Sandwell Health and Wellbeing Board
15 December 2021

Report Topic:	Sandwell Better Care Fund Plan 2021-22
Contact Officer:	Christine Guest, ASC Service Manager Paul Moseley, BCF Programme Manager
Link to board priorities	2030 Vision **The BCF supports Ambition 2**: Sandwell is a place where we live healthy lives and live them for longer, and where those of us who are vulnerable feel respected and cared for. We will help keep people safe and support communities **The BCF supports Ambition 10**: Sandwell now has a national reputation for getting things done, where all local partners are focused on what really matters in people's lives and communities.
Purpose of Report:	To seek retrospective approval from the HWBB of the BCF Plan for 2021/22.
Recommendations	That the Board notes the content of the report. That the Board approves the BCF Plan for 2021/22
Key Discussion points:	Early feedback from the regional NHSE team recommended minimal amendments to the draft report prior to submission. This contributes directly to **Ambition 10.** The Sandwell BCF programme provides funding and protection for vital Adult Social Care services, enabling us to support our vulnerable individuals and communities when resources are scarce. This contributes directly to **Ambition 2.** The Sandwell BCF programme has to date achieved several notable successes including: i) No.1 ranking nationally for Delayed Transfers of Care (DToC) performance at the time reporting was suspended in March 2020. ii) Establishment of an integrated commissioning team across the CCG and Adult Social Care iii) Establishment of an Integrated Discharge Hub to improve the effectiveness of out of hospital care

	pathways and support better patient flow between local hospitals and the community iv) Making the approved Dementia Strategy a reality by implementing the commissioning plan. v) Building the new Integrated Social Care and Health Centre on the Knowle site in Rowley Regis vi) Establishing the Shared Care Record to enable health and social care professionals to access appropriate information to improve the care of local citizens.
Implications (e.g. Financial, Statutory etc)	
The BCF Pooled Budget quantum for 2021/22 is confirmed as £57 million, broken down into the following income streams: Minimum CCG Contribution £28,370,453 iBCF £22,344,516 DFG £4,728,713 Additional LA Contribution £1,156,064 Additional CCG Contribution £269,051	
What engagement has or will take place with people, partners and providers?	The BCF Plan for 2021/22 has been developed in collaboration with partners from Sandwell Council, Black Country and West Birmingham CCG, Sandwell and West Birmingham Hospitals Trust and Sandwell Council for Voluntary Organisations.

SANDWELL HEALTH AND WELLBEING BOARD BETTER CARE FUND PLAN 2021/22

1. Purpose of the Better Care Fund

1.1. The Better Care Fund (BCF) is a national programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible. The BCF encourages integration by requiring CCGs and local authorities to pool budgets and agree an integrated spending plan.

1.2. The BCF has been created to improve the lives of some of the most vulnerable people in our society and offers a genuine opportunity for health and social care partners to develop effective and sustainable services capable of meeting the unique needs of our local people and communities now and in the future.

1.3. The legal framework for the BCF derives from the amended NHS Act 2006 (s. 223GA), which requires that in each area CCG(s) transfer minimum allocations (set by national bodies) into one or more pooled budgets, established under Section 75 of that Act, and that approval of plans for the use of that funding may be subject to conditions set by NHS England. NHS England will approve plans for spend from the CCG minimum in consultation with DH and DCLG as part of overall plan approval.

1.4. The DFG and iBCF Grants form part of the pooled budget and are subject to grant conditions set out in grant determinations made under Section 31 of the Local Government Act 2003.

2. The following partners were involved in the development of this plan

Sandwell Metropolitan Borough Council
Black Country and West Birmingham Clinical Commissioning Group
Sandwell and West Birmingham Hospitals NHS Trust
Sandwell Council for Voluntary Services (SCVO)

2.1. The plan has been developed by the Sandwell Joint Partnership Board (JPB), which is an executive group of the Sandwell Health and Wellbeing Board (HWBB) where statutory partners meet monthly to provide leadership and governance to the Sandwell Better Care Fund programme.

2.2. The JPB brings together senior leaders from the NHS and social care commissioning and provider partners in Sandwell to offer strategic leadership in relation to the Sandwell Better Care Fund programme. The remit of the JPB includes the development of the annual BCF plan and S75 agreement which

is undertaken on behalf of the JPB by the jointly appointed BCF Programme Manager.

2.3. The Board has a standing agenda item for national BCF updates and has been kept up to date with the BCF planning requirements for 2020/21. The Programme Manager has also engaged with other stakeholders from the voluntary sector and housing in the development of this plan.

3. Executive Summary

3.1. The aim of the Sandwell HWBB is to sustainably meet the health and care needs of Sandwell's population now and in the future. The HWBB is leading a complex system change agenda requiring Sandwell to balance its duty to meet the needs of local people and manage the expected growth in demand for services whilst ensuring that this is achieved on a sustainable basis. All this is to be achieved within the constraints of the available funding and the challenges of delivering services during and following the global COVID-19 pandemic.

3.2. The priorities for the BCF programme in 2019/20 and 2020/21 focused on progressing the integration agenda across three key themes of integrating the delivery of health and social care, integrating the commissioning of health and social care services and integrating the provision of intermediate care and reablement. Sandwell's blueprint for integration has established a platform that will enable partners to deliver on our current priorities which will be discussed later in the paper. The key priorities for the Sandwell Better Care Fund programme for 2021/22 include:

3.3. **Supporting the implementation of the D2A operating model**

3.3.1. The communities of Sandwell have experienced some of the highest rates of COVID-19 infection in the country throughout the pandemic. Whilst many areas are fortunate to have seen pressures on local hospitals fall to a more manageable level, the proportion of Sandwell General Hospital's beds occupied by COVID-19 patients remains one of the highest in the country at around 11% for the eight weeks to 5 October. Whilst numbers have started to fall, the hospital remains extremely challenged in terms of the impact the pandemic continues to exert on its staff and services.

3.3.2. The unprecedented pressures on the Sandwell health and social care system have impacted on local D2A implementation. However, the HWBB and BCF partners are working closely with the LGA and ADASS to fully implement the D2A operating model by the end of March 2022. Our local approach to implementing D2A to this point will be discussed in more detail in the section on Supporting Discharge (National Condition 4).

3.4. **Supporting the wider system through Winter 2021**

3.4.1. The HWBB has continued to maintain many of the schemes implemented during previous Winters and which were funded substantially from a ring-fenced Winter grant which is now included within the annual iBCF allocation. The following schemes totaling £2.3 million were implemented in previous Winters and continue to be supported for 2021/22:

Scheme Name	Brief Description of Scheme	Scheme Type	Area of Spend	Commissioner	Provider	Source of Funding	Annaul Expenditure (
Grants to the voluntary sector for winter support	Grants made to VCS organisations to support vulnerable patients following dicharge from hospital (currently Sapphire Service)	Prevention / Early Intervention	Social Care	LA	Charity / Voluntary Sector	iBCF	£157,000
Better discharge co-ordination for EOL patients (Discharge Enablement Team)	Rapid response to step down fast-track CHC patients (initially commissioned as part of previous winter plan)	High Impact Change Model for Managing Transfer of Care	Community Health	CCG	NHS Acute Provider	iBCF	£172,000
Additional Admission Avoidance Capacity	Additional capacity for Admission Avoidance (initially commissioned as part of previous winter plan)	High Impact Change Model for Managing Transfer of Care	Community Health	CCG	NHS Acute Provider	iBCF	£677,525
48 hours post discharge follow-up	Post discharge welfare checks (initially commissioned as part of previous winter plan)	High Impact Change Model for Managing Transfer of Care	Community Health	CCG	NHS Acute Provider	iBCF	£59,000
Frailty in A&E post	Specialist support for frail elderly in A&E (initially commissioned as part of previous winter plan)	High Impact Change Model for Managing Transfer of Care	Community Health	CCG	NHS Acute Provider	iBCF	£83,065
Additional Intermediate Care at Home beds	Additional capacity for home-based IMC (initially commissioned as part of previous winter plan)	High Impact Change Model for Managing Transfer of Care	Community Health	CCG	NHS Acute Provider	iBCF	£256,250
iCARES attendance at EAB MDTs	Provider attendance at community bed MDTs (initially commissioned as part of previous winter plan)	High Impact Change Model for Managing Transfer of Care	Community Health	CCG	NHS Acute Provider	iBCF	£33,999
iCARES Plus	Therapy support to Community Beds (initially commissioned as part of previous winter plan)	High Impact Change Model for Managing Transfer of Care	Community Health	CCG	NHS Acute Provider	iBCF	£614,324
Care Home Admission Avoidance (Virtual Ward)	Wrap-around clinical support to care homes to reduce emergency call-outs (initially commissioned as part of previous winter plan)	High Impact Change Model for Managing Transfer of Care	Community Health	CCG	NHS Acute Provider	iBCF	£290,468

3.4.2. The BCF Pooled Fund has also invested an additional £912,000 to expand the number of packages of integrated care and therapy support to people in their own homes which helps to reduce the use of community reablement and intermediate care beds throughout the year. In addition

to these investments which have proven to be effective in supporting the year-round resilience of the local health and care system, the following new schemes will be established in addition to support system pressures and further implement the D2A approach ahead of the coming Winter:

	Annual	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total 2021/22
Single Handed Care Training	£ 40,000						£ 40,000	£ 40,000
Re-stocking equipment sub-store	£ 15,000	£ 1,250	£ 1,250	£ 1,250	£ 1,250	£ 1,250	£ 1,250	£ 7,500
Handyman service	£ 72,000		£ 6,000	£ 6,000	£ 6,000	£ 6,000	£ 6,000	£ 30,000
Transport	£ 72,000		£ 6,000	£ 6,000	£ 6,000	£ 6,000	£ 6,000	£ 30,000
Discharge enablers fund	£ 12,000		£ 1,000	£ 1,000	£ 1,000	£ 1,000	£ 1,000	£ 5,000
	£ 211,000	**£ 1,250**	**£ 14,250**	**£ 14,250**	**£ 14,250**	**£ 14,250**	**£ 54,250**	**£ 112,500**

3.5. **Transforming and right-sizing community health and care services**

3.5.1. Sandwell operates a significant number of short-term community step-down beds which in previous years were crucial to enabling Sandwell to effectively manage acute bed capacity and comply with Delayed Transfers of Care policy. However, following our collective efforts across health and social care to develop alternative and more appropriate provision, these beds are now under-utilized and poorly aligned with the 'home first' ethos and national Discharge to Assess (D2A) requirements which are the cornerstone of current national health and social care policy.

3.5.2. Health and social care commissioners are working with Sandwell and West Birmingham Hospitals Trust to substantially repurpose the funding for the community beds towards increasing the provision of home-based alternatives and ensuring sufficient capacity is available across the health and social care activities involved in the delivery of care and support for hospital discharge pathways 0 - 2.

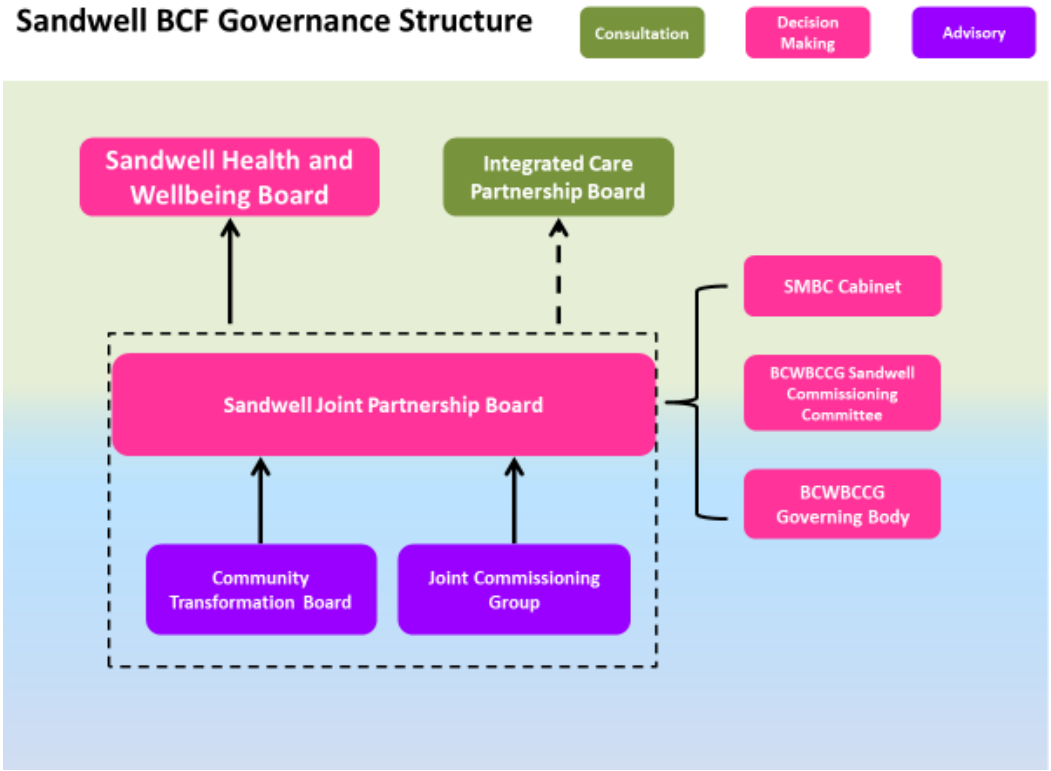
3.5.3. To support the shift of activity away from hospitals into the community via these pathways the Sandwell Better Care Fund is investing around £1m per annum in the VCS to provide advice, guidance and social support interventions including falls prevention, hospital discharge support, community dementia support and carer services. Our VCS partners use strengths-based approaches to fully harness the abilities and capacity of the sector to support people to stay independent, connected to their communities and well-informed of their care and support options.

3.5.4. Our collaborative arrangements and relationships also extend to Russells Hall Hospital in Dudley. Due to the proximity of the hospital to Sandwell's Westernmost communities of Tipton and Rowley Regis, some of the residents in these areas who need urgent and emergency care will be conveyed to Russell's Hall, which may be over a mile closer for those residents than Sandwell General Hospital. To help mitigate this impact on Russells Hall, Sandwell has a team of social workers based at the

hospital to arrange care placements and facilitate timely discharges for our residents. Through these integrated arrangements we can offer our Sandwell residents the same opportunities to benefit from timely and effective discharges as they would get at Sandwell General Hospital.

4. Governance

4.1. As in previous years the development and implementation of the BCF plan will be overseen by the Sandwell Joint Partnership Board (JPB) which comprises of senior leaders from across the CCG, Acute and Community Health providers, Social Services and Public Health. The Joint Partnership Board is responsible for key decision-making in respect of the BCF programme and approving investment from the BCF Pooled Fund. The JPB is supported by the Sandwell Transformation Board which oversees the implementation of D2A policy across health and social care, and the Joint Commissioning Group is formed of the commissioning leads for the services funded through the BCF programme and makes commissioning recommendations to the JPB. The BCF programme is currently connected to the wider local health and social care governance as set out in the illustration below but we expect this to change going forward to ensure alignment with the emerging Integrated Care Partnership and Integrated Commissioning Board governance structures:



4.2. The BCF Programme Manager is responsible for developing the annual BCF plan in collaboration with specialists in commissioning, finance and performance. The completed plan documents are reviewed by the JPB and any final amendments made ahead of presenting to the HWBB for approval.

If the Board is unable to meet to approve the plan before it is submitted for assurance, the Director for Adult Social Services has the authority to provisionally approve the plan prior to submission pending retrospective approval by the HWBB. Once approved, the plan is then implemented through a programme management approach led day to day by the BCF Programme Manager under the direction of the BCF Director with ongoing stewardship by the JPB which meets monthly.

5. Overall approach to integration

5.1. The Sandwell HWBB strategy for integrating health and social care is based on three key themes of integrating the delivery of health and social care, integrating health and social care commissioning and integrating the provision of care.

5.2. **Integrating the delivery of health and social care**

5.2.1. In 2018 the Sandwell HWBB set a mission to sustainably meet the health and care needs of the people of Sandwell and West Birmingham over the next five years. The HWBB understands that behind this simple statement is a complex system change agenda which requires Sandwell to balance its duty to meet the needs of local people and the expected growth in demand whilst ensuring that this is achieved on a sustainable basis within the constraints of the available funding. The emergence of the COVID-19 pandemic has added further complexity and challenge to these ambitions but the HWBB is committed to driving integration in Sandwell through the Better Care Fund programme and offering high quality, joined-up services capable of meeting the complex and changing needs of our local population.

5.2.2. In Sandwell we understand that integrated care brings 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.

5.2.3. 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 achieving the transformation needed to offer our residents and communities effective, well-coordinated and personalised care and support in the right place at the right time.

5.2.4. As part of our integration strategy, the HWBB established an integrated health and social care hub in West Bromwich to provide a single point for

discharge coordination and enabling the joined-up care planning and assessment that is so important for improving the care outcomes and experience of care for our vulnerable people and communities. 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) having reached number one in the country at the time that DToC reporting ended in March 2020.

5.2.5. To support the Hub, we established a multi-professional D2A working group of commissioners and community and social care providers to design and implement streamlined and integrated out of hospital care pathways aligned to the D2A Operating Model and Hospital Discharge Policy. The new pathways are person-centred and enable people to exercise genuine choice and control to achieve the outcomes that are important to them. Health and care professionals will work collaboratively to manage the customer journey from start to finish and promote independence through effective co-ordination of input from across the health, social care and voluntary and community sectors.

5.2.6. This work will deliver a patient-centred model of care which is fully compliant with the D2A Operating Model and Home First ethos. Our ambition is to provide as much care and support to people in their own homes as possible and for services to be available 7 days a week.

5.2.7. Our efforts to support people to stay well at home and maintain their health and independence will be supported by a transformation programme that changes the way that our community health and care services are delivered to ensure that as much care, reablement and therapy as possible is provided to people at home rather than in community beds following discharge from hospital.

5.2.8. The HWBB recognises that some variation in access to services exists within Sandwell in common with many areas of England. We believe that by continuing to invest BCF resources intelligently to meet the unique and changing needs of our communities and ensuring that hard to reach populations and those with protected characteristics enjoy parity of access to services, we will reduce inequalities for Sandwell people both within the Borough and compared with other areas across the Black Country and England.

5.3. **Integrating health and social care commissioning**

5.3.1. We have discussed the actions we have taken to align social care and community health services to support the delivery of integrated care, but we recognise that success in delivering true person-centred care demands effective partnership working across all the agencies and

services that support our people and communities to achieve their health, care and wellbeing goals. Achieving high quality, joined-up services is only possible through strong and effective commissioning and to deliver this the Sandwell BCF Programme includes a joint commissioning team established in 2018 to drive integrated commissioning. Formed of experienced commissioners, project managers and performance specialists from the CCG 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.

5.3.2. The Joint Commissioning team leads on a range of important enablers for integration, including the development of a local Integrated Shared Care Record (ISCR), an exciting and ambitious project delivered in partnership between the Sandwell BCF programme, the local Acute Trust, the Mental Health Trust, Adult Social Care and Primary Care. With implementation expected ahead of Winter 2021, the ISCR enables professionals from across health and social care to share appropriate information about patients' care needs and treatment through an integrated electronic care record which will support improvements in the quality, timeliness and experience of care.

5.3.3. The Joint Commissioning Team also commissions schemes that are instrumental to the successful implementation and delivery of D2A. Whilst these schemes are set out in detail in the planning template, they include for example 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. For residents of care homes where the rate of emergency call-outs is historically 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.

5.3.4. Commissioning services jointly also enables health and social care to commission similar services once, which helps to reduce variation in service quality and access, and duplication of services and waste. Cost efficiencies can also be achieved through the removal of price variances where commissioners from health and social care sometimes pay different prices for similar services commissioned from the community care market.

5.4. **Integrating the provision of care**

5.4.1. In March 2018 the Sandwell HWBB supported the long-term options to provide an integrated Health and Social Care Centre in Sandwell. This was in response to three 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 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

5.4.2. Due to open in July 2022 the new centre will support people in the following ways:

- Improved health, well-being and confidence, helping people to live longer with a good quality of life and contribute to local community life
- Maintaining people's independence at home
- Avoidance of unnecessary admission to hospital
- Avoidance 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 clinically ready for discharge
- More generally, the new centre will build strong links with the local community, work effectively with the NHS and voluntary and community sector organisations, and ensure practice standards are promoted and followed

5.4.3. The integrated care centre will be ground-breaking nationally and will be designed, built, equipped, operated and supported to the highest possible standards to reduce or delay the need for Sandwell's older residents to be admitted into hospital or long-term residential care.

5.4.4. 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 as far as possible. 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.

6. Supporting discharge (National Condition 4)

6.1. Leaders from the CCG, Council and the local Acute & Community Trust agree that to successfully achieve a true Discharge to Assess model we must move away from the traditional approach of using short-stay community beds to facilitate timely discharges and develop alternative care models that are aligned to the Home First ethos and D2A Operating Model. To deliver this transformation the BCF partners have agreed to substantially repurpose the £1.3 million of funding currently invested from the BCF Pooled Fund in the community beds (See Scheme ID 29 in the Planning Template) for commissioning more therapy and reablement services that support people in their own homes and in so doing deliver improved outcomes and a better experience of care.

6.2. As well as delivering better outcomes for people, the new offer will be more cost-effective and capable of meeting the higher levels of demand for out of hospital health and care that the Discharge to Assess operating model will generate. The BCF will continue to invest over £6.5 million annually in services that support people to avoid preventable admissions to hospital and maintain their independence at home (see Scheme IDs 28, 65, 66, 71), and over £1 million each year in the local Voluntary and Community Sector to support effective discharges and provide social opportunities for people to stay connected to their communities and reduce isolation which is a key risk factor for unplanned hospital admissions.

6.3. Additional investment will be made available to ensure a safe transition from a model of delivery based around community beds to a 'home first' approach that provides more care in people's own homes and supports our shared ambitions to reduce the length of time people spend in hospital after they are clinically ready for discharge. The £1.3 million of funding that will be repurposed to support the transformation is included within the planning template against the Social Care Ward (Scheme ID 29) and is in addition to the current funding of £1.5 million for home-based packages of care (Scheme IDs 68, 74 and 77).

6.4. We recognise that a significant number of Sandwell residents are admitted each year to Russells Hall Hospital in Dudley due to the closer proximity of that hospital to Sandwell General Hospital as explained in para 3.5.4. Well-established and effective collaborative arrangements already in place between Russells Hall and Sandwell Council will ensure that our inpatient residents at Russells Hall will have the same opportunities for timely and effective discharge home as those receiving care at Sandwell General Hospital, with all

discharges being managed through the Integrated Discharge Hub regardless of which acute hospital has provided care for our residents.

6.5. We will achieve the improvements set out in this paper by delivering our plans to implement true Discharge to Assess and transforming our community health and care services so that more people can be cared for at home and assessed for their ongoing care needs outside of hospital. Our new integrated care centre operated jointly by Sandwell Council and Sandwell and West Birmingham Hospitals Trust will open in July 2021 and will enable safe and timely discharges from hospital whilst avoiding the need to commission community care placements, which can often lead to delays. Additionally, the Integrated Discharge Hub now manages all discharges from hospital, working to streamlined, joined-up hospital to home care pathways that minimise the time people need to spend in hospital whilst supporting more people to be discharged home once they are clinically ready.

7. Disabled Facilities Grant (DFG) and wider services

7.1. The Sandwell BCF Programme Team understands the importance of housing quality as a wider determinant of health and wellbeing. We have a housing specialist based within the Joint Commissioning Team who has developed strong relationships 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 2021/22 are set out in the following table:

Purpose	Budget Allocation	Description
Minor Adaptations	£0.36m	Funding for minor adaptation to all non-council housing
Lift &Hoist Servicing and Maintenance	£0.2m	Funding to service and maintain all lifts and hoists installed via a DFG
Adult Social Care Directorate -Revenue Costs	£0.323m	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
Budget for Disabled Facilities Grants	£3.3m	Assuming an average grant value of £14,000 this equates to funding to approve in the region of 240 Disabled Facilities Grant applications
Total	**£4.7m**	

7.2. 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 provide several Discharge to Assess flats in the community that are typically offered to younger adults leaving hospital who are unable to access their own accommodation immediately following discharge. Often this is because work must be undertaken to adapt or make safe their own homes. In some cases, individuals may be homeless so the D2A flats provide an opportunity to discharge people from hospital whilst agencies work with individuals to help them regain their strength and daily living skills and identify suitable housing options going forward.

7.3. We also offer 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.

7.4. 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:

- Increasing the maximum amount for minor adaptations to £1,500 which will enable us to offer more interventions without having to undertake the more complex major adaptions process.
- Improving our offer to people living with dementia by making a new Dementia Dwellings Assistance grant of up to £2,000 available to support with hospital discharge, enabling people to return home quickly and to help reduce demand for residential care placements.
- 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 £15,000 to homeowners where the costs of works is 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.

7.5. In addition, the Prevention Stores team is funded through the BCF programme and continues to play 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 are 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 CCG to no extra cost, often going above and beyond its formal remit by delivering and installing equipment for CCG patients that reside outside of Sandwell.

8. Equality and Health Inequalities

8.1. **Equality**

8.1.1. We are confident that the Sandwell BCF Programme for 2021/22 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 plans for services funded from the BCF programme are required to demonstrate that an Equalities Impact Assessment has been carried out prior to the plans being considered for formal approval.

8.1.2. We have considered whether the BCF plan activities could constitute conduct prohibited by the Equality Act. 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.

8.1.3. The services funded through the Sandwell BCF programme are aligned to BCF policy which exists in part to promote 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.

8.1.4. We know from the available evidence that people with protected characteristics and particularly older and disabled people, are more likely to experience hospital admission and stay longer in hospital for treatment. We know also that many people with protected characteristics suffer disproportionately from social isolation and loneliness compared to people who do not share those characteristics. The BCF plan supports all people with protected characteristics to avoid unnecessary visits to hospital and where admission is necessary our community health and care services will ensure people spend no longer in hospital than they need to and are well supported following discharge to lower the risk of readmission.

8.1.5. The BCF plan also 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 are advised to minimise their direct social contacts during 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 with dementia and their families have been disproportionately impacted by the social restrictions imposed in response to the pandemic. To respond to this need to combat the isolation and mental health impacts, 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 social restrictions were in place.

8.2. **Health inequalities**

8.2.1. The health of people in Sandwell is generally poor compared with the England average. Sandwell is one of the 20% most deprived areas in England and about 25% of children live in low income families. Sandwell has a 32% greater mortality rate than the England average for all causes of death and life expectancy for both men and women is lower than the England average, with men and women living on average 2.7 and 2.1 years fewer respectively than the England average. More significant

variations in life expectancy are observed within the Borough, with men and women in the most deprived areas living for an average of 8.6 and 8.0 fewer years respectively than those in the least deprived areas.

8.2.2. The Sandwell population is worse than the England average across several important health indicators including obesity, diabetes and cancer mortality. Sandwell residents also experience significantly higher levels of hospital admissions due to hip fractures than the England average. It is also well documented that Sandwell has been impacted disproportionately by the COVID-19 pandemic compared to its neighbours and England generally.

8.2.3. Despite these challenges, Sandwell has a proud track record of delivering better outcomes and experience of care through strong and effective partnerships across health and social care, and intelligent investment from the Better Care Fund. For example, health and care partners worked in collaboration to design and deliver new integrated out of hospital care pathways that substantially shifted the locus of post-acute care and support activity from hospitals to peoples' own homes.

8.2.4. This approach was based on the D2A model and Home First ethos that is now the cornerstone of national health and social care policy, helping Sandwell to rise from 73 out of 151 local authorities in England for performance against hospital delays in July 2017 to become the number one area in the country at the time reporting was suspended in March 2020.

8.2.5. The Better Care Fund has delivered additional successes including the protection of prevention-focused services provided by Sandwell Council, including Community Equipment Stores, Community Alarms and Floating Support, which together provide vital support to vulnerable people, enabling them to live independently in the community and reducing the demand on stretched primary, community and social care resources.

9. Metrics

9.1. From the BCF Data Pack, the latest available data for unplanned hospital admissions due to Ambulatory Care Sensitive (ACS) conditions shows that Sandwell had 1243.1 admissions per 100,000 population in 2019/20 and our projections suggest a figure of 1,196.9 for 2020/21 and 1,186.6 for 2021/22. These figures represent a 3.9% reduction in admissions between 2019/20 and 2020/21, which have been achieved by collective system efforts to implement D2A and support more people in the community to avoid hospital during the COVID-19 pandemic. The projected reduction of 0.9% in admissions between 2020/21 and 2021/22 is more conservative and reflects the likelihood of our continued efforts to reduce avoidable admissions through the D2A operating model being constrained to an extent by increased demand for hospital

services as the longer-term impacts of the pandemic on community and primary care present.

9.2. For the 14-day Length of Stay (LoS) metric we are projecting figures of 9.9% of inpatients residing in hospital for 14 days or more in Q3 of 2021/22 and 10% in Q4 compared to figures of 11.2% and 12% for the equivalent periods last year, which represents an expected improvement in the metric of 11.6% between Q3 2020/21 and Q3 2021/22 and 16.7% between Q4 2020/21 and Q4 2021/22.

9.3. For the 21-day LoS metric we are projecting figures of 5% of inpatients residing in hospital for 21 days or more in Q3 of 2021/22 and 5% in Q4 compared to figures of 6% and 6.3% for the same periods last year, which represents an expected improvement in the metric of 16.7% between Q3 2020/21 and Q3 2021/22 and 20.6% between Q4 2020/21 and Q4 2021/22.

9.4. Paragraphs 3.5.4 and 6.4 identified that a significant number of Sandwell's residents receive acute care at Russells Hall Hospital in Dudley due to the closer proximity of the hospital to where they live compared to Sandwell General Hospital. Assurance is offered that the established partnerships and arrangements between Sandwell Social Services and Russells Hall ensure that discharges for Sandwell residents are equally as effective as discharges from Sandwell General. The table below shows the comparable performance against the 14 and 21-day LoS for Sandwell residents in both Sandwell General Hospital and Russells Hall Hospital across Q1 and Q2 of 2021:

14-day LoS (Apr-Sep 21)		21-day LoS (Apr-Sep 21)	
Sandwell General	9.9%	Sandwell General	5.2%
Russells Hall	10%	Russells Hall	5%

9.5. We are also planning to discharge 94.1% of Sandwell residents to their normal place of residence in 2021/22 compared to 91.3% for 2020/21.

9.6. We can also demonstrate a significant reduction in care home placements, with only 350 placements made per 100,000 population in 2020/21 compared to 447 in 2019/20, representing a 21.7% reduction. However, this is in large part due to care home placements being curtailed during the COVID-19 pandemic and whilst we expect to maintain lower admission rates going forward we are projecting a slight increase to 360 placements per 100,000 for 2021/22.

9.7. The 2020/21 reablement rate of 64% of people aged over 65 remaining at home 91 days after discharge from hospital is expected to improve to 66.9% for 2021/22. Whilst we expect the impact of the D2A and Home First approach to enable more people than ever to stay well and independent at home following a hospital stay, we are at the same time discharging more people

into the community with higher levels of need which is likely to impact on reablement performance in the short term until the wider community transformation is complete and services are operating at full capacity.

9.8. Our health and care leaders through the HWBB remain united in their commitment to continuously improve outcomes for Sandwell residents and reduce inequalities and health inequalities within the Borough and compared to the rest of England. During 2021/22 the Better Care Fund programme will continue to build on its proud track record of success and innovation to deliver the cost-effective, joined-up services our residents and communities deserve.