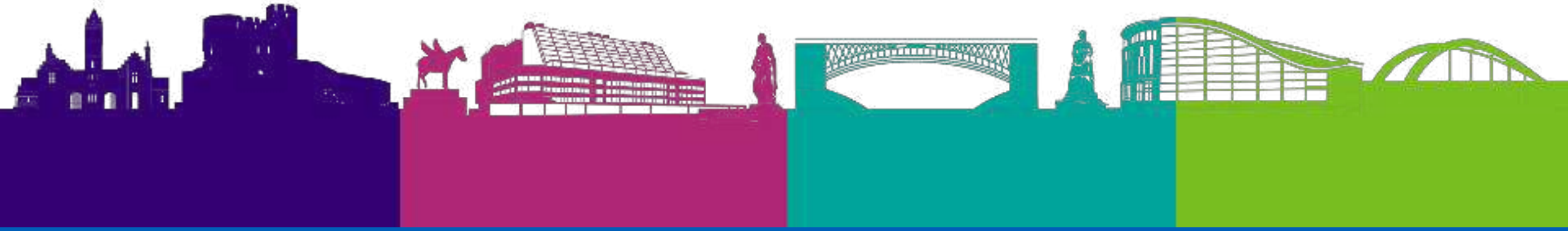
NHS
Black Country
Integrated Care Board

NHS Black Country Joint Forward Plan

May 2023



Black Country Integrated Care Board

Contents

Foreward

Welcome to the Black Country draft Joint Forward Plan.

The plan has been developed in collaboration with wider system partners & sets out our challenges, health needs, strategic vision & strategic priorities over the next five years.

Whilst Our Joint Forward Plan sets out our vision and strategic priorities over the next five years, it is important to recognise the challenging landscape within which we will deliver our plan as we recover from Covid-19 and face a challenging financial position across our System.

Implementation of our plan will see in the following achievements

- Opening of the Midland Metropolitan University Hospital in Spring 2024.
- Implementation of our Black Country Operating Model, with effective Provider Collaborative & Place Based Partnerships whose role is to deliver efficient, productive, high quality services, address health inequalities and deliver integration of health & social care services
- As we recover from Covid, delivery of maximum wait time guarantee of no patients waiting more than 52 weeks by 2024/2025, and a return to no patients waiting more than 40 weeks by 2026/2027.
- Improving access to a number of our services, including primary care
- Implemented a shared care record that brings together data across health and care settings by 2024/2025
- Improved health outcomes and reduced health inequalities across our population

In addition, the ICB will take commissioning responsibility for Pharmacy, Optometry and Dental Services from 1st April 2023 and Specialised Commissioned services from 1st April 2024 which will allow us greater control of resources for these services.

The plan has been informed by an internal and external engagement programme which has been undertaken over the course of the last six months.

The publication of the final plan on the 30th June is just the start of our journey, we will continue to evolve and develop our plans over the next year, the plan will be reviewed and updated on an annual basis.

Principles

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 in the best interest of our patients, local community and the wider population

Integration – Integrated Care System partners will work together to take collection responsibility for planning and delivering joined up health & 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

Tacking Inequalities – We will ensure that we continue to focus on delivering exceptional healthcare for all through equitable access, excellent experience, and optimal outcomes

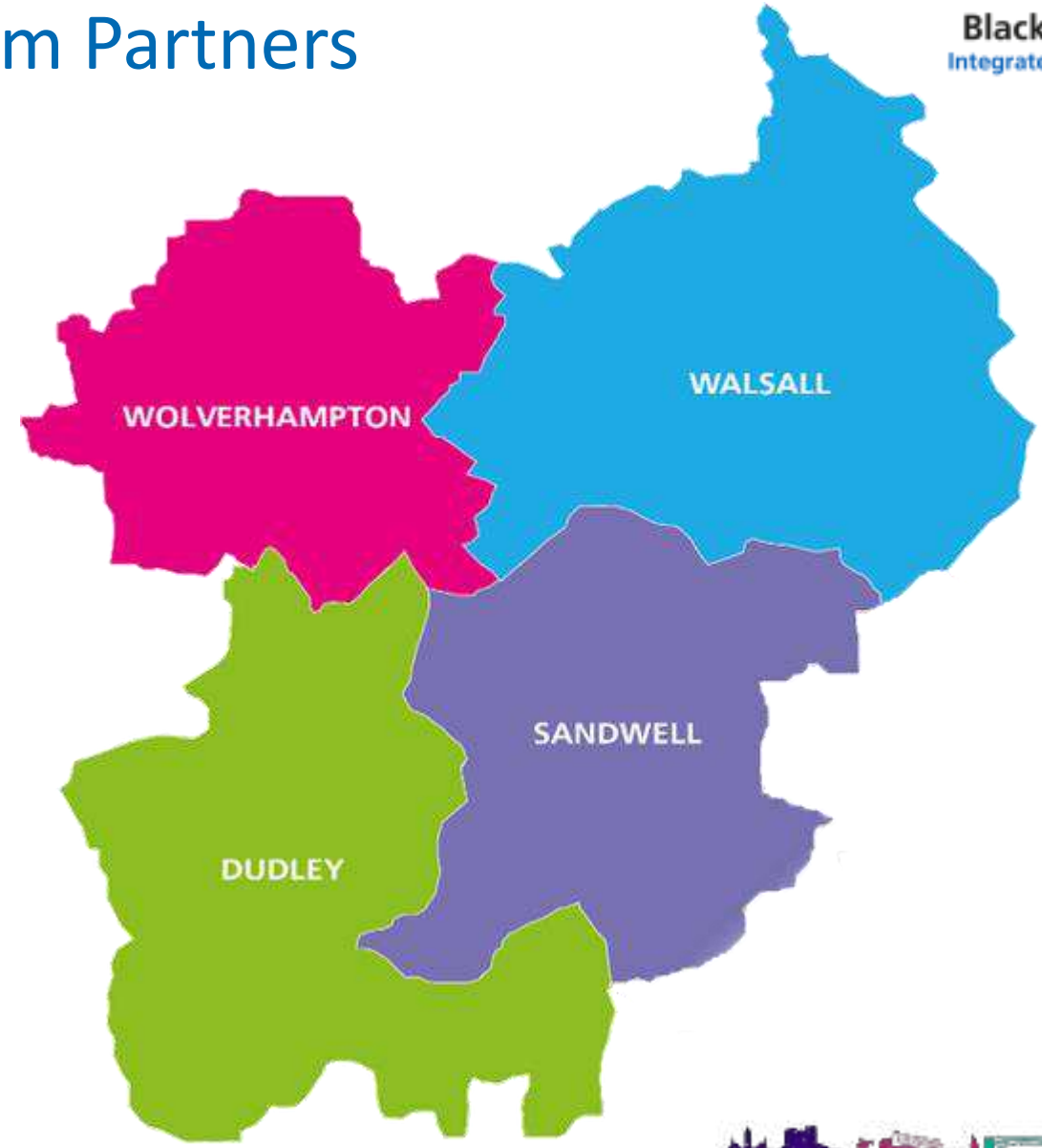
As the System transitions to a new way of working in line with our Operating Model, we have secured an Organisational Development partner to help facilitate cultural development and behaviours which will strengthen the way we work with partners across our system.

Our Places & Integrated Care System Partners

The Black Country has 1.26 million residents and is made up of four distinct places: Dudley, Sandwell, Walsall and Wolverhampton.

We recognise that the Black Country is a hugely diverse area and there is no “one size fits all” approach to working with local people or partners.

The Black Country Integrated Care System (ICS) is made up of a number of partners including an Integrated Care Board (ICB) acting as the strategic commissioner, four Acute and Community Trusts, one Mental Health & Learning Disabilities Trust, one Ambulance Trust, one Integrated Care Trust, four Local Authorities, 181 GP practices, 288 Community Pharmacies, 121 Community Optometrists & 159 General Dental Practices in addition to wider voluntary & third sector partners.



Our Health Challenges

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The gap in life expectancy and healthy life expectancy (HLE) between the Black Country and England is driven by wider determinants of health, our health behaviours and lifestyles, the places and communities we live in and with and our health services.

Within the Black Country:

- Life expectancy is 77 years for males and 82 years for females, less than life expectancy of 79 years for males and 83 years for females in England
- People with mental health problems and learning disabilities have shorter life expectancies (18 years for males, 15 years for females) which is driven by their physical health.
- Healthy life expectancy is 59 years for males and 60 years for females, which is lower than the national healthy life expectancy of 63 years for males and 64 years for females.
- 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.
- Both child (43% vs 35%) and adult (72% vs 63%) obesity rates are higher than England, whilst physical activity levels (56% vs 66%) are significantly lower.
- 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.
- Locally, we have higher recorded prevalence of diabetes, chronic kidney disease, chronic heart disease (1 & or more)
- High number of premature deaths from CVD & respiratory disease, under 75 mortality rate for CVD is 99 per 100,000 & 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 62%

Our Health Challenges

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	Dudley	Sandwell	Walsall	Wolverhampton
Average age women will live to	82 years	81 years	82 years	81 years
Average age men will live to	79 years	76 years	78 years	77 years
Children aged 0-17 who are overweight or obese	8	11	10	9
People (all ages) living with depression	17	22	19	21
Children aged 5-17 with a mental health disorder	2	2	2	2
People (all ages) who will die from cancer	24	23	24	21
Adults (18+) overweight or obese	59	58	52	52
Estimated adults (16+) living with diabetes	7	9	8	8
People (all ages) living with a long standing health condition	57	46	53	52
People (all ages) who will die from heart disease	24	22	22	23
Adults (18+) who smoke	10	11	11	10
Adults (19+) who take less than 30 minutes exercise a week	21	24	25	24
People over 75	10	6	8	7
People live in the most deprived (bottom 20%) areas	28	60	52	52
People (16-64) who are employed	42	44	42	40
Children (0-19) living in low income families	4	6	5	5

The graphic above identifies the variation in our population for a number of indicators and shows how many people in each place would be affected if there were 100 people in each place.

Wider System Challenges

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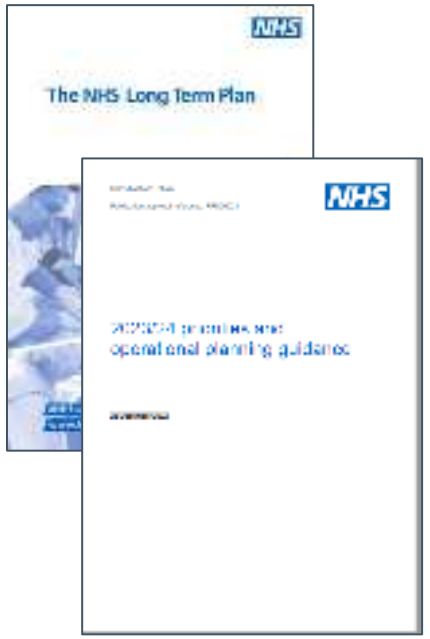
Whilst Our Joint Forward Plan sets out our ambition over the next five years, it is important to recognise the challenging landscape within which we will deliver our plan.

- **Restoration & recovery from COVID-19** - Whilst significant progress has been made to improve access to services and recover waiting lists there is further work to do to ensure patients are treated in a timely manner. By working in partnership across our system we have made some good progress starting with clearing the backlog of patients waiting more than 104 weeks and are now focusing on reducing 78 week waits. Primary Care have delivered an 7.8% increase in the number of additional appointments compared to pre-pandemic levels (period February 2019/20 compared to February 2022/23).
- **Urgent & Emergency Care Winter Pressures** – Urgent care remains of our most significant pressures, with the challenge surrounding patient flow of patients from the Emergency Department into hospital and with delays in ambulance response times and hospital handover delays. In addition there has been pressure in regards to discharging people from hospital. Whilst we have made some progress in recent months, by taking an more integrated approach with our social care providers and expanding our Out of Hospital Pathways there is still further opportunity to effectively support patients into the most appropriate setting as quickly as possible, thereby minimising all non-essential hospital stays.
- **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 & retention challenges and that looking after the health & being of staff is a key priority.
- **Finance & Efficiency** – Our system is facing significant financial challenges which only be addressed by partners working together to transform & redesign services to drive improved outcomes and & make better use of resources which will help support system wide financial sustainability.
- **Our Health Population Needs** – We know that the Black Country population has significant health challenges & that COVID-19 has exacerbated existing health inequalities. By tackling these challenges we can ensure people across the Black Country can start well, live well and age well

Priority Drivers

Purposes of an ICS:

- Improve health outcomes
- Tackle inequalities
- Enhance productivity and VFM
- Support social and economic development



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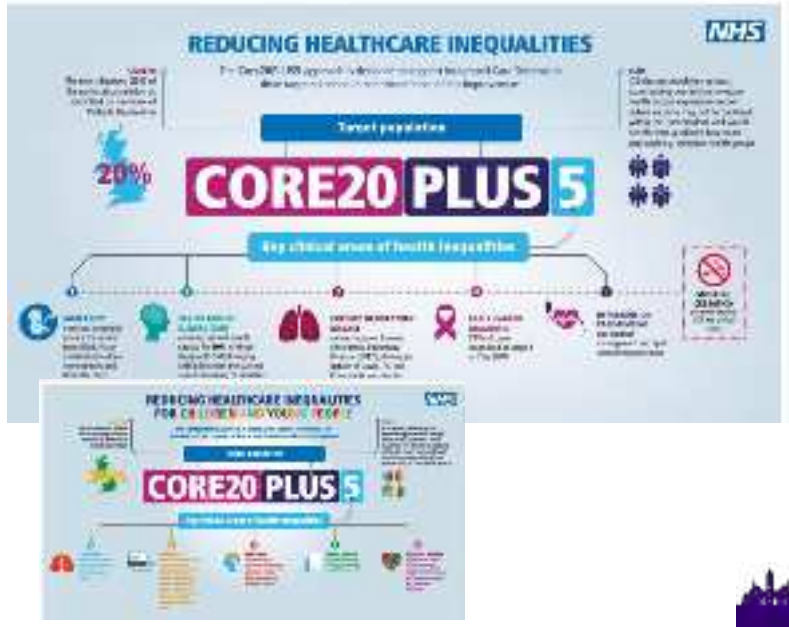
NHS Planning Priorities:

- NHS Long Term Plan (2019-2029)
- NHS Joint Forward Plan priorities (2023-2028)
- NHS Operational Planning Priorities (2023/24)

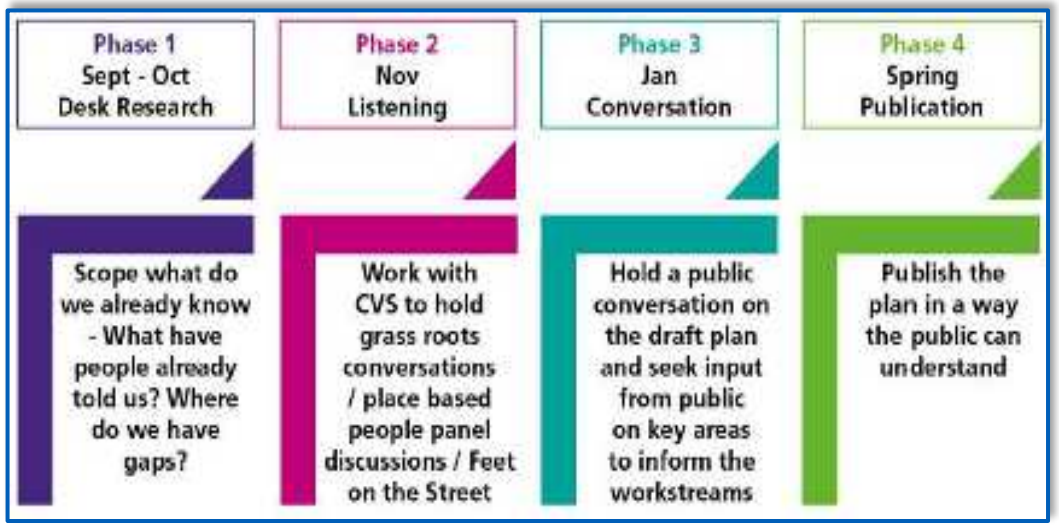
Black Country ICP Priorities:

- Mental Health
- Social Care
- Workforce
- Children & Young People



NHS Core20PLUS5 Programme

Public Involvement

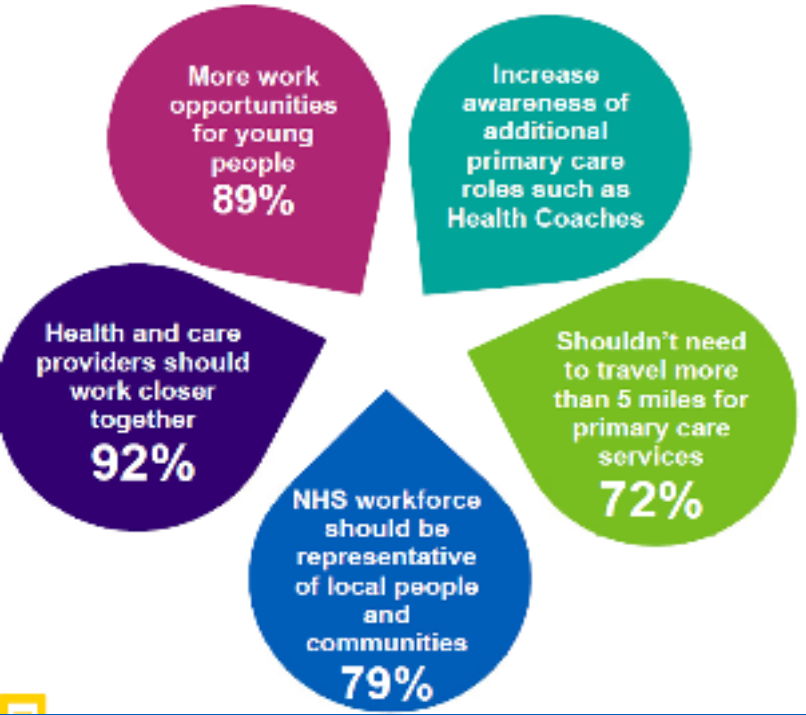


3 phase involvement approach which included desk research, public events, a survey a conversations through CVS partner services

We attended/hosted 41 activities during January at community venues, libraries and warm hubs to talk to people about the plan and help complete paper/online surveys.

1,178 completed the survey, which as a sample size of the Black Country population gives us a margin of error of 2.86%.

27 VCSE organisations hosted friendly cooking lessons, crafts sessions and coffee mornings to return insights from people who all too often go unheard.



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
- Services to tackle, loneliness, isolation and mental wellbeing
- A Cost of living theme was the 'voluntary care squeeze' - the worry of working age people caring for older/ younger dependents due to cost of care
- Cost of living will increasingly impact upon those determined as 'comfortable communities' impacting on health and care services in the short and long term

Approach to Reducing Health Inequalities

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- Our approach to reducing health inequalities is centred on focusing on the key clinical areas set out in the Core20 PLUS5 framework for Adults & Children

- In recognition of the significant health inequalities being experienced for patients with diabetes, the Black Country has agreed diabetes as an sixth local clinical priority area.

- Noting everyone has a role & responsibility to address Health Inequalities our plans to address our clinical priority areas is interwoven into respective Strategic Workstream, Enabling & Place delivery plans

- We have adopted a whole system approach to tackling inequalities which includes five strategic pillars of activity which will help us address complex & varied inequalities faced by our communities
  - Involving People & Communities
  - Population Health Management
  - Achieving Health Equity
  - Focusing on Prevention
  - Wider Determinants of Health

NHS Joint Forward Plan Priorities

NHS Black Country

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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
- Access to appointments in Primary Care
- Improved choice of care provider

- Better Patient Experience
- More joined up care
- New technologies
- Reduced variation in way services are delivered and outcomes achieved

Priority 2 : Community where possible Hospital where necessary

Outcomes
- Reducing the time spent in hospital
- Care Closer to home
- Better management of Long Term Conditions
- More Personalised care
- Early identification of disease
- Use of digital technologies for increased independence

Priority 5 : Best place to work

Outcomes
- Compassionate and inclusive
- 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

Priority 3 : Preventing ill health and tackling health inequalities

Outcomes
- Improve screening
- Closer working with local authorities and wider system partners
- Supporting our most deprived communities with better prevention, detection and treatment of ill health
- Working with colleagues in housing, education and employment to improve the wider determinants of health

Priority 4 : Giving people the best start in life

Outcomes
- Increase in breast feeding rates
- Reducing smoking in pregnancy
- Improving neonatal deaths
- Increased protection of disease through improved childhood immunisations
- Supporting families to make healthy life choices and reduce obesity rates in children

What will be different for our population?

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Shorter waiting times, faster diagnosis

Increased dental & GP appointments

Increased screening uptake

Reduced waiting times for community services

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 & 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 & succession planning
- Estate, equipment and digital technologies to enhance working practice
- Opportunities for improvement and personal development
- Pride in the care we deliver

Improved staff survey results

SUCCESS: WHAT AND HOW?

Reduced demand for tobacco & alcohol services

Reduced patient readmissions

Reduced sickness levels and staff turnover

For our Organisations

- 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 System

- Reduction in health inequalities for our population
- Cohesive approach quality improvement & 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

Engagement with Best Start to Life Programme

Improved Core20PLUS5 outcomes

Vaccination uptake

Priority 1: Improving access & quality of services starting with recovery from covid-19

Priority 2: Community where possible, hospital where necessary

Priority 3: Preventing ill health and tackling health inequalities in health outcomes

Priority 4: Give people the best start in life

Priority 5: Best place to work

How will we measure delivery of our priorities?

Priority 1 - Improving access & quality of services starting with recovery from covid-19	Example Metrics • Reduced waiting times, 52/ 65 week waits, 62 Day Cancer waits, Cancer Faster Diagnosis Standard, IAPT, OOA Placements, patient experience, readmissions
Priority 2 – Community where possible, hospital where necessary	Example Metrics • Primary Care Appointments, Units of Dental Activity, Virtual ward occupancy, community waiting lists
Priority 3 – Preventing ill health and tackling health inequalities in health outcomes	Example Metrics • Proportion of people adult or maternity settings offered tobacco dependence services, vaccination/flu uptake, Core20PLUS5, screening uptake
Priority 4 – Give people the best start in life	Example Metrics • Number of neonatal deaths, childhood vaccinations, engagement with Family Hubs/ Start for Life Programme
Priority 5 – Best place to work	Example Metrics • Staff Sickness levels, turnover/vacancy rates, staff survey results

We will identify key metrics to support each strategic priority and report regularly on delivery

Delivery of our Plan – Operating Model

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Black Country ICS – Operating Model to support Joint Forward Plan

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DRIVERS	Purposes of an ICS: Improve health outcomes; Tackle inequalities; Enhance productivity and VFM; Support social & economic development Black Country ICP Priorities: Mental Health; Social Care; Workforce; Children & Young People						
STRATEGY	BLACK COUNTRY INTEGRATED CARE PARTNERSHIP BLACK COUNTRY INTEGRATED CARE BOARD HEALTH & WELLBEING BOARDS						
JOINT FORWARD PLAN PRIORITIES	**Priority 1:** Improving access and quality of services starting with recovery from Covid-19 **Priority 2:** Community where possible, hospital where necessary **Priority 3:** Preventing ill-health and tackling inequalities in health outcomes **Priority 4:** Give people the best start in life **Priority 5:** Be the best place to work						
JOINT PLANNING	MHLDA Joint Oversight Committee	Provider Collaborative Joint Oversight Committee	Dudley Integrated/Joint Committee	Sandwell Integrated/Joint Committee	Wolverhampton Integrated/Joint Committee	Walsall Integrated/Joint Committee	Primary Care Joint Oversight Committee
DELIVERY	Mental Health / LDA Lead Provider	Provider Collaborative (Acute)	Dudley Health & Care Partnership	Sandwell Health & Care Partnership	One Wolverhampton	Walsall Together	Primary Care Collaborative
PRINCIPLES	Supported by the principles of Collaboration: Integration; Productivity; Targeting inequalities						

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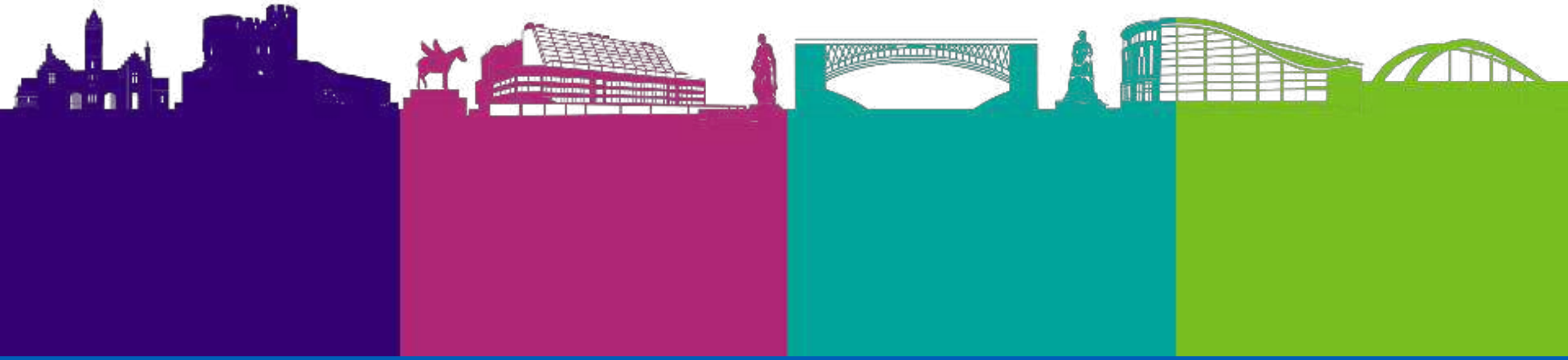
Strategic Workstreams



Elective Care

Our vision is to deliver as one healthcare system, across multiple sites, working in partnership to provide better, faster and safer care to the population of the Black Country and beyond.

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Strategic Priorities

Working as one healthcare system, across the Acute Collaborative's Clinical Networks, Primary Care and the system's network of Operational Groups, we will apply evidenced best practice to improve safety and optimise efficiencies in pathways and processes. Our strategic priorities are as follows:

- Improving access (recovery & 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

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 (FUs, PIFU, SA)
- Increased capacity and service resilience

For our System:

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

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 GIRFT and national transformation initiatives, and local transformations such as dedicated elective care hubs, theatre reconfigurations and a new hospital site (MMUH). 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.	✓	✓	✓	✓	✓

Cancer

Our vision 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.

NHS Black Country Integrated Care Board

Strategic Priorities

A priority area is to better understand differences in cancer outcomes and experience across our diverse population and ensure that unwarranted variation is addressed. It is imperative that we are able to reach and engage with our population groups in order to improve their cancer outcomes once diagnosed. Cancer shares many of the same risk factors as other major causes of ill health and early death, for example obesity and smoking, therefore our work programmes to improve prevention and tackle wider determinants will support a reduction in cancer incidence. Earlier diagnosis is a priority and we plan to accelerate improvements through better engagement with our population and working collaboratively to better utilise the resources we have to improve services. We aim to ensure that patients have the best experience possible through every stage of their cancer journey and we will do that by providing caring and compassionate services for our population.

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 and
- 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.	✓	✓	✓	✓	✓

Diagnostics

Our vision is to provide receive equitable access to modern, state of the art, high-quality diagnostics, in a timely manner

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Strategic Priorities

Diagnostics plays a key role within 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, these services are predominantly based in our main hospitals, serving urgent as well as routine planned care. The need to increase capacity provides an opportunity to deliver services in a different way. We will develop our diagnostic strategy ensuring alignment with wider workstreams such as elective care and cancer.

- 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

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 & cancer services, driving efficiency & productivity, ensuring safe & 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 & 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.		✓	✓	✓	✓

Urgent and Emergency Care (UEC)

Our vision 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.

NHS Black Country Integrated Care Board

Strategic Priorities

Our overarching aim is to ensure that we can deliver an Urgent & Emergency Care Service that is fit for the future. We will do this by reviewing our current capacity & demand to ensure that we have a sustainable UEC model that will meet future demand. Our strategic priorities include focusing on expanding and better joining up new types of care outside of Emergency Departments (Out of Hospital/Community Services) by ensuring effective utilisation of Urgent Community Response Services, Urgent Treatment Centres, the expansion of Virtual Wards and use of remote monitoring. We will also ensure that we continue to improve development at pace of step down and hospital discharge pathways to effectively deescalate need and promote a return to independence in community settings following a UEC health crisis. The delivery of the UEC plan is underpinned by strong system leadership through the Urgent & Emergency Care Strategic Board and the System Control Centre.

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 SDEC, UTC and UCR.
- Improvements in handover times between the Ambulance Service and Emergency Departments

For our System:

- Sustainable & resilient Emergency & Care Model across the system
- Consistency of Urgent & Emergency Care Services & 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 SDEC provision and increase UEC/bed capacity.	✓	✓			
Increasing utilisation, capacity & range of services provided outside ED 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 & 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.	✓	✓	✓		

Out of Hospital

Our vision is to transform and build Out of Hospital & Community Services to deliver a 'home first' philosophy.
Supporting people to stay well and independent for as long as possible, through the provision of high quality and accessible services, tackling inequalities in access and outcomes, whilst ensuring a supported, skilled and fulfilled workforce.

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Strategic Priorities

There are a number of core strategic priorities that will help achieve our Out of Hospital vision centred around promoting greater care in patients homes, increasing the use of virtual wards and investment in remote monitoring. Achieving equitable access to services will only be achieved in collaboration with system partners and with the co-production of seamless pathways with health & social care partners, including third sector to create seamless pathways, which reduce duplication and variation across the Black Country. A priority is to understand the demands on the care home sector and ensure the availability of effective and supported care, for example implementing the Enhanced Care in Care Homes Framework. Underpinning delivery of the plan is of transparency of data to enable outcomes measures to be monitored as well as stakeholder engagement and effective communication to citizens on prevention, education, self care, access and experience & investment into the community workforce to enable the home first philosophy to grow.

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

For Organisations:

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

For our System:

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

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 & 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 UEC services.	✓	✓			
Continued Development of Remote Monitoring & Virtual Wards The expansion of monitoring in care & at home & 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 & End of Life Care Implementation of the Palliative & End of Life Care Strategy	✓	✓	✓		

Long Term Conditions Management

Our vision 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.

NHS Black Country Integrated Care Board

Strategic Priorities

The Black Country is recognised as suffering from one of the highest levels of deprivation across England and many people struggle to access healthcare to diagnose and manage their long-term conditions. It is recognised that long term conditions such as Diabetes and Cardio-Vascular Disease (CVD), are amongst the top five causes of early death in our population. Our priority is to prevent treatable conditions, through effective prevention programmes, active patient engagement and improved health literacy. We will ensure that where patients have long term conditions they are supported to manage them effectively, through self-care and use of digital technologies. We will integrate pathways to manage care in primary and community settings and avoid exacerbation and inappropriate admission to hospital. Our programme of work will support the delivery of local health inequalities initiatives based upon the Core20PLUS5 framework.

Outcomes to be Achieved

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 & 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 & 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	✓	✓			
CVD Delivery of initiatives to improve early detection & management of CVD including hypertension case finding, BP at Home Service, delivery of Cardiac Improvement Programme	✓	✓	✓	✓	✓
Respiratory Development & delivery of pulmonary rehabilitation five year plan including development of spirometry services, expansion of remote monitoring programme & lung health check programmes	✓	✓	✓	✓	✓

Children and Young People Services

Our vision is that every child gets the right help, at the right time, by the right service, to ensure they meet their full potential

NHS Black Country Integrated Care Board

Strategic Priorities

To achieve our vision we will develop a Children and Young People's Strategy that will provide focus and clarity on the priorities for improving services and life opportunities for children and young people living in the Black Country. Our strategy will ensure the needs of all CYP cross our diverse population are met, recognising that 53% or our CYP are within the 20% most deprived IMD sectors nationally. In light of our local challenges, are system has committed to delivering the national Transformation Programme for CYP. CYP access care across all sectors and domains of health our Joint Forward Plan recognises this. We will develop robust monitoring mechanisms for use across the system to understand and take action where variation and/or outcomes requires improvement actions. The ambition is to ensure all services provide high quality and equitable services for all, including CYP across the Black Country.

Outcomes to be Achieved

For our Patients:

- Increase ability to self-manage LTC and increase quality of life (QALY)
- 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 CYP across the system, embedding all age commissioning
- Improved health outcomes for our most vulnerable including LAC, SEND, 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 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 CTP 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.	✓	✓	✓		

Maternity and Neonatal Services

To deliver high-quality maternity and neonatal services across the Black Country, through co-production with our women, which will be safe, personalised and equitable to ensure every woman and baby receives the best possible care

NHS Black Country Integrated Care Board

Strategic Priorities

There are a number of strategic priorities to address the core challenges for the Local Maternity and Neonatal Service (LMNS), which will transform maternity and neonatal services and meet both locally identified priorities and national expectations. These strategic priorities are Perinatal Quality Surveillance, Maternity Continuity of Carer (CoC), Workforce, Reduced Perinatal Mortality and Morbidity and implementation of the action plan to improve Perinatal Health Inequalities. Our LMNS is well established with all partners engaged in collaborative working and collective learning, supported by a strong Maternity and Neonatal Voices Partnership (MNVP) ensure our service users voices are heard. Reducing health inequalities and fulfilling our Core20PLUS5 requirements is a core element of all work programmes.

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 MNVP
- 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 & 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 5-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 EDI leads we will implement our action plan, ensuring we accelerate work to support those at greatest risk of poor health outcomes.					✓

Mental Health and People with Learning Disabilities and Autism

Our vision 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

NHS Black Country Integrated Care Board

Strategic Priorities

We have a comprehensive programme of work to increase access and availability of support across the pathway from helping people to stay mentally well, to urgent and crisis support when needed. Through our programmes we are embedding community focused and trauma informed models of care, with integrated pathways across agencies. We have a strong focus on community advocacy, engagement and inclusion, and are committed to advancing health equity and increasing focus on the wider determinants of health.

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 & 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 & 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 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 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 UEC Services have a fair/equitable service, recognising both their physical and MH needs; through an assessment hub outside of A&E environment, a drug and alcohol strategy, High Intensity User support, bed strategy to reduce Out of Area Placements, eg.		✓			
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 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.			✓		

Medicines Management

Our vision is to transform pharmacy and galvanise medicines optimisation so that our population gets the best from their medicines and pharmacy services, leading to improved health outcomes and reduced health inequalities, improved service quality and sustainability.

NHS Black Country Integrated Care Board

Strategic Priorities

Medicines are the most common therapeutic intervention and the second highest area of NHS spending after staffing costs. We invest approximately 13% of the total funding on medicines, therefore prescribing plays a vital role in improving health outcomes and ensuring the most efficient use of NHS resources. It is of vital importance our decision-making processes are clear, transparent and decrease unwarranted variation, whilst ensuring we engage with all stakeholders involved in prescribing and supply of medicines across the Black Country. In addition, we recognise that medicines optimisation is a key enabler to support delivery of our Joint Forward Plan across a number of workstreams.

Outcomes to be Achieved

For our Patients:

- Early prevention of infections
- Appropriate prescribing and use of antimicrobials
- Effective management of infections/ disease
- Reduced medicine related errors, reducing harm for patients
- Reduced risk of hospitalisation of our most vulnerable people
- Improved 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

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 Formulary harmonisation across the system will be achieved to reduce differences in the prescribed medication available to patients.	✓				

Primary Care

Our vision is to implement a transformed Primary Care operating model that delivers equitable access to high quality care that is safe, integrated, consistent and citizen-centred across the care continuum

NHS Black Country Integrated Care Board

Strategic Priorities

Our priorities are to develop the future integrated operating model of primary care, embed the Black Country Primary Care Collaborative as a key vehicle for consensus building and collaboration leading and driving the provision of excellent integrated primary care, and to enable Primary Care Networks to maximise their contribution within resilient communities. Working together will we will embark on a 'big conversation' with local people and improve access sustainably through addressing quality, improving the working lives or our staff, adopting digitisation, optimising our estates and communications, whilst embracing the opportunities afforded by best practice, research and national policy, including the Fuller recommendations. We will also ensure we have the infrastructure, capacity, and capability to deliver our delegated responsibilities regarding the commissioning of GP and Pharmaceutical, General Ophthalmic and Dental services (the four pillars of primary care).

Outcomes to be Achieved

For our Patients:

- Increase GP appointments, improve access, and reduce waiting times
- Increase dental activity
- Increase patient satisfaction and experience
- Increase digital functionality, including telephony

For Organisations/ Our System:

- Grow our workforce, expand new roles
- Implementation of Fuller recommendations
- Deliver our delegated responsibilities (GP & POD)
- Optimised estates and communications
- Establish integrated ways of working
- Deliver the PCC Transformation Programme

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 OD & work programme focussing on access, LTC & unwarranted variation			✓		
PCC 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	✓				
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 & deliver improvement plans					✓
ICS Primary and Community Care Training Hub contract/system workforce development programme – Embed workforce planning & secure the resources to deliver the improvements		✓			

Social, Economic, and Environmental Development

Our vision is to deliver positive economic, social and environment outcomes locally through collaboration and collective action

NHS Black Country Integrated Care Board

Strategic Priorities

The wider determinants of health are a diverse range of social, economic and environmental factors which influence people's mental and physical health. Our established Black Country Anchor Institutions Network (BCAIN) will harness their collective assets for economic and social benefits, driving positive change to achieve a more inclusive economy. BCAIN will evolve to become more strategic and engage wider employers to better focus local assets on areas of need/impact. Through the use of insights and economic data we will gain a better understanding of the wider determinants of health factors for our population, thus enabling us to shape the social and economic context in which our services are provided. We will maintain oversight of the 'Economy of Together 2030 Action Plan' building mutual accountability, focusing on leadership and spreading the intentionality of the anchor movement. This will enable us to scale up local initiatives, working with partners, for the benefit of our population.

Outcomes to be Achieved

For our Patients:

- Fairer more equitable society with equality of opportunity
- Closing the inequality gap
- Education system that provides the same opportunities for all
- A more physically activity and engaged population, with access to safe spaces

For Organisations:

- Careers and employment initiatives that inspire all members of society to fulfil their potential
- Improved workforce resilience, representative of the communities they serve

For our System:

- Diversity in leadership, equipped and informed to act
- A thriving well supported social enterprise sector
- Maximise local employment in our supply chains

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Local Employment Opportunities To contribute to the local economy by skilling up and employing local people who are unemployed or at risk of unemployment, and committing to inclusive practices and continued professional development for our existing staff.	✓	✓	✓	✓	✓
Enable new procurement / supply chain policies To source goods/services locally and ensure economies are inclusive. Use contracts to improve social, environment & economic value, including prioritising investment that reduces inequalities, and build this approach into sourcing processes.	✓	✓	✓	✓	✓
Collective Action on Climate Change Support achievement of Our Greener NHS Plan, through using our assets to pursue projects that take action towards our climate change goals, improve the lives of our population and reduce health inequalities in our communities.	✓	✓	✓	✓	✓
Oversight of the Economy of Together 2030 Strive towards our ambition for a more equitable Black Country, better educated, enterprising with greater social responsibility, and healthier and environmentally friendly.	✓	✓	✓	✓	✓

Prevention

Our vision is to increase healthy life expectancy so people can live the life that matters to them, preventing illness and improving life expectancy

NHS Black Country Integrated Care Board

Strategic Priorities

Improving the population's health and preventing illness and disease is key to reducing health inequalities and is at the heart of the NHS Long Term Plan. 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 people reduce their dependency on alcohol or tobacco, to offering weight management services, to cancer screening and through access to the Diabetes Prevention Programme. We will develop our prevention capacity and capability across the Integrated Care Partnership, working to harness our collective assets and embedding preventative approaches as a continuum, ensuring health equity is our golden thread.

Prevention is a key theme across the Joint Forward Plan, please see wider workstreams for further action on prevention, eg Long Terms Conditions, Out of Hospital, Primary Care, etc.

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

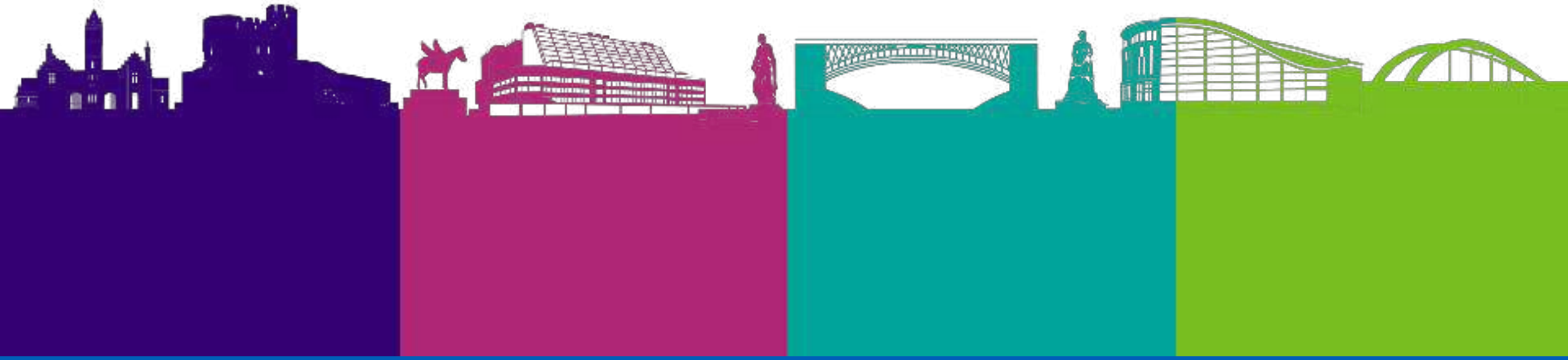
For our System:

- 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.	✓				

NHS
Black Country
Integrated Care Board

Place Plans



Dudley Place

Community where possible; hospital when necessary, by working together, connecting communities, enabling coordinated care for our citizens to live longer, happier and healthier lives.

NHS Black Country Integrated Care Board

Strategic Priorities

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 & 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

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

For our System:

- Thriving VCS with increased collaboration
- Sustainable health and care system
- Improved health and wellbeing for our population
- Sustainable workforce reflective of the population we serve

Work Programme — To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Strengthen Partnership Effectiveness 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 (Integrated Care Teams) Through Integrated Care Teams and adoption of Population Health Management approaches we will deliver safe, coordinated and effective care in the community, that meets the needs of our patients.					✓
Shift the Curve of Future Demand To implement our Primary Care Strategy including the following; access, sustainability, population health, MDT, personalisation, collaboration, development and resilience. We will grow and nurture our workforce from our local community.					✓
Health Inequalities Contribute to Dudley's Joint Health, Wellbeing and Inequalities Strategy with a focus on prevention and access. To reduce health inequalities with a specific focus on our health and wellbeing priorities, and addressing wider determinants of health.					✓
Children and Young People Initially we will focus on Family Hubs/ Start for Life which has 6 specific areas of action, to provide seamless support for families and an empowered workforce					✓

Sandwell Place

People living in Sandwell will receive excellent care and support within their local area, exactly when they need it.

NHS Black Country Integrated Care Board

Strategic Priorities

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 & Wellbeing Priorities

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

Outcomes to be Achieved

For our Patients:

- Responsive, coordinate 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 avoidance admissions
- 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, LTCs, CYP, and social isolation.					✓
Primary Care - Facilitate the delivery of the DES, 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 & 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			✓	✓	✓

Walsall Place

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

NHS Black Country Integrated Care Board

Strategic Priorities

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 & 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 & 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

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 & self-care.					✓
Family Hub programme - Focus on Family Hubs/ Start for Life which has 6 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 & 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 Place

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.

NHS Black Country Integrated Care Board

Strategic Priorities

Supporting this vision is the development of joint commissioning arrangements for Place, with a programme of work underpinning the vision delivered through the One Wolverhampton partnership and through other programmes of work aligned to the HWB Health Inequalities Strategy.

Health & Wellbeing Priorities

- Growing Well (Early Years & CYP Mental Wellbeing)
- Living Well (Workforce, City Centre, Prevention)
- Ageing Well (Integrated Care, Dementia Friendly)
- System Leadership

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
- Reduce health inequalities
- Sustainable workforce

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 DES, 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.	✓	✓	✓		

NHS
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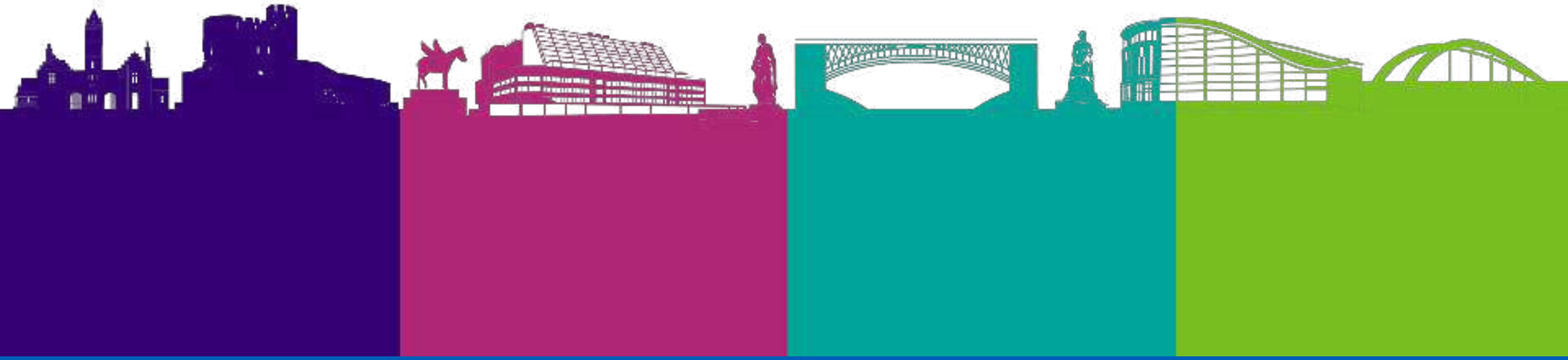
Enabling Workstreams



People

NHS Black Country Integrated Care Board

What?

Healthier Futures
Black Country Integrated Care System

- As 'one workforce' we're better
- Developing the culture and infrastructure for 'one workforce'
- Adopting NHS England guidance on the ICS people function
- Co-creating a People Plan across the system in collaboration with partners

Why?

Through creating psychologically safe and supportive environments, where all of our diverse colleagues feel belonged, we can provide the architecture for developing a workforce that is sustainable for the future.
Coordinated workforce planning, education and training to develop an optimised model and drive improvements in health inequalities.

How?

Focus on retaining our people and supporting them to be the best they can be, which in turn optimises our resources

Underpinned with 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.

When?

Develop 2022/23 annual report for the people programme	April 2023
Facilitate two workshops that aim to co-produce the governance framework and people priorities for 2023/24	May 2023
Create people programme delivery plan for 2023/24 and commit investment and resources	June 2023
Co-produce the system People Plan for 2023 – 2028 and engage stakeholders for feedback and sign off	July 2023

Finance

NHS Black Country Integrated Care Board

During the planning period we aim to achieve financial sustainability as a System. This will be supported by the development of a financial framework, the purpose of which will be:

To set out the financial strategy and approach for the Black Country Integrated Care System to support the delivery of its aims and core strategies. This will include:-

- To outline the strategic context (including “why this is an imperative now”).
- To describe the current financial position in the Black Country.
- To outline options for the improvement to the depth, quality, and reporting of key financial information to all parties.
- To summarise the recent planning guidance and how it might affect the ICS.
- To explore the approach to the development of strategy and resource allocation.
- To describe options for the cross-system management of key issues.
- To outline options for better working and collaboration.

Provide a ‘staging post’ in respect of policy, history and direction of travel.

Support the improvement of organisational relationships and collaboration.

Part of a new way forward to improve services and benefit patients.

Key Themes with the Financial Framework

- **Principles** agreed by system CFOs to improve joint working, including:-
  - Transparent, system first, compliance with Nolan principles of public office, share risk, collaborate at scale, etc.
- Developing the level of **collaboration** within system finance
- **Statutory financial duties** and supporting metrics
  - All NHS organisations within the ICS have a statutory duty to maintain a balanced financial position (capital and revenue).
  - Supporting metrics include MHIS, cash, Better Care Fund, Running Costs Allowance/Trust corporate costs, agency spend, supplier payment, etc.
- Improving **financial planning**
  - Acknowledge the need to improve our system financial planning arrangements and consider improved methods for the future, e.g., an eight quarters 'rolling' financial plan.
- Developing the **system's financial reporting**
  - Mandated elements, e.g., national and regional reporting to NHSE
  - Local elements,
- **Internal Reporting** (CFO/AO/Productivity and Value Group, partner organisations, system committees, etc.)
- **Additional Reporting** (Benchmarking, productivity, linkages to workforce and activity, etc.)
  - Improved decision making/maximising the use benchmarking information to optimise use of Black Country resources, VFM, etc.
- **Resource distribution**
  - Limited resource in short to medium-term (In 2023/24 - the baseline capital allocation is £79.6m and revenue £2.6 billion)
  - Considerations for distribution (both financial and non-financial)
  - To ensure a fair distribution linked to output, performance, need, etc.
  - Consideration of sector-based approaches to resource distribution.
- Developing **future productivity and efficiency programmes** to ensure long-term financial sustainability
  - Efficiency and increasingly strategic transformation programmes will be essential as we enter a period of financial challenge.
- **Governance and system oversight arrangements**
  - Role of the Productivity and Value Group/proposed oversight arrangements

Improving Quality

Our quality strategy will focus on embedding the benefits of working as a single strategic commissioner, in 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

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The local health economy remains challenged with significant diversity and deprivation, therefore a clear vision for quality improvement is essential. Working in collaboration with health and social care partners we are engaged in ambitious improvement work across the Black Country, to improve outcomes in population health and healthcare. We will continue to learn and develop, adopting new ways of working to further strengthen our resilience, using specialist skills and expertise to deliver a high-quality range of health and social care services fit for the future, delivering opportunities to build on the integration and close working between health and social care. Collaborative clinical leadership will enable us to develop a unified approach to quality improvement fit for the future, and will provide a sound platform to embed a standardised approach across the four Places and avoid unwarranted variation in care. We will use this unified approach to continue to improve quality across all services as we continue to embed a new approach to integrated delivery of services for our population.

Key Priorities

Our priorities include delivery of the ambitions in the NHS Long Term Plan and other national initiatives, considering system and specific Place-based issues.

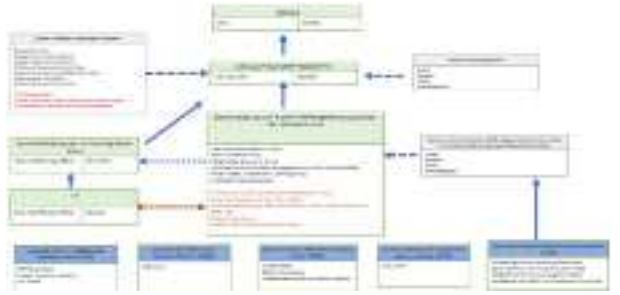
Our strategy sets out plans to improve quality across the following domains:

- Addressing the impact of health inequalities
- Improve patient experience, personalised and engagement
- Developing our workforce
- Assuring quality and safety
- Safeguarding children and adults
- Supporting victims of abuse
- Continuous quality improvement, supporting strategic workstreams

Oversight and Assurance

The Black Country is recognised through its four Place structure, it is important therefore that the quality strategy reflects the local Place agenda and improvement requirements, and maximises the opportunities at system to bring together good practice, understand key themes and trends and align learning and improvement across the system. To enable this, the quality strategy is supported through a series of subcommittees aligned to key portfolio areas of living well, staying safe, prevention, access and response and ageing well. These system oversight boards/groups will be fed through Place-based assurance and improvement activity and reported at system level to ensure consistency across the Black Country ICS.

Assurance via the monthly Black Country ICB Quality & Safety Committee and quality sub-group structure will then be fed into a System Quality Oversight Committee (SQOC). The SQOC will collectively consider and triangulate information to safeguard the quality of care across all services.



Personalised Care

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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 (Carr, 2008). It provides an overarching lens or ethos for the care provided over the whole course of a person's life from birth to end of life and enables people to have choice and control, considering what matters to them and empowering them to have responsibility over their own health. Our Joint Forward Plan describes our commitment to implementing the Comprehensive Model of Personalised Care. The model core components and our strategic actions are set out below, further detail can be found within our wider workstreams regarding the implementation of personalised care across our Joint Forward Plan.

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 & 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 CYP, 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.

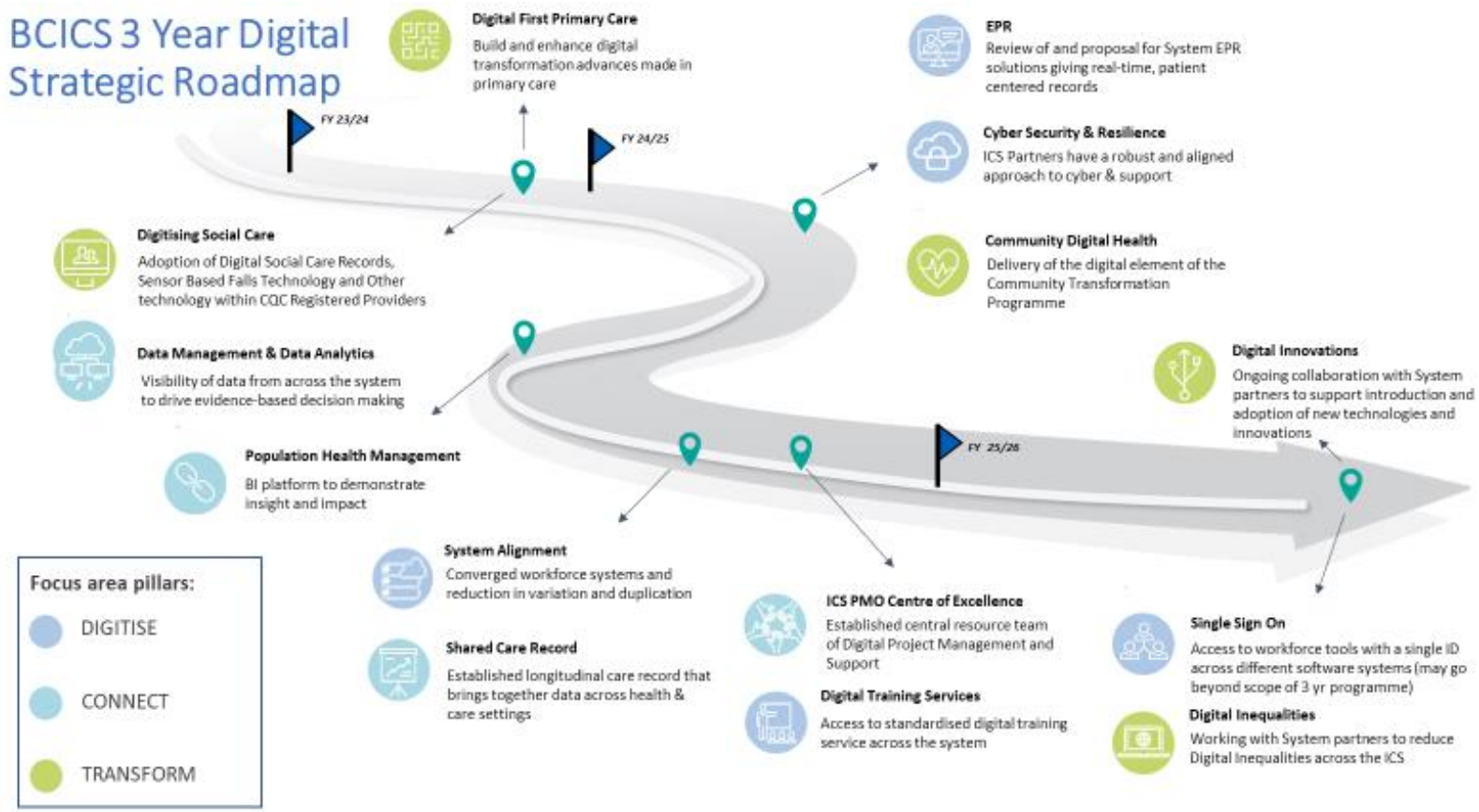
Personal Health Budgets

A personal health budget 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.

Digital

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.
The ICS Digital Programme Board has recently agreed the systemwide Digital Strategy and costed milestone delivery plan. This was co-developed between over 80 representative across system partners and patient groups to support and enable all sections of this Joint Forward Plan, a high level roadmap is shown below.



Climate Change

Our ambition as an ICS is to support the NHS in the Black Country - through our organisations, teams, and individual staff members and in collaboration with our wider partnerships - to drive changes which achieve the NHS net zero targets, support the health and wellbeing of our patients and staff and improve the local environment.

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Greener Clinical Care and Procurement

Through this programme we will consider environmental and social factors when purchasing, including how we can reduce the environmental impact of consumables used in clinical practice, and also implementing a national policy so that all our tenders included a minimum 10% net zero and social value weighting. We will use all available mechanisms within our procurement routes to lower our carbon footprint and deliver improved environmental and social impacts.

Digital Transformation

This programme seeks to maximise opportunities to deliver services more efficiently and effectively. Though using eConsult and telephone appointments for Primary Care we have reduced travel, similar service models are being used in Secondary Care. In addition remote monitoring technology enables patients to measure blood pressure and undertake ECG at home. We will continue to work with our digital team and wider workstreams/partners to maximise opportunities.

Estates and Waste Management

This programme will focus on sharing best practice and wider opportunities across system to improve the utilisation of our existing estate and expand services, without extending our estates carbon footprint. We will ensure compliance with green planning regulations and developing greener and more efficient waste management systems.

Travel and Transport

We are delivering a programme to transition our vehicle fleet to ultra-low emission /zero emission vehicles and encouraging staff to also do this through salary sacrifice schemes. Elective vehicle charging points are available on a number of sites and we are working with public transport to develop initiatives to encourage staff and visitors to use active travel / public transport to get to work or access services.

Medicines and Anaesthetic Gases

Through this programme we will achieve reductions in the numbers of inhalers that use an aerosol spray more potent than carbon dioxide. We intend to move to lower carbon inhalers without compromising patient care. Our use of desflurane, an anaesthetic gas with a large carbon impact, has been reduced during 2022/23. We are also reviewing our use of nitrous oxide, developing plans to limit the impact use of this produce has on the environment.

Research and Innovation

Our ambition is to develop, promote and facilitate high quality research that is integral to delivering health and care, for the benefit of our population. We will promote the adoption and spread of innovations that enable the achievement of our system priorities and support the reduction of health inequalities.

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Research

Through a system wide collaborative approach to health and care research, we will achieve our aims to increase participation in research both at organisational and population level, enable equity of access to research opportunities and generate impact in health and care pathways. We will develop a Research Strategy with partners, ensuring all decisions and processes are underpinned by robust evidence based policies and an ethical decision making framework. There is a clear focus on disease/ condition priorities and ensuring alignment of research activities with key system priorities. We will increase the participation of system partners in research studies, and work with research teams to understand and grow the participation by underserved communities, to ensure adequate diversity and inclusion in research. The **Black Country Research Academy** will be critical to the delivery of this.

Through research we will:

- Improve Outcomes – research evidence will inform commissioning decisions to improve patient care, outcomes, and experience
- Tackle Inequalities – research provides us with a better understanding of our local populations and the wider determinants of health, and the steps required to maintain health and narrow health inequalities.
- Enhancing Productivity – we will consider how research is undertaken and delivered, increasing the flexibility of workforce or recruitment, while reducing bureaucracy and improving research productivity and value for money
- Supporting social and economic development – we will create an active research ecosystem, bringing revenue and jobs to the region

Innovation

Our ICB will develop strong working partnerships across sectors and organisations, including the West Midlands Academic Health Science Network (WMAHSN) and our Voluntary, Community and Social Enterprise (VCSE) groups and community advocates, to promote the adoption and spread of innovations that enable the achievement of our system priorities, support the reduction of health inequalities, and address the needs of inclusion groups in the Core20PLUS5 health inequalities framework. We will develop an ICS Innovation Strategy, describing our ambition to improve cross-sector/organisation partnerships, and introduce the **Black Country Innovation Hub**.

Our objectives include the following:

- Adopt and adapt good innovation practices building on the UK Standards for Public Involvement in research and aligning with our principles for working with people and communities
- Capture and share widely our community, clinical and care and digital knowledge to inform and shape our innovation priorities in clinical and care model design, improve digital clinical safety, ease complex pathways, reduce digital inequalities, enable care integration and care in the community, while encompassing the core clinical and care leadership pillars empowering our workforce to build future capabilities.
- Use our collective knowledge to develop inclusive and sustainable mechanisms e.g. our proposed remuneration and recognition policy, accessibility assessment group and co-production framework to enable the development and adoption of innovations that meet the needs of our communities and workforce.
- Make the Black Country innovation approach accessible to all parts of the system, reaching across places and into neighbourhoods.

Strategic Risks

There are a number of strategic risks that may impact on delivery of our plan

Risk	Description	Mitigation
Workforce Capacity	Risk that there will be insufficient workforce, resilience & retention of staff to deliver our plan	• Ongoing local recruitment continues at place, more collaboration and engagement with local communities and encourage uptake of post from those new to care. • Skills mix reviews at provider level to continue; • Social Care recruitment partnership forum now set up support recruitment into social care – run by WM Consortium. • System retention plan in place focusing on staff over 55; retire and return flexibilities. Reviewing action plans from year 1 retention plan on flexible working for new and existing staff to aid retention & health and wellbeing. • Robust monitoring of sickness absence levels at system level monitored by People Board. • Range of Health & Wellbeing initiatives in place across the system, example include menopause training for managers
Finance	Challenging financial landscape, requirement to deliver a balanced finance position may impact on ability to invest in services to deliver our plans	• System Productivity and Value Group established to drive productivity and efficiency improvements and oversee financial improvement trajectories. • Enhanced expenditure controls to be put in place to maximise the value for money and health impact of every pound spent.
Seasonal Winter Pressure Challenges	Risk that winter pressures lead to increasing demand for health services including primary (GPs) hospital & emergency services, increase in importing out of area ambulance activity resulting in additional pressure and increased risk to patient safety resulting in ambulance handover delays	• Urgent Treatment Centre, • Increased GP appointments available • Ambulance receiving centre & discharge lounges/hubs in across a number of system partners Consistent approach to patient initial triage and streaming by Emergency • Consistency of zoning arrangements within Emergency Departments • Departments, to maximise capacity within departments and ensure patients are accessing care at the correct point of entry

Strategic Risks Cont....

NHS Black Country Integrated Care Board

Risk	Description	Mitigation
Social Care Capacity	Risk that there will be insufficient workforce, resilience & retention of staff to deliver plan	• System partners working together via Place Based Partnerships to ensure use of adult social care funding and BCF arrangements helps minimise social care discharge delays
Independent Sector Capacity	Risk that there may be insufficient Independent Sector capacity to help support delivery of our system elective plan	• Oversight and monitoring of elective care plan delivery and utilisation of Independent Sector taking place through Elective Care and Diagnostic Strategic Board, remedial actions being agreed where necessary • Utilisation of alternative capacity available through use of DMAS or mutual aid
Physical Capacity	Risk that reliance on sourcing external capital funding to replace equipment estates and facilities will impact on our ability to deliver our plans	• Prioritisation of capital schemes taking place • Estates plan in place to review and maximise physical estates utilisation • All opportunities for additional funding being explored
Government instability	Potential change in government with elections due in 2024 may result in a potential change in government & policy regime	• Plan will be reviewed and refreshed on annual basis to take into account any emerging changes in policy approach
Cost of Living/Inflation	Current economic climate is a threat as it contributes towards deprivation and wider determinants of health. The cost of living crisis & fuel poverty are recognised as factors which may impact on health outcomes and exacerbate inequalities	• Government assistance with fuel payments • Council warm spaces

Feedback on Plan

Thank you

Email address for comments: bcicb.strategicplanning@nhs.net

Comments to be received by **22nd May 2023** please