Gateshead Better Care Fund Narrative Plan 2022/23

Contents

Introduction

In line with the requirements of the planning process and BCF Policy Framework, this document ***describes our approach in updating our BCF plan***, which has been to focus on how commissioners and providers will ***work together in 2022-23 to:***

- ***continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services***
- ***set out how the Gateshead system will make progress against the two objectives set out in national condition 4***
- ***provide an overview of how BCF funding is supporting unpaid carers***
- ***priorities for promoting equality and reducing health inequalities***

Health and Wellbeing Board

Gateshead Health & Wellbeing Board.

1. The Gateshead BCF Plan for 2022/23 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. the Gateshead Place health and care system which is representative of:***

    - ICB Gateshead Place (formerly 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
    - VCS (via Connected Voice)

2. The programmes of work of Gateshead Cares partners are being ***undertaken in collaboration with representatives across the health and care sector.*** This includes the ***adult home care*** and ***care home models***, ***promoting independence centres, housing*** and ***mental health specialist centres*** for adults of working age and older persons.

3. Our work within the ***Care Home sector*** is aligned and supports the national ***Enhanced Health in Care Home*** NHS operating model and is driven through our ***Primary Care Networks and their wider neighbourhood teams.*** These are supported by Community Nurse Practitioners in each older persons' care home and Community Geriatricians working through MDT's to ensure that Care Home residents are appropriately supported.

4. Our approach to the BCF Plan, building upon what is already in place for 2022/23, and arrangements for bringing the BCF Plan together have been considered by the:

    - **Integrated Commissioning Group**, which includes representatives of commissioners and providers;

    - **Gateshead Cares System Board**, representative of the organisations listed under paragraph 2 above;

    - **Gateshead Health & Wellbeing Board**, representative of statutory and other partners at Gateshead Place

    - **ICB (Gateshead Place)**

    - **Gateshead Council's Corporate Management Team**

How we involved our stakeholders in preparing the Plan

5. Our BCF Plan continues to be ***developed in collaboration with stakeholders*** across health and care, including housing, with a review of schemes overseen by the ICB (Gateshead Place), Gateshead 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. This will also incorporate BCF Plans for future years beyond 2022/23.

Executive Summary

7. This section includes:

    - Priorities for 2022-23
    - Key changes since the previous BCF plan

8. In July 2022, the ***North East and North Cumbria Integrated Care Board (NENCICB) was*** established which took on the responsibilities of former CCGs. It aims to work collectively, joining up resources and expertise to provide the best health and care for local communities, and is responsible for ensuring that high quality and safe health services are accessible to all communities.

9. The ICB has a wide range of functions including ***promoting integration of health and care services, improving people's health and wellbeing, and reducing health inequalities.*** ICB staff also work at place level with local Health and Wellbeing Boards in each of the 13 local authority areas. These teams also work alongside 64 primary care networks, social care teams and other community-based area providers.

10. By ***working with local communities, partner organisations and health and care staff***, the ICB's ambition is to significantly improve the health and wellbeing of the people who live in the region and create a health care system which is fit for the future.

11. The ICB has agreed the ***following overarching objectives***, which have also been ***mapped to Gateshead place-based priorities (Appendix 1)***

    - Improve outcomes in population health and healthcare
    - Tackle inequalities in outcomes, experiences and access
    - Enhance productivity and value for money
    - Help the NHS support broader social and economic development

12. The overarching strategy for Gateshead Place is our ***Health & Wellbeing Strategy 'Good jobs, homes, health and friends'*** which sets out where we need to focus our attention to ***reduce levels of inequality*** through altering the circumstances that lead to inequality. We want to make ***Gateshead a place where fewer people need direct support and more people are thriving***. The six policy objectives of the strategy are:

    - Give every child the best start in life
    - Enable all children, young people and adults to maximise their capabilities and have control over their lives
    - Create fair employment and good work for all
    - Ensure a healthy standard of living for all
    - Create and develop healthy and sustainable places and communities
    - Strengthen the role and impact of ill health prevention

13. We see the ***integration of health and care in Gateshead*** as a key requirement to deliver our ambitions for the people of Gateshead. It is an evolving journey and ***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.***

14. 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.

15. 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.***

16. The ***focus*** of 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.

17. As mentioned in our submission for 2021/22, 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 2022-23

18. Our broad priorities for 2022/23 ***relevant to the BCF 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 people to ***remain independent at home***, with a focus on ***prevention, early help and self-help*** to avoid hospital admission.
    - To support ***safe, timely and effective discharge from hospital*** and to ***progress a home-first approach.***
    - To continue to develop an ***Integrated Discharge Team and Placement function*** that supports the ***Hospital Discharge service*** to maximise same day discharges from hospital.
    - To ***support and work with providers*** of health and care across our local system in ***addressing key challenges*** presented by a combination of Winter pressures, the implementation of recovery plans, Fair Cost of Care for Care Homes and Home Care, and workforce (recruitment, development and retention).
    - 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 continue to ***embed learning from the pandemic*** in developing our plans and to enhance our resilience as a system.
    - To continue to ***respond to changes in the health and care landscape*** (ICB / Place).

Key changes since the previous BCF Plan

19. 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)

20. The **DFG pool remains at the same level as in 2021/22,** the ***NHS minimum contribution requirement has increased by 5.7%*** and the ***iBCF has increased by 3%.*** The Gateshead specific figures are shown below:

BCF Contribution	2021/22 (£)	2022/23
Minimum NHS Contribution	£17,713,351	£18,715,926
Disabled Facilities Grant	£ 2,111,149	£ 2,111,149

Improved Better Care Fund	£ 11,051,841	£ 11,386,636
Total	**£30,876,341**	**£32,213,711**

21. At the ***time of submission of our current BCF Plan for 2022/23*** (September 2022), we will have ***already completed 6 months of the 2022/23 year period***. As well as continuing with the 'steady-state' approach from previous years, we have also sought to make best use of the 2022/23 uplift to:

    - ***provide additional support for 'discharge to assess'*** including increased community capacity from the minimum NHS contribution (£938,000) so that the process adopted under the hospital discharge programme can be continued;
    - ***increase LA core spending power for key schemes*** (£334,800) from the iBCF contribution.

22. Allocation of the 'growth' funding within the BCF pool against schemes ***has undergone a review*** to ensure that the funding is utilised in the most effective way to align with the Better Care Fund Metrics.

23. Although guidance allows NHS and Council contributions to be in excess of the nationally prescribed minimum contributions, ***the pool has been matched to national expectations, in line with previous years.***

Governance

24. 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.

25. ***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.***

26. 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 BCF plan and approach to integration

27. In this section we outline ***our approach to embedding integrated, person centred health, social care and housing services including:***

    - Joint priorities for 2022-23
    - Approaches to joint/collaborative commissioning
    - How BCF funded services are supporting our approach to integration.
    - Describing changes to the services we are commissioning through the BCF from 2022-23.

28. Our overall approach to integration is ***built upon a collective leadership approach*** which 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 2021.

Our Gateshead Joint priorities for 2022-23

30. Our broad priorities for 2022/23, ***relevant to the BCF, 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 people to ***remain independent at home***, with a focus on ***prevention, early help and self-help*** to avoid hospital admission.
    - To support ***safe, timely and effective discharge from hospital and to progress a home-first approach***.
    - To continue to develop an ***Integrated Discharge Team and Placement function*** that supports the ***Hospital Discharge service*** to maximise same day discharges from hospital. This includes delivering a Pilot service from October 2022 to March 2023 to enhance the Placement function.
    - To ***support and work with providers*** of health and care across our local system in ***addressing key challenges***, presented by a combination of Winter pressures, the implementation of recovery plans, Fair Cost of Care for Care Homes and Home Care, and workforce (recruitment, development and retention).
    - 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 continue to ***embed learning from the pandemic*** in developing our plans and to enhance our resilience as a system.
    - To continue to ***respond to changes in the health and care landscape*** (ICB / Place).

31. These ***priorities for 2022/23 are consistent with*** and ***complement the priorities*** that have been developed for Gateshead Place at Appendix 1.

Our approaches to joint/collaborative commissioning

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 since 2019.

33. The ***Alliance Agreement*** 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:***

    - sets out details of work programme areas that partners have committed to take forward;
    - formalises governance arrangements to support the delivery of those programmes;
    - will be an evolving agreement that will be reviewed and developed further on an ongoing basis i.e. it will be an iterative process;
    - importantly, it provides a framework that the Gateshead system can continue to use to build upon.

35. ***The Alliance Agreement covers*** the:

    - 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 the subsidiarity principle, whereby decisions should be taken as close to communities as possible.
    - The need to focus on addressing health and other inequalities, which were 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 an initial set of work programme areas for inclusion within the Agreement for 2021/22. Following a Development Session for Gateshead Cares in March 2022, ***these programme areas were reviewed and updated for 2022/23:***

(i) CYP Best Start in Life: SEND (including transition to adulthood)
(ii) Ageing Well: Adults & Older People: Transformation of Home Care
(iii) Ageing Well: Adults & Older People: Transformation of Care Homes
(v) Ageing Well: Frailty (Prevention)
(iv) Mental Health Transformation
(vi) Multiple & Complex Needs (people@the heart)

40. Each programme area ***will address health inequalities, prevention, integrating pathways and evaluating outcomes.***

41. Gateshead Cares has also updated and is taking forward work programmes relating to the following '***enablers of integration' for 2022/23:***

(i) Workforce
(ii) Digital Gateshead (inc Digital Poverty)
(iii) Primary Care Network Development
(iv) Estates
(v) Data: Axym / Outcomes Framework

42. Our ***digital work*** will also feed into the national ***NHS Community Health Service Digital programme,*** where we will explore opportunities to further support ***Community Services in their digitalisation agendas.***

43. We describe in more detail later in the plan our work linking ***Axym, the system oversight framework and health inequalities.***

44. The ***BCF Plan for 2022/23*** forms part of these ***broader work programmes to integrate health and care at a local level in Gateshead.*** When agreeing how BCF funding is used we have also been cognisant of the need to ensure ***continued alignment with broader plans across health and care.***

45. Our BCF plan will continue to help link the Gateshead system with broader geographies, including the newly established NENC ICB. It will also ***link with the person-centred health and care agenda*** e.g. through the ***Ageing Well and Population health and prevention workstreams*** of which we have been active participants, and enables us to focus on delivering the best outcomes for patients and service users locally.

46. We also have ***clear alignment*** between our ***BCF plan, UEC networks and A&E Delivery Boards*** in Gateshead.

47. We recognise that ***sustainability and success of UCR*** models will only be achieved if they are embedded within our ***Intermediate Care system*** as part of responsive and proactive, preventative care, where Universal Personalised Care is at its core.

48. Work is underway ***around the 9 UCR clinical areas (e.g. falls, frailty),*** integration to wider services such as ***Virtual Wards*** as well the consideration of value-based outcomes and data quality in the UCR service. Links with NEAS on these areas and redirection of their Priority 3 and 4 patients will help ensure that individuals receive the right care at home. Our plans for the virtual ward include the development of frailty and respiratory pathways of care to support people within the community. Admission to the wards following an UCR will ensure that these patients can be overseen by Consultant and Nursing staff virtually 24/7.

49. Our work will also reflect national policy with local fit. We are mindful of the ***recent Fuller Stocktake Report*** on developing a new Integrated Primary Care offer through neighbourhood teams. This report is clearly reflected in all our work to date.

50. ***Joint posts*** to progress ***health and care integration*** include:
    - Director for Gateshead System (ICB Place and the Council)
    - Associate Director for Gateshead System (ICB Place and the Council)
    - Associate Director Transformation, System Resilience and EPRR

How BCF funded services are supporting our approach to integration.

51. In this section we describe ***changes to the services we commission*** through the BCF from 2022-23.

52. 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.

53. Our BCF schemes both:

    - Reflect a continuation of the 'steady-state' that served our local system well during the pandemic; and
    - Provide a foundation that we can build upon to enable us to take forward our ambitions through integrated care models beyond 2022/23.

54. Allocation of the ***'growth' funding within the BCF pool*** against schemes has ***undergone a review process to ensure that*** the funding is utilised in the most effective way to align with the Better Care Fund Metrics. This includes:

    - ***providing additional support for 'discharge to assess' including increased community capacity from the minimum NHS contribution;***
    - ***increasing LA core spending power for key schemes from the iBCF contribution.***

Implementing the BCF Policy Objectives (national condition four)

In this section we have attempted to ***provide examples*** of how we are ***implementing and making progress on National condition 4*** and the two policy objectives for the BCF, describing:

1. ***our approach to enabling people to stay well, safe and independent at home for longer and***
2. ***to providing the right care in the right place at the right time***

Our approach to enabling people to stay well, safe and independent at home for longer and how BCF funded services will support delivery of the objective

55. We deploy our BCF resource into capacity that ***supports hospital discharge*****,** and those services which prevent admission to hospital, keeping people out of hospital by keeping them well at home.

56. The following examples, demonstrate the positive impact funding has had in delivering ***more effective integrated ways of working across adult social care and health*****,** taking a preventative approach to improve outcomes for service users, reduce pressures on the NHS and stabilise the social care market.

57. The PRIME and Rapid Response teams work collaboratively to seek to avoid hospital admissions and to facilitate discharge. The Hospice @ Home team work with end of life patients to undertake the same service.

58. As mentioned in the section above on 'Approaches to joint/collaborative commissioning', ***one of the Programme Areas of Gateshead Cares is 'Ageing Well: Adults /Older People - Transformation of Home Care'.*** This programme supports our Health &

Wellbeing Strategy 'Good jobs, homes, health and friends' in a number of respects. It is clear that in order for some of the most vulnerable people in Gateshead to Thrive and to live in their local communities, ***good joined up Community Services are required as well as housing models to meet their current and future needs***.

59. Work to ***facilitate a vibrant Home Care sector*** will also support the health and care system to achieve ***better outcomes*** for people in the community.

60. Work is underway to ***move away from 'Time and Task' to outcomes for individuals by the end of 2022/23.*** In the short-term, ***an additional Community Discharge Service has been commissioned to support hospital discharges until 31st March 2023*** which will enhance our Pathway 1 offer.

61. A ***working group has*** also been formed to look at commencing a pilot in an area of Gateshead by the end of 2022. The aim is to look at the ***workforce across health, social care and the voluntary sector and see how they can best deliver support to the population.***

62. For example, ***Skills and Competencies for admission avoidances*** are in place with all Community Nurse Practitioners as part of the plans to try and ***free up more senior time to promote admission avoidance.***

63. The ***Home Care Market is currently going through the Fair Cost of Care (FCOC***) process as part of the ASC reforms, to be completed by October 2022 with ***a Market Sustainability plan developed***.

Digital Enablers

64. As part of enhancing health in Care Homes, Health Call has been commissioned to provide a service allowing Care Homes to refer to both the Locality and Rapid Response teams through their digital technology. This will allow NEWS scores and more detailed information to be provided on referral and will assist health teams to provide the correct advice and support.

65. This work will feed into the national ***NHS Community Health Service Digital programme,*** where we will explore opportunities to further support Community Services in their digitalisation agendas.

66. We have ***allocated system funding to appoint a Programme Manager*** who will be embedded within the VCS to work across Health, Care and the VCS to develop a programme of work to better understand and address digital exclusion. This work is supported by the AHSN and, in conjunction with the regional ADASS team, we are looking at possible NIHR/ARC funding bids to further enhance this work.

67. On behalf the region, ***the Council has led a procurement exercise linked to Tech Enabled Care***. The new DPS/Frameworks will support LAs to explore new and emerging tech solutions in a seamless way, as well as working with local SMEs to coproduce tech solutions for care needs.

Primary Care Networks

68. Our work is also aligned to the current contractual requirements within the ***evolving Primary Care Networks*** and wider neighbourhood teams as they establish plans to ***tackle Health Inequalities and deliver Personalised Care.***

69. We are doing this by:

    - Reviewing and further developing the way we deliver services ***at place*****,** aligning services and workforce to better reflect the individual at the centre of a personalised care offer;
    - Ensuring we have a workforce that continues to be ***responsive, dynamic, and efficient*** in meeting the needs of our local communities;
    - Focusing on prevention and ***delaying the onset of long-term care***, working with key partners as enablers to ensure people have the right levels of support, balancing statutory support alongside ***an individual's own support networks****;*
    - Promoting and supporting people's choice by listening to their views and aspirations, focusing on the ***strengths of the person*** and the support they have around them. Understanding what is strong within an individual and their community;
    - Identifying, developing and delivering integrated services and responses, at ***local place-based level*** with partners across NHS, local government, voluntary and community sector organisations and communities themselves.

70. Our BCF plan highlights a number of ways which the Gateshead system is linked with the ICB ***Ageing Well workstream of which we are active participants*****,** and which supports us to locally deliver the best outcomes for patients and service users. ***Ageing Well*****,** aims to support the aims of anticipatory care, the urgent 2-hour crisis response and the enhanced care in care homes model.

71. The Gateshead system (like other local places) ***are involved in the ICS PHM Anticipatory Care programme via the Ageing Well Network***. We are developing with our NECS colleagues a ***PHM tool to help identify people who are eligible and would benefit from the new Anticipatory Care Model offer***.

72. We continue to **consider how resources can best be used to achieve shared ambitions and strategic priorities**, and importantly, ***link up across*** work programmes which support complex care, urgent and emergency care, ***Virtual Wards, 2hr UCR,*** as we believe this will support our priorities to improve out of hospital care, reduce pressure on hospital services; and support the collaborative working required to deliver the requirements of the hospital discharge operating model.

73. Our place programmes provide us a great platform to support our ***Primary Care Networks*** **and Neighbourhood teams** as we embark on exploring delivery of the

national Anticipatory Care NHS operating model in 2023 that offers a personalised, proactive offer to vulnerable people in our communities.

74. The Council has funded the capital development of a new Intermediate Care Centre with 60 beds, which will open in Spring 2023. This scheme will consolidate the core bed-based IC functions on one site in a state-of-the-art building, with strong links to the local community and the VCS (Age UK, Older People's Assembly and Equal Arts). The service pathway is currently being refined, and it is anticipated will bring together in a Single Point of Access, routes into bed-based IC, community IC and step-down beds.

Our approach to providing the right care in the right place at the right time and how BCF funded services will support delivery of the objective

75. The current social care workforce crisis is well understood locally, regionally and nationally. Working with HEE and the LGA we are analysing our workforce data to understand the size of the challenge going forward. Regionally and locally, we are ***developing new and innovative approaches to workforce recruitment and retention*** across the health and care sector.

76. In light of the pressures on home care services and to improve our performance in terms of 'home first' we have ***commissioned a Community Discharge Service on a block contract*** who have a team of salaried workers specifically to support Hospital Discharge.

77. Plans for improving discharge include the ***appointment of a system co-ordinator for transfer of care***. This post will ensure that services inside and outside hospital are well co-ordinated to make the most of commissioned capacity.

78. In recognising the impact that Discharge to Assess has had on step-up capacity for reablement services, partners have agreed that the LA will ***expand its home based reablement offer*** in order to ensure a balance of admission avoidance capacity, and support people to remain in their own homes.

79. Metrics for ensuring the effectiveness of services in place to keep people within their own homes, through reablement and appropriate housing combined with health care needs, are in development.

80. This year the first ***new Extra Care scheme*** for a number of years was opened with great success. 15 apartments within the scheme were designated as dementia care apartments, specifically to support people who due to risk of wandering, 'sun downing', unintentional self-neglect or isolation distress, were at risk of being admitted into residential care. Working with colleagues in the ARC and Ageing Well Network, we are evaluating the impact both for individuals and for the system.

81. ***Voluntary and Community services that can support with low level needs will be further developed*** to ensure a smooth transition from hospital to home.

82. Our approach to integrating care to deliver better outcomes, ***includes collaborative commissioning,*** across primary, community and social care services to enable people to remain at home, or return home following an episode of inpatient hospital care.
83. The Programme Area of Gateshead Cares '***Ageing Well: Adults /Older People - Transformation of Care Homes'*** is a positive example of ***Providing the right care in the right place at the right time.***

84. This programme also supports our Health & Wellbeing Strategy 'Good jobs, homes, health and friends' in a number of respects. A ***new model to deliver care home provision*** in Gateshead will enhance the quality of support for some of the most vulnerable adults, but also help ***shape how both residential and nursing care is developed and delivered over the next 10 years***. With around 70% of people working in Care Homes living locally, ***a thriving Care Home Sector market*** will not only support those living in care homes, but also those who work into the sector.

85. The Older Persons Care Market is also currently going through the ***Fair Cost of Care (FCOC) process as part of the ASC reforms, to be completed by October 2022*** with a Market Sustainability plan developed. The FCOC will be key to ***understanding the challenge/financial commitment needed to co-inside with the development of new models and approaches*** to deliver good quality care provision in Gateshead.

86. ***Key deliverables***:

    - Market Analysis completed
    - Care Home vision agreed
    - Discharge to Assess capacity secured for next 12 months
    - New models consulted and created through a Consultation programme
    - New Care Home Joint Contracts in place by April 2023
    - Procurement processes carried out to phase in new models / contracts throughout Spring / Summer 2023

Digital Enablers - Investment in RITA (Reminiscence Interactive Therapy Activities)

87. There has been ***investment in RITA (Reminiscence Interactive Therapy Activities)*** which is an interactive system developed by My Dementia Improvement Network Limited which delivers person centred care through downloaded content provided through an electronic tablet or flat screen TV, primarily targeted at older people with dementia. It is being installed in all 45 older persons care homes in Gateshead.

88. ***RITA has been evidenced to achieve impactful outcomes*** which will directly contribute to significant cost reduction, patient flow improvement and reduce demand on beds from more complex patients who are prone to longer stays in hospital.

89. Usage of RITA in other areas has evidenced reduced hospital admissions, reduced falls, reduced length of stay, reduced delayed transfers of care, reduced need for high cost 1-1, 2-1 & 3-1 care, reduced use of anti-psychotic and sleeping medication improvements

in nutrition and hydration rates and significantly enhanced patient/resident/family and staff experience.

90. The introduction of RITA will support care homes and the wider system to positively respond to pressures across health and social care whilst maximising outcomes for residents at the same time. It will also provide valuable learning on the use of technological solutions to meeting peoples' needs across health and social care.

BCF narrative plan template – Capacity and Demand

91. In developing our capacity and demand plan we have ***collaborated with our partners across the Gateshead system*** using established groups and forums such as hospital discharge design groups, those involved in transformation ***and, more importantly, those involved in day-to-day operational planning*** in order to ensure those ***best placed*** to provide the most up to date and relevant data and information have participated.

92. Unsurprisingly, as this is the first time we have completed this exercise ***it has been a difficult task***, especially in determining figures for capacity and demand because of ***different timescales being used, the residual impact of COVID-19, people being in bed based IC services/step down beds longer than required due to community pressures, discrepancies in how we count numbers, interpretation of intermediate care despite NICE guidance.***

93. However, we have provided a detailed narrative to ***share the assumptions used***. It hasn't necessarily highlighted ***gaps in provision or resulted in any changes*** as a result of the planning process, but it has ***highlighted data gaps*** which we will work together to address.

94. ***In completing the template we have used the following assumptions:***

- No increase in levels of **Covid**.
- **Flu** – depending on the severity, this could impact on the acuity of patients and workforce capacity if there are high levels of sickness.
- **Workforce** – known issues e.g. less number of people applying for posts, economic impact (heating, cost of living etc.) affecting staff looking outside health and care for employment opportunities and where they have better pay, terms and conditions.
- **Recruitment** across the system continues to present issues and both health and care providers have a number of long term vacancies that they are unable to recruit to, which could impact on capacity going forward.
- **Fragile provider market** – provider fragility is a national issue due to workforce recruitment and retention issues, Winter pressures, the implementation of recovery plans and Fair Cost of Care for Care Homes and Home Care. If providers fail, this will impact on capacity across the system and could cause blockages within

intermediate care provision, with packages (where long term need is identified) unable to be transferred to long term provision in a timely way.

95. ***We have identified the following gap:***

- This exercise has highlighted some ***data recording issues with the VCS for step-up before hospital services*** are required. We are now seeking to rectify as a priority.

96. The following section describes assumptions made when developing our figures included in the aggregated template:

Tab 3.1 – Demand Hospital Discharge – In the box below please describe any assumptions made when developing your figures which we included in the aggregated Template.
Initial projections and activity for May 2022 onwards were based on actual levels of recorded discharges by Pathways, and then modelled through with assumed average increase in activity (based on 2020), and additional planning assumption of providing 104% activity in 2022/23. However, final revised down figures are projected based on case sampling and revising down to align more with hub data, return guidance and the local view of around 10-15% gap in capacity vs demand.

Tab 3.2 – Demand Community – In the box below please describe and any assumptions made when developing your figures.
Urgent Community response projections are based 100% of 2hr Rapid Response Team activity; however, the Team has only been up and running from April 2022, so figures are averaged based on limited activity data we have to date. The Community response (non-urgent) is ***significantly higher than this figure as the Rapid Response team in Gateshead also see patients for follow up at 4 and 12 hours depending on clinical need.*** Reablement/support estimated based on 100% of previous levels activity in 2021/22 from Community Rehabilitation assistants and Therapy Staff. This includes new OT visits, new Physio visits and new rehab intervention. Social Care reablement demand reflects the gap in step-up capacity given that home based reablement services are still almost exclusively focused on Discharge to Assess. Data has been calculated by comparing people waiting for care services currently, and pre pandemic step-up rates. We are confident that these two data sets are similar/comparative, but would note that this is not a definitive way of measuring.

Tab 4.1 Capacity Discharge – In the box below please describe and any assumptions made when developing your figures.
Urgent Community response ***projections are based 5% of 2hr Rapid Response Team activity; however, these figures have only been collated since April 2022***, so are averaged figures based on limited activity data we have to date. Going forward, a ***direct referral line for out of hospital discharges will be identified*** so that this figure is more accurate. Again, the team see patients at 4 and 12 hours and

most referrals from hospital (primarily Same Day Emergency Care) fall within these categories (for example, a request to follow up a patient's bloods the evening of discharge).

Reablement/support estimated based on previous levels activity in 2021/22 from Community Rehabilitation assistants and Therapy Staff, modelled on 10% new OT visits, 10% new Physio visit and 50% new rehab intervention.

LA
The figures provided bear relevance to ***both standard and historical flow Hospital Demand into either Pathway 0,1 or 2 services***, as well as projected levels over the next 6 months (considerate of increases in Winter / Surge pressures).

Tab 4.1 shows the ***out of hospital capacity provided by Age UK*** to support patients on Pathway 0 discharges who require voluntary and community sector support. It is possible that patients access support elsewhere but this figure is not collected. Age UK actively promote their service within the Hospital and contact patients on pathway 0 who have been discharged. As a System, we believe that this capacity adequately meets current demand.

Capacity in December to March has been increased to reflect the additional investment in the reablement service.

Tab 4.2 – Capacity Community – In the box below please describe and any assumptions made when developing your figures.
Such figures are based upon the proportionate rates of referrals into Pathway 1 (13% Community 'Step-up' and 87% Hospital 'Step-down' Discharge) and Pathway 2 (15% Community and 85% Hospital Discharge) that have operated throughout the Pandemic. An increasing level of complex and critical community cases that need Pathway 1 and Pathway 2 provision (predominantly to prevent acute Hospital admissions or long term residential care placements) may change such referral rate percentages over the next 6 months. Capacity in December to March has been increased to reflect the additional investment in the reablement service.

Improving discharge processes, including Acute hospital discharge 100 day challenge and HICM

97. The National Health and Social Care Discharge Taskforce brings together partners from ***across health and social care to focus on opportunities to improve discharge***. In particular, the taskforce aims to improve the outcomes for patients who no longer meet the 'criteria to reside' so they can be discharged from hospital, cared for in more appropriate settings, and to release much-needed capacity within acute providers.

98. The taskforce has found there is still ***significant variation between hospitals and systems*** as a result of the processes employed by individual trusts and their partners. As a result, there is a need to systematically implement change across England to ensure consistency and ***drive improvement for the benefit of patients, carers, and families***.

99. A ***baseline exercise*** was undertaken to self-assess against the ***10 best practice initiatives*** and measure the progress monthly ***in preparation for winter 2022/23***, identifying areas of best practice and highlighting any additional support required. In response to the 100 day discharge challenge, ***materials around Home First have been distributed to all patients, and capacity within PRIME and H@H teams to be increased in line with the aim of supporting people at home.***

100. The Gateshead system also recently held a ***Rapid Process Improvement Workshop (RPIW)*** over five days with staff coming together from relevant teams to ***review and improve the discharge processes across health and social care***, in particular looking at ***response times, trusted assessment, equipment, role of discharge co-ordinator and timeliness of discharge.***

101. ***Outputs*** from the RPIW explored issues such as:

- ***timely response*** to a referral,
- agreement for ***shared access to systems to avoid duplication*** and
- agreement that patients can be moved to the discharge lounge ***to create capacity within the hospital earlier in the day.***

102. Regular reporting will continue to be fed back into the system on a regular basis, 30, 60 and 90 days.

103. We are cognisant that the ***High Impact Change 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'***. Therefore, the ***results of both of these exercises*** have been built into the ***HICM Action Plan (Appendix 2)*** to enable the system to have up to date data and provide timely reporting whenever needed. ***Progress on the 10 initiatives will be updated on a regular basis as part of our unscheduled care and community transformation Boards.***

Supporting unpaid carers

How BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

In this section we provide an overview of how BCF funding is supporting unpaid carers.

104. Informal and unpaid carers continue to play a crucial role in providing care and support for some of Gateshead's most vulnerable residents, maintaining quality of life for those they care for and in many instances preventing admission and readmission to hospital.

105. ***It is clear that unpaid carers have been impacted by the Coronavirus pandemic.*** For some, caring through the pandemic was a positive experience as, due to restrictions on movement etc, family and friends were more available to provide additional support. However, in the main, the impact of caring during this time was negative with many carers struggling to cope with their caring responsibilities, seeing a decline in their social contacts and their socialising opportunities and in turn their mental health as their ***caring responsibilities increased.***

106. In addition, many carers of those living with dementia also saw a decline in the health of the person they cared which in turn had a significant impact on them.

107. ***The pandemic has raised the profile of unpaid carers with many, previously unidentified, carers recognising themselves as such and seeking information, advice and support.***

108. ***The profile of unpaid Caregivers in Gateshead has been raised*** through the development of an enhanced Multi-Agency Carers Partnership. In early 2019, the Partnership resumed following the award of an all-age Carers Contract, which commenced on 1st May 2022. The Partnership is attended by key stakeholders, including Healthwatch, Adult Social Care, VCSE partners and officers from the ICB. The new Partnership meetings also encouraged direct participation from caregivers in Gateshead. The Partnership continued throughout the pandemic and not only raises the profile of Caregivers in Gateshead but also gives Caregivers a voice and a forum where important issues, including where to receive further advice or guidance, can be discussed and resolved.

109. The profile of unpaid Caregivers has also been raised through the ongoing development of a refreshed Caregivers Strategy, due to be published in January 2023. The new Strategy has been co-produced with several Caregivers and other key stakeholders, including existing service providers. Caregivers have been at the forefront of Strategy development, including the text, structure and identification of key aims and objectives. The publication of the Strategy, including final consultation, marketing once published and ongoing ease of access, i.e., single point of entry, further encourages unidentified Caregivers to seek support.

110. ***Support to carers is provided in a number of ways***:

- As a local authority we have a duty to offer a ***statutory carers assessment*** to any carer who presents to us with an appearance of need. Since 2021, our individual carers assessments have been commissioned from Gateshead Carers Trust, (joint assessments are still undertaken by the social care teams). The purpose of this commission was to better join up the assessment and support functions for Care Givers, ensure that Care Givers who want an independent assessment have access to one, and encourage the uptake of Carers Assessments. A carers assessment determines a carers eligibility for support which can be met in a number of ways. This includes the provision of advice and information, signposting and support to Care Giver groups/networks, referral to Gateshead Carers Trust

sitting service, and/or referral into the Carers Wellbeing fund, a grant scheme to support, maintain or improve a carer's health and wellbeing. A carer's needs may also be met by direct care provision of care to the adult with care needs. If outstanding needs remain, we look to provide the carer with a direct payment which can be used flexibly to meet those needs.

- A ***wide variety of online, face-to-face and hybrid self-help and support groups*** along with other services, including:

  - Online Carers Café
  - Arts and Crafts Group
  - LGBTQ+ Group
  - Walking and Exercise Groups
  - Training Programmes
  - Signposting to other services
  - Referrals to Carer Replacement Service
  - Wellbeing Fund
  - 1 to 1 Carer Wellbeing Sessions
  - Telephone Befriending Service
  - Tailored support, e.g. Young Adult Carers
  - Holiday Home
  - A Community Allotment
  - Community engagement

111. In relation to ***hospital discharge, we seek to provide the relevant care and support to enable a safe discharge*** and involve the carer in this. NHSE funded a project with Age UK and Gateshead Health to look at how we can better support carers with hospital discharge. Drawing on the experience of carers in Gateshead, this project has now reported back which provides a good basis to inform future service development.

Disabled Facilities Grant (DFG) and wider services

112. In this section we ***describe our approach to bringing together health, social 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.

113. Gateshead Cares (Health and Care System) recognises the importance of the Occupational Therapy and adaptations services that it delivers to support vulnerable people to remain in their own homes and facilitating swift access to alternative housing where this is the best option.

114. 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.

115. The ***outcomes of the strategic system wide review of Occupational Therapy services, including the Disabled Facilities Grant (DFG) and adaptations services, are informing improvements*** in future service delivery.

116. 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.

117. The Council has recently ***reviewed its tenancy strategy and allocations policy*** and strengthened the offer to people who require re-housing on medical/disability grounds. It is also working with Foundations to undertake a review of the processes associated with the DFG.

118. ***A revised version of the 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). The policy will continue to be reviewed to ensure it incorporates the most up to date guidance.

119. ***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. We are ***progressing towards establishing a home improvement agency*** which will help develop cost and process efficiencies, whilst offering an improved and more extensive service to vulnerable people within Gateshead.

120. ***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.

121. 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.

122. Housing Support can help break the cycle of disadvantage and inequity. Support is provided in many ways and by a range of organisations such as the Council (including housing services), 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***.

123. 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

124. In this section we have ***updated the role of the ICB*** and the ***links to wider system work***. Our work is also ***aligned to the current contractual requirements within the evolving Primary Care Networks and wider neighbourhood teams*** as they establish plans to tackle Health Inequalities and delivery of Personalised Care.

125. ICBs are required to have ***regard to the NHS Operational Planning and Contracting Guidance*** regarding the ***reduction of health inequalities***, emphasising the importance of partnership working for effective use of the available resources to ensure that reducing inequalities in access is embedded in the NHS's approach, including to ***address inequalities under Core20PLUS5***.

126. Across the NENC ICB footprint we are proud of our high quality and frequently high performing health and health and care services, and strong legacy of innovation and partnership working that yielded reductions in some aspects of health inequalities such ***as teenage pregnancies, smoking prevalence, cardiovascular disease mortality and, mortality from myocardial infarctions***. However, despite very good NHS services that remain amongst the best in the country and strong partnerships, ***health outcomes remain poor and health inequalities within the ICS, and in comparison, to the rest of the country, remain stubbornly high.***

127. The causes of health inequalities are often driven by the social determinants of health, and action to address these are driven through Health and Wellbeing Boards, with local health and care partners uniquely placed to address inequalities in access, experience, and outcomes from the population we serve as well as in our contribution to tackle the social determinants as anchor organisations.

128. The ***ICB is committed to articulating where the NHS should lead***, where it should ***collaborate*** and where it should ***advocate for changes to address inequalities***. As a result, and to ensure a systematic and co-ordinated approach to embedding health inequalities into all planning and decision making, a ***Health Inequalities Advisory Group*** and associated governance structure (task groups) has been established.

129. This multi-agency expert advisory group ***(across the NHS, Local Authorities, OHID, Academic partners and VCSE)*** is utilising the skills of all partners across the NENC ICB to provide strategic leadership and ensure delivery of key national and local priority areas.

130. Led by a ***Head of Population Health Management (PHM),*** the ICB will adopt a population health led system to ***truly drive change using insight and intelligence*** with the aim to deliver equitable access and excellent experience whilst driving improvements in outcomes and tackling health inequalities. Examples of specific actions to address ***health inequalities and CORE20PLUS5 requirements are shared in Appendix 3.***

131. 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.

Axym

132. The Gateshead ***outcomes framework is a system framework agreed by the Gateshead system*** and is set against ***13 cross cutting strategic outcomes*** or domains that were developed by Gateshead system partners. The framework measures ***performance across the health and social care system using system based outcomes*** that require partners to work together, for example ***delivering the prevention agenda, a specific focus on health inequalities as well as ensuring health and care is built around our communities.***

133. These domains have subsequently been mapped over to the HWB strategy themes so the framework lines up with the health and wellbeing strategy for Gateshead.

134. ***Axym*** will enhance the existing outcomes framework by providing ***a linked client level dataset across health and social care.*** It will allow the Gateshead System Board to better understand performance against metrics in the framework as well as variation in each of the metrics supported by the linked client dataset.

135. The framework will allow ***organisations to collaborate*** in shared space on the same datasets to produce analysis that can be used to inform decisions.

136. This will be used to help establish an ***integrated approach*** to service management and delivery, ***support with PHM and health inequalities*** and help understand the performance of ***jointly commissioned services.*** It provides an ability to re-design services across health and social care.

137. At place, 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. - 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.

138. 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 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. 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 then inform PCN planning to address inequalities.
    - Ensuring that Community Health resources are ***aligned to effectively prioritise areas with high levels of inequality*** and bespoke, targeted roles introduced to support this.
    - Gateshead Cares works closely with 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 these approaches will be a key component to ***addressing health inequalities***.

139. ***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.

Approach to setting Metrics for 2022/23

140. In developing our metrics for the BCF plan ***system partners from ICB Place, the 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. The rationale for the ***metrics set for 2022/23 is included in detail in the BCF Planning template.***

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

142. 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 arrangements*** and links with the ***Ageing Well work programme, including achieving the 2 hour Urgent Community Response (UCR) target***.

143. In developing our 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 ICB 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***.

144. Across the Gateshead system we have and will continue to gather 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. ***The HICM has also been reviewed when developing our metrics.***

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

Appendix 1 Place Based ICB Priorities 2022/23

1.	**Children & Young People – Best Start in Life /SEND** • SEND Health Partner and Expert Clinician • Oversight and Assurance for health services for 0–25-year-olds • Assurance and Coordination around panel and EHCP process • SEND System Board • SEND Strategy • Needs assessment and forward planning • Workforce engagement and development in SEND • Coproduction • Provider audit – including developing provider policy for SEND • Learning Disability Annual Health Checks (14+) • Ensure Code of Practice and statutory duty for CCG is upheld • SEND Joint Commissioning strategy • Transformation, CYP/System engagement, Review of Services • Voice of the child /co-production • Maternity and Primary Care, Sick and Injured Child/Best start in Life • Prevention/Promotion • Reduction of children who have child protection plans • Reduction of children who come into our care • Ensuring that children leave our care in a timely and robust way • Stability of homes for children in our care • Pathway planning and supporting care experienced children post 18 • Business support stability • Narrative practice drive across partner agencies • FDAC continuation	6.	**System Leadership** • Review and Update to Alliance Agreement • Implementation of Agreement Programme Areas • Establishment of Professional Forum • Preparation for / responding to changes in health and care landscape (ICS/ Place) • System Updates to Health & Wellbeing Board and CHW OSC • Joint OSC for NENC ICS & North & Central ICPs - scrutiny of arrangements • Better Care Fund Submission 2022/23 • MP and elected members forum • System CEX forum

	• Foster care reviews – QA standards of care provided to our children and promoting trauma informed practice for carer • Stability of the LADO post and improved LADO data collation		
2.	**Ageing Well** • New Care Home Model and Contracts • Pilot of Community Model to support Home Care Market • Home Care Market – Potential Future Tender • Development of 2 additional Extra Care Developments • System Quality Assurance Team – Support both a prevention and reactive approach to support Care Providers • Intermediate Care Model • Transfer of CHC Contracting and Payments to Local Authority • Frailty: Prevention	7.	**Primary Care / Contracting** • Gateshead Outer West procurement • Practice Engagement Programme (PEP) • PCN DES requirements • Local Enhanced Services • IIF/DES PCN support plans • Primary Care access • Estates strategy and survey • Implement weight management service • Reprocure home oxygen assessment service • Complete winter access funding claims • Support practice visits with team • Support quality & performance clinics • Active Travel funding bid on behalf of primary care • Support extended access work • PCN development/Develop and manage PCN support plan • Chair community and primary care multi-disciplinary meetings • Practice support visits to improve quality and CQC visits • Primary Care representation in MH Transformation Plans
3.	**Mental Health Transformation** • Peer Support and Peer Network	8.	**Hospital Discharge** • Home Care procurement

	• MH hub • Urgent and Emergency Crisis • PD Hub • IPS • Peri natal/maternal/post partum • Eating Disorder • Workforce MHLDA • Dementia Pathway • MHC Review incl Residential Beds • Housing and Accommodation development MHLDA • IAPT Expansion • CYP IAPT • CYP Getting Help Getting More Help and SPA • Personalisation LD & S117 • ASD • ADHD • Rose Lodge Working Group CCG's • Pre & Post diagnostic Support and Autism Hub • Adult LDA 3 Yr Plan • CYP LDA 3 Year Plan • SMI Health checks (HR) • LEDER (CS) • STOMP/STAMP (CS) • CYP and Adults MHLDA contracts and monitoring		• Coordinator and Exec Director roles • Daily sit-rep
4.	**Multiple & Complex Needs: People@theheart** • Appointment of Programme Manager (2 year post) • Set up Programme Board • Commence next phase of engagement • Set up high level programme plan	9.	**Adult Social Care Reform** • Fair Cost of Care Exercise for Care Homes and Home Care • Fairer Charging Reform – Care Cap • CQC Inspection for ASC – Commissioning Plan to ensure meeting requirements

5.	**Enablers, Safety and Quality**
	• Workforce
	  ○ Primary Care workforce hub – reoccurring funding
	  ○ Recruitment and retention of GPs and Primary care staff
	  ○ Contract with CBC to deliver various elements to support workforce plans over next three years
	  ○ Training and development plans for primary care and education, including Diabetes education, masterclasses for staff CPD, etc.
	  ○ CYP MH workforce – identify priorities / needs in the system and gaps in delivery of current providers.
	  ○ Pathways from UEC to CPCS – Two NHSE pilots to support system resilience
	• Digital development inc Axym data sharing
	• Finance
	  ○ Balancing the budget but also attracting new funding opportunities and doing business differently
	  ○ Devolved budgets to place
	  ○ Joint work with colleagues across disciplines and organisations
	  ○ Approval of a financial framework to support financial planning across health and social care in Gateshead and also link with the priority programme areas
	  ○ Implementation of a pooled budget to support the continuation of discharge to assess processes after the cessation of national HDP funding
	• 'One Estate' approach as a system to estates solutions
	• Further developing the Gateshead outcomes framework
	• Safety and Quality place functions delivered
	• Public engagement
		10.	**Covid Response**
			• Planning and allocations for LVSs and CPs
			• SRO for Gateshead
			• Deliver for vaccine inequalities
			• Daily comms to LVSs
			• SVOC interface
			• Surge planning

How these priorities support and inform the overarching objectives of the ICB *(please colour fill box)*	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
• Improve outcomes in population health and healthcare	x	x	x	x	x	x	x	x	x	x
• Tackle inequalities in outcomes, experiences and access	x	x	x	x	x	x	x	x	x	x
• Enhance productivity and value for money	x	x	x	x	x	x	x	x	x	x
• Help the NHS support broader social and economic development	x	x	x	x	x	x	x	x	x	x

Those things that are important to us with regards to the further development of place based working *(free text)*

In Gateshead we are working to ensure that we have processes that involve the Elected Member roles in order to satisfy both health and local government functions.

We have developed and invested in a robust integrated commissioning team from the local Authority, Public health and CCG including many joint appointments, and we are keen to continue to co-locate these teams and maximise the use of delegated budgets that they have access to for example the budget for prevention and reducing inequalities.

We ask for support with specific areas that are important to the further development of place based working including:

- Autonomy at place over place based teams and working arrangements;
- Vesting the Director of Place with maximum delegation e.g. budgets, responsibility for the full place based team - avoiding multiple reporting lines for place based teams;
- Place based input into the acute services contract;
- Influence/ input to provider collaboratives and mental health contracting at ICP/ICS;
- Support for prevention and reducing health inequalities;
- Support for enabling place to work with all sectors, providers and partners working for the public in Gateshead;
- Co-location of staff from across the teams.

Our approach for Gateshead Cares builds on the Gateshead "Thrive" approach which can be broadly summarised as follows:

‘Good jobs, homes, health and friends’ is the underlying mantra for the Gateshead Health and Wellbeing Strategy and what drives the priorities for the Borough. There are five pledges that we have agreed as a Gateshead system and these are to:

- Put people and families at the heart of everything we do
- Tackle inequality so people have a fair chance
- Support our communities to support themselves and each other
- Invest in our economy to provide sustainable opportunities for
- employment, innovation and growth across the borough
- Work together and fight for a better future for Gateshead

Further development of place based working will be reviewed by the system partners and we have recently agreed our priorities for 2022-23 that are included in the table above. Further integration of health and care services for example with regard to the ageing well agenda is something that we are currently working on as well as ‘Giving our children the best start in life’, joining up health and care teams and ways of working to provide high quality, effective and resilient decision making.

We are very passionate about embedding prevention and reducing health inequalities as cross cutting themes in everything that we do at place and our ways of working are very much inclusive of the wider determinants of health and proportionate universalism.

Appendix 2 Gateshead High Impact Change Model September 2022

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you know it has been successful?
Change 1: Early discharge planning	Discharge system coordinator role - interviews for start later in year. Discharge co-ordinators on medicine wards. RPIW undertaken to look at response times, trusted assessment, equipment, role of discharge co-ordinator and timeliness of discharge. Discharge hub operational 6 days per week with trusted assessment through Rapid Response team on 7th day. Internal work underway to ensure EDD and tomorrow's discharges today are planned for effectively. Hospice @ Home can take discharge of end of life patients to their own homes.	Ensure Out of Hospital capacity is sufficient to meet demand for pathway 1-3 patients. Ensure that we are making best use of Age UK, Rapid Response teams to support early discharge.	March 2023	Every patient has a relevant EDD. Medications are ordered before discharge Equipment to support discharge is in people's homes early. Number of patients on discharge list is reduced.
Change 2: Monitoring and responding to system demand and capacity	Capacity and demand work has taken place to support the BCF return. Further data collection will be required to ensure that support for community step up activity is accurately recorded. Ensuring that weekend discharge requiring support is delivered at the same level as week day discharge is key to moving forward with meeting demand for discharge	Collect further data from all partners and develop a dashboard to allow daily scrutiny of discharge flow (System Co-ordinator will undertake this). Ensure that Capacity outside hospital can meet discharge demand including care home beds and hospice @ home.	January 2023	Resources in place out of hospital to meet demands of discharge.
Change 3: Multi-disciplinary working	Out of hospital: Integrated Discharge Team in place; Community Rapid Response team now working closely with Local Authority PRIME team to support discharge and admission avoidance. Teams soon to be co-located in Civic Centre. In Acute Trust: Work to separate discharge role from medical/nursing role for patients is underway. This will help teams identify the most suitable	Develop better models for complex discharge support that do not rely on any form of assessment when patient in a hospital bed. Seek to ensure that barriers to discharge (house cleans, Safeguarding concerns) are dealt with outside rather than inside the hospital.	March 2023	Improved seamless discharge to assess process.

	placements for individuals.			
Change 4: Home first	As part of 100 day discharge challenge, materials around Home First have been distributed to all patients. Capacity within PRIME and H@H teams to be increased in line with aim of supporting people at home.	To continue to reinforce the home first approach with teams involved in discharge in both health and social care. Challenge when POC not available and have to ask patients to accept an interim placement.	Ongoing	Home first approach is evident in all discharge plans.
Change 5: Flexible working patterns	Staff members are already flexible within the internal teams and work across six days or seven when required. This includes services to which patients are discharged on a "Home First" principle. Challenges with Care Home discharges at weekends and overall challenges with capacity to care for patients outside hospital.	Patients are discharged at the weekend, but there is scope to improve this. This would need investment to fully staff a 7 day service which had no change from a week day service.	March 2023	Improved recruitment and retention. More flexible working patters available to staff.
Change 6: Trusted assessment	Trusted Assessor in place for Packages of Care and EOL through Hospice @ Home. Trusted assessment passed to social worker team for approval for pathways 2 and 3 currently.	Further work required in order to develop wider use of the trusted assessor model across discharge pathways and to reduce duplication of work within the pathways.	March 2023	Efficient discharge processes in place across the system. No duplication of assessments across the discharge pathway.
Change 7: Engagement and choice	Bespoke materials now given to all wards to support simple discharge and more challenging conversations. Support from DLN's and SLMs for patients who are reluctant to accept out of hospital placement which has been offered. Widely distributed video from Rapid Response to avoid admissions.	More work needed to ensure clear process for discharge and assure people that long term care planning is not being undertaken for them in hospital.	March 2023	Patients and carers are aware of discharge planning process. Primary Care and wider system aware of and understand discharge pathways and their roles in these.
Change 8: Improved discharge to care homes	CHS (Company who specialize in improving Care Home discharges) engaged for Gateshead from November 2022 to work with homes and improve processes.	Needs regular review to ensure that relationships are strong and discharge is appropriate.	December 2022	No delayed transfers of care for pathway 3 patients.

Change 9: Housing and related services	This requires further work with Housing provider. Providers generally responsive but challenges with housing can delay discharge.	Generate a list of key issues – house cleans, alterations etc. and reach a shared understanding of referral and a commitment to dealing with these within a specific time frame.	January 2023	Pathways in place and no delayed transfers of care for these patients.

Appendix 3

Examples of specific actions to address health inequalities and CORE20PLUS5

- A **confirm and challenge process** to support priority workstreams to place health inequalities front and centre of approaches and workplans. This utilises a checklist aligned to the Health Inequalities Well Led Framework.
- ICB **priority area performance dashboards** that proactively identify areas of high deprivation, BAME, age-sex adjustment etc. that reflect of utilise the national and regional HIID tools to monitor progress and delivery, and to understand specific geographical challenges.
- **Embedding a Population Health Management (PHM) approach** across the different geographical footprints within the ICB, ICP, Place, PCN and Provider Collaborative, ensuring sharing of best practice whenever possible. Proactively supporting PCNs to adopt a PHM approach to identify their priority population groups. Using analysis and insight to understand specific demographical challenges in need and access across specific groups to enable targeted delivery models tailored to anticipated shortfalls. Reasonable adjustments are made to how services are promoted, delivered, and evaluated to accommodate these vulnerable groups.
- **RAIDR** (NECS Health Intelligence Tool) underpins approach to PHM using advance analytical techniques which link and aggregate data to provide comprehensive cohort analysis. This is helping us to understand our Core 20 and supporting condition specific analysis such as that for respiratory conditions, expanding our knowledge in relation to the Plus 5.
- **Trusts are starting to include the Index of Multiple Deprivation** (IMD) quintile in several key data sets and reports, including the development of the **ICS Preparing Well Dashboard** to support elective recovery which will be rolled out across the ICS.
- **Supporting opportunities and frameworks using examples of best practice** to support the rapid roll out of a standardised approach (where applicable) as services are restored; for example, the piloting of a Trust Health Inequalities toolkit and development of a Primary Care Health Inequalities toolkit.
- **Development and implementation of additional indicators to monitor inclusiveness of restoration plans** using indicators of vulnerability and or disadvantage (performance indicators are being developed for monthly NHS reporting to include deprivation (patients from the 20% most deprived neighbourhoods) and ethnicity.
- Supporting the **major expansion and development of integrated teams in the community**, with primary care networks (PCNs) serving as the foundation and in line with the national requirements (PCN Directed Enhanced Service (DES) 2021/22).
- Continue to actively participate in the **National Health Anchor Learning Network** and ensure application of relevant learning; specific work to create more employment opportunities for young people.
- The **NENC Deep End programme** focuses predominantly on the 'Core 20 Plus ' and is a key priority area across the NENC due to levels of deprivation. The Deep End programme has developed a PHM approach to consider the impact of health inequalities on health resource utilisation. This is being shared nationally as an influence to primary care payment algorithms.

- Directed through the Health Inequalities Advisory Group, work continues to identify our **'plus' communities**. We are currently developing specific profiles for SMI, LD, BAME, carers, substance misuse, homeless, Gypsy, Roma and Traveller communities, Asylum seekers and refugees. Consideration to a 'double jeopardy' approach is being given.
- **CVD prevention data is initially being viewed through a deprivation (IMD) and ethnicity lens** before widening this to areas of known inequalities, i.e. learning disabilities and severe mental illness, thus determining more specific areas of need.
- **Equity and Health Inequalities Impact Assessments** will be used to support interventions and plans moving forward.
- **Increased digital access and digital literacy for the most vulnerable groups** will be facilitated by using learning and infrastructure from the NHS Digital/Widening Digital Participation work.
- The **NENC Mental Health workstream** has an established governance structure that brings together system leaders and relevant partners. The **Quality, Performance and Finance Group** is creating a **'single version of the truth'** data source to generate meaningful system intelligence to inform strategic plans. A **population health data and demand modelling pack** is now available. Alongside a community assets mapping exercise (https://www.signpostnenc.co.uk/), this is being used to refine approaches to ensure a health inequalities lens is utilised.
- **Children & Young People with Learning Disability** – Established a new workstream focussed specifically on increasing annual health checks (AHCs) for this group. Initiatives include the development of a Health & Wellbeing resource toolkit for schools to use to promote the importance of AHCs for school workforce, drama/music based workshops for children and young people promoting their health and wellbeing and including AHCs, postcard/birthday card for 14th birthday to remind families to book an AHC etc.
- Ongoing NENC work and with national colleagues on **improving identification of children and young people with learning disability** specifically in order that they can be added to GP QOF registers at the earliest opportunity.
- **Learning Disability Primary Care Facilitators/Community Learning Disability Nursing Teams** linked to individual GP practices to provide support and advice regarding AHCs.
- **Experts with Lived Experience** leading Health Quality Checks of General Practice including AHC delivery.
- **Preparing Well dashboard** enables users to view waiting lists by IMD, Ethnicity, LD – developing further links with IMD recording for example within patient records.