NHS Black Country - Joint Forward Plan 2023-2028

Updated April 2024

Strategic and Enabling Workstreams Delivery Plans:

- Planned Care (Elective)
- Diagnostics
- Cancer
- Urgent and Emergency Care
- Out of Hospital
- Preventing Ill Health
- Personalisation
- Primary Care
- Maternity and Neonates
- Children and Young People
- Mental Health, Learning Disabilities and Autism
- Long Term Conditions Management
- Workforce

Draft for Involvement

Strategic and Enabling Workstreams

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

Planned care (Elective)

Planned care is what we say when we mean a treatment which is planned, things like operations for hips and knees. This area of the plan explains how we will recover from the pandemic and ensure that capacity is there to meet future health needs and to ensure any treatment needs are identified in a timely way. Our aim is for organisations to work together to provide better, faster and safer care for local people. The plan describes how we will do this by:

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

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

Outcomes to be achieved

For our Patients:

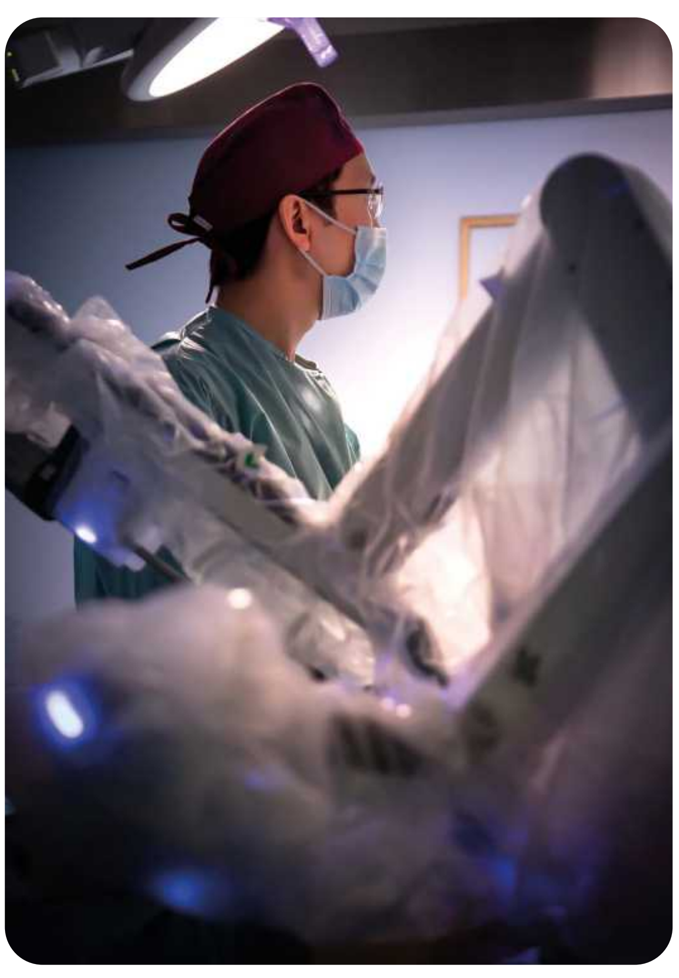
- Improved access, reduced waiting times and timely access to treatment leading to improved clinical outcomes
- Improved choice, personalisation and experience, improved life expectancy

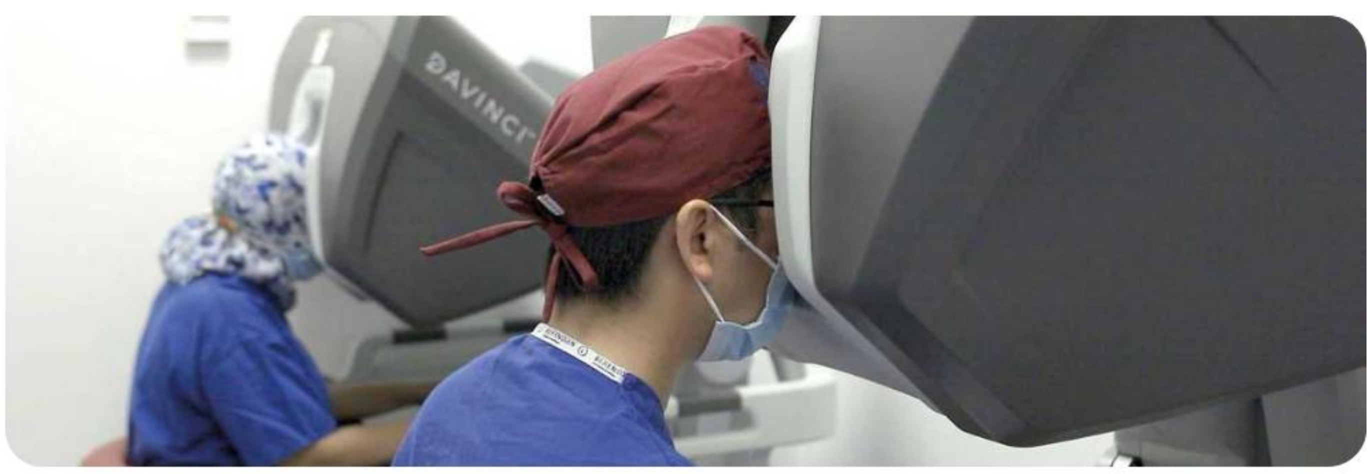
For Organisations:

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

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, use of Patient Initiated Digital Mutual Aid System, 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 align and implement plans such as Getting It Right First Time (GIRFT), national transformation initiatives, and local transformations such as dedicated elective care hubs, theatre reconfigurations and a new hospital site (Midland Metropolitan University Hospital). We will optimise care pathways and improve productivity.	✓	✓			
System Resilience and Transformation Through our transformation activities, use of innovative technologies, new workforce models and system leadership we will achieve greater system resilience.			✓		
Improving Quality To implement standardised approaches and pathways to both align practice and support the reduction of health access equity. Centres of Excellence will be explored to reduce unwarranted variation in access, experience and outcomes.	✓	✓	✓	✓	✓

Significant improvement made on reducing long waiting times for planned care.

Roll out of the Patient Initiated Digital Mutual Aid System (PIDMAS) which supports those patients waiting over 40+ weeks on a hospital pathway to move to a provider with a shorter waiting time. Through an accreditation process more providers are being added to PIDMAS, therefore expanding choice for patients and reducing waiting times.

Diagnostics

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

Our plan includes:

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

Outcomes to be achieved

For our Patients:

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

For Organisations:

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

For our System:

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

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Optimise Clinical Pathways Implement best practice timed pathways across urgent, elective and cancer services, driving efficiency and productivity, ensuring safe and patient-centred pathways.		✓			
Reduce Inequalities in Access Consider physical, cultural and social needs of different/ diverse population health groups and implement actions to improve pathways and achieve equity of access.		✓			
Implement Community Diagnostic Centres (CDC) Maximize the capacity of existing facilities, equipment and staff training; improve health outcomes through earlier, faster and more accurate diagnoses supporting recovery of waiting lists.				✓	
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, particularly in challenged areas.	✓	✓	✓	✓	✓
Adopted Technological/Digital Innovation Implement innovative technologies and supporting infrastructure to improve care for patients by changing how tests are conducted and analysed.		✓	✓	✓	✓

Increased diagnostic and treatment capacity resulting in reduced waiting times.

Additional investment in scanners (CT and MRI) at one of our Community Diagnostic Centre Sites.

Development of the workforce to address staff shortages and skill gaps.

Cancer

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

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

The plan covers our work in four key areas:

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

Outcomes to be achieved

For our Patients:

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

For Organisations:

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

For our System:

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

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Prevention and Reducing Health Inequalities Working collaboratively we will improve cancer prevention and develop improvement plans to reduce health inequalities.	✓	✓	✓	✓	✓
Screening and Early Detection Achieve improvements in screening programme uptake to enable 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 Centres.	✓	✓	✓	✓	✓
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.	✓	✓	✓	✓	✓

Achieved a 45% reduction in people waiting more than 62 days for treatment.

Increase in the number of patients receiving a timely cancer diagnosis.

Targeted Lung Health Check programme commenced in one Place, with plans to extend the service next year.

Targeted screening uptake, as set out in the earlier case study.

A centre for a new specialist type of skin cancer treatment opened in Sept 2023 in a new £1.3m facility, that will ensure patients are seen quicker and treated closer to home.

Urgent and emergency care

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

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

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

Outcomes to be achieved

For our Patients:

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

For Organisations:

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

For our System:

- Sustainable and resilient urgent and emergency and care model across the system
- Consistency of urgent and emergency care services and pathways across our system

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

Patients attending Accident and Emergency are being seen sooner, with Black Country system amongst the top performing in England.

Investment in our buildings and workforce to improve patient flow.

Increased availability of Same Day Emergency Care Services.

Supported care home facilities to reduce the number of avoidable 999 calls.

Out of hospital/community services

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

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

- Investing in community services to respond quickly when people are in need and to prevent hospital attendances.
- Recognising and preventing falls as these are a major contributor to hospital stays.
- Developing more capacity for people to receive care in a home setting through remote technology and virtual wards.
- Supporting people in their end-of-life choices and ensuring there is support and care there for people to die in a place of choice with dignity.
- Delivering the ambitions of the Black Country Integrated Care Board (ICB) Dementia Strategy ensuring it aligns to the Palliative and End of Life Strategy.
- Creating a recognised tool to assess and direct individuals to the most appropriate community service across the ICB, providing care closer to home.
- Implementing the National Chief Nurse Officer's Strategy.

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 and estates)

For our System:

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

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

Consistently met the national target for 2 hour urgent community response.

Increased the number of patients being managed in the community, through Virtual Wards and use of technology.

Working well with the social care sector to support the community workforce, fostering stronger working relationships and greater collaboration.

Preventing ill health

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

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

Our plan includes:

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

Outcomes to be achieved

For our Patients:

- Improved life expectancy
- Reduced 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

Ongoing support from pharmacies to stop smoking

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 with analysis of the 'obesity burden profile'. A review of services is being undertaken, taking into account new guidance.	✓	✓			
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. A clinical audit will be undertaken during 2024/2025.	✓	✓			

The Tobacco Dependency Programme has been rolled out to the majority of providers, supporting patients in hospital (and maternity services) to access tobacco dependence treatment, thus improving the health and wellbeing of the person smoking and their family.

Alcohol care teams have been fully mobilised across the Black Country. Alcohol care teams provide specialist expertise, early intervention and access to treatment for alcohol dependent patients.

Personalisation

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

Locally, we will increase personalised care planning with:

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

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 offered and principles built into models of care and care pathways.

Social Prescribing and Community Based Support

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

Our plans include expanding the service to all communities including children and young people, workforce training and development including peer support, and building in creative cultural health opportunities.

Support Self-Management

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

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

Personal Health Budgets

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

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

The personalisation agenda is a cross cutting theme and examples of key achievements delivered are set across other Strategic, Place and enabling workstreams.

Primary care

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

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

Outcomes to be achieved

For our Patients:

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

For Organisations/ Our System:

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

Improved access through a variety of ways including delivering additional appointments.

Launch of 'Pharmacy First' that enables pharmacists to assess and treat minor conditions without the need to see a GP.

Improvements to GP websites making them accessible and user friendly, including better access through the use of digital tools such as online consultations and NHS App.

Improved dental access including providing tailored support to migrant and refugee groups.

Secured more urgent access dental appointments and invested in Oral Health Improvement Schemes.

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Development/Embedding of Primary Care Collaborative Establish the governance, clinical leadership and the required infrastructure to deliver collaborative working.		✓			
Establish/Develop The Primary Care Workforce and Transformation Unit (Primary Care Delivery Vehicle) Establish new ways of working, deliver organisational development and work programme focussing on access, Long Term Condition and unwarranted variation.			✓		
Primary Care Collaborative Transformation Work Programme (Future Operating Model) Undertake strategic development and implement the transformation programme.					✓
Improving General Medical Services (GP) Access Support PCNs to implement practice-based solutions to improve patient access and experience.	✓				
Primary Care Network (PCN) Estates Programme Reconfiguration of vacant space, maximise e-booking systems, and deliver the Estates Strategy.					✓
PCN Development Programme Support PCNs to 'maturity' and embed the development programme reflecting the Fuller recommendations.			✓		
Increasing Dental Access Programme Develop a dental strategy and deliver improvement plans in line with the national recovery plan, use of health equity audit to inform the strategy with a continued focus on improving access.					✓
ICS Primary and Community Care Training Hub Contract/System Workforce Development Programme Embed workforce planning, focus on retention and secure the resources to deliver the improvements.		✓			

Maternity and neonatal

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

We have developed strategic priorities which are:

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

Outcomes to be achieved

For our Patients:

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

For Organisations:

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

For our System:

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

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

Significant progress made towards delivering 'Saving Babies Lives' care bundle, with investment in our workforce including the appointment of LMNS Pre-Term Birth Lead to support our ambition to reduce infant mortality.

Children and young people

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

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

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

Outcomes to be achieved

For our Patients:

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

For Organisations and the System

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

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

New NHS website providing a range of health advice for every stage, from pregnancy and birth through to nursery, school and beyond.

New Black Country CYP Diabetes Network with a focus on rolling out of hybrid closed loop technology to all children and young people with Type 1 diabetes by 2029 and Epilepsy Network who have undertaken an in-depth consultation with 12-18 years with lived experience of epilepsy.

11 schools across the Black Country have achieved the asthma friendly school status, and a story book and lesson plans for Key Stage 2 have been developed for asthma and clean air.

Mental health, learning disabilities and autism

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

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

Outcomes to be achieved

For our Patients:

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

For Organisations:

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

For our System:

- Parity of esteem between physical and mental health, successful achievement of national ambitions for MH and LDA, benefit from economies of scale and specialism

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

Additional resources invested in Mental Health Bed Management to prevent Out of Area Placements and provide crisis beds for those with complex emotional needs. In the Black Country the number of patients placed Out of Area are currently at the lowest levels in the country, supporting patients to remain in their local communities.

Transformed community services to support people with severe mental illness to be cared for in the community.

Long-term conditions management

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

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

Our plan is to:

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

Outcomes to be achieved

For our Patients:

- Earlier diagnosis
- Reduced preventable illness
- Improved life expectancy
- Reduced mortality
- Patient empowerment, increased patient led condition management

For Organisations:

- Reduced pressure on urgent and emergency 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

Roll out of 'T2Day: Type 2 Diabetes in the Young', where patients benefit from extra one-to-one reviews as well as the option of new medicines and treatments where indicated, to help better manage their diabetes. The NHS is the first health system in the world to put in place a national, targeted programme for this high-risk group of people.

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, Multi-Disciplinary Footcare Teams. New guidance is also been considered.	✓	✓	✓	✓	✓
Post COVID-19 Services Ensuring patients continue to receive access to post COVID-19 services in a timely manner.	✓	✓			
Cardiovascular Disease (CVD) Delivery of initiatives to improve early detection and management of CVD including hypertension case finding, Blood Pressure at Home Service, delivery of Cardiac Improvement Programme.	✓	✓	✓	✓	✓
Respiratory Development and delivery of pulmonary rehabilitation five-year plan including development of spirometry services, expansion of remote monitoring programme and lung health check programmes.	✓	✓	✓	✓	✓

Workforce

We know that a key enabler for the successful delivery of our Joint Forward Plan is our workforce. Currently there are approximately 60,000 colleagues working across health and social care in the Black Country, each providing a unique contribution to the delivery of care to our community. We know that for us to thrive we need to look after our workforce and become a place where people want to work. As a health and care system we know that as 'one workforce' we are better and that we need to develop the right culture and infrastructure for the Black Country to be the best place to work.

We hope to do this through creating psychologically safe and supportive environments, where all our diverse colleagues feel they belong and we can provide the architecture for developing a workforce that is sustainable for the future. The NHS England Long Term Workforce Plan is a key document that will act as a framework for supporting and developing our workforce.

We will:

- Focus on retaining our people and supporting them to be the best they can be, which in turn optimises our resources.
- Create an inclusive talent management approach.
- Publish a Black Country Health and Wellbeing Strategy along with our refreshed People Plan 2023-2028 that describes the priorities, actions, and impact to make the Black Country the best place to work.
- Work collaboratively to coordinate a workforce development plan that articulates our approach to workforce planning, education and training.

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

Looking after our people

Belonging in the **NHS**

Growing for **the future**

New ways of **working** and **delivering care**

Continued focus on training, recruitment and staff retention.

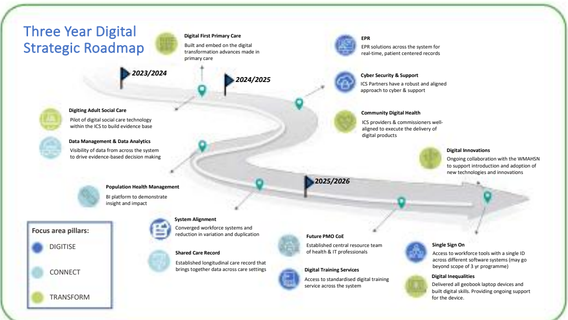
Offering a package of support to all our staff, including emotional wellbeing, physical health, and financial support, for example.

Invested in leadership programmes to grow a more diverse staff group and ensure our future leaders are representative of the community we serve; for example, our Next Generation Senior Leadership Programme.

Recruitment of 29 International Radiographers who will support across hospital sites, addressing workforce challenges and improving diagnostic capacity for our patients.

Digital

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



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

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

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

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

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

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

Shortlisted for HSJ Awards – Black Country Connected Programme; including Best Consultancy Partnership with the NHS, Most Impactful Project Addressing Health Inequalities, Social Value Initiative of the Year and Best Community Services with the NHS.

Increased participation in One Health and Care, our system wide patient shared care record.

Rollout of Digital Social Care Record across Adult Social Care (ASC) Providers.