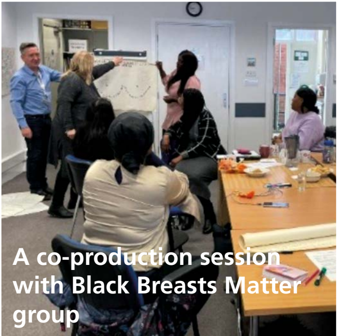
NHS Black Country
Joint Forward Plan 2023-2028

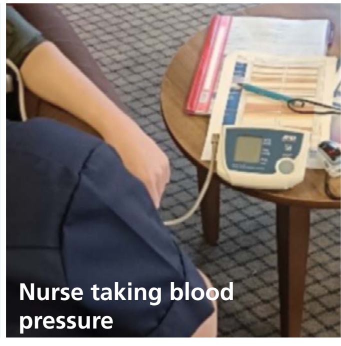
Updated April 2024

Virtual wards allow patients to get the care they need, at home safely and in familiar surroundings.


A co-production session with Black Breasts Matter group

Draft for Involvement

Midland Metropolitan University Hospital


Nurse taking blood pressure

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 - Care closer to home
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 our priorities. 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.

Priority 6 - Fit for the future
This new priority recognises that the Black Country health system needs to change the way that it works to embrace the opportunities and meet the challenges it faces. This includes the need to be more productive and cost-effective to meet our financial challenges. We also need to ensure that we support our Places and providers to work better together. We need to reduce the carbon footprint of the NHS and be more sustainable. All of this will require strong, sustainable leadership and enabling functions.

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
- a financially sustainable system
- a reduced carbon footprint

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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 for the five year period of 2023-2028.

This update represents Year 2 of the plan and describes achievements since the plan was published in July 2023, and learning from our continued engagement with the public and partners over the last year.

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.

This Joint Forward Plan describes how NHS organisations within the Black Country will support the delivery of the priorities our public and partners have described as essential in meeting the needs of our population.

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. 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 set our five strategic priority areas in our five-year plan as follows:

- **Priority 1**- Improving access and quality of services
- **Priority 2-** Care Closer To Home
- **Priority 3**- Preventing ill health and tackling health inequalities
- **Priority 4**- Giving people the best start in life
- **Priority 5**- Best place to work

2023/2024 as our first full year as an Integrated Care System (ICS) has evidenced the collective strength of the Black Country system partners working collaboratively to deliver more timely and efficient services. However, we need to build on the good progress made to date and ensure we change the way we work to meet the financial and other challenges we face. This includes our new Operating Model with greater devolution and responsibility to our four Places (Dudley, Sandwell, Walsall and Wolverhampton) and provider collaboratives, the leadership model to support this and how our support functions are aligned to the different ways of working. As a result, the update to the Joint Forward Plan includes a new priority for the system to reflect the challenges we face.

The new priority is:

- **Priority 6**- Fit for the future

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 focused 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.

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.

Within the five-year period of our plan, 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 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 ICS 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 delivering optimal outcomes.

The publication of the refresh of the plan for Year 2 (2024/2025), is just the continuation of our journey. We will continue to hold conversations with local partners, people and communities to inform future iterations as the plan, which will include a significant 'Mid-Term Review' of the plan for the start of the 2025/2026 financial year. We will use this year to review and refresh our system strategies – both the Integrated Care Partnership strategy and this Joint Forward Plan – and incorporate any changes to our strategic and operational priorities based on those conversations. We look forward to continuing to engage with you over the coming 12 months - continuing the progress already made in working together in delivering the priorities in this plan and to 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

Updates to the plan – April 2024

Since the publication of the Joint Forward Plan in July 2023 we have made progress in a number of key strategic priority areas.

We have seen the development of our Integrated Care Partnership with a formal Board established, meeting in public and bringing together partners to meet the health and wellbeing needs of our population. The Partnership has confirmed that its priorities remain Children and Young People, Mental Health, Social Care and Workforce for 2024/2025. These priorities continue to align with our six strategic priorities as demonstrated in the diagram below:

To help support delivery of our partnership priorities, the ICB Academy has worked with all partners to develop a Population Outcomes Framework. The framework sets out 'four pillars' of population outcomes; Wellbeing, Prevention, Management and Intervention. The supporting digital tool enables transformation initiatives to be mapped to the four pillars, and will be used to inform, measure and take action to improve the health and wellbeing of our population.

A further significant development during the last year resulted in the ICB taking on delegated responsibility for Pharmacy, Dental and Optometry Services from 1 April 2023. This enabled us to take a more integrated and joined up approach to planning and designing care around our population's health needs. From 1 April 2024 we will also be taking on delegated responsibility for 59 Acute Specialised Services which will enable us to maximise opportunities to improve our patients' experience and outcomes across primary, community, and acute services.

Further developments have been detailed later in the document, examples include:

- Commenced our journey to develop a five-year programme to transform primary care
- Continued to evolve our Operating Model including the development of Provider Collaboratives and Place Based Partnerships
- Refreshed our transformation programmes and undertook a review of achievements to date, examples of these are captured within the Strategic Delivery Plan document. Please note these provide a sense of our core strategic achievements, rather than a complete list.

Unfortunately, the financial challenges we face have increased since last year. To date we have been a system which has delivered our financial plans, achieving a system breakeven position, however our system now faces a number of local and national pressures which are driving excess costs. The Black Country system is responsible for meeting the health needs of 1.26 million people. Our local population has a number of specific characteristics, including being the second most deprived ICS population nationally; highly diverse populations; and a significant younger population. These characteristics translate to a range of specific healthcare challenges including higher levels of obesity levels compared to the national average; some of the highest infant mortality rates in the country; lower than average healthy life expectancy and significant health inequalities which have widened since the pandemic. These healthcare challenges mean our NHS services are used more significantly, meaning more resources are required to provide the

appropriate care to our populations, which puts pressure on our finances.

As a result of this, we have developed a system Financial Recovery Plan (FRP) which sets out our planned financial trajectory and options on how this will be delivered. Over the next year we will develop the detailed actions that will reduce our costs and achieve our financial plan.

To recognise this, we are including a new priority in our Joint Forward Plan – Fit for the Future. This will include the implementation of the system Financial Recovery Plan; adoption of new ways of working across the Black Country in line with the Operating Model; strengthen our enablers to support service improvement, such as digital and estates; and organisational development adopting the leadership behaviours required to transform the way we work. It will also include the sustainability/Greener NHS agenda.

This refresh of the plan describes the actions the NHS will undertake to implement the six strategic priorities. Updates to the plan have been made where new Health and Wellbeing Strategies have been published in 2023/2024. The plan reflects updates to the prioritisation of initiatives in each of our Places and Programme Boards, and provides a summary of some of our key achievements that support the delivery of our Joint Forward Plan and Integrated Care Partnership priorities. It also includes outputs from new conversations with the public in line with our Involving People and Communities work.

Our Successes – Achievements

Our plan sets out how we will measure our success, key headline achievements since publication in July 2023 are set out below:

- Successfully recruited additional roles in primary care, supporting the national target (26,000 additional staff)
- Reduced the number of people waiting for community services (50% reduction)
- Significant progress made towards delivering 'Saving Babies Lives' care bundle
- For patients who need an urgent community response 82% were seen within 2 hours (target 70%)
- Reduced the number of cancer patients waiting over 62 days, by more than our agreed target
- Increased the number of GP appointments 86% of patients are seen within 2 weeks, 45% on the same day
- Consistently increased the use of our Virtual Ward capacity (99% January 2024)
- Increased the number of patients with CVD prescribed lipid lowering treatments
- Eliminated the very long elective care waits (no patient waiting longer than 104 weeks)
- 87% of patients living with SMI have received an annual health check (target 60%)
- Increased the number of maternity staff, which underpins delivery of continuity of care
- Patients attending A&E are being seen sooner, 71% patients seen within 4 hours (target 76%). We are amongst the best performing system in England.
- Made significant progress to reduce waiting times for Talking Therapies

Improving Access
Improving Quality
Workforce
Social Care
Care Closer to Home
Mental Health and Wellbeing
Preventing Ill Health
Tackling Health Inequalities
Best Place to Work
Best Start in Life
Children and Families

Our Successes – Case Studies

A number of case studies are set out below, showcasing our more strategic developments and achievements over the last year:

Paediatric Virtual Ward Programme enabling children to go home from the hospital sooner in the Black Country

Virtual wards allow patients to get the care they need, at home safely and in familiar surroundings, helping speed up their recovery while freeing up hospital beds.

The ICS was the first in England to introduce virtual wards for children. After a successful pilot scheme in Dudley, where the first paediatric virtual ward opened on 1 March 2022 at Dudley Group NHS Foundation Trust, a total of 593 children have been treated since then. Following this success, paediatric virtual wards have now been introduced in Walsall, Wolverhampton and Sandwell, with more than 1,150 children supported to date.

How does the paediatric virtual ward work? Parents and carers are given access to state-of-the art remote monitoring technology, so their child can receive specialised care at home tailored to their unique needs. To do this the virtual ward uses Docobo's remote monitoring solution, DOC@HOME®, to monitor children who have been discharged from hospital but require a level of specialist care and monitoring to maintain their safety at home.

The children's ward team works closely with the family to train them to use the equipment, answer their questions and ensure they are fully comfortable before their children are discharged. The family then takes part in virtual "ward rounds" with clinicians and have direct telephone access to specialist clinical staff in case of any queries.

Tyler was a patient admitted to Russells Hall Hospital in Dudley last year with a severe infection. When his condition improved, the family was offered the chance to take a virtual ward kit home. Mr Lewis, parent of Tyler said: "Tyler just wanted to be at home with his family as we all do. The virtual ward was completely new to us, and we took full advantage of it. It's a brilliant piece of kit because you can bring it home and they can monitor your child at home. They can see every result from home, which is beneficial to us and the hospital. It saves them resources with beds, it saves us the time having to sort out arrangements at home, sort out businesses and work commitments, travelling back and forward, or wasting services that other people can benefit from in a more serious condition."

Midland Metropolitan University Hospital (MMUH)

MMUH is a brand-new, state-of-the-art acute hospital that will serve over half a million people living in Sandwell and West Birmingham.

When it opens later this year, MMUH will bring together all acute and emergency care services that are currently provided across City and Sandwell Hospital into one place. MMUH will provide a hub for emergency care, with the build also boosting regeneration in the local area.

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 and staff will work with new technology in modern purpose-built facilities, helping to improve patient care and experience.

The new state-of-the-art facility will be the first new hospital to open in the West Midlands since 2010, with a host of facilities including:

- A purpose-built ED with imaging and diagnostic services
- A dedicated children's EDand assessment unit
- Adult and children's wards with 50% of beds being within single ensuite rooms
- Operating theatres for both emergency, major planned surgery and maternity
- A midwife led birth unit next to a delivery suite, two maternity wards and an antenatal clinic
- A neonatal unit
- Same day emergency care for adults
- Sickle cell and thalassaemia centre

Visit the Sandwell and West Birmingham NHS Trust website for more information.

Recognising Walsall Together

Walsall Together Partners Celebrating their award

Walsall Together were crowned winners of the Place Based Partnership and Integrated Care Award at the HSJ Partnership Awards in November 2023, for its work to improve outcomes for the citizens of Walsall. The ceremony recognised the partnership for the significant integrated work that has been achieved from hospital avoidance, discharge pathways (NHSE national pilot site), enhanced care homes support, workforce recruitment and retention, and community resilience.

The entry was described by the panel of judges as "An excellent example of partnership and effective leadership and structure with the implementation of some unique projects. This is a shining example of what other systems should be aiming for."

Michelle McManus, Director of Transformation and Place Development for Walsall Together, said, "The partnership has gone from strength to strength since it was formally established in 2019 and this is down to the sheer passion and drive of all our partners and our wider colleagues in the voluntary and community sector. The strong relationships and can do attitude have meant we have been able to work together to make a real difference to the citizens of Walsall putting their voices at the heart of what we do and helping them to stay well and out of hospital, reduce inequalities and improving access to services for our most disadvantaged communities."

For more information about Walsall Together visit their website at www.walsalltogether.co.uk

The Frailty, Recognition, End of Life, Escalation of Deterioration (FREED) Pathway

An integrated care pathway has been introduced to provide safe, compassionate care for older people living with frailty in care homes across the Black Country.

The pathway aims to support all social care staff to improve early recognition and avoid deterioration of frailty to aid pre-empting end-of-life discussions and planning, also aiding carers and families to identify and respond to the health decline of individuals in a care home setting. We achieve this by using tools such as Stop and Watch, the NEWS2 scoring system and assessing residents clinical and soft signs of deterioration, including undertaking basic clinical observations skills ensuring responsive, timely escalation to the most appropriate service and timely access to holistic health care services.

The purpose of the pathway is to ensure the best evidence assessments and care planning prevents inappropriate admissions to hospital and ensures residents are on the right pathway, at the right time, and are cared for in the right place based on their wishes and condition, promoting choice and control at end of life.

Since September 2022, training has been delivered to more than 178 care providers and more than 3320 staff working within social care, caring for our most vulnerable. This has been extended to include the training of FREED champions within this sector building resilience and sustainability through increasing staff knowledge, confidence, competency and capability on the FREED pathway. An electronic resource pack was also developed which included tools, versions of assessments and support documents for care services including electronic version to either have printable access to these resources or to be uploaded to the electronic devices.

In recognition of their commitment to improving safety, culture and experience in patient care, the FREED team were shortlisted for the Deteriorating Patients and Rapid Response Initiative of the Year at the HSJ Patient Safety Awards 2023 and were highly commended in the HSJ Partnership Awards 2023.

Walsall's new Emergency Department

The new ED entrance at Walsall Healthacre NHS Trust

Walsall Healthcare NHS Trust has a new Urgent and Emergency Care Centre which brings much improved facilities and space for patient care.

The multi-million-pound urgent and emergency care centre significantly improves emergency care facilities and capacity – providing almost 5,000 square metres of additional clinical space.

The two-storey development – the most substantial investment Walsall Healthcare has seen - includes:

- An urgent treatment centre
- Emergency department including resus and rapid assessment and treatment area, and children's Emergency Department (ED)
- Co-located paediatric assessment unit
- Acute medical unit
- Provision for frailty and community integrated assessment services

The new £40m building also includes reconfiguration of the current ED footprint, to incorporate improved ambulatory emergency care and imaging services.

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 how we will address 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 a full version of the plan on our website.

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, a large number of GP practices, community pharmacies, community optometry sites and general dental practices.

We are all part of the Black 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.

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

Our health challenges

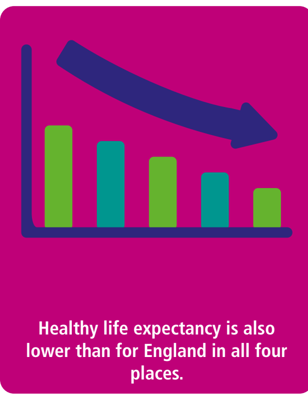
We know that our health is determined by much more than our access to health services. How healthy we are and how long we live in good health is dependent upon other factors such as our health behaviours and lifestyles, the places and communities we live in and the way in which we use health services.

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

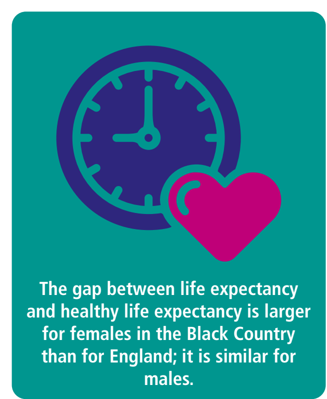
Within the Black Country:

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.



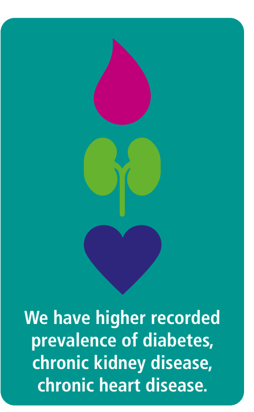
Healthy life expectancy is also lower than for England in all four places.



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.

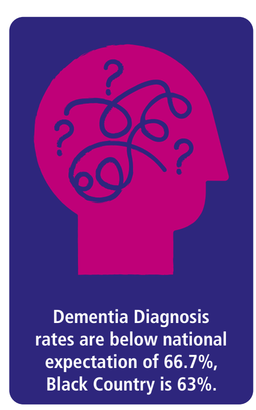
Both child (43% locally vs 35% in England) and adult (69% locally vs 64% in England) obesity rates are higher than England.

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 to reduce waiting list backlogs, we need to ensure that we continue to recover services and address existing health inequalities in access.

Urgent and emergency care pressures – Whilst we are one of the better performing systems for delivery of the four-hour accident and emergency target, 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.

Out of hospital care demand – Whilst we have improved access to out of hospital services, the demand for out of hospital services including primary, mental, community services and social care is continuing to increase as a result of a growing ageing population and chronic disease.

Workforce – Our workforce is a key asset to help us deliver our five year plan. We know that we have significant 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

Policy drivers

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

- NHS priorities

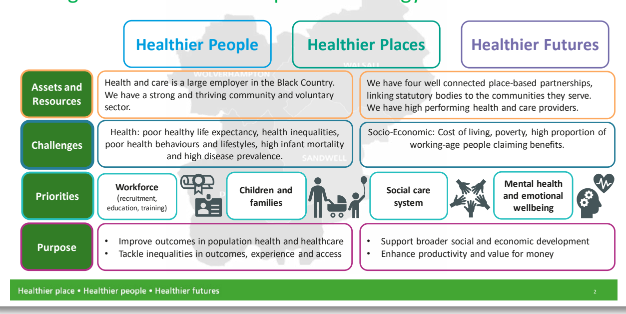
Each year, and periodically over longer periods, a set of 'NHS Objectives' to be achieved by NHS organisations within the NHS are published.

Guidance documents that our plan takes account of:

- NHS Long Term Plan (2019-2029)
- NHS Joint Forward Plan priorities (2023-2028)
- NHS Operational Planning Priorities (2024-2025) (Not yet published)

- Our local Integrated Care Partnership Strategy

An Integrated Care Partnership 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:

Integrated Care Partnership

- Mental health
- Social care
- Workforce
- Children and young people

- Core20 Plus 5

The Core20Plus5 framework 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.

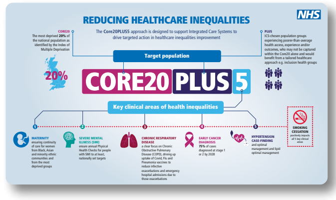
The 'PLUS' are the population groups experiencing poorer than average health access or outcomes, and who may not be captured within the Core20 alone so may benefit from a tailored approach.

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 five focused clinical areas requiring accelerated improvement. These are:

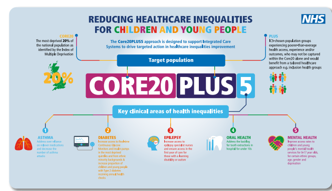
Adults:

- Maternity
- Severe mental illness (SMI)
- Chronic respiratory disease
- Early cancer diagnosis
- Hypertension



Children:

- Asthma
- Diabetes
- Epilepsy
- Oral health
- Mental health



Our approach to involving people and communities

In 2022 we 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.

The Black Country is committed to 11 co-produced principles for how our people and communities expect to be involved, these principles fit neatly into the six core themes below:

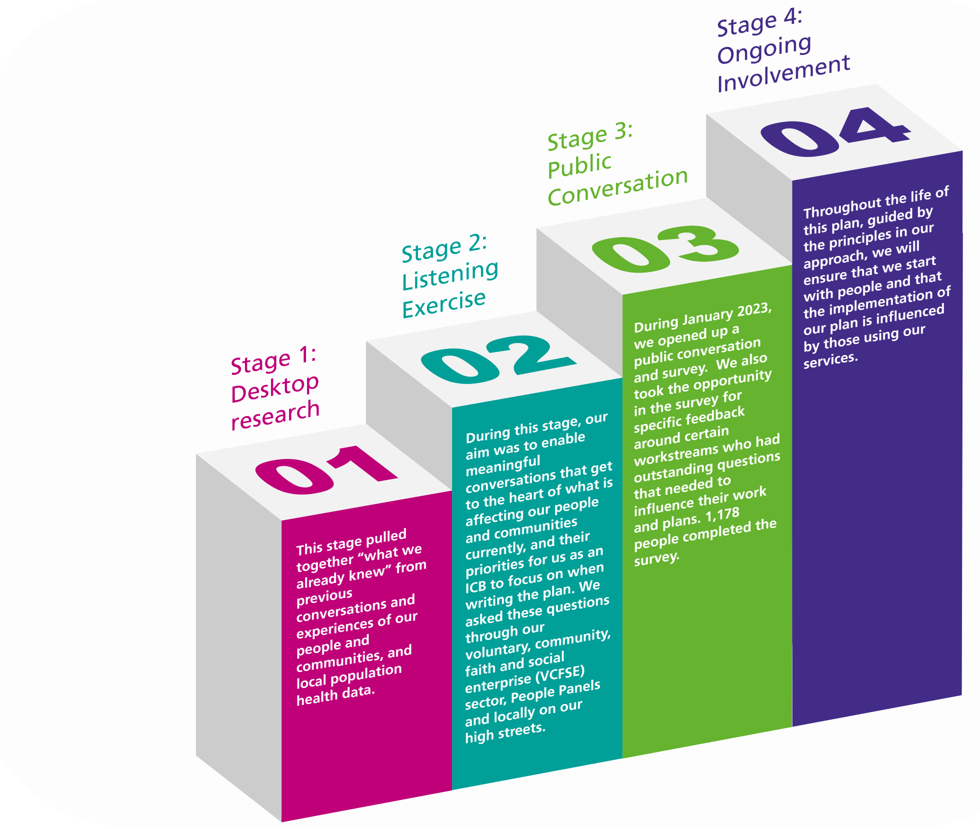
- Be accountable to our people and communities
- One size does not fit all
- Start with people and communities
- Trusted voices are key
- Invest in people and communities
- Nurture relationships across the ICS

We have developed mechanisms for involvement which crosscut neighbourhood, place and Black Country, and are designed to be participatory, inclusive, representative, and culturally competent.

The Black Country Approach can be found on our ICB website.

Involving people and communities in our plan

Ensuring that people and communities have been involved in the development of the plan is important to us, 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 the original five-year plan and this year's refresh has been undertaken in stages:



What we have heard

The 2023 Black Country Joint Forward Plan was informed by three stages of involvement activity to establish the overarching areas that local people wanted us to focus on. There is a full involvement report available online, but in summary local people told us they 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 ill health. 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.

These areas informed our priorities for the five-year plan and also helped the transformation workstreams to shape their plans.

Throughout the last 12 months we have continued our conversations with people and communities to support the delivery of the plan.

Refreshing our plan

Each year we will refresh our five-year plan, updating on progress made and any changes which might impact on our delivery or indeed the priority areas. This year is our first refresh and we have taken the opportunity to check in with stakeholders and communities on the priority areas and to update on the progress made in the first year.

We plan to involve local people, community leaders and trusted voices in the following ways:

- We will be hosting a period of public involvement between 27 February and 20 March 2024
- An updated short read version of the Joint Forward Plan will be published on the ICB website with an invitation to local people and stakeholders to share their feedback and views on our priorities
- During the involvement period, we will be hosting conversations with participants at People Panels to seek feedback and views from local people and stakeholders on our priorities

Along with ensuring that local people are informing the refresh of our plan, we will also be engaging with partners and other important stakeholders such as Healthwatch, Health and Wellbeing Boards and Local Authority Health Overview and Scrutiny Committees.

This section is reserved to include a summary of this involvement work which is currently underway.

Continuing the conversation

We know that conversations can create health. Instead of broadcasting and trying to 'fix' people and communities, by listening more, we can better understand what's important and what really matters. In our first year as an ICB, we made good progress in bringing to life the principles of our approach which we captured in a short video.

We know from the development of our approach to involving people and communities that starting with people by default, meeting them on their terms, and recognising that one size doesn't fit all are key to a future where we work together to improve health and happiness.

Take a look on our website at some of our involvement activities to see how we're listening, acting and feeding back what people and communities have shared with us. Highlights of our ongoing involvement work, and the participative dialogue spaces we're convening, which is shaping the delivery of this five-year plan, include:

- Records of the conversations from People Panels
- Listening to understand through Community Conversations
- Refreshing our support offer to Patient Participation Groups

Our approach is helping the ICB and Integrated Care System (ICS) partners to nurture stronger relationships, increase connectivity with the people they serve, rebuild trust and provide under-represented communities with a meaningful way to inform lasting change.

By taking a more collaborative and joined up approach to involvement, transformation workstreams are benefiting from, and beginning to respond to, what we are hearing through our mechanisms for involvement. Highlights include:

- Black Breasts Matter
- Developing a new Black Country dementia strategy
- Launching Midland Metropolitan University Hospital
- Research into usage of urgent and emergency care services
- Listening to views on elective care (planned care)

Our commitment to increasing collaboration and nurturing stronger relationships has seen us play a lead role in the development of a range of resources and opportunities for further sharing and learning with a focus on participative practices and asset-based development approaches. Examples include:

- Art of Hosting taster session
- Black Country Insight Library
- 'What If...?' community reporting project

Hearing the Voice of Black and African Caribbean Women to Improve Breast Screening Uptake

The ICB commissioned a project, led by a partnership of eight voluntary, community and social enterprise (VCSE) sector organisations from across the Black Country, representatives from the ICB involvement team, ICS colleagues and the University of Wolverhampton in order to better understand the barriers to attending breast screening appointments for Black and African Caribbean women, and to co-design solution focused initiatives.

Underpinned by the remarkable insights, stories and experiences of local women, which were only accessible through the trusted relationships nurtured by the eight VCSE organisations involved, three products were co-created to tackle common misconceptions and barriers to attending screening appointments; an infographic dispelling myths around cancer screening, a video of a mother and daughter talking about the importance of screening and a video from local TV sports presenter, Denise Lewis with a 'call' to attend screening appointments. The project has had recognition locally, regionally, and nationally for the approach taken in working with local people and communities in this way. You can hear from some of those involved in the project about what drew them to the project, and the difference the process made in a video.

There are ambitions to continue the project to create a culturally competent training package to equip the system with the knowledge of the cultural and religious beliefs that may be preventing someone from attending screening, but also on the presentation of black women with symptoms. The group has also been awarded a "Research Engagement Network Development" grant to continue their vital research into barriers to breast cancer screening for black women by training and remunerating people with lived experience as 'community reporters' who in turn, gather and curate real-life stories of others with lived experience to continue our learning and response to increasing screening uptake.

NHS Black Country Joint Forward Plan strategic priorities

Taking into account all of the above we have identified six strategic priority areas for the NHS:

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 - Care closer to home
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 our priorities. 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.

Priority 6 - Fit for the future
This new priority recognises that the Black Country health system needs to change the way that it works to embrace the opportunities and meet the challenges it faces. This includes the need to be more productive and cost-effective to meet our financial challenges. We also need to ensure that we support our Places and providers to work better together. We need to reduce the carbon footprint of the NHS and be more sustainable. All of this will require strong, sustainable leadership and enabling functions.

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 supporting delivery plan document. 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.

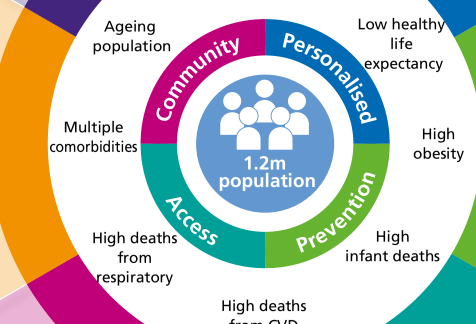
NHS Joint Forward Plan Priorities

Priority 1 : Improving access and quality of services

Outcomes
- Recovery from Covid-19
- Improved access to Urgent and Emergency Care
- Reduced waiting times for Elective and Diagnostic Care
- Timely diagnosis and faster treatment for Cancer
- Improved access to appointments in Primary Care
- Better Patient Experience
- More joined up care
- Accessible technologies
- Reduced variation in outcomes achieved

Priority 2 : Care closer to home

Outcomes
- Reducing the time spent in hospital, where appropriate
- Care closer to home
- Better management of Long Term Conditions
- More Personalised Care
- Early identification of illness
- Use of digital technologies for increased independence
- Better access to mental healthcare



Priority 3 : Preventing ill health and tackling health inequalities

Outcomes
- Improved screening uptake rates
- Closer working with local authorities and wider system partners
- Targeted support to those communities of greatest need
- Working with colleagues in housing, education and employment to improve the wider determinants of health

Priority 6 : Fit for the Future

Outcomes
- Financial recovery
- A sustainable and greener NHS
- New collaborative ways of system working
- Improved leadership capacity, capability and succession
- Strong enabling functions

Priority 5 : Best place to work

Outcomes
- Recognise and reward our staff
- Create a learning culture
- Lead with compassion and inclusivity
- Working flexibility
- Collaborative team working
- Create a safe and healthy environment for people to work in
- Upskilling staff

Priority 4 : Giving people the best start in life

Outcomes
- Reduce infant deaths
- Reduce emergency admissions for childhood related conditions including asthma
- Tackling inequalities in outcomes, experience and access for Children and Young People
- Increased protection from illness through improved childhood immunisations
- Supporting families to make healthy life choices and reduce obesity rates in children

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

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 2024.

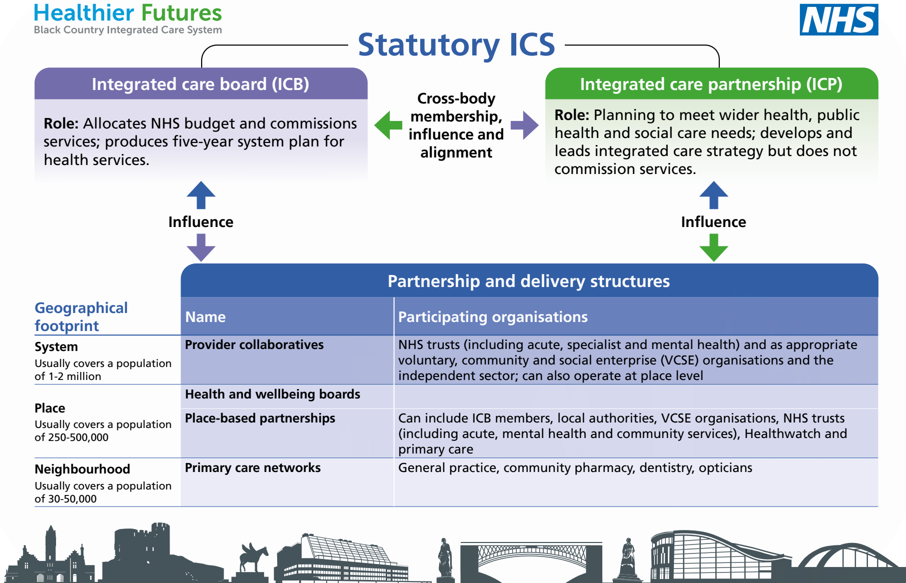
Working with partners to understand research needs and priorities, to inform the development of the research strategy. Ongoing sharing of research opportunities across system helping to support a positive approach to research.

A new Regional Network Research Delivery Network to support health and social care research is being hosted by The Royal Wolverhampton NHS Trust.

During 2023 entry-level employment initiatives were established and/or expanded in all four Places, including; Dudley's iCAN; Walsall's Work4Health; Wolverhampton's various schemes including work with Step Into Work, initiatives at Sandwell and West Birmingham Hospital Trust, the Prince's Trust and St Basil's to support young people at risk of homelessness.

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 - Strategy, policy and guidance, oversight and assurance of providers, resource allocation and approval of major service change.

ICB Committees - ICB oversight and assurance, including statutory duties and Strategic Commissioning Committee as a decision-making body for the overseeing the strategic programme boards.

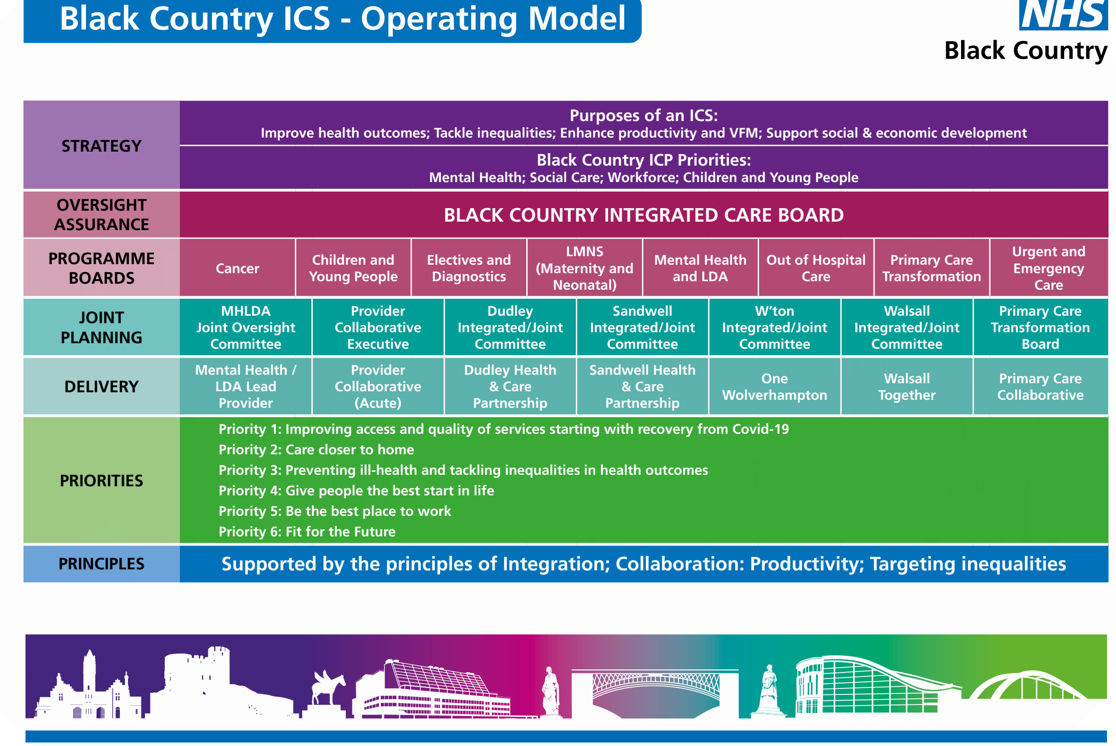
Strategic Programme Boards - Bring commissioners and providers together to develop strategy, outcomes and priorities in portfolio areas within the devolved budget. The programme boards will also oversee performance metrics and produce recovery plans for areas behind trajectory. They will identify areas for transformation, service change and service development and form business cases to define the opportunity.

Integrated/Joint Committees - Joint committees have been established to undertake joint planning between the ICB, local authorities, and where appropriate, NHS England and respective collaboratives/partnerships both at system and Place level. They 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, with local Place support structures, 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 Local Authorities 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 will 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 will 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 or GP Practices 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

- Black Country Provider Collaborative (Acute and Community)

The Black Country Pathology Services team

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

- 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

- Primary Care Collaborative

By primary care we mean, pharmacy, dental, opticians and general practice. The Black Country Primary Care Collaborative (BCPCC) was established in early 2022 and is continuing to establish its role and purpose within the system. To ensure that the BCPCC can represent the views of all primary care providers and remain connected, four Local Primary Care Collaboratives (Dudley, Wolverhampton, Walsall and Sandwell) have been established.

The Local Primary Care Collaboratives (LPCCs) are the fundamental building blocks of BCPCC, each of them with three nominated representatives with a seat at the BCPCC. The LPCCs core membership is comprised of the PCN Clinical Directors. In this way there are two-way lines of communication, engagement, representation and accountability that flow between individual providers, neighbourhoods (PCN), Place (LPCC) and System (BCPCC).

- 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 organisation, or partner, within a provider collaborative is also a member of a place-based partnership. This is to embed the benefit we achieve as a system of our providers, working both at scale and within their communities.

The priorities of each of our four Places are described later.

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.
- Financially sustainable system

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
- Reduced carbon footprint

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 within the system. Such indicators are likely to change dependent on priorities or issues that may arise during the year. We also recognise that we want to improve our metrics associated with National Oversight Framework.

In view of operational planning guidance publication being delayed, a further review of the key metrics will need to be undertaken as part of our mid-year full review of the plan, however we have set out a number of new metrics for measuring Priority 6.

Improving access and quality of services

- Eliminate long waits for elective care
- Continue to reduce the number of cancer patients waiting for treatment
- Increase the number of adults and older adults accessing Talking Therapies treatment
- Improve Accident and Emergency waiting times
- 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.

Care Closer to Home

- Consistently meet or exceed the two-hour urgent community response (UCR) standard
- Continue on the trajectory to deliver more appointments in general practice
- 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

- Ensuring annual health checks for those living with Severe Mental Illness (SMI)
- Increase percentage of patients with hypertension treated to NICE guidance
- 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
- 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

- Measles, Mumps and Rubella for two doses (5 years old) to reach the optimal standard nationally
- Reduce the number of stillbirths per 1,000 total births

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
- Reduce % of staff who have left the NHS during a 12-month period
- Reduce sickness absence rates for NHS staff in England
- Increase the mean score NHS Staff Survey Staff engagement theme

Fit for the future

- Adherence to Financial Recovery Plan
- Relevant metrics from Greener NHS Plan in place, aligned to Delivering a Net Zero NHS
- Achieve well led Care Quality Commission assessment in each of our organisations

Dudley - Place Delivery Plan

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:

- Children are ready for school
- Fewer people die from circulatory disease
- More women are screened for breast cancer

Across all of these goals, we will embed an approach to health inequalities.

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
- Reduced unplanned hospitalisation for chronic ambulatory sensitive admissions
- Improved health and wellbeing outcomes for our CYP
- Enhanced emotional resilience for our population, and supporting people (all ages) to stay mentally well and reducing mental health inequalities
- 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.	✓	✓	✓		

Roll out of "I Can – Dudley" recruitment model offering training and placements for people with care experience and young people with Special Educational Needs and Disabilities resulting in 45 placements across both the NHS and Local Authority, embedding a culture of inclusive recruitment for all and delivering a sustainable workforce reflective of the population we serve.

The Integrated Front Door Team have helped avoid unnecessary admissions and supported patients to remain in their usual residence by adopting a multi-disciplinary team approach working in partnership with physical and mental health, Social Care, housing and voluntary and community services. Since the launch of the service referrals have increased by 34% and 95 patients have been referred to alternative services.

The Healthy Heart Hubs outreach model has helped support communities (circa 300 patients) to monitor and manage their blood pressure along with delivering educational cardiovascular disease reduction sessions with the support of Health and Wellbeing Coaches. In addition to focusing on hypertension the Hubs also focus on Lipid Optimisation and Smoking Cessation with a targeted approach to help reduce health inequalities.

In partnership with Connecting Health Communities, we have commenced the Brockmoor & Pensnett Community Innovation Project which is delivered by the Institute for Voluntary Action Research. The project aims to adopt an innovative system wide approach to meeting and reducing the inequality gap for residents in this ward. Focusing on developing links between reducing childhood obesity in the ward and improving family income, employability and access to healthy food by engaging residents, community groups and voluntary organisations in the design of health and care services. To date over 60 residents have participated in community research events and are helping to co-produce plans to meet the needs of this community.

Successfully rolled out "Advancing health equity through income maximisation" which provides welfare rights support for people with severe mental illness. This has resulted in identifying that 98% of people who have a review undertaken are receiving less than they are entitled to. In the first six months alone an additional £319,488 income which equates to an average increase of income of £1936 per person has been delivered.

Dudley Council has received £25m from the Towns Fund to create a higher education facility in Dudley which will have a focus on health and care. The new facility, to be known as Health Innovation Dudley, is currently under construction and partners are co producing the design of the building and the services it will offer to ensure that the available facilities meet the requirements of all partners. Work is expected to be completed by the autumn of 2025.

Recruitment of 17 Family Hub Practitioners across midwifery, Local Health and Health Visiting to the Integrated F1001 Days Team to provide early interventions and support to families. This has resulted in 50% increase in families accessing additional support, 30% increase in speech, language and communication needs early identification and intervention, increase in number of expectant and new parents accessing education opportunities, 15% increase in trained peer to peer supporters, with infant feeding peer support available across all five Hubs and an 25% increase in out of hours infant feeding support.

Sandwell - Place Delivery Plan

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.			✓	✓	✓

Over the last 12 months significant progress has been made towards embedding our Integrated Discharge Hub which has helped reduce the time spent in hospital and support patients in their home. Key quality improvements have been around virtual wards, urgent community response (UCR), avoiding readmission to hospital, reablement and rehabilitation delivered in an integrated way, and greater partnership working with the third sector.

Sandwell community UCR Services deliver in excess of 1500 contacts per month, with 85% of people staying at home after an assessment.

Sandwell Health and Care Partnership have supported a number of projects aimed at reducing health inequalities over the last year. The Sandwell Language Network (SLN) has delivered 42 'English for Speakers of Other Languages' (ESOL) courses, and 1 'International English Language Testing System' (IELTS) course across Sandwell, covering West Bromwich, Smethwick, Tipton and Oldbury. 483 people took part in a survey on completing the course and a positive impact reported with 84% reporting an improved ability to understand the UK NHS and 90% an improved ability to explain a personal health concern to a healthcare professional.

Produced a winter booklet for all Sandwell residents to enable them to get the information they need to support them through this winter and through the ongoing cost of living crisis. As well as being delivered to all households this resource is available online and in a variety of accessible formats.

Walsall - Place Delivery Plan

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. Resilient Communities and Health Inequalities work supports ambitions to reduce differences between the health of the poorest and richest in the Borough. 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
- Citizens involved in decisions about services

For Organisations:
- Outcomes framework to identify opportunities
- Digital technology and innovation
- Integrated services to remove barriers, duplication and provide better value
- Maximising opportunities across providers, streamlining access to primary and community services
- Delivering population health at scale

For our System:
- Reduction in health inequalities
- Increased social capacity and resilience
- Sustainable workforce

Work Programme / To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Communities (Resilient Communities) Focus on social prescribing, community associates and wellbeing outcomes framework and integrated commissioning of wellbeing	✓	✓	✓	✓	✓
Joined up Health & Social Care (Integrated Neighbourhood Teams) Focus on diabetes pathway, primary care access recovery plan and community mental health transformation	✓	✓	✓	✓	✓
Specialist Community Services Focus on end of life, frailty and falls prevention. Integrated place based teams supporting adolescents with complex needs, family hubs, dementia services, healthcare maintenance.	✓	✓	✓	✓	
Hospital Services Focus on integrated front door, and Urgent Treatment Centre alignment to community services and primary care out of hours.		✓	✓		

We have established four Locality Family Hubs and 10 Community Spokes in Walsall all of which provide a welcoming space where children, young people aged 0-19 and up to 25 for those young people with additional needs and their families can go to get advice and support when they need it. The Hubs are in the heart of communities, services such as Midwives, Health Visitors, School Nurses, Speech & Language Early Help, Children's Social Care, DWP Housing and Police have come together to provide a central access point for families to get help and support.

Through the Health Inequalities Improvement Programme Walsall Housing Group (WHG) ran a Kindness Champions scheme, recruiting and training Champions because of their lived experience to engage and support lonely and/or isolated residents offering emotional support, a resident-led wellbeing plan and providing a bridge to services/projects/activities in the community.

The Integrated Assessment Hub enables people who are directly contacting the Frail Elderly Service or Ambulatory Care at Manor Hospital with post-discharge complications to be seen by Rapid Response, Enhanced Care Home Support Team or CIT team instead, and receive a community-based assessment and clinical review, thereby avoiding conveyance to hospital.

A Care Navigation Centre (CNC), supported by a multidisciplinary team (MDT), takes referrals from primary care, care homes, domiciliary care agencies, ambulances, and social care. Citizens access the most appropriate care (e.g. rapid response, MDT) and avoid unnecessary hospital admissions. Five virtual wards are run from the CNC, primarily on a 'step-down' approach for patients following an acute admission. A total of 1,564 patients have been treated since July 2022, making a positive impact on discharge pathways during winter, easing winter pressures.

Work4Health, an initiative supporting long-term unemployed adults into NHS jobs has helped more than 137 people to secure employment (83% were previously unemployed), generating £2.1m in social value.

Our Intermediate Care Service has reduced the length of stay for medically stable patients from 7.3 to 2.3 days since it was introduced in 2020 – saving £4.96m a year. The savings are because of improved integration within the ICS, and we have one of the best performing ICS's and discharge rates in the country which has improved productivity outcomes and satisfaction amongst residents are positively impacted.

Walsall Wellbeing Directory launched in January 2024, features a wide range of support, advice, activities and events to support the wellbeing of local citizens. The directory has been developed by Walsall Together Partnership in collaboration with local citizens and the voluntary, community and social enterprise sector.

Wolverhampton - Place Delivery Plan

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:
- Put people at the heart of what we do
- Active daily, live longer happier healthier lives
- Improved GP access, improved patient experience, and personalised care
- Patients will have greater choice about the way their care is planned, and access to information
- Access to responsible and timely interventions, including prevention
- Improved patient outcomes, early detection/screening and management of long-term conditions

For Organisations:
- Right care, right place, right time
- Reduced demand for hospital services, supporting people to stay well advise, education and support
- Admission avoidance ensuring only those needed hospital go into hospital, and expedited discharge
- Integrated, joined up services, reducing duplication and using technology

For our System:
- Work better together
- Work collaboratively to achieve our partnership objectives by making the best use of our resources and ensuring every pound is spent in the best way possible to meet the needs of our population
- Tackle unwarranted variation in service quality and reduced health inequalities, using data
- Sustainable workforce, fit for the future through investment in training and development

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Primary Care Development Develop new services to delivery care closer to home, supporting people with long term conditions and complex needs, delivering primary care resilience.	✓	✓			
Adult Mental Health Prioritising prevention, delivering the community transformation programme, improving physical health of people with a mental health diagnosis, embedding suicide prevention approaches.	✓	✓			
Children and Young People Improving immunization uptake, care for children with asthma, deliver a first 1001 days agenda, healthy weight and oral health, and support for mental health and emotional wellbeing.	✓	✓	✓		
Living Well Increase cancer screening rates, improve health check uptake and deliver a preventative approach, delivery of health and wellbeing hubs and development of healthy lifestyle services.	✓	✓	✓		
Care Closer to Home Ensure effective discharge from hospital, supporting people to age well, high quality palliative and end of life services, high quality care home services.	✓	✓			
Urgent and Emergency Care Integrated approach to demand and capacity planning, ensuring people with urgent need can access the right care, ensure a timely experience when accessing urgent care, expand community provision and ensure effective discharge from hospital.	✓	✓	✓		

Establishment of a primary care led acute respiratory infection hub that has seen 130 patients a week on average since mobilisation successfully managed in the community, ensuring timely access to same-day treatment for individuals and reducing the demand on emergency services at New Cross Hospital.

Our integrated approach to winter planning has resulted in community services responding to more ambulance calls thereby supporting a reduction in ambulance handover delays; and, closer working with adult social care has also delivered a reduction in the number of individuals waiting for a package of care in hospital supporting them to be discharged home safely.

In December 2023, Wolverhampton's Health and Wellbeing Board became a signatory to the Prevention Concordat for Better Mental Health. To achieve this, we have evidenced our commitment to promote 'protective factors' for mental health, such as early years support, good education and good quality work. It also ensures that work is taking place to reduce 'risk factors' such as unemployment, poverty, loneliness, violence and discrimination.

We have successfully delivered a suite of interventions to both prevent falls in the city and also support people to receive treatment closer to home when falls do occur. This has included the delivery of strength and balance classes in care homes across the City and the delivery of an integrated falls service between the City of Wolverhampton Council and The Royal Wolverhampton NHS Trust.

Following targeted, multi-agency work, the alcohol-specific mortality rate has seen a significant decrease over the last reporting period and Wolverhampton has moved from having the highest mortality rate in the country to fourteenth nationally.

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
Await feedback on the plan

Councillor Hartwell, Chair of Sandwell Health & Wellbeing Board
Await feedback on the plan

Councillor Flint, Chair of Walsall Health & Wellbeing Board
Await feedback on the plan

Councillor Jaspal, Chair of Wolverhampton Health & Wellbeing Board
Await feedback on the plan

Find out more

To read a more detailed version of our plan and see this document in other formats please visit our website http://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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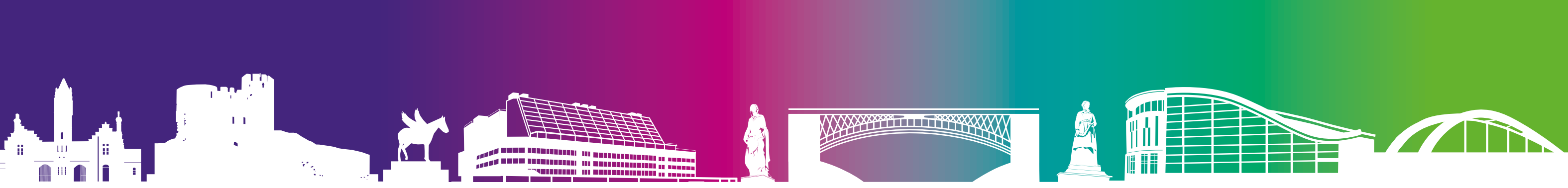

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