NHS
Black Country

Appendix 1

NHS Black Country Joint Forward Plan

Shorter read
Published June 2023

Our vision is to improve the health outcomes for local people, making the Black Country a healthier place with healthier people and healthier futures.

Priority 1 - Improving access and quality of services
The core function of the NHS is to provide quality healthcare to the population in a timely manner. We know that across the country, and within the Black Country, there is more that we can do to ensure that where required the public have access to an appropriate intervention, and for that intervention to be of the highest quality possible. Our ambition is to improve accessibility and the quality of such care across all parts of our system.

Priority 2 - Community where possible – hospital where necessary
The NHS has seen more people than ever before in recent years, across all parts of the NHS. Beds within our hospitals are almost always full and our GP practices have never been so busy. Our ambition is to ensure that our hospital beds are available for those people that need them, and that we have appropriate service provision in the community to care for people where appropriate.

Priority 3 - Preventing ill health and tackling health inequalities
As we know, prevention is better than cure. We intend to work with partners, to invest in preventative services, where we can, to reduce the pressure on the NHS. Also, we are committed to ensuring that the health inequalities we face within the Black Country are reduced effectively.

Priority 4 - Giving people the best start in life
In order to ensure that children and young people in our communities have the best start in life, we will refocus our efforts, with partners, on delivering improved access and services for this population.

Priority 5 - Best place to work
It is vitally important that we have a vibrant, effective workforce across all parts of the Black Country system if we are to achieve the priorities described above. Currently there are approximately 60,000 colleagues working across health and social care in the Black Country and we know that for us to thrive we need to look after our workforce and become a place where people want to work.

In five years time there will be:

- improved quality (access, experience and outcomes) for local people
- a greater sense of belonging, value and satisfaction for our workforce
- well led, well organised, system for our partners to engage with
- a reduction in health inequalities for our population.

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Welcome to the NHS Black Country Joint Forward Plan

The NHS Black Country Joint Forward Plan has been developed in collaboration with partners and our population and sets out our challenges, health needs, strategic vision, and strategic priorities over the next five years.

The main aim of our plan is to improve the health outcomes for local people, making the Black Country a healthier place with healthier people and healthier futures.

We created this plan following conversations with local people and partners. Our approach to working with people and communities sets out the 11 principles for how our people and communities expect to be involved in shaping priorities, developing plans, and continually improving services to address the health and care challenges that we face locally. This plan has been informed by an internal and external involvement programme which was undertaken over the course of a six-month period. Building on this, we are committed to a future where we start with our people and communities by default, broadcast less and listen more, and act and continually feedback to ensure that Black Country people are empowered and involved at every stage of the planning process.

Through the conversations that we have had we heard that local people want:

- improved access
- better preventative services
- community focus
- more personalised care.

There was also feedback to support more investment in services to tackle loneliness, isolation and mental wellbeing. Generally, it was clear that the rising cost of living, will increasingly impact upon our communities and upon health and care services in the short and long term. A big theme in conversations about the cost of living was the 'voluntary care squeeze' which was the worry expressed by some working age people caring for older/ younger dependents due to the cost of care.

We know that our health is determined by much more than our access to health services. How healthy we are and how long we live in good health is dependent upon other factors such as our health behaviours and lifestyles, the places and communities we live in, and the way in which we use health services.

Taking into account the national action, the views of local people and the advice on areas that will make the most difference to local people's health, we have set our five priority areas as follows:

- **Priority 1**- Improving access and quality of services
- **Priority 2**- Community where possible – hospital where necessary
- **Priority 3**- Preventing ill health and tackling health inequalities
- **Priority 4**- Giving people the best start in life
- **Priority 5**- Best place to work.

These priorities and the contents of this plan have been shaped to respond to the local health needs and represents our commitment to addressing the challenges which local people and communities face. The challenges culminate in some stark statistics, such as Black Country people generally not living as long as people in other parts of England. The years of life spent in good health (what we call healthy life expectancy, HLE) is also less than other parts of England. This is something which we are focussed on addressing now to benefit people in the years ahead.

We recognise that health can't do this alone - wider determinants are the most important driver of health. They include income, employment, education, skills and training, housing, access to services, the environment and crime. In this plan you will read about how we are working in partnership, in each of our places, to address wider determinants of health.

Across the NHS locally, our collaborative approach has helped us to perform well against NHS targets and priorities, including referral to treatment times in elective care, and access to urgent and emergency care, however there is no question that this is a challenging time for

health and care services. In addition to local people's health outcomes, we have challenges, including:

- **Restoration and recovery from COVID-19** – Whilst significant progress has been made there is still work to do to recover from the effects of COVID-19. We also know that local people have significant health challenges and that these are not experienced equally across all parts of our communities. COVID-19 has exacerbated some of these existing health inequalities.
- **Urgent and emergency care pressures** – Urgent and emergency care remains our most pressured area. The demand for services at peak times, particularly in the colder months, risks exceeding the capacity we have if it continues to grow at the rate seen in recent years.
- **Workforce** – Our workforce is a key asset to help us deliver our plans over the next five years, we know that we have significant work challenges including an ageing workforce, recruitment and retention challenges and that looking after the health and wellbeing of staff is a key priority.
- **Finance and efficiency** – Our system is facing significant financial challenges which can only be addressed by partners working together to deliver increased productivity, transforming and redesigning services to drive improved outcomes and make better use of resources.

We are clear that if we are to achieve the outcomes we want in these areas, we will need to work together differently, as we shift our focus from treatment to prevention, create healthier places which support people to make healthier choices and support those who work for us to provide the highest quality care.

Over the next five years there will be some significant developments in our bid to make the Black Country healthier. These include a shared care record, ensuring that direct care is improved through access to the right information, and the Midland Metropolitan University Hospital, which will open its doors to new state-of-the-art facilities in Spring 2024. There will also be improved access to diagnostics and elective care through community diagnostic centres and increased theatre capacity, resulting in the reduction in waiting lists.

The following principles will underpin our approach to delivering our plan:

- **Collaboration** – we will work across organisational boundaries and in partnership with other system partners, including our people and communities, in the best interest of delivering improved outcomes for the population we serve.
- **Integration** – Integrated Care System partners will work together to take collective responsibility for the planning and delivery of joined up health and care services.
- **Productivity** – we will ensure we improve productivity by making the best use of our collective resources by transforming the way we deliver services across the Black Country.
- **Tackling Inequalities** – we will ensure that we continue to focus on delivering exceptional healthcare for all through equitable access, excellent experience, and optimal outcomes.

As the system transitions to a new way of working in line with our operating model, we have secured an organisational development partner to help facilitate cultural development and behaviours which will strengthen the way we work with partners across health and care.

The publication of this plan on 30 June 2023 is just the start of our journey. We will continue to hold conversations with local partners, people and communities to inform future iterations as the plan gets updated on an annual basis. I look forward to working with all local partners, people and communities to bring this plan to life and make a real difference to the health of the Black Country.

I want to thank everyone who contributed.

Best wishes

Mark

Mark Axcell

Black Country Integrated Care Board
Chief Executive

What is an NHS Joint Forward Plan?

The plan is a joint document developed in partnership with NHS organisations in the Black Country (the Black Country Integrated Care Board and our provider NHS Trusts).

The development of this plan has been an opportunity for us to work with local people, our health and care partners and staff to develop a plan that is locally owned, delivers the national ambitions and recognises our collective strength in working together to resolve our common challenges. It describes our ambition to improve quality and outcomes for people who use our services.

In addition, the plan:

- describes how we intend to use our NHS budget to ensure that local services are of the highest quality and that they meet local need
- sets out the challenges which we face today and those that we recognise are affecting the future health of local people
- explains how we will support our workforce so that it is fit for the future and create a system of health and care organisations that are seen as employers of choice
- describes how we will support local people with the knowledge and skills to have more choice and control over their own health and care
- sets out how we will change the way organisations work together moving forward.

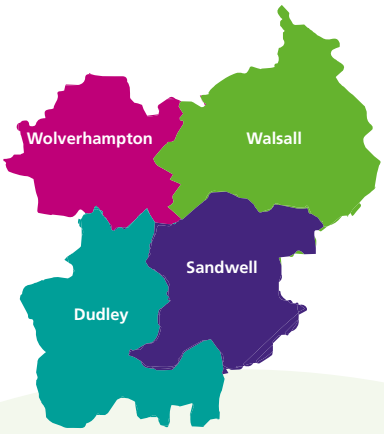
If after reading this summary you may want to read more, there is full version of the plan on our website www.blackcountry.nhs.uk

The Black Country

The Black Country is home to our 1.2 million people who bring a diversity within the four distinct places: Dudley, Sandwell, Walsall, and Wolverhampton.

As NHS Black Country Integrated Care Board, we are responsible for ensuring that local people have access to the best possible NHS services. Our NHS landscape is made up of a number of partners including the Integrated Care Board (ICB) acting as the strategic commissioner, four Acute and Community Trusts, one Mental Health Learning Disabilities and Autism Trust, one Ambulance Trust, one Integrated Care Trust, four Local Authorities, 181 GP practices, 288 community pharmacies, 122 community optometry sites and 159 general dental practices.

We are all part of the Black Country Integrated Care System (ICS) which brings health and care partners together with a number of other partners including community and voluntary sector organisations, housing, fire, police, large employers and education to improve the health and wellbeing of Black Country people.



Map of Black Country showing our four places of Dudley, Sandwell, Walsall and Wolverhampton

We also have thriving Voluntary, Community, Faith and Social Enterprise (VCFSE) partners in the Black Country. This is a vast and diverse sector, comprising nearly 4,000 member organisations across our four place-based Community and Voluntary Services (CVS).

Our health challenges

We know that our health is determined by much more than our access to health services. How healthy we are and how long we live in good health is dependent upon other factors such as our health behaviours and lifestyles, the places and communities we live in and the way in which we use health services.

In the Black Country people generally do not live as long as people in other parts of England. The years of life spent in good health (Healthy Life Expectancy) is also less than other parts of England.

Wider determinants are the most important driver of health. They include income, employment, education, skills and training, housing, access to services, the environment and crime.

Within the Black Country:

Life expectancy in the Black Country is significantly lower than for England in all four places.

The gap in life expectancy between the Black Country and England is 2.2 years for males and 1.6 years for females.

Healthy life expectancy is also lower than for England in all four places.

The gap between life expectancy and healthy life expectancy is larger for females in the Black Country than for England; it is similar for males.

Both child (43% locally vs 35% in England) and adult (69% locally vs 64% in England) obesity rates are higher than England.

We have some of the highest infant mortality rates in the country, whilst smoking rates in pregnancy remain high and breast-feeding rates are low.

We have higher recorded prevalence of diabetes, chronic kidney disease, chronic heart disease.

We have a high number of premature deaths from Cardiovascular Disease (CVD) and respiratory disease, under 75 mortality rate for CVD is 99 per 100,000 and under 75 mortality rate from respiratory disease is 38 per 100,000.

Dementia Diagnosis rates are below national expectation of 66.7%, Black Country is 63%.

Other challenges

Whilst our Joint Forward Plan sets out our ambition over the next five years, it is important to recognise the challenging landscape within which we will deliver our plan.

Restoration and recovery from COVID-19 – Whilst significant progress has been made there is still work to do to recover from the effects of COVID-19. We also know that local people have significant health challenges and that these are not experienced equally across all parts of our communities. COVID-19 has exacerbated some of these existing health inequalities.

Urgent and emergency care pressures – Urgent and emergency care remains our most pressured area. The demand for services at peak times, particularly in the colder months, is exceeding the capacity which we have.

Workforce – Our workforce is a key asset to help us deliver our plans over the next five years, we know that we have significant work challenges including an ageing workforce, recruitment, and retention challenges and that looking after the health and wellbeing of staff is a key priority.

Finance and efficiency – Our system is facing significant financial challenges which only be addressed by partners working together to deliver increased productivity, transforming and redesigning services to drive improved outcomes and make better use of resources.

Writing our plan

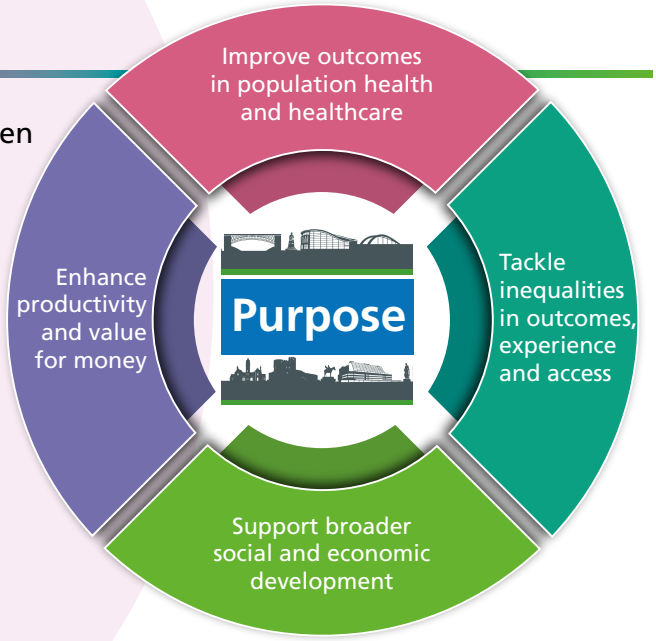
In addition to seeking the views of local people, when writing our plan we have considered the following:

The ICS purpose

Integrated Care Systems (ICSs) are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas. There are four core purposes of an ICS to:

- improve health outcomes
- tackle inequalities
- enhance productivity and value for money
- support social and economic development.

This plan describes how the NHS will contribute to achieving the ICS purposes.



Black Country ICS Purpose wheel showing four core purposes

Policy drivers

In writing our plan we have taken into consideration the following:

NHS priorities

Each year, and periodically over longer periods, a set of 'NHS Objectives' to be achieved by NHS organisations within the NHS are published. There are three current guidance documents on which this plan has been based:

- NHS Long Term Plan (2019-2029)
- NHS Joint Forward Plan priorities (2023-2028)
- NHS Operational Planning Priorities (2023-2024).

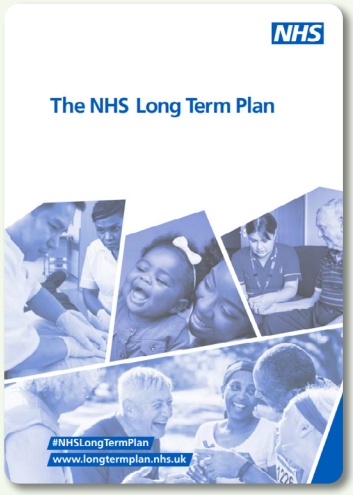
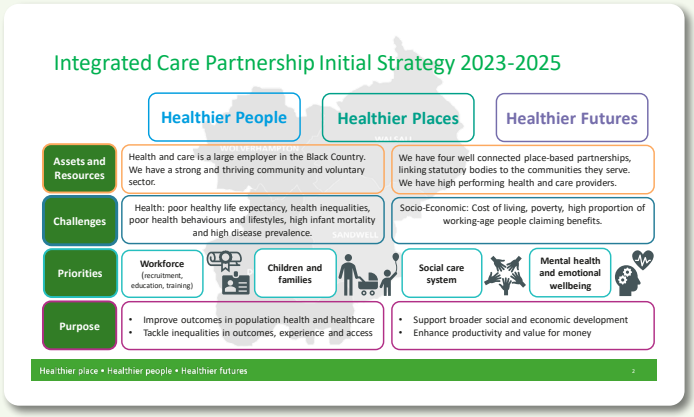


Image of front cover of NHS Long Term Plan document

Our local Integrated Care Partnership Strategy

An Integrated Care Partnership (ICP) is a forum jointly convened by Local Authorities and the NHS, comprised of a broad alliance of organisations and other representatives as equal partners concerned with improving the health, public health and social care services provided to their population. The Black Country ICP has established that we should focus on the areas described below. This plan describes how the NHS will play its part, jointly with partners, in making improvements to these areas:

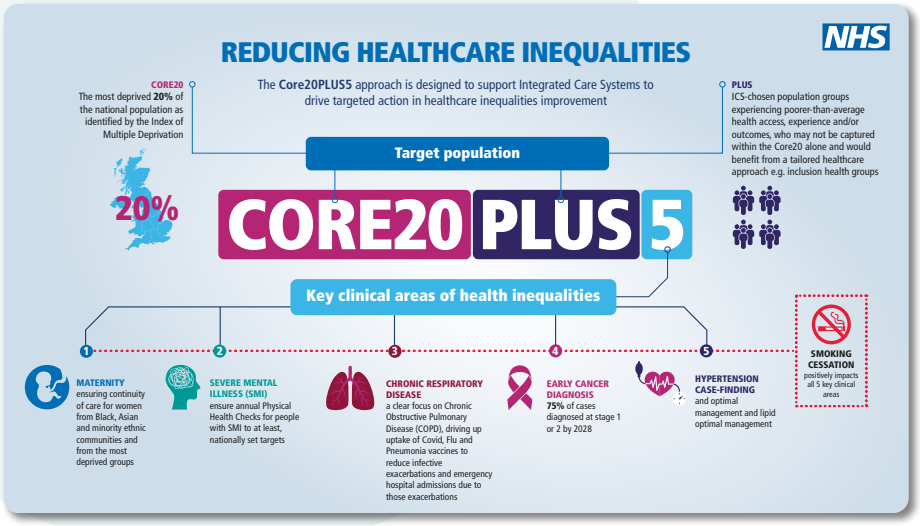
- mental health
- social care
- workforce
- children and young people.



Integrated Care Partnership Initial Strategy 2023-2025

Core20 Plus 5

The Core20Plus 5 work is designed to support ICSs to drive specific actions to reduce health inequalities. Core20 means the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). Half the population of the Black Country live in these Core20 areas. Although there is variation in the proportion of people living in Core20 areas across our four places, all four are higher than the national average.



Core 20 Plus 5 approach to reducing health inequalities

The 'PLUS' are the population groups experiencing poorer than average health access or outcomes, and who may not be captured within the Core20 alone so may benefit from a tailored approach. PLUS groups include ethnic minority communities, inclusion health groups, people with a learning disability and autistic people, people with multi-morbidities, and other protected characteristic groups.

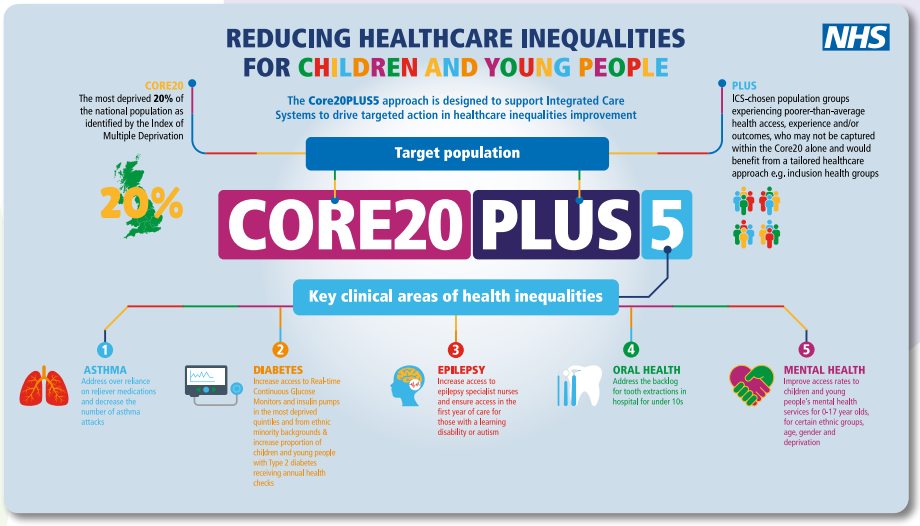
Along with defining target population cohorts, it also identifies '5' focus clinical areas requiring accelerated improvement. These are:

1. maternity
2. severe mental illness (SMI)
3. chronic respiratory disease
4. early cancer diagnosis
5. hypertension.

Core +5 for CYP

There are also clinical areas of focus for children which are:

1. asthma
2. diabetes
3. epilepsy
4. oral health
5. mental health.



Core 20 Plus 5 approach to reducing health inequalities for Children and Young People

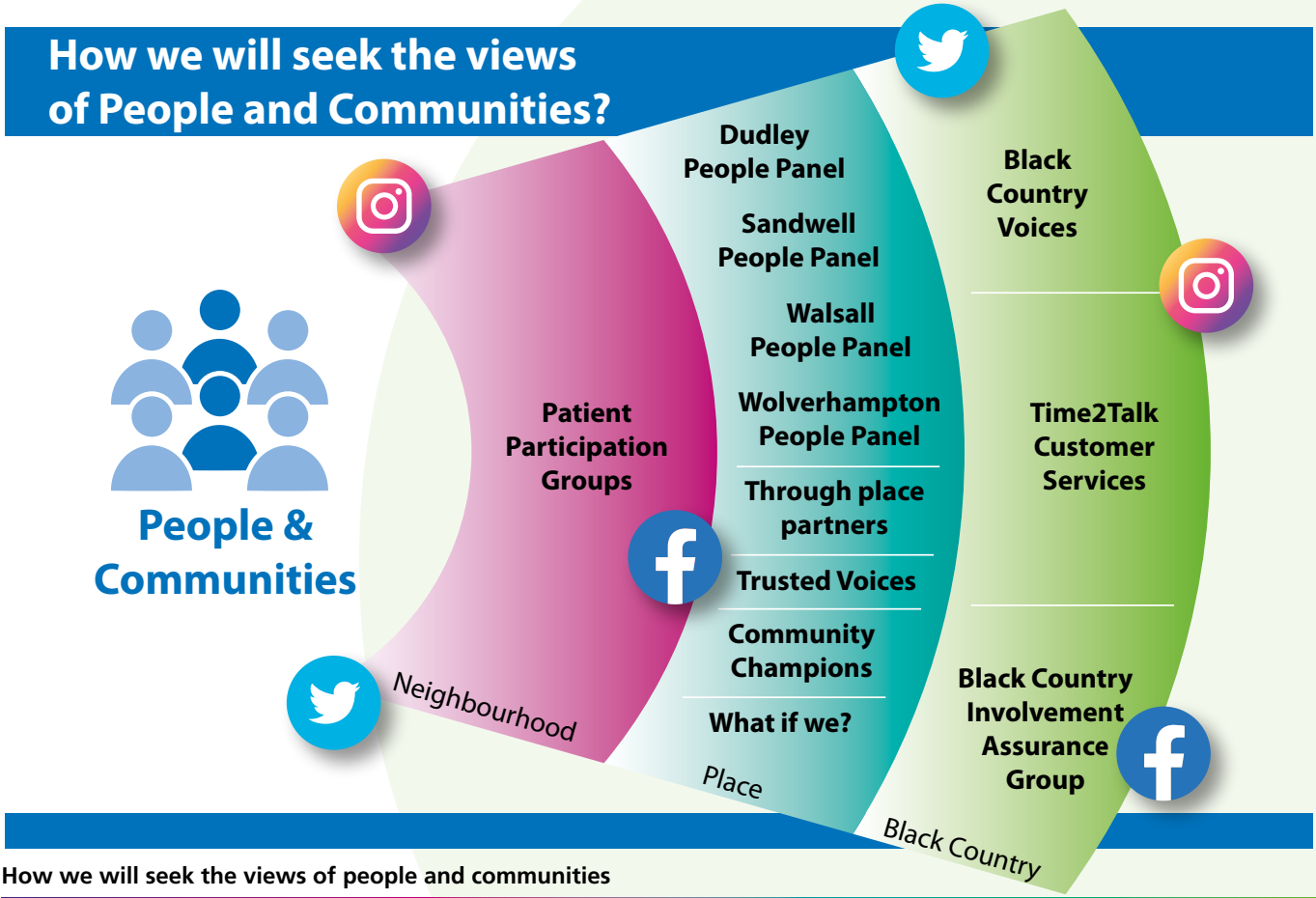
Our approach to involving people and communities

We have worked with local people and partners to co-produce our approach to working with people and communities. The approach supports our commitment to meaningfully involving people and communities in the decisions we make, as well as outlining how we will meet our statutory duties. In it, we set out the 11 co-produced principles for how our people and communities expect to be involved. The 11 co-produced principles fit neatly into the six core themes below:

- be accountable to our people and communities
- one size does not fit all
- start with people and communities
- trusted voices are key
- invest in people and communities
- nurture relationships across the ICS.

It can also be found on our website.

The mechanisms for involvement outlined in our approach crosscut three different levels: neighbourhood, place and Black Country, and are designed to be participatory, inclusive, representative, and culturally competent. Our methods for involvement are underpinned by placing value on strong relationships and connections with people and communities and promote the belief that we make the best decisions for our people and communities when we start with people.



How we will seek the views of people and communities

Involving people and communities in our plan

Ensuring that people and communities have been involved in the development of the plan has been a key priority not only to discharge our statutory duties, but to ensure that the plan is reflective of the needs and wants of our communities.

The development of this plan has been undertaken in stages:

What we have heard

There is a full involvement report available online, but in summary local people would like a focus on:

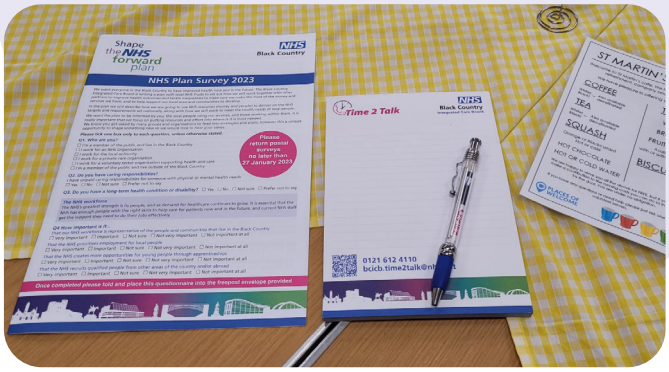
- improved access - to appointments and emergency/urgent care, to resources and reasonable adjustments, to digital devices/ data/skills
- better preventative services
- community focus – clinical and non-clinical
- more personalised care options and choices.

There was also feedback to support more investment in services to tackle, loneliness, isolation and mental wellbeing. A big theme in conversations about the cost of living was the 'voluntary care squeeze' which was the worry expressed by some working age people caring for older/ younger dependents due to cost of care.

"I am poorly but I have to keep working as I can't afford not to, and this is really impacting on my health, and I am constantly depressed."

"We need quicker care that is kind and calm."


Walsall People Panel



See what local people said to us and survey results throughout the document

NHS Black Country Joint Forward Plan priorities

Taking into account all of the above we have identified five priority areas in our plan.

Priority 1 - Improving access and quality of services
The core function of the NHS is to provide quality healthcare to the population in a timely manner. We know that across the country, and within the Black Country, there is more that we can do to ensure that where required the public have access to an appropriate intervention, and for that intervention to be of the highest quality possible. Our ambition is to improve accessibility and the quality of such care across all parts of our system.

Priority 2 - Community where possible – hospital where necessary
The NHS has seen more people than ever before in recent years, across all parts of the NHS. Beds within our hospitals are almost always full and our GP practices have never been so busy. Our ambition is to ensure that our hospital beds are available for those people that need them, and that we have appropriate service provision in the community to care for people where appropriate.

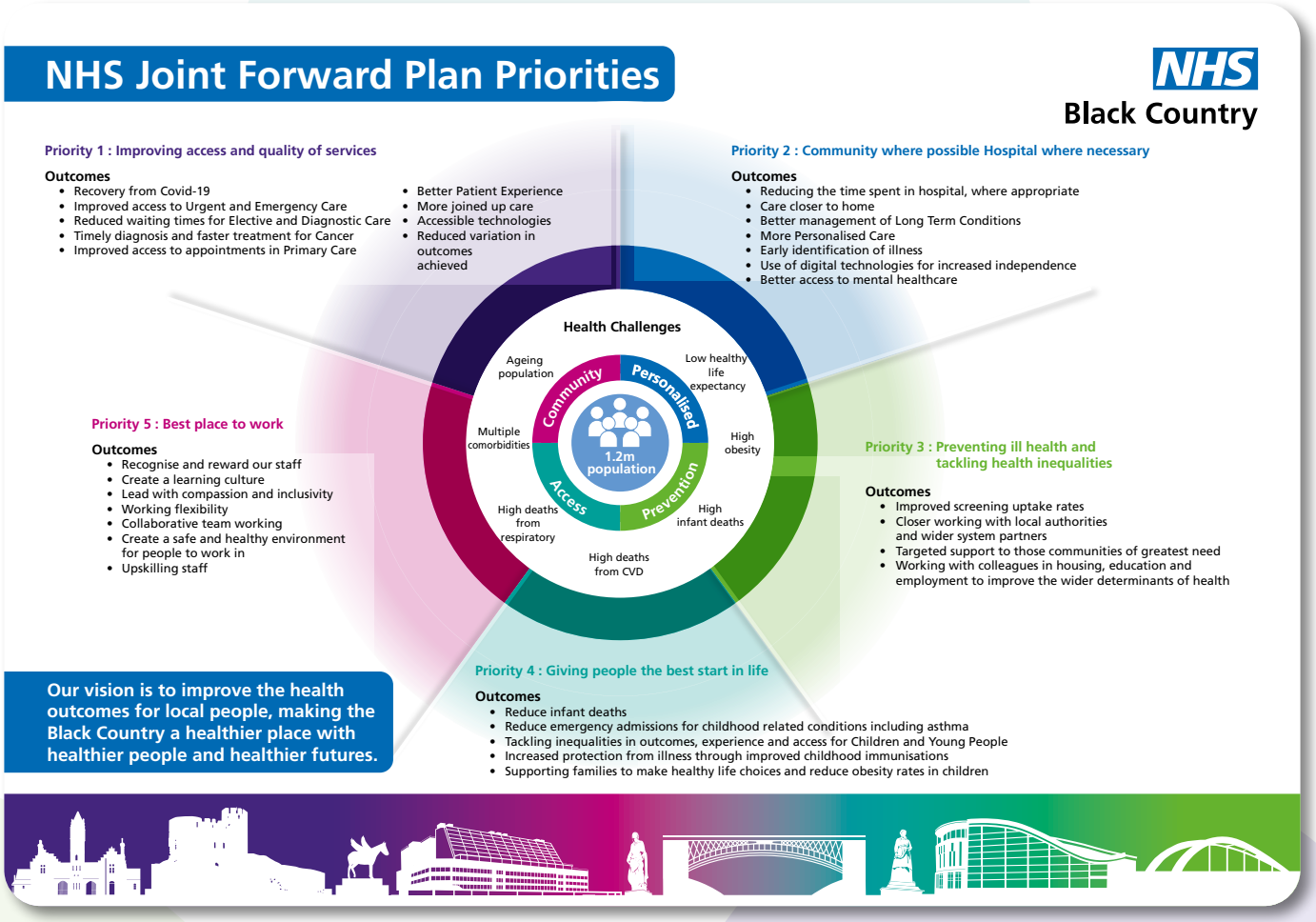
Priority 3 - Preventing ill health and tackling health inequalities
As we know, prevention is better than cure. We intend to work with partners, to invest in preventative services, where we can, to reduce the pressure on the NHS. Also, we are committed to ensuring that the health inequalities we face within the Black Country are reduced effectively.

Priority 4 - Giving people the best start in life
In order to ensure that children and young people in our communities have the best start in life, we will refocus our efforts, with partners, on delivering improved access and services for this population.

Priority 5 - Best place to work
It is vitally important that we have a vibrant, effective workforce across all parts of the Black Country system if we are to achieve the priorities described above. Currently there are approximately 60,000 colleagues working across health and social care in the Black Country and we know that for us to thrive we need to look after our workforce and become a place where people want to work.

Our Strategic Programme Boards all have a role to play in achieving these priorities, further details on their work programmes are set out later in the plan. Delivery of these priorities will enable us to play our part in achieving the core purposes of our ICS and the triple aim which requires us to consider the effect of our decisions on the health and wellbeing of people, quality of services and efficient use of resources.

Further details on how we will address these specific priorities can be found throughout this document, or in full within our long read Joint Forward Plan available on our website.



NHS Black Country Joint Forward Plan Priorities diagram

Our principles

In implementing our plan, we will work to the following principles:

- **Collaboration** – we will work across organisational boundaries and in partnership with other system partners including our people and communities in the best interest of delivering improved outcomes for the population we serve.
- **Integration** – ICS partners will work together to take collection responsibility for planning and delivering joined up health and care services.
- **Productivity** – we will ensure we improve productivity by making the best use of our collective resources by transforming the way we deliver services across the Black Country.
- **Tackling Inequalities** – we will ensure that we continue to focus on delivering exceptional healthcare for all through equitable access, excellent experience, and optimal outcomes.

We will **use resources effectively** and find more cost-effective ways of delivering the high-quality care that local people deserve.

We will encourage **research and innovation** to bring new ideas into the way that we work. We will support **new digital technologies** and improve the coordination of care through **safe data sharing**. We will also invest in growing the skills and capabilities of local people to use new digital technology so that they can have more options for accessing care when they need it.

We will also recognise our **social, economic, and environmental role** as one of the biggest employers and investors in the local economy. Where possible we will strive to reduce our impact on the planet through **Greener NHS choices** and we will aim to increase our impact locally through investment in local supply chains, employment of local people and working with partners to support healthier local people, places, and futures.

We will **continuously improve quality** and develop a strategy which will focus on supporting an ageing, ethnically diverse population and will aim to ensure services continue to be delivered in the right way, at the right time, in the right place and with the right outcome.

We are maximising opportunities to attract funding for state of the art new facilities such as the new Midland Metropolitan University Hospital which will open its doors in spring 2024.

Case study - Midland Metropolitan University Hospital

Midland Metropolitan University Hospital stands between Sandwell and West Birmingham.

It will bring together specialties and provide a hub for emergency care, proudly serving our diverse communities in Sandwell, West Birmingham and beyond. The build also represents a regeneration opportunity as the hospital sits within a designated regeneration zone.

The brand new, state-of-the-art acute hospital will offer emergency department, maternity, children's and adult acute inpatient services to half a million people. When it opens in Smethwick, it will bring together all acute and emergency care services that currently take place at City and Sandwell Hospitals.

Midland Met University Hospital

Midland Metropolitan University Hospital will signify a change in how care is delivered. The hospital will serve patients who are acutely unwell and need a hospital stay; or whose care is an emergency.

All acute clinical teams will combine to operate as one. The hospital will provide clinical teams with modern purpose-built facilities. New technology will enhance the patient experience – one such example is a modern nurse call system. It allows remote communication, meaning patients can speak to a nurse at the touch of a button without leaving their room.

50% of the beds will be in single rooms with their own shower room preserving privacy and dignity. This will also mean that we have the ability to tackle any future infection outbreaks that are of a similar nature to COVID-19 will be vastly increased.

The new care model will see the majority of outpatient appointments and planned diagnostic tests on the existing sites at Sandwell and on the existing City Hospital site in the Birmingham Treatment Centre, Birmingham and Midland Eye Centre and Sheldon building. These sites will also provide rehabilitation wards.

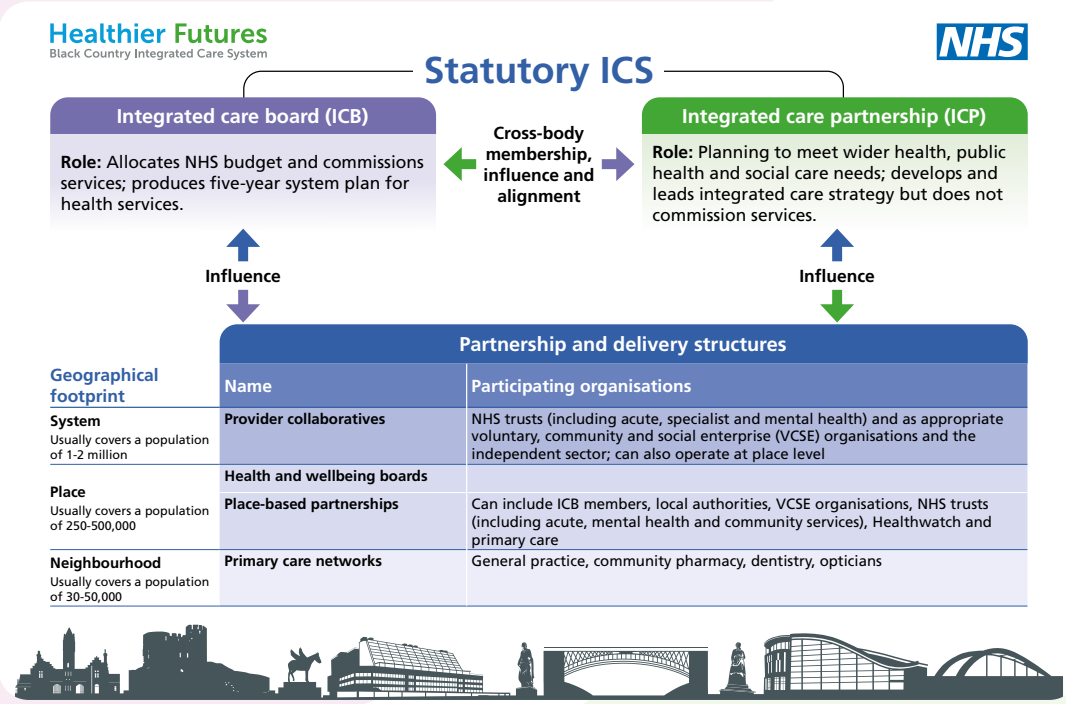
You can take a closer look at the new hospital by watching this video.

"The problems faced cannot be managed only by health and care leaders."

- **94% of people agreed that health and care organisations should work more closely together**
- **70% of people think it's important that the NHS understands how things like housing, employment and education can affect people health**
- **92% of people think the NHS should increase recycling**
- **Over 55% of people felt the NHS should support people to use digital services**

Working together to enable change

Local health and care organisations will work together at three different levels to support the delivery of our key areas of work.



Health and care organisations with partnership and delivery structures for an ICS

We have defined how our System will work differently to deliver this plan. This is called our Operating Model and has the following components:

Integrated Care Board - System strategy, resource allocation and oversight and assurance of the NHS system

ICB Committees - ICB oversight and assurance, including statutory duties and a governance mechanism from the Strategic/Enabling Programme Boards to ICB Board

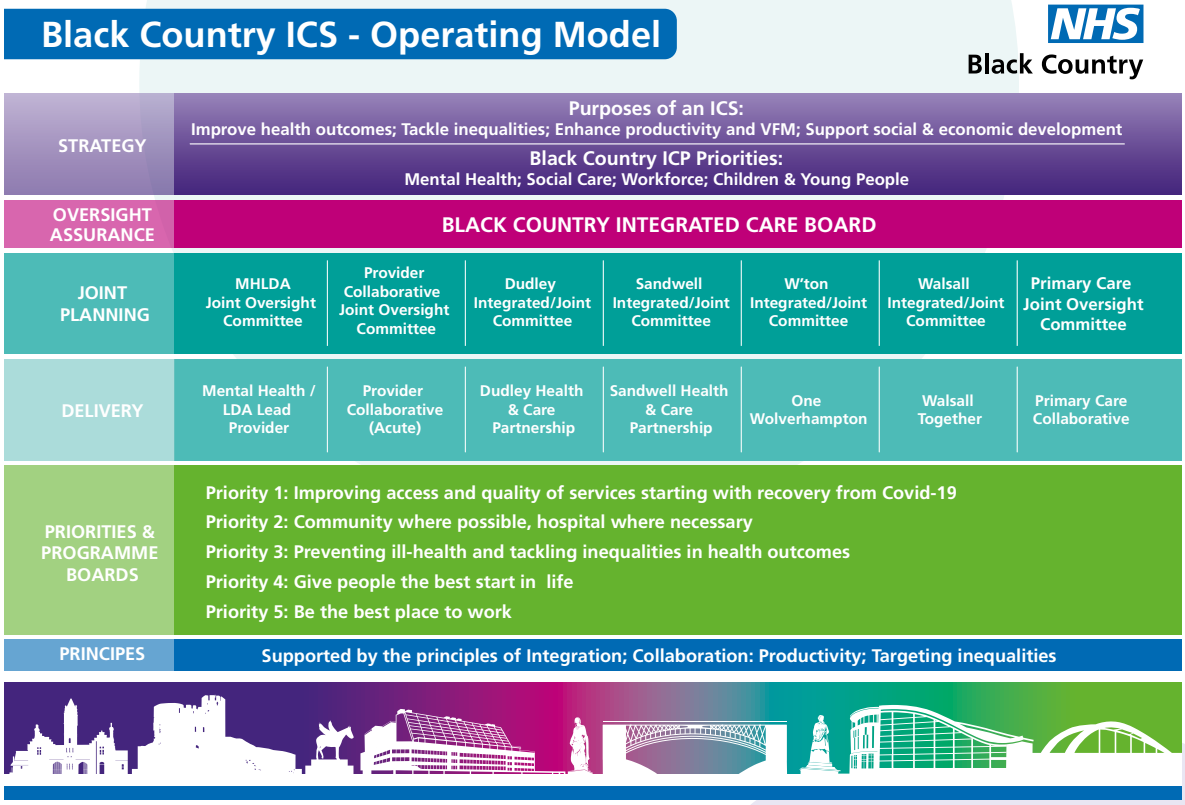
Strategic Programme Boards - Bring commissioners and providers together into a joint dialogue around a portfolio area to define the high level strategy, outcomes and priorities for the portfolio area. Will also identify areas for transformation, service change and service development and form business cases to define the opportunity.

Integrated/Joint Committees - Joint committees will be established to undertake joint planning between the ICB, local authorities, and where appropriate, NHS England and respective collaboratives/partnerships. It will act as the vehicle to hold resource and decisions devolved or delegated by the ICB (and partners) and take joint responsibility for implementation of plans.

Provider Collaboratives - Partnerships that bring together our provider trusts to work together at scale to plan and deliver services. They are Black Country wide collaboratives that provide and/or coordinate services with the aim of improving quality, productivity, sustainability, and effectiveness of services. There are different types of collaboratives in our System as described later.

Place Based Partnerships - Partnerships that bring together NHS, local government, public health and other local organisations to help ensure more effective use of combined resources within a local area (Place) and to tackle the wider determinants/factors that influence health and drive inequalities. They will both plan and deliver services defined as in-scope, predominantly out of hospital services, focussing on demand management, relationship management with LA and partners and targeting local inequalities.

The graphic below shows how the system will deliver the ambitions of this plan through the ways of working described.



Black Country ICS Operating Model

Developing our Operating Model

The operating model for the Black Country will evolve over time. As collaboratives and place-based partnerships mature, this will result in the ICB devolving a range of responsibilities to collaboratives and place-based partnerships, which could include:

1. Commissioning and contracting of services:

Place-based partnerships and collaboratives will be given responsibility for commissioning and contracting health and care services for the local population. This could include setting priorities, identifying the needs of the population, and working with local providers to ensure that services are delivered in a coordinated and efficient way, including setting priorities.

2. Resource allocation:

Place-based partnerships and collaboratives will be given greater control over the allocation of resources, such as funding and staff, to health and care services in their area. This could enable them to make decisions that are more tailored to the needs of their local population and ensure that resources are used efficiently.

3. Integration of services:

Place-based partnerships and collaboratives may be given greater responsibility for integrating different health and care services in their area, such as primary care, mental health services, and social care. This could involve developing new models of care and ensuring that services are joined up and patient centred.

4. Prevention and public health:

Place-based partnerships and collaboratives may be given greater responsibility for promoting prevention and public health initiatives in their area. This could include working with local authorities, community groups, and other stakeholders to promote healthy lifestyles and prevent ill-health.

Provider Collaboratives

In the Black Country we have three provider collaboratives. Provider collaboratives are partnership arrangements involving at least two NHS trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements, to:

- reduce unwarranted variation and inequality in health outcomes, access to services and experience
- improve resilience by, for example, providing mutual aid
- ensure that specialisation and consolidation occur where this will provide better outcomes and value.

1. Black Country Provider Collaborative (Acute and Community)

In the Black Country there is agreement between our acute and community providers to work together to deliver effective, accessible, and sustainable acute care services. The agreement is between Sandwell and West Birmingham NHS Trust, The Dudley Group NHS Foundation Trust, The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust.

The Collaborative has agreed a number of priorities for the short-term, including:

- identification of new service models, including Centres of Excellence and services applicable for a Black Country networked service solution, with those services transitioning to a new service model
- clinical improvement programmes, to improve health outcomes and performance standards where appropriate
- corporate improvement programmes, to improve resilience, efficiency and effectiveness where required.

Black Country
Provider Collaborative

2. Mental Health, Learning Disability and Autism Lead Provider

In the Black Country we have a lead provider for mental health, learning disabilities and autism services. Black Country Healthcare NHS Foundation Trust (BCHFT). The Trust takes responsibility for the whole pathway of care, which means the Trust has the flexibility to decide the best services and support for local people (working collaboratively with a range of partners to achieve the aims of this plan). Find out more on Black Country Healthcare NHS Foundation Trust website.

A number of strategic priorities have been identified for the lead provider, including:

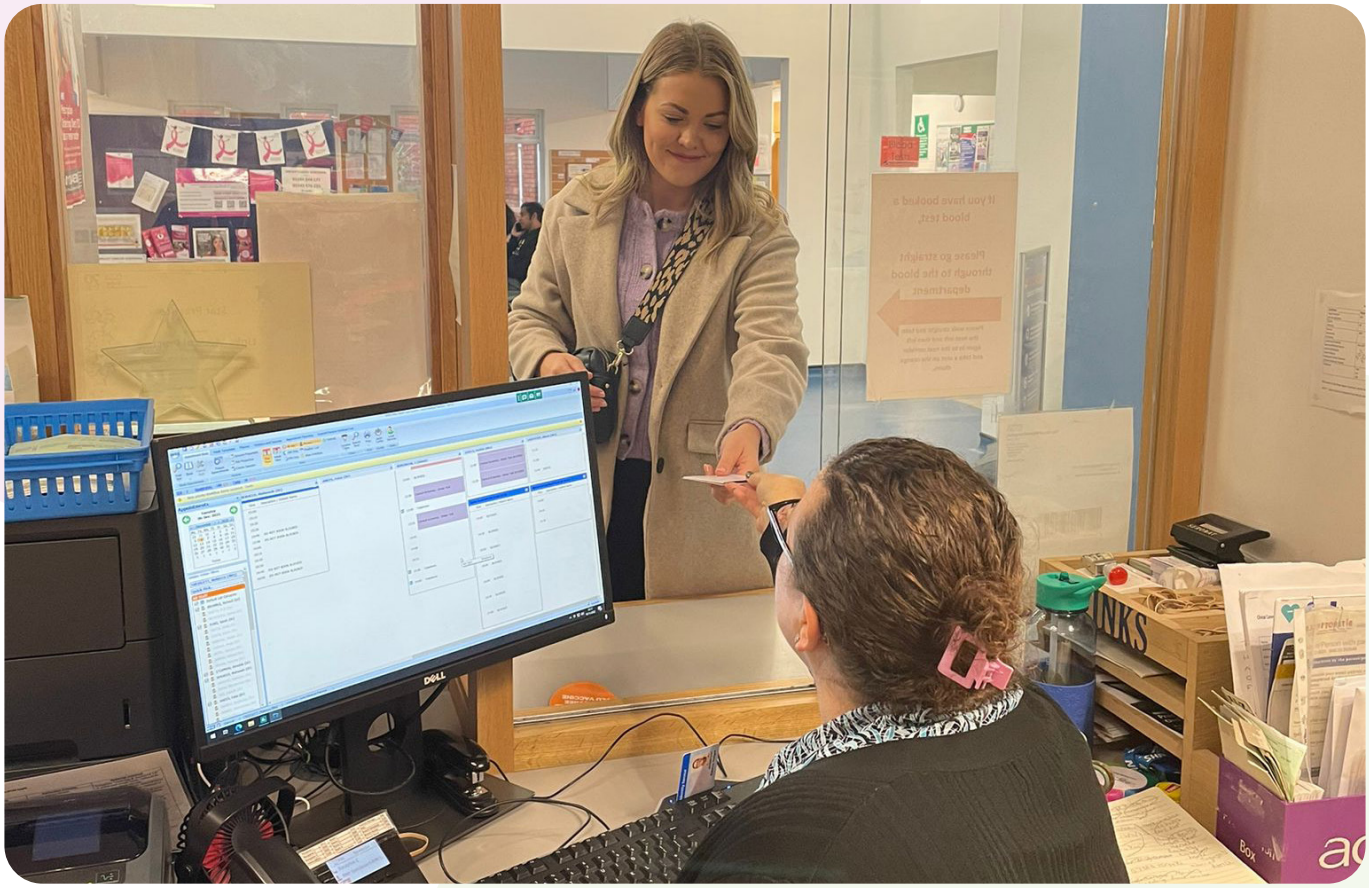
- exploiting our collective strength across the Black Country, achieving a level of scale and pace of transformation that would not be accessible, or sustainable, at our individual Place based levels, whilst also addressing variation where it is agreed to be unwarranted
- through more integrated community models across primary and secondary care, we are dissolving the boundaries and gaps between services to being greater integration between mental and physical health
- to make optimal use of our Black Country bed stock, which is flexible, therapeutic, promotes dignity and privacy.

3. Primary Care Collaborative

By primary care we mean, pharmacy, dental, opticians and general practice. Primary care is a crucial part of the healthcare system. Up to 95% of interactions with patients, carers and other service users occur in primary care.

In the Black Country primary care is working together and they have formed a primary care collaborative to:

- promote the interests, wellbeing, consistency and sustainability of primary care services
- to ensure that a single voice for primary care is properly heard in decision making at all levels.



Place-based Partnerships

There are four local place-based partnerships in the Black Country covering populations which mirror the boundaries of local councils in Dudley, Sandwell, Walsall and Wolverhampton. Whilst working at a Black Country level can bring the benefits of working at scale to tackling some of the bigger challenges in health and care, smaller place-based partnerships are better able to understand the needs of local people and design/deliver changes in services to meet these needs.

In the Black Country, place is the level at which most of the work to join up budgets, planning and pathways for health and social care services will happen.

Each of our place-based partnerships involve the NHS, local government and other partners, such as voluntary, community and social enterprise (VCSE) sector organisations, education, housing and social care providers.

Dudley

Our vision is connecting communities and coordinated care to help citizens live longer, safer, happier, healthier lives for all. Our mission is for health and care in Dudley to be in the right place at the right time and to be in the community where possible, hospital when necessary.

Our vision will be delivered through a number of work programmes set out below. Collaboration and integration are critical when designing new and often complex solutions and through strengthening our partnership we will achieve our vision. Our health and wellbeing priorities are addressed throughout our work programme, and as an anchor network we will undertake actions to support social and economic determinants of health and wellbeing.

Health and wellbeing priorities:

- improving school readiness*
- reducing circulatory disease deaths*
- improving breast cancer screening coverage*.

*with a focus on those neighbourhoods with the greatest need.

Outcomes to be achieved

For our Patients:

- Care close to home with improved outcomes
- Longer healthy life expectancy
- Personalised care and improved patient experience
- More say in their care through co-production of health and care in Dudley
- Enhanced emotional resilience for our population, with a focus on children and young people
- Improved physical health for our population with severe mental illness

For Organisations:

- Increase in people attending community services, reducing pressure on hospitals, primary care and social care
- Timely discharge from hospital
- New models of integrated and coordinated healthcare
- Effective Anchor network and partnership, providing leadership for change
- Improved integrated pathways

For our System:

- Sustainable health and care system that includes a thriving voluntary and community sector with increased collaboration
- Improved health and wellbeing for our population
- Sustainable workforce reflective of the population we serve through the "I can" approach
- A system engagement strategy that draws on the wealth of community insight and eases navigation
- Increased utilisation of digital technology innovations

Work Programme	To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Strengthen Partnership Effectiveness A new model of care has been developed to provide care where possible in community settings, relieving pressure on acute and mental health services, but ensuring that they are accessible when required. We will work to ensure the sustainability of Dudley's thriving voluntary and community sector, to include establishing an Anchor network and Compact.		✓	✓			
Transform Citizen Experience Through Community Partnership Teams and adoption of Population Health Management approaches we will deliver safe, coordinated, and effective physical and mental health care and support in the community for, that meets the needs of our patients and utilise digital technology to support the delivery of effective services across all partners.		✓	✓	✓		
Shift the Curve of Future Demand To implement our Primary Care Strategy including the following; access, sustainability, population health, Multi-Disciplinary Teams, personalisation, collaboration, development, and resilience.		✓	✓	✓	✓	✓
Health Inequalities Implement Dudley's Joint Health, Wellbeing and Inequalities Strategy with a focus on prevention and access to reduce health inequalities in our communities.		✓	✓	✓		
Children and Young People Our priority will be Family Hubs/ Start for Life which has six specific areas of action, to provide seamless support for families and an empowered integrated workforce.		✓	✓	✓		

Dudley Castle

Sandwell

Our vision is that people living in Sandwell will receive excellent care and support within their local area, exactly when they need it.

Our vision will be delivered by a team of people working together in partnership with local citizens. Through our partnership we will support and engage with communities to enable people and families to lead their best possible lives regardless of health status, age, background or ethnicity. Together we will tackle inequalities, supporting people born and living in Sandwell to have opportunities to lead happy, healthy lives.

Health and wellbeing priorities:

- help people stay healthier for longer
- help people stay safe and support communities
- work together to join up services
- work closely with local people, partners and providers of services.

Outcomes to be achieved

For our Patients:

- Responsive, coordinated care
- Improved outcomes for people living with long term conditions, empowered to live healthier lives
- Increased GP access, person-centred approach to care
- Improved patient experience, right care right time
- Supported to maintain usual place of residence where able

For Organisations:

- Improved pathways between primary, community and secondary care to avoid duplication and delays
- Reduction in referrals, unplanned demand, and admission avoidance
- Use of digital technology/innovations

For our System:

- Utilisation of population health data to support a reduction in health inequalities
- Sustainable workforce
- Provision co-designed with local people

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Healthy Communities Working in partnership with local communities to empower citizens to lead healthier lives; focused on lifestyle, addictive behaviours, Long Term Conditions, Children and Young People and social isolation.					✓
Primary Care Facilitate the delivery of the Directly Enhanced Service, develop a transformational approach to a sustainable future model, ensuring services are developed for local citizens.			✓		
Town Teams Develop integrated teams in each town, inclusive of community health, social care and mental health; delivering a person-centred approach.			✓	✓	✓
Intermediate Care Citizens will be supported to live their best possible lives, receiving rehabilitation, reablement and appropriate interventions when required.	✓	✓			
Care Navigation Facilitate professionals and citizens to get the right service at the right time, through a single point of access, accessing seamless pathways.		✓	✓		
Sustainable Workforce Grow a productive sustainable workforce that will increase staff satisfaction, and provide opportunities for local people.				✓	✓
Digital Utilise digital technology to support the delivery of effective services, ensuring the local people receive support to minimise digital inequalities.			✓	✓	✓

Guru Nanak Nishkam Sewak Jatha in Sandwell

Walsall

Our vision is to level up on social and quality of life issues - such as mental wellbeing, uneven life expectancy, excessive elective surgery waiting time, fighting gang crime, encourage healthier lives, and creating a safer environment.

Our plan outlines the intention to invest in the mental and physical wellbeing of residents to continue to build a borough to be proud of and improve the outcomes for the people of Walsall. Our overall programme reflects our commitments to our health and wellbeing priorities and addressing wider determinants of health.

Health and wellbeing priorities:

- maximising people's health, wellbeing and safety
- creating health and sustainable places and communities
- reducing population health inequalities.

Outcomes to be achieved

For our Patients:

- Joined up/connected services across primary and community services
- Health and wellbeing centres/ network of specialist care
- Reduced loneliness and social isolation
- Improved health outcomes and patient experience
- Holistic approach to care

For Organisations:

- Outcomes framework to identify opportunities
- Digital technology and innovation
- Integrated services to remove barriers, duplication and provide better value

For our System:

- Reduction in health inequalities
- Increased social capacity and resilience
- Sustainable workforce

Sister Dora statue

Work Programme	To be delivered by: Yr1	Yr2	Yr3	Yr4	Yr5
Primary Care Networks (PCN) Development Programme To support delivery of the DES, establish stronger partnerships and join up care.					✓
Resilient Communities (Tier 0) Working together to ensure citizens are supported to live healthy lives; Prevention, identification, early intervention and self-care.					✓
Family Hub programme Focus on Family Hubs/ Start for Life which has six specific areas of action, with seamless support for families and an empowered workforce.					✓
Integrated Place Based Teams (Tier 1) Integrated Primary, Social and Community Services, delivering care at scale through a hub and spoke model across each locality.					✓
Specialist Community Services (Tier 2) Accessible, high-quality care with local hospital teams working in a locality 'Health and Wellbeing Centres'.		✓			
Intermediate, Unplanned and Crisis Services (Tier 3) Network of care delivered from Health and Wellbeing Centres, preventing unnecessary hospital admissions.		✓			
Acute and Emergency Services (Tier 4) Access to high quality acute hospital services for patients needing specialist intervention.	✓				
BCH Community Mental Health Transformation Working together to expand working relationships, review current pathways and development opportunities.					✓

Wolverhampton

Our vision is partners working together to improve the health and wellbeing of the people who live in Wolverhampton, providing high quality and accessible services and tackling inequalities in access and outcomes.

Supporting this vision is the development of joint commissioning arrangements for place, with a programme of work underpinning the vision delivered through the OneWolverhampton partnership and through other programmes of work aligned to the local Health and Wellbeing Board's Health Inequalities Strategy.

Health and wellbeing priorities:

- quality and access of care
- starting and growing well
- reducing harm from smoking, alcohol, drugs and gambling
- getting Wolverhampton moving more
- public mental health and wellbeing.

Outcomes to be achieved

For our Patients:

- Active daily, live longer happier healthier lives
- Improved GP access, improved patient experience
- Access to responsible and timely interventions, including prevention
- Improved patient outcomes, early detection/screening and management of long-term conditions

For Organisations:

- Admission avoidance and expedited discharge
- Reduced demand for hospital services
- Integrated, joined up services, reducing duplication

For our System:

- Tackle unwarranted variation in service quality
- Reduced health inequalities
- Sustainable workforce

St. Peter's Collegiate Church

Work Programme	To be delivered by: Yr1	Yr2	Yr3	Yr4	Yr5
Physical Inactivity Exemplar Residents supported to have longer, happier and healthier lives, enabled to be active every day including safe spaces, address wider determinants.				✓	✓
Primary Care Development Support delivery of the Direct Enhanced Service, improve pathways, share good practice and achieve consistent standards.	✓	✓			
Adult Mental Health Delivery of the community transformation programme, understand local need and deliver responsive/enhanced services.	✓	✓			
Children and Young People Support the development of Family Hubs/ Start for Life, integrating services to improve the interface between services and access.	✓	✓	✓		
Living Well Supporting people to live well and as independently as possible within their communities, increasing opportunities for self-help and community resilience, increasing uptake of screening, health checks and diagnosis.	✓	✓	✓		
Out of Hospital Further develop existing services and discharge pathways, ensure a joined-up approach, supporting people with complex needs.	✓	✓			
Urgent and Emergency Care Expansion of the integrated front door model and wider integration with care coordination, improved access to urgent diagnostics.	✓	✓	✓		

Key development areas

The following sections describe how within the Black Country we will improve the services we provide over the next five years. It is described by the type of service and includes the vision, priority actions and the improvements in health outcomes we expect to achieve.

Planned care (Elective)

Outcomes to be achieved

For our Patients:

- Improved access, reduced waiting times and timely access to treatment leading to improved clinical outcomes
- Improved choice, personalisation and experience
- Improved life expectancy

For Organisations:

- Improved organisation, productivity and workforce resilience
- New technologies and transformed care
- Outpatient transformation (Follow Ups, Patient Initiated Follow Ups, Specialist Advice)
- Increased capacity and service resilience

For our System:

- Greater collaboration and integration, driving system leadership
- System resilience at times of peak/pressure

Surgical robot at Dudley hospital

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Improving Access/Eliminating Long Waits Through improving capacity, mutual aid, outpatient transformation, a shared patient waiting list, and increasing the scale of inclusive initiatives, we will implement new models and ways of working to improve access.	✓	✓	✓	✓	✓
Improve Capacity and Productivity To implement plans such as alignment to Getting It Right First Time (GIRFT) and national transformation initiatives, and local transformations such as dedicated elective care hubs, theatre reconfigurations and a new hospital site (Midland Metropolitan University Hospital. We will optimise care pathways and improve productivity.	✓	✓			
System Resilience and Transformation Through our transformation activities, use of innovative technologies, new workforce models and system leadership we will achieve greater system resilience.			✓		
Improving Quality To implement standardised approaches and pathways to both align practice and support the reduction of health access equity. Centres of Excellence will be explored to reduce unwarranted variation in access, experience and outcomes.	✓	✓	✓	✓	✓

Planned care is what we say when we mean a treatment which is planned. Things like operations for hips and knees. This area of the plan explains how we will recover from the COVID-19 pandemic and ensure that the capacity is there to meet future health needs and to ensure any treatment needs are identified in a timely way.

"A delayed or cancelled surgery after a long wait is very worrying."

Our aim is for organisations to work together to provide better, faster and safer care for local people. The plan describes how we will do this by:

- improving access (recovery and restoration), capacity and productivity
- improving quality – achieve equity and address health inequalities through standardisation of care and the reduction of unwarranted variation
- system resilience and transformation – new models of care, system strategic developments including enhancing workforce recruitment and retention.

We will be exploring the potential for centres of excellence and dedicated sites doing just elective work, to reduce the disruption in emergency care peaks. We hope to be in a position where the Black country is seen as an exemplar for elective care and is able to support other neighbouring systems with their capacity. The big outcome for local people will be increased capacity for planned care and the introduction of new technologies and approaches. We expect this to reduce waiting lists, improve quality of care and improve patient choice.

81% of people would be willing to travel outside of the place they live to receive treatment from a specialist team.

Case study - Robot arm-assisted surgery

Robot arm-assisted surgery for hip and knee replacement patients was first launched in the Black Country in 2022 at Walsall Manor Hospital – the first district general hospital in the country to do so.

The innovation within the Trauma & Orthopaedic (T&O) Department gives Walsall Healthcare NHS Trust the opportunity to blaze a trail for elective arthroplasty (surgery to restore joint function), within the Integrated Care System.

Consultants say the £1.8m technological investment will transform outcomes and experience for patients and are excited to see what the future holds.

Mr Thomas Moores, Clinical Director for T&O, said: "This is a fantastic opportunity for our patients and equally as exciting for our surgeons to be involved in such cutting-edge advancements.

"The precision that Mako SmartRobotics allows in joint replacement surgery will transform the way total knee replacements are performed. For our patients there will be shorter lengths of stay in hospital, reduced bone and soft tissue injury and improved outcomes such as greater flexibility and movement.

"This technology means surgeons know more about their patients than before and are therefore able to cut less. For some patients, this can mean less soft tissue damage, for others, greater bone preservation."

We are proud to be the first to offer this advanced robotic technology which further demonstrates our commitment to providing our communities with improved healthcare. Since its launch in Walsall, we are exploring the expansion of robotic assisted surgery at other hospital sites.

Diagnostics

More capacity for diagnostic tests closer to home.

We know that waiting for any health diagnosis, especially cancer, can be an extremely worrying time. Our aim is to provide equitable access to modern, state of the art, high-quality diagnostics, in a timely manner. Diagnostics play a key role within our system recovery and is at the centre of disease and patient pathways, to detect disease as early as possible and accurately guide to the right treatments. Currently, diagnostic services are mostly based in hospital settings. We want to increase the capacity, particularly in community locations, to make it even easier to access these essential services. Our plan includes:

- recovery and maintenance of waiting times for diagnostic testing to pre-covid levels and meet the diagnostic standards set out for the NHS
- equity of testing access across the system and standardisation of pathways to reduce variation and health inequalities
- build a resilient, system-wide service for the future that provides value for money through continuous improvement in service delivery, capability and technological implementation.

30% of people have heard of or used the community diagnostic centres.

Outcomes to be achieved

For our Patients:

- Reduced waiting times for patients, reduced uncertainty
- Ensuring equal access for all patients across our system
- Local imaging/ testing, with reporting networks across organisations, improving patient experience

For Organisations:

- Shared capacity and management of reporting backlogs to optimise reporting turnaround times
- Staffing consistency and flexibility to provide more opportunities for personal and professional development
- Sharing and levelling of resources (staff and equipment)

For our System:

- A cohesive, system-wide approach to quality improvement, addressing health inequalities
- Improved sustainability and service resilience
- Standardised system pathways with reduced variation
- Maximised economies of scale in procurement

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Optimise Clinical Pathways Implement best practice timed pathways across urgent, elective and cancer services, driving efficiency and productivity, ensuring safe and patient centred pathways.		✓			
Reduce Inequalities in Access Consider physical, cultural and social needs of different/ diverse population health groups and implement actions to improve pathways and achieve equity of access.		✓			
Implement Community Diagnostic Centres (CDC) Increase capacity by investing in new facilities, equipment and staff training; Improve health outcomes through earlier, faster and more accurate diagnoses.				✓	
Develop and Implement a Workforce Strategy Ensure a system-wide diagnostic workforce strategy aligned to the People Plan. Identify staff shortages and skills gaps to inform recruitment actions.	✓	✓	✓	✓	✓
Adopted technological/ digital innovation Implement innovative technologies and supporting infrastructure to improve care for patients by changing how tests are conducted and analysed.		✓	✓	✓	✓

Case study - Community diagnostic centres

Two community diagnostic centres have been opened in the Black Country to help speed up diagnostic tests for patients.

Community Diagnostic Centres (CDCs) are key to transforming current care delivery by providing access to "right first time" diagnostics and treatment services closer to patients' homes. They have played an important role in supporting the Black Country to become one of the first systems in the country to eliminate 104-week referral to treatment waiting times.

The centres, one at the Corbett Outpatient Centre in Dudley and one at Cannock Chase Hospital in Cannock, aim to improve patient outcomes in areas such as cancer, stroke and heart disease, as well as provide quicker access to testing and results for patients in their community.

As well as helping to cut waiting times for patients receiving scans and other tests, CDCs also offer:

- a one-stop diagnostic location to allow patients to have all tests in one place (where appropriate)
- separate emergency diagnostics from planned/elective diagnostics
- a location away from an acute hospital site
- a focus on locations with greatest population need
- easy access for patients
- connection with primary, secondary and community care
- support for increasing workforce numbers by offering training capacity.

There are plans to deliver at least two more CDCs in the Black Country in the future.

Cancer

Our aim is to save lives through improvements in the prevention, detection and treatment of cancer. We will provide compassionate and consistent cancer services with improved support, outcomes and survival for people at risk of and affected by cancer.

"We need better early detection which will save lives, time and money."

The NHS diagnoses and treats thousands of people each year with cancer. Detecting and treating cancer early is important. This area of the plan looks at how we get the right services in place to ensure people can be seen quickly. The plan covers our work in four key areas:

- preventing cancer where possible, supporting healthier lifestyles and reducing the existing inequalities in the outcomes for local people
- improve screening and detection to enable detection of cancer at earlier stages
- improve diagnosis, treatment, care and support to get diagnosis early and improve access through new community diagnostic centres leading to improved outcomes and survival rates
- research and innovation is key in the development of new treatments and we will look to increase local participation in trials to develop new technologies.

Outcomes to be achieved

For our Patients:

- Preventing cancer where possible, supporting healthier lifestyles
- Optimal diagnosis, treatment, care and support, leading to improved outcomes and survival rates
- Best possible patient experience, timely access to information
- Faster Diagnosis, increase uptake in screening programmes

For Organisations:

- Efficiencies through the deployment of innovation
- Best practice pathways informed by cancer research, early deployment of new innovations

For our System:

- Maximise improvement opportunities through collaborative working, and clinical networks
- Reducing health inequalities

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Prevention and Reducing Health Inequalities Working collaboratively we will improve cancer prevention and develop improvement plans to reduce health inequalities.	✓	✓	✓	✓	✓
Screening and Early Detection Achieve improvements in screening programme uptake to enable earlier detection of cancers at earlier stages, to improve patient outcomes and survival of cancer.	✓	✓	✓	✓	✓
Optimal Cancer Diagnosis, Treatment, Care and Support Monitor outcomes and patient experience to ensure our services meet the needs of our diverse population, implementing best practice pathways across our system along with innovations such as Community Diagnostic Services.	✓	✓	✓	✓	✓
Cancer Research, Collaboration and Innovation Cancer research is a significant part in the development of new treatments to improve care; we will achieve enhanced access and participation in clinical trials, along with the deployment of innovation.	✓	✓	✓	✓	✓

Understanding what our communities need to increase screening and early detection.

Case study - NHS-Galleri Research trial

Finding cancer early often means it can be treated more successfully. The NHS-Galleri trial is looking into the use of a new blood test to see if it can help the NHS to detect cancer early when used alongside existing cancer screening.

The NHS-Galleri study was supported in the Black Country, with mobile clinics hosted in Walsall.

NHS-Galleri is a randomised controlled trial (RCT) of a new cancer screening blood test. The trial is designed to establish if screening with the Galleri® test reduces the incidence of late-stage cancer when used in an asymptomatic population in combination with existing NHS cancer screening programmes.

The trial is a partnership between NHS England and GRAIL, the company who developed the test. Cancer researchers and trial managers from King's College London are coordinating the trial and analysing the results.

Since the trial launched in September 2021, thousands of participants have volunteered to take part with participants invited to attend appointments for blood samples to be taken.

Each participant was randomly assigned to the intervention or control arm of the trial. Participants in the intervention arm with a 'Cancer Signal Detected' result following their blood test were referred directly to a two-week urgent cancer referral pathway for diagnostic assessment, as agreed by NHS England, and their GPs informed if their patient received a 'Cancer Signal Detected' result.

For more information, visit nhs-galleri.org

NHS Galleri study mobile clinic

Urgent and emergency care

When you need us most, the local NHS needs to be there to respond. Our aim is to ensure patients have access to high quality urgent and emergency care services in the right place at the right time, delivered by the right professional.

"How would I manage in the event of an emergency?"

Our plan details how our emergency care services will work better to meet the needs of local people today and in the future. This includes:

- improving processes and standardising the care in our hospital-based emergency services
- increasing out of hospital pathways to get people seen in the right place
- improving the flow through our hospitals and developing improved discharge processes and care for people to step down from hospital services with the support that they need
- understanding the reasons for people using emergency services inappropriately, supporting them to access care in the right place.

Outcomes to be achieved

For our Patients:

- Services delivered closer to home
- Shorter waiting times at all points in patient pathway, and improved patient experience
- Reduced emergency admissions
- Personalised Care

For Organisations:

- Enhanced triaging and streaming to increase the number of people receiving urgent care in settings outside of the Emergency Department to include Same Day Emergency Same Day Emergency Care, Urgent Treatment Centres, Urgent Community Response.
- Improvements in handover times between the Ambulance Service and Emergency Departments

For our System:

- Sustainable and resilient Emergency and Care Model across the system
- Consistency of Urgent and Emergency Care Services and pathways across our system

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Creating a sustainable hospital based urgent and emergency care model To achieve a sustainable Emergency Care model that is fit for the future and meets current and future patient demand, we will improve processes and standardise care, expand Same Day Emergency Care provision and increase Urgent and Emergency Care/bed capacity.	✓	✓			
Increasing utilisation, capacity and range of services provided outside Emergency Department We will improve utilisation of Urgent Treatment Centres, scale up of Virtual Ward provision, develop mental health urgent response services, and improve access to urgent primary care.	✓	✓	✓		
Development of step down and discharge pathways To continue to work in partnership with Out of Hospital Services and Place Based Partnerships to deliver effective discharge pathways which promote a return to independence in community settings.	✓	✓			
Enhancing/Improving Access Identification and resolution of barriers to accessing primary and community services, reducing unwarranted variation and inequity, supporting High Intensity Service Users, and early help and prevention services.	✓	✓	✓		

Improved handover times between ambulances and our hospital emergency departments.

Case study - New Ambulance Receiving Centre

An Ambulance Receiving Centre (ARC) opened at Wolverhampton's New Cross Hospital in January 2023, improving the experience of hundreds of patients each week and allowing paramedics to get back on the road sooner.

Ambulance Receiving Centre at New Cross Hospital

The ARC provides an additional 17 ambulance offload spaces, as well as additional staff to support with handovers as part of OneWolverhampton Partnership's plans to ease pressures on the Emergency Department (ED) over winter.

Gwen Nuttall, Chief Operating Officer at The Royal Wolverhampton NHS Trust, said: "The ARC is enabling us to release ambulance crews back onto the road quicker than before.

"The ARC is also a much better facility for patients waiting to be seen rather than the back of an ambulance and it also allows us to start the triage process sooner."

Michelle Brotherton, Assistant Chief Ambulance Officer at West Midlands Ambulance Service, said: "The pressures we are seeing in health and social care lead to long hospital handover delays with our crews left caring for patients that need admitting to hospital, rather than responding to the next call.

"We continue to work incredibly hard with all of our NHS and social care partners to prevent these delays and are pleased to see this initiative by New Cross Hospital to help us hand over patients quickly so our crews can respond more rapidly and save more lives."

Around 25% of people said they would consider going at A&E with a non-life-threatening health condition.

Over 50% of people didn't feel confident that an ambulance would arrive quickly if they needed it.

Out of hospital/community services

We recognise that people want to remain as independent as possible, for as long as possible and that they want to have care as close to home as they can. Therefore, supporting people to stay out of hospital where possible but also to return to a home setting after a hospital stay as quickly and safely as we can is important.

Our aim is to transform and build out-of-hospital and community services to deliver a 'home first' philosophy. The plan describes how we will do this by:

- investing in community services to respond quickly when people are in need and to prevent hospital attendances
- recognising and preventing falls as these are a major contributor to hospital stays
- developing more capacity for people to receive care in a home setting through remote technology and virtual wards
- supporting people in their end-of-life choices and ensure there is support and care there for people to die in a place of choice with dignity.

Outcomes to be achieved

For our Patients:

- Increased independence
- Care Closer to Home
- Equity of Services
- Reducing time spent in hospital
- Reduced readmissions to hospital

"Set up more community hubs and incentives for people to use these services rather than hospitals."

For Organisations:

- Increased efficiency/productivity by improved utilisation/standardisation of out of hospital pathways
- More efficient use of resources (workforce, equipment and estates)

For our System:

- Collaboration/Joint working with wider system partners e.g. Local Authorities, third sector
- Greater integration of pathways/services
- Improved access and health outcomes
- Reduction in health inequalities

37% of people had heard of virtual wards.

At the end of life, people felt the most important thing to them was to be in a homely setting with family and friends at their side.

More support, care and technology to enable care at home rather than hospital

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Single Triage Model for Urgent Community Response (UCR) Service To deliver a single integrated model that achieves consistency, removes duplication and embeds collaborative working.	✓	✓			
Recognised Falls Model in the Black Country To implement a consistent standardised falls management approach across the system, minimising risk to patients and reducing the demand for Urgent and Emergency Care services.	✓	✓			
Continued Development of Remote Monitoring and Virtual Wards The expansion of monitoring in care and at home and virtual wards offer across the Black Country, working in partnership with Local Authority to support roll out of tech enabled schemes.	✓	✓	✓	✓	
Effective Discharge from Hospitals to create flow We will discharge to the most appropriate setting in a timely/ effective way to support the best patient outcomes, ensuring flow for patients requiring acute care, working with partners and neighbouring systems.	✓	✓			
Palliative and End of Life Care Implementation of the Palliative and End of Life Care Strategy	✓	✓	✓		

Case study - Virtual wards

Virtual wards have been introduced across all four places in the Black Country, helping to support patient flow out of hospital and improve patient experience.

A virtual ward combines state-of-the-art app technology and medical devices such as pulse oximeters, with on-demand access to specialist nurses and doctors, enabling patients to be looked after in the comfort and familiarity of their own home.

Patients who are suitable for a virtual ward are identified during hospital ward rounds, and if the patient is willing, they are enrolled in the programme. Patients and/or their carers receive training so they can understand how the virtual ward equipment works and are then sent home with a kit consisting of state-of-the-art monitoring equipment. From their arrival home, the patient is then monitored virtually, but all alerts, interventions and outcomes are recorded and acted upon, with direct access to professionals within the hospital via phone for any concerns.

The Black Country was also the first in England to introduce virtual wards for children. Following a successful pilot in Dudley, the model has been rolled out to Walsall, Wolverhampton, and Sandwell.

To date, more than 3,500 patients have been supported via the virtual wards, with the ability to run hundreds of 'beds' across the Black Country.

Preventing ill health

Preventing ill health is better than treating it and our growing and ageing population means that without good prevention we will see an increasing number of people needing NHS care. Our aim is to increase healthy life expectancy so people can live the life that matters to them, preventing illness and improving life expectancy.

Many conditions which can contribute to shorter healthy life expectancy are preventable. While the factors which can lead to these conditions are many and varied, through prevention our aim is to help people improve their own health through targeted support to help reduce alcohol or tobacco dependency, to offer weight management services, and increase access to cancer screening and diabetes prevention programmes. We will develop our prevention capacity and capability across the Integrated Care Partnership, working together to harness our collective assets and embed preventative approaches as a continuum, ensuring health equity is our golden thread.

Our plan includes:

- supporting people to not smoke and to support those that are tobacco dependant with services to reduce their dependency
- supporting people to lose weight and make healthy life choices
- supporting people to not drink excessively and to support those that are alcohol dependant with services to reduce their dependency.

Outcomes to be achieved

For our Patients:

- Improved life expectancy,
- Reduce preventable illness
- Reduced morbidity and mortality
- A voice for change, through co-production

For Organisations:

- Improved capacity and capability to accelerate prevention activities
- Reduced dependency on specialist services

For our System:

- Improved health outcomes, reduced health inequalities
- Reduced demand on health and social care services

Work Programme	To be delivered by: Yr1	Yr2	Yr3	Yr4	Yr5
Tobacco Dependence To complete the establishment of Tobacco Dependence Services across all inpatient and maternity services. We will identify opportunities to improve pathways and support in the community and primary care. An assurance cycle will be established to enable targeted support, along with an evaluation.	✓				
Healthy Weight To further embed the Tier 2 programme through training and awareness across sectors, with targeted support where needed. Performance monitoring will continue and analysis or the 'obesity burden profile'. Further exploration of inequity across Tier 3/4 interventions to be undertaken and addressed.	✓	✓			
Alcohol Dependence To evaluate the Alcohol Care Teams established in each hospital to inform future decision making and test the early intervention and targeted prevention pilot.	✓				

More support, to help people stop smoking and to make healthy life choices

Personalisation

Personalisation is about giving back power to people – focusing on placing the individual at the centre of their care, reinforcing that the individual is best placed to know what they need and how those needs can be best met. It is one of the changes to the NHS set out in the Long Term Plan and represents a change of relationship between people, professionals and the health and care system – designed to have a positive shift in the decision-making process, enabling people to have choice and control over the way their care is planned and delivered.

Locally, we will increase personalised care planning with:

- increased availability of personal health budgets
- more shared decision making (SDM) training to ensure people are supported to understand the options available and can make decisions about their preferred course of action
- more conversations about what matters to local people rather than conversations about what is the matter with them. This will be done through more care planning approaches, education and awareness
- supporting more patient choice, ensuring that quality information is available to patients, that choice is proactively extended, and principles build into models of care and care pathways
- expanding social prescribing to be available to all communities including children and young people.

We will embark on more conversations about what matters to you.

"One route does not fit for everyone. We need more time to discuss options and choices about health conditions."

Shared Decision Making

Shared decision making (SDM) refers to a point in a pathway where a decision needs to be made, people are supported to understand the options available and can make decisions about their preferred course of action.

Our plans include delivering SDM training across our workforce, embedding SDM foundations in all pathways, a public awareness campaign and the development of decision support tools.

Personalised Care and Support Planning

Proactive and personalised care and support planning focuses on the clinical and wider health and wellbeing needs of the individual. Conversations should focus on what matters to the individual.

Our plans include establishing care plans and care coordinators across a range of services, embedding Compassionate Communities approach, and expanding roles in primary care to support care planning.

Enabling Choice, including legal rights to choose

Enabling choice concerns the legal right to choice of provider in respect of first outpatient appointment and suitable alternative provider if people are not able to access services within waiting time standards.

Our plans include ensuring that quality information is available to patients, that choice is proactively extended and principles build into models of care and care pathways.

Social Prescribing and Community Based Support

Social prescribing is an approach that connects people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing.

Our plans include expanding the service to meet all communities including Children and Young People, workforce training and development including peer support, and building in creative cultural health opportunities.

Support Self-Management

This is the way that health and care services encourage, support and empower people to manage their ongoing physical and mental health conditions themselves.

Our plans include developing primary based self management education, rolling out health coaching and workforce training with a focus on prevention and self-management approaches.

Personal Health Budgets

A personal health budget (PHB) supports creation of an individually agreed personalised care and support plan that offers people choice and flexibility over how their assessed health and wellbeing needs are met.

Our plans include widening the availability of PHB linked to population health need, further develop the finance and clinical governance framework to support extension, pilot integrated health and care budgets.

Primary care

Improving access to high quality care from GPs, dentists, opticians, and pharmacists is something which local people raise with us regularly. Our aim is to implement a transformed primary care operating model that delivers equitable access to high quality care that is safe, integrated, consistent and person-centred.

The plan describes the work underway to:

- develop more joint working in primary care to support the services to be future fit
- support workforce growth, retention, and recruitment
- maximise opportunities to develop better premises
- implement new solutions to improve access, including new technologies.

Outcomes to be achieved

For our Patients:

- Increased primary care appointments, improved access, and reduced waiting times
- Increased dental activity
- Increased patient satisfaction and experience
- Increased digital functionality, including telephony

"I struggle to get a GP appointment face to face and don't think I can get the right help over the phone."

For Organisations/ Our System:

- Grow our workforce, expand new roles
- Implementation of Fuller recommendations
- Deliver our delegated responsibilities (GP and Pharmacy, Optometry and Dental Services)
- Optimised estates and communications
- Establish integrated ways of working
- Deliver the Primary Care Collaborative Transformation Programme

Dr Okey Obidiegwu at Sandwell Hub

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Development/embedding of Primary Care Collaborative Establish the governance, clinical leadership and the required infrastructure to deliver collaborative working.		✓			
Establish/develop the primary care workforce and transformation unit (primary care delivery vehicle) Establish new ways of working, deliver organisational development and work programme focussing on access, Long Term Condition and unwarranted variation.			✓		
Primary Care Collaborative transformation work programme (future operating model) Undertake strategic development and implement the transformation programme.					✓
Improving general medical services (GP) access Support PCNs to implement practice-based solutions to improve patient access and experience.	✓				
Primary Care Network (PCN) Estates Programme Reconfiguration of vacant space, maximise e-booking systems, and deliver the Estates Strategy.					✓
PCN Development Programme Support PCNs to 'maturity' and embed the development programme reflecting the Fuller recommendations.			✓		
Increasing Dental Access Programme Develop a dental strategy and deliver improvement plans.					✓
ICS Primary and Community Care Training Hub contract/system workforce development programme Embed workforce planning and secure the resources to deliver the improvements.		✓			

63% of people would be happy to speak to a trained pharmacist about their health rather than waiting for a doctor.

We will embark on a big conversation to include local people in our plans to improve access to primary care.

Case study - Respiratory hubs in primary care

During 2022, Acute Respiratory Infection (ARI) hubs were set up across the Black Country to provide extra support for patients with respiratory illnesses (those affecting the lungs and airways).

Located in Sandwell, Dudley and Walsall, the ARI hubs supported local GP practices by providing same-day, face-to-face appointments.

They were set up for children with suspected respiratory syncytial virus (RSV), a common winter virus that causes cold-like symptoms and coughs, and can lead to hospital admissions in babies, young children, and vulnerable adults.

The ARI hubs were by appointment only and GP practices could book children into the hub if all their own face-to-face appointments were filled that day. Providing appointments in the community also supported urgent care as parents were less likely to take their child to a walk-in centre or A&E if they were unable to get in at their normal GP practice.

Each hub sees approximately 800 patients per month and less than 1% of children seen at the hubs need an onward referral into urgent care.

In December (2022), all hubs increased their capacity to see 40% more children due to the rise of Strep A and RSV cases in the community.

Maternity and neonatal

Making it safer than ever to have a baby is an area of focus for us. Supporting mothers, babies and families during pregnancy and birth is so important. Our aim is to deliver high-quality maternity and neonatal services across the Black Country, through co-production with women, which will be safe, personalised, and equitable to ensure every woman and baby receives the best possible care.

We have developed strategic priorities which are:

- monitoring the quality of perinatal (the period before and after birth) services to ensure they are of the highest standard
- improved continuity of care, and experience for mothers, families, and babies
- a focus on workforce to create new roles, share recruitment and allow our staff to work across organisational boundaries
- reduced perinatal mortality and morbidity, and improve access to specialist care when needed
- implementation of the action plan to improve health inequalities and accelerate work to support those mothers and babies at greatest risk of poor health outcomes.

Outcomes to be achieved

For our Patients:

- Improved safety and outcomes for women and their families
- Improved continuity of care, and experience
- Lower rates of morbidity/mortality

For Organisations:

- Improved monitoring and assurance of safety
- Strengthened workforce resilience, and succession planning

For our System:

- System leadership, supported by Maternity and Neonatal Voices Partnership
- Collaboration and peer review/ learning
- Reduced health inequalities

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Perinatal Quality Surveillance Model To enhance the existing model a robust quality assurance process will be implemented, included peer review to achieve assurance of quality and safety, and delivery of Saving Babies Lives Care Bundle v2 and v3.	✓				
Workforce To further build on our progress, we will develop a workforce strategy focusing on consolidating recruitment for cross boundary working, new roles, shared recruitment and succession planning.			✓		
Maternity Continuity of Carer (CoC) To implement our five-year transformation plan, ensuring our model reflects the needs of our population and focuses on choice of place of birth rather than geography.					✓
Reduce Perinatal Mortality and Morbidity Work collaboratively to identify improvement actions to improve outcomes and reduce health inequalities. Improving access to specialist care where required.			✓		
Perinatal Equity and Equality Strategy and Action Plan Through our dedicated Equality, Diversion and Inclusion leads we will implement our action plan, ensuring we accelerate work to support those at greatest risk of poor health outcomes.					✓

If concerned about pregnancy, the majority of people would contact their community midwife.

Children and young people

Our aim is that every child gets the right help, at the right time, by the right service, to ensure they meet their full potential. We want Black Country people to have the best start in life and we will be developing a separate strategy to give this the focus that it needs. Recognising that over half of our children and young people are within the 20% most deprived communities nationally, our strategy will ensure the needs of all children and young people across our diverse communities are met.

Partnerships are vital for us to achieve our aim as we initially focus on the areas of:

- developing transformative care pathways for asthma, epilepsy, diabetes, and obesity
- work with partners in education, mental health, safeguarding to ensure that, no matter how complex, our children's needs are met
- hear the voices of children as we plan and deliver their care
- use the Core20Plus5 children's model to drive improvement and reduce inequalities.

"There is more chance of having a positive impact on health if we start young."

"The NHS should listen to young people and let them take the lead."

Outcomes to be achieved

For our Patients:

- Increase ability to self-manage Long Term Condition and increase quality of life years
- Co-production and ability to inform, challenge and embed service improvements
- Clear service pathways for patients

For Organisations and the System

- Developed joint commissioning, improved service efficiency and effectiveness
- Increased understanding of the need of Children and Young People (CYP) across the system, embedding all age commissioning
- Improved health outcomes for our most vulnerable including Children in Care, Special Educational Needs and Disabilities, most deprived etc
- Development of an integrated specification for CYP, evidencing good partnership working and shared outcomes

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Implement the Children and Young People (CYP) Transformation Programme An assessment will be undertaken against all elements of the programme and an action plan developed to ensure all standards/deliverables are met, robust care pathways in place and transition guidelines are robust; asthma, epilepsy, diabetes, and obesity.	✓	✓	✓	✓	✓
Establish CYP Joint Commissioning Plan Working collaboratively with partners we will develop a joint commissioning plan that meets the needs of CYP and supports them to achieve their full potential, this will including SEND, mental and physical health, safeguarding and CYP with complex needs.	✓	✓	✓	✓	✓
Implement CYP Voices Model To ensure the voices of CYP are heard during the development, review and delivery of services we will co-produce and embed this model.	✓	✓	✓		
Tackling Health Inequalities Using the national CYP Core20PLUS5 framework we will drive improvement action across CYP services; asthma, diabetes, epilepsy, oral health and mental health.	✓	✓	✓		

Robust care pathways for asthma, epilepsy, diabetes and obesity.

Mental health, learning disabilities and autism

Creating a Black Country where people with mental health, learning disabilities and or autism have more say over their care and supporting them to live well in their communities is key. Services for people to live in the community, get support in a crisis, and being there when they need information and guidance is important. Our aim is to ensure our citizens have access to services that are of outstanding quality, and that support people to live their best lives as part of their local community.
We will do this through:

"The NHS needs to focus on mental health and wellbeing to ensure our future generations are productive and happy."

- a review of children and young people's mental health services
- more community connected services to give people more choice and control
- services in place to ensure that people who find themselves within urgent care services have fair and equitable treatment for their physical and mental health needs
- reduce out of area hospital placements
- focus on prevention, timely diagnosis and personalised care and support for those with dementia and their families
- create an all-age Black Country suicide prevention strategy with partners.

Outcomes to be achieved

For our Patients:

- Accessible and equitable service provision
- Exceptional experience of care for all
- Increase mental wellbeing and earlier intervention
- Increased support in the community
- Support our Children and Young People to thrive
- Suicide prevention

For Organisations:

- Better understanding of population health and wellbeing
- Improved use of resources across the system
- Greater connectivity to local communities
- Improved workforce resilience and wellbeing

For our System:

- Parity of esteem between physical and mental health
- Successful achievement of national ambitions for MH and LDA
- Benefit from economies of scale and specialism

Work Programme	To be delivered by: Yr1	Yr2	Yr3	Yr4	Yr5
Children and Young Peoples Mental Health (MH) Services To achieve a shared and coherent vision across our system, to drive forward our transformation programme; including a full review across a number of service elements, alignment of pathways, and expansion of services where needed.				✓	
Community Mental Health Services (CMHS) Implement our new integrated model of CMHS to modernise services and workforce models, delivering holistic care aligned with Primary Care Networks, giving people greater choice and control over their care.		✓			
Urgent and Emergency Care Mental Health Services To ensure that people with MH needs who find themselves within Urgent and Emergency Care Services have a fair/ equitable service, recognising both their physical and MH needs; through an assessment hub outside of Accident and Emergency (A&E) environment, a drug and alcohol strategy, High Intensity User support, bed strategy to reduce Out of Area Placements.		✓			
Dementia Improve the lives of people with dementia focusing on prevention, timely diagnosis, crisis prevention, personalised care and support for family/carers.			✓		
Learning Disabilities and Autism (LDA) Reduce the reliance on inpatient care for people with learning disabilities and address unwarranted variation/gaps in autism care.		✓			
Suicide Prevention Collaborative working to develop an all-age Black Country Suicide Prevention Strategy and implement associated actions including education and awareness, urgent community response model and 24/7 Liaison Teams in A&E.			✓		

Most people would go to their GP if they were concerned about their mental health, followed by family and friends and then online.

Long-term conditions management

Locally we have high levels of deprivation, and this can mean that some people struggle to access healthcare to diagnose and manage their long-term conditions. Long-term conditions such as diabetes and cardio-vascular disease (CVD), are amongst the top five causes of early death for local people.

"Support patients with lifelong illness better. Lifelong illness should mean lifelong care, not having to go to the back of the queue each time."

Our aim is to ensure we reduce the prevalence of people with long term conditions in our population, and that we support those people living with long term conditions to live longer and happier lives through effective processes of prevention, detection, and treatment.

Our plan is to:

- prevent treatable conditions, through effective prevention programmes
- ensure patients continue to receive services post COVID-19 to help them to recover
- engage patients to improve their understanding of their condition and how to manage it
- support patients to manage their condition effectively, through self-care and use of digital technologies
- integrate pathways to manage care in primary and community settings and avoid conditions getting worse or having an urgent need for health intervention (exacerbation)
- support the delivery of local health inequalities initiatives based upon the Core20PLUS5 framework.

Outcomes to be achieved

"We should be educating people on how to manage their own health."

For our Patients:

- Earlier Diagnosis
- Reduce preventable illness
- Improved life expectancy
- Reduced mortality
- Patient empowerment, increase in patient led condition management

For Organisations:

- Reduced pressure in unplanned and urgent care
- More effective utilisation of capacity/resources
- Better use of technologies

For our System:

- Improved health outcomes, reduced health inequalities
- Collaboration/Joint Working with wider system partners e.g. Local Authorities, third sector
- Greater integration of pathways/services
- Leadership through Clinical Learning Networks

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Diabetes Delivery of prevention, detection and treatment programmes relating to structured education programme, National Diabetes Prevention Programme, Low Calorie Diet, Extended Continuous Glucose Monitoring, Joint Diabetes and Improving Access to Psychological therapies pilot, Multi-Disciplinary Footcare Teams.	✓	✓	✓	✓	✓
Post COVID-19 Services Ensuring patients continue to receive access to post COVID-19 services in a timely manner.	✓	✓			
Cardiovascular Disease (CVD) Delivery of initiatives to improve early detection and management of CVD including hypertension case finding, Blood Pressure at Home Service, delivery of Cardiac Improvement Programme.	✓	✓	✓	✓	✓
Respiratory Development and delivery of pulmonary rehabilitation five-year plan including development of spirometry services, expansion of remote monitoring programme and lung health check programmes.	✓	✓	✓	✓	✓

More support and education for people living with long term conditions.

Workforce

We know that a key enabler for the successful delivery of our Joint Forward Plan is our workforce. Currently there are approximately 60,000 colleagues working across health and social care in the Black Country, each providing a unique contribution to the delivery of care to our community. We know that for us to thrive we need to look after our workforce and become a place where people want to work. As a health and care system we know that as 'one workforce' we're better and that we need to develop the right culture and infrastructure for the Black Country to be the best place to work. We hope to do this through creating psychologically safe and supportive environments, where all our diverse colleagues feel they belong and we can provide the architecture for developing a workforce that is sustainable for the future.

"Staff are stretched, and they can't care for people if they are not given the right support themselves when it comes to their own health."

We will:

- focus on retaining our people and supporting them to be the best they can be, which in turn optimises our resources
- create an inclusive talent management approach
- co-produce a system people plan 2023-2028 that describes the priorities, actions, and impact to make the Black Country the best place to work
- work collaboratively to coordinate a workforce development plan that articulates our approach to workforce planning, education and training.

79% of people felt our workforce should represent the people and communities we serve.

65% of people would consider a job in the NHS for themselves or a loved one.

We pledge to our health and care workforce to support them in continuing to deliver excellent care, whilst promising to enhance their working experience. We will lead with compassion and create a culture of inclusivity and openness, with the health and wellbeing of our workforce at the heart of all we do. We will work together to create an environment removed from discrimination; providing a sense of belonging to our diverse colleagues.

Medicines management

With over 10% of local funding being spent on medicines, it is clear that prescribing plays a vital role in improving health outcomes and ensuring the most efficient use of NHS resources. Our aim is to transform pharmacy and use medicines appropriately which will lead to improved health outcomes and reduced health inequalities.

Great medicines management will improve the management of infections and diseases, reduce medicine related errors and harm for patients, reduce the risk of hospitalisation of our most vulnerable people and improve detection of conditions such as hypertension. We will do this by:

- supporting the appropriate use of antibiotics
- establishing a medicines safety network and education programme
- ensuring COVID-19 medicines are delivered in a place to meet the needs of local people
- using the right medicines, swapping them for lower cost items where possible
- reducing variation in prescribing.

Outcomes to be achieved

For our Patients:

- Appropriate prescribing and use of antimicrobials
- Effective management of illness
- Reduced medicine related errors, reducing harm for patients
- Reduced risk of hospitalisation related to medicines use, especially of our most vulnerable people
- Establish and promote safer prescribing and detection of conditions such as hypertension

For Organisations:

- Maximise value through medicines supply and use
- Efficient use of resources

For our System:

- Reduced unwarranted variation in prescribing across our system

55% would be willing to switch meds if an alternative was more environmentally friendly.

The vast majority of people would prefer face to face appointments with GPs.

71% would be happy with a telephone appointment.

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Appropriate Use of Antibiotics Implement our strategy and annual work plan to deliver education to all sectors, surveillance of antibiotic usage and reduction of 'watch and reserve' antibiotics.		✓	✓	✓	✓
Medicines Safety Establish a multi-sector network and education programme to reduce high dose opioid prescribing and reduce administration errors.		✓	✓		
COVID Medicines Delivery Unit Ensure accessible services are in place to meet the needs of our population. Equitable access will be achieved through delivering treatment to the patient home.	✓	✓			
Maximise Value A Better Value Medicines Programme will be established to maximise efficiencies across sectors, along with a High-Cost Drugs Group to monitor use and spend.	✓	✓			
Reduce Unwarranted Variation in Prescribing -ICS wide Medicines Governance Formulary harmonisation across the system will be achieved to improve the conformity of medicines available and ensure equity of medicines available.	✓				
Workforce Establish a Pharmacy Faculty to formally bring together stakeholders from across the ICS to deliver a collective approach to pharmacy workforce activity.	✓				
Health Outcomes and Inequalities Support community pharmacies, practices and Cardiovascular Disease network to maximise the detection of hypertension through community pharmacy and optimise treatment.		✓			
Quality of Pharmacy Services Embed and improve the provision of services available from community pharmacies.		✓			

Improved detection of conditions such as hypertension.

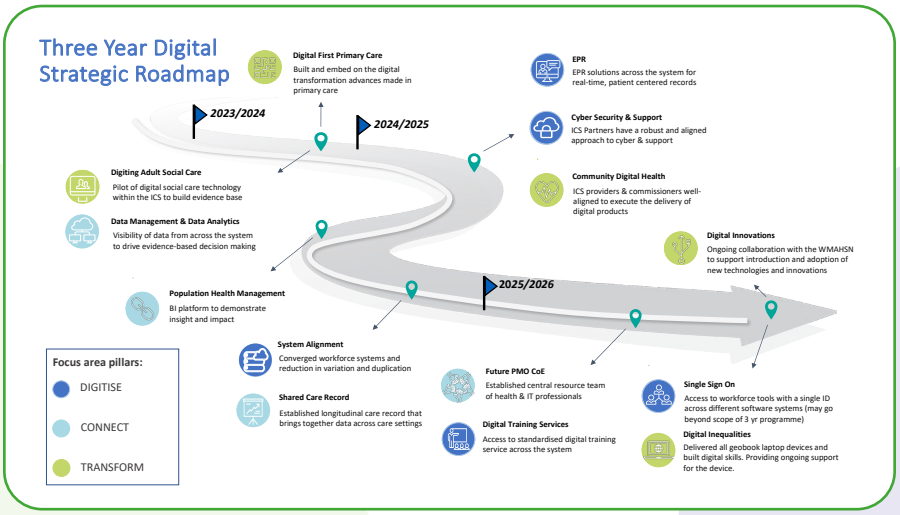
Digital

Digital is a key enabler to successfully deliver the Joint Forward Plan strategic priorities. Digital Innovation gives us an opportunity to improve patient care and increase efficiency, whilst supporting the wider strategic aims and objectives of the system.

Whilst the COVID-19 pandemic provided an opportunity to accelerate the implementation of digital solutions to provide care, in some cases, this unfortunately led to an increase of digital exclusion within some patient cohorts. It is our duty of care to ensure that we do not inadvertently increase digital exclusion through the implementation of technologies and must ensure that we seek to reduce existing inequalities by working collaboratively with our system partner organisations and local communities.

Our ambition for a digitally enabled Black Country NHS is to coordinate a system wide digital programme, ensuring our staff members and partner organisation have access to the digital facilities to not only achieve our strategic priorities but do so in a way in which addresses digital inequalities, maximises innovation in both the organisation and delivery of care, and provides our workforce with an efficient working environment.

A Digital Roadmap has been developed with key milestones for delivery of the ICS Digital Strategy, the diagram below provides an overview of the three-year digital roadmap.



Digital strategic roadmap identifying key activities that will be achieved over the next three years

The diagram below provides an overview of the current Digital work programme that will support delivery of the ICS Digital Strategy.

1. Digitise	2. Connect	3. Transform
Electronic Patient Record This will be real-time, patient centred records for instant information.	**Data Management & Data Analytics** Data capability to enable visibility of data from across the system to drive evidence based decision making.	**Community Digital Health** This seeks to align ICS community providers & commissioners to co-design, coordinate, drive, advise on and execute the delivery of digital projects.
Cyber Security & support Ensuring that the ICS Partners' cyber & support approach is robust & aligned for the challenges that come.	**Population Health Management** Iterative, hypothesis driven use of business intelligence to quickly test out ideas, demonstrating insight and impact e.g. repeat attendance in A&E.	**Digitising Adult Social Care** Pilot digital social care technology within the ICS to build an evidence based for their impact, develop implementation guidance, assure supplier solution.
System Alignment Clinically led programme to review all clinical workforce systems – converging where appropriate to reduce variation or duplication.	**Future PMO Centre of Excellent (CoE)** A central resource team of health & care IT professionals qualified in project and programme management which can flex across partner organisations.	**Digital First Primary Care** Embed and build on the digital transformation advances made in primary care and ensure that every patient is offered digital-first primary care by 2023/24.
Digital Training Services A digital training service that will be available across the system, ensuring that there is a standardised approach to training.	**Shared Care Record** A longitudinal care record that brings together data across settings of care. This supports the proactive approach for coordinating care.	**Digital Inequalities** Providing citizens with a Geobook laptop device, connectivity, training to build their digital skills and ongoing support for the device.
Single Sign on (SSO) SSO is an authentication scheme that allows the workforce to access tools with a single ID across different software systems.		**Digital Innovations** Collaboration with the WMAHSN to support the ICS with the introduction and adoption of new innovations and technologies.

Digital Work Programme

The difference our plan will make in five years

For the public:

- improved quality (access, experience and outcomes)
- care provided in the right place, by the right person
- reduced harm/ incidents of poor care
- improved physical and mental health for all
- improved life expectancy and quality of life
- greater choice and options to personalise care
- new models of integrated healthcare
- supported to have the best start to life.

For our staff:

- greater sense of belonging, value and satisfaction
- improved working conditions and succession planning
- estate, equipment and digital technologies to enhance working practice
- opportunities for improvement and personal development
- pride in the care we deliver.

For NHS partners:

- well led, well organised, system anchors
- greater efficiency and value for money
- reduced demand, through new models of care and improved patient outcomes
- productive, motivated, flexible workforce
- greater access to research and innovation
- modernised estates and facilities
- integrated care, with greater capacity to provide sustainable resilient services.

For the wider system:

- reduction in health inequalities for our population
- cohesive approach quality improvement and prevention
- reduction in unwarranted variation of care
- healthier people, healthier communities
- thriving voluntary, social and community sector
- engaged and growing workforce, fit for the future
- diversity in leadership, equipped and informed to act
- sustainable services designed to meet future need.

Measuring our success

It is important to have the ability to measure whether the plan we have developed is being implemented effectively and to understand whether it is achieving the impact it intended.

To support this, we have identified key metrics and indicators aligned to each strategic priority that will be regularly reported to all NHS organisations within the system. Such indicators are likely to change dependent on priorities or issues that may arise during the year.

Improving access and quality of services

- Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties).
- Continue to reduce the number of cancer patients waiting over 62 days.
- Increase the number of adults and older adults accessing Improving Access to Psychological Therapies treatment.
- Improve Accident and Emergency waiting times so that no less than 76% of patients are seen within four hours by March 2024 with further improvement in 2024/25.
- Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.

Community where possible – hospital where necessary

- Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard.
- Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024.
- Establish a baseline of the numbers of Children and Young People (CYP) and adult patients on Community Services waiting lists and develop and agree a plan for reduction of lists.
- Increase the utilisation of virtual wards.
- Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels.

Preventing ill health and tackling health inequalities

- Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024.
- Increase the percentage of patients aged between 25 and 84 years with a Cardiovascular Disease risk score greater than 20 percent on lipid lowering therapies to 60%
- Ensuring annual health checks for 60% of those living with Severe Mental Illness (SMI) (bringing SMI in line with the success seen in learning disabilities)
- A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

Giving people the best start in life

Reduce the number of stillbirths per 1,000 total births.

Measles, Mumps and Rubella for two doses (5 years old) to reach the optimal standard nationally (95%).

Ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups.

Best place to work

Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise.

Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024.

% of staff who have left the NHS during a 12-month period.

Sickness absence rates for NHS staff in England.

Increase the mean score NHS Staff Survey Staff engagement theme.

Feedback on our plan

Each of our four places has a Health and Wellbeing Board (HWB), these are statutory forums where political, clinical, professional and community leaders from across the care and health system come together to improve the health and wellbeing of the local population and reduce health inequalities.

Each of our HWBs has commented on the plan, their feedback is summarised below:

Councillor Bevan, Chair of Dudley Health & Wellbeing Board

Dudley Health and Wellbeing Board considered the ICB's Joint Forward Plan at its meeting on 8th June 2023 and can confirm our full support for the plan. It takes into account Dudley's Health, Wellbeing and Inequalities Strategy priorities. We look forward to continuing our work with the ICB to improve the health and wellbeing of Dudley residents and reducing health inequalities.

Councillor Hartwell, Chair of Sandwell Health & Wellbeing Board

The Chair of Sandwell Health and Wellbeing Board has reviewed and approved the Joint Forward Plan.

Councillor Flint, Chair of Walsall Health & Wellbeing Board

Walsall Health and Wellbeing Board is satisfied that ICB Joint Forward Plan takes into account the Joint Health and Wellbeing Strategy.

Councillor Jaspal, Chair of Wolverhampton Health & Wellbeing Board

Wolverhampton Health and Wellbeing Board welcome the principles articulated in the plan of collaboration, integration, productivity and tackling inequalities, alongside a focus on our collective challenges. The Plan priorities also align well with our local priorities.

Equally, the strategic workstreams reflect our local priorities, and Health and Wellbeing Boards have a key role to play in supporting the activity to improve prevention and tackle wider determinants.

Find out more

To read a more detailed version of our plan and see this document in other formats please visit our website www.blackcountry.nhs.uk.

To follow our progress why not check out our social media accounts.

To get involved and stay in touch please contact bcicb.involvement@nhs.uk or call **0300 0120 281**.

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