Meeting of the Dudley Health and Wellbeing Board

Thursday 14th March 2024,
at 4.00pm on Microsoft Teams
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Agenda - Public Session

(Meeting open to the public and press)

1. Apologies for absence.

2. Appointment of Substitute Members.

3. To receive any declarations of interest under the Members' Code of Conduct.

4. To confirm and ratify the minutes of the informal meeting held on 14th December, 2023 as a correct record (pages 4-20)

16:10 5. Public Voice

6. Items for Board sign-off

16:30 a) Refreshed Terms of Reference and Governance (pages 21-34)

7. Goal Progress:

16:40 a) Deep Dive – Breast Cancer Screening (pages 35-60)

17:05 b) Growing up in Dudley

8. Items for Information:

17:20 a) Highlight Report – School Readiness (pages 61-77)

17:30 b) Report of the Children and Young People's Partnership Board (pages 78-82)

17:40 c) Refresh of Black Country Integrated Care Board (ICB) Joint Forward Plan (pages 83-146)

17:50 d) Dudley Pharmaceutical Needs Assessment – Supplementary Statement (2) March 2024 (pages 147-157)

17:55 e) Sport England Place Based Investment (pages 158-159)

9. Any other business

10. To consider any questions from Members to the Chair where two clear days' notice has been given to the Monitoring Officer (Council Procedure Rule 11.8).

Please note the following important information concerning the meeting:

- This meeting will be held virtually by using Microsoft Teams.
- This is a formal Board meeting, and it will assist the conduct of business if participants speak only when invited by the Chair.
- The Chair reserves the right to adjourn the meeting, as necessary, if there is any disruption or technical issues.
- All participants should mute their microphones and video feed when they are not speaking.
- Please remember to unmute your microphone and switch on your video feed when it is your turn to speak. Speak clearly and slowly into your microphone.
- Members of the public can view the proceedings by clicking on the link provided on the agenda.
- The Council reserves the right to record meetings. Recording/reporting is only permitted during the public session of the meeting.
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information is securely stored and destroyed within six months.

- Elected Members can submit apologies by contacting Democratic Services: Telephone 01384 815238 or E-mail Democratic.Services@dudley.gov.uk

Distribution:
Members of the Dudley Health and Wellbeing Board:
Councillors I Bevan, R Buttery, M Rogers, S Ridney and L Taylor-Childs.
B Heran – Deputy Chief Executive
M Bowsher – Director of Adult Social Care
M Abu Affan – Director of Public Health and Wellbeing
C Driscoll – Director of Children's Services
K Jones – Director for Housing and Communities
N Bucktin – Dudley Managing Director – Black Country Integrated Care Board (BCICB)
P Kingston – Independent Safeguarding Board Chairperson
Dr R Edwards – Black Country Integrated Care Board (BCICB)
A Gray – Dudley CVS CEO
Commander A Tagg - West Midlands Police Representative
A Shakespeare - West Midlands Fire and Rescue Service
M Foster –Chief Executive - Black Country Healthcare NHS Foundation Trust
D Wake – CE Dudley Group NHS Foundation Trust
P Wall – Head of Strategic Planning (West Midlands Ambulance Service)

Officer Support
Dr S Dougan – Interim Head of Services in Public Health
L Grainger – Casual Public Health Project Manager

Minutes of the Dudley Health and Wellbeing Board
Thursday 14th December 2023 at 4.00pm
Microsoft Teams Meeting

Present:

Councillor I Bevan (Chair)
Dr R Edwards (Vice- Chair)

Councillors: S Ridney

Officers: M Bowsher (Director of Adult Social Care), N Bucktin (Dudley Managing Director - Black County Integrated Care Board), C Driscoll (Director of Children's Services), A Gray (Dudley Council for Voluntary Service (DCVS) - Chief Executive Officer), J Griffiths (Chief Officer Healthwatch Dudley), K Jones (Director for Housing and Communities), Professor P Kingston, (Independent Adult Safeguarding Board Chair), Commander A Tagg (West Midlands Police), and H Mills and L Jury (Democratic Services Officers).

Also in attendance:

K Rose (Dudley Group NHS Foundation Trust)
Dr S Dougan (Interim Head of Services in Public Health)
R Tipson and A Welsh - Representatives from Action Heart - for agenda item no. 5
L Hester-Collins - for agenda item no. 5
L Grainger (Health and Wellbeing Business Support) – for agenda item no. 6(a)
Dr D Jenkins (Dudley Integrated Health and Care) and S Cleary (Public Health Manager) – (for agenda item no. 6(b)
V Buchanan – (Commissioning and Support – for agenda item no. 8(b)
Dr D Pitches – (Head of Healthcare Public Health) – for agenda item no. 7(a)

Bishop Ghimire	J Weston
S Cornfield	M Foster
J Tomlinson	

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48 **Apologies for absence**

Apologies for absence from the meeting were submitted on behalf of Councillor R Buttery, M AbuAffan, and D Wake.

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49 **Appointment for Substitute Members**

It was reported that K Rose (Dudley Group NHS Foundation Trust) and S Dougan (Public Health Directorate) had been appointed to serve as substitutes for D Wake (Dudley Group NHS Foundation Trust) and M AbuAffan (respectively), for this meeting of the Board only.

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50 **Declarations of Interest**

No Member made a declaration of interest in accordance with the Members' Code of Conduct.

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51 **Minutes**

Resolved

That, the minutes of the meeting of the Board held on 14th September, 2023, be approved as a correct record.

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52 **Public Voice**

On introducing the item, L Hester-Collins advised that the presentation had been produced with the assistance of Action Heart and comprised of a Member of the public called Mr R Morriss, who had agreed to share his recorded story with the Board with regards to heart disease and his hope that by sharing his story would encourage others to seek support if they felt a decline in their health, or if they felt too concerned to talk to their Doctor or others about health issues. The Board were also informed that two representatives from Action Heart were in attendance at the meeting to answer any questions that may arise.

Arising from the presentation, and on behalf of the Board, the Chair requested that thanks be expressed to Mr R Morriss for providing such a comprehensive and interesting journey from his initial symptoms to his treatment and beyond.

In response, the representative from Action Heart advised that Mr R Morriss's story was a typical story of a person who had been experiencing a heart attack and in particular, the psychological support required upon experiencing such an illness. The after service provided by hospitals was praised, and Action Heart aimed to continue with the support by increasing the patient's confidence and getting them back into work by helping them to recognise the prospect of a prosperous future going forward.

The Chief Officer Healthwatch Dudley expressed thanks for the presentation and referred to a specific issue raised, regarding the lack of communication with patients when on the ward with regard to their condition and it was suggested that this story be referred to the Patients Experience Group to be addressed, especially for patients who enter hospital without any family or other support.

In response, K Rose acknowledged the issue of communication with patients whilst in hospital care as an area which required improvements.

In response, the Vice-Chair advised that when patients present to their General Practitioner (GP's) with exertional pain, they can be referred through the cardiac pathways to be seen fairly quickly in clinic where they would be assessed and started on treatment before the heart attack occurred. Reference was made to the education sessions offered by Action Heart or information supplied by GP's or hospitals at follow-up appointments, where patients were informed of what had happened to them and future care after leaving hospital. It was acknowledged however, that when patients were in hospital, the information supplied to them may not always be absorbed by the patient during this stressful time, and it was agreed that communication with patients whilst in hospital was an area that required improvement.

In response, the representative from Action Heart concurred with the Vice-Chair and made reference to the reduced time patients now spend in hospital after a heart attack and acknowledged that the first few hours a patient spends in hospital could be very confusing, with information supplied not accepted or understood by the patient, and it was hoped that this was an area where Action Heart could assist in the future. Reference was made to the pandemic which had reduced the number of Action Heart volunteers who would spend time in post-coronary care talking to patients and the challenges faced getting the information to patients in the short timeframe before the patients were discharged.

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53 **Items for Board sign-off:**

(a) Revised Terms of Reference and Governance

The Board received a report of the Director of Public Health and Wellbeing updating Members on the Health and Wellbeing Board's Terms of Reference (ToRs) and sub-groups for delivery of the new Health, Wellbeing and Inequalities Strategy.

In presenting the report, the Public Health Project Manager advised that the last meeting of the Board had been held as an informal meeting due to the Board not being quorate and, therefore, this item had been deferred. The Terms of Reference had been revised following agreement at the Board's Development session held in January 2023 and also to reflect recent changes in membership. It was advised that the report be presented for approval from Members, on the revised Terms of Reference for the HWBB, noting that the proposals ensured compliance with constitutional requirements, appropriate revised membership, and further recommendations as set out in the report.

In relation to voting rights, two options were proposed:

Option one - all Members of the HWBB having voting rights with the exception of Council Officers,

Option Two - voting rights, in addition to Councillors, will be statutory representatives from the Integrated Care Board (ICB) and Healthwatch (or their representatives) will be entitled to vote at meetings, but co-opted members and Council Officers will not be entitled to vote.

Arising from the presentation, the Interim Head of Services in Public Health advised that it would be in exceptional circumstances that voting would be required although mindful that other HWBB's have had instances when voting had been necessary, therefore it would be beneficial to add voting rights into the Terms of Reference. In response, the Director of Children's Services made reference to government guidance that had been followed at a previous authority, which stated that Councillors and statutory Directors from the Local Authority, such as, the Director of Public Health, Adult Services and Children's Services were entitled to vote, together with the CCG. However, it was acknowledged that due to each HWBB's unique role and membership, this could prove problematic, and it was advised that up-to-date national guidance be followed.

In response, Members were assured that Section 102 of the Local Government Act 1972 had been reviewed and referring to the unique role and membership of HWBBs, it was advised that it was unusual to have Council Officer's and external parties voting at a Council meeting.

In response, the Director of Children's Services advised that when the legislation had been passed, HWBBs had not existed and HWBBs were seen as controversial as they specifically required Senior Directors to have voting rights, the same as Elected Members, and the importance to consider national guidance was stressed before a decision be taken by the Board.

The Chief Officer Healthwatch Dudley advised that clarification also be sought from Healthwatch England in relation to voting and the Vice-Chair proposed that information be sought from other local authority HWBB's in relation to their voting arrangements.

In response, the Director of Adult Social Care referred to a report issued by the Local Government Association entitled 'Making an Impact Through Good Governance – A Practical Guide for Health and Wellbeing Boards'. It was noted that the report stated that many HWBBs do have voting Council Officers in their constitution, and therefore, it was proposed that a link to the document be sent to the relevant officers to consider with Democratic Services.

Arising from the comments received, the Chair proposed that a decision on the Revised Terms of Reference, including voting rights, be deferred until the next meeting to allow Officers to consider further guidance as discussed and submit a revised report for consideration.

Resolved

That, the Revised Terms of Reference and Governance be deferred to be consideration at the next meeting of the Board.

(b) Reducing deaths due to Circulatory Disease

A joint report of Dr D Jenkins, Associate Director, Pharmacy and Clinical Divisional Director, Pharmacy and Health Management, Dudley Integrated Health Care (DIHC) and S Cleary (Dudley MBC Public Health Manager) was presented in relation to a deep dive into the action plan for reducing deaths due to Circulatory Disease in Dudley.

In presenting the report, Dr Jenkins acknowledged the contribution made by S Cleary and Dr Pitches to this item and advised that both officers were in attendance at the meeting.

Dr Jenkins made reference to the term circulatory disease, terminology used by the World Health Organisation, and the similarity of cardiovascular disease. It was advised the presentation would focus on issues including, angina and heart attacks, and acknowledgement was given to the story received from a member of the public earlier in the meeting in relation to his experience of a heart attack, heart failure, stroke, heart rhythm, disease of the heart valves and high blood pressure.

A scarf plot graph was then presented which outlined the life expectancy between Dudley's most and least deprived areas and the causes of the differences between males and females. It was noted that the overall gap averaged just over seven years for males and six years for females and when considering the causes of that reduced life expectancy, circulatory disease was accredited to the biggest proportion of deaths, with the four main causes of deaths noted as: Covid, circulatory disease, cancer and respiratory.

When considering the Black Country in terms of mortality rates from circulatory disease, both for under 75 year olds, it was noted that the overall mortality rates were some of the highest in the country, which closely tied with deprivation. Information relating to Electoral Wards and rates of mortality was then presented, noting that the more deprived wards had higher mortality rates from circulatory disease in all ages, and specific reference was given to the under 75 years olds which tied in with reduced life expectancy and premature deaths relating to circulatory disease.

When considering the distribution across Dudley, it was noted that certain Electoral Wards had high rates of circulatory disease mortality for all ages, and a list of those Wards were presented.

Challenges in relation to the way data was captured was then noted which resulted in deprivation being a proxy for mortality. However, the overall approach was to consider populations in areas where there was a high circulatory disease mortality rate, which related to under performance by general practice, and it was stressed that this could be for a number of reasons. Other important areas in addition to deprivation, were then presented which included, ethnicity, and severe mental illness, noting that people with severe mental illness had a twenty-year reduced life expectancy and a threefold mortality rate from circulatory disease, which were important inequality issues that needed to be considered.

Gender inequalities were acknowledged, as it was advised that mortality rates in males were higher than females, and it was noted that the British Heart Foundation had revealed that females receive a lower standard of care than males when experiencing a heart attack. Evidence also demonstrated that females did not receive the same standard of care in relation to secondary prevention with regard to medication and after care, and it was noted that this was an area that would be investigated further, specifically relating to Dudley.

The plan on a page was presented in relation to longer-term objectives, described as being the wider determinates of health, and the short to medium-term objectives, principally the lifestyle and factors, and the services being offered by the health service in relation to prevention.

Reference was then made to the direct lifestyle factors that influenced circulatory disease which included: diet, physical activity, smoking and alcohol intake, and the broader environmental and social factors, such as, income, employment and educational attainment. It was noted that these issues were primarily associated with deprived populations and had an impact on the risk of circulatory disease, together with environmental factors such as, the quality of housing conditions and air quality.

It was advised that the long-term objectives had been incorporated into the plan and the Board and Local Authority were asked to acknowledge the importance of circulatory disease. Reference was again made to the presentation at the beginning of the meeting where the member of the public had raised the importance of exercise and the use of places such as the canal tow path, and the challenges experienced exercising during the winter months due to poor weather conditions and darker nights. Reference was made to gym membership and the importance to recognise that some members of the public would be unable to afford gym membership and it was advised that this was an area that needed further consideration.

Reference was made to short to medium term objectives, specifically the lifestyle factors which it was noted were being addressed predominately through the Health Improvement Service, a newly recommissioned service, which focused and targeted deprived and high-risk populations for circulatory disease, providing preventative interventions such as, healthy eating, physical exercise and alcohol reduction. Improved signposting for hospital inpatients was noted, and specific reference was made to those who were smokers at the time of their heart attack and the importance to signpost them to services to encourage them to quit smoking such as, community pharmacies.

Reference was made to health checks, a national programme which was locally commissioned, and it was advised that 96% of checks were undertaken by GP's, with the remaining 4% covered by the health improvement service.

Challenges relating to the uptake of health checks in some of the less deprived areas in previous times was acknowledged, which ran the risk of widening health inequalities, and it was advised that Dr Pitches and S Cleary had been focusing on supporting practices to identify patients that would benefit from health checks, particularly targeting populations where uptake had been low.

Three areas of interventions were than presented. Firstly, the focus on detecting hyper-tension and specific reference was made to the service provided by community pharmacies and the aim to improve the working relationship between pharmacies and GP's. The success in previous years in Dudley having the highest detection rate in the country was acknowledged, however it was advised that further improvements could be made and blood pressure control was also an area which required improvement, although it was noted that the Black Country on the last release of data had the best improvement rate in England.

The second area related to statins, and other cholesterol medications, with the aim to increase the usage of such drugs in patients diagnosed with circulatory disease. Focus would be aimed at improving the prescription rates of such medication and where high cholesterol was being treated, reducing the cholesterol levels successfully.

The third area related to triple control of diabetes, as it was noted that diabetes carried a high risk of circulatory disease and triple control referred to controlling blood pressure, cholesterol and blood sugar as reducing these areas could reduce the risk of developing circulatory disease significantly.

The final work in progress was presented which related to GP's targeted with providing physical health checks for people with severe mental illness. Particular reference was made to a specific intervention for people with severe mental illness which had declined during the pandemic and would now be restored.

Graphical data was presented which evidenced the success in the areas of blood pressure control in Dudley. It was acknowledged that further improvements could be made, and the target over the next 5 years was to progress all primary care networks up to the national target of 80%, a target produced alongside the long-term plan which had been released in 2019. Two further graphs related to cholesterol, specifically patients who were being treated with a cholesterol lowering drug and Dudley's success in this area was noted, with the aim to increase the target to 90% moving forward.

The final presentation slide related to diabetes triple control by practice and demonstrated the variation between practices, and it was advised that the Diabetes Steering Group would work with the practices to improve triple control, to achieve a 44% target.

In conclusion, Dr Jenkins advised that the plan was still in its early stages, with some work streams more established than others, and contained the wider determinates as well as upstream and downstream interventions. Relating to the upstream interventions, the presentation on the public voice at the beginning of the meeting, illustrated the aim to engage with people at an earlier stage and reference was made to the healthy heart hub which aimed to liaise with communities using peer workers to raise awareness of the importance of things such as, diets, smoking, blood pressure and an awareness of blood pressure, cholesterol and Body Mass Index numbers. Reference was made to the asks from the Board which were to allocate circulatory disease with the appropriate priority in terms of strategy and plans, giving it the right focus to ensure the right capacity and incentives were in place to address circulatory disease both upstream and downstream.

Arising from the presentation, the Chair thanked the officer for an informing and interesting report.

In response to a question from the Chief Officer Healthwatch Dudley, in relation to the concessionary gym membership scheme offered by the Council which could help address the issue of increasing a healthy lifestyle in those who were unable to afford gym membership, Dr Jenkins advised that this issue would be explored with the Circulatory Disease Board.

Councillor S Ridney raised concern with regard to the position of Upper Gornal and Woodsetton Wards in relation to death from circulatory disease in comparison to other higher deprivation wards and questioned the possible connection between the number of cases and lack of leisure facilities within the area and the need to consider this issue further. In response, Dr D Pitches advised that some areas within Dudley had a higher degree of risk factors for circulatory disease than others and this would need to be looked at in more detail. It was noted that more Ward profiles would be published shortly which would assist in understanding the factors relating to these figures.

The Interim Head of Services in Public Health requested further clarification on the variation in the management of diabetes and circulatory disease in the different practices in Dudley. In response, Dr Jenkins advised that further work would be undertaken on this issue, with the aim to improve care services in areas of high mortality rates.

The Chair, referred to the suggestion to promote the concessionary gym membership scheme in operation to encourage a healthier lifestyle, and questioned whether the financial barrier was the only factor that prevented people from accessing exercising. In response, Dr Jenkins advised on a number of barriers that deterred some people from attending public gyms, which included, cultural and confidence issues and stressed the importance of encouraging people to exercise in areas where they felt most comfortable such as walking, running and cycling. The challenges faced by some commuters in relation to the condition or lack of appropriate cycle and walking pathways in the area was acknowledged.

The Chief Officer Healthwatch Dudley referred to statistics that Active Black Country had produced that could add support to this work, noting that the statistics had indicated that the Black Country was the least active area in the whole of the Country and referred to the active schemes that they offered with regard to fitness.

The Independent Adult Safeguarding Board Chair stressed the importance to include the high consumption of low cost, ultra-processed food which had a significant impact on health and the need to increase the offer of affordable healthier food. In response, Dr Jenkins concurred with the issue raised and advised that the three biggest killers, namely, poor diet, smoking and high blood pressure, needed to be investigated further.

The Chief Executive Officer of Dudley Council Voluntary Service, (DCVS) stressed the importance of including Active Black Country who were experts in sedentary lifestyles and had undertaken a number of surveys with sedentary people within the area. Reference was made to the DVS having employed a Community Activator that assisted with walking routes and groups in parks, and the River and Canal Trust who had employed a person in Dudley that investigated the blue water and canal walking routes.

Resolved

(1) That, the report submitted in relation to a deep dive into the action plan for reducing deaths due to Circulatory Disease in Dudley, and comments made by Members, be noted.

(2) The key asks of the Board/wider system, as set out in the report, be approved.

(c) Joint Strategic Needs Assessment (JSNA) update

The Board received a report of the Head of Integrated Intelligence, Performance and Policy on an update of the Joint Strategic Needs Assessment (JSNA).

In presenting the report, the Interim Head of Services in Public Health referred to the work that the Head of Integrated Intelligence, Performance and Policy undertaken, around the JSNA which had been carried out specifically to coincide with the timing of the new financial year and the new commissioning cycle. This included, considering all the population demographics, and the current position with relation to the public health outcomes and health and wellbeing priorities.

Referring to the population, it was noted that the latest census had confirmed that Dudley had an estimated population of 323,581 people and by 2028 it was believed that this could increase to 330,400. It was advised that most of the increase would be as a result of the movement of people into the Borough.

It was noted that the birth rate had fallen over time and that death rates in men and women varied, with the average life expectancy of a man being 78 years, and a woman 82.2 years. Life expectancy in most deprived areas was lower than in the most affluent areas, noting for men this was a 9.2-year difference between the most deprived and least deprived and for women, an 8.6-year difference.

Reference was made to the ageing population and the impact this had on hospitals, health care services and adult social services. A breakdown of the population for the over 65 years was presented, and it was noted that it was expected that an extra 4,000 people over the age of 65 year olds would be living in the Borough in the next five years, an increase that was expected across the country.

In referring to the children's population, it was important to note that the demographic of the population was very different for the older population. It was advised that in the over 65 years population, 95% of people were showing as White British ethnicity, in comparison to 73% of the 15 years and under, showing as White British.

The public health outcomes framework was then presented, which included, a higher percentage of children in Dudley in low-income families not being school ready; fewer children achieving a good level of development in school; a higher than the national average in Dudley for teenage conception rates, although it was noted that this rate had fallen over time; and pupil absence rates being higher than the national average.

Reference was made to circulatory disease, which had been covered in detail in the previous agenda item, and it was noted that the Borough had recorded both children and adults as having higher rates of obesity and some of the lowest levels of physical activity.

Referring to breast cancer screening, it was noted that Dudley, in comparison with national data, was still below average however, data still to be published had seen some improvements, with inequalities still evident across the Borough.

It was advised that, beyond the HWB goals, the recommendations that had been set for Commissioners to consider, included Dudley remaining below average for bowel cancer screening, although the diagnosis of cancers early overall in Dudley remained better than the national average; Dudley had higher than the national average of people in fuel poverty; the diagnosis rate for dementia from GP's was lower than the national average, and Dudley had higher rates of people reporting with long-term musculoskeletal problems.

In conclusion, the Interim Head of Services in Public Health, advised that Dudley had recorded lower rates for hospital admissions from childhood injuries, self-harm and falls, although a higher rate had been recorded for hip fractures which would be investigated further, and a lower rate of emergency readmissions after thirty days of discharge from hospital.

Arising from the presentation, the Chair referred to the Ward profiles that were to be produced and the Interim Head of Services in Public Health advised that the profiles would be available shortly.

Resolved

(1) That, the report submitted updating Members on the Joint Strategic Needs Assessment (JSNA), be noted.

(2) That, the key asks of the Board/wider system, as set out in the report, be approved.

(d) Health Inequalities Funding 2023/2024.

The Board received a report of the Dudley Managing Director, Black Country Integrated Care Board (BC ICB) on the current position in relation to the Integrated Care Board's health inequalities funding for 2023/2024.

In presenting the report on behalf of the Dudley Managing Director, BC ICB, the Vice-Chair made specific reference to information in the report relating to a small allocation of money to the Voluntary Sector however, it was noted that this had been retracted.

Resolved

That the report submitted on the current position in relation to the Integrated Care Board's health inequalities funding for 2023/2024, be noted.

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54 **Items for Information – Goal Progress**

(a) Joint Health and Wellbeing Inequalities Strategy 2023-2028 Breast Screening

The Board received a joint report from the Head of Healthcare Public Health and the Dudley, Wolverhampton and South West Staffordshire Breast Screening Programme Manager on an overview of activity and progress against delivery of the health and wellbeing goal to improve breast cancer screening coverage.

In presenting the item, the Head of Healthcare Public Health advised that support had been given to the training of Cancer Champions working in a number of GP practises to talk about screening and support patients who were either deciding or who had not attended a screening appointment, to help them understand the process and the benefits of screening.

A deep dive of the data had been undertaken as most of the nationally produced data was approximately 18 months old and referred to historic patterns. It was noted that Dudley and Netherton needed specific attention and a mapping exercise had been carried out where practises would be inviting people to attend. The practices in Central Dudley would be inviting patients in the spring of 2024 and an awareness campaign was being undertaken with GP's practices, pharmacies and other organisations, in order to encourage people to attend screening and develop a pathway for people with learning disabilities to explore a way in which to help carers to access screening more effectively. A review had been undertaken on what had worked in other areas, including what interventions had been most effective in inviting people, specifically people who had not usually attended screening to improve the acceptability of the services.

In conclusion, reference was made to the key asks of the Board namely, the support for Cancer Champion training and the opportunities this would provide in primary care, acknowledging their effectiveness in helping people access the wider screening programmes, not just breast screening, and helping to support the mobile breast screening van to become more accessible to all communities.

Resolved

That the activity and progress made against delivery of the health and wellbeing goal to improve breast cancer screening coverage, be noted.

(b) Black Country Integrated Care Partnership – update

The Committee received a report of the Dudley Managing Director – Black Country Integrated Care Board (ICB) on the current position in relation to the development of the Black Country Integrated Care Partnership (ICP) and its Integrated Care Strategy.

In presenting the report, the Director for Children's Services advised that there had been one meeting to date and it was acknowledged that the partnership was still at its development stage.

Resolved

That, the current position in relation to the development of the Black Country Integrated Care Partnership (ICP) and its Integrated Care Strategy, be noted.

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55 **Dudley Safeguarding Adult Board Annual Report 2022-2023**

The Board received a report from the Dudley Safeguarding People Partnership on the Dudley Safeguarding Adult Board Annual Report 2022-2023.

In presenting the report, the Independent Adult Safeguarding Board Chair made specific reference to the Borough having continued to have considerable increase in self-neglect, in comparison to Dudley's comparable authorities.

It was noted that specific Safeguarding Adult Reviews (SARs) had been undertaken on this issue and much time had been spent trying to understand the cause. The report outlined that SARs had been amalgamated together for a review combining all the strategic reviews that had been undertaken on this specific issue. Reference was made to the volume of calls and referrals that the service received year on year which put the service under severe pressure.

In conclusion, reference was made to the work that was undertaken on the Deprivation of Liberty Safeguards (DoLs). It was recognised that DoL cases were higher than the service wanted, but not as high in comparison to other areas. It was advised that extra resources had been put in place to help address this issue.

In response, the Director of Adult Social Services advised that a reduction in DoLs had been seen for a second month running, however it was unlikely that this reduction would continue and a detailed discussion had taken place at a recent Health Scrutiny Committee in relation to the seriousness of the issue and the need to understand what was driving self-neglect in the Borough, not just from a safeguarding point of view, but as a broader strategic issue which would be effect other partners on the Board. It was advised that numbers of self-neglect related referrals received in the last twelve months had increased by 100%.

The Independent Adult Safeguarding Board Chair, referred to an individual review that had been undertaken, which confirmed the seriousness of the situation within the Borough.

The Chief Officer Healthwatch Dudley made reference to a piece of work that was to be undertaken shortly with people that had experienced the safeguarding process to ascertain their views which could provide valuable feedback.

Resolved

That the report submitted from the Dudley Safeguarding People Partnership on the Dudley Safeguarding Adult Board Annual Report 2022-2023, be noted.

56 **Dudley Children's Safeguarding Annual Report 2022-2023**

The Board received a report from the Dudley Safeguarding People Partnership on the Dudley Children's Safeguarding Annual Report 2022-2023.

In presenting the report, V Buchanan advised that the role of the Independent Scrutineer in Children's differed from adults in relation to the review of the effectiveness of the multi-agency arrangements to safeguarding children and detailed her position in relation to reviewing the report on behalf of the partnership, reporting on the accuracy of the information contained in the report. Assurance was given to the Board that the report gave an accurate reflection of the current position within Children's Services.

It was noted that two bespoke areas of scrutiny had been undertaken during 2023 these included: a visit to Russells Hall Hospital where a meeting had taken place with Safeguarding Teams, time spent with the Maternity Services, talks had taken place with front-line staff to obtain assurance around safeguarding, and time spent with front-line Police Officers to ascertain their understanding of safeguarding on a daily basis. It was noted that as a result of the scrutiny undertaken, action plans had been developed.

Referring to challenges moving forward, specific reference was made to the forthcoming publication of the new version of Working Together, a guide on how services should work together around safeguarding children. It was noted that there were some significant changes that would need to be considered as a partnership to meet the requirements.

Reference was made to page 125 of the report submitted, which listed the key people involved from a partnership perspective and the expectation that the 2023 version would involve a much stronger line of sight from Chief Officers in organisations, such as the Chief Executive of the ICP, the Chief Executive of Dudley MBC, and the Chief Constable of the West Midlands Police and the importance of the need to focus on the work of the partnership moving forward.

In relation to positive aspects of the report, reference was made to the work being undertaken around the family safeguarding model, a partnership approach to working differently with families, and although it was noted that it was still in its early phase, the positive work in relation to the model was acknowledged. One of the early signs of success of the model related to the reduction in children subject to a Child Protection Plan, which was down significantly from 2022 to 2023, however the importance of keeping this issue under review to ensure that all processes for children remained safe was emphasised.

Specific attention was drawn to work being undertaken in relation to criminal exploitation, as detailed on page 134 of the report. In particular, the importance of listening to young people and a quote received from a young person who had received support for Barnardos was presented.

In conclusion, reference was made to the priorities for 2023-2024 as detailed in the report, which highlighted the amount of work that was being undertaken throughout the partnership.

Arising from the presentation, the Director for Children's Services advised that V Buchanan had been working with the authority as a partnership for approximately two years and the partnership had been aware of the challenges faced by Children's Services in recent years, and having an independent, critical friend approach to scrutiny, had been very helpful for the Directorate. Assurance was provided that the work was being undertaken appropriately to keep children safe. Reference was made to family safeguarding and the multi-disciplinary model of working approach being taken across the board to support children from birth through to 25 years for some young people. It was noted that this approach was beginning to make a difference, especially in terms of family setting being the right place for most children however, having the reassurance that children who were at need of urgent action were kept safe.

37 **Questions Under (Council Procedure Rule 11.8)**

There were no questions to the Chair pursuant to Council procedure Rule 11.8.

Meeting ended at 6.10pm.

CHAIR

DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item no. 6a**

DATE	**14th March 2024**
TITLE OF REPORT	**Revised Terms of Reference**
Organisation and Author	Dudley Metropolitan Borough Council Dr Mayada Abu Affan, Director of Public Health mayada.abuaffan@dudley.gov.uk
Purpose	• As requested at its meeting on the 14th December 2023, the purpose of this paper is to provide further assurance and guidance on the options for voting rights for the HWB Board. • The options provided are in-line with guidance from *the S102 of the Local Government Act 1972 and Making an impact through good governance - A practical guide for health and wellbeing boards* and guidance (appendix 1). • The Terms of Reference from other HWB Board's across the West Midlands have also been sourced and reviewed to ensure consistency of voting rights across the patch (appendices 2, 3, 4, 5 & 6).
Background	Following agreement at the Board development sessions held in January 2023, the Terms of Reference have been updated and also recent changes in membership. At its meeting on the 14th December 2023 the Board sought further guidance on the options for voting rights.
Key Points	This report presents, for approval, revised Terms of Reference for the Health and Wellbeing Board update to include: - agreement on voting rights of the Board - the proposals contained within this report ensures compliance with constitutional requirements

	- appropriate revised membership and representation to reflect recent approval on the 8th June 2023 to co-opt additional members - the recommendation that the Board will publish an annual report on the progress that has been made against the Health, Wellbeing and Inequalities Strategy - the recommendation for the Terms of Reference to be reviewed at the first meeting of each municipal year - the sub-groups under the HWB Board which will deliver on the goals in the Board's strategy. *To note - There are specific issues about the role of council officers on the board. In some areas, both council elected members and council officers are uncomfortable about the idea of officers having voting rights, for example in case of awkward splits along party lines. Some boards are happy with council officers having voting rights, taking the pragmatic view that voting will hardly ever be necessary. Other HWB Boards, have, with the agreement of all board members, removed the right of officers to vote, because of concerns about potential awkward splits along party-political lines. Either of the above solutions is acceptable – the important point is that boards should have discussed and made a decision about voting rights of members, in advance of any voting having to take place, rather than allowing the situation to be decided by default.*
Emerging issues for discussion	This is the guidance on voting rights on HWB Boards: *Ordinarily S102 of the Local Government Act 1972 prevents non members of the Council from voting at section 102 committees except in relation to a specified set of committees. However, regulation 6 of the Regulations provides that unless the Council chooses to restrict voting rights to certain members of the Health*

	and Wellbeing Board, all members of the Health and Wellbeing Board will have voting rights. *Although Health and Wellbeing Boards have a unique role and membership requirement, the voting regulation presents a problem to local authorities. It is highly unusual to have officers of the council and (potentially) external partners voting on a council committee since this goes against the principles of local democracy and decision making by elected representatives.* Options for voting rights based on other HWB Boards: 1. All members of the Health and Wellbeing Board will have voting rights, **including** council officers 2. All members of the Health and Wellbeing Board will have voting rights, **except** council officers 3. Voting Rights in addition to Councillors: the statutory representatives from the Integrated Care Board and Healthwatch (and their substitutes if required) will be entitled to vote at meetings but Co-opted Members and Council officers will not. The recommended option would be option 1. **To note** Walsall Council's HWB Board TOR – do not stipulate voting rights – Appendix 2 Birmingham City Council's HWB Board TOR - do not stipulate voting rights – Appendix 3 Sandwell Council's HWB Board TOR – cabinet members, representatives from the CCG and Healthwatch representative have voting rights, council officers and discretionary members do not have voting rights **There are four places for Sandwell and West Birmingham CCG. All CCG representatives are eligible to vote but there are*

	only 3 votes available at any Board meeting. The CCG will specify which representatives are voting at the start of the Board meeting – Appendix 4 Solihull Council's HWB Board TOR - do not stipulate voting rights, however, the TOR do state that substitutes, whilst able to attend and participate in the Board, will not have voting rights – Appendix 5 Wolverhampton Council's HWB Board TOR – stipulates that decisions taken by Health and Wellbeing Together are generally done so by consensus. If a Board decision should require a vote, then all members may participate having one vote each; in the event of a tie then the Chair will have the casting vote. Observers do not have a vote. – Appendix 6.
Key asks of the Board/wider system	• To agree voting rights • To agree the updated Terms of Refence for the Board, noting that changes in councillor membership requires separate approval.
Contribution to H&WBB key goals: • **Improving school readiness** • **Reducing circulatory disease deaths** • **More women screened for breast cancer**	Dudley Health and Wellbeing Board will act as the strategic delivery structure to co-ordinate delivery of agreed actions and pieces of work aligned to the agreed key goals.
Contribution to Dudley Vision 2030	Dudley Health and Wellbeing Board's focus is on prevention and the wider determinants of health and to reduce health inequalities and improve the health and wellbeing across all stages of life by working with our communities.

Contact officer details

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Louise Grainger, Casual Public Health Project Manager
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Appendix 1 - Making an impact through good governance - A practical guide for health and wellbeing boards

Making an impact through good gove

Appendix 2 – Walsall Council HWB Board Terms of Reference

Walsalls Health and wellbeing Board 29-

Appendix 3 – Birmingham City Council HWB Board Terms of Reference

Appointment of Birmingham Health

Appendix 4 – Sandwell Council HWB Board Terms of Reference

Sandwell HWB APPROVED Constitu

Appendix 5 – Solihull Council HWB Board Terms of Reference

HWBBTOR2021revisedFinal.docx.pdf

Appendix 6 -Wolverhampton Council HWB Board Terms of Reference

Wolverhampton HWB TOR.pdf

Dudley Health & Wellbeing

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Dudley Health & Wellbeing Board

Dudley Health and Wellbeing Board – Terms of Reference Update August 2023

The Health and Wellbeing Board has responsibility for health and wellbeing across Dudley.

Core Purpose

1.1 Dudley's Health and Wellbeing Board provides strategic leadership, oversight and democratic accountability for the health and wellbeing of those who live, study and work in Dudley. This includes a focus on reducing health inequalities.

1.2 The Board adds value by leveraging its unique role in bringing leaders together from across the community, voluntary and public sector services in Dudley to take collective action on health, wellbeing, and inequalities.

Role

2.1 The Board has a statutory role, outlined in the Health and Social Care Act 2012

- assessing the health and wellbeing needs of the local population in Dudley and publishing a joint strategic needs assessment (JSNA)
- publishing a Joint Local Health and Wellbeing Strategy (JLHWS) that should directly inform the development of joint commissioning arrangements (see section 75 of the National Health Service Act 2006)
- encouraging integrated working across health and social care
- developing a Pharmaceutical Needs Assessment (PNA)

2.2 To support this role the Board will:

- advocate for partnership working across Dudley to improve health and wellbeing, prioritising action to reduce health inequalities and encouraging integration through the Health and Care Partnership Board.
- develop an in-depth and longer-term place perspective, including a focus on the wider determinants of health working with the Forging a Future Executive and other Strategic Partnership Boards in Dudley, the Black Country, and the West Midlands.
- work with partners across Dudley to embed community participation and involvement across the system to improve health and wellbeing.
- ensure that services are commissioned based on health and wellbeing needs, and that there is equitable access and provision.
- develop outcomes focussed action plans to support the implementation and evaluation of Dudley's Joint Health, Wellbeing, and Inequalities Strategy goals.
- hold the Dudley system to account and have regular progress reports made to Board on the delivery of the goals outlined in the Strategy, as well as other outcomes from the JSNA.
- advocate for Dudley and its health and wellbeing needs and approach within the Black Country, West Midlands and a national level.

Board Member Roles

3.1 Board members will:

- recognise that every Board member is an equal and active partner bringing different experiences and knowledge.
- endeavour to act first in the interests of the health and wellbeing of those who live, study and work in Dudley and working collaboratively together.
- contribute to delivering the health and wellbeing strategic goals including a reduction in health inequalities, to champion the work of the Board, drive board decisions and goals through individual organisations and networks.

- adopt an integrated commissioning approach
- ensure Board meetings are effective by:
  - attending meetings
  - attending Board development sessions
  - producing reports in a consistent format

Governance and Accountability

4.1 The Board will work other Boards and partners across Dudley *(See Appendix A)*, the Black Country and West Midlands.

4.2 The Board will have a Forward Plan which will be shared and agreed with Board Members and accessible on Dudley Council's Website.

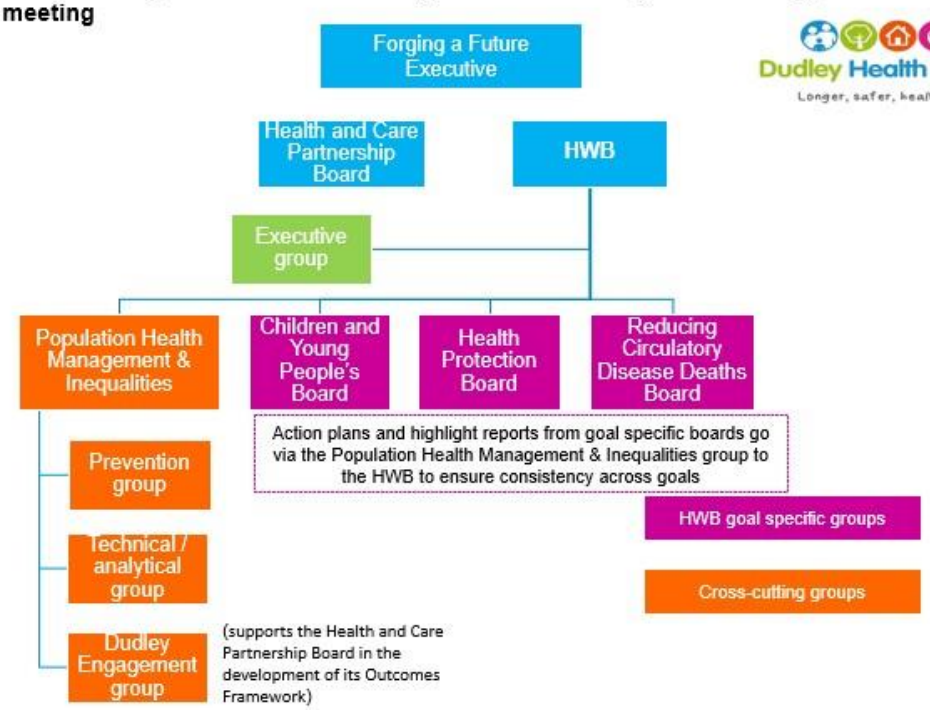
4.3 Agendas and supporting papers will be issued at least five clear working days before each meeting. Minutes will be produced and, at the next meeting, confirmed as a true record of the meeting to which they refer and signed by the Chair.

4.4. The minutes will be accompanied by an action tracker which will be used to update on the progress made on specific actions set at Board meetings.

4.5 There are several sub-groups under the Board that proactively support the delivery of the Health, Wellbeing and Inequalities Strategy. These are shown in Diagram 1.

Diagram 1

Proposed governance for Dudley's Health and Wellbeing Board for delivery of the strategy - for formal agreement at September's HWB meeting



Health and Wellbeing Board Membership

5.1 The core members of Dudley's Health and Wellbeing Board are:

Organisation	**Role**
Dudley MBC	Cabinet Member for Health and Wellbeing (Chair)
	Cabinet Member for Adult Social Services
	Cabinet Member for Children and Young People
	Cabinet Member for Housing
	One member from the Opposition Group

	Director for Public Health and Wellbeing
	Director of Adult Social Services
	Director of Children's Services
	Director of Housing
Black Country ICB	Dudley Managing Director
Dudley Group NHS Foundation Trust	Chief Executive
Dudley Council for Voluntary Service (CVS)	Chief Executive Officer
Dudley Healthwatch	Chair
Black Country Healthcare NHS Foundation Trust	Chief Executive
Dudley Safeguarding Board	Independent Chair
Dudley Primary Care Collaborative	GP
Dudley Integrated Health and Care NHS Trust	Chief Executive
West Midlands Police	Chief Superintendent
West Midlands Fire Service	Operations Commander
West Midlands Ambulance Service	Head of Strategic Planning
Church of England	The Bishop of Dudley

5.2 The Board can co-opt additional members on a temporary or permanent basis, with agreement of Board members. Other colleagues will attend by invitation of the Chair or Vice Chair in relation to specific agenda items.

5.3 Each Elected Member representative shall serve for their full term of twelve months commencing and ending with the Annual Meeting of the Council in May of each year.

5.4 If members are unable to attend a meeting, they may be substituted as a last resort, by notifying Democratic Services at least 24 hours prior to the meeting.

5.5 The Board cannot require any partner to act in a way contrary to its statutory responsibility.

5.6 At its first meeting in each municipal year, all Board members, will elect a Chair, and appoint a Co-Chair from a different agency to the Chair.

5.7 The Board will be advised and supported by officers from the local authority.

Meetings of the Board

6.1 The Health and Wellbeing Board will meet quarterly and in public. Dates and times of meetings will be agreed and published in advance. Additional meetings can be convened as required.

6.2 The provision of the Local Government Act 1972, as contained in the Council's Constitution, will apply to Board meetings in terms of the Notice of Meetings and consideration of exempt matters. Unless specified on the Board agenda, the public may attend all meetings. The public agenda, minutes and reports will be published on the Council's Website.

Decision making

7.1. In the exceptional circumstances where decisions cannot be reached by consensus, voting will take place, on a 1 member, 1 vote basis.

7.2 The Board is entitled to make recommendations to any relevant decision maker on matters falling within its terms of reference. The Board may make recommendations on:

- policies and strategies
- the way funds are allocated
- allocation of pooled and other funds as they become available
- the realignment of resources where there is evidence that services are not contributing to the improvement of health and wellbeing outcomes for the Dudley population.

7.3 Commissioning decisions will only be taken when each commissioning Organisation providing funds is present or has previously conveyed their agreement to the Chair.

Quorum

8.1 Quorum of the Board will be achieved when the following members are present:

- Chair or Vice Chair
- At least one elected member
- Director of Public Health and Wellbeing or representative
- A second DMBC Director or representative
- Chief Officer, ICB or representative
- Two other agency's representatives.

8.2 Members and non-elected representatives are required to disclose any conflict of interests that may be so significant that they would be likely to prejudice their judgement of the public interest. In such circumstances, the Member would be required to withdraw from the meeting.

8.3 The majority of Board meetings will be held virtually via Microsoft Teams with additional developmental meetings held in person as required.

Quality Assurance, Outcomes and Performance

9.1 The Board will hold the health and wellbeing system, including partners, to account on the delivery of the goals outlined in the Joint Health, Wellbeing and Inequalities Strategy with the Board receiving regular progress reports.

9.2 Through the JSNA process the Board will review a wider set of health, wellbeing and inequalities outcomes on an annual basis and will make recommendations for commissioners.

9.3 The Board will report into the Forging a Future Executive to provide updates on work to support the Borough Vision.

Amendments to the Terms of Reference

10.1 The Director of Public Health and Wellbeing, in consultation with the Leader of the Council, the Cabinet Member for Public Health and Wellbeing and the Lead for Law and Governance be authorised to amend the Terms of Reference of the Board in accordance with wishes expressed by the Board.

Resources and Support

11.1 Democratic services will provide support to the Board with an officer and provide minute-taking and distribution of the agenda and associated papers.

11.2 The Health and Wellbeing Policy Officer in the Public Health and Wellbeing Directorate will support the coordination of the work programme for the Health and Wellbeing Board.

Code of Conduct and Declarations of interest

12.1 All members of the Board are required to disclose any conflict of interests that may be so significant that they would be likely to prejudice their judgement of the public interest.

Reporting Mechanisms

13.1 The actions of the Health and Wellbeing Board will be subject to independent scrutiny by the relevant Scrutiny Committee(s) of Dudley Council. The Board will publish an annual report on the progress that has been made against the Health and Wellbeing Board Strategy.

Dudley Health & Wellbeing

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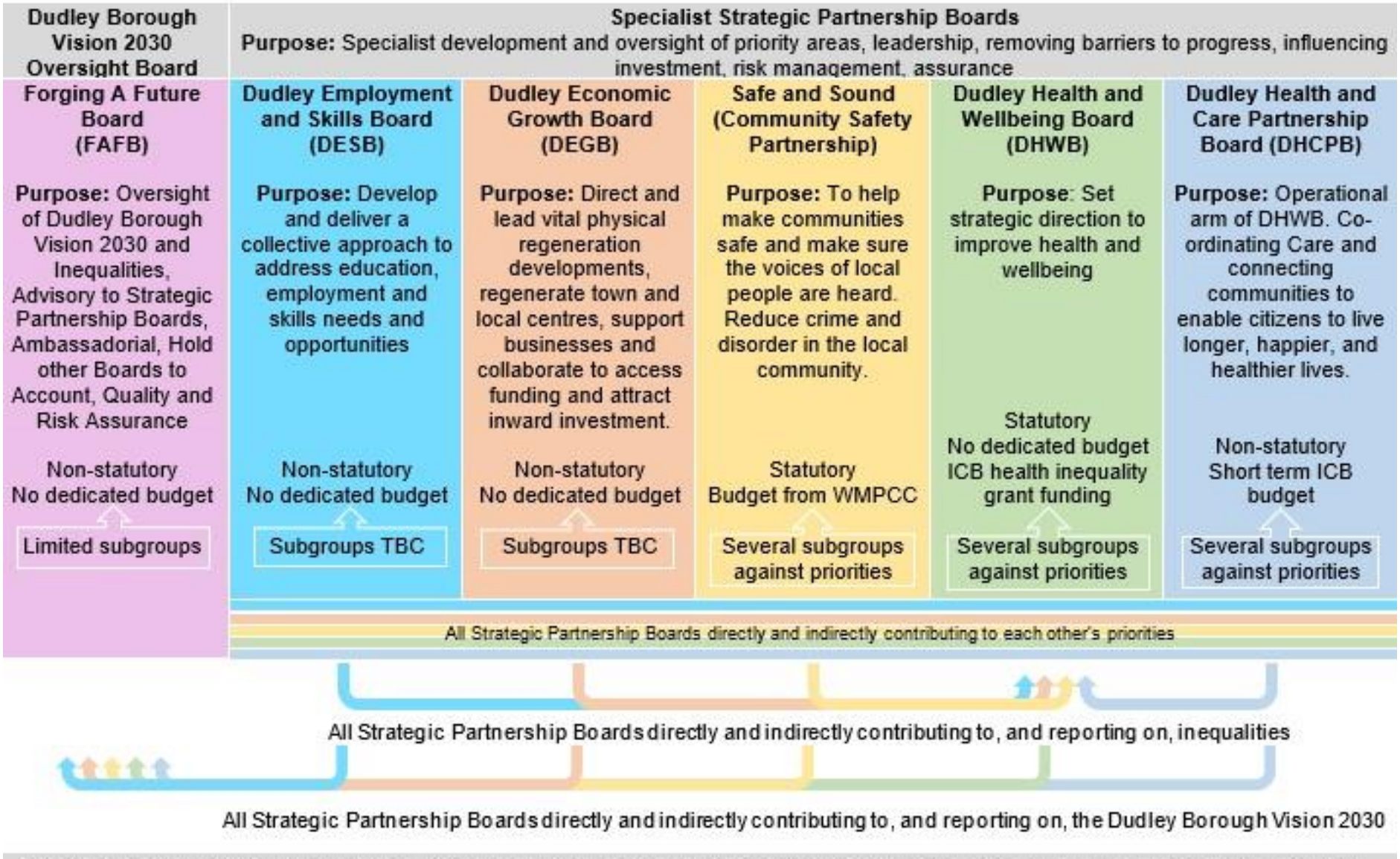
Appendix A – Draft Simplified Mapping of the Major Strategic Partnership Boards within Dudley – Subject to FAFE approval



Dudley Health & Wellbeing

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DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item no. 7(a)**

DATE	14th March 2024
TITLE OF REPORT	Joint Health, Wellbeing and Inequalities Strategy 2023-28 Breast Screening Deep Dive
Organisation and Author	Project leads: David Pitches, Consultant in public health and head of service, healthcare public health, Dudley Metropolitan Borough Council Joanne Essex, Program Manager, Dudley, Wolverhampton and South Staffordshire Breast Screening Programme with kind assistance from several other contributors Contact officer details – David Pitches, *Head of service, Health Care Public Health, DMBC (David.pitches@dudley.gov.uk)*
Purpose	This report is to: a) Brief the Board on breast screening uptake and coverage in Dudley, and what is currently being done to tackle this problem. b) To explore barriers, challenges and system solutions to improving screening uptake and coverage for discussion by the Board.
Background	On 8 June 2023, Dudley's Health and Wellbeing Board (HWB) agreed to select breast screening as one out of three of its priority goals for inclusion within Dudley's Joint Health, Wellbeing and Inequalities Strategy 2023-28.
Key Points	Women between the ages of 50 and 70 are invited once every three years to attend breast screening at a mobile unit which endeavours to be located not far from their GP practice. As a result of the COVID-19 pandemic there was a temporary drop in screening opportunities that the service has been working hard to overcome since. Within that there is considerable variation in the proportion of women who attend screening, with those living in areas of higher levels of deprivation in general being less likely to attend.

	We undertook an analysis of the available data to increase our understanding of the reasons why breast screening rates had fallen, and the extent to which this was a temporarily and recoverable issue driven by COVID versus a more systemic inequality. We identified certain areas that, based on their previous track record, were likely to recover well, so instead of taking a blanket approach across the borough, we prioritised a small area of the borough within Dudley and Netherton Primary Care Network (PCN). We established that this area had some of the highest levels of socio-economic disadvantage in the borough, and historically was under-served by the screening service as it was one of only two of six PCNs not to have identified a location for the screening mobile unit. We discussed with women and primary care staff in the areas and recognised that transport to other parts of the borough to attend the van presented a real barrier to some women. In partnership with the breast screening service, we identified a potentially suitable site for the mobile unit in central Dudley on local authority-owned land and negotiated to host it there in the spring of 2024 on a pilot basis to improve accessibility for women in three practices. With the assistance of local women, we co-produced promotional materials which are being distributed by local pharmacies and displayed in healthcare premises and local hairdressers and beauty salons. We have supported several local health promotional activities and day events in partnership with other groups to raise awareness of the breast cancer screening program. The latest data validates our approach and shows that overall, the coverage (proportion of eligible women who have been screened within the past three years) for Dudley is significantly better than the England average, but that Dudley and Netherton PCN remains significantly below the England value.
Emerging issues for discussion	Overall, the breast screening coverage in Dudley is significantly better than the England value but remains significantly lower than England for one PCN. We believe

	this validates our approach to developing very localised, targeted support to a small area to improve screening rates. Lessons learned and the transferrable skills and partnership being developed to improve breast screening could be adapted to take a similar approach to improving other cancer screening programs too. Both bowel cancer and cervical cancer in 50–64-year-olds have the most potential to gain by targeting Dudley and Netherton PCN.
Key asks of the Board/wider system	Continuing support to primary care and the breast screening service to promoted breast screening awareness, especially in areas of high levels of deprivation; Sharing learning of what works well across the wider health and care system; Consideration to how transferable skills learned during the breast screening improvement project could be used to help improve other screening programs.
Contribution to H&WBB key goals: • **Improving school readiness** • **Reducing circulatory disease deaths** • **More women screened for breast cancer**	Directly contributes to increasing the number of women screened for breast cancer.
Contribution to Dudley Vision 2030	Directly contributes to Dudley being a place of healthy, resilient, safe communities with high aspirations and the ability to shape their own future and the 2030 goal of improved health outcomes and higher wellbeing.

Contact officer details
David Pitches
Head of Service, Health Care Public Health

Dudley Health and Wellbeing Board

Deep Dive Report on Breast Cancer Screening, March 2024

Key contributors (* Dudley HWB leads)
Oluwagbemisola Arolasafe, *Foundation Year 2 Doctor (formerly at DMBC)*
Parminder Bhatia, *Health Improvement Practitioner, DMBC*
Meroe Bleasdille, *Public Health Manager, DMBC*
Jayne Burness, *Health Inequalities Lead, Dudley, Wolverhampton and South West Staffordshire Breast Screening Programme*
Shelagh Cleary, *Public Health Manager, DMBC*
Joanne Essex*, *Program Manager, Dudley, Wolverhampton and South Staffordshire Breast Screening Programme*
Neil Langford, *Senior Intelligence Analyst, Public Health Intelligence, DMBC*
David Pitches*, *Consultant in public health and head of service, healthcare public health, Dudley Metropolitan Borough Council*

Executive summary
This report outlines why breast cancer screening is an important health service for women in Dudley and why it has been selected as a key priority for Dudley's Health and Wellbeing Strategy 2023-28. Historic trends at borough and primary care network level are presented, along with mortality and screening data. The impact of the COVID-19 pandemic on screening coverage and uptake is explored. Analysis of local data has been undertaken to prioritise areas of particular concern and opportunity. Having identified particular areas and primary care practices for focus, a description is provided of interventions being undertaken or planned to support improvements in screening uptake in areas that have historically experienced barriers to accessing screening, resulting in low uptake. It should be noted that results, in terms of improvements to screening uptake, will not be available until some time after the areas have invited women for screening.

1. Why we screen for breast cancer

One in seven women born since 1960 can expect to be diagnosed with breast cancer during their lifetime; men can also get breast cancer but are at much lower lifetime risk at around one in 870[1]. Compared to other similar countries, the UK has a relatively high mortality rate from breast cancer, and in England in 2022 it was the most common cause of death in women who died between the ages of 35 and 64[2].

Thankfully, mortality due to breast cancer has nearly halved since the 1980s. Between 2016 and 2020, 96.1% of women diagnosed with breast cancer survived more than a

[1] Cancer Research UK (2016) cited in https://www.nice.org.uk/guidance/dg34/documents/final-scope
[2]https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregistrationsummarytables/2022#leading-causes-of-death

year and 85.9% survived at least five years following their diagnosis. However, there is an inequality gradient. For women living in the most deprived quintile, the latest five year survival figure is 82.1%, whilst for those living in the least deprived quintile, five year survival is 88.4%[3].

A number of factors have potential to increase the risk of developing breast cancer, including presence of certain genes, obesity, lack of physical activity, alcohol consumption and not breast feeding. Cancer Research UK has estimated around a quarter of cases of breast cancer are potentially preventable[4]; increasing age is a significant but unmodifiable risk factor.

Relatively few breast cancers could be entirely prevented exclusively through lifestyle changes, so improvements in survival have come primarily through a combination of better treatments once diagnosed, and early detection. The aim of breast screening is to detect breast cancer when it is at an early stage, before the woman is aware that she has it and before the cancer has had chance to spread around the body. Cancers that are detected early can be treated more easily and have better outcomes.

Because survival from breast cancer is much higher when diagnosed at an early stage, and because breast cancers can easily be detected by mammography (a type of breast X-ray) before they can be felt by the patient, breast cancer screening has been introduced to many countries to reduce the mortality from the disease. In the UK the NHS Breast Screening Programme has been estimated to save the lives of more than 1400 women a year[5].

A recent report has estimated the total cost of breast cancer to the economy (including direct treatment costs and societal costs including care and lost productivity) annually in the UK to be between £2.6 and £2.8 billion[6]. Applied to Dudley that could equate to around £14 million per year.

2. How we screen for breast cancer

The NHS Breast Screening Programme began in 1988. It aims to invite all women aged 50 - 70 years old for breast screening once every three years. The screening programme also offers women over 70 a free breast screen every three years. These women will not be sent an invitation but are encouraged to call their local service to make an appointment that suits them.

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[3] NHS Digital. Cancer Survival in England, cancers diagnosed 2016 to 2020, followed up to 2021. Adult cancer survival data tables for 2016 to 2020 diagnoses. https://digital.nhs.uk/data-and-information/publications/statistical/cancer-survival-in-england/cancers-diagnosed-2016-to-2020-followed-up-to-2021

[4] Cancer Research UK: breast cancer risk. https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/breast-cancer/risk-factors

[5] Indicator Definitions and Supporting Information - breast screening uptake: aged 50 to 70 years old. OHID Fingertips

[6] The cost of breast cancer. Modelling the economic impact to the UK. DEMOS (2024) https://demos.co.uk/wp-content/uploads/2024/01/Cost-of-Breast-Cancer-Report.pdf?utm_source=The%20King%27s%20Fund%20newsletters%20%28main%20account%29&utm_medium=email&utm_campaign=14306009_NEWSL_HMP_Library%202024-01-23&dm_i=21A8,8IML5,FNH0UY,Z8V82,1

Once every three years, all women at any given GP practice who are aged between 50 and 70 (unless ineligible for some reason) will be invited to attend for screening when the mobile screening unit is next visiting a location close to their GP practice. Hence some women may not receive their first invitation until they are 51 or 52.

The Dudley, Wolverhampton and South Staffordshire Breast Screening Service ("Breast Screening Service") is responsible for breast screening in Dudley and some of the surrounding areas. Screening usually takes place in a large mobile screening unit (Figure 1) which is periodically moved to different locations around the area, such as supermarket carparks. Support is available for women with additional needs such as learning difficulties and can also on occasion be arranged at Russells Hall Hospital. When a practice is due for its registered patients to be invited, those women who are eligible for screening will be contacted and invited to attend an appointment, which can be rearranged if not at a time that is convenient. The screening itself takes a few minutes, though women are advised to allow half an hour[7].

Figure 1 *The Dudley, Wolverhampton and South Staffordshire Breast Screening Service mobile unit*

Historically, screening sites have been used in four of Dudley's six PCN areas, the exceptions being Halesowen PCN and Dudley and Netherton PCN as suitable sites have not been available. The most frequently used site is the Asda carpark in central Brierley Hill. Unfortunately not only has Dudley and Netherton not had a suitable screening site identified until recently, it also has the lowest breast screening coverage and some of the highest levels of deprivation in the borough. Therefore accessing the mobile unit when located at Brierley Hill for those women coming from Dudley and Netherton has been cited as a significant barrier to screening.

[7] Breast screening program – frequently asked questions. https://www.bscreen.org.uk/Questions

Unlike other NHS screening programs, breast screening is unusual in that there is a narrow window of opportunity to increase uptake in a given GP practice population that only comes around once every three years. Because screening involves the use of low dose X-rays, there is a practical limit to the minimum safe time between screening rounds. This also means it is very difficult to change the sequence in which practices are selected for screening.

Preparation begins several weeks before invitation letters are sent out, as practices are informed that their patients are almost due to be invited for screening. The screening service works with practices to identify specific groups of patients such as those who have a learning or physical disability for which additional support may be required. The screening service also seeks to identify women who are eligible and reside in care homes so that a bespoke information pack can be sent to the premises to encourage attendance. Finally, the service checks that invitations are not sent inappropriately, for example to patients who may have very recently died.

3. Breast cancer diagnoses in Dudley

Between 2015 and 2019 (the latest publicly available data), 1,457 women were diagnosed with breast cancer in Dudley, which works out at an average of around 290 per year. This is not significantly different from the national incidence (as 95% confidence intervals overlap on the chart in Figure 2).

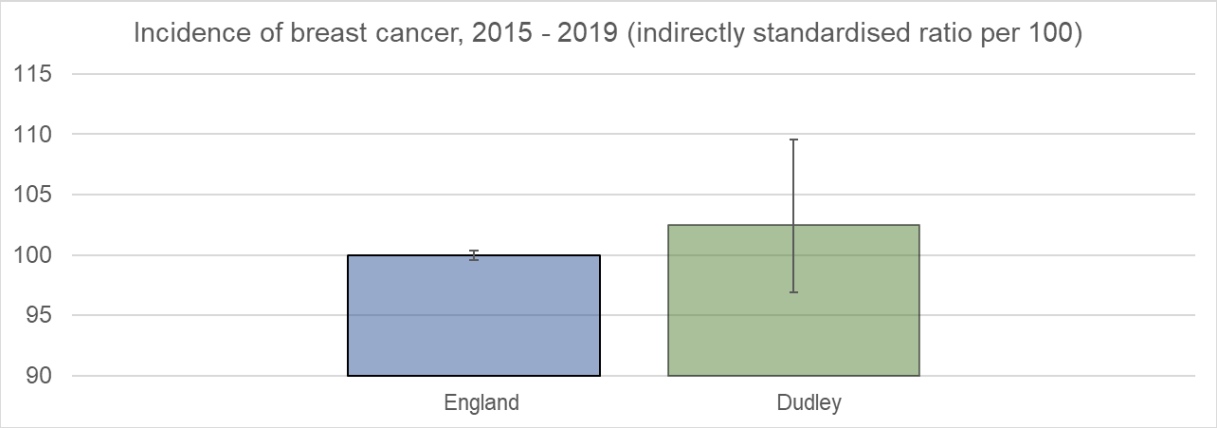


Figure 2 *Source: NHS England/OHID Fingertips: Local health*[8]

Similarly, when looking at available ward level data over a five year period, there is little variation in rates of diagnosis beyond what would be expected nationally (Figure 3), and nothing from the local data suggests significant concerns anywhere in particular.

[8] https://fingertips.phe.org.uk/profile/local-health

Area	Count	Value	95% Lower	95% Upper
England	233,645	100.0	99.6	100.4
Dudley	1,457	102.5	97.3	107.9
Wollaston and Stourbridge Town	81	128.6	102.1	159.8
Kingswinford South	78	119.8	94.7	149.5
Lye and Stourbridge North	59	117.2	89.2	151.2
Halesowen South	74	115.2	90.5	144.7
Brierley Hill	60	112.1	85.5	144.3
Hayley Green and Cradley South	64	111.6	85.9	142.5
Sedgley	68	107.6	83.6	136.4
Quarry Bank and Dudley Wood	60	107.0	81.6	137.7
Belle Vale	63	105.7	81.2	135.3
Netherton, Woodside and St Andrews	61	103.9	79.5	133.5
Amblecote	58	101.6	77.2	131.4
Kingswinford North and Wall Heath	69	101.0	78.6	127.9
Pedmore and Stourbridge East	67	99.4	77.0	126.2
St James's	59	97.4	74.1	125.6
Coseley East	52	96.2	71.8	126.1
Castle and Priory	51	95.4	71.1	125.5
Norton	61	94.7	72.4	121.6
Wordsley	59	94.6	72.0	122.1
Brockmoor and Pensnett	50	94.3	70.0	124.3
Upper Gornal and Woodsetton	60	94.0	71.7	121.0
St Thomas's	47	91.9	67.5	122.2
Cradley and Wollescote	49	90.5	66.9	119.6
Halesowen North	49	89.0	65.8	117.7
Gornal	58	88.7	67.4	114.7

Figure 3 *Ward level incidence of breast cancer in Dudley, 2015-19 (indirectly standardised ratio per 100). Source: NHS England/OHID Fingertips: Local health*

11,019 women in Dudley were referred urgently (as a result of screening or through other routes) to investigate suspected breast cancer over the five year period between 2018-19 and 2022/23, an average of 2,200 per year. It should be noted that this figure is considerably larger than the number of cases of breast cancer actually diagnosed, since for the majority of patients no cancer was ultimately diagnosed (Figure 4).

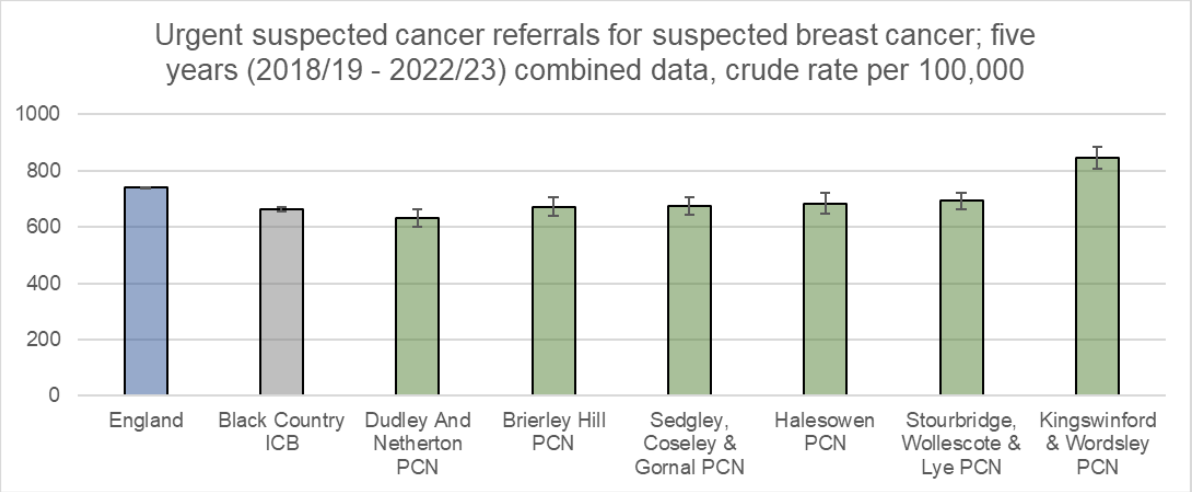


Figure 4 *Source: NHS England/OHID Fingertips: cancer services*[9]

Overall, nationally the breast screening programme was responsible for the detection of around a third of all new breast cancer diagnoses in 2018, and this number has been steadily increasing over the past two decades. Even so, the number of women who are found to have breast cancer as a result of routine screening is a very small proportion of the total number of women being screened – in 2021-22 for every 10,000 women screened, only 92 had breast cancer detected at screening (Figure 5)[10].

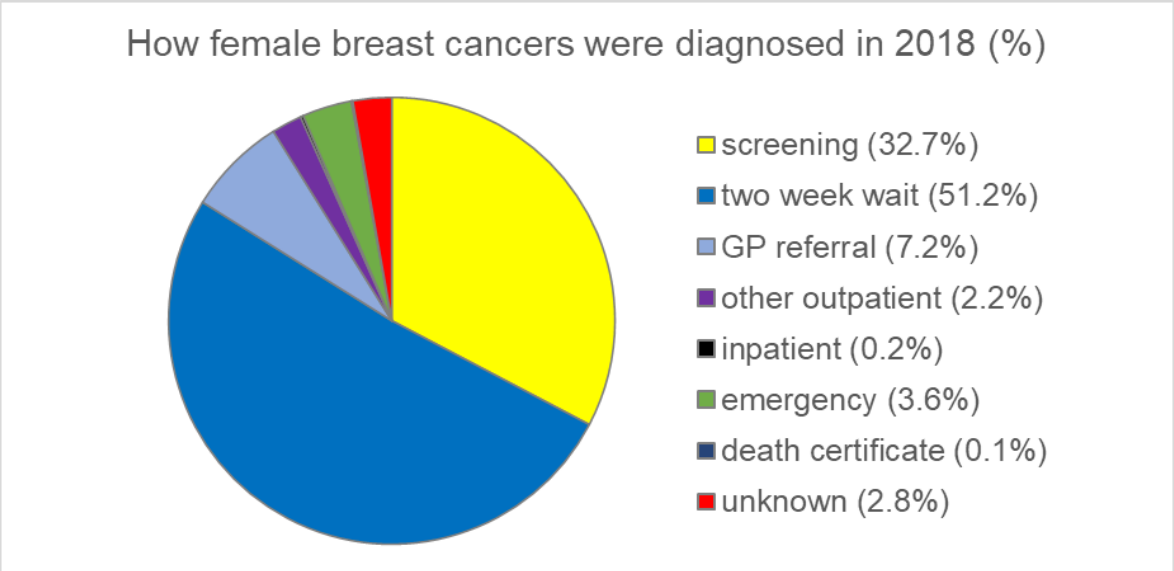


Figure 5 *Source: National Cancer Registration and Analysis Service (NCRAS)*[11]

[9] https://fingertips.phe.org.uk/profile/cancerservices
[10] https://digital.nhs.uk/data-and-information/publications/statistical/breast-screening-programme/england---2021-22
[11] https://www.cancerdata.nhs.uk/routestodiagnosis

The clear benefit of early detection through screening can be seen from Cancer Research UK data (Figure 6). A greater proportion of women are diagnosed at an earlier and more favourable stage of disease (i.e. stage I or stage II) if their diagnosis is made through breast screening than if their diagnosis is made as a result of coming through any other route[12].

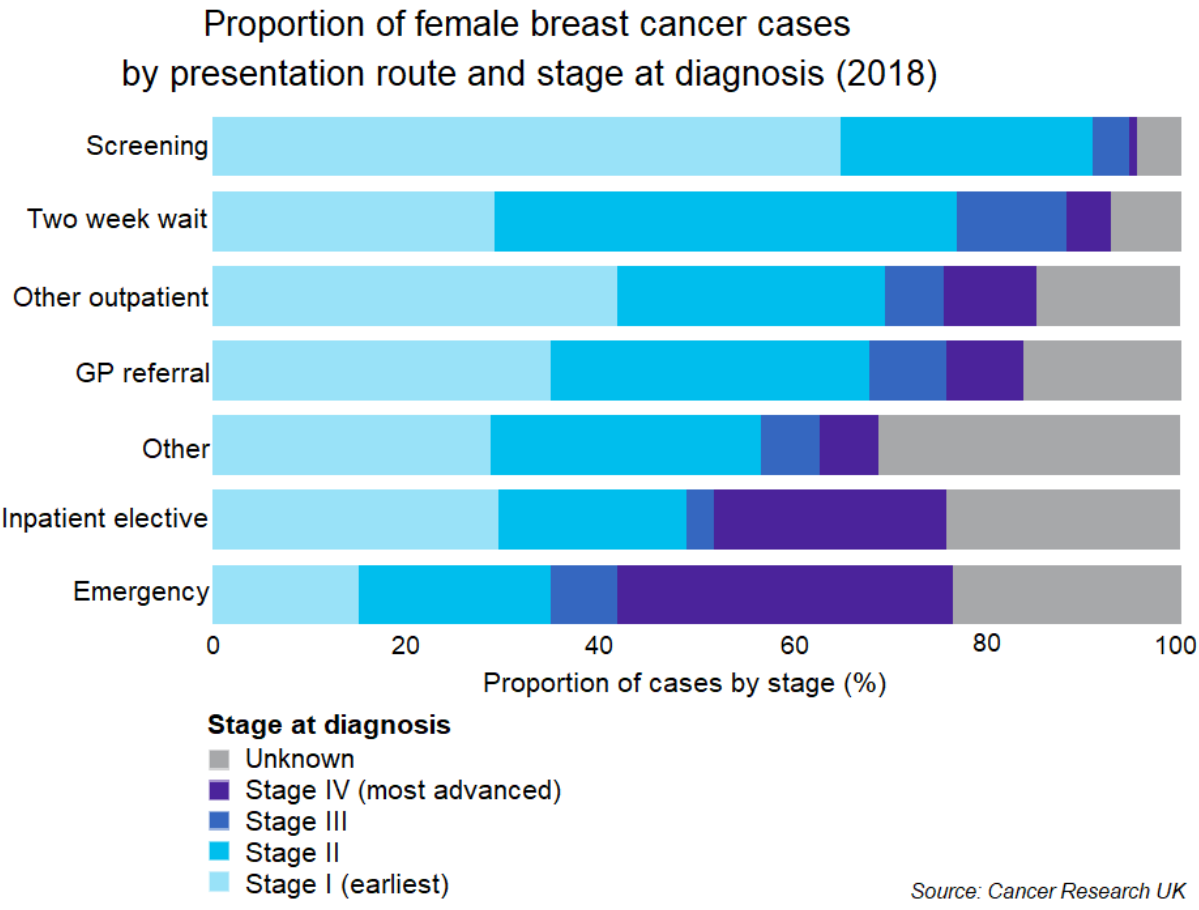


Figure 6 *Stage of diagnosis for various presentation routes for breast cancer*

4. Breast cancer mortality in Dudley

On average over the past decade, around 70 women in Dudley each year have died from breast cancer, and slightly fewer than half of these women (43%) were younger than 75 years when they died (Figure 7). Over the last ten years no men died from breast cancer in Dudley[13].

[12] https://crukcancerintelligence.shinyapps.io/EarlyDiagnosis/
[13] Office for National Statistics, mortality statistics - underlying cause, sex and age (https://www.nomisweb.co.uk/)

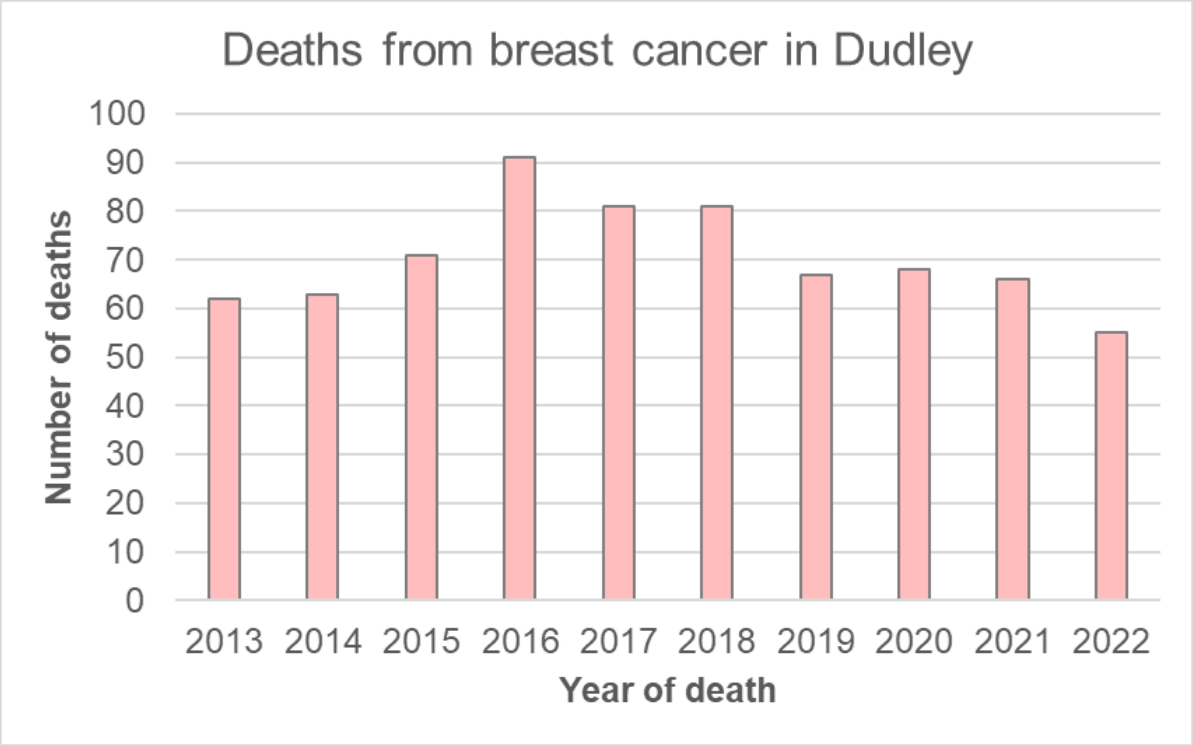


Figure 7 *Source: Office for National Statistics*

5. Breast screening rates in Dudley

There are essentially two key indicators that measure the success of breast screening:

- **Coverage.** This is defined as the proportion of women who are aged between 53 and 70 and eligible for screening, who have been screened at least once in the previous 36 months. Note that depending on when a woman's GP practice population is invited, she may be 50, 51 or 52 before she receives her first invitation, hence why the indicator starts at the age of 53. Also, until recently the indicator included people between the ages of 50 to 70, so historic data trends are not currently available beyond 2021-22.
- **Uptake**. This is defined as the number of women aged between 50 to 70, who were invited for breast screening in the previous twelve months and who attended breast screening within six months of the invitation.

There may be minor differences in the precise figures provided for both metrics. They can include people in one of two ways, (i) all those living in Dudley irrespective of whether they have a Dudley-based GP, or (ii) all those who have a Dudley-based GP, irrespective of whether they are a Dudley resident or not. Breast screening uptake is generally calculated according to where the woman's GP practice is based. Both metrics are also available at primary care network (PCN) level and at GP practice level. Note too that local authority time periods may run from January through to December whereas NHS data periods often run from April through to March the following year.

For both indicators the national "acceptable" target is 70%, with an "aspirational" target of 80%, though very few places have exceeded this.

The COVID-19 pandemic had a significant effect on both screening coverage and uptake, at least during the first half of 2020 and many screening appointments had to be postponed. This created a temporary fall in both coverage and uptake (Figure 8), which the Breast Screening Service and other screening services have been striving to make up for subsequently. But at least in the short term, the impact in Dudley meant that a service that historically had tended to provide a higher coverage than the national average, fell sharply and to significantly lower than what the national figure fell during the pandemic period. By the end of 2022 across Dudley, 22,400 out of a total of 36,182 women aged between 53 and 70 had participated in breast screening during the previous three years, giving a coverage of 61.9% for that period. This has raised the profile of breast screening and led to it becoming a key priority of Dudley's Health and Wellbeing Board.

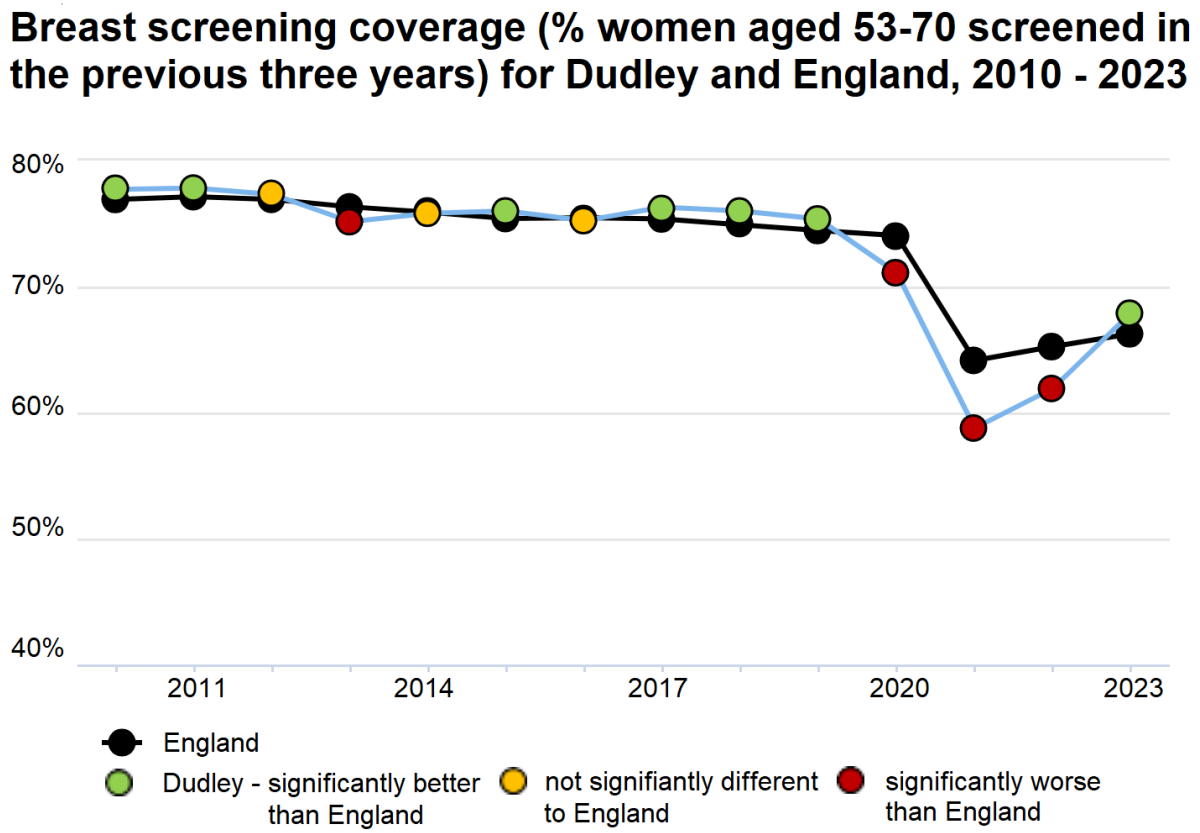


Figure 8 *Source: Public Health Outcomes Framework (Dudley residents)*

However, during 2023 the picture improved considerably, so that by the end of the year overall coverage of Dudley residents (67.9%) was significantly better than that of England (66.2%) though still yet to reach the 70% target. For the population registered with Dudley GPs, in aggregate, the coverage across Dudley's six PCNs (68.2%) now exceeds both that of the Black Country (63.6%) and the England coverage (66.6%) (Figure 9). Meanwhile uptake (women who have been screened within six months of receiving an invitation exceeded the Black County for Dudley as a whole, and three of Dudley's six PCNs exceeded the England uptake in 2022-23 (Figure 10). This improvement represents a significant achievement for Dudley's breast screening program.

A note of caution when analysing charts of uptake or coverage at PCN level is that because women in each GP practice are all invited over a short period of time and then must wait a further three years before the practice population is reinvited, in some years very few women in any given PCN will attend screening. Hence rates can vary considerably from year to year and if there is a significant fall in attendance during the period of invitations, data may not show complete recovery for up to three years.

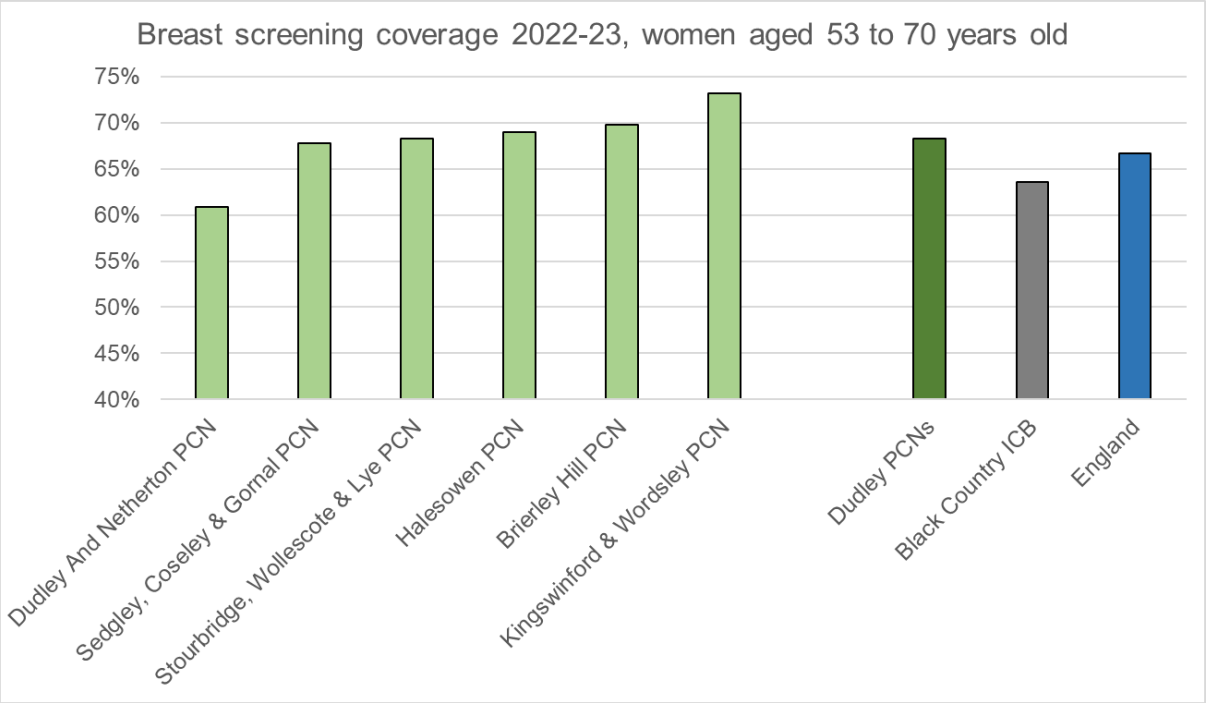


Figure 9 *Source: OHID public health profiles – cancer services (Dudley GP registrations)*

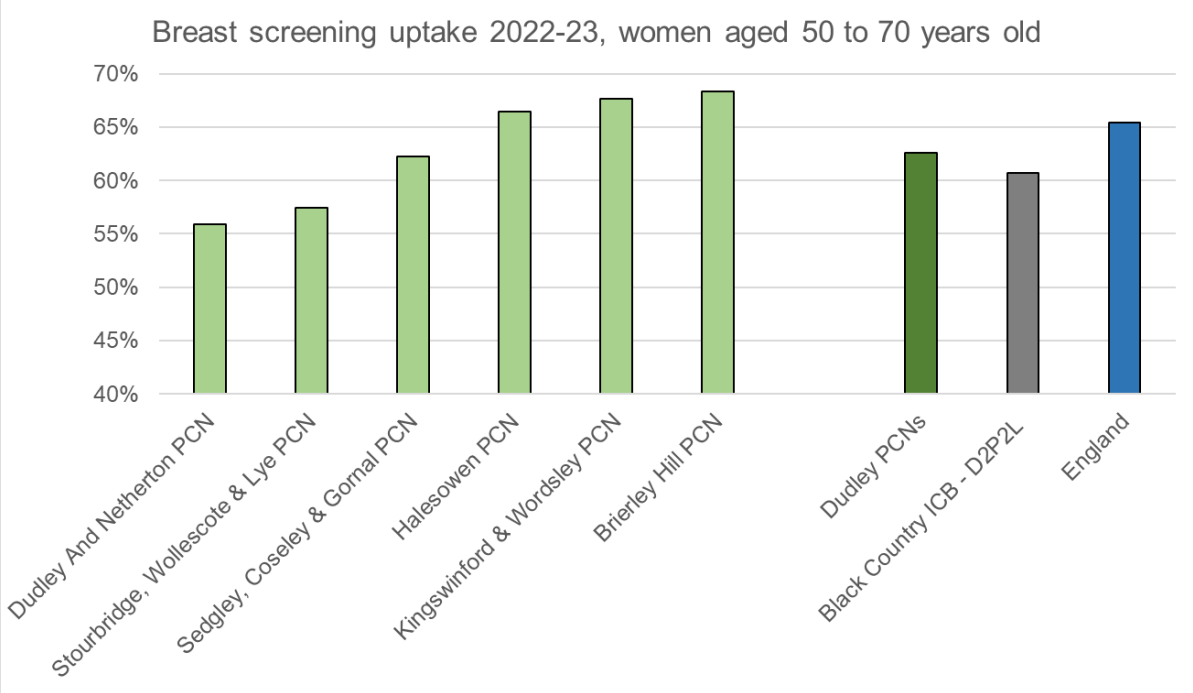


Figure 10 *Source: OHID public health profiles – cancer services (Dudley GP registrations)*

The coverage for one of the six PCNs, Dudley and Netherton, has consistently lagged several percentage points below the others (Figure 11). This PCN area also includes some of the most disadvantaged parts of the borough and hence it warranted a more in-depth analysis and local research to understand what some of the barriers to screening in this part of the borough could be.

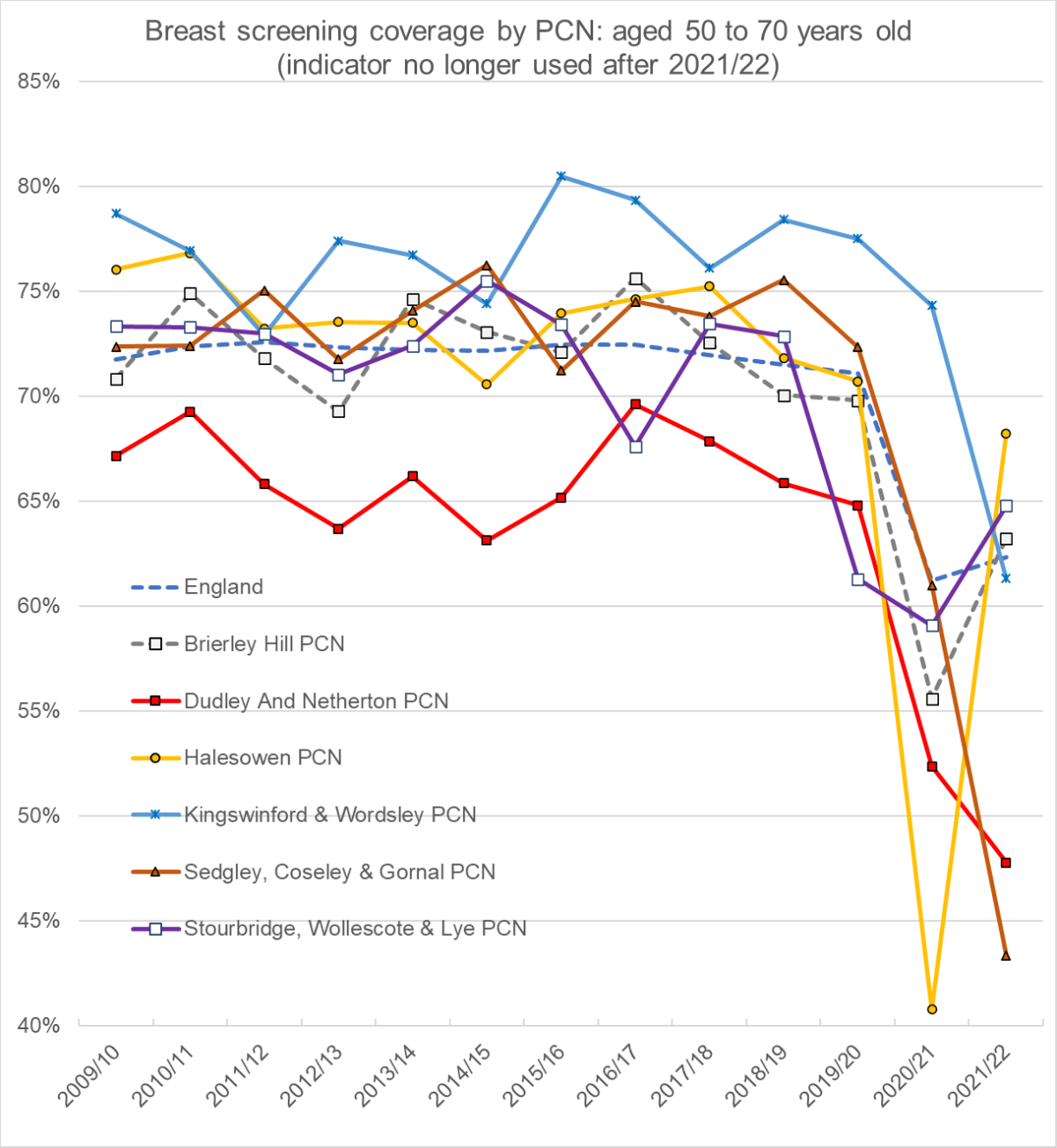


Figure 11 *Source: OHID public health profiles – cancer services (Dudley GP registrations)*

Of the eleven primary care practices in Dudley and Netherton PCN, three are scheduled to invite their registered and eligible women patients in the spring of 2024, and the remaining eight practice populations are due to invite their patients in late 2024 or early 2025. Consequently, any PCN-level changes in uptake and coverage will be gradual as the practice uptakes average out and significant improvements to published indicators may not become apparent for another two years. However, this provides an

excellent opportunity to pilot new and innovative approaches to improving uptake in the PCN during early 2024 with a view to rolling them out across the PCN later if successful.

6. Breast cancer screening literature search

To improve our understanding of which interventions are most strongly evidence based and likely to be most effective at encouraging women to attend breast screening, particularly those from more disadvantaged groups, we undertook a review of the literature and evidence base with the assistance of DMBC Knowledge Services and UKHSA Library Services. Drawing mainly from research conducted in the UK and comparable high-income countries, we paid particular attention to studies that considered breast screening in the light of inequalities, socioeconomic deprivation and ethnicity.

Education and information

- Across the articles explored, it was evident that provision of information leaflets had the ability to increase knowledge (benefits and harms) of breast cancer screening as well as elicit more positively explicit attitudes towards the service. However, there are likely to be disparities in engagement with information between ethnic groups, age profiles and whether they had a previously attended an appointment.
- Literature shared with the target audience must be factually correct and sensitive to people's perceptions, language needs and be culturally relevant.
- Education-based interventions in the community and healthcare settings can produce favourable outcomes in terms of the BCS uptake, knowledge, and beliefs among women.
- Education and information-based interventions need to be combined with additional healthcare support or incentives to have a positive impact on screening attendance.

Collaborative working with health care services

- Collaborative healthcare approaches, the effectiveness of specific interventions like scheduling assistance, and the potential of nurse-led interventions may improve uptake.
- Increased interaction with primary care physicians was linked to improved screening mammography adherence.
- Patient navigation services and increasing diversity in the physician workforce are potential interventions to improve access to preventive care, particularly for underserved populations.

Group interventions in the community

- Targeted group-based interventions with underserved and ethnic minority women in community settings can improve self-efficacy and increase health literacy; see more eligible women indicating an interest in or need for screening; increase attendance at subsequent screening appointments (even amongst participants who were under or never screened for cancer) were all cited as intervention results.

Reminders

- A telephone reminder can improve on the number of women attending breast screening appointments. Reminders may positively impact on underserved communities, but the significance of this impact differs between ethnic groups.
- Postal reminders and text message reminders can also show some improvement on attendance.
- Target strategies to improve health inequalities amongst ethnic and socially deprived groups.

Social media

- Social media may have a role to play in providing peer emotional support. Issues were highlighted around social media not always being managed by health professionals however, plus the importance of tailoring information to targeted populations.

7. Specific interventions and initiatives

Dudley Council's health and wellbeing directorate is working with a wide range of internal and external stakeholders and partner organisations to plan, develop and deliver a number of interventions that seek to address barriers to attending breast screening across Dudley and particularly within Dudley and PCN. These include:

- Primary care interventions
- Breast Screening Service interventions
- Improving pathways for people with learning or physical disabilities
- Improving access to screening for carers
- Community engagement events
- Improving geographic access to breast screening
- Breast screening awareness campaigns

8. Primary care interventions

General practices play a pivotal role in helping to raise awareness of screening and identifying people who do not take up screening. Evidence shows that by endorsing the value of screening, GPs can encourage people to attend who otherwise might not have done so.

Most practices in Dudley have a designated Cancer Champion, usually a member of the administrative team who has received specific training about cancer screening programs and who is able to support patients to be screened if they have queries or have missed a screening opportunity. The public health and wellbeing directorate at Dudley Council helped to initiate this training several years ago. This is now being led through the Black Country Integrated Care Board (BC ICB), supported by the Macmillan Cancer Facilitator. Several PCNs also have a cancer care coordinator to help them address systematic barriers and plan and coordinate interventions aimed at improving screening uptake.

It is imperative that breast screening data is recorded accurately within each practice. This enables practices to identify every registered patient who is eligible for breast

screening, including those with learning disability, mental health service users, homebound patients, and those who have not attended clinics, not responded to invitations or did not meet screening criteria during the previous cycle. Subject to data sharing agreements, this information may be shared with the Breast Screening Service to ensure that where appropriate women can receive the right kind of support and information, such as timed appointments, easy read invitation letters and leaflets or referral to a specialist service.

It is recognised that there are inconsistencies in coding patient screening data onto the primary care health information system (EMIS Web) for a number of reasons, including staff turnover, uncertainty about which codes should be used when there are many options, or failure to recognise the significance of certain codes (such as whether a patient has specific additional needs). This is in the process of being standardised by the NHS at a higher level for breast screening.

To help address this issue, the Cancer Care Coordinator at Brierley Hill PCN has also been writing a protocol for general practices to use which explains why this is important for practices, and which codes to use. It provides sample text messages and letters that can be used by Cancer Champions or other practice staff before and during the six-month period around the time the practice is inviting women to raise awareness and encourage patients to attend screening. This initiative is currently being piloted at the Three Villages Medical Practice in Brierley Hill PCN, with a view to wider rollout once it has been thoroughly tested in operation.

9. Breast Screening Service interventions

Around six weeks before a practice is due to invite its population for their three-yearly screening, the inequalities lead from the Dudley and Wolverhampton and South Staffordshire Breast Screening Service will visit the practice to remind staff what is expected of them in coming weeks. National and local marketing materials may be supplied by the service, and support is available to ensure practices correctly identify and contact the eligible population.

As well as working closely with general practices ahead of sending out invitations, the Breast Screening Service has been piloting an initiative to encourage women that have not attended their previous appointment. The intervention includes sending these women a personalised endorsement letter from their GP that informs them about the benefits of attending screening and encourages them to attend when they receive their invitation letter. Evaluation will inform how this intervention might be taken forward in Dudley.

Some people whose first language is not English find there is a lack of information in an appropriate format and language that could empower them to make an informed decision about screening. The Breast Screening Service worked in partnership with stakeholders across the Black Country ICS and the community to produce breast screening awareness information videos in English, Arabic, Hindi, Polish, Romanian and Urdu, which are amongst the languages most widely spoken across the Black Country. The videos have been shared on a number of platforms including the ICB website, the Healthwave app and through the community channels. Further work is being planned to produce videos in these languages for the bowel and cervical

screening programme. A new video is expected to be made during March 2024 featuring women from the “Black Breasts Matter” project demonstrating the mobile breast screening van.

10. Improving experience of screening for people with learning disabilities

People with learning disabilities can experience inequalities when accessing mainstream services. The Promoting Access to Main Stream Health Services (PAMHS) learning disabilities team at the Black Country Health Care NHS Foundation Trust has established a screening project group which includes representation from Kingswinford Medical Practice, Dudley Integrated Health and Care NHS Trust, BC ICB and the Breast Screening Service Inequalities Lead. The purpose is to review screening pathways for people with learning disability and ensure that they receive person-centred care that meets their individual needs when they access breast screening.

Key to success is enabling primary care practices firstly, to identify their registered patients who have a learning disability who are eligible for breast screening, and secondly, to inform the Breast Screening Service so that reasonable adjustments can be put in place that would enable them to attend. This can be achieved by carrying out an assessment to determine if a Capacity / Best Interest documentation and reasonable adjustments are required and ensure that referrals for specialist support are made in a timely manner. The revised pathway is being trialled in Kingswinford Medical Practice with a view to refining the pathway and rolling it out more widely across the four local authority areas within the Black Country ICB.

11. Carers

Women who are paid or informal carers are in another vulnerable group of people who can find it difficult to attend breast screening appointments. If someone who is a carer informs their GP practice, a “flag” may be placed on their records to indicate this, and around 8% of women eligible for screening in the first two practices where this flag has been searched for are listed as carers.

As there is no systematic route either for adding or removing the flag, GP records may not a particularly accurate means of identifying carers, but the numbers so far appear to be in line with expectations. Further work is ongoing to see how this information may be used, for instance when planning events about screening and health for carers.

12. Community Engagement Activity

Over the past year several community awareness-raising events have been held across Dudley to raise awareness of health and wellbeing in places where people are likely to congregate and be able to build trusting relationships. At some of these events breast screening awareness has been promoted by officers from Dudley Council Public Health and from the Breast Screening Service. Examples include:

- *Dudley College Awareness Event 23rd May 2023*
  BC ICB cancer team in partnership with the Breast Screening Service attended Dudley College event to raise awareness of Breast Health and other screening programs. They engaged with a number of students who wanted information about how to be breast aware and were motivated to cascade this information to other women in their community. Work is ongoing with the college and further health and wellbeing awareness events are anticipated.

- *Women's Health Event 11th June 2023, Ghausia Community Centre, Lye*
  This very successful community event with over 100 women attending was particularly intended for women from minority communities and included promotion of breast cancer along with other cancer screening programs and promotion of cardiovascular health.

- *African Caribbean Health and Awareness Event, 30th September 2023*
  Dudley Integrated Health and Care NHS Trust worked with partners including the High Oak Youth and Community Centre, the Dudley Caribbean Friends Association Reconnect Befriending Service, Change, Grow, Live and local diabetes ambassador Tony Kelly, to codesign and deliver a celebratory event heralding the start of Black History Month. The event at the Dudley African Caribbean Community Centre focussed on taking health advice and support out into the community, working with an under-served population.

  Health checks for blood pressure, kidneys, cholesterol and diabetes were available on the day through the Healthy Hearts Hub, Solutions4Health and the pharmacy team with University of Birmingham pharmacy students. Volunteers and NHS partners bought along information on a range of topics including Dudley Talking Therapies for Anxiety and Depression, Black Breasts Matter, Breast Screening, White House Cancer Support, Macmillan, Atlantic Recovery Centre, Thrive Into Work, Community Inclusion Team, Diabetes UK and Prostate Cancer UK. A number of fun activities including face painting, arts and crafts, a smoothie bike, masked theatre, music and dominoes were used to engage with the audience. Over 120 people of all ages attended the event and overwhelming feedback was that such events should be held more regularly.

- *Breast Cancer Awareness Month, October 2023*
  Breast Cancer awareness month is an ideal opportunity to amply awareness messages. To coincide with the month a number of awareness events were organised across the borough, including a breast cancer awareness event at The Faithful Coffee Lounge, Albion Street, Brierley Hill. This helped to raise awareness of screening and breast health; the importance of being breast aware, and knowing to report any unusual changes to a doctor. The breast awareness model proved effective at engaging with women and helping to dispel cultural barriers and myths in a relaxed ambience.

- *Don't leave your health on the shelf, November 2023*
  A pop-up health and wellbeing shop was set up for a week in the Churchill shopping precinct in central Dudley and included promotion of breast screening and other cancer screening programmes.

- *Breast screening awareness bus tour, central Dudley 29th February 2024*
  A breast screening awareness bus is visiting Dudley centre, which coincides with the area we are focussing a forthcoming campaign on, in late February 2024.

13. Community screening champions

White House Cancer Support have secured funding to work with African Caribbean communities to develop a community champion programme. This program aims to recruit and train people to become advocates and raise awareness of cancer screening within their communities. This initiative is a twelve month pilot, with the possibility of developing it further in other areas if successful, subject to funding.

14. Improving accessibility of the mobile breast screening unit

As noted earlier, Dudley and Netherton is both the PCN with the greatest level of socioeconomic deprivation in Dudley and has the lowest screening uptake. Three practices in the PCN, Keelinge House, St James 1 and Central Clinic, are due to be invited in early 2024 with the remaining eight practices not due for invitation until late 2024 or early 2025. These three practices are therefore a particular focus of attention as the key to improving overall screening rates in Dudley is to narrow the inequality gap and improve coverage in this area in particular.

Research carried out in Dudley with PCN practice managers and women who have not attended previous screening appointments has identified travel distance and accessibility as a barrier, especially for those with limited access to a car. Childcare is another factor, and women have cited not having time to go by themselves to Brierley Hill for screening if they are looking after children or grandchildren, though they felt a central Dudley venue would be easier to reach.

To address this geographical barrier, the Dudley Council healthcare public health team and community development workers have worked closely with the Breast Screening Service and other stakeholders to identify potentially suitable locations within central Dudley that are capable of hosting the mobile unit, thus helping to overcoming some of the accessibility issues faced by these women. The Dudley Council public car park in Stafford Street has been identified as meeting Breast Screening Service criteria for mobile unit locations. Plans are well advanced to relocate the mobile unit to Stafford Street on a pilot basis to enable patients to attend in approximately April 2024 if they are registered at one of these three practices in central Dudley. This intervention will subsequently be evaluated to determine if it has helped to increase the screening uptake in these three practices before making further plans for the remaining eight practices in the PCN later in the screening round.

15. Breast screening awareness campaign

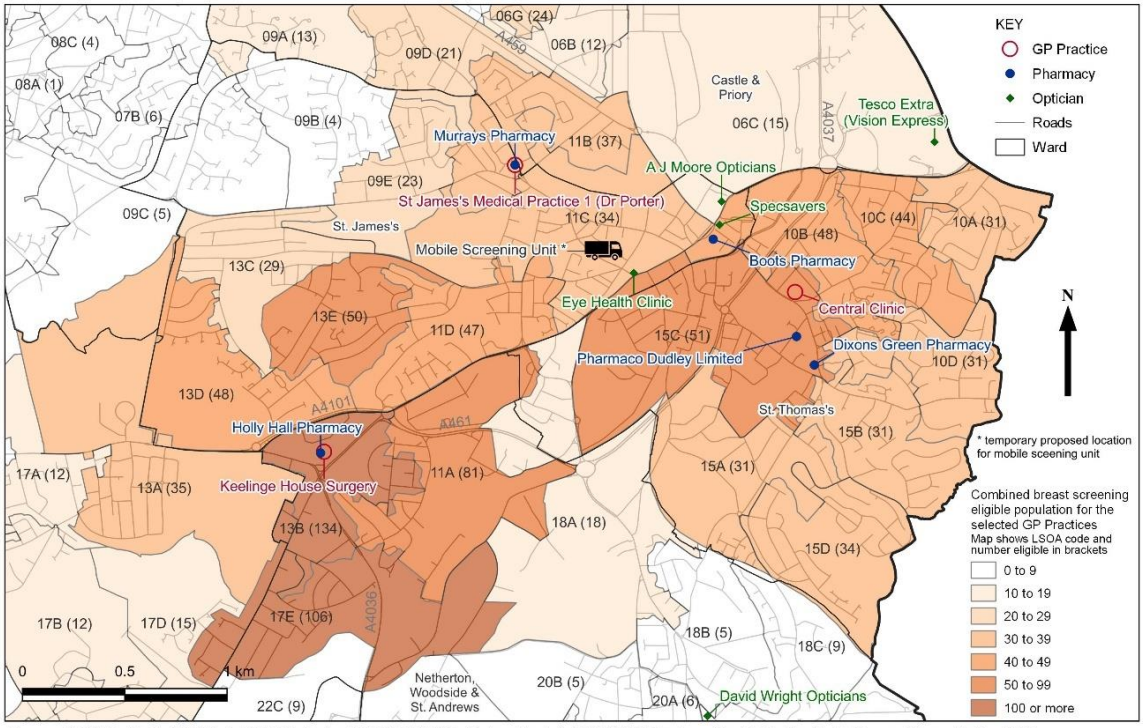
The area in which the majority of women live, who are registered at the three practices and eligible for screening in the spring of 2024 in the three practices in Dudley and Netherton PCN being screened shortly, has been mapped (Figure 12). This map includes the numbers of women in different locations to help define where most of the

women being invited currently live. Nearby pharmacies, optometrists, beauty salons and hairdressers were identified through Google Streetview and local knowledge.

A localised awareness campaign has been developed through close partnership working between Dudley Council, the Breast Screening Service, Local Pharmacy Committee (LPC) and the Local Optical Committee (LOC). The key message of the campaign is that their breast screening is due and that the mobile unit is now in their area. This represents a call to action following receipt of a screening invitation.

The campaign message will be delivered through five pharmacies and five optical practices closest to the three primary care practices, which are expected to be the most likely used by people registered at these practices. Pharmacies will use campaign branded bags when dispensing medicines, and display health promotion materials in their Health Zone area to encourage conversations with customers.

Selected Dudley and Netherton PCN GP Practices in relation to selected Pharmacy and Optician locations, showing the combined breast screening eligible population for the three GP practices by Lower Layer Super Output Area (LSOA)



Source: ODS DataPoint, NHS Digital / LLPG, Dudley MBC / EMIS Web (data extracted 18/01/2024). Produced by: Public Health Intelligence Team, Dudley MBC

Figure 12 *Map of the area around central Dudley towards Holly Hall, where an awareness-raising campaign is being prepared for launch in the spring of 2024*

The campaign has been developed through meticulous community engagement. Four very different creative designs were produced by Dudley Council's communications (CAPA) team and were tested with the target audience of women aged 50-71 who live in the Dudley and Netherton PCN catchment area. The Care Coordinator for Dudley and Netherton PCN sent a short questionnaire to 377 women from a variety of ethnic backgrounds from 10 practices across the PCN asking them their preferred design and why. 107 women responded to the questionnaire, and a large majority favoured

one particular design (Figure 13). This design has been selected for the campaign branding and will feature on dispensing bags and posters.

The campaign message will be delivered through various communication channels, including GP practices, Facebook advertising, posters in local Asian supermarkets, Dudley Library, Duncan Edwards Leisure Centre, faith settings, beauty salons, hairdressers, local schools and Family Hubs. In addition, a community engagement group has been established which includes partners from community and voluntary organisations to identify community and events at which the target audience can be reached.

Following the campaign, a robust evaluation framework is being planned to assess the effectiveness of the campaign alongside the impact of moving the mobile unit closer to where the local population lives. If successful it is anticipated that similar interventions will be undertaken when the remaining practices in Dudley and Netherton PCN are invited to attend screening from late 2024 and into 2025.

Figure 13 *The campaign design preferred by women in Dudley and Netherton*

16. Conclusions

Breast screening is organised in a relatively unusual way for NHS screening programmes. Although sensitisation can and probably should be taking place throughout the cycle, in reality there is a short period once every three years during which interventions to improve uptake have an opportunity to be implemented, especially in areas that historically are found to have a low uptake.

In the first year of the Health and Wellbeing Board strategy we have detailed how careful epidemiological analysis and on the ground research has identified particular locations within Dudley to prioritise interventions for improving uptake of screening. In the first few months of 2024 certain interventions, especially relating to accessibility and awareness of the mobile screening unit, are being piloted with a view to repeating them when other practices in the area are due to send invitations later in the screening round (2025). Breast screening coverage in Dudley appears to be improving since the difficulties of COVID, but we will continue to monitor this.

A further benefit of trialling these approaches to breast screening is the capacity building of primary care teams, particularly cancer screening champions in most practices and cancer care co-ordinators in primary care networks, who will be able to apply the lessons learnt to improve the uptake of other NHS screening programs.

17. Request to HWB

Dudley Health and Wellbeing Board is asked to note the content of this Deep Dive and progress against activities in the breast screening action plan. The ongoing support of partners to meet the objective of increasing breast screening across the borough, and particularly in areas and populations with greatest need, is appreciated.

Dudley Health & Wellbeing Board

Joint Health & Wellbeing Strategy 2023-2028 Outcomes: Breast Screening Overview

Domain	Period	Dudley Value	Dudley Count	WM Value	England Value
Overarching					
Breast screening coverage in women with learning disabilities aged 50-69 (%)	2022/23	78.2	136		47.6
Breast screening coverage: aged 53 to 70 years old (%)	2022/23	68.2	24,915		66.6
Breast screening uptake: aged 50 to 70 years old (%)	2022/23	62.5	10,720		65.4
Referrals					
Urgent suspected cancer referrals for suspected breast cancer (per 100,000)	2018/19 - 22/23	698.5	22,868		740.1
Disease and death					
Mortality rate from breast cancer, all ages (female)	2021	35.5	66	31.6	30.3
Under 75 mortality rate from breast cancer (female)	2021	19.7	29	18.6	18.1
Incidence of breast cancer, standardised incidence ratio	2015 - 19	102.5	1,457		100.0

Key

- Better than England
- Similar to England
- Worse than England
- no England data available
- Higher than England
- Lower than England

Dudley Health & Wellbeing Board

Joint Health & Wellbeing Strategy 2023-2028 Outcomes: Breast Screening

Outcome	Dudley & Netherton	Brierley Hill	Sedgley, Coseley & Gornal	Stourbridge, Wollescote & Lye	Halesowen	Kingswinford & Wordsley	Dudley Value	Time period
	most deprived		Primary Care Network			least deprived		
Overarching								
Breast screening coverage in women with learning disabilities aged 50-69 (%)	79.5	64.0	63.2	81.3	83.3	89.7	78.2	2022/23
Breast screening coverage: aged 53 to 70 years old (%)	60.1	69.8	67.8	68.3	70.1	73.1	68.2	2022/23
Breast screening uptake: aged 50 to 70 years old (%)	55.8	68.4	62.2	57.4	66.4	67.6	62.5	2022/23
Referrals								
Urgent suspected cancer referrals for suspected breast cancer (per 100,000)	609.7	671.5	674.2	692.6	729.7	845.1	698.5	2018/19 - 22/23

Outcome	Dudley Central	Dudley North	Brierley Hill	Halesowen	Stourbridge	Dudley Value	Time period
	most deprived		Community Forum Area		least deprived		
Disease and death							
Incidence of breast cancer, standardised incidence ratio	99.1	96.6	104.4	102.4	108.3	102.5	2015 - 19

Key

- Better than Dudley
- Higher than Dudley
- Lower than Dudley
- Similar to Dudley
- Worse than Dudley

Joint Health & Wellbeing Strategy 2023-2028 Outcomes: Breast Screening Data Sources

Outcome	Data Source
Overarching	
Breast screening coverage in women with learning disabilities aged 50-69 (%)	EMIS web (Dudley GP data) / NHS Digital (England data)
Breast screening coverage: aged 53 to 70 years old (%)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 05/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Breast screening uptake: aged 50 to 70 years old (%)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 05/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Disease and death	
Incidence of breast cancer, standardised incidence ratio	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 05/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Mortality rate from breast cancer, all ages (female)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 05/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Under 75 mortality rate from breast cancer (female)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 05/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Referrals	
Urgent suspected cancer referrals for suspected breast cancer (per 100,000)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 05/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]

HWB Strategy 2023-2028 - Highlight Reports – Goal Achievements

Purpose

Bi-annual "Highlight Reports" will provide an overview of activity and progress of local shared projects supporting the delivery of the three goals of the Health and Wellbeing Strategy. These reports will describe what has been achieved against the outcomes, how collaborative working has aided this progress and identify new data and insights that have been released in the previous 6 months.

Highlight Reports will be used to increase awareness through organisations of delivery of the strategy and are intended for wider use with partners and the public, and to support a wider understanding of the priorities within the Health and Wellbeing Strategy.

Highlight Reports will provide an overview of each goal, describe what has been achieved in the previous reporting period and how collaborative working has aided this progress. Detailed implementation plans will continue to sit behind the Highlight Reports with risks escalated to the HWB Board as necessary.

Highlight Report

Goal 1. Children are ready for school

Goal 1 - Children are ready for school				
Reporting timeframe - 1st October 2023 – 31st March 2024				
RAG Rating – please complete status for goal achievement (tick relevant box)				
Red – no progress		Amber – Moderate progress		Green - Significant progress
Overall goal achievement/progress against outcome		**Overall goal achievement against reducing health inequalities**		
Red	RED	Red	RED	
Amber		Amber		
Green		Green		

Outcomes by 2028

- Children across Dudley will achieve a good level of development at the end of reception that is at least similar, if not higher, than the average for the West Midlands. While it has been improving, Dudley has consistently had a lower percentage (62% in 21/22) of children that are achieving a good level of development at the end of reception compared to the West Midlands (64%) and England averages (65%).

- The gap between children on free school meals who have a good level of development at the end of reception and those who are not eligible for free school meals will have narrowed. Only 45% of Dudley children on free school meals were school ready in 21/22 compared to 66% of children who were not eligible for free school meals

Who is leading this?	Goal sponsors: Phil Bullingham on behalf of Sal Thirlway, Service Director of Education, SEND & Family Solutions, DMBC Sarah Dougan, Contractor, Head of Children, Young People, Adults and Older People, DMBC

Goal 1 is focused on:

- Providing shared leadership to set the vision and 10- year strategic plan for whole-system early years transformation.
- Increasing integration of early years health, education and local authority services, so that parents and children do not have to repeat their stories. This means improving links both between services and between commissioning responsibilities.
- Working to keep the best parts of Family Hubs & Start for Life programme, by supporting the longevity of priority commitments and activities beyond the programme's 3-year funding period (ending on 31 March 2025).

What has been achieved for this reporting period under Goal 1: (please	**Speech, Language and Communication Needs** Dudley has poorer outcomes in the percentage of children achieving at least the expected level in communication and language skills at age 2-2.5 years

include specific achievements with respect to health inequalities)	and age 5 compared to the West Midlands and England averages. There has been a focus on making improvements in earlier identification and action on Speech, Language and Communication Needs (SLCN) during the past 6 months: <u>Wellcomm Toolkit Rollout:</u> The Integrated Early Years Service (IEYS) have delivered a rollout of the Wellcomm toolkit which helps to identify pre-school and primary school children who are experiencing barriers to speech and language development. Early years settings are now benefiting from a tool which enables them to recognise need and (pending any further assessment) undertake levels of support and intervention. This is a key aspect in supporting school readiness. We have seen an increase in confidence across the Early Years network where children are connected more rapidly to early identification pathways and targeted support for speech and language. The aim is to boost good levels of development measures for under 5's particularly around communication and language development and in response enable additional support via heath and hub services – such as home learning and parent coaching to compliment early years experiences and enhance school readiness. Health visitors will be accessing Wellcomm training in Spring 2024 with a view to embedding the toolkit into heath and development reviews. The Wellcomm data return tool has been developed and we will request returns from Spring term (retrospectively for autumn 23 then summer 24). This is a trial period of the tool with selected providers and is underway to ensure engagement in completion is optimised. We have had some positive feedback where gaps in language development are being identified earlier and

	interventions are in place. Speech and language services have fed back that early education provision are submitting referrals with Wellcomm assessment, showing children are receiving interventions early. Once the data is available, we will make further improvements to the offer based on the results. <u>SLCN Digital Offer</u> This is a resource hub and for parents and practitioners to access support and resources to support children's language and communication development from universal services onwards. The Speech Language Communication (SLCN) Digital Offer 'soft launch' February 2024 is underway. Further co production with Dudley Family Voices and stakeholders is ongoing. We will gather further feedback to inform development of this pathway. This approach has been advised by Speech and Language UK who are complimentary of the work we have undertaken his area. <u>Needs analysis and commissioning</u> A task and finish group from across the partnership is driving forward a whole-system approach to commissioning to meet local 0-24 SLCN. They will oversee the development of a needs assessment on SLCN which will be led by Public Health to inform commissioning and the development of a joint commissioning framework for 0-24 SLC support in Dudley. The needs assessment will be developed in early summer with the exception that a joint commissioning framework will be completed by April 2025. **Special Educational Needs and Disabilities** Equally, there has been a concerted effort to improve outcomes for children with special educational needs and disabilities (SEND).

	<u>Inclusion Hubs</u> The development of Early Years inclusion Hubs across the Borough had moved into its operation phase and children have commenced in their settings. This is linked to school readiness as inclusion experiences in mainstream settings can improve the early identification of need and to ensure children get the right support at the right time – connected to local services. 4 out of 5 Early Years Inclusion Hubs operational as of January 24, offering early intervention across the Borough. The 5th Hub for the Brierley Hill area was delayed due to a change in provider as part of the LA's due diligence. We are identifying a replacement resource to and will soon be able to determine timeframes. <u>Health Early Notification (EN)</u> The pathway enables health professionals to carry out their statutory duty to inform the LA where children are identified with SEND and where the need is likely to be ongoing. To ensure the right support is in place at the right time. The pathway has been revisited to raise its profile, new DCO will take lead going forward to embed further across health partners. Plan for a Black Country Early Notification process to be launched by March 24. Internal and partner work ongoing to rase awareness of the pathway. Referrals into the pathway remain low and we expect this to progress as the awareness work embeds. <u>Early intervention and assessment resource (AIRC)</u> This is a support service, which is targeted and a time bound intervention to support those reception year children who arrive at school where further assessment and support is required. The main purpose is to support the re-integration of children back to their mainstream provision, in addition to the upskilling of staff of the home school.

	0-19 (25 SEND) public health services Shropshire Community Health NHS Trust has been awarded the 0-19 (SEND) public health services contract from 1st April and Public Health are working with all providers to mobilise the new service. The first year of the contract will be a development year as this is a new service model for Dudley. To inform this we have been undertaking the following work: - Equity audit of health visiting outcomes by deprivation and ethnicity - Identification of key priorities for the new service, working with partners - Developing a governance framework for the service, which will involve key partners
Latest Data and insights	*All of the figures are in the appendix to enable font sizes to be larger* When interpreting the data against activities to improve school readiness in the borough, it is important to consider that initiatives such as the Family Hubs for example, were only being set up during 22/23. • In 22/23, Dudley was worse than England for all school readiness indicators (fig 1) and ranked 11th out of 14 local authorities in the West Midlands region for the overall proportion of children achieving a good level of development at the end of Reception (fig 2). • The overall proportion of children achieving a good level of development at the end of Reception and the proportion of children achieving the expected level in phonics in year 1 has increased in Dudley since 2021/22 (fig 3). However, the national average has increased more so the gap with Dudley has widened. • The proportion achieving the expected level in communication and language skills has

	remained the same in 2022/23 as the previous year in Dudley (fig 3), while the national average has increased, further widening the gap. • There has been no increase in the proportion of children with free school meal status achieving a good level of development at the end of Reception, which has resulted in a widening of the gap between children with and without free school meal status (figs 3 and 4). Dudley has the lowest level of good development for children on FSM in the West Midlands (fig 5). • The gap in the proportion of children achieving the expected level in phonics in year 1 for those children with and without free school meal status has narrowed slightly in 2022/23 (fig 4).
Opportunities	Delivering integrated early years assessment is key in this work. Some of this will be achieved by working with Shropshire Community Health NHS Trust as the new provider for the 0-19 Service. We will review ways of working across the integrated partnership network and become more effective in our joint work. For example, to strengthen the integrated review 2-2.5 year model and data sharing practices around the Ages and Stages Questionnaire (ASQ). There are opportunities to become more data driven to ensure that we are targeting the children and areas of greatest need to make quicker improvements. We will do this by: - developing “scorecards” for Family Hubs across a range of demographic and equalities indicators as well as service-level indicators. - undertaking equity audits to look at whether there need to be changes in service delivery and accessibility. - developing the SCLN needs assessment. The Growing Up in Dudley report has just been published and we will also need to take stock of the insights within it to help further shape this programme of work.

Challenges	Workforce capacity to deliver transformation and organisational change for some partners/services while continuing with business as usual is the biggest challenge. To address this, we will be developing a more robust programme management approach to delivering against school readiness. The latest data shows that while there has been some improvement in school readiness in Dudley, the rate of improvement between 21/22 and 22/23 has been less than that seen for the West Midlands and England averages, so the gap is increasing. We need to do more work to understand why this is the case and where greater improvements need to be made, noting that this work started part way through 22/23. There needs to be more focussed work on children on free school meals as there has been no improvement on school readiness between 21/22 and 22/23. The analysis on Child Poverty across Dudley has just been completed. This needs to be shared with partners and next steps agreed. A recommendation from this includes needing to look at the distribution of resource (workforce and expenditure) across the borough to ensure it is aligned with need. This also needs to be joined up with other work on poverty / financial wellbeing.
Milestones or expected achievements for the next 6 months	<u>SLCN:</u> 1. Continue to roll-out WellComm and monitor and act on data 2. Deliver an effective Digital Pathway for SLCN 3. Complete the SLCN needs assessment and commissioning framework <u>SEND:</u> 4. Fully operational Inclusion Hubs 5. For Co-production and Outcomes profiling to be embedded 6. For the partnership to build in data sharing systems to ensure integrated approaches are effective - so we can target support services.

	7. To increase usage of the early notification of need pathway. <u>0-19 (25 SEND) Public Health service:</u> 8. Successful mobilisation of new service 9. Equity audit of health visitor checks/outcomes completed 10. Development priorities identified across partners and being implemented, to include actions on equity <u>Other:</u> 11. Family Hub “scorecards” developed

APPENDIX

Figure 1

Indicator	Time period	Dudley (%)	Compared to England	England (%)
School readiness: percentage of children achieving a good level of development at the end of Reception	2022/23	63.3	Worse	67.2
School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception	2022/23	44.2	Worse	51.6
School readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception	2022/23	75.8	Worse	79.7
School readiness: percentage of children achieving the expected level in the phonics screening check in Year 1	2022/23	76.0	Worse	78.9
School readiness: percentage of children with free school meal status achieving the expected level in the phonics screening check in Year 1	2022/23	63.4	Worse	66.5

Figure 2

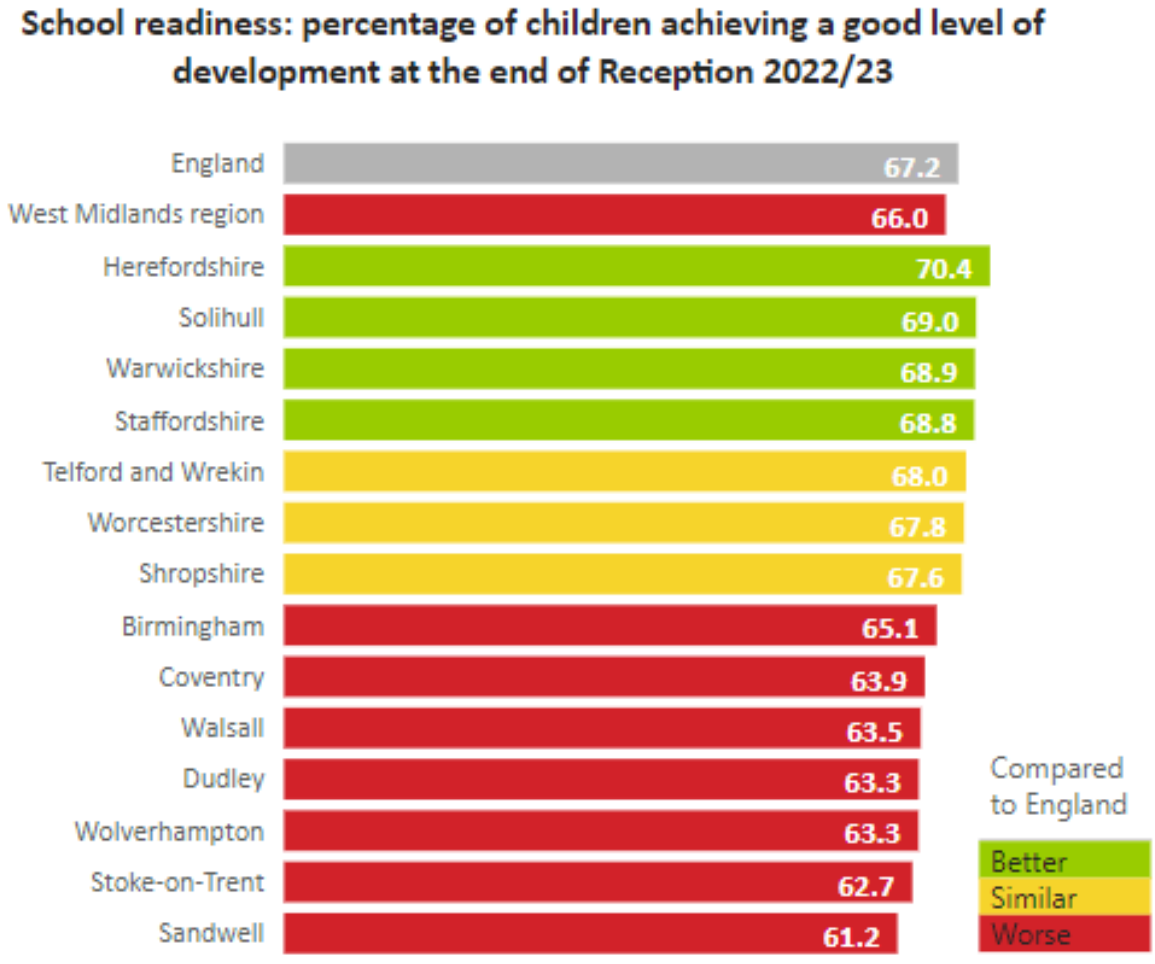


Figure 3

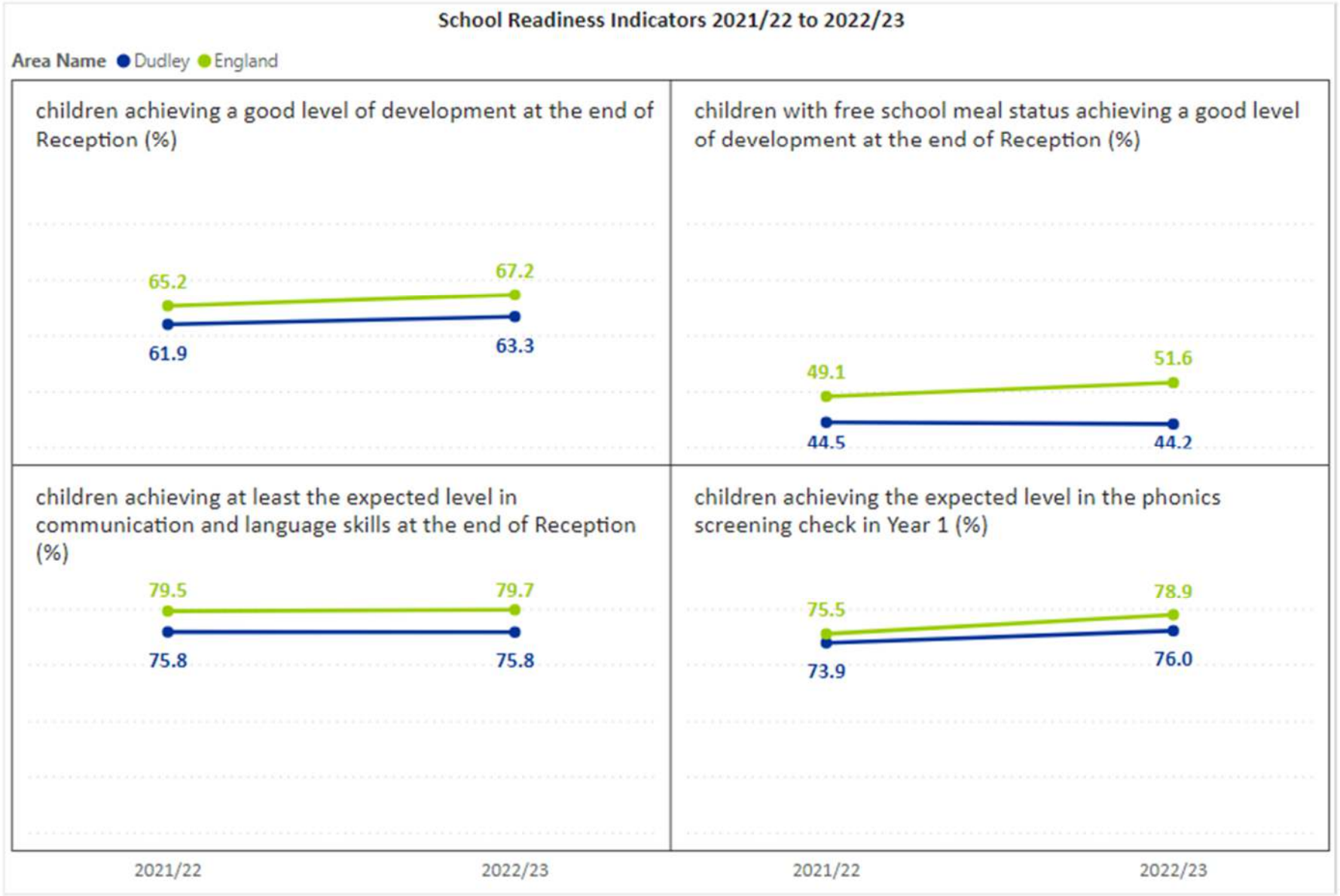

School Readiness Indicators 2021/22 to 2022/23
Area Name Dudley England
children achieving a good level of development at the end of Reception (%)
65.2
67.2
61.9
63.3
children with free school meal status achieving a good level of development at the end of Reception (%)
49.1
51.6
44.5
44.2
children achieving at least the expected level in communication and language skills at the end of Reception (%)
79.5
79.7
75.8
75.8
children achieving the expected level in the phonics screening check in Year 1 (%)
75.5
78.9
73.9
76.0
2021/22
2022/23
2021/22
2022/23

Figure 4

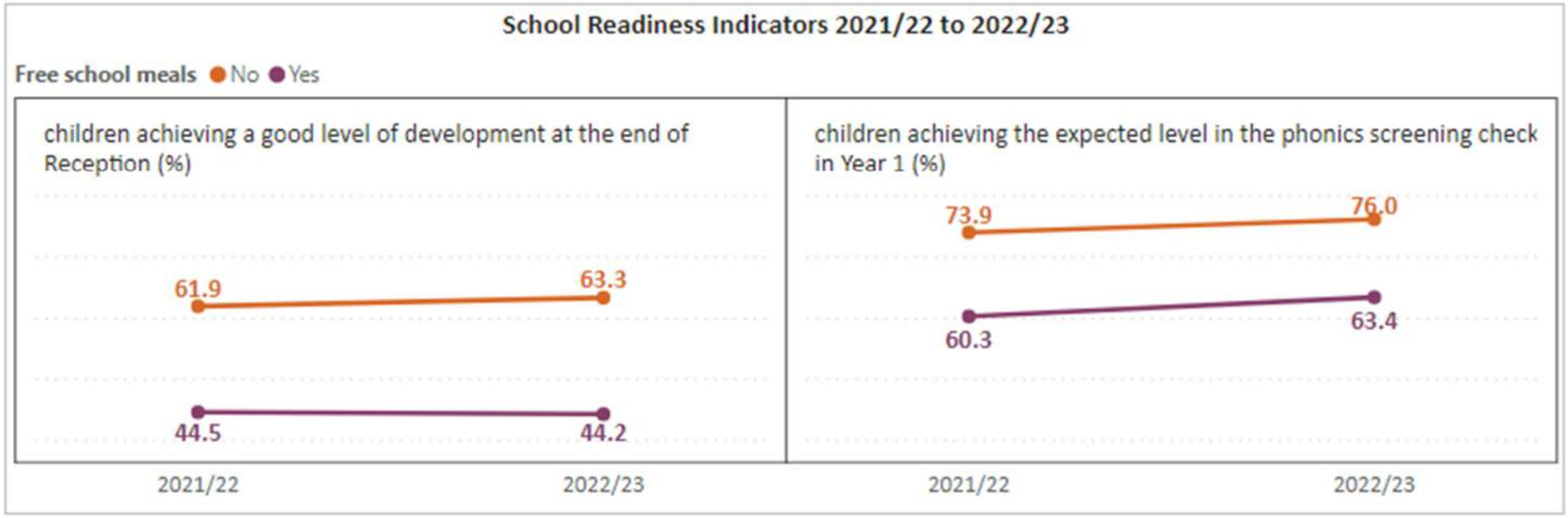
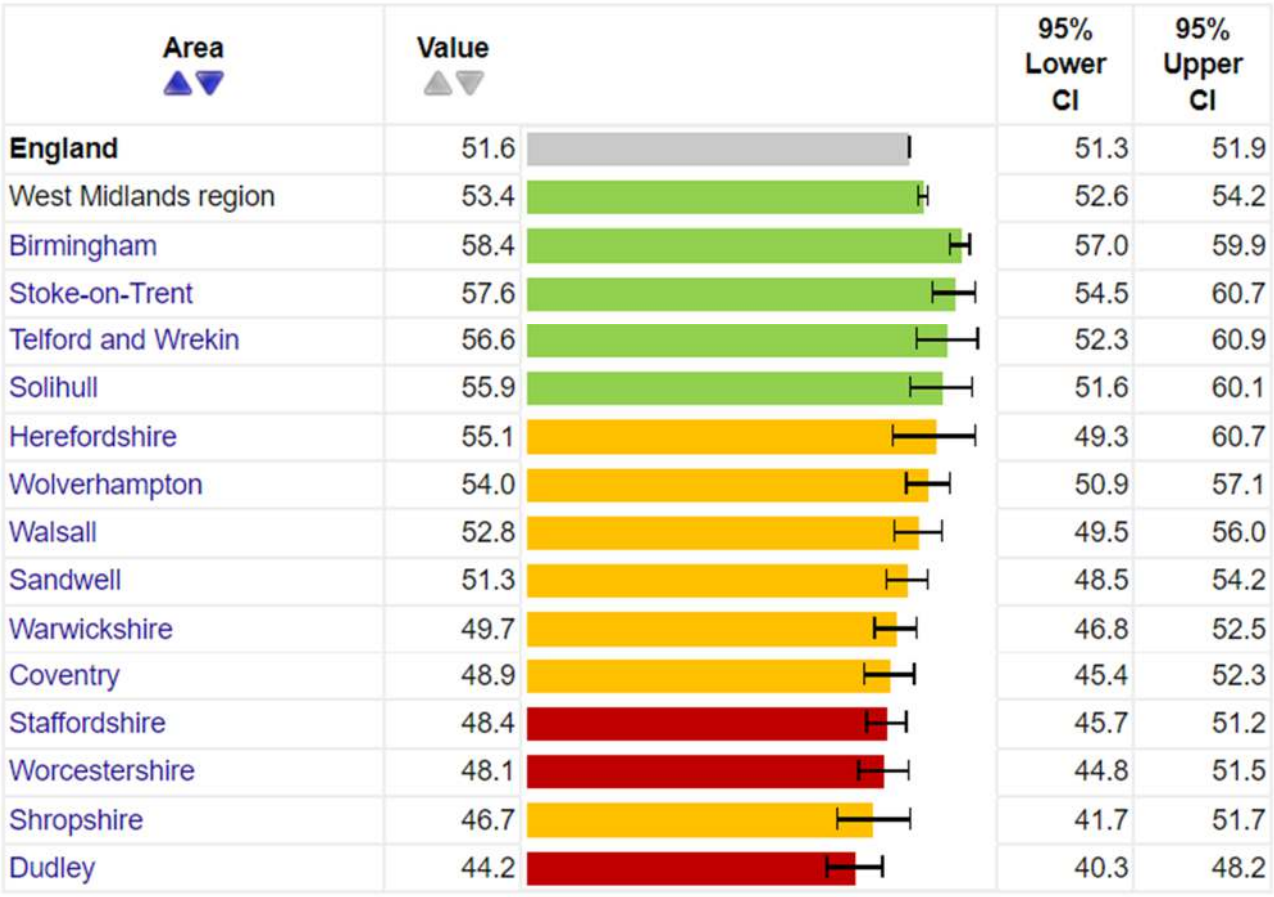

School Readiness Indicators 2021/22 to 2022/23
Free school meals No Yes
children achieving a good level of development at the end of Reception (%)
61.9
63.3
44.5
44.2
2021/22
2022/23
children achieving the expected level in the phonics screening check in Year 1 (%)
73.9
76.0
60.3
63.4
2021/22
2022/23

Figure 5



Area	Value	95% Lower CI	95% Upper CI
England	51.6	51.3	51.9
West Midlands region	53.4	52.6	54.2
Birmingham	58.4	57.0	59.9
Stoke-on-Trent	57.6	54.5	60.7
Telford and Wrekin	56.6	52.3	60.9
Solihull	55.9	51.6	60.1
Herefordshire	55.1	49.3	60.7
Wolverhampton	54.0	50.9	57.1
Walsall	52.8	49.5	56.0
Sandwell	51.3	48.5	54.2
Warwickshire	49.7	46.8	52.5
Coventry	48.9	45.4	52.3
Staffordshire	48.4	45.7	51.2
Worcestershire	48.1	44.8	51.5
Shropshire	46.7	41.7	51.7
Dudley	44.2	40.3	48.2

Source: Department for Education, Early Years Foundation Stage Profile (EYFS Profile): Early Years Foundation Stage Profile statistical series

Dudley Health & Wellbeing Board

Joint Health & Wellbeing Strategy 2023-2028 Outcomes: School Readiness Overview

Outcome	Period	Dudley Value	Dudley Count	WM Value	England Value
Overarching					
Children achieving a good level of development at the end of Reception (%)	2022/23	63.3	2355	66.0	67.2
Children achieving the expected level in communication and language skills at the end of Reception (%)	2022/23	75.8	2819	78.1	79.7
Children with free school meal status achieving a good level of development at the end of Reception (%)	2022/23	44.2	270	53.4	51.6
Factors relating to the child					
Smoking status at time of delivery (%)	2022/23	9.8	344	9.1	8.8
Low birth weight of live babies, five year pooled (%)	2016 - 20	7.9	1417		6.8
Breastfeeding prevalence at 6-8 weeks after birth (%)	2022/23	41.2	1451		49.2
A&E attendances (0-4 years)(Rate per 1,000)	2021/22	1061.9	19175	827.4	762.8
Children achieving a good level of development at 2 to 2½ years (%)	2022/23	60.3	1746	76.3	79.2
Children achieving the expected level in communication skills at 2 to 2½ years	2022/23	78.1	2262	83.0	85.3
Reception: Overweight (including obesity), 3-years data combined (%)	2020/21 - 22/23	24.6	2265	23.3	22.1
Special educational needs (Reception year) (%)	2023	12.9	478	12.9	11.9
Received DTaP/IPV booster and at least 2 doses of an MMR vaccine between the ages of 1 and 5	2022/23	65.5	2503		81.5
5 year olds with experience of visually obvious dental decay (%)	2021/22	17.3		23.8	23.7
Family factors relevant to school readiness					
Under 18s conception rate / 1,000	2021	17.3	95	15.2	13.1
Looked after children under 5 (rate per 10,000 population)	2017/18	44.3	86	39.4	34.9
Children in relative low income families (under 16s) (%)	2021/22	27.1	16477	27.0	19.9
Households with dependent children owed a duty under the Homelessness Reduction Act (rate per 1,000)	2020/21	8.2	312	11.8	11.6
Factors relating to the system					
Children receiving a 12-month review (%)	2022/23	91.0	3375	85.8	82.6
Children aged 2-2½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review (%)	2022/23	100.0	2897	94.4	92.5
Uptake of funded education by eligible children at 2 years of age (%)	2022/23	72.9	827	71.3	73.9
Free school meals: % uptake among all pupils (Primary school age)	2023	20.8	5944	23.1	19.3

Key

- Better than England
- Similar to England
- Worse than England
- no England data available

Dudley Health & Wellbeing Board

Joint Health & Wellbeing Strategy 2023-2028 Outcomes: School Readiness

most deprived ← Community Forum Area → least deprived

Outcome	Dudley Central	Dudley North	Brierley Hill	Halesowen	Stourbridge	Dudley Value	Period
Factors relating to the child							
Low birth weight of live babies, five year pooled (%)	8.9	7.8	7.4	8.1	6.5	**7.9**	**2016 - 20**
Reception: Overweight (including obesity), 3-years data combined (%)	26.4	28.2	24.2	21.4	22.6	**24.6**	**2020/21 - 22/23**
Family factors relevant to school readiness							
Children in relative low income families (under 16s) (%)	35.1	24.5	24.1	23.7	20.6	**27.1**	**2021/22**
Factors relating to the system							
Free school meals: % uptake among all pupils (Primary school age)	20.5	14.1	15.1	15.2	13.6	**20.8**	**2023**

most deprived ← Primary Care Network → least deprived

Outcome	Dudley & Netherton	Brierley Hill	Sedgley, Coseley & Gornal	Stourbridge, Wollescote & Lye	Halesowen	Kingswinford & Wordsley	Dudley GPs Value*	Period
Factors relating to the child								
Received DTaP/IPV booster and at least 2 doses of an MMR vaccine between the ages of 1 and 5	51.5	81.4	52.8	82.5	71.4	55.3	**65.5**	**2022/23**
A&E attendances (0-4 years)(Rate per 1,000)	1583.0	1538.7	1346.8	1188.8	1174.5	1393.8	**1383.4**	**2021/22**

*Values shown are for Dudley GP registered population, so may differ from the Dudley value on page 1, which relates to the Dudley resident population.

Key

Better than Dudley
Similar to Dudley
Worse than Dudley

Dudley Health & Wellbeing Board

Joint Health & Wellbeing Strategy 2023-2028 Outcomes: School Readiness KPIs

Indicator	Dudley Value	WM Value	England Value	Dudley 5-year trend
Uptake of funded education by eligible children at 2 years of age (%)	72.9	71.3	73.9	65.1, 71.9, 63.3, 73.1, 72.9
Children achieving a good level of development at 2 to 2½ years (%)	60.3	76.3	79.2	70.3, 72.3, 72.0, 62.3, 60.3
Children achieving the expected level in communication skills at 2 to 2½ years	78.1	83.0	85.3	96.2, 82.6, 82.7, 77.6, 78.1
Children achieving a good level of development at the end of Reception (%)	63.3	66.0	67.2	61.9, 63.3
% point difference of GLD in children entitled to Free School Meals (FSM) (compared to those not entitled to FSM)	23.5	17.0	19.9	22.2, 21.3, 23.5
% point difference of GLD in children with identified special educational needs (SEN) (compared to those with no SEN)	48.6	53.3	54.2	49.7, 48.8, 48.6
Children achieving the expected level in communication and language skills at the end of Reception (%)	75.8	78.1	79.7	75.8, 75.8

2018/19 2019/20 2020/21 2021/22 2022/23

Note:
the Early Years Foundation Stage profile was significantly revised in 2021.
It is therefore not possible to directly compare assessment outcomes from 2021/22 onwards with earlier years.

Also, the 2019/20 and 2020/21 data collections were cancelled due to coronavirus (COVID-19).

Key

- Better than England
- Similar to England
- Worse than England
- no England data available

Dudley Health & Wellbeing Board

Joint Health & Wellbeing Strategy 2023-2028 Outcomes: School Readiness Data Sources

Outcome	Data Source
Overarching	
Children achieving a good level of development at the end of Reception (%)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Children achieving the expected level in communication and language skills at the end of Reception (%)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Children with free school meal status achieving a good level of development at the end of Reception (%)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Factors relating to the child	
Smoking status at time of delivery (%)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Low birth weight of live babies, five year pooled (%)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Breastfeeding prevalence at 6-8 weeks after birth (%)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
A&E attendances (0-4 years)(Rate per 1,000)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Children achieving a good level of development at 2 to 2½ years (%)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Children achieving the expected level in communication skills at 2 to 2½	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Reception: Overweight (including obesity), 3-years data combined (%)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Special educational needs (Reception year) (%)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Received DTaP/IPV booster and at least 2 doses of an MMR vaccine between the ages of 1 and 5	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
5 year olds with experience of visually obvious dental decay (%)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
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Looked after children under 5 (rate per 10,000 population)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Children in relative low income families (under 16s) (%)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Households with dependent children owed a duty under the Homelessness Reduction Act (rate per 1,000)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Factors relating to the system	
Children receiving a 12-month review (%)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Children aged 2-2½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review (%)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]
Uptake of funded education by eligible children at 2 years of age (%)	Department for Education, available at https://explore-education-statistics.service.gov.uk/data-catalogue
Free school meals: % uptake among all pupils (Primary school age)	Office for Health Improvement & Disparities. Public Health Profiles.[accessed 09/02/24] https://fingertips.phe.org.uk © Crown copyright [2024]

Dudley Health & Wellbeing

Longer, safer, healthier lives for all

DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item no. 8(b)**

DATE	**14th March 2024**
TITLE OF REPORT	**Report of the Children and Young People's Partnership Board**
Organisation and Author	**Neill Bucktin – Dudley Managing Director, Black Country ICB, Chair, Dudley Children and Young People's Partnership Board**
Purpose	**To advise the Board of matters considered by the Children and Young People's Partnership Board**
Background	**1. The Children and Young People's Partnership Board is responsible to this Board for the oversight of a number of partnership activities that contribute to the overall health and wellbeing of Dudley's children and young people.** **2. This report describes the recent activities of the Board.**
Key Points	**1. "Growing Up in Dudley" report received with implications for partnership bodies.** **2. Self-Harm action plan, developed based on the experiences of School Health advisers, implemented.** **3. Premature baby pathway being developed.** **4. Refreshed Early Help Strategy being developed including Lead Practitioner role.** **5. New Emotional Health and Wellbeing group established and all age mental health needs assessment to be completed by October 2024.** **6. SEN/D Partnership Board focussing on new SEN/D Strategy and readiness for potential OFSTED/CQC inspection.** **7. Positive feedback following recent ungraded OFSTED inspection relating to children in care.**

Emerging issues for discussion	**Growing Up in Dudley raises a number of issues that will require a system wide response across a number of partnership bodies.**
Key asks of the Board/wider system	**Further consideration to be given to the implications of Growing Up in Dudley.**
Contribution to H&WBB key goals:	**The Board's activities contribute to the goal of improving school readiness**
Contribution to Dudley Vision 2030	**The Board contributes to the aspiration of :-** **"A place of healthy, resilient, safe communities with high aspirations and the ability to shape their own future"**

Contact officer details:

Neill Bucktin – neill.bucktin@nhs.net

1.0 PURPOSE OF REPORT

1.1 To advise the Board of matters considered by the Children and Young People's Partnership Board.

2.0 BACKGROUND

2.1 The Children and Young People's Partnership Board met on 6 February 2024. This report sets out the main issues considered by the Board.

3.0 GROWING UP IN DUDLEY

3.1 The Board will be aware of a comprehensive needs assessment carried out relating to the lived experience of children and young people's services across the life course called "Growing Up In Dudley".

3.2 The Board has received the report and reviewed an animated summary. These are now available on the All About Dudley website https://www.allaboutdudley.info/

3.3 The needs assessment involved engaging with children, young people and families in some of the most challenged parts of Dudley and has raised issues which affect a number of partnership bodies including the SEN/D Partnership Board, the Safe and Sound Board and the Forging a Future Board. Work is now taking place to review the recommendations and agree responsibilities for responding to these.

4.0 SELF HARM ACTION PLAN

4.1 In 2023, the Council commissioned School Health Adviser Service identified an increase in the number of instances of self-harm amongst school age pupils.

4.2 As a result of this intelligence, an action plan was developed to address the issues raised. The Board has noted that all actions have now been completed and the number of reported self-harm cases have reduced.

5.0 PREMATURE BABY PATHWAY

5.1 The Board has noted progress with the development of a premature baby pathway. A further report will be considered as the work nears completion.

6.0 PREVENTION AND EARLY HELP STEERING GROUP

6.1 The Board has reviewed the progress of this Steering Group in developing a clearer and more accessible early help offer.

6.2 Workstreams have been established which complement the development of Family Safeguarding and the redesign of children's services. A key element of this work is the refreshment of the Early Help Strategy with a focus on the first 1001 days of life and an inclusive approach to help and support.

6.3 It is recognised that a mature Early Help System requires Lead Practitioners who co-ordinate the activity of the team around the family, ensure the assessment and the family plan responds to all needs identified and leads on ensuring the family co-produce the plan. Developing such roles across all partners will be a priority.

7.0 CHILDREN AND YOUNG PEOPLE EMOTIONAL HEALTH AND WELLBEING GROUP

7.1 The Board has received a report on the establishment of this Group which brings all relevant partners together to address the emotional health and wellbeing needs of children and young people.

7.2 To inform its work, the Council has commissioned an all-age mental health needs assessment. This is being carried out by the University of Wolverhampton and is expected to be completed by October 2024. This will form the basis of a refreshed all age emotional health and wellbeing strategy.

8.0 SEN/D PARTNERSHIP BOARD

8.1 The Board has received a report from the SEN/D Partnership Board.

8.2 The Board has focussed on the readiness of the local system to respond to an anticipated OFSTED/CQC inspection. This has involved ensuring that actions from its Accelerated Progress Plan are completed and developing a Self-Evaluation Framework that will inform a refreshed SEN/D Strategy.

8.3 In addition, the Board now receives an updated performance report which will form the basis for a focussed “balanced score cared”.

9.0 OFSTED THEMATIC INSPECTION

9.1 The Board has received an update on an ungraded inspection, reviewing decision-making in relation to children in care.

9.2 The inspectors’ feedback was highly positive and staff were praised for their restorative practice.

10.0 RECOMMENDATION

10.1 That the matters considered by the Children and Young People’s Partnership Board be noted.

Neill Bucktin
Chair – Children and Young People’s Partnership Board
February 2024

Dudley Health & Wellbeing

Longer, safer, healthier lives for all

DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item no. 8(c)**

DATE	14th March 2024
TITLE OF REPORT	Black Country Integrated Care Board Joint Forward Plan Refresh
Organisation and Author	Mr N Bucktin – Dudley Managing Director – Black Country Integrated Care Board
Purpose	To update the Board on the Black Country Joint Forward Plan Refresh
Background	1. All ICBs and their partner NHS Trusts were required to prepare a Joint Forward Plan in conjunction with wider system partners covering the period 2023 to 2028. The plan set out how the ICB fulfils its statutory requirements and duties, addresses local needs and aligns with the priorities, and targets set out in the NHS Operational Planning Guidance and the NHS Long-Term Plan. 2. Updated 'Joint Forward Plan' guidance was published on the 22 December 2023, which set out the requirement to publish a refreshed plan by the 31 March 2024.
Key Points	Engagement will be undertaken with wider stakeholders and the public on the content of the draft plan which was published on the ICB website on 27 February 2024. The engagement period will run until 15 March 2024. People Panel meetings scheduled during March 2024 will also look at the draft plan. All feedback will be collated to help inform the final version the plan ahead of publication on the 31 March 2024.

Emerging issues for discussion	The Board will need to consider whether the draft plan takes account of the Joint Health, Wellbeing and Inequalities Strategy.
Key asks of the Board/wider system	1. That the refreshed Joint Forward Plan be noted. 2. That the Board be invited to comment as necessary on the refreshed Joint Forward Plan.
Contribution to H&WBB key goals:	The Dudley element of the plan takes account of the Joint Health, Wellbeing and Inequalities Strategy priorities.
Contribution to Dudley Vision 2030	A place of healthy, resilient, safe communities with high aspirations and the ability to shape their own future.

Contact officer details:

Neill Bucktin – neill.bucktin@nhs.net

1.0 PURPOSE OF REPORT

1.1 To update the Health and Wellbeing Board on the Black County ICB Joint Forward Plan refresh.

2.0 BACKGROUND

2.1 All ICBs and their partner NHS Trusts were required to prepare a Joint Forward Plan in conjunction with wider system partners covering the period 2023 to 2028. The plan set out how the ICB fulfils its statutory requirements and duties, addresses local needs and aligns with the priorities, and targets set out in the NHS Operational Planning Guidance and the NHS Long-Term Plan.

2.2 The NHS Black Country Joint Forward Plan (JFP) was published in June 2023 and was developed in a range of accessible formats and can be accessed on the ICB website at https://blackcountry.icb.nhs.uk/about-us/our-priorities/our-5-year-joint-forward-plan.

2.3 The full JFP for 2023-28 was constructed to meet national and local planning requirements and was assured in full by NHSE. A 'shorter-read' version was subsequently developed which is the version of the plan utilised by the System.

2.3 The Joint Forward Plan was shared with the Board in draft form earlier in the year to provide assurance that it is aligned with and supports the delivery of priorities set out in the Dudley Joint Health, Wellbeing, and Inequalities Strategy. A statement of support was received from this Board.

3.0 REFRESH OF PLAN

3.1 Updated 'Joint Forward Plan' guidance was published on the 22 December 2023, which set out the requirement to publish a refreshed plan by the 31 March 2024.

3.2 The focus of the refresh will be on the shorter read version of the plan, reflecting progress we have made to date as well taking into account other related strategies and plans.

4.0 STAKEHOLDER ENGAGEMENT

4.1 A joint engagement session will be held with Chief Executives of NHS Trusts and Councils.

4.2 Engagement will be undertaken with wider stakeholders and the public on the content of the draft plan which was published on the ICB website on 27 February 2024. The engagement period will run until 15 March 2024. People Panel meetings scheduled during March 2024 will also look at the draft plan. All feedback will be collated to help inform the final version the plan ahead of publication on the 31 March 2024.

4.3 An update will be provided to the Board in due course.

5.0 KEY RISKS

5.1 The delay in publication of 2024/2025 NHS Operational Planning Guidance prevents full alignment of our 2024/2025 Operational Plan with our Joint Forward Plan refresh due to the publication deadline of the refresh being the 31 March 2024. It is intended to address this post refresh by undertaking a fuller mid-year review of the Joint Forward Plan later this year.

6.0 RECOMMENDATION

6.1 That the refreshed Joint Forward Plan be noted.

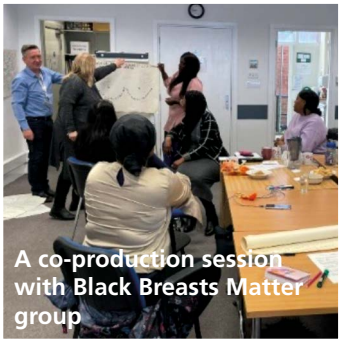
6.2 That the Board be invited to comment as necessary on the refreshed Joint Forward Plan.

NHS Black Country

NHS Black Country
Joint Forward Plan 2023-2028

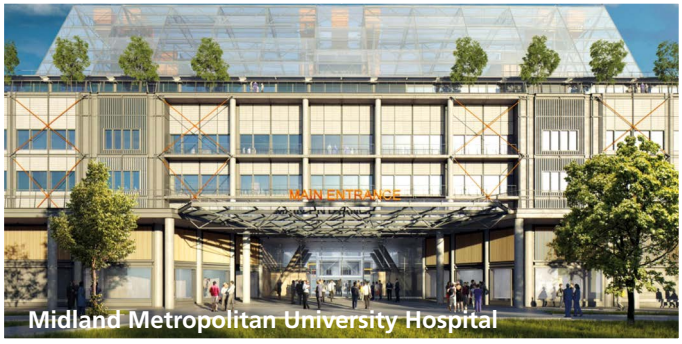
Updated April 2024

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

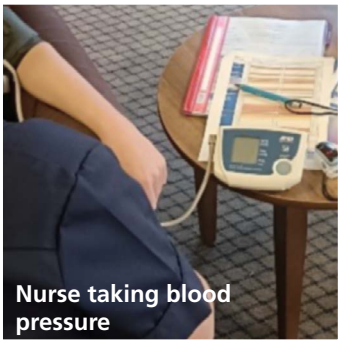


A co-production session with Black Breasts Matter group

Draft for Involvement



Midland Metropolitan University Hospital



Nurse taking blood pressure

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

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

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

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

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

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

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

In five years time there will be:

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

Contents

Welcome to the NHS Black Country Joint Forward Plan

The NHS Black Country Joint Forward Plan has been developed in collaboration with partners and our population and sets out our challenges, health needs, strategic vision, and strategic priorities for the five year period of 2023-2028.

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

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

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

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

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

- Improved access
- Better preventative services
- Community focus
- More personalised care

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

We know that our health is determined by much more than our access to health services.

How healthy we are and how long we live in good health is dependent upon other factors such as our health behaviours and lifestyles, the places and communities we live in, and the way in which we use health services.

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

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

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

The new priority is:

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

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

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

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

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

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

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

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

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

I want to thank everyone who contributed.

Best wishes

Mark

Mark Axcell

Black Country Integrated Care Board
Chief Executive

Updates to the plan – April 2024

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

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

* Cross cutting priorities

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

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

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

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

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

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

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

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

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

Our Successes – Achievements

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

Successfully recruited additional roles in primary care, supporting the national target (26,000 additional staff)

Reduced the number of people waiting for community services (50% reduction)

Significant progress made towards delivering 'Saving Babies Lives' care bundle

For patients who need an urgent community response 82% were seen within 2 hours (target 70%)

Reduced the number of cancer patients waiting over 62 days, by more than our agreed target

Increased the number of GP appointments 86% of patients are seen within 2 weeks, 45% on the same day

Consistently increased the use of our Virtual Ward capacity (99% January 2024)

Improving Quality

Improving Access

Workforce

Social Care

Care Closer to Home

Mental Health and Wellbeing

Preventing Ill Health

Tackling Health Inequalities

Best Place to Work

Best Start in Life

Children and Families

Increased the number of patients with CVD prescribed lipid lowering treatments

Eliminated the very long elective care waits (no patient waiting longer than 104 weeks)

87% of patients living with SMI have received an annual health check (target 60%)

Increased the number of maternity staff, which underpins delivery of continuity of care

Patients attending A&E are being seen sooner, 71% patients seen within 4 hours (target 76%). We are amongst the best performing system in England.

Made significant progress to reduce waiting times for Talking Therapies

Our Successes – Case Studies

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

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

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

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

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

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

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

Midland Metropolitan University Hospital (MMUH)

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

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

The hospital will serve patients who are acutely unwell and need a hospital stay, or whose care is an emergency. All acute clinical teams will combine to operate as one and staff will work with new technology in modern purpose-built facilities, helping to improve patient care and experience.

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

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

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

Recognising Walsall Together

Walsall Together Partners Celebrating their award

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

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

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

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

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

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

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

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

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

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

Walsall's new Emergency Department

The new ED entrance at Walsall Healthacre NHS Trust

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

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

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

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

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

What is an NHS Joint Forward Plan?

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

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

In addition, the plan:

- Describes how we intend to use our NHS budget to ensure that local services are of the highest quality and that they meet local need
- Sets out how we will address the challenges which we face today and those that we recognise are affecting the future health of local people
- Explains how we will support our workforce so that it is fit for the future and create a system of health and care organisations that are seen as employers of choice
- Describes how we will support local people with the knowledge and skills to have more choice and control over their own health and care
- Sets out how we will change the way organisations work together moving forward
- If after reading this summary you may want to read more, there is a full version of the plan on our website.

The Black Country

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

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

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

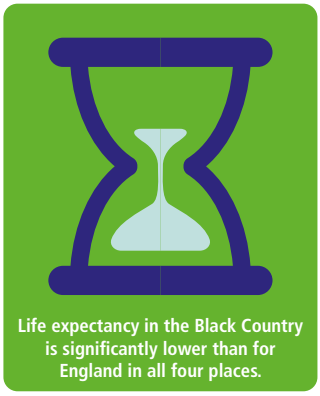
We also have thriving Voluntary, Community, Faith and Social Enterprise (VCFSE) partners in the Black Country. This is a vast and diverse sector, comprising of nearly 4,000 member organisations across our four place-based Community and Voluntary Services (CVS).

Our health challenges

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

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

Within the Black Country:



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

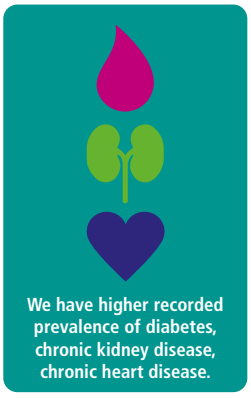
The gap in life expectancy between the Black Country and England is 2.2 years for males and 1.6 years for females.

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

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

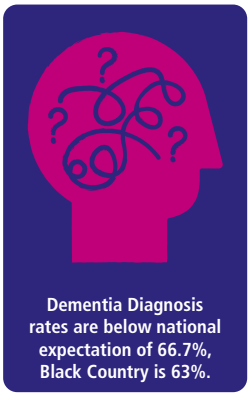
Both child (43% locally vs 35% in England) and adult (69% locally vs 64% in England) obesity rates are higher than England.

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



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

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



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

Other challenges

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

Restoration and recovery from COVID-19 – Whilst significant progress has been made to reduce waiting list backlogs, we need to ensure that we continue to recover services and address existing health inequalities in access.

Urgent and emergency care pressures – Whilst we are one of the better performing systems for delivery of the four-hour accident and emergency target, urgent and emergency care remains our most pressured area. The demand for services at peak times, particularly in the colder months, is exceeding the capacity which we have.

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

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

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

Writing our plan

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

The ICS purpose

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

- Improve health outcomes
- Tackle inequalities
- Enhance productivity and value for money
- Support social and economic development

Policy drivers

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

- NHS priorities

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

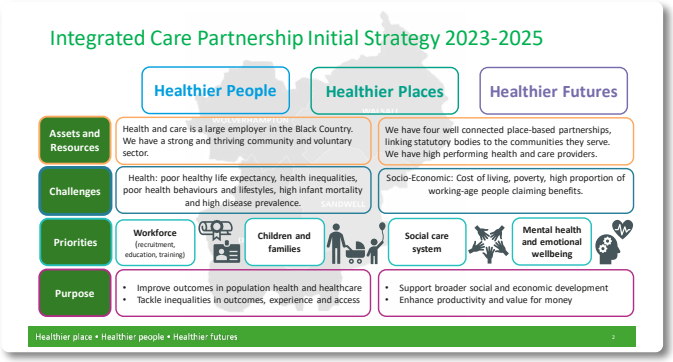
Guidance documents that our plan takes account of:

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

- Our local Integrated Care Partnership Strategy

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

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



Integrated Care Partnership

- Core20 Plus 5

The Core20Plus5 framework is designed to support ICSs to drive specific actions to reduce health inequalities. Core20 means the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). Half the population of the Black Country live in these Core20 areas. Although there is variation in the proportion of people living in Core20 areas across our four Places, all four are higher than the national average.

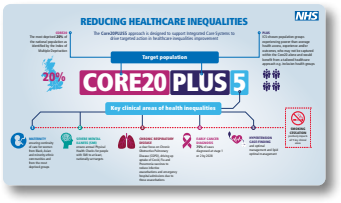
The 'PLUS' are the population groups experiencing poorer than average health access or outcomes, and who may not be captured within the Core20 alone so may benefit from a tailored approach.

PLUS groups include ethnic minority communities, inclusion health groups, people with a learning disability and autistic people, people with multi-morbidities, and other protected characteristic groups.

Along with defining target population cohorts, it also identifies five focused clinical areas requiring accelerated improvement. These are:

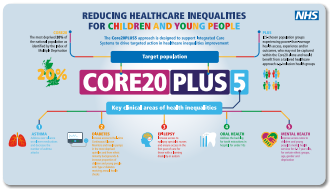
Adults:

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



Children:

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



Our approach to involving people and communities

In 2022 we worked with local people and partners to co-produce our approach to working with people and communities. The approach supports our commitment to meaningfully involving people and communities in the decisions we make, as well as outlining how we will meet our statutory duties.

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

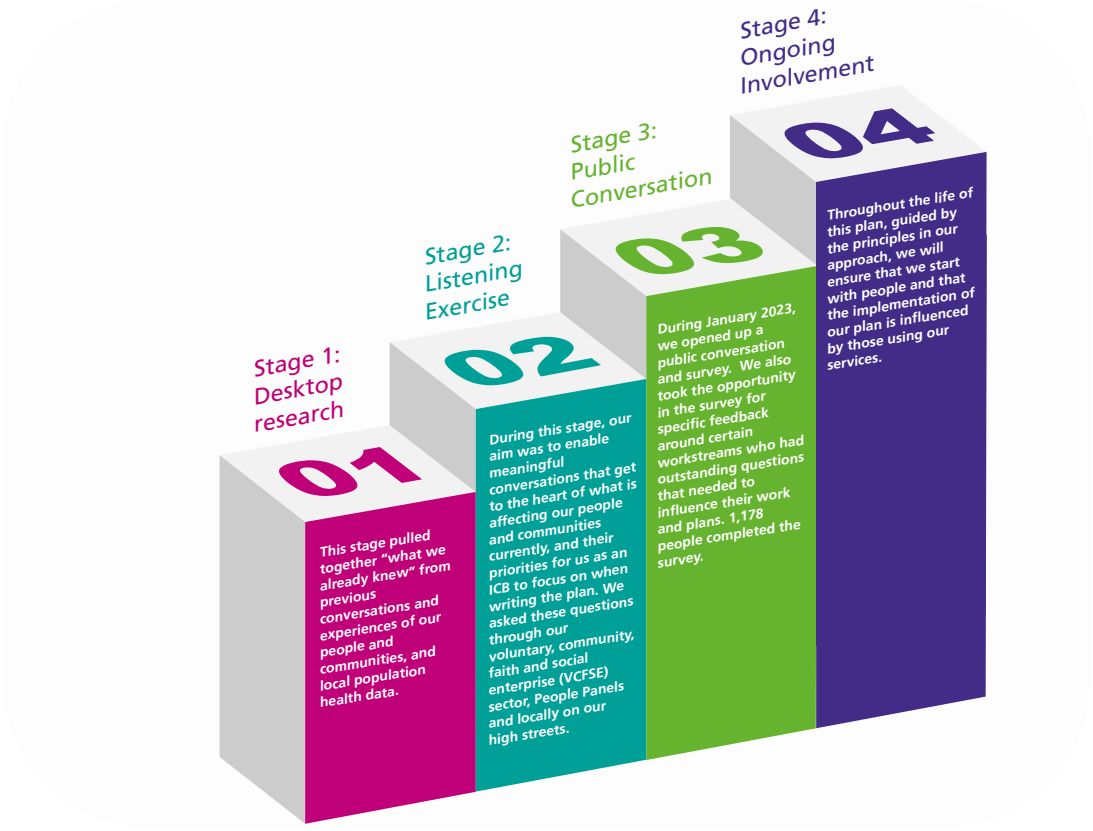
- Be accountable to our people and communities
- One size does not fit all
- Start with people and communities
- Trusted voices are key
- Invest in people and communities
- Nurture relationships across the ICS

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

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

Involving people and communities in our plan

Ensuring that people and communities have been involved in the development of the plan is important to us, not only to discharge our statutory duties, but to ensure that the plan is reflective of the needs and wants of our communities. The development of the original five-year plan and this year's refresh has been undertaken in stages:



What we have heard

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

- Improved access - to appointments and emergency/urgent care, to resources and reasonable adjustments, to digital devices/ data/skills
- Better preventative services
- Community focus – clinical and non-clinical
- More personalised care options and choices

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

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

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

Refreshing our plan

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

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

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

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

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

Continuing the conversation

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

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

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

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

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

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

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

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

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

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

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

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

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

NHS Black Country Joint Forward Plan strategic priorities

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

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

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

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

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

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

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

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

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

NHS Joint Forward Plan Priorities

NHS
Black Country

Priority 1 : Improving access and quality of services

Outcomes

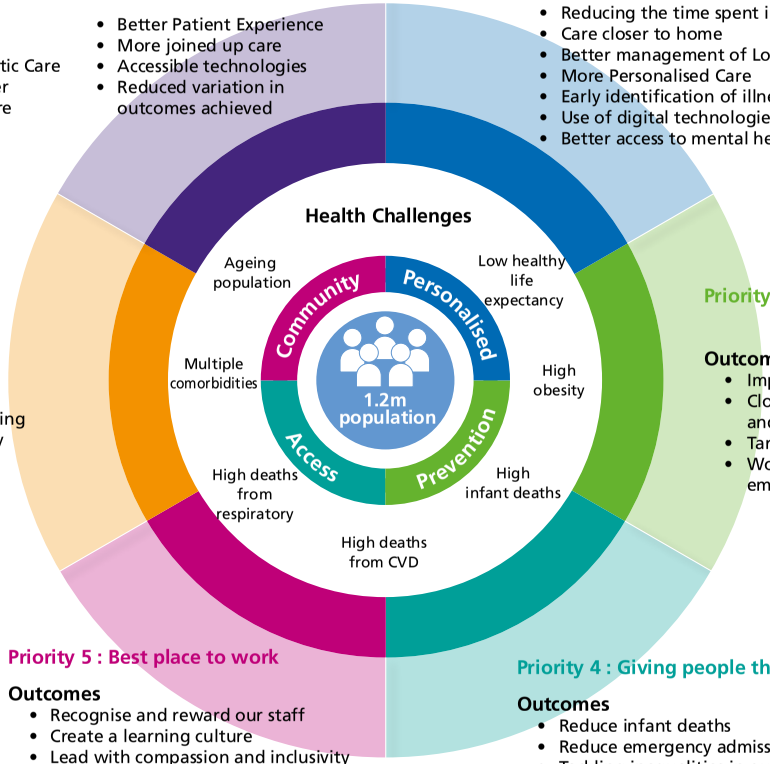
- Recovery from Covid-19
- Improved access to Urgent and Emergency Care
- Reduced waiting times for Elective and Diagnostic Care
- Timely diagnosis and faster treatment for Cancer
- Improved access to appointments in Primary Care

- Better Patient Experience
- More joined up care
- Accessible technologies
- Reduced variation in outcomes achieved

Priority 2 : Care closer to home

Outcomes

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



Priority 3 : Preventing ill health and tackling health inequalities

Outcomes

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

Priority 6 : Fit for the Future

Outcomes

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

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

Priority 5 : Best place to work

Outcomes

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

Priority 4 : Giving people the best start in life

Outcomes

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

NHS Black Country Joint Forward Plan Priorities diagram

Our principles

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

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

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

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

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

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

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

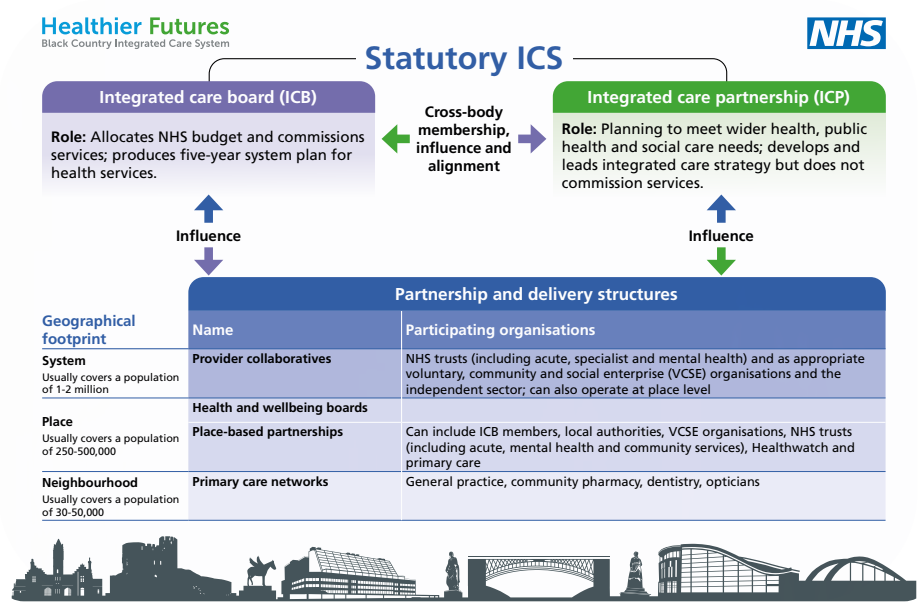
Working with partners to understand research needs and priorities, to inform the development of the research strategy. Ongoing sharing of research opportunities across system helping to support a positive approach to research.

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

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

Working together to enable change

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



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

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

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

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

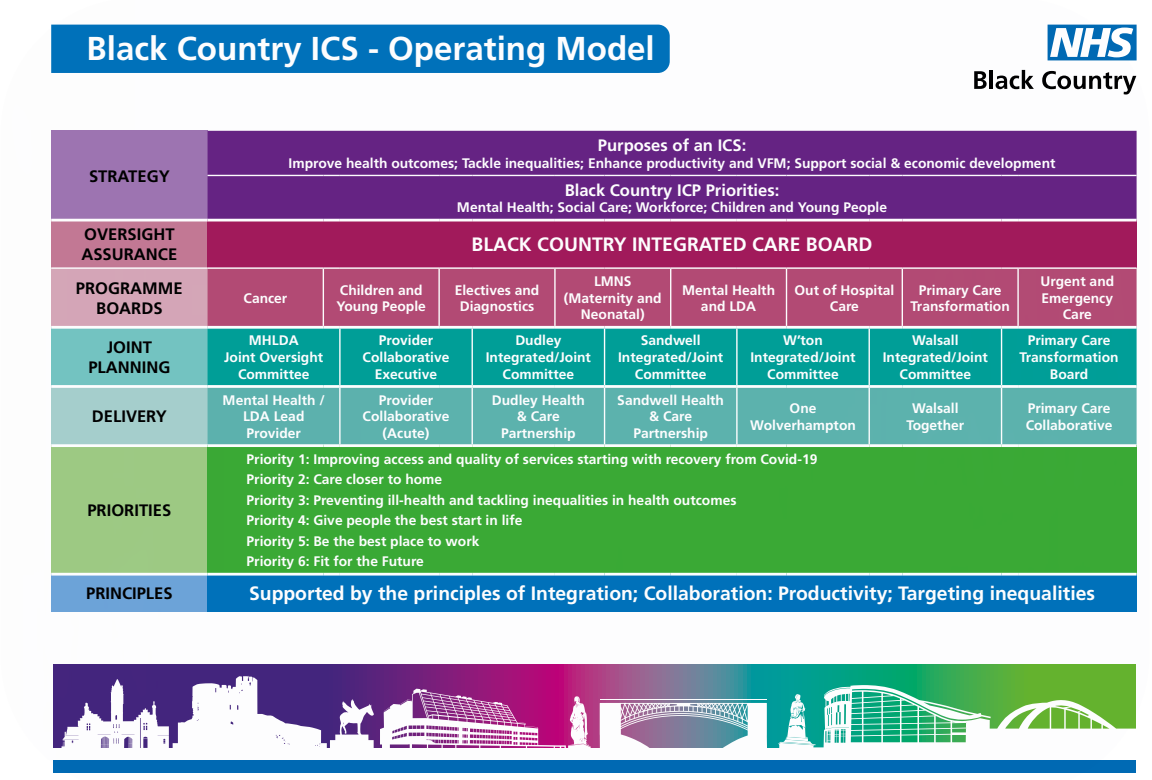
Strategic Programme Boards - Bring commissioners and providers together to develop strategy, outcomes and priorities in portfolio areas within the devolved budget. The programme boards will also oversee performance metrics and produce recovery plans for areas behind trajectory. They will identify areas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

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

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

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

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



Black Country ICS Operating Model

Developing our Operating Model

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

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

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

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

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

Provider Collaboratives

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

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

- Black Country Provider Collaborative (Acute and Community)

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

Black Country Provider Collaborative

The Black Country Pathology Services team

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

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

- Mental Health, Learning Disability and Autism Lead Provider

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

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

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

- Primary Care Collaborative

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

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

- Place-Based Partnerships

There are four local place-based partnerships in the Black Country covering populations which mirror the boundaries of local councils in Dudley, Sandwell, Walsall and Wolverhampton.

Whilst working at a Black Country level can bring the benefits of working at scale to tackling some of the bigger challenges in health and care, smaller place-based partnerships are better able to understand the needs of local people and design/deliver changes in services to meet these needs.

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

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

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

Walsall Together
Collaborating for happier communities

OneWolverhampton
Working together for better health and care

Sandwell Health and Care Partnership

Dudley Health and Care Partnership
Connecting communities and coordinating care to help citizens live longer, safer and healthier lives.

The difference our plan will make in five years

For the public:

- Improved quality (access, experience and outcomes)
- Care provided in the right place, by the right person
- Reduced harm/ incidents of poor care
- Improved physical and mental health for all
- Improved life expectancy and quality of life
- Greater choice and options to personalise care
- New models of integrated healthcare
- Supported to have the best start to life

For our staff:

- Greater sense of belonging, value and satisfaction
- Improved working conditions and succession planning
- Estate, equipment and digital technologies to enhance working practice
- Opportunities for improvement and personal development
- Pride in the care we deliver

For NHS partners:

- Well-led, well organised, system anchors
- Greater efficiency and value for money
- Reduced demand, through new models of care and improved patient outcomes
- Productive, motivated, flexible workforce
- Greater access to research and innovation
- Modernised estates and facilities
- Integrated care, with greater capacity to provide sustainable resilient services.
- Financially sustainable system

For the wider system:

- Reduction in health inequalities for our population
- Cohesive approach quality improvement and prevention
- Reduction in unwarranted variation of care
- Healthier people, healthier communities
- Thriving voluntary, social and community sector
- Engaged and growing workforce, fit for the future
- Diversity in leadership, equipped and informed to act
- Sustainable services designed to meet future need
- Reduced carbon footprint

Measuring our success

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

To support this, we have identified key metrics and indicators aligned to each strategic priority that will be regularly reported within the system. Such indicators are likely to change dependent on priorities or issues that may arise during the year. We also recognise that we want to improve our metrics associated with National Oversight Framework.

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

Improving access and quality of services

- Eliminate long waits for elective care
- Continue to reduce the number of cancer patients waiting for treatment
- Increase the number of adults and older adults accessing Talking Therapies treatment
- Improve Accident and Emergency waiting times
- Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.

Care Closer to Home

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

Preventing ill health and tackling health inequalities

- Ensuring annual health checks for those living with Severe Mental Illness (SMI)
- Increase percentage of patients with hypertension treated to NICE guidance
- Increase the percentage of patients aged between 25 and 84 years with a cardiovascular disease risk score greater than 20 percent on lipid lowering therapies
- A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

Giving people the best start in life

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

Best place to work

- Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
- Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles
- Reduce % of staff who have left the NHS during a 12-month period
- Reduce sickness absence rates for NHS staff in England
- Increase the mean score NHS Staff Survey Staff engagement theme

Fit for the future

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

Dudley - Place Delivery Plan

Our vision is connecting communities and coordinated care to help citizens live longer, safer, happier, healthier lives for all. Our mission is for health and care in Dudley to be in the right place at the right time and to be in the community where possible, hospital when necessary. Our vision will be delivered through a number of work programmes set out below. Collaboration and integration are critical when designing new and often complex solutions and through strengthening our partnership we will achieve our vision. Our health and wellbeing priorities are addressed throughout our work programme, and as an anchor network we will undertake actions to support social and economic determinants of health and wellbeing.

Health and wellbeing priorities:

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

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

Outcomes to be achieved

For our Patients:

- Care close to home with improved outcomes
- Longer healthy life expectancy
- Personalised care and improved patient experience
- More say in their care through co-production of health and care in Dudley
- Reduced unplanned hospitalisation for chronic ambulatory sensitive admissions
- Improved health and wellbeing outcomes for our CYP
- Enhanced emotional resilience for our population, and supporting people (all ages) to stay mentally well and reducing mental health inequalities
- Improved physical health for our population with severe mental illness

For Organisations:

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

For our System:

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

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

- Roll out of "I Can – Dudley" recruitment model offering training and placements for people with care experience and young people with Special Educational Needs and Disabilities resulting in 45 placements across both the NHS and Local Authority, embedding a culture of inclusive recruitment for all and delivering a sustainable workforce reflective of the population we serve.
- The Integrated Front Door Team have helped avoid unnecessary admissions and supported patients to remain in their usual residence by adopting a multi-disciplinary team approach working in partnership with physical and mental health, Social Care, housing and voluntary and community services. Since the launch of the service referrals have increased by 34% and 95 patients have been referred to alternative services.
- The Healthy Heart Hubs outreach model has helped support communities (circa 300 patients) to monitor and manage their blood pressure along with delivering educational cardiovascular disease reduction sessions with the support of Health and Wellbeing Coaches. In addition to focusing on hypertension the Hubs also focus on Lipid Optimisation and Smoking Cessation with a targeted approach to help reduce health inequalities.
- In partnership with Connecting Health Communities, we have commenced the Brockmoor & Pensnett Community Innovation Project which is delivered by the Institute for Voluntary Action Research. The project aims to adopt an innovative system wide approach to meeting and reducing the inequality gap for residents in this ward. Focusing on developing links between reducing childhood obesity in the ward and improving family income, employability and access to healthy food by engaging residents, community groups and voluntary organisations in the design of health and care services. To date over 60 residents have participated in community research events and are helping to co-produce plans to meet the needs of this community.
- Successfully rolled out "Advancing health equity through income maximisation" which provides welfare rights support for people with severe mental illness. This has resulted in identifying that 98% of people who have a review undertaken are receiving less than they are entitled to. In the first six months alone an additional £319,488 income which equates to an average increase of income of £1936 per person has been delivered.
- Dudley Council has received £25m from the Towns Fund to create a higher education facility in Dudley which will have a focus on health and care. The new facility, to be known as Health Innovation Dudley, is currently under construction and partners are co producing the design of the building and the services it will offer to ensure that the available facilities meet the requirements of all partners. Work is expected to be completed by the autumn of 2025.
- Recruitment of 17 Family Hub Practitioners across midwifery, Local Health and Health Visiting to the Integrated F1001 Days Team to provide early interventions and support to families. This has resulted in 50% increase in families accessing additional support, 30% increase in speech, language and communication needs early identification and intervention, increase in number of expectant and new parents accessing education opportunities, 15% increase in trained peer to peer supporters, with infant feeding peer support available across all five Hubs and an 25% increase in out of hours infant feeding support.

Sandwell - Place Delivery Plan

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

Health and wellbeing priorities:

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

Outcomes to be achieved

For our Patients:

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

For Organisations:

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

For our System:

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

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

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

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

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

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

Sandwell Health and Care Partnership

Walsall - Place Delivery Plan

Our vision is to level up on social and quality of life issues - such as mental wellbeing, uneven life expectancy, excessive elective surgery waiting time, fighting gang crime, encourage healthier lives, and creating a safer environment. Our plan outlines the intention to invest in the mental and physical wellbeing of residents to continue to build a borough to be proud of and improve the outcomes for the people of Walsall. Resilient Communities and Health Inequalities work supports ambitions to reduce differences between the health of the poorest and richest in the Borough. Our overall programme reflects our commitments to our health and wellbeing priorities and addressing wider determinants of health.

Health and wellbeing priorities:

- Maximising people's health, wellbeing and safety
- Creating health and sustainable places and communities
- Reducing population health inequalities

Outcomes to be achieved

For our Patients:

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

For Organisations:

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

For our System:

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

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

- We have established four Locality Family Hubs and 10 Community Spokes in Walsall all of which provide a welcoming space where children, young people aged 0-19 and up to 25 for those young people with additional needs and their families can go to get advice and support when they need it. The Hubs are in the heart of communities, services such as Midwives, Health Visitors, School Nurses, Speech & Language Early Help, Children's Social Care, DWP Housing and Police have come together to provide a central access point for families to get help and support.
- Through the Health Inequalities Improvement Programme Walsall Housing Group (WHG) ran a Kindness Champions scheme, recruiting and training Champions because of their lived experience to engage and support lonely and/or isolated residents offering emotional support, a resident-led wellbeing plan and providing a bridge to services/projects/activities in the community.
- The Integrated Assessment Hub enables people who are directly contacting the Frail Elderly Service or Ambulatory Care at Manor Hospital with post-discharge complications to be seen by Rapid Response, Enhanced Care Home Support Team or CIT team instead, and receive a community-based assessment and clinical review, thereby avoiding conveyance to hospital.
- A Care Navigation Centre (CNC), supported by a multidisciplinary team (MDT), takes referrals from primary care, care homes, domiciliary care agencies, ambulances, and social care. Citizens access the most appropriate care (e.g. rapid response, MDT) and avoid unnecessary hospital admissions. Five virtual wards are run from the CNC, primarily on a 'step-down' approach for patients following an acute admission. A total of 1,564 patients have been treated since July 2022, making a positive impact on discharge pathways during winter, easing winter pressures.
- Work4Health, an initiative supporting long-term unemployed adults into NHS jobs has helped more than 137 people to secure employment (83% were previously unemployed), generating £2.1m in social value.
- Our Intermediate Care Service has reduced the length of stay for medically stable patients from 7.3 to 2.3 days since it was introduced in 2020 – saving £4.96m a year. The savings are because of improved integration within the ICS, and we have one of the best performing ICS's and discharge rates in the country which has improved productivity outcomes and satisfaction amongst residents are positively impacted.
- Walsall Wellbeing Directory launched in January 2024, features a wide range of support, advice, activities and events to support the wellbeing of local citizens. The directory has been developed by Walsall Together Partnership in collaboration with local citizens and the voluntary, community and social enterprise sector.

Walsall Together

Collaborating for happier communities

Wolverhampton - Place Delivery Plan

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

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

Health and wellbeing priorities:

- Quality and access of care
- Starting and growing well
- Reducing harm from smoking, alcohol, drugs and gambling
- Getting Wolverhampton moving more
- Public mental health and wellbeing

Outcomes to be achieved

For our Patients:

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

For Organisations:

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

For our System:

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

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

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

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

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

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

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

OneWolverhampton

Working together for better health and care

Feedback on our plan

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

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

Councillor Bevan, Chair of Dudley Health & Wellbeing Board
Await feedback on the plan

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

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

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

Find out more

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

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

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

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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:

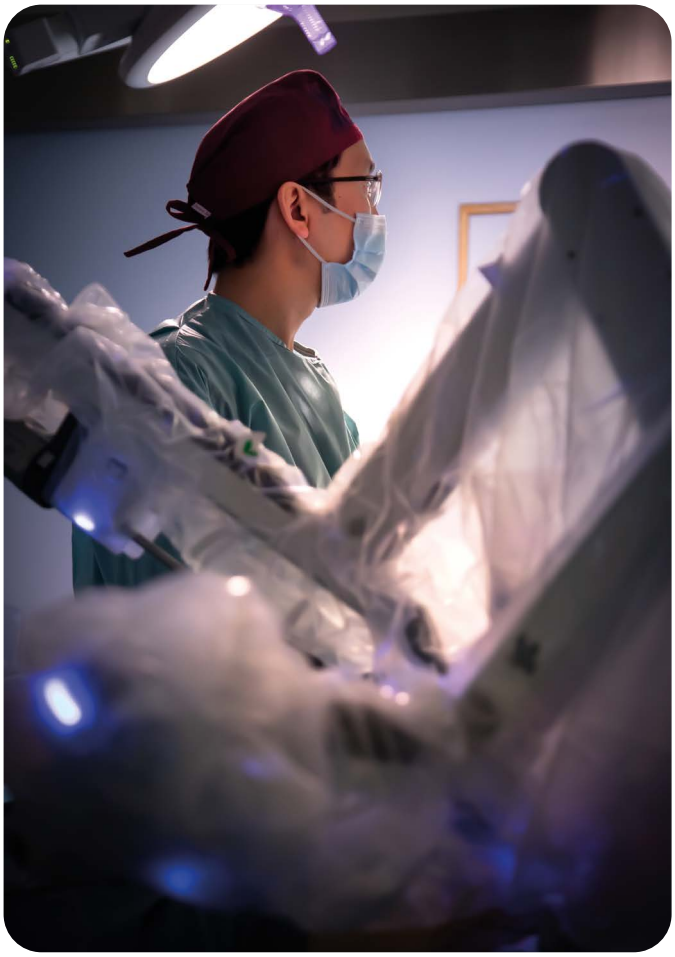
- Improved access, reduced waiting times and timely access to treatment leading to improved clinical outcomes
- Improved choice, personalisation and experience, improved life expectancy

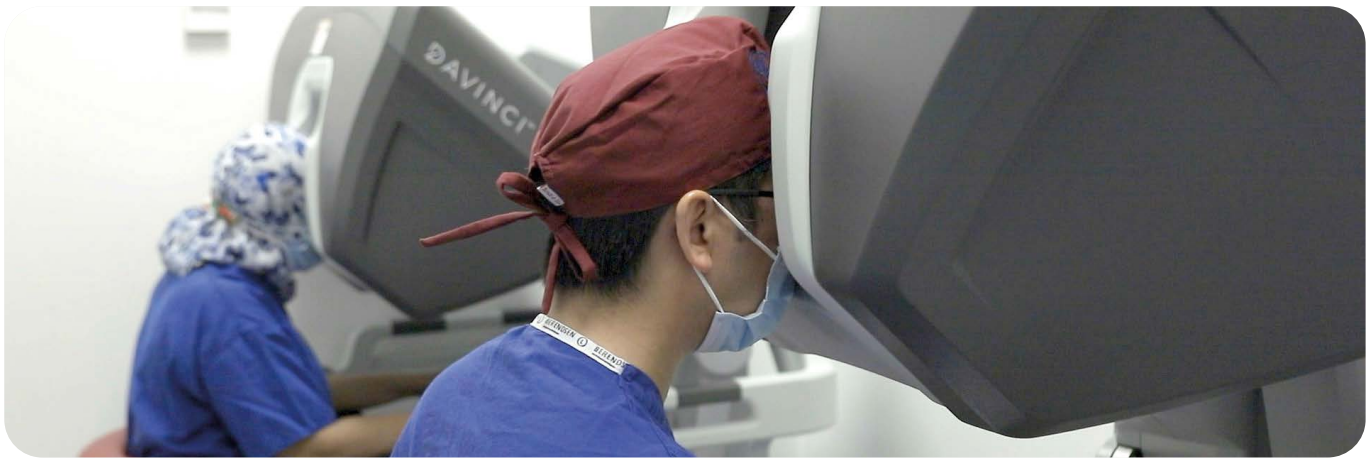
For Organisations:

- 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

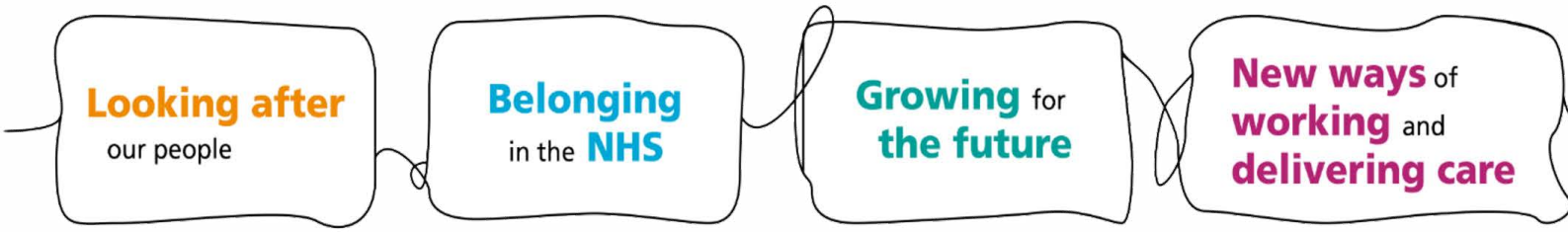
We know that a key enabler for the successful delivery of our Joint Forward Plan is our workforce. Currently there are approximately 60,000 colleagues working across health and social care in the Black Country, each providing a unique contribution to the delivery of care to our community. We know that 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.



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.

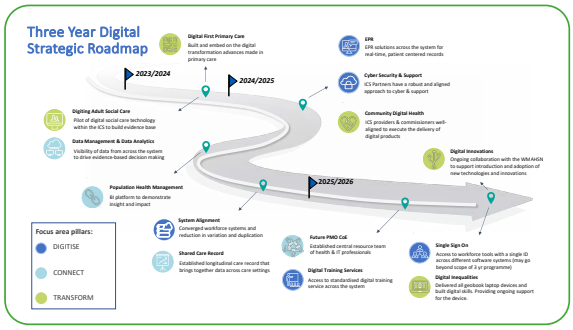
Recruitment of 29 International Radiographers who will support across hospital sites, addressing workforce challenges and improving diagnostic capacity for our patients.

Digital

Digital 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.

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.

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.

Dudley Health & Wellbeing

Longer, safer, healthier lives for all

DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item no. 8(d)**

DATE	14th March 2024
TITLE OF REPORT	Dudley Pharmaceutical Needs Assessment – Supplementary Statement 2 (March 2024)
Organisation and Author	Dr David Pitches, Head of service, Healthcare Public Health Jag Sangha, Pharmaceutical Adviser, Partnerships and Public Health, Dudley Integrated Health and Care NHS Trust on behalf of the Community Pharmacy Development Steering Group
Purpose	To inform the Health and Wellbeing Board of material changes to provision of community pharmacy services in Dudley since the publication of the first Supplementary Statement (September 2023) to the 2022 Pharmaceutical Needs Assessment
Background	Section 128A of the National Health Service Act 2006 (NHS Act 2006) requires each Health and Wellbeing Board periodically to assess the need for pharmaceutical services in its area and to publish a statement of its assessment (Pharmaceutical Needs Assessment, PNA) every three years. When subsequent changes in pharmacy provision or local population occur (e.g. if a pharmacy closes through consolidation with a nearby existing pharmacy), a "supplementary statement" of changes should be published by the Health and Wellbeing Board to indicate that it does not believe this creates a gap in provision that could be met by application from another provider. This is typically provided on an annual basis. Following approval of the first Supplementary Statement in September 2023, the Health and Wellbeing Board

	requested a six-monthly update. This was in response to concerns that access to certain pharmacies that are open for extended hours was becoming more difficult due to staffing and financial pressures.
Key Points	As of the end of January 2024 there were no further changes to provision of pharmacy services in Dudley, though several pharmacies have changed ownership during the past six months. Since the first Supplementary Statement was published three new NHS services have begun to be delivered through pharmacies, including (1) lateral flow devices for people eligible for COVID treatments, (2) oral hormonal contraception and (3) treatments for a range of common infections. Some of the implications of these new services for the population of Dudley are discussed.
Emerging issues for discussion	The need to continue monitoring access to pharmacy services, especially those outside usual working hours. Also, the need to ensure equitable access to new services that are designed to complement and relieve pressure from primary care.
Key asks of the Board/wider system	The Community Pharmacy Development Steering Group requests the Health and Wellbeing Board to: (a) note that changes in pharmaceutical provision since the 2022 PNA are unlikely to impact service users due to alternatives nearby. (b) publish a second Supplementary Statement to record that conclusion.
Contribution to H&WBB key goals: • **Improving school readiness** • **Reducing circulatory disease deaths**	Pharmacies have an important role to play in the prevention of circulatory disease through healthy living advice and interventions, for example in promoting blood pressure measurement and safe dispensing of medication for circulatory disease.

• **More women screened for breast cancer**	Pharmacies can also assist local targeted health information campaigns, e.g. breast cancer awareness.
Contribution to Dudley Vision 2030	

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Dudley Pharmaceutical Needs Assessment

Supplementary Statement 2 (March 2024)

Contact officer:
Dr David Pitches, Head of Service for healthcare public health, Dudley Metropolitan Borough Council (DMBC)

Acknowledgements:
Parminder Bhatia, Health Improvement Practitioner, DMBC
Neil Langford, Senior Intelligence Analyst, Public Health Intelligence, DMBC
Jag Sangha, Pharmaceutical Adviser – Partnerships and Public Health, Dudley Integrated Health and Care NHS Trust (DIHC)

Introduction

Dudley Health and Wellbeing Board's Pharmaceutical Needs Assessment (PNA) was originally published 26th September 2022. The first Supplementary Statement was issued on 1st September 2023. Since then, the following items have been identified as needing updating for correction, clarification or amendment. The principal source of information used to compile this Supplementary Statement has been the Pharmacy Market Administration Services, which are delivered through Primary Care Support England on behalf of NHS England by Capita. This updated information should be read in conjunction with the 2022 PNA and the first Supplementary Statement and reflects the position as of 31st January 2024.

Overview of recent NHS changes to pharmacy contracts

Since publishing the PNA, two new Advanced Services have been commissioned by NHS England/Improvement – ***Lateral Flow Device Service*** and ***Pharmacy Contraception Service***. A third Advanced Service called ***Pharmacy First*** (not to be confused with the Minor Ailments Service commissioned by Black Country Integrated Care Board (ICB)) is being commissioned nationwide from 31st January 2024.

(1) Lateral Flow Device (LFD) Service

The Lateral flow device tests supply service for patients potentially eligible for COVID-19 treatments (LFD service) was commissioned as an Advanced Service from November 2023.

The NHS offers COVID-19 antiviral treatment to people with COVID-19 whose pre-existing medical condition places them at increased risk of becoming seriously ill. Prior to the introduction of this service, rapid lateral flow device (LFD) tests were available to order by these patients on GOV.UK or by calling NHS 119. These kits were then delivered directly to the patient's home.

From 6th November 2023, LFD tests have no longer been available via GOV.UK or via NHS 119. LFD tests still need to be available and easily accessible to people who are potentially eligible for COVID-19 treatments through routine NHS access routes. Although access to LFD tests may be supplemented by other pathways (e.g. through anticipatory or specialist care), community pharmacy is well placed within the local community to provide local and rapid access for patients.

The objective of this service is to offer eligible at-risk patients access to LFD tests to enable testing at home for COVID-19, following symptoms of infection. In line with some of the recommended treatments' product licences, a positive LFD test result informs a clinical assessment to determine whether the patient is suitable for and will benefit from NICE recommended COVID-19 community-based treatments.

Further information about this service is available online[1].

At the time of writing, activity data for this service is unavailable at place level for individual pharmacy contractors (latest available data is October 2023 and the service was commissioned in November 2023), so we cannot make any assessment on the impact of this change on our PCNs and our local population. It is recognised that access to this service is desirable to support health protection and we conclude that all community pharmacies support access to this service across Dudley. Once at least six months' worth of data becomes available, the impact of this service and access for our population can be considered within a future supplementary statement.

(2) Pharmacy Contraception Service (PCS)

The Pharmacy Contraception Service (PCS) was initially commissioned in April 23 for the ongoing supply of the oral progestogen only pill (POP), Desogestrel 75micrograms daily. From December 2023, this has been extended to initiation of POP as well. Supply of the POP via this service is legally made possible through use of a patient group direction (PGD) to implement supply.

Strategically, this service supports the primary care access and recovery plan for general practice as well as the Women's Health Strategy for England[2] which identified that community pharmacy can provide increased access to contraception choice for females.

The objectives of the service are to:

- Provide a model for community pharmacy teams to initiate provision of oral contraception (OC), and to continue the provision of OC supplies initiated in primary care (including general practice and pharmacies) or sexual health clinics and equivalent. Both initiation and ongoing supply will be undertaken using PGDs to support the review and supply process; and
- Establish an integrated pathway between existing services and community pharmacies that provides people with greater choice and access when considering continuing their current form of OC.

[1] https://cpe.org.uk/national-pharmacy-services/advanced-services/lfd-service/

[2] https://www.gov.uk/government/publications/womens-health-strategy-for-england

The service aims to provide:

- People with greater choice from where they can access contraception services;
- Extra capacity in primary care and sexual health clinics (or equivalent) to support meeting the demand for more complex assessments.

Further information about this service is available online[3].

At the time of writing, being a relatively new service, both the details of pharmacies in Dudley that are accredited to deliver and service activity levels are not known. It is recognised that women have access to contraception through other local providers (e.g. sexual health clinics, GP practices, private online services and purchase direct through community pharmacy as "Pharmacy only" medicines), we conclude that this service is desirable for our population as it creates additional access and choice and helps to create capacity for general practice to manage more complex clinical care.

We further conclude that the commissioner (Black Country ICB, through delegated function from NHS England/Improvement) should work with PCNs, DIHC pharmacy team and Community Pharmacy Dudley (formerly Dudley Local Pharmaceutical Committee) to ensure mobilisation of these services is delivered in a consistent and harmonised manner that supports seamless care for the service user. Clear pathways of communication will be required by community pharmacy and general practices to ensure it is a sustainable service for our population and delivers the proposed outcomes. We further conclude to support integration and efficient patient referral from General practice to community pharmacy (and *vice versa*), the commissioner should commit financial resource to developing a digital platform that ensures safeguards and appropriate referrals by non-clinical members of the general practice team (in today's general practice these are referred to as "care navigators").

Once data is available for a minimum of six months, this can be analysed and access for our population considered within a future supplementary statement.

(3) Pharmacy First Service

The Pharmacy First service commenced on 31st January 2024 where the required IT systems were in place. It recognises the vast amount of healthcare advice that community pharmacies provide to the public every day and establishes pharmacy as the first port of call for healthcare advice.

This new service involves pharmacists providing advice and NHS-funded treatment, where clinically appropriate, for seven common conditions:

- sinusitis
- sore throat
- acute otitis media
- infected insect bite
- impetigo
- shingles
- uncomplicated urinary tract infections in women

[3] https://cpe.org.uk/national-pharmacy-services/advanced-services/pharmacy-contraception-service/

Consultations for these seven clinical pathways can be provided to patients presenting to the pharmacy as well as those referred by NHS 111, general practices and others. The service also incorporates the existing elements of the Community Pharmacist Consultation Service, *i.e.* minor illness consultations with a pharmacist and the supply of urgent medicines and appliances, following a referral from NHS 111, general practices and other authorised healthcare providers (*i.e.* patients are not able to present to the pharmacy without a referral).

During a consultation with a pharmacist, people with symptoms suggestive of the seven conditions will be provided with advice and will be supplied, where clinically necessary, with a prescription-only treatment under a PGD or an over-the-counter medicine (supplied under a clinical protocol) at NHS expense.

Further information about this service is available online[4].

Although this is a new national advanced service, several of the common conditions were described in our 2022 PNA under the heading of Tier 1 and Tier 2 Extended Care Services which from a contractual viewpoint was considered a local enhanced service. Through development of this new service nationally, it secures much needed commitment to funding long term for community pharmacy which is commendable.

As this is also a new service at the time of writing, we cannot offer any conclusions about access for our population. However, this service supplements existing providers (especially GP practices) and we conclude that this is a desirable service which all community pharmacies should sign up to support across Dudley to release capacity in over-stretched general practices. This service is aligned to support the Black Country Primary Care Access and Recovery Plan.

We further conclude that the commissioner (Black Country ICB, through delegated function from NHS England/Improvement) should work with PCNs, the DIHC pharmacy team and Community Pharmacy Dudley (formerly Dudley Local Pharmaceutical Committee) to ensure mobilisation of these services is delivered in a consistent and harmonised manner that supports seamless care for our population. Similar to PCS as discussed above, clear pathways of communication will be required by community pharmacy and general practices to ensure it is a sustainable service for our population. We further conclude that to support integration and efficient patient referral from general practice to community pharmacy (and *vice versa*), the commissioner should commit financial resource to developing a digital platform that ensures safeguards and appropriate referrals by non-clinical members of the general practice team (in today's general practice these are referred to as "*care navigators*"). Local evidence from implementation of CPCS service within Dudley has demonstrated that an IT solution that refers patients from general practice (via the clinical system EMIS Web) to community pharmacy has greatly supported uptake of this service.

Once sufficient data for activity by Dudley pharmacy contractors is available, we will review local access and comment further in a future supplementary statement.

[4] https://cpe.org.uk/national-pharmacy-services/advanced-services/pharmacy-first-service/

Pharmacy openings
No new pharmacies in Dudley have opened since the cut-off date for the previous supplementary statement.

Pharmacy closures
No existing pharmacies in Dudley have closed since the cut-off date for the previous supplementary statement.

Pharmacy relocations
No pharmacies in Dudley have relocated since the cut-off date for the previous supplementary statement.

Changes in opening hours
No pharmacies in Dudley have changed their total opening hours since the cut-off date for the previous supplementary statement.

Ownership and/or trading change
Lloyds Pharmacy at Wychbury Medical Centre, 121 Oakfield Road, Wollescote DY9 9DS (reference 35 in table and map). This pharmacy is now operated by LP SD Thirty Eight Limited. The pharmaceutical service provision and operating hours remain unchanged.

Lloyds Pharmacy Ltd at St Margaret's Well Surgery, 2 Quarry Lane, Halesowen B63 4WD (reference 36 in table and map). This pharmacy has changed ownership and is now operated by Opal Pharmacy Limited, trading as Hasbury Pharmacy. The pharmaceutical service provision and operating hours remain unchanged.

Murrays Healthcare at 5-6 Halesowen Road, Halesowen B62 9AA (reference 45 in table and map). This pharmacy has changed ownership and is now operated by Chestnut Healthcare Ltd, trading as Peak Pharmacy. The pharmaceutical service provision and operating hours remain unchanged.

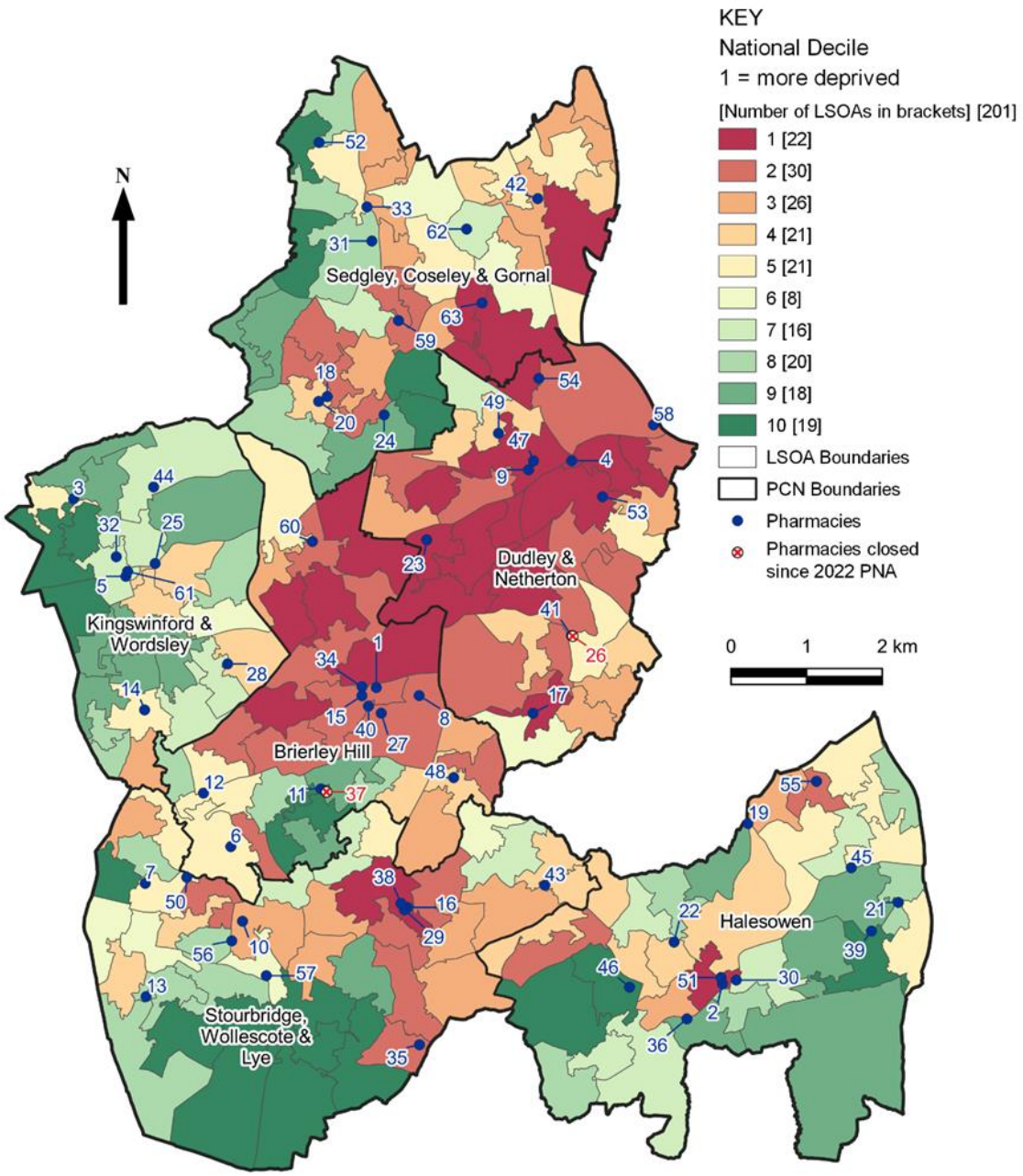
Northway Pharmacy, 6 Alderwood Precinct, The Northway, Sedgley, Dudley DY3 3QY (reference 52 in table and map). This pharmacy has changed ownership and is now operated by Bestway National Chemists Ltd, trading as Well. The pharmaceutical service provision and operating hours remain unchanged.

Dispharma Chemist at 5 Bean Road, Dudley DY2 8TH (reference 53 in table and map). This pharmacy has changed ownership and is now operated by Jeevan Pharma Ltd. The pharmaceutical service provision and operating hours remain unchanged.

Norchem Healthcare Limited, 4 The Arcade, Upper Gornal, Dudley, West Midlands, DY3 2DA (reference 59 in table and map). This pharmacy has changed ownership and is now operated by Bestway National Chemists Ltd, trading as Well. The pharmaceutical service provision and operating hours remain unchanged.

Conclusion

Overall, it is concluded these changes will not impact pharmaceutical services access for our population in Dudley. The new Advanced Services are welcomed and will provide additional access for our population as well as supporting our general practices to liberate capacity aligned to the primary care access and recovery plan.



Source: ODS DataPoint, NHS Digital / LLPG, Dudley MBC / Indices of Deprivation 2019, MHCLG
Produced by: Intelligence Team, Dudley MBC

Appendix 1: Key to pharmacy locations, summary of changes and map

ID	Pharmacy	Address	Postcode	PCN
1	Asda Pharmacy	PEARSON STREET, BRIERLEY HILL	DY5 3BJ	BH
2	Asda Pharmacy	THE CORNBOW SHOPPING CTR, QUEENSWAY MALL, HALESOWEN	B63 4AB	H
3	Boots	14 ALBION PARADE, WALL HEATH	DY6 0NP	KW
4	Boots	25-26 MARKET PLACE, DUDLEY	DY1 1PJ	DN
5	Boots	16-18 MARKET STREET, KINGSWINFORD	DY6 9JR	KW
6	Boots	STOURBRIDGE HTH & SCC, JOHN CORBETT DRIVE, AMBLECOTE	DY8 4HZ	BH
7	Boots	141 BRIDGNORTH ROAD, WOLLASTON	DY8 3NX	SWL
8	Boots	UNIT3, MERRY HILL CENTRE, BRIERLEY HILL	DY5 1QT	BH
9	Steppingstone Pharmacy	STEPPING STONES MED CTR, STAFFORD STREET, DUDLEY	DY1 1RT	DN
10	Boots	5 RYEMARKET, STOURBRIDGE	DY8 1HJ	SWL
11	Withymoor Pharmacy	OFF SQUIRES COURT, WITHYMOOR VILLAGE, BRIERLEY HILL	DY5 3RJ	BH
12	Brettell Lane Pharmacy	108B BRETTELL LANE, STOURBRIDGE	DY8 4BS	BH
13	Broadway Pharmacy	95 THE BROADWAY, NORTON, STOURBRIDGE	DY8 3HX	SWL
14	County Pharmacy Ltd	15 WORDSLEY GREEN CENTRE, WORDSLEY	DY8 5PD	KW
15	Day Night Pharmacy	20 ALBION STREET, BRIERLEY HILL	DY5 3EE	BH
16	Day Night Pharmacy	45 HIGH STREET, LYE	DY9 8LQ	SWL
17	Dudley Wood Pharmacy	2 BUSH ROAD, DUDLEY	DY2 0BH	DN
18	Eggington JT Ltd	ABBEY ROAD, LOWER GORNAL	DY3 2PG	SCG
19	Evergreen Pharmacy	161 COOMBS ROAD, HALESOWEN	B62 8AF	H
20	Gornal Wood Pharmacy	18 ABBEY ROAD, GORNAL WOOD	DY3 2PG	SCG
21	Grange Pharmacy	8 HOWLEY GRANGE ROAD, HALESOWEN	B62 0HN	H
22	Hawne Chemist	177 STOURBRIDGE ROAD, HALESOWEN	B63 3UD	H
23	Holly Hall Pharmacy	178 STOURBRIDGE ROAD, HOLLY HALL, DUDLEY	DY1 2ER	DN
24	Jhoots Pharmacy	100A MILKING BANK, DUDLEY	DY1 2TY	SCG
25	Jhoots Pharmacy	468 HIGH STREET, KINGSWINFORD	DY6 8AW	KW
26	[now closed]			
27	Jhoots Pharmacy	BRIERLEY HILL H & S C C, VENTURE WAY, BRIERLEY HILL	DY5 1RG	BH
28	Lad Chemist	30 MADELEY ROAD, HIGH ACRES, KINGSWINFORD	DY6 8PF	KW
29	Lymes Pharmacy	173A HIGH STREET, LYE	DY9 8LN	SWL
30	Halesowen Pharmacy	11 PECKINGHAM STREET, HALESOWEN	B63 3AW	H
31	Lloyds Pharmacy	175 THE RIDGEWAY, SEDGLEY	DY3 3UH	SCG
32	Lloyds Pharmacy	MOSS GROVE SURGERY, 15 MOSS GROVE, KINGSWINFORD	DY6 9HS	KW
33	Sedgley Pharmacy	24-28 DUDLEY STREET, SEDGLEY	DY3 1SB	SCG
34	Lloyds Pharmacy	204 TALBOT STREET, BRIERLEY HILL	DY5 3DS	BH
35	Lloyds Pharmacy (Change in operator)	WYCHBURY MEDICAL CTR, 121 OAKFIELD ROAD, STOURBRIDGE	DY9 9DS	SWL

ID	Pharmacy	Address	Postcode	PCN
36	Hasbury Pharmacy (Change in ownership)	ST MARGARETS WELL SURGERY, 2 QUARRY LANE, HALESOWEN	B63 4WD	H
37	[now closed]			
38	Lye Pharmacy	37 HIGH STREET, LYE	DY9 8LF	SWL
39	Manor Pharmacy	12 MANOR LANE, HALESOWEN	B62 8PY	H
40	McArdle I Ltd	92 HIGH STREET, BRIERLEY HILL	DY5 3AP	BH
41	Milan Chemist	137 HALESOWEN ROAD, NETHERTON	DY2 9PY	DN
42	Millard & Bullock	UNIT 2, JOSIAH HOUSE, CASTLE STREET, COSELEY	WV14 9DD	SCG
43	Modi Pharmacy	118 COLLEY GATE, HALESOWEN	B63 2BU	SWL
44	Morrisons Pharmacy	CHARTERFIELD SHOPPING CTR, STALLINGS LANE, KINGSWINFORD	DY6 7SH	KW
45	Murrays Pharmacy (Change in ownership)	5&6 HALESOWEN ROAD, HALESOWEN	B62 9AA	H
46	Murrays Pharmacy	33 THORNHILL ROAD, HALESOWEN	B63 1AU	H
47	Murrays Pharmacy	CROSS STREET HEALTH CTR, CROSS STREET, DUDLEY	DY1 1RN	DN
48	Murrays Pharmacy	37-38 HIGH STREET, QUARRY BANK, BRIERLEY HILL	DY5 2AA	BH
49	Murrays Pharmacy	ST JAMES MEDICAL PRACTICE, MALTHOUSE DRIVE, DUDLEY	DY1 2BY	DN
50	Murrays Pharmacy	LION MEDICAL CTR, 2 LOWNDES ROAD, STOURBRIDGE	DY8 3SS	SWL
51	Murrays Pharmacy	57 QUEENSWAY, THE CORNBOW SHOPPING CTR, HALESOWEN	B63 4AG	H
52	Well (Change in ownership)	6 ALDERWOOD PRECINCT, THE NORTHWAY, SEDGLEY	DY3 3QY	SCG
53	Pharmaco Dudley Limited (Change in ownership)	5 BEAN ROAD, DUDLEY	DY2 8TH	DN
54	Priory Community Pharmacy	95-97 PRIORY ROAD, DUDLEY	DY1 4EH	DN
55	Rajja Chemist	5 CLEMENT ROAD, HALESOWEN	B62 9LR	H
56	Stourbridge Pharmacy	35 WORCESTER STREET, STOURBRIDGE	DY8 1AT	SWL
57	Swinford Pharmacy	90 HAGLEY ROAD, STOURBRIDGE	DY8 1QU	SWL
58	Tesco Pharmacy	TESCO SUPERSTORE, BIRMINGHAM NEW ROAD, DUDLEY	DY1 4RP	DN
59	Well (Change in ownership)	4 THE ARCADE, UPPER GORNAL	DY3 2DA	SCG
60	The Pharmacy Galleria	96 HIGH STREET, PENSNETT	DY5 4ED	BH
61	Village Pharmacy	9-11 MARKET STREET, KINGSWINFORD	DY6 9JS	KW
62	Woodsetton Pharmacy	41 BOURNE STREET, DUDLEY	DY3 1AF	SCG
63	Wrens Nest Pharmacy	100 MAPLE GREEN, DUDLEY	DY1 3QZ	SCG

Primary Care Network (PCN) key
BH = Brierley Hill
DN = Dudley and Netherton
H = Halesowen
KW = Kingswinford and Wordsley
SCG = Sedgley, Coseley and Gornal
SWL = Stourbridge, Wollescote and Lye

Dudley Health & Wellbeing

Longer, safer, healthier lives for all

DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item no. 8(e)**

DATE	14th March 2024
TITLE OF REPORT	Sport England Place Based Investment
Organisation and Author	Dudley MBC Public Heath Balraj Johal
Purpose	Inform the Board of the funding opportunity and to seek input into the development of Dudley's bid.
Background	In recent years Sport England have placed a strong emphasis on 'Place Based' & 'System' approaches to tackle physical inactivity. Over the next 5 years £190 million will be invested by Sport England to expand their place-based partnerships into 80-100 additional places via the network of people in their existing Local Delivery Pilots and Active Partnerships. It is a fundamentally new approach to investment. One that is based on data, local intelligence of places, readiness and avoiding competition between partners. Delivery to take place over 4-5 years. To filter down the 80-100 places Sport England are prioritising those places where the need is greatest and the leadership and conditions are in place to progress work at pace. They are doing this through a phased approach with 3 tranches. All the Black Country LA areas have been approved as priority places as part of tranche 1.
Key Points	There will be a 6-month period where plans can be developed. It is important at this stage to not start the conversation with the amount of money but to outline the commitment, readiness and priorities that can inform the investment ask.

	The emphasis on Sport England is to see places adopt a coproduction approach, piloting interventions that have been developed with systems partners and communities, before scaling up to wider delivery. This is a major shift in approach for the funder who have previously had a transactional approach to investment, leading with pre determined solutions.
Emerging issues for discussion	To discuss priority areas for the bid. Initially three areas that have been identified are; • Transport / active travel • Children and Young People • Embedding activity into adult social care
Key asks of the Board/wider system	The ask of the Board is consider how best they would like to input into the Dudley bid to help ensure it progresses as a truly system wide programme of work.
Contribution to H&WBB key goals: • **Improving school readiness** • **Reducing circulatory disease deaths** • **More women screened for breast cancer**	Through increasing levels of physical activity levels the main contribution to H&WBB goals would be through reducing circulatory disease deaths.
Contribution to Dudley Vision 2030	• More people walk and cycle for work, studying and leisure • Improved health outcomes and higher wellbeing • Connected, empowered people making things happen in their communities

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