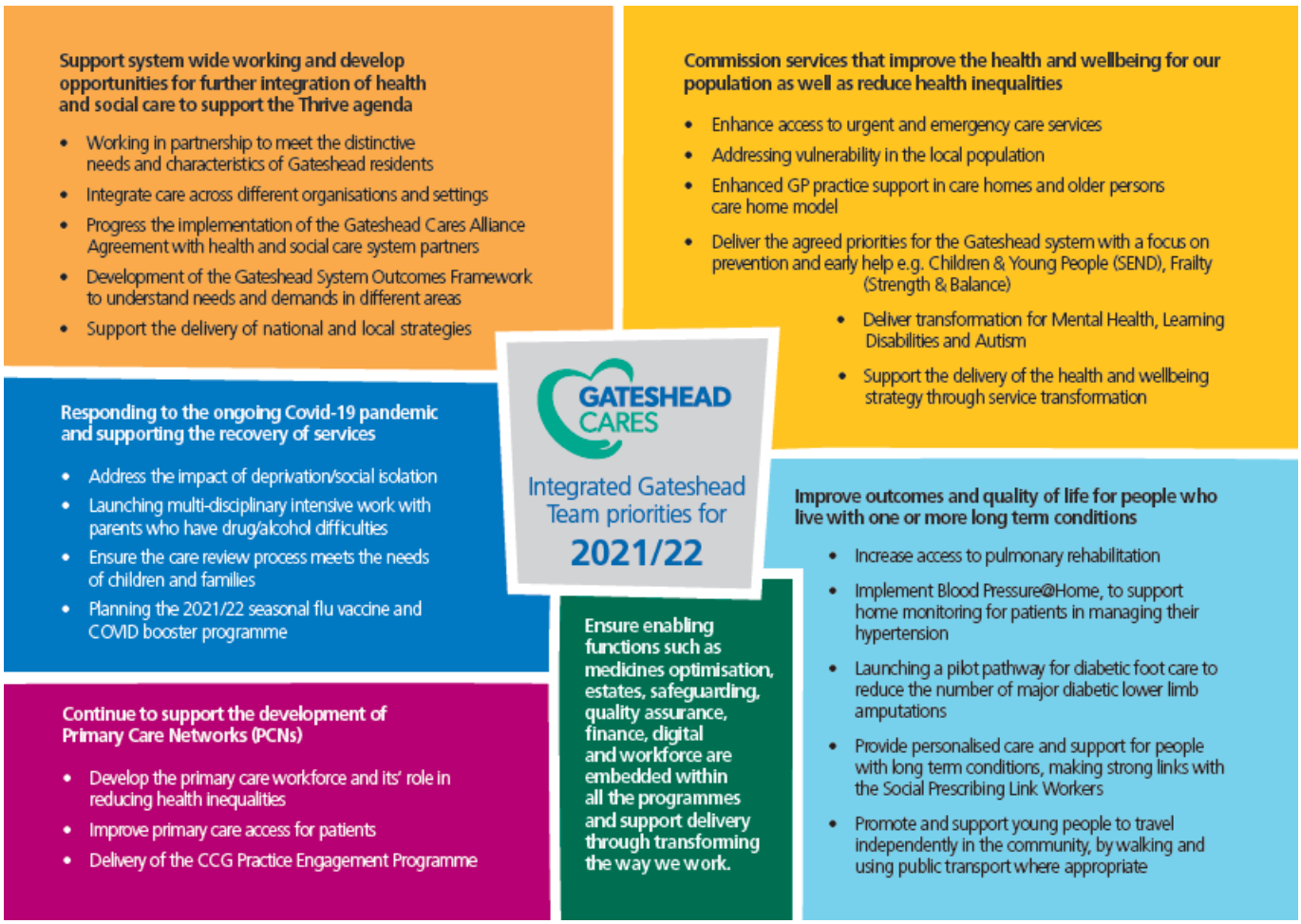
Almost 80% of patients indicated that they preferred to make their initial appointment with the GP practice by telephone and those who preferred to make online appointments were more likely to be male or patients without a disability or long-term illness. The most common reason given by those preferring making initial contact by telephone was because it was perceived to be easy, quick and convenient.

Although around 90% of patients were aware of alternatives to face-to-face consultations (including telephone and video consultations), a majority of patients 67.1% still preferred face-to-face consultations. This was true of patients across all age groups and abilities. Being able to be seen visually was the most frequently given reason by patients who preferred video consultations. Many of these patients also indicated that felt it was the safest way to have a consultation during the pandemic.

Some of our report's recommendations include improving "traditional" ways of making bookings (incl. telephone) to ensure that those who can or will not use other methods still receive an equal service from their practice.

Appendix 1

Integrated Gateshead Team Priorities for 2021/22



Appendix 2

Rationale for the Metrics set for 2021/22

The rationale for the Metrics set for 2021/22 is as follows:

Avoidable admissions

There was a significant drop in unplanned hospitalisations for ambulatory care sensitive conditions at the onset of the pandemic and there has been a gradual increase to pre-pandemic levels through this year. Given the challenging winter, it would seem sensible to set a plan for this year at a rate of 1,200 admissions per 100,000. Already in April – August 2021, the rate is high at 1,098; therefore, we are planning for an anticipated further significant increase through the winter months given this has been an unprecedented year and is expected to be a difficult winter. Although the 2 hour crisis response is being embedded throughout this year, this is not expected to have full impact in this financial year, due to the significant pressures which are currently being felt across the system. Furthermore, patients are presenting with higher levels of acuity and whilst these patents are being responded to within the 2 hour timeframe, they then require further clinical input or support which invariably requires an impatient stay. To this effect we feel that to maintain the current level of admissions is unrealistic and this will increase further to 1200 admissions per 100,000.

Plans are in place to ensure that admission avoidance schemes are maintained, while ensuring that the concerns regarding a challenging winter are adequately reflected. Improvements include the introduction of additional Community Nurse Practitioners into all Older Person's Care Homes and the introduction of a more robust 2 hour community response which should assist to achieve these aims. We believe such plans will help prevent the admission rate increase to what could be to unprecedented levels, with a lesser growth to 1200 per 100,000.

Length of Stay (LOS)

Discharge to Assess (D2A) schemes are in place to reduce length of stay following Government statutory guidance on discharge. Once patients no longer meet the Right to Reside criteria, a prompt discharge from hospital is arranged via the discharge hub. This may include support from PRIME, PICs, placement in a residential care home, support from a local care provider or support from Hospice at Home, support from District Nurses or Rapid Response team. It is anticipated that this will continue going forward and that the opening of the new Intermediate Care Facility in Gateshead in 2022 will complement this. Agreement to maintain the baseline data which has been published (currently at 10.3% 14+ and 5.3% 21+), which will be a challenge throughout what is expected to be a challenging winter. Significant pressures in the system, with lack of home care capacity being of the highest concerns, and there being a substantial number of people who cannot access home care services due to lack of availability. The Gateshead Health and Care System is working jointly to identify potential solutions, but the issue is a deep rooted and endemic one in respect of the home care workforce, which the pandemic has worsened. Hospital discharges continue to be prioritised, and partners are proactively considering options in terms of the additional

workforce funding granted, however the temporary nature of the funding does present a challenge in and of itself.

Discharge to normal place of residence

We hope to maintain the current level of 92% discharged to usual place of residence; however, we recognise that this may be challenging as care packages for the Home Care market are limited at the current time. Despite health and social care colleagues working seamlessly to manage the flow of people out of the hospital, through reablement services and onto health and care assessment processes, maintenance of this challenging target will be difficult. The Council continues to prioritise services which support discharge, including reablement at home (PRIME) and bed based reablement (Promoting Independence Centres) with additional capacity from other services such as day centres. The discharge liaison and hospital social work functions are completely aligned in delivering the Discharge to Assess model, and then ensuring that people receive a timely assessment post discharge. There are however significant pressures in the system, with lack of home care capacity being of the highest concerns, and there being a substantial number of people who cannot access home care services due to lack of availability. The Gateshead Health and Care System is working jointly to identify potential solutions, but the issue is a deep rooted and endemic one in respect of the home care workforce, which the pandemic has worsened. Hospital discharges continue to be prioritised, and partners are proactively considering options in terms of the additional workforce funding granted, however the temporary nature of the funding does present a challenge in and of itself.

Residential admissions

Care home admissions – Based on a population of 40,273 and a planned target of 890.2 per 100,000.

Due to the pressures on the Adult social care workforce (particularly home care) and the focus on D2A, it is noted that this is going to be a very challenging target to meet. Focus is being maintained on reablement services, and a new extra care scheme is due to open in January 2022, which will see some people ‘diverted’ from residential care.

Reablement

The service is seeking to attain the 87.9% target by continuing to promote the independence of service users within its short term residential (Promoting Independence Centres) and domiciliary care (PRIME) provision. A further performance management approach is being introduced in late 2021 to maximise the amount of ‘hands on’ hours delivered by each PRIME Domiciliary care employee. Furthermore, the Promoting Independence Centres are integrating the Encop (Enhanced Care of Older People) framework which will not only serve to optimise the individual functioning of service users, but, through its relationship based values approach, will also lead to the development of the skills and confidence of individual practitioners in how they go about their role.