BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as the excel planning template.

Cover

Health and Wellbeing Board(s)

Sandwell

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

Sandwell Metropolitan Borough Council (SMBC); Black Country Integrated Care Board (BCICB); Sandwell and West Birmingham Hospitals NHS Trust (SWBHT); Sandwell Council for Voluntary Services (SCVO)

How have you gone about involving these stakeholders?

Most stakeholders have been engaged in the BCF plan development through the established BCF governance (the Sandwell Joint Partnership Board is a partnership of SMBC, BCICB and SWBHT and leads on the development of the BCF plan). The BCF Programme Manager has engaged separately with the Chief Executive of the Sandwell Council for Voluntary Organisations who is also a member of the Sandwell Health and Wellbeing Board. Whilst there are effective links between health, social care and housing at the operational level, work is underway at the Sandwell Placed-Based Partnership Board how best to integrate housing at a strategic level.

Executive summary

This should include:

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

The priorities for the Sandwell BCF programme for the last three years has focused on progressing our local ambitions for integration across the three key themes of integrating the commissioning of health and social care, integrating the delivery of health and social care, and integrating the provision of health and social care. Throughout 2022/23 we will continue to strengthen our collaborative commissioning arrangements across our partnerships to further develop our integrated, person-centred care pathways whilst shifting the balance of provision for out of hospital care away from community bedded approaches to more innovative, home based models founded on the Home First ethos and aligned to the Discharge To Assess operating model.

From 1 April 2022 commissioners have repurposed £3m of recurrent annual investment in Community Intermediate Care beds in partnership with the existing provider to deliver a more cost-effective and contemporary model of delivering care, reablement and therapy support to people in their own homes following a stay in hospital or as an intervention to prevent a hospital admission. This model of support is delivered through a multi-disciplinary partnership of clinical professionals, reablement specialists and the voluntary and community sector to help support with safe and timely discharges and to help vulnerable people remain connected to their communities, reducing the risk of social isolation.

Further repurposing of BCF investment in traditional, more costly, and less effective models of care will be achieved during 2022/23 to achieve an optimal mix of community beds and home-based care and support capable of meeting the current and future needs of our local population.

In November 2022 we look forward to opening our 80-bedded integrated health and social care centre. The centre is funded through the Sandwell BCF programme and will be operated in partnership between Sandwell Council and Sandwell and West Birmingham Hospitals Trust through an innovative Co-operative Working Agreement.

The purpose-built facility will deliver time-limited person-centred care, physical therapy and reablement support for people leaving hospital or for people who live in the community who need some extra support to help them avoid an unnecessary hospital admission. The centre will adopt a recovery model that is sharply focused on supporting people to reach their reablement goals in as short a time as possible to maximise their opportunity to lead independent lives.

The increased investment in more home-based models of care and the integrated care centre align well with the policy objectives of National Condition 4.

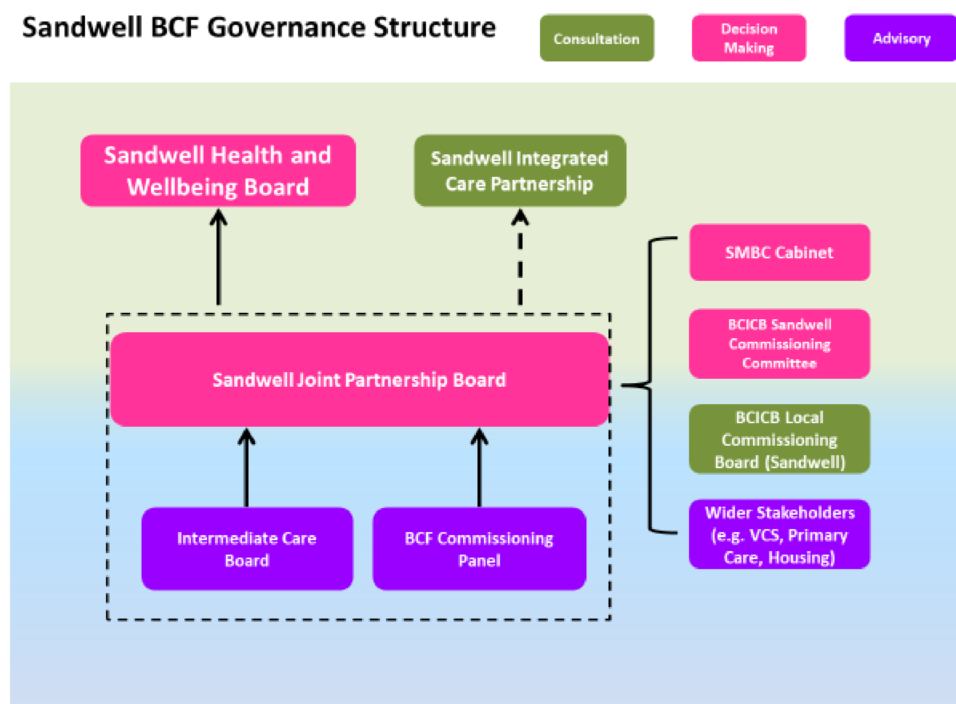
Governance

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

The development of the plan has been led by the Sandwell Joint Partnership Board (JPB), an executive group of the Sandwell Health and Wellbeing Board (HWBB), where senior partners from our statutory health and care services meet monthly to provide leadership and governance in relation to the ongoing delivery of the Sandwell Better Care Fund programme.

The Board has a standing agenda item for national BCF updates and has been engaged regarding the BCF planning requirements and reporting timeline for 2022/23. The Programme Manager has also engaged with senior stakeholders from the voluntary sector, primary care and housing in the development of this plan, which will be approved provisionally by the Director for Adult Social Services in line with delegations from the HWBB, which will be asked to formally approve the plan at the next available meeting in December 2022. Additionally, this year the plan will also be approved by the Chief Executive of the Local Authority prior to the plan submission date.

The image below is a diagrammatic representation of the current governance structure for the Sandwell BCF Programme:



Wider local system governance developments are underway following the statutory changes to the NHS structures on 1 July and work is ongoing to establish collaborative relationships between the Joint Partnership Board and the new local structures. The Sandwell BCF Programme Manager has also presented the requirements and reporting timelines for the 2022/23 BCF Plan to the Sandwell Local Commissioning Board (a committee of the ICB), with a commitment to provide quarterly updates thereafter.

Overall BCF plan and approach to integration

Please outline your 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 your approach to integration.
- Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

The Black Country ICS has three current priorities:

1) Building healthier, happier communities
2) Making the Black Country the best place to work
3) Creating a system that is fit for the future

Building healthier, happier communities is about improving the quality of services and placing local people at the centre of their care. It will ensure that:

- People will live healthier for longer
- People who are most vulnerable will get what they need to stay healthy
- There will be more opportunities for healthy life choices
- There will be more investment in mental, primary and community healthcare
- Care will be personalised
- There will be more digital options available
- There will be better access to affordable housing, greater employment and training opportunities, better air quality and safer green spaces

Making the Black Country the best place to work focuses on developing the health and care workforce and making the Black Country capable of attracting the staff we need to deliver the high-quality services our populations deserve.

Creating a system that is fit for the future is about how we create a system that supports the integration of health and care services, whilst making the best use of the money we have. It will ensure:

- Localised health and care teams will work together to support peoples' social, physical, and mental health
- People will be supported to self-care, including exploring options for digital technology
- Local hospitals will work together to deliver accessible and safe care
- Buildings will be fit-for-purpose
- More investment in local front-line services

The Sandwell BCF programme will support the ICS priorities of building healthier, happier communities and creating a system that is fit for the future. We have already achieved some success in redesigning our community services, with significant ongoing investment already committed to providing more capacity to ensure that where possible people receive the care and support they need in their own homes rather than in hospital or community wards.

We also recognise that strong communities are essential to good health and wellbeing and building individual resilience and independence. By strengthening our communities we will improve physical, emotional and mental wellbeing, and by refreshing our Community Offer during 2022/23 we will continue to promote healthier lifestyles whilst providing effective signposting and referrals to community asset-based services and support that enables people to take control of their health and wellbeing.

A Sandwell Integrated Delivery Hub has been established, bringing community health and social care professionals together from the ICB, Sandwell Council and Sandwell and West Birmingham Hospitals Trust to offer integrated, person-centred care and support. The Hub provides a single point for hospital discharge coordination and enables joined-up care planning and assessments that are crucial to improving the experience of care and outcomes for our population.

The primary focus of the Hub is to support timely and effective hospital discharges and hospital avoidance, building on Sandwell's legacy of strong performance against delayed transfers of care (DToC). Sandwell's health and care leaders are committed to extending this multi-speciality collaborative approach across the Borough through the creation of integrated town-based teams dedicated to helping people avoid hospital where possible and supporting people back home after a hospital stay.

We recognise and understand the real contribution that digital technology and the voluntary and community sector can make to supporting people's independence and improving care outcomes so we are commissioning two dedicated posts within the Sandwell Better Care Fund team to devise and implement our ambitions in

these areas and explore further opportunities to integrate grass roots services into our wider out of hospital care and support offer.

Shared commissioning arrangements and effective joint working are well established in Sandwell and whilst the new governance arrangements created by the Health and Social Care Act 2022 will help to ensure that the expansion of integration beyond the BCF programmes is a key focus for the local system, our joint commissioning commitments through the BCF programme will continue to focus on integrating services to improve peoples' experience, to remove duplication in services and to redesign our health and social care system to reduce reliance on hospitals and long-term care.

Commissioning services jointly also enables the whole system to commission services collectively, which helps to reduce waste and variation in service quality and access. Cost efficiencies are also achieved by eliminating variation in prices where commissioners from health and social care have historically paid different prices for similar services commissioned from the independent sector. Our local approach to joint commissioning for better outcomes is explained further on pages 10-11 of the following section.

The Sandwell BCF programme also maintains important links with Housing, not only in respect of aids and adaptations funded through the Disabled Facilities Grant but also contributing significant BCF funding towards the council's Floating Support service, Extra Care, reablement flats for people with learning disabilities and community flats to support timely hospital discharges, hospital avoidance and the local implementation of Discharge to Assess (D2A). The BCF also funds a Welfare Rights post, hosted by the Housing directorate of Sandwell Council to support people to maximise access to the benefits to which they are entitled.

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe, and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

Implementing the BCF Policy Objectives: How we will enable people to stay well, safe, and independent at home for longer

Sandwell place leaders understand that there is more work to do to scale up our response in community and primary care to keep people as well as possible at home and reduce or delay the need for people to access acute hospital and long-term care services. The actions we are taking in partnership to shift activity away from acute and community beds towards the provision of more integrated care, therapy and reablement to people in their own homes are already supporting the shift in the balance of investment across the system to deliver a better experience of care and improved outcomes for local people.

In Sandwell all Primary Care Networks (PCN) are actively working on the delivery of the Primary Care Direct Enhanced Service (DES) which will offer a range of approaches to support people to remain at home, or return home following a stay in hospital, that will complement and support our other services and initiatives that have a shared purpose of enabling people to stay well, safe and independent at home for longer .

The PCNs support these aims by:

1) Improving access to Primary Care – all PCN's have extended hours access which increases the number of appointments offered in primary care as well as expand the core hours of General Practice so that appointments and access are available until 8pm on week days and available all day on Saturday

2) Medicines Review & Optimisation – the PCNs use risk-stratification tools to identify and prioritise patients who would benefit from a structured medication review, with a focus on patients in care homes, patients with complex and problematic polypharmacy, patients with severe frailty, and those who are particularly isolated or housebound, or who have experienced recent hospital admissions and/or falls

3) Enhanced Health in Care Homes – all Care Homes are aligned to a single PCN who works with community health and care services and other partners to establish and coordinate a multidisciplinary team approach to deliver the Enhanced Health in Care Homes service requirements which enable the development of personalised care and support plans for people living in the PCN's Aligned Care Homes

4) Social Prescribing – all PCN's provide patients with access to a social prescribing service and further work will be undertaken during 2022 and beyond to develop the relationships between the social prescribing services and the voluntary and community sector services funded through the Sandwell BCF programme

5) Anticipatory Care – PCNs will be required to agree a plan for delivery of Anticipatory Care with their ICS and local partners with whom the service will be jointly delivered. This will include an agreed plan covering the following key elements:

    a. How to identify the population cohort which will benefit most from proactive care in the community
    b. How to assess patient need
    c. How care planning will be carried out and updated when needed
    d. How interventions will be decided upon
    e. How anticipatory care will be coordinated across partners

Through the BCF we also invest over £1m a year in our partnership with the community and voluntary sector to give people access to local services that can give support tailored to individual needs, empowering people to be in control of their own lives and strengthening the resilience of our communities:

The Community Offer is a partnership of local organisations who deliver wellbeing support services to residents across Sandwell through a community asset-based approach. The services are culturally appropriate and inclusive of people with protected characteristics, including those with disabilities and long-term conditions, mental health, learning disability and dementia, as well as carers. The Community Navigators support people to

- Access specialist and mainstream support services
- Provide personalised advice, information, and guidance

- Manage their finances and maximise benefits
- Access their local community and play an active role in it
- Connect to others and build social networks
- Build peoples' confidence to help them manage their own needs

The Sapphire Service provides a range of practical support, information, and advice to vulnerable people on discharge from hospital. The service continues to have a demonstrable impact on reducing hospital delays, lengths of stay and readmissions for users, which are mainly vulnerable older people living at home, typically with multiple complex conditions that, in the absence of the right support delivered at the right time, are at a high risk of hospital admission or readmission. Services and interventions provided by Sapphire include:

- Pre and post discharge support to include a discharge checklist and helping patients to settle back at home immediately after discharge and ensure their immediate needs are met (including food and sundries, and a home risk assessment to guard against slips, trips and falls)
- Up to six weeks of practical and emotional support post-discharge, helping people to maintain their independence at home and reduce readmissions. The period of support may be extended where patients are at high risk of hospital admission or readmission
- Advice and guidance on keeping fit and healthy, including referrals to falls prevention services. This will be particularly important as we come out of lockdown and find that many vulnerable people need support to combat the chronic physical deconditioning resulting from the impact of social restrictions
- Care navigation and support with communication between patients and professionals, including GPs, hospital clinicians, community nurses, therapists, and social workers.
- Signposting to the Community Offer and other services as required on exit from the Sapphire Service.

Implementing the BCF Policy Objectives: How we will provide the right care in the right place at the right time

In Sandwell we understand that effective integrated care should bring together the different groups involved in somebody's care so that, from the perspective of the citizen, the services delivered are consistent and coordinated. Not only do we aim to offer seamless, joined up care, but care that meets the holistic needs of our customers, identifying their strengths, interests, skills and talents so that we can agree outcomes that focus on the activities people value or like to do and not just the aspects of life that they struggle with.

This person-centred approach is essential to maximise our opportunities to support people to maintain their independence and enjoyment of life and our BCF partners are committed to providing our local people and communities with effective, well-coordinated and personalised care and support in the right place at the right time.

We understand too that implementing a D2A approach where going home is the default pathway is the right thing to do for patients and that supporting people to continue their lives at home is vital for their long-term wellbeing outcomes. We know that staying in hospital for longer than necessary has a negative impact on patient outcomes and we are committed to ensuring that patients achieve a timely and safe discharge home and are supported to live full and independent lives.

Our multi-agency, joined-up approach to the commissioning and delivery of reablement and rehabilitation support and hospital avoidance across Sandwell ensures that more people are supported to maintain their independence by providing them with the care they need in the right setting at the time they need it. System partners are working hard to increase the pace of change to deliver preventative, outcomes-focused, and cost-effective community health and care services for Sandwell.

We have taken positive steps to integrate our services where appropriate and where possible. For example, the council's Short Term Assessment and Reablement, Occupational Therapy services and Intermediate Care Team (scheme no.s 9, 69, 30 and 33 from the Planning Template) work collaboratively with the community health services (scheme no.s 24, 52, 58, 74 and 75) to manage the reablement and therapy needs of people living in the community. We have also integrated the Sapphire (Voluntary and Community Sector) service into Pathway 1 to support community health services to deliver timely and effective hospital discharges and help to keep people well at home following discharge.

The community health teams are also integrated with the independent sector care home providers and community social work teams via multi-disciplinary team working to support joint care planning for users of the council-commissioned Enhanced Assessment Beds (EAB). We have brought health and social care teams together to work collaboratively in the Integrated Care Delivery Hub and we look forward to opening the Integrated Health and Social Care Centre in November, which will bring front-line health and social care professionals together to jointly deliver person-centred reablement and rehabilitation services to manage flow whilst supporting the shift in the burden of care activity from hospitals to the community.

However, we recognise that success in delivering true person-centred care demands effective collaboration across all of the agencies and services that support our people and communities to achieve their health and wellbeing goals, including Public Health, Housing and the Voluntary and Community Sector.

Providing high quality, joined-up services that deliver the right care in the right place at the right time is only possible through joined-up commissioning and to achieve this the Sandwell BCF Programme supports a joint commissioning team that brings together experienced commissioners, project managers and performance specialists from the ICB and social services. The team works in a matrix way with our partners in housing, primary care, public health, mental health, acute and community care, as well as the voluntary and community sector.

The Joint Commissioning Team commissions a range of schemes that are central to the successful implementation of the D2A operating model and achievement of 'Home First' principles. Whilst these schemes are set out in detail in the planning template, they include the Own Bed Instead scheme that promotes the Home First ethos by providing time-limited intermediate care and reablement support to people in their own homes following a stay in hospital or to help people avoid a hospital admission.

For residents of care homes where the rate of emergency call-outs is high we also commission wrap-around therapy, social care, pharmacy and clinical support to those homes at highest risk to enable them to manage the care and support needs of their residents more effectively and reduce unnecessary hospital admissions.

To provide better year-round support for people living in the community who are experiencing crises, or who are at high risk of hospital admission, we have committed additional recurrent investments in 'Admission Avoidance' capacity from our local community healthcare provider and a rapid-response domiciliary care service from the independent sector to help people whose own care and support arrangements have broken down, to avoid a hospital admission where possible. The BCF investments in these 'step-up' services and our new Integrated Health and Social Care Centre will support the delivery of our Avoidable Admissions targets set out in the Planning Template.

For people with care and support needs who no longer meet the criteria to reside in hospital and who can return home, it is imperative that they are supported to return home quickly and safely to minimise delays. To support this aim, the BCF programme invests in a range of services to support timely and effective discharges. The Short Term Assessment and Reablement (STAR) service is an in-house reablement service operated by Sandwell Council that provides time-limit reablement support to vulnerable people returning home from a stay in hospital and who require additional support to regain their daily living skills or some aspect of their functionality.

An Early Supported Discharge service is also funded by the BCF programme. Commissioned from the independent sector, the service provides responsive domiciliary care support to enable individuals with care needs to leave hospital once they are clinically ready to do so, and is an important mechanism for ensuring that people with care needs do not spend longer than they need to in hospital whilst a care package is arranged. People using the service are usually transferred

to a longer-term package of care within a few days to ensure that the rapid-response nature of the service is maintained. Our investments in these services, as well as significant increases in the capacity of home-based intermediate care and continued investment in our Voluntary and Community Sector services will help to deliver our ambitions to ensure that 95% of Sandwell residents leaving hospital during 2022/23 return to their normal place of residence and meet our reablement target of 68% of people discharged from hospital remaining at home 91 days after discharge.

Whilst the two new BCF policy objectives of enabling people to stay well, safe, and independent at home for longer and providing the right care in the right place at the right time are presented separately, they are inextricably linked. We want to support people to stay well and independent at home because we know that with few exceptions, home is always the right place for people to receive the care they need. However, there are times when it is not possible or appropriate to care for people in their homes where they have care and support needs but who no longer require hospital treatment.

We currently commission several block contracts with the local care home market for the provision of Enhanced Assessment Beds to support this cohort of patients. Unfortunately, the quality of care is variable, and outcomes for people are generally poor.

However, from 1 November 2022, local people for whom the 'home first' approach is not appropriate and who have reablement goals will be offered access to our new and nationally ground-breaking integrated care centre following a stay in hospital, or for a few days to avoid a hospital admission. The centre was developed to respond to four main strategic challenges:

i) To help deliver sustainable progress on hospital delays

ii) To provide more effective hospital avoidance (step-up) services

iii) To commission high quality but time-limited, bed-based reablement care and support that is accessible all year round to avoid the need to commission reactively to seasonal changes in demand

iv) To remove variation in care quality for people discharged from hospital on a home-based pathway who require a short stay in a community bed for assessment of their ongoing care needs.

The centre will support people in the following ways:

- Improving health, well-being, and confidence, helping people to live longer with a good quality of life and able to participate in their local community

- Supporting people to maintain their independence at home

- Avoidance of unnecessary hospital admissions
- Avoidance or delay of preventable or premature admission to long term residential or nursing care
- Maximising health and care outcomes by supporting people to maintain their functionality and skills through rehabilitation and reablement
- Support for the transition from hospital to home as soon as people are medically ready for discharge
- The new centre will also build strong links with the local community and work effectively with the NHS and voluntary and community sector organisations, promoting best practice in out of hospital care

Where a hospital stay is unavoidable the centre will support reduced lengths of stay and support people to be quickly and safely discharged into a more appropriate care and support setting and where possible return home with their support needs minimised. In so doing, the centre will further enhance and improve Sandwell's reputation as a regional and national leader in promoting the independence of its older citizens, supporting the resilience of individuals and communities, and minimising avoidable delays in transfers of people from hospital settings.

The risk of NHS workforce recruitment challenges for the community services right-sizing programme and integrated health and social care centre is being mitigated through two main approaches:

- Comprehensive recruitment campaign led by the NHS provider
- Phased redeployment of health staff into community services in line with the planned reduction of Community Beds (Social Care Ward and Intermediate Care Wards)

Though there are challenges in recruiting staff with the right skills and experience to deliver the new care approaches required in the community and the integrated health and care centre, we are confident of delivering on the recruitment timescales that have been presented to, and approved by, the Sandwell Joint Partnership Board.

Whilst we have not experienced significant issues in recruiting to the social care workforce for the integrated health and social care centre, it is acknowledged that implementing a true D2A operating model across 7 days for some aspects of social services will present some challenges and require a comprehensive programme of consultation with staff and unions to implement new working patterns.

The BCF programme manager, senior community commissioner, lead for Intermediate Care and other healthcare professionals from the local acute and community provider have met under the authority of the Intermediate Care Board to assess Sandwell's current maturity level against the High Impact Change Model

and to establish an improvement plan. There is a commitment to undertake the assessment every six months going forward and for the HICM improvement plan to play a key role in influencing local priorities.

Supporting unpaid carers.

Please describe 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.

There are currently 35,084 carers in Sandwell, almost one third of whom are caring for over 50 hours per week: an increase of 6.8% since the 2011 Census. This figure may exceed 49,000 by 2037 owing in part to an ageing population and legacy impacts of the COVID-19 pandemic.

We recognise that providing support to unpaid carers is one of the most effective ways to improve their wellbeing and support them to continue caring, keep their families and friendships together and thriving, and to help prevent a breakdown in care which can otherwise result in an emergency admission or need for domiciliary, nursing or residential care for the cared-for person.

The Council has a duty under the Care Act 2014 to put carer wellbeing at the heart of delivery and to identify carers on appearance of need. Accordingly, carers are often identified by the statutory services and offered advice, signposting and assessment, support planning and review of carers' needs as part of hospital discharge planning or while the needs of the cared-for person are being assessed.

GPs and Primary Care staff are also trained to identify and register carers as part of their agreements in the Primary Care Commissioning Framework, and our Voluntary and Community Sector partners also identify carers and promote services to support them.

The Sandwell BCF programme invests £460,000 a year supporting unpaid carers. The types of support offered includes:

- listening to experiences over the phone, online, or in person
- offering advice and information on support available
- social activities, like quizzes and outings with or without the loved one
- training courses– such as training in mental health or using a hoist
- providing groups to make friends and share caring experiences
- advice on asking Sandwell Council Enquiry Service for a formal assessment of carer needs.

Support is delivered through a range of approaches including funding to voluntary sector-based carers organisations that provide practical support to carers and through carers direct payments which are used to meet needs identified as part of a carers assessment, and can be used to support breaks for carers.

Care Management provides information and advice, signposting and assessment, support planning and reviews of carers' needs in compliance with the Care Act 2014. Carers are offered a direct payment to meet eligible needs around health and wellbeing.

Formal replacement care is usually funded through a care package for the cared for person, but the Sandwell BCF programme also contributes over £110,000 each year to the funding of Direct Payments (schemes 21 and 38), which are accessible by eligible individuals, including unpaid carers, who can use Direct Payments to fund short breaks, or pursue hobbies or social activities that are important to them. The BCF programme also contributes £2.4m per year to the social work teams (schemes 12, 32, 33) to deliver the necessary assessment capacity, including carer's assessments.

Disabled Facilities Grant (DFG) and wider services

What is your 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?

The Sandwell BCF Programme Team understands the importance of housing quality as a wider determinant of health and wellbeing. Strong relationships exist between the adult social care, therapy, and housing teams to help ensure that we are supporting people to create living environments which enable them to manage their health and care needs effectively and improve their wellbeing. Our DFG investments for 2022/23 are set out in the following table:

Purpose	**Budget Allocation**	**Description**
Minor Adaptations	£0.36m	Funding for minor adaptations to all non-council housing
Lift & Hoist Servicing and Maintenance	£0.25m	Funding to service and maintain all lifts and hoists installed via a DFG
ASC Directorate – Revenue Costs	£0.35m	Contribution towards the revenue costs of the Therapy Services Team

Housing Directorate – Revenue Costs	£0.45m	Contribution towards the revenue costs of the Home Improvement Agency
Handyperson Service	£0.1m	A service to provide minor housing interventions in private housing
ASC – Moving with Dignity Project	£0.4m	A timebound project to review and improve the manual handling of vulnerable residents
Disabled Facilities Grants	£2.84m	Assuming an average grant value of £15,000 then this equates to funding for 190 grants
Total	£4.75m	

In addition to our DFG programme we offer a range of housing-related services, including a handyperson to carry out small jobs to maintain safety in and around the home where the householder is no longer able to, including cleaning guttering and drainpipes, changing washers on leaking taps and pipes, and securing cables to prevent slips, trips and falls.

We also fund minor adaptations to the value of £1,000, which include installing grab-rails and over-bath showers, and major adaptations costing over £1,000 where significant changes are required to a property, to enable people to occupy their home safely and independently for as long as possible. Such work may include lift installation, Bath Out Shower In (BOSI), level access showers, ramps and extensions.

We are planning to improve our housing-related offer in line with the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) and are currently considering several options including:

- Offering a simpler non-means tested grant to fund typical adaptions such as shower and ramp installations where the cost of adaptations is less than £15,000.
- Making the property clean and safe with deep clean, property clearance and urgent falls prevention measures.
- Relocation allowances of up to £10,000 for homeowners and £2,000 for private tenants to move to a more appropriate house where making appropriate adaptations is not possible. The grant helps with the costs and fees associated with moving, such as solicitor's fees, valuation survey and estate agents' fees.

- DFG top-up grants of up to £30,000 to homeowners where the costs of work are expected to exceed the DFG maximum threshold of £30,000.

- Hazard Removal Grant offered to homeowners aged 60 plus who are in receipt of Guaranteed Pension Credit. Up to £5,000 for removal of hazards that may present a serious and immediate risk to health and safety.

- Adapting a second home: shared custody of a child. Available to all Sandwell residents where the courts have granted shared custody of a child. Usually only the child's main home would be adapted but the council believe this approach may affect shared custody arrangements and may consider funding adaptations at a child's second home subject to eligibility criteria and available funding.

- Lifts (currently a major adaptation) will become part of the equipment pathway so they can be fast-tracked through the process.

In addition, the Prevention Stores (scheme 3) is funded through the BCF programme and plays an important role in supporting people to stay independent, supplying a range of digital and equipment technologies to enable people to live at home and avoid or delay the need for admission to long term care. Prevention Stores is also a key enabler for Sandwell's excellent performance on hospital discharges, offering a rapid-response service to support timely discharges and helping to prevent readmissions. Prevention Stores also stores and maintains specialist health equipment on behalf of the ICB at no extra cost, often going beyond its formal responsibilities by delivering and installing equipment for ICB patients that reside in neighbouring Boroughs.

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

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

Sandwell is a vibrant, multi-cultural region with 40% of the Sandwell population coming from black, Asian and minority ethnic communities compared to the national average of 14%. However, the Black Country ICS is the second most deprived system in the country and whilst nationally 20% of the population lives in an area of the highest deprivation indices, for Sandwell this figure is 60%, with the remaining Black Country places also significantly above the national average. For males and females in Sandwell both life expectancy (76.1yrs and 80.7yrs) and healthy life expectancy (61.6yrs and 60.6yrs) are significantly lower than the national average (79.4yrs and 83.1yrs, 63.1yrs and 63.9yrs respectively).

Sandwell's population falls behind the national average across a range of measures and indices, including mortality from all preventable causes (224.1 per 100,000 for Sandwell compared to 140.5 per 100,000 for England) and the Sandwell rate for mortality from all causes is the second highest in the West Midlands region at 1403 per 100,000 and 35% higher than the England average of 1042 per 100,000. The Sandwell rate is also significantly higher than England for other diseases considered preventable amongst under 75-year-olds, such as cardiovascular, liver, and respiratory diseases, as well as cancer. Sandwell has the fourth-highest rate of childhood obesity in the country, whilst 70.8% of adults in Sandwell are overweight or obese compared to 64% nationally.

Sandwell residents also experience significantly higher levels of hospital admissions due to hip fractures than the England average and it is also well documented that Sandwell has been impacted disproportionately by the COVID-19 pandemic compared to its neighbours, with 245 deaths per 100,000 in 2020 compared to the England average of 140.1.

Despite these challenges, Sandwell has a strong record of improving peoples' outcomes and experience of care through collaborative working across system partners and agencies, and targeted investment from the Better Care Fund that focuses on delivering more of the right types of care in the right place at the right time and supporting more people to maintain their independence. Health and care partners worked in collaboration to design and deliver new integrated out of

hospital care pathways that are now supporting the shift in the locus of post-acute care and support activity from hospitals to the community and peoples' own homes, and we will continue to develop our out of hospital offer to improve outcomes for our population.

People with protected characteristics and particularly older and disabled people, are at higher risk of hospital admission and tend to experience longer lengths of stay. Many people with protected characteristics also suffer particularly from social isolation and loneliness compared to people without those characteristics.

The BCF plan supports all people, including those with protected characteristics, to avoid unnecessary visits to hospital and where admission is necessary our community health and care services will ensure that people spend no longer in hospital than they need to and are well supported following discharge to lower the risk of readmission or crisis.

We are confident that the Sandwell BCF Programme for 2022/23 will deliver high quality integrated and person-centred services that will help to reduce inequalities and health inequalities for the local population and for those with characteristics protected under the Equality Act 2010. Commissioning proposals for services funded from the BCF programme are required to demonstrate that an Equalities Impact Assessment has been carried out prior to them being considered for formal approval.

We have considered whether the BCF plan activities could constitute conduct prohibited by the Equality Act 2010. In general, the services funded through the BCF will apply to all persons irrespective of protected characteristics though some services are specifically commissioned for individuals or groups who possess protected characteristics and will therefore not constitute direct or indirect discrimination on that basis. We believe that the services and activities funded through the Sandwell BCF programme will have a positive impact on people with protected characteristics and will help to reduce the health inequalities and other inequalities experienced by people who share protected characteristics compared with not having those services available.

The BCF plan funds services that help to connect people to their communities to reduce the impact of loneliness and isolation, which is especially important as many people with protected characteristics continue to restrict their social contacts in the wake of the COVID-19 pandemic. The Community Offer schemes funded through the BCF programme support people to connect with their communities and neighbours and have focused additionally on providing practical support such as shopping and prescription collections during the pandemic. In addition, we found that people living with dementia and their families were disproportionately impacted by the social restrictions and so we commissioned a scheme that provided tablet devices loaded with specialist apps to stimulate and occupy people living with dementia and to enable them and their families to connect with others and maintain social support networks during the period when

face to face contacts were restricted. The scheme was a proven success and the ICB has continued to invest in it. Although our dementia specialists are now back in the community providing face to face support, we remain vigilant for opportunities to support those who are at highest risk of social isolation.

The services funded through the Sandwell BCF programme are aligned to the BCF Policy Framework which promotes equality of opportunity between people who share a protected characteristic and people who do not share it – for example our services support disabled and older people to enjoy the same level of independence as people who do not share these protected characteristics as far as this is possible based on individuals' personal circumstances and health needs.

Across our NHS partners, the Core20Plus5 approach is being used across Sandwell to drive targeted action to reduce health inequalities. As part of the Dartmouth Programme and PCN DES work, PCNs have identified specific elements for action that are linked to the Core 20+5 (Which is actually +6 within Sandwell as Diabetes has also been added) within their local populations and across the Sandwell place there is commitment to improve Early Cancer Diagnosis and CVD prevention and diagnosis.

The Healthy Communities workstream within the Sandwell Health and Care Partnership is responsible for the development and delivery of the Sandwell Health Inequalities Strategy and ensuring there is an increased focus in terms of prevention. Key priorities have been identified as: Drug harm reduction, alcohol harm reduction, smoking cessation, weight management and physical activity, children's' health and education, housing and environment and social isolation. The work on social prescribing and health coaching will also be linked to this workstream.

The Sandwell Health and Care Partnership has committed to:

- Increase our understanding around health inequalities and our local population
- Work collaboratively across all parts of the health and care system to join-up, promote and embed action to reduce health inequalities
- Work in partnership with local people, groups, and forums to ensure health and care pathways are informed and co-produced by people with lived experience, and under-represented and protected groups.