Integration and Better Care Fund

Better Care Fund 2025-26 HWB submission

Narrative plan template

	HWB area 1	HWB area 2
HWB	Sandwell	Please insert HWB name here
ICB	Black Country	Please insert ICB name here
ICB	Please insert ICB name here (where appropriate)	Please insert ICB name here (where appropriate)
ICB	Please insert ICB name here (where appropriate)	Please insert ICB name here (where appropriate)

Section 1: Overview of BCF Plan

This should include:

- Priorities for 2025-26
- Key changes since previous BCF plan
- A brief description of approach to development of plan and of joint system governance to support delivery of the plan and where required engage with BCF oversight and support process
- Specifically, alignment with plans for improving flow in urgent and emergency care services
- A brief description of the priorities for developing intermediate care (and other short-term care).
- Where this plan is developed across more than one HWB please also confirm how this plan has been developed in collaboration across HWB areas and aligned ICBs and the governance processes completed to ensure sign off in line with national condition 1.

Priorities for 2025-26

The Better Care Fund (BCF) Plan for Sandwell in 2025-26 is focused on enhancing integration across health, social care, housing, and the voluntary sector to improve outcomes for residents, promote independence, and reduce reliance on acute hospital services. The priorities for this period include further embedding the Home First approach, strengthening intermediate care pathways to prevent unnecessary hospital admissions, and expanding community-based support to ensure individuals can receive care closer to home. There is also a strong emphasis on addressing health inequalities, supporting unpaid carers, and leveraging digital innovations to enhance service delivery and efficiency.

Recognising the essential role of primary care in delivering preventative healthcare and reducing demand on acute services, we will explore opportunities to strengthen the integration of primary care within the BCF programme. Prevention is a growing priority, and while a fully

developed prevention plan is in progress, we acknowledge its critical importance and commit to building towards a comprehensive strategy ahead of next year's BCF plan submission.

Aligned with the emphasis of the latest planning guidance on prevention and early intervention, the Sandwell BCF Programme for 2025/26 will explore opportunities to involve Mental Health (MH), Learning Disabilities & Autism (LDA) and Children's services which play a crucial role in supporting individuals to live independently and prevent crisis-driven admissions to acute settings. To reflect this, we will explore the potential to align mental health pathways within our intermediate care offer, ensuring that where possible, individuals with MH and LDA needs receive tailored support, including early intervention, crisis response, and step-down care.

We will consider opportunities to increase participation in service and pathway design from Black Country Healthcare NHS Foundation Trust (BCHFT) to ensure that specialist MH and LDA input informs service delivery. Additionally, workforce capacity within MH and LDA services should be reviewed to ensure sufficient provision of therapeutic interventions, including psychology-led rehabilitation within community settings.

We will also seek to strengthen the alignment between mental health services and our Home First approach, ensuring people with MH and LDA needs are supported to remain in the community with appropriate wraparound care.

Key changes since the previous BCF plan for 2023-25

Key changes since the previous BCF plan include the removal of the discharge funding ringfence, which allows for greater flexibility in shifting investment from step-down care towards more proactive admission avoidance initiatives. This reallocation of resources aligns with the broader national objectives of the BCF, supporting urgent and emergency care services by reducing demand through preventative interventions.

The introduction of revised national metrics also marks a shift towards a more outcome-driven approach, ensuring a clearer focus on emergency admissions, hospital discharge delays, and long-term admissions to residential care homes.

To enhance transparency and collaboration, we will strengthen the governance underpinning the BCF Plan with an advisory role for the Sandwell Health and Care Partnership (SHCP), with responsibility remaining within the Sandwell Joint Partnership Board (JPB). This approach ensures that all key partners are actively involved in decision-making while maintaining clear lines of accountability and governance.

The governance framework will be refined where necessary to ensure systematic engagement with wider stakeholders, including voluntary and community sector (VCS) organisations, primary care, and housing partners.

A formalised consultation mechanism will be explored to capture ongoing feedback from partners and service users. This may include partnership workshops and structured feedback loops through the Programme Delivery Group (PDG)[1] to ensure that the BCF priorities remain aligned with emerging system needs. This strengthened approach will reinforce a culture of shared ownership and collaborative decision-making across the health and social care system in Sandwell.

Our approach to developing the BCF plan and ensuring joint system governance to support the delivery of the plan

The development of the BCF plan has been a collaborative process, involving key stakeholders from Sandwell Council (SMBC), the Black Country Integrated Care Board (ICB), Sandwell and West Birmingham Hospitals NHS Trust (SWBHT), Primary Care, and local voluntary and community sector (VCS) partners. The plan has been informed by wider engagement work with service users, carers, and frontline professionals, ensuring that it reflects the needs and aspirations of the local population. Governance structures have been designed to support effective oversight, with the Sandwell Health and Wellbeing Board (HWB) providing strategic leadership and the JPB ensuring that operational decisions align with BCF priorities.

Engagement with the BCF oversight and support process

Whilst no support needs have been identified at this time either by our local health and care system or by the national BCF team, Sandwell is committed to engaging with the national BCF oversight and support process to ensure compliance with national conditions and to draw on best practice from other areas.

[1] Groups or Boards mentioned in this report may be reconfigured and renamed as part of a Sandwell system governance review by the Sandwell Health and Care Partnership during 2025/26

Alignment with plans for improving flow in urgent and emergency care services

The plan supports efforts to improve patient flow within urgent and emergency care services. Through its investments in reablement, rehabilitation, and community-based care, the plan aims to reduce the pressure on acute hospitals, enabling more people to receive timely and appropriate support in their own homes. The transformation of intermediate care services is central to this approach, with a focus on developing new models of home-based rehabilitation and enhancing capacity within the Integrated Discharge Hub. This will help to ensure that individuals can be discharged from hospital safely and without unnecessary delays, thereby improving both patient outcomes and system efficiency.

Priorities for developing intermediate care (and other short-term care)

The BCF plan prioritises the development of sustainable, high-quality, short-term intermediate care options that promote independence and recovery. This includes increasing the availability of home-based rehabilitation services, strengthening integrated community teams, and ensuring that therapy-led interventions are embedded within all intermediate care pathways.

The 2025-26 plan continues to emphasise the importance of shifting care delivery from bed-based approaches to more innovative, home-based models anchored in the Home First ethos and aligned with the Discharge To Assess (D2A) operating model. This shift is necessary to provide better outcomes for individuals by delivering care, reablement, and therapy support in their own homes after a hospital stay or as a preventive measure to avoid hospital admission.

Whilst the shift towards home-based rehabilitation and reablement remains a priority, we recognise the need to maintain a balanced approach that ensures sufficient step-down bed capacity for those who require more intensive support post discharge. We will conduct a comprehensive capacity review to assess demand fluctuations and ensure a dynamic response to service pressures. The review will also explore the role of Technology Enabled Care (TEC) in supporting individuals at home, aligning with Sandwell's TEC Strategy to maximise the use of remote monitoring, assistive technology, and virtual care solutions.

Additionally, we will strengthen the integration of the Home First model with the Discharge to Assess (D2A) framework, ensuring that bed-based intermediate care remains available for those with complex needs while prioritising home-based care wherever possible. Investment

in workforce development, particularly in therapy-led interventions, will ensure a skilled multidisciplinary team is available to support rehabilitation pathways effectively.

In Sandwell we have successfully repurposed over £4 million of recurrent annual investment from traditional intermediate care and step-down beds into a home-based model of care, which has achieved recurrent annual savings of over £1m that are then reinvested in out-of-hospital services to meet growing demand and support the development of a 7-day D2A model.

We established the Programme Delivery Group (PDG) to streamline care pathways, eliminate duplication across providers, and facilitate coordinated, person-centred care. This approach involves operational and strategic collaborations across adult social care, community health, and voluntary and community sector partners to establish unified teams responsible for overseeing the entire care journey, from hospital admission to discharge and rehabilitation.

Workforce capacity is a critical enabler of this vision, and our continued efforts will address recruitment challenges through targeted workforce development initiatives. The plan also recognises the importance of digital innovation in supporting intermediate care, with an emphasis on remote monitoring, virtual wards, and assistive technology to help individuals manage their health and wellbeing at home.

External specialists are collaborating with partners to support our collective needs to review current services. The main objective of this work is to review current services for opportunities to reduce operational costs, enhance productivity, and identify opportunities for integration within intermediate care services to achieve significant cost savings in response to the increasing demand for adult social care and community health services. The review will evaluate the Council's internal reablement service and the community therapy team and will explore pathway development to improve efficiency within intermediate care services through the Integrated Discharge Hub.

While this BCF plan is specific to Sandwell, it is considerate of regional priorities and in collaboration with the Integrated Care Board and oversight from the Health and Wellbeing Board. This ensures consistency in service delivery and facilitates joint working across neighbouring areas to address shared challenges.

The governance process for sign-off meets National Condition 1, with formal agreement secured through the Sandwell Health and Wellbeing Board, and the Chief Executive Officers from Sandwell Council and the Black Country ICB. This collaborative approach reflects a

shared commitment to integrated working and will enable a more coordinated response to the evolving health and care needs of the local population.

The shift towards home-based rehabilitation and reablement remains a priority; however, we recognise the need to maintain a balanced approach that ensures sufficient step-down bed capacity for those who require more intensive support post-hospital discharge. We will conduct a comprehensive capacity review to assess demand fluctuations and ensure a dynamic response to service pressures. The review will also explore the role of Technology Enabled Care (TEC) in supporting individuals at home, aligning with Sandwell's TEC Strategy to maximise the use of remote monitoring, assistive technology, and virtual care solutions.

Additionally, we will strengthen the integration of the Home First model with the Discharge to Assess (D2A) framework, ensuring that bed-based intermediate care remains available for those with complex needs while prioritising home-based care wherever possible. Investment in workforce development, particularly in therapy-led interventions, will ensure a skilled multidisciplinary team is available to support rehabilitation pathways effectively.

Section 2: National Condition 2: Implementing the objectives of the BCF

Please set out how your plan will implement the objectives of the BCF: to support the shift from sickness and prevention; and to support people living independently and the shift from hospital to home. This should include:

- A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money

- Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans
- Demonstrating a “home first” approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care
- Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step-down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.

How we will demonstrate a joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money

Sandwell’s BCF Plan for 2025-26 implements the national objectives of shifting the focus from treating sickness to prevention and enabling people to live independently by moving care closer to home. This approach is underpinned by a strong commitment to integration, early intervention, and community-based support, ensuring that individuals receive the right care in the right place at the right time. This commitment is reflected in our newly established shared vision for the delivery of care and support in Sandwell: **“The right support, at the right time and the right place, to maximise independence and empower people to remain safe and healthy”**

The joint system approach to meeting BCF objectives builds on existing partnerships between health, social care, housing, and the voluntary sector, ensuring that services are better coordinated and person-centred. Through the JPB, key partners including Sandwell Council, Public Health, the ICB, SWBHT and the SHCP will work collaboratively to align strategic priorities and operational delivery.

This model incorporates local learning from implementing previous BCF plans while also drawing on national best practice to ensure effective service delivery and value for money. By improving access to preventative care, community-based services, and digital health solutions, this plan seeks to reduce unnecessary hospital admissions and long-term reliance on residential and nursing care.

Our goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans

The plan is structured around achieving ambitious goals aligned with the three national BCF metrics: reducing emergency admissions for people aged 65 and over, decreasing the average length of discharge delays for adult patients, and minimising long-term admissions to residential and nursing care.

By investing in expanded community-based services and intermediate care, the plan aims to ensure that more people can receive timely support at home, preventing avoidable hospital admissions and facilitating smoother transitions out of acute settings. The plan also incorporates a comprehensive intermediate care demand and capacity plan, ensuring that resources are allocated effectively to meet projected needs.

Capacity planning for 2025-26 was informed by an analysis of 2024-25 demand, ensuring that gaps in service provision are addressed and that there is sufficient workforce capacity to deliver effective rehabilitation and reablement services.

Demonstrating our “home first” approach that aims to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care

A core principle of the plan is the continued implementation of the Home First approach, which prioritises supporting people to remain independent at home rather than relying on hospital or institutional care. This is achieved through enhanced community reablement services, integrated multidisciplinary teams, and the increased use of assistive technology and remote monitoring solutions.

The Home First approach encapsulated in our previous BCF plans will continue to be a key driver for improving care delivery and outcomes in Sandwell throughout 2025-26 and beyond. We will build further on our successes in shifting from community bedded approaches to home-based delivery models anchored in the Home First ethos, by offering more care, reablement, and therapy support to people in their own homes where appropriate and enabling them to access other support, including social support through the voluntary and community sector to keep people connected to their communities and to increase the opportunities for people to strengthen their social networks and participate in community life.

The Home First model ensures that hospital stays are minimised, and individuals receive rehabilitation and therapy in a familiar home environment whenever possible. The Sandwell Integrated Discharge Hub plays a critical role in facilitating this transition by coordinating care planning and ensuring that support services are in place before discharge. Investment in home-based therapy services and digital care solutions will further strengthen this approach, enabling more people to recover and regain independence without the need for prolonged hospitalisation or long-term residential placements.

The PDG drives the streamlining of care pathways, eliminates duplication across providers, and facilitates coordinated, person-centred care. This approach involves operational and strategic collaborations across adult social care, community health, and voluntary and community sector partners to establish unified teams responsible for overseeing the entire care journey, from hospital admission to discharge and rehabilitation.

We will align our BCF planning with the national guidelines on neighbourhood health models to ensure its suitability for future needs. The BCF plan's focus on shifting from traditional community bedded approaches to home-based models aligns well with the neighbourhood health guidelines' aim to provide better care at home or closer to home. This will be delivered by additional repurposing of resources from intermediate care beds into home-based care, as highlighted in the BCF plan, and ensuring that these home-based services are well-integrated with primary and community care as outlined in the neighbourhood health guidelines.

The PDG supports the neighbourhood health guidelines' emphasis on integrated working. By developing unified teams responsible for overseeing the entire care journey, the BCF plan can support the neighbourhood health guidelines' goal of reducing fragmentation and improving coordination across health and social care providers.

Additionally, the BCF plan's focus on the Home First approach and the Discharge To Assess (D2A) model can be aligned with the neighbourhood health guidelines' emphasis on preventing unnecessary hospital admissions and supporting timely discharges. By increasing capacity for home-based care and support, the BCF plan can help achieve the neighbourhood health guidelines' aim of reducing the time people spend in hospitals and care homes.

Moreover, the BCF plan's commitment to providing funding to address recruitment challenges in the health and social care workforce will support the neighbourhood health guidelines' goal of building a flexible and integrated workforce. Joint recruitment events and workforce planning

can ensure that staff are deployed effectively across different settings, improving continuity of care, and enabling more agile working practices.

Finally, the BCF planning guidance and the neighbourhood health guidelines both emphasise the importance of using data and technology to improve care delivery. To enhance accountability and drive service improvements, our performance dashboard will be reviewed and refined to provide real-time insights into BCF-funded service delivery. The PDG oversees performance monitoring, ensuring that key indicators such as emergency admissions, delayed discharges, and intermediate care utilisation and outcomes are actively tracked.

New mechanisms will be introduced to ensure that data-driven decision-making underpins service planning. The use of predictive analytics will be expanded to identify groups, if not individuals, at risk of hospital admission, allowing for targeted interventions before a crisis occurs. Additionally, intermediate care performance will be subject to ongoing scrutiny through periodic impact reviews, ensuring that resources are being allocated effectively and that service pathways remain responsive to emerging trends.

The BCF-funded approaches to establishing virtual multidisciplinary teams, virtual wards, and virtual complex case management can support the neighbourhood health guidelines' focus on digital solutions to enhance care coordination and support patient-initiated follow-up.

By integrating these elements, the BCF programme for Sandwell can begin to align with the neighbourhood health guidelines to create a more cohesive, efficient, and person-centred health and social care system.

How our ambitions to shift planned expenditure away from discharge and step-down care to admissions avoidance or other services following the consolidation of the Discharge Fund are expected to enhance UEC flow and improve outcomes

In Sandwell we found the government’s decision to ring-fence Adult Social Care Discharge Funding to support hospital discharge to be restrictive, particularly considering the opportunity costs associated with limiting its use to supporting discharges rather than admissions avoidance.

While the policy aimed to alleviate the pressures on hospitals by facilitating quicker discharges, it simultaneously limited local health and care systems from investing in preventative measures that could reduce hospital admissions in the first place. The focus on hospital

discharge assumed that the primary bottleneck in the urgent and emergency care (UEC) system was delayed transfers of care rather than the wider demand pressures leading to unnecessary admissions. This narrow approach appears to have overlooked the broader systemic benefits that could have been achieved had local systems been allowed to allocate resources more flexibly towards admission avoidance strategies.

One of the key limitations of the ring-fencing policy was its inherent short-termism. By prioritising discharge, it attempted to create immediate hospital capacity without addressing the upstream causes of admissions, such as inadequate community-based support, poor primary care access, and gaps in early intervention services. Preventative measures, including enhanced reablement services, investment in rapid response community teams, and greater social care support to keep people at home, were underfunded due to the discharge funding restrictions. Consequently, this created a situation where patients were discharged more quickly but without sufficient support to prevent readmission, exacerbating system-wide pressures rather than mitigating them in a sustainable manner.

The removal of the ring-fence around the discharge funding presents an opportunity to shift resources towards preventative measures that reduce hospital admissions and permanent admissions to care homes. In response, the BCF programme will look for opportunities to expand investment in early intervention services, particularly for high-risk groups including individuals with frailty, long-term conditions, and learning disabilities. This may include scaling up proactive care planning, enhancing community-based crisis response teams, and further developing the 72-hour wraparound service to provide intensive support and stabilisation that enables people to remain at home whilst they received the appropriate treatment and support.

A targeted focus will also continue to be placed on falls prevention, frailty management, and anticipatory care planning to mitigate the risks of hospitalisation among vulnerable populations. The plan will embed robust mechanisms to monitor the impact of these initiatives, ensuring that the reallocation of resources demonstrably improves urgent and emergency care (UEC) flow and reduces preventable admissions.

By preventing avoidable admissions, fewer people will require hospital stays in the first place, reducing the need for crisis-driven discharge interventions. This rebalancing of resources towards earlier intervention also aligns with the strategic aim of reducing dependence on acute hospital beds and strengthening out-of-hospital care. Moreover, shifting resources towards admission avoidance is likely to lead to better patient outcomes. Avoiding a hospital stay altogether, where possible, reduces the risks associated with hospitalisation, such as

deconditioning, hospital-acquired infections, and loss of independence, particularly among older adults.

There are already strong examples of preventative measures within Sandwell that we will look to expand upon. These include proactive management of long-term conditions within primary care networks (PCNs), social prescribing models, and community-based interventions aimed at supporting individuals before they reach crisis point. The expansion of anticipatory care planning and the development of integrated neighbourhood teams will further support this shift towards prevention.

To provide a structured pathway towards a fully developed prevention plan, we will recommend the development of a road map outlining key milestones over the next year. This will include strengthening data-sharing mechanisms between primary care and social care, leveraging wider investment in public health initiatives, and piloting new models of preventative care in high-risk populations. By embedding prevention more firmly within the BCF Plan, we will support a long-term vision that prioritises early intervention, reduces health inequalities, and alleviates pressures on urgent and emergency care services.

Through the BCF programme we will also work to strengthen community-based alternatives and initiatives such as enhanced social care packages, stronger partnerships with the Voluntary and Community Sector, establishment of multidisciplinary crisis response teams, and provision of community equipment and digital technology to help to ensure that individuals receive timely and effective support in the most appropriate setting. These measures not only contribute to better patient experience and improved recovery but also relieve pressure on emergency departments and acute wards.

The improved flexibility in funding allocation is also expected to enhance system resilience by allowing local areas to respond to their specific pressures rather than adhering to a centrally mandated approach. Different localities experience different challenges, with some areas struggling more with delayed discharges while others face excessive emergency admissions. By removing the ring-fence, we can now target our spending to address the most pressing needs for Sandwell, leading to more efficient use of resources and a more balanced approach to managing demand across health and social care.

The JPB will consider supporting a strategic shift in funding allocation for the BCF programme from step-down care towards admission avoidance initiatives. However, this will only be considered where there is compelling evidence of effectiveness for novel approaches. Such a

resourcing shift can be expected to enhance urgent and emergency care (UEC) flow by reducing the number of individuals requiring acute hospital admission in the first place.

Instead of focusing primarily on post-hospital discharge services, the plan prioritises strengthening preventative measures including frailty interventions, falls prevention, proactive care planning and low-level social support provided by the voluntary sector. By investing in community-based crisis response teams, integrated social prescribing services, and enhanced support for care homes, the plan will support more effective demand-management and prevent avoidable escalation of health conditions. There will be more focus on investment up-stream to create more resilience in the at-risk cohorts such as people with Mental Health needs, Learning Disabilities and Autism. This approach aligns with national priorities by ensuring that hospital resources are reserved for those who genuinely require acute medical care, while the wider health and social care system works proactively to keep people well in the community.

The BCF plan's financial strategy ensures that these shifts in investment are carefully managed and evidence-based to maximise system-wide efficiencies while improving outcomes for residents. By reducing dependency on costly step-down beds and increasing the availability of personalised support at home, the plan promotes sustainability and long-term improvements in care provision.

Additionally, the use of data-driven decision-making and predictive analytics will support targeted interventions, enabling early identification of individuals at risk of hospital admission and ensuring timely access to support. This integrated approach, rooted in collaboration and innovation, ensures that Sandwell's BCF plan delivers tangible improvements in health outcomes, promotes independence, and creates a more resilient and efficient health and care system for the future.

Please describe how figures for intermediate care (and other short-term care) demand and capacity for 2025-26 have been derived, including:

- how 2024-25 demand and capacity actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)
- how capacity plans take into account therapy capacity for rehabilitation and reablement interventions

Summary of our Demand and Capacity Planning Approach

Intermediate Care Demand and capacity Planning for 2025-26

The figures for intermediate care (and other short-term care) demand and capacity for 2025-26 have been determined through a structured approach, taking account of the BCF planning and demand & capacity guidance for 2025-26. This approach considers actual demand and capacity data from 2024-25 (as provided through the quarterly returns) and anticipated service improvements.

Incorporating 2024-25 Actuals into 2025-26 Planning

A review of demand and capacity data from 2024-25 has been undertaken to assess trends, including peak demand periods and the effectiveness of service pathways. No capacity shortfalls were identified in 2024-25. However, proactive mitigation strategies are in place should any shortfalls arise during 2025-26, including:

- **Expanding Home-Based Rehabilitation and Reablement Services** – Further reducing reliance on bed-based intermediate care.
- **Enhancing Workforce Recruitment Efforts** – Addressing potential staff shortages in reablement and therapy services.
- **Targeted BCF Investment** – Scaling up proven interventions that effectively reduce hospital admissions and delays.

Seasonal demand fluctuations, including Winter pressures, have been factored into the 2025-26 forecast alongside expected service improvement impacts. The removal of the ring-fence from the former discharge funding and its inclusion in the baseline BCF income for 2025-26 provides commissioners with greater flexibility, allowing for improved forward planning ahead of the Winter period.

Capacity Planning and Therapy Considerations

Therapy services play a pivotal role in helping people to achieve their reablement and rehabilitation outcomes. Sandwell's capacity planning ensures:

- **Integrated Therapy Support** – Occupational therapy (OT) and physiotherapy are embedded within intermediate care teams to provide timely interventions.

- **Investment in Multidisciplinary Teams** – Ensuring adequate therapy staffing levels to support home-based rehabilitation pathways and reduce reliance on traditional bed-based care.
- **Efficiency Gains through Digital and Assistive Technology** – Utilising telehealth and assistive technologies to enhance therapy interventions at home.

Balancing Home-Based vs. Bed-Based Capacity

Sandwell continues to prioritise the Home First approach, further shifting the balance of activity towards community-based reablement services while reducing dependence on bed-based care.

Intermediate Care Workforce and Recruitment Strategies

To address workforce challenges and maintain service efficiency, the following initiatives are in place:

- **Ongoing Recruitment Events** – Funded via the BCF to attract skilled professionals.
- **Review of Pay Structures** – Where necessary, to improve recruitment and retention of therapy staff.
- **Expansion of Workforce Training Programs** – Upskilling existing staff to enhance service delivery.

By integrating these measures, the 2025-26 intermediate care demand and capacity planning aligns with national BCF objectives whilst ensuring the needs of Sandwell's local population are met efficiently and sustainably. For the purposes of reporting, we will be using the templates provided by the national Better Care Fund Team for both the narrative plan and the Demand and Capacity plan.

Detailed Discussion

The Better Care Fund (BCF) plan for 2025-26 has been designed to reflect national priorities and guidance, ensuring a structured and effective strategy for managing intermediate care demand and capacity. This plan supports both 'step-up' services, which help individuals maintain independence at home or access a short-term community bedded unit to assess and support their needs if they cannot be supported safely at home, and 'step-down' services that facilitate timely and safe hospital discharge. To ensure consistency in planning and reporting, we have adopted the national demand and capacity templates recommended in the latest BCF Demand and Capacity Planning Guidance refresh.

The demand and capacity figures for 2025-26 are based on a comprehensive review of actual data from 2024-25, allowing for the identification of trends, service pressures, and areas

requiring enhancement. We have undertaken an in-depth analysis of hospital discharge pathways, community referrals, and the utilisation of intermediate care beds to ensure informed decision-making. Whilst no capacity shortfalls have been identified, mitigation strategies have been integrated into the 2025-26 BCF programme as in previous years. These include expanding home-based reablement capacity, strengthening recruitment initiatives, and increasing investment in therapy-led rehabilitation. Seasonal variations, particularly the anticipated rise in demand during Winter, have also been factored into capacity planning to support resilience in service provision.

Therapy-led rehabilitation and reablement remain a crucial component of our intermediate care strategy. We recognise the essential role that occupational therapists and physiotherapists play in supporting individuals to regain their independence. To ensure adequate therapy capacity, we have embedded registered therapists within multidisciplinary teams, expanded workforce training, and we continue to review staffing models across our intermediate care bed bases to align to needs and demands.

For example, we have realigned staffing rotas in the council's Short-Term Assessment and Reablement (STAR) service to better match demand. This has released capacity and is illustrates how we have used demand and capacity modelling to make practical changes that have meaningful impacts for the people we serve. A review of Harvest View's reablement criteria is also underway to ensure that the service provision aligns to presenting needs, reducing the need to spot purchase placements from the wider market.

To further enhance alignment, we will ensure that intermediate care rehabilitation access criteria are reviewed and standardised, cross-referencing with Harvest View's reablement criteria to improve clarity in service provision by presenting need. By taking a proactive approach to workforce planning, we aim to optimise service efficiency and improve outcomes, reducing reliance on bed-based care where home-based support is more appropriate.

To ensure that intermediate care services meet both anticipated and unplanned demand, we have adopted a dynamic capacity planning approach. The analysis of 2024-25 data has helped identify peak demand periods, enabling us to implement appropriate contingency measures such as additional step-down beds and increased home-based reablement capacity.

Continuous monitoring of intermediate care demand allows for responsive adjustments throughout the year, ensuring service sustainability. Furthermore, we are leveraging digital tools to enhance operational oversight and decision-making, increasingly enabling real-time data to drive resource allocation. A review of block and spot beds is scheduled for early 2025-26 to ensure that resources are allocated effectively, reducing under-utilisation, and redirecting funding towards the most effective care models.

Ensuring consistency in data collection and reporting remains a priority. Data sources, including hospital systems, local authority systems, the Discharge Hub, and other referral

pathways including from the VCS, are integrated into our processes to enhance accuracy and effectiveness.

Virtual wards and Urgent Community Response (UCR) services are key elements of our local care offer, though in accordance with the BCF Demand and Capacity Guidance, virtual ward capacity is treated as an alternative to acute care and is not included in intermediate care capacity planning. Recognising the interdependencies between UCR, intermediate care services and discharge support, we have established mechanisms to facilitate robust information sharing and coordination, ensuring that patients receive the appropriate level of care whilst minimising inefficiencies.

Optimising the use of intermediate care beds and improving patient flow remain key priorities. Our planning process includes a detailed review of service utilisation to reduce reliance on bed-based care where home-based reablement is a more suitable alternative. Regular audits of peoples' outcomes inform commissioning decisions, ensuring resources are effectively allocated. This includes ensuring that workforce requirements at Harvest View and across other intermediate care services align with the complexity of individuals' needs, ensuring that staff are appropriately trained and resourced to deliver high-quality care.

Our approach is integrated with wider health and social care strategies, aligning with NHS operational plans and local authority adult social care plans. Collaboration with the acute trust ensures that assumptions regarding acute inpatient care growth are incorporated into our capacity planning. Additionally, our planning supports urgent and emergency care (UEC) flow, with a clear focus on reducing unnecessary hospital admissions and expediting discharges through well-structured intermediate care pathways.

By ensuring our approach aligns with national guidance, the BCF programme provides a structured and effective delivery vehicle for intermediate care. Through a combination of robust data collection, proactive workforce development, adaptable capacity planning, and strong system-wide collaboration, we are well-positioned to deliver high-quality, person-centred care that promotes independence and improves outcomes for our population.

Section 3: Local priorities and duties

Local public bodies will also need to ensure that in developing and delivering their plans they comply with their wider legal duties. These include duties:

- to have due regard to promoting equality and reducing inequalities, in accordance with the Equality Act 2010 public sector equality duty.
- to engage or consult with people affected by the proposals. For ICBs, trusts and foundation trusts this includes their involvement duties under the NHS Act 2006.
- for ICBs, to have regard to the need to reduce inequalities in access to NHS services and the outcomes achieved by NHS services.
- for ICBs, to have regard to the duty to support and involve unpaid carers in line with the Health and Care Act 2022

Please provide a short narrative commentary on how you have fulfilled these duties

Sandwell's BCF plan for 2025-26 has been developed with a strong commitment to fulfilling the wider legal duties of local public bodies, ensuring that equality, inclusivity, and stakeholder engagement remain at the heart of service planning and delivery. In accordance with the public sector equality duty under the Equality Act 2010, the plan prioritises reducing health disparities and improving access to services for all residents, including those from disadvantaged or marginalised communities.

The BCF programme incorporates a structured approach to Equality Impact Assessments (EIAs) to ensure that service design actively promotes inclusivity and reduces health inequalities. We will explore the introduction of specific monitoring mechanisms to track the impact of BCF initiatives on different population groups, with a focus on addressing disparities in access and outcomes.

Sandwell has a diverse population with significant variations in health outcomes, and the BCF programme actively addresses these inequalities through targeted interventions such as enhanced support for older adults, those with disabilities, and individuals from ethnic minority backgrounds. The BCF programme will also align with the NHS Core20PLUS5 framework to target interventions at the most deprived communities and underrepresented groups. Furthermore, co-production with service users from diverse backgrounds will be embedded within service development processes, ensuring that BCF-funded initiatives are culturally responsive and accessible to all residents

The wider engagement and consultation work in relation to services funded by the BCF has played a crucial role in shaping the BCF plan, ensuring that the voices of service users, carers, and local partners are incorporated into decision-making. Input has been incorporated into the Plan from wider engagement work in relation to services funded by the BCF, involving a range of stakeholders, including voluntary and community organisations, care providers, and user groups.

The JPB and HWB have provided oversight, encouraging co-production with service users and their families to ensure that planned initiatives genuinely reflect local needs. This approach is in line with the involvement duties outlined in the NHS Act 2006, ensuring that individuals and communities affected by changes to care provision can contribute to service design and improvement.

The BCF plan is also cognisant of the legal duty of Integrated Care Boards (ICBs) to reduce inequalities in access to NHS services and in the outcomes achieved by different population groups. Sandwell has embedded a place-based, person-centred approach that strengthens primary and community care services, making it easier for residents to access preventative and ongoing support before their health conditions escalate.

Specific initiatives such as social prescribing, anticipatory care planning, and enhanced community frailty services are designed to bridge gaps in access and ensure that care is delivered equitably. Furthermore, digital health solutions, including remote monitoring and virtual consultations, are being explored to enhance accessibility for those who may face physical or socioeconomic barriers to in-person healthcare.

The plan also fully aligns with the duty under the Health and Care Act 2022 to support and involve unpaid carers, recognising their essential role in the health and social care system. Supporting unpaid carers is a critical aspect of the Better Care Fund plan, ensuring they receive the assistance they need to sustain their caregiving roles while maintaining their own health and well-being and to this end we are pleased to confirm that from August this year BCF in Sandwell will be supporting a brand-new Carers Service which will support all carers in Sandwell.

The new Carers Service will play a pivotal role in identifying and supporting both visible and seldom-heard carers, ensuring they receive tailored assistance. The service will integrate with existing voluntary sector providers to avoid duplication and ensure a coordinated approach to carer support.

To enhance accessibility, a digital Carers Register will be introduced, allowing carers to register themselves or be registered by healthcare and social care professionals. This will enable the proactive distribution of information, advice, and guidance tailored to carers' needs.

Respite care options will be expanded beyond traditional bed-based provision, offering more flexible short-break solutions that align with carers' needs. Direct Payments for carers will be realigned to provide practical financial support, ensuring that they can access personalised respite and well-being services. Additionally, emotional, and mental health support for carers will be strengthened, with dedicated counselling services and peer support networks embedded within the Carers Service.

The new Carers Service will be responsible to identifying and supporting Sandwell's visible carers as well as working proactively to identify and engage with the seldom heard carers from Sandwell's diverse communities and across all ethnicities. The new service will link in with existing organisations that provide support for carers to co-ordinate and not duplicate and this will include the Young Carers support service.

To enhance the introduction of the service a review of the replacement care offer in Adult Social Care is underway including the option of more flexible short breaks and a move away from traditional bedded respite options. This will allow carers to take breaks without concern for the safety and comfort of the individuals they support. More practical support will be improved through signposting to specialist carers support services and universal services, including increased access to welfare benefit advice. This is underpinned by a full review of our Adult Social Care front door (Sandwell Enquiry) which will be undertaken during 2025-26.

In addition, training and skill development programs will be made widely available to equip carers with the knowledge and skills required to manage complex health conditions, medication, and care planning effectively. Early identification and assessment pathways will be strengthened to ensure that carers are recognised at the earliest opportunity and connected with appropriate support services.

A digital app is to be introduced shortly so carers in Sandwell will be able to access a wide range of information advice and guidance online including health information sourced through NHS websites using their mobile phones or other mobile devices. This will also include content specifically for young carers.

We will also be introducing a new Carers Register which will enable Carers to register themselves or be registered by GPs and other Health Professionals as well as those from the Social Care workforce and the Voluntary & Community Sector.

Carers in Sandwell will be able to register themselves on the new Carer's Register through multiple methods. They can complete a simple registration form by following a link or scanning a QR code. Additionally, carers will have the option to register via a new app that will provide access to online support, including AI coaches and information from both local and national sources such as the NHS. Once registered, carers will be contacted by the Carers Service, which will help connect them to a range of support services, reducing their need to rely on GPs for assistance.

GPs and other healthcare professionals will be able to register carers on their behalf using the same simple online process via a link or QR code. Furthermore, they will be able to refer carers directly to the app, ensuring carers can access additional digital resources and support.

To ensure GPs and other healthcare professionals are aware of the Carer's Register, the Carers Service will actively promote it once it becomes operational. This will involve making direct contact with GPs and healthcare teams to raise awareness of the register and the wider Carers Service.

Employers will be encouraged to implement workplace policies that support working carers, including flexible work arrangements, carer-friendly policies, and access to paid leave options. Digital solutions will be enhanced to ease caregiving responsibilities, including online care coordination platforms, assistive technologies, and telehealth services that allow carers to manage appointments and monitor health conditions remotely. The co-production of support services with carers will ensure that their lived experiences and insights shape the design and delivery of carer-focused services.

Employers will be encouraged to implement workplace policies that support working carers through initiatives outlined in Sandwell's Joint Carers Strategy. A key element of this strategy is the new Carers Service, which will actively engage with employers to promote carer-friendly working practices and policies. This will include advocating for flexible work arrangements that enable carers to balance their responsibilities while remaining in employment.

Additionally, the specification for the new Carers Service includes a requirement to secure external funding to deliver a dedicated support programme for working carers. This programme will not only support those currently in employment but will also assist carers in

returning to work. By fostering partnerships with employers, the service aims to encourage the adoption of policies such as paid leave options for carers, workplace support networks, and access to tailored advice and resources.

The Carers Service will also play a proactive role in raising awareness among employers about the benefits of supporting carers in the workplace. Through direct engagement, it will highlight the positive impacts of carer-friendly policies on employee wellbeing, retention, and productivity. By embedding these practices into workplace cultures, employers can contribute to a more inclusive and supportive working environment for carers.

Targeted interventions will be introduced for young carers, ensuring they receive educational, mental health, and social support to prevent caregiving responsibilities from negatively impacting their personal development. Carer support will be embedded within wider Better Care Fund priorities to guarantee seamless integration between carer services and broader health and social care initiatives, ensuring that unpaid carers receive sustained and meaningful support within Sandwell's health and care system. Our commitments include:

- **Expanding respite care and well-being services for unpaid carers**, ensuring access to flexible short-term and overnight respite options.
- **Improving access to financial support for carers**, including direct payments, benefits advice, and financial grants to help sustain caregiving roles.
- **Enhancing emotional and mental health support**, including dedicated counselling services, peer support groups, and online mental well-being resources.
- **Providing training and skill development programs** to empower carers with essential knowledge on managing health conditions, medication, and care planning.
- **Strengthening identification and assessment pathways** to ensure that carers' needs are recognised early and that they receive tailored support.
- **Developing workplace policies for working carers**, encouraging employers to implement flexible work arrangements, carer-friendly policies, and paid leave options.
- **Enhancing digital solutions for carers**, including online care coordination platforms, assistive technologies, and telehealth options to ease caregiving responsibilities.

- **Co-producing support services with carers**, ensuring that lived experiences shape the design and delivery of carer-friendly services.

- **Improving young carers' support**, establishing targeted interventions that provide educational, mental health, and social assistance to prevent negative impacts on their personal development and well-being.

- **Embedding carer support within wider BCF priorities**, ensuring seamless integration between carer services and broader health and social care initiatives.

- **Development of a place-based Carers Register** which can be used by GP's and other health professionals to register or advise carers to register themselves so regular carers newsletters and other information can be shared and circulated.

By embedding these legal duties into our BCF planning and governance framework, Sandwell ensures that its approach to health and care integration is both equitable and inclusive. The plan not only meets statutory obligations but also fosters a health and social care system that prioritises fairness, responsiveness, and long-term sustainability, improving outcomes for the entire community.