Integration and Better Care Fund

Walsall

Better Care Fund 2025-26

Narrative Plan

Walsall Council

Walsall Together

NHS Black Country Integrated Care Board

31 March 2025

HWBB	**Walsall Place**
Local Authority	**Walsall Metropolitan Borough Council**
ICB	**Black Country ICB Walsall Place**

Section1

Introduction

In line with national requirements, Walsall Better Care Fund (BCF) has been in place as a joint programme since 2015. As one of the four programmes across the Black Country, the partnership approach in Walsall remains a key driver for the BCF at Place level in responding to key national priorities.

The BCF 2025 to 2026 Policy Framework, reaffirms a clear direction for the BCF to be one of the government's national vehicles for driving health and social care integration.

The BCF 2025 vision is to help people stay independent and healthy at home for longer, support people to live healthy, independent and dignified lives and aims to provide the right care in the right place at the right time.

National leads continue to prioritise integration as key driver, through joint approaches between health and social care, with a new emphasis on prevention and use of digital technology. To ensure alignment, the national vision underpins the government's commitment to reforming and strengthening neighbourhood services across health and social care, with the goal of:

- providing more care closer to home
- increasing the focus on prevention so that people are living healthier and more independent lives
- harnessing digital technology to transform care.

This in turn aligns with the two core BCF objectives for 2025 to 2026:

- Reform to support the **shift from sickness to prevention** by helping people remain independent for longer and prevent escalation of health and care needs, including:
    - timely, proactive and joined-up support for people with more complex health and care needs
    - use of home adaptations and technology
    - support for unpaid carers.

- Reform to support people living independently and the **shift from hospital to home**
    - help prevent avoidable hospital admissions

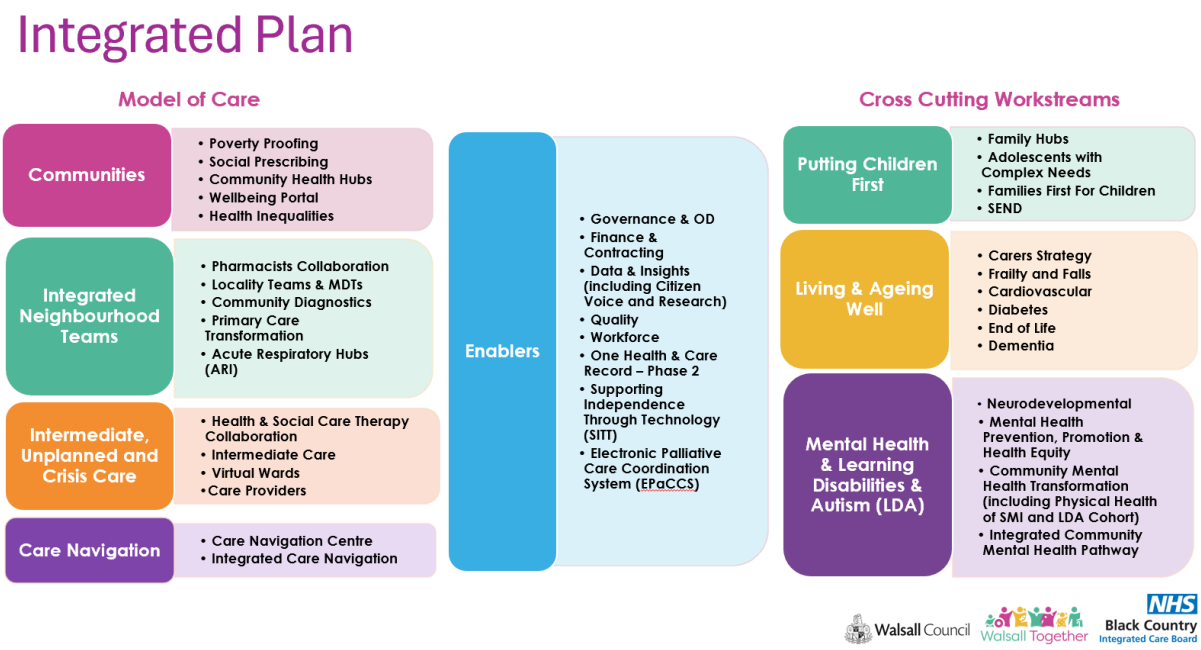
- achieve more timely and effective discharge from acute, community and mental health hospital settings, supporting people to recover in their own homes (or other usual place of residence)
- reduce the proportion of people who need long-term residential or nursing home care.

Overview of BCF Plan 2025 to 2026

In line with national priorities, the Walsall BCF Plan supports the national objectives in the shift from sickness to prevention and hospital to home.

The wider integrated approach in Walsall through the Walsall Integrated Commissioning and Transformation Plan showcases elements of the BCF programme.

Figure 1. Walsall Integrated approach through Integration Plan



Walsall Market Position Statement

The intentions and ambitions of the Market Position Statements developed in Walsall Support the navigation of programmes and actions of the BCF for Residential and Nursing care, Community-based services and supporting adults with long term needs. These are aligned to the Walsall 2040 vision to develop a thriving, inclusive and sustainable borough by 2040. Residential and Nursing Care, Home Care and Supported Living all show a substantial projected increase in demand through to 2040. Utilising improved community-based services, prevention, early help and strengths-based practices will support implementation of actions to improve this forecasted outcome:

Residential and nursing care
"To have a right sized, good quality, affordable and sustainable residential and nursing care home market in Walsall offering a range of bed-based services that flexibly provide care for older people and working age adults in the areas and specialisms where it is most needed, now and into the future."

Community-based services
"To grow and shape services that meet people's needs in their own homes and communities to help maintain independence, and to prevent and delay the need for long-term care and support options for as long as possible".

"We expect there to be an increasing need for community-based services to support people in future, particularly as demand grows as projected. We will prioritise building relationships with providers, users of services and their families/carers and partners to ensure that services and support are available across the Borough to ensure good quality, responsive, locally based services that improve outcomes for local people. "

Working Age Adults with Long Term Needs
"For people, where possible, to be living in their own homes with little or no support because they have maximised their independence. Where working age adults with long-term needs do need care and support in supported living, shared lives and other services ensure that this is good quality, progressive, meets needs and desired outcomes."

Key Walsall BCF priorities for 2025-26 include:

- Building on the exemplary status of the integrated Intermediate Care Service
- Supporting effective hospital discharge with care and rehabilitation including redesign of the Pathway 2 rehabilitation beds provision
- Review of the Pathway 3 process
- Development of ICS Power BI Dashboard for clear data collection and reporting
- Creating greater efficiency in the Integrated Community Equipment Service with potential to extend the reach of the service (Children's equipment provision)
- Continuing to support those with complex health needs including dementia support
- Establishing clear reporting of 'fit for hospital discharge, not ready for rehabilitation' cohort (i.e. non-weight bearing and delirium)
- Supporting carers and advocacy for parents with disabilities
- Providing rapid response support to Urgent Community Response, Frail and Elderly Service and Front door teams through packages of care/care calls.

Key projects and areas of work include:

- Walsall Intermediate Care/Hospital Discharge service (ICS) - multidisciplinary and multiagency integrated team across health and social care organisations.
- Integrated Community Equipment Service - supports adults with equipment and adaptation provisions across both health and social care.
- Additional BCF programmes include - support for Carers, Dementia support, End of Life Care, Stroke Care and Cardiac Rehabilitation and Mental Health support.

Culture and Urgent Community Response

The Walsall BCF will continue to evoke the Home First ethos and further develop programmes through the pooled resources to keep patient pathways flowing and supporting independence and care in the community.

The Walsall Care Navigation Centre (CNC) serves as a central point of contact for patients in urgent need of assistance. Support is offered through a community-based care plan, focusing on keeping patients at home and avoiding unnecessary visits to Hospital.

CNC staff provide advice on self-care, direct individuals to relevant organisations, or make referrals to various community services. Patient's requiring hospital care are referred to the Same Day Emergency Care teams, offering direct access to specialist hospital staff and eliminating long waiting times in Accident and Emergency.

Patients with urgent health concerns that can be addressed in the community, are referred to the Urgent Community Response team, who will conduct an assessment and, if needed, arrange temporary care to avoid hospitalisation. Patients are also referred to social workers, specialised community teams, or voluntary organisations as necessary.

Virtual Wards support those patients who may require additional support to ensure safety at home. Supported by a specialist team of hospital and community healthcare professionals, patients on the Virtual Ward receive the same high level of care as they would in a hospital.

Intermediate Care – Locality Areas

The ICS locality teams across Walsall support hospital discharge by delivering a personalised Intermediate Care Service for people with a range of needs.

Supporting patients/clients to develop/regain skills and confidence through a co-ordinated programme of reablement following a stay in hospital, illness, crisis, fall at home or change in circumstances in relation to themselves or their carer.

The multidisciplinary team works cohesively to maximise independence and reduce the need for ongoing support, allowing patients/clients to enjoy full access to the resources in their community, develop informal support networks and participate as active, equal citizens

Data

Extensive improvement work has been undertaken to develop more robust data collection and reporting through the MOSAIC system with the aim of developing a local ICS Power BI dashboard to enable accurate reporting of the patient journey as well as spend.

A differentiation of those patients within the ICS pathway who are 'fit for discharge, not ready for rehabilitation' has been highlighted and will require a stronger model of adequate support and flow through the pathway continuing to support independence.

Current data for Capacity and Demand Step-up Social Support and other Short Term Social Care does not provide an accurate representation of activity. It is an under representation based on the activity. The Mosaic data system work is developing to establish clear processes and workflows that will accurately capture this data and allow confident reporting in year as the system is developed.

Governance

Walsall BCF receives programme management by the BCF Manager as a dedicated sole resource, with joined BCF oversight agreed by Walsall Council specifically Adult Social Care (ASC) and Black Country Integrated Care Board (BC ICB) at Place level.

At Black Country level, the BC ICB have oversight and receive assurance from Place Managing Directors. At Place level, the programme continues to align to integration agendas and joint commissioning and transformation priorities, whereby activity, spend and performance are subject to review.

There is clear governance for the programme, ensuring assurance and approval mechanisms. The Place Integrated Commissioning Committee (PICC), adopted in 2023, ensures Walsall BCF continues to be an integrated programme, contributing significantly to key priorities for Older People. Further integration has developed as overview of the BCF programme has greater breadth with partners in Children's Services and Public Health being key members of PICC; further aligning to structures at Health and Wellbeing Board level.

In line with developments at Committee level, PICC has received delegation from Walsall Health & Wellbeing Board and Black Country Integrated Care Board to discuss and approve in scope budgets, recommendations and develop agreed in scope services in line with Place strategy priorities for Walsall Better Care Fund as a

key programme of activity. Walsall Health & Wellbeing Board regularly receives the BCF programme, where agreement and assurance is sought, ensuring the programme continues to work effectively to support agreed local agendas and national priorities.

Planning and Priorities

The Walsall BCF Plan is developed jointly between health and care partners determining the direction to strengthen and support patient/client flow in their journey to independence.

Walsall BCF Plans are aligned with supporting and improving flow in urgent and emergency care services through:

- A lateral landscape of multi-skilled/multi-trained staff who can all deliver a core urgent community response.
- Developing a pilot project around 72 hour sits to decrease the over prescription of care for admission avoidance teams working alongside the ICS team to ensure access to appropriate care when they are trying to avoid admission.
- Alignment of Pathway 2 and 3 to UCR, monitoring patients in the sub-acute phase has shown a reduction in readmission rates since the launch of virtual wards (readmission rate decreased from 18% (11/2023) to 7% (05/2024)).

The further development of intermediate care in Walsall is highlighted through prioritising:

- A capacity and demand review leading to a business case focusing on staffing capacity investment to meet the increasing demand on the service
- Development of a robust and accurate metrics reporting system (MOSAIC) with clear processes and pathways
- Developing a Power BI dashboard to enable ‘one version of the truth’ and show a snapshot of service activity at any one time
- Scoping out digital offers to use alongside pathways, therefore reducing the footfall of professionals going in and creating greater independence for patients, through support of their wider wellbeing/wider determinants of health, which would create capacity in the workforce

Section 2: Implementing the objectives of the BCF Plan

The BCF objectives reform to support the shift from sickness and prevention; and reform to support people living independently and shift from hospital to home will be met in Walsall through:

- The well-established completely joint NHS and Social Care service with a single service lead and joint budget
- Maintaining over 85% of patients to return home following hospital discharge
- Continuing the in-built Home First ethos across the Partnership
- Highlighting the transfer of care hub on site at the local acute trust, therefore allowing for a single point of access for all Walsall residents and easy navigation for other hospitals
- Close working relationship and alignment with UCR teams
- Supporting Carers
- Development of an integrated Falls Prevention provision

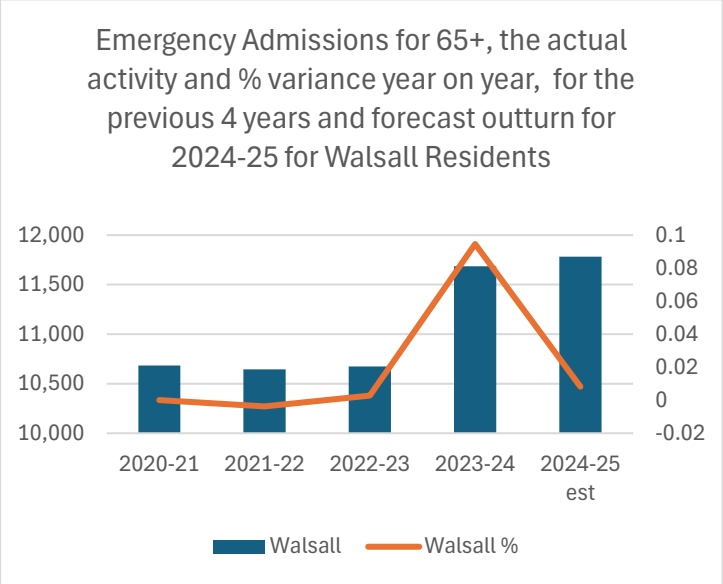
National Metrics

Achievement of the three national metrics will be aligned to the NHS Operational Plans and Local Authority Social Care plans.

Emergency Admissions - Emergency admissions to hospital for people aged 65+ per 100,000 population

Emergency admissions data for the past 5 years has been analysed to identify any patterns and trends. For 2024-25, data was only available up until November 2024, therefore, the remaining months were forecast. Over the 2024-25 period, Walsall has seen a steady increase in emergency admissions by 0.83%, this is attributed to the ageing population, complexity, increase in falls and comorbidity of over 65s. The sharp percentage decrease suggests hospital admission avoidance schemes are making a positive impact. The anticipated 2024-25 percentage increase in emergency admissions has been used to model the 2025-26 planned goals.

Figure 2. Emergency Admissions for 65+, the actual activity and % variance year on year, for the previous 4 years and forecast outturn for 2024-25 for Walsall Residents



The following will be implemented to keep emergency admissions from increasing:

- The large, multi-skilled UCR team with single point of access Care Navigation Centre also has an integrated front door team to support returning patients back to community who present at Emergency Department but do not require acute care
- The Frail Elderly Service (FES) in Emergency Department supports those over age 65 to return to community when presenting to hospital
- Support the community clinical intervention team to provide IV medication and monitor DVT in the community
- Development of an integrated falls prevention provision.

Discharge Delays - Average length of discharge delay for all acute adult patients

Discharge delay data has been analysed to identify any patterns and trends. A 0.5% uplift was applied to the 2023-24 data to account for the ageing population, complexity and comorbidities.

The following will be implemented to avoid delays in discharge:

- Maintaining the average discharge ready date (DRD) for Walsall residents awaiting Pathway 1, 2 or 3 to continue to consistently be less than 2 days.
- Build on the Virtual Ward model to support patients in the sub-acute phase and aid earlier hospital discharge.

- Ensure access and availability of equipment provisions to support the increase in case complexity.

Residential Admissions - Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population

Long term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population are based on a calendar year using the latest available, mid-year estimates (12 month rolling basis). To calculate the 2025-26 planned goals, data from the past few years has been analysed to identify any patterns and trends. The planned goals for 2025-26 are slightly lower (300) than the estimated 2024-25 end of year position (309). This reconciles with building wider networks of support through care and provisions in the community**.**

The following is recognised to support residential admissions:

- Residential & Nursing Market Position Statement outlines the intention to right -size the market with expected decrease of standard residential care placements over time as community-based alternatives grow.
- Bed-based care for people with nursing and more complex needs is expected to grow.
- Enhanced model for primary care GPs to support care of patients in Residential and Nursing homes.

Intermediate Care Service Capacity & Demand

A comprehensive Demand & Capacity review has been undertaken to assist in the stronger understanding of the performance levels of critical resources, developing an understanding of future needs, assessing the availability and requirements for the service, and identifying opportunities where service areas require further support across the ICS team.

Figure 3. Intermediate Care Service Referral Rates 2019 to 2024 in Therapies and Reablement

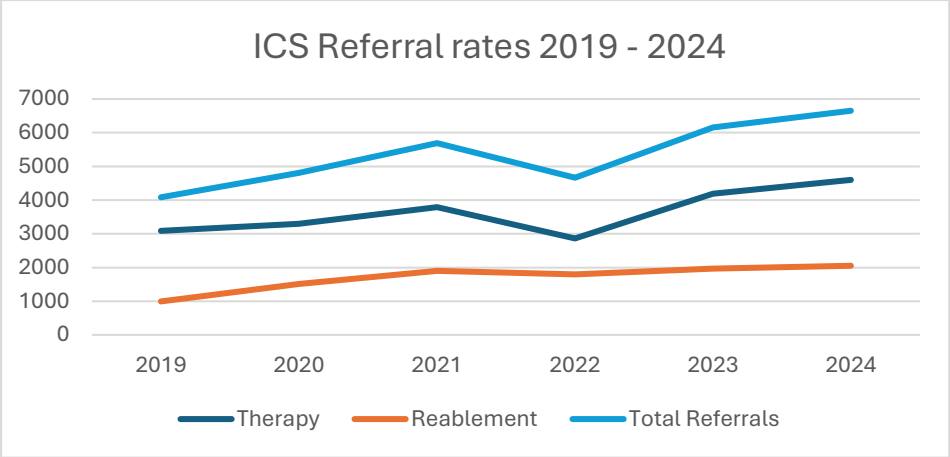
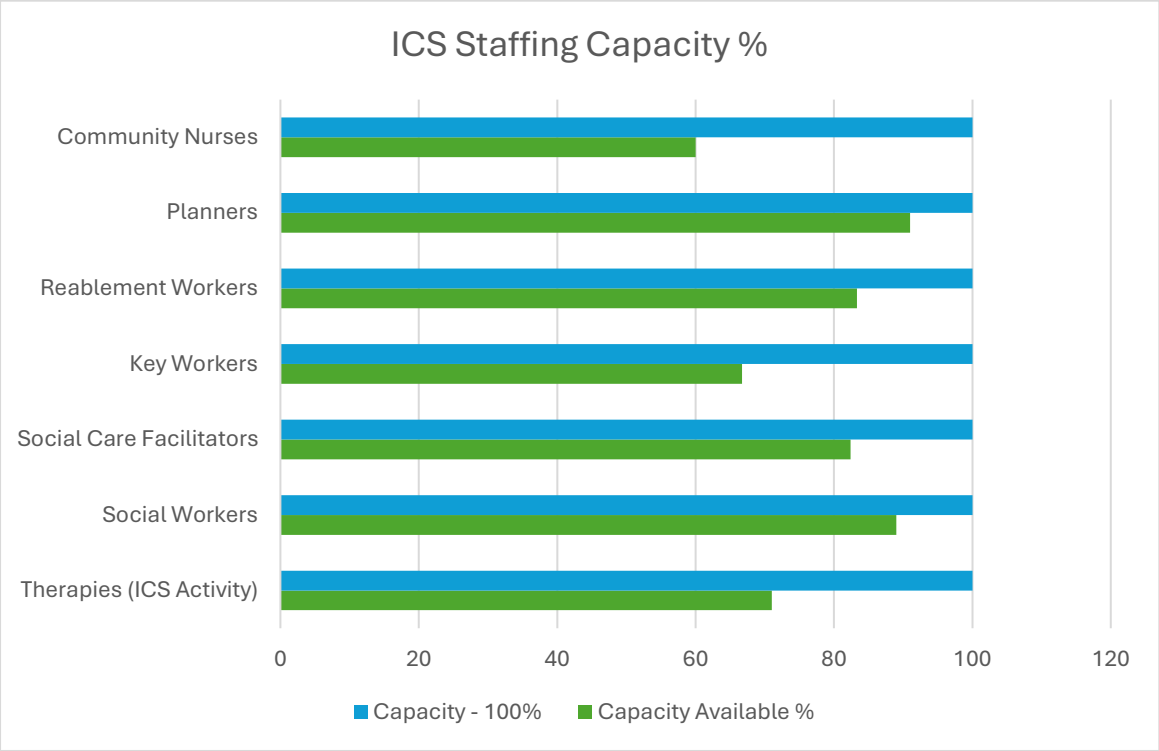


Figure 4. Intermediate Care Service Percentage Staffing Capacity across teams 2024



The evidence highlights a need to develop staffing to meet the demand and continue to provide an efficient service providing adequate support towards independence.

A Home First ethos is supported in Walsall with 85% of patients consistently returning home following hospital discharge, a joint health and social care team

providing rehabilitation in the person's own home and all therapy outcomes being measured and reported.

The demand on the intermediate care service has seen a year-on-year increase. Expenditure will continue to be invested in the ICS until a clear reduction in demand from the acute is established.

As the ICS sits within the community division in Walsall Health Care Trust and is a joint care group with Urgent Community Response, this allows for leads in both areas to develop projects collaboratively to shift and support the enhancement of UCR flow and lead to improved outcomes.

Intermediate Care Pathway 2 and Pathway 3

There is an emphasis on co-production, engagement and consultation, in further developing the intermediate care service. People with lived experience of their intermediate care and rehabilitation journeys have been approached in developing the Pathway 2 and Pathway 3 processes and pathways.

A review and recommissioning of residential and nursing care is being undertaken:

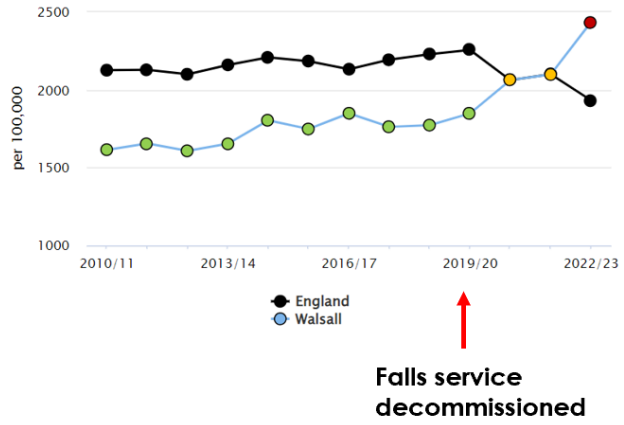
- A focus on reviewing the current model and delivery of pathway 2 rehabilitation beds as part of wider hospital discharge project
- Pathway 3 intermediate care beds are currently spot purchased under Walsall's residential and nursing contract.
- The ICS is undertaking a review of the Mosaic information management system to improve process and workflows to improve data recording and accuracy.

Falls

The impact of falls in the older population is evidenced in Walsall, through stakeholder and experienced workshops, consultations and evaluations an equitable offer can be developed in those areas and for those people most requiring support to prevent falls and providing an open offer, thereby reducing inequalities.

Figure 5. Emergency Hospital Admissions due to falls in people aged 65 and over

Source: OHID based on ONS and NHSE data



Recent trend: Increasing & getting worse

Period		Walsall Count	Value	95% Lower CI	95% Upper CI	England
2010/11		699	1,614	1,495	1,740	2,126
2011/12		737	1,655	1,536	1,780	2,128
2012/13		740	1,608	1,493	1,728	2,100
2013/14		780	1,654	1,539	1,775	2,160
2014/15		870	1,804	1,686	1,929	2,209
2015/16		855	1,748	1,632	1,870	2,184
2016/17		920	1,849	1,731	1,973	2,133
2017/18		895	1,762	1,648	1,882	2,194
2018/19		900	1,773	1,658	1,893	2,228
2019/20		955	1,848	1,732	1,970	2,256
2020/21		1,055	2,063	1,940	2,192	2,062
2021/22		1,085	2,098	1,974	2,228	2,100
2022/23		1,280	2,435	2,303	2,573	1,933

The Falls service in Walsall was decommissioned in 2019/20 and this has had an impact on hospital admissions due to falls as seen above. Walsall 2023/24 data highlights 375 new admissions to residential and nursing homes of which 76 (20%) were triggered by a fall. In 2024/25 (to Dec 2024), 1970 new packages of community- based care were issued, with 246 of those triggered by a fall (12%). Supporting the development of services

Carers

The development of the Walsall Carers Strategy 2024 – 2027 supports the role of carers and encourages active involvement to enhance the lives of those caring and those being cared for.

The key priorities developed under the Strategy include:

1. Identify and recognise people with caring responsibilities
2. Improving opportunities for Carers to maintain good wellbeing
3. Importance of having access to good quality information, advice and guidance
4. To support carers to have a good life outside of caring, as well as after caring
5. To improve carers assessment and support
6. Support carers with crisis management and professional awareness

Carer supported schemes in the BCF will be guided by and support the local Carers Strategy.

Section 3: Local Priorities and Duties

The established BCF footprint in Walsall makes positive use of BCF funding through the continuation and development of programmes which promote integrated working through the funding of services and teams across pathways. More can be done in the future to expand these areas of work to include a wider prevention focus, and services outside of those currently commissioned through BCF.

In Walsall, we continue to strive in our ambition of improving services and funded activity to strengthen our Place joint working approach aligning priorities to our Health and Wellbeing and Walsall Together Strategies.

Over the course of 2024/25 much learning has been gained and will be applied to develop and enhance service offers and delivery in 2025/26. Aligning to the BCF objectives, Walsall BCF priorities and key BCF work areas for 2025/26 areas of focus will include (projected timescale):

- Evaluation of Capacity and Demand within the Intermediate Care Service to inform the required provisions in staffing to enable meeting demand and adapting to ensure the continued efficiency of hospital discharge within 2 days (average) with the services in place to initiate rehabilitation and approach independence in a timely manner. (Quarter 1)
- Extensive improvement work on processes and workflows to develop more robust data collection and reporting through the MOSAIC information management system with the aim of developing a local Intermediate Care Service Power BI dashboard to enable accurate data reporting of the patient journey as well as spend. (Quarter 1-3)
- Recognition of the impact of falls and development of service provisions to reduce hospital admissions and support prevention of falls. (Quarter 2-4)
- Learning and evaluation from the Admission Avoidance pilot on provisions of ‘Pop in Calls’ versus 72 Hour Sits for hospital admission avoidance; working with Urgent Community Response, Frail Elderly Service and Front Door teams to develop a more streamlined and robust service offer. (Quarter 1&2)
- Evaluation of the Integrated Community Equipment Service, supporting adults with equipment and adaptation provisions across both health and social care. (Quarter 2-4)
- Review of the current model and delivery of Pathway 2 rehabilitation beds as part of a wider hospital discharge project. (Quarter 1&2)
- Consideration of the Pathway 3 intermediate care beds set-up under Walsall’s Residential and Nursing contract. (Quarter 3)
- Emphasis on co-production and involvement of carers and community in service design and delivery. (Quarter 1-4)

- Opportunity to integrate use of digital technology within the Intermediate Care Service. (Quarter 2-4)

Funding and conditions for the BCF for 2025-26 will support the government initiatives and commitment to reforming and strengthening neighbourhood and community services across health and social care, with the goal of providing more care closer to home, harnessing digital technology to transform care and increasing focus on prevention as outlined.

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