Meeting of the Dudley Health and Wellbeing Board

Thursday 8th June 2023, at 4.00pm on Microsoft Teams
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Agenda - Public Session

(Meeting open to the public and press)

1. Election of the Chair

   The Elected Members of the Board to elect a Chair for the municipal year.

2. Election of the Vice-Chair and Co-opted additional Members

   The Elected Members of the Board to elect a Vice-Chair and Co-opted additional Members for the municipal year.

3. Apologies for absence.

4. Appointment of Substitute Members.

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

6. To confirm the minutes of the meeting held on 9th March, 2023, as a correct record (Pages 4 - 24)

7. Public Voice

8. Items for Board sign-off
    a) Draft Evaluation of Joint Health and Wellbeing Strategy 2017-2022 – Sarah Dougan (Pages 25 to 42)
    b) Draft Joint Health, Wellbeing Inequalities Strategy 2023-28 – Sarah Dougan (Pages 43 to 53)
    c) Dudley's approach to reducing health inequalities – Sarah Dougan (Pages 54 to 77)

9. Items for Information
    a) Report from the Joint Boards Away Day – verbal report – Sally Cornfield
    b) Better Care Fund Plan 2023/25 Approval – Sarah Knight/Matt Bowsher (Pages 78 to 118)
    c) Black Country NHS Joint Forward Plan – Sarah Knight (Pages 119 to 167)

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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- 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, N Neale and S Ridney.
B Heran – Deputy Chief Executive
M Bowsher – Director of Adult Social Care
M Abu Affan – Acting Director of Public Health and Wellbeing
C Driscoll – Director of Children's Services
K Jones – Director for Housing and Communities
H Ellis - Service Director – Early Help/Schools and SEND
N Bucktin – Dudley Managing Director – Black Country and West Birmingham Clinical Commissioning Groups (CCGs).
P Kingston – Independent Safeguarding Board Chairperson
Dudley GP Clinical Commissioning Group – Dr R Edwards
A Gray – Dudley CVS CEO
C Craddick - West Midlands Police Representative
Operations Commander Matt Young – West Midlands Fire and Rescue Service
M Foster – Acting 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

Minutes of the Dudley Health and Wellbeing Board
Thursday 9th March 2023 at 4.00pm
Microsoft Teams Meeting

Present:

Councillor I Bevan (Chair)
Councillor: R Buttery and S Ridney

Officers: M Abu Affan (Acting Director of Public Health and Wellbeing), N Bucktin (Managing Director for Dudley – Black Country Integrated Care Board), S Cartwright (Dudley Integrated Health Care NHS Trust), S Cornfield (Programme Director – Health and Care Partnership).

S Dougan (Head of Adults and Public Health), M Forster (Acting Chief Executive of Black Country Health Care), A Gray (Dudley Council for Voluntary Service - Chief Executive Officer), J Griffiths (Chief Officer Healthwatch Dudley), A Henry (Health and Wellbeing Policy Officer), P Kingston (Independent Chair – Safeguarding - Dudley), S Thirlway (Service Director of Education, SEND and Family Solutions), J Weston (Strategic Partnership Manager Forging the Future), and L Jury (Democratic Services Officer).

Also in attendance:

B Clifford (Working for Councils in the Black Country Integrated Care System - WM-ADASS Associate)
K Rose substitute for D Wake (Dudley Group NHS Foundation Trust)
J Vaughan (Assessment and Independence) substitute for Director of Adult Social Care
S Thirlway (Service Director of Education, SEND and Family Solutions) substitute for Director of Children's Services

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20 **Apologies for absence**

Apologies for absence from the meeting were submitted on behalf of Councillor L Taylor-Childs; M Bowsher, S Brooks, C Driscoll, Bishop of Dudley, Dr R Edwards, B Heran, Commander A Tagg, S Tranter, D Wake and J Whyley.

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21 **Declarations of Interest**

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

22 **Minutes**

K Rose, referring to page 22, minute 23, commented that her name had been stated as K Jones and requested that this be amended.

Resolved

That subject to the amendment below, the minutes of the meeting of the Board held on 1st December, 2022, be approved as a correct record.

Page 22, Minute 23, replace K Jones with K Rose.

23 **Change in order of Business**

Pursuant to Council Procedure Rule 13 (c) it was:

Resolved

That the order of business be varied and that the agenda items be considered in the order set out in the minutes below.

24 **Joint Health and Wellbeing Strategy 2023-2028, assessment of potential goals and inclusion of health inequalities.**

The Board received a report of the Acting Director of Public Health and Wellbeing on the Joint Health and Wellbeing Strategy (JHWS) 2023-2028, assessment of potential goals and inclusion of health inequalities.

The Head of Adults and Public Health presented the report and in doing so, made reference to attendance at the previous Health and Wellbeing Board development sessions and subsequently the work that had been undertaken with various partners to produce a paper on the new goals for the JHWS for 2023-2028.

The proposed goals in the paper had been informed by the development session and the group were of the view that the HWBB focus on a small number of goals which could visibly make a difference, both with short-term and longer-term outcomes.

The goals identified were distinct from other Boards and it was hoped would avoid duplication and repetition. The group were keen to capitalise on the unique position of the HWBB in bringing partners together who had influence within Health and Care Services and also on the social determinantes of health and thinking through how the Board sits between the Dudley Health and Care Partnership and the Forging a Future.

It was also proposed to embed the approach to health inequalities into the JHWS rather than introducing a separate Inequalities Strategy for Dudley.

The paper sought the Board's approval to encompass health and equalities into the JHWS and the Board were requested to discuss and agree on the goals it would wish to focus on, out of the four that were proposed at the development session namely:

1. **Reducing circulatory disease deaths** – proposed as it was the biggest cause of early mortality amongst residents in Dudley and the largest in men within the life expectancy gap. It was noted that Dudley had a consistently higher death rate from circulatory disease compared to its neighbouring authorities and the national average, and concerns had been raised that this would increase, due to the effects of Covid, where the management of this condition had seen a reduction, together with the back logs in the NHS. The interventions already in place were presented and included helping people to stop smoking, encouraging people to partake in physical activity, holding physical health checks, especially for people suffering from mental health conditions, and finding and treating people with high blood pressure, part of the NHS Core20PLUS5, the national initiative to reducing healthcare inequalities. It was noted that the role of the Board would be to collate these initiatives together into a system-wide Action Plan and reference was also made to the opportunity to reduce heath inequalities as the difference seen in mortality were driven by health inequalities.

2. **Improving breast cancer screening coverage** – a proposed goal as Dudley had seen a reduction in screening during Covid and it was noted that previously Dudley had a higher-than-average uptake in screening amongst women. It was noted that large inequalities were again highlighted in women who did not partake in screening, as Dudley and Netherton had a lower uptake than Halesowen. Most opportunities would lie within the NHS rather than a role with system partners and it was noted that some discussion had taken place on whether screening would be better placed with the Health Protection Board, chaired by the Acting Director of Public Health and Wellbeing.

3. **Increasing school readiness** – proposed as a goal as Dudley had a lower achievement in school readiness, noting that Dudley had a good level of development at age 5, and acknowledging the ongoing work being undertaken around the first 1001 days within the Borough and initiatives around family starts and neglect and safeguarding. The Board would collate together all the initiatives already in place to work on improving school readiness in children. Reference was made to particular groups in relation to inequalities, such as children with special educational needs, boys, those in receipt of free school meals and acknowledging that Asian children had a lower level of school readiness compared to their peers. It was noted that like circulatory disease, there would be a role for system partners, ranging from mental health services, health visits, school nursing, children's services, educational services and childcare, a role for public health, and again the social determinates of health in all of this. Reference was made to the strong role of poverty in this area that would lead to an extension of the previous HWBB goal around reducing poverty.

4. **Focusing on a place-based approach in the most deprived areas of Dudley-** proposed as a goal as cumulative impacts of poor health in the Borough were highlighted and therefore, a need for a focus in those areas. Reference was made to the data that had been captured, which had focused on the three most deprived wards for simplicity, however, it was noted that should the Board agree to take this approach, consideration would need to be given to whether this needed to be undertaken by neighbourhood rather than Ward but the proposal was that focus be put on the most deprived areas and look at how, across all services and all the determinates of health, outcomes could be improved.

In conclusion, the Head of Adults and Public Health, commented that should members be minded to choose the first three goals referred to above namely; Reducing circulatory disease deaths, Improving breast cancer screening coverage, and Increasing School Readiness, then the place-based approach could be embedded within those three goals.

Arising from the presentation of the report, Members made comments and asked questions which were answered at the meeting as follows:

(a) The Managing Director for Dudley (Black Country Integrated Care Board) welcomed the report and proposed that the Board focus on the goals numbered 1 to 3 above with particular focus on the areas of highest deprivation.

(b) The Acting Director of Public Health and Wellbeing thanked the officer for such an informative and useful report and proposed that the Board focus on goals 1 and 3 and that the goal relating to breast screening be overseen by the Health Protection Board and strengthening the work of David Pitches, the Lead for Screening, with the responsibility for improving uptake resting with NHS England. However, the Board could support the improvement in the uptake and monitor screening across the life-course approach. Support was given to having a place-based approach as a thread across any goals agreed.

(c) The Acting Chief Executive of Black Country Health Care welcomed the report and commented that the goals 1 to 3 were likely to have a disproportionate profile in the more deprived areas and therefore, goal 4 would run through the other 3 goals. In response to a question raised in relation to the interface between these priorities and the Dudley Partnership work, and whether any consideration had been given as to how these priorities fitted in with the emerging priorities of the Integrated Care Partnership, the Head of Adults and Public Health advised that reference had been made to the Dudley Health and Care Partnership and the approach taken to align to the work that was being undertaken and further discussions could be held. Once the Board had agreed the goals it wished to pursue, a more detailed system action plan would be developed looking at how all partners in the system would contribute to the plan and looking at primary prevention, secondary prevention and treatment, most likely within the NHS, being very clear who would be undertaking what and where it would fit in with other programmes.

(d) The Service Director Education, SEND and Family Solutions, commented that from a Children's Services point of view, he was keen to see the school readiness as a key approach for reasons including, the impact on children's education, health outcomes and for parents and carers as a wider impact. It was noted that this would also help align with the Child Friendly Dudley approach that the authority was keen to develop within the Borough. Support was also given to the systemic approach to looking at these issues and echoed other colleagues' proposals put forward to focus on areas of deprivation as a golden thread to support priorities.

(e) K Rose echoed comments made by other members in relation to the golden thread of deprivation areas approach which would be helpful and support could be given from the work being undertaken by the Integrated Care Teams which could be linked in. Support was given to the first three goals as priorities with the place-based approach running as a thread across all the goals. In relation to the next steps being a joint plan going forward, it was questioned how to co-produce the plan around addressing these and questioned whether these goals resonated with residents within Dudley in terms of the wording used.

(f) S Cartwright echoed comments made by the Acting Chief Executive of Black Country Health Care to ensure that the link was made with the Integrated Care Partnership and acknowledging the amount of work already undertaken in the development of the strategy and recognising the good opportunity to now demonstrate the new system with regard to the integrated care partnerships and the importance of ensuring the link.

(g) The Chief Officer Healthwatch Dudley also agreed with the proposal to prioritise the first three goals and particularly in terms of the fourth goal in targeting communities and actively going out to work with people as the real difficulties have been identified and the need to now be proactive. It was commented that further consideration would be needed going forward on how to communicate these priorities with the public.

(h) The Chief Executive – Dudley Community Voluntary made reference to the second Poverty Summit hosted by Dudley MBC recently and raised the importance of framing this work to the rising poverty in the Borough, recognising that people were struggling at present just for the basic needs before considering attending breast screening, etc and the link between the two, and the need to be cognisant and frame all of the priorities against the backdrop of rising poverty within the Borough.

(i) In response to a question raised by Councillor Buttery in relation to the impact on the system and families, the Head of Adults and Public Health advised that whichever goals were finally selected, that would be the challenge going forward and the need to look at doing things that were meaningful. Members in the development session had emphasised the importance of clearly identifying things that could demonstrate as having made an impact in the short-term, as well as building things in for the medium and long-term.

In response to the comments made, the Head of Adults and Public Health welcomed the comments made by members and the proposed goals identified and advised that the draft strategy be presented to the Board at its June meeting for consideration. In acknowledging the importance of community engagement, it was advised that a strategy for community engagement be developed for the whole period of the JHWB and Inequalities Strategy and recognising the intensive community engagement that was being undertaken in parts of the Borough, link into this engagement and involve communities, in particularly the communities that were most impacted by the goals identified and capitalise on any work already being undertaken in partner organisations.

In conclusion, the Acting Director of Public Health and Wellbeing advised that the priorities of other Boards would be considered, including the Black Country Integrated Care Partnership (ICP), and a discussion would take place before finally agreeing the Board's priorities to ensure no duplication and to ensure synergy.

Resolved

(1) That the report presented on the Joint Health and Wellbeing (JHW) Strategy for 2023-2028, and comments made by Members as stated above, be noted.

(2) That the goals numbered 1 to 3 as stated above, namely, Reducing circulatory related disease deaths, Improving breast cancer screening coverage and Increasing school readiness, be proposed as the goals adopted in the new JHW Strategy for 2023-2028, with the goals focusing on a place-based approach in the most deprived areas of Dudley.

(3) That following on from further discussions and consideration of other Board's goals/priorities, a further detailed report on the goals be submitted to the June meeting for consideration.

25 **Priorities from other Boards and opportunities to work together to achieve agreed Health, Wellbeing and inequalities goals:**

(b) Black Country Integrated Care Partnership

The Committee received a verbal report of Brendan Clifford (???) on the Board's commitment to working with the Integrated Care Partnership (ICP) across the Black Country. Reference was made to the recent development sessions which he had attended to offer some reflections, together with colleagues, about the touchpoints between localities and the wider partnership and system, acknowledging the close co-operation required with localities and organisations for the ICP to function successfully. Acknowledgement was given to colleagues from Dudley who had attended a number of meetings that had been held which would allow the Dudley voice to be heard.

Reference was made to a Working Group that had overall responsibility for the development of the strategy, including a Joint Committee attended by the Chief Executive of the ICB and Chief Executives of Local Authorities and the tight timescale for the production of an initial Integrated Care Strategy (ICS) for the Black Country was acknowledged. Effort had been made to locate the strategy to the Black Country, and the importance in trying to get the balance understood on how the wider system could help the place and the place/locality could be good for the wider system, emphasising the need for collaboration and competition not duplication.

A summary of the ICS was then presented and a hyperlink to the full strategy was shared with the Board and members were urged to review the document.

It was noted that the strategy acknowledged the changes that had taken place in the Black Country over the years, and living with the effects of the changes, such as the focus on heavy industry now giving way to the introduction of tourism and the opportunities this provided.

Alongside this, the strategy showed the real picture of the Black Country as the second most deprived area in the Black Country next to Birmingham and Solihull and it was noted that as a result of the discussions that had been held, four broad priorities had been identified and it was emphasised that the success of the strategy would be judged on the success of the priorities going forward.

The four priorities were:

- Black Country people – great and skilled
  Workforce: Recruitment Education and Training.
- Growing up in the Black Country
  Children and Families
- Black Country Cares
  Social Care System
- Feeling well in the Black Country
  Mental health and emotional wellbeing.

Refence was made to the number of different partnerships that were already actively working on these areas, but it was emphasised that more focus needed to be given.

Reference was made on how the priorities were delivering at the moment and how the overall governance processes could work. The importance of collaboration between the partners was noted, such as the NHS, Councils, and wider partners including the Police, Voluntary sector, Further Education colleges and local universities. The importance of dialogue with the local communities was raised, noting that an event that would be taking place imminently would focus on extending the dialogue with the community, and supporting the work that had already been undertaken across the localities.

Aspirations were then presented, with the desire for people to see that the Black Country were trying to make a difference to people's lives, highlighting the areas strengths, assets, and opportunities, in spite of the challenges the area faced.

The next steps were highlighted, particularly working together on the priorities, making the most of the partnerships to meet the population health challenges faced by the people living in the Black Country.

In conclusion, reference was made to the partnerships who had contributed to the production of the strategy up to the point of publication, and comments that had been made by colleagues on the process in developing the strategy were highlighted. It was noted that these comments and other issues that had been identified would be addressed as the strategy was developed going forward.

Arising from the presentation, the Acting Director of Public Health and Wellbeing thanked the officer for the presentation and welcomed the four priorities that had been identified which would be reviewed at a Black Country level. In response, B Clifford acknowledged that the priorities highlighted were not new priorities but emphasised the importance of working in a partnership in a way that had not been previously done to try to make a big difference and build on the achievements that had already been attained.

(c) Safeguarding and Safety

The Independent Chair (Safeguarding) Dudley presented on the priorities for the Dudley Safeguarding People Partnership.

It was recognised that some of the priorities overlapped with priorities identified in the previous agenda items and reference was made to the need to triangulate the priorities. It was noted that the partnership had set three priorities for 2022 to 2024 based on national prioritise, rapid review, audit practice, management data that had been collected, triangulations from inspections, peer reviews, and national research. This had resulted in the three priorities namely: Exploitation, Neglect and adopting a Think Family approach.

Reference was made to the sub-groups that had been introduced to ensure that the priorities were actioned.

Child Neglect Sub-Group, - work that had been undertaken included, an update of the Child Neglect Strategy which had formally been launched in November 2022, the continuation to publish self-neglect Safeguarding Adult Reviews (SARs) which included the resources for practitioners to identify self-neglect, updated work on PIPOT (People in Positions of Trust) and it was noted that a new system had been introduced and work was being undertaken on improving consistency on this across the Black Country, continuing to send out briefings to enhance practitioners knowledge on certain areas such as safeguarding topics, professional curiosity, domestic abuse, professional challenge and resolution, the creation of a Non-accidental Injury Forum and pathway, raised awareness on what was not brought/did not attend and links to neglect to improve on consistency. It was noted that this work could be accessed on the Dudley Safeguarding People Partnership website.

The Learners Sub-Group – work continued to undertake Child Safeguarding Practice Reviews and safeguarding Adult Reviews on a consistent basis and a monthly thematic-learning plan had been produced to ensure that this learning was disseminated appropriately and as quickly as possible to practitioners in the field. The Learning Plan included a combination of tools, procedures, information briefings, promotion of training and other learning opportunities.

It was reported that the group had produced good practice guidance for professionals on the use of language when discussing and recording work with exploitation and links had been made with Sir Charles Trust, who were based with the Dudley Group of Hospitals, to receive assurance on work undertaken with exploited individuals, with the aim to developing information sharing videos on what good exploitation screening looked like. The group would also continue to receive information around areas of concern and good practice, and continue to work with the Police, particularly around raising awareness of the County Lines Intensification Week and Child Exploitation Day in quarter four of this year. Information would continue to be developed on cuckooing and county lines and this had been shared with the national adult safeguarding week which had taken place recently.

Referring to quality assurance and performance, it was reported that all agencies within the safeguarding partnership footprint were asked to give assurance that their system of safeguarding was fit for purpose on a regular basis. It was noted that multi-agency audits were also undertaken looking at various aspects which might result in a deep dive into certain aspects of child protection or adult protection as and when necessary, and as a result of a SAR report or a rapid review with children where an area of potential concern had been highlighted, a deep dive would be undertaken based on that particular finding.

It was noted that preparation was underway for a joint targeted area of inspection which would take place imminently, and later into 2023-2024, the partnership would assist Children's Services in promoting family safeguarding across the partnership, noting that this would link into the Think Family priority and would link into the issue of poverty within Dudley.

In conclusion, reference was made to the excellent training offer available and it was noted that this was an area that would be developed further digitally, and members were urged to contact the people partnership should they wish to see any training developed across the partnership, and it was noted that training was a standard agenda item on each sub-group. Reference was made to a development session which would take place on 27th March which would look at the progress and priorities of the Dudley Safeguarding People Partnership and would provide an opportunity for networking, sharing good practice, identifying clear ways forward and progressing the priority groups with plans for the next twelve months.

Arising from the presentation, the Acting Director of Public Health and Wellbeing requested clarification on the priority relating to the Think Family approach. The Independent Chair (Safeguarding) Dudley replied that with regard to safeguarding, if it was found that a child was potentially at risk, it was believed that it would be naive not to ask questions about the family circumstances, any concerns about the parents, possibly an alcohol issue or domestic violence issue within the home, not just focusing on the person at risk, but the need to think about the wider family circumstances and any implications. For example, if signs of neglect were evident, questions should be asked in relation to poverty, ask about their circumstances and how the family were surviving.

Councillor Buttery welcomed the report and commented that the Think Family approach needed to run through the whole system, taking into consideration the family circumstances, for example, whether the parents had received good parenting themselves, whether alcohol/drug/domestic abuse or mental health issues existed within the family, and the need for professional curiosity from all teams who engage with children and their families to offer safeguarding across the life course was raised.

(a) Dudley Health and Care Partnership

The Managing Director for Dudley – Black Country Integrated Care Board presented an update on the Dudley Health and Care Partnership Board (DHCPB) and in doing so, it was noted that much of the activity in the recent past had been concerned with developing and implementing Dudley's integrated model of health and care. Moving forward it was reported that the Board were developing their contribution to the Integrated Care System Joint Forward Plan which had five main programmes of activity namely: strengthening the effectiveness of the partnership itself, transforming the experience of our citizens, shifting the curve of demand, health inequalities, and children and young people. It was noted that a number of work streams sat within those programmes including, pathway development, primary care, children, mental health, care co-ordination, the clinical hub, recovery and reablement, engagement, community resilience and workforce.

It was noted that one of the programmes of activity was around health inequalities, however, there were health inequality dimensions and links to a potential joint health and wellbeing strategy across a number of those areas, and if taking the view that there were three dimensions to health inequalities, namely; prevention of ill health, access to services, and the wider determinants off ill health, then a number of areas of concern contribute to that.

From a preventative perspective, it was noted that a particular focus had been on the first 1001 days of life which would continue as part of the work described earlier. Referring to access, it was noted that one of the main areas of activity had been around the integration of services, integrating services to improve access, integrating services to deal with people who needed better continuity of care (many who had long-term conditions), co-ordinating services for people with more complex needs, and people whose experience was one in relation to the areas of health inequalities referred to in the previous presentation.

It was noted that whilst the main focus from a health and care perspective was on prevention and access, in terms of the wider determinates, an interest was also being taken in workforce, how people get careers in health and care, how that contributes to economic growth and skills and employment, trying to develop these through an anchor-network.

In conclusion, the Managing Director for Dudley – Black Country Integrated Care Board stated that from a Health and Care Partnership Board perspective, a particular focus was being taken on health and equalities as a programme of activity but across the range of activities being considered, there were a number of areas where a contribution would be made to the health and equalities and health and wellbeing agenda discussed earlier in the meeting.

(d) Forging a Future

The Board received a presentation from the Strategic Partnership Manager (Forging a Future) with regard to the seven aspirations of the Dudley Borough Vision 2030 – Forging a Future for All which had been drafted following community and stakeholder engagement in 2019. It was noted that the objectives had also been drafted within those time scales as shorter-term objectives for the vision, as opposed to the aspirations being longer-term outcomes for 2030.

It was reported that over the last few years, work had been undertaken on progressing these particular objectives within a partnership environment to ensure that each of the objectives within them would not be single agency, considering where further improvements could be made when agencies came together to work in partnerships.

It was noted that discussions had taken place in many Board meetings with regards to the overlap between the aspirations and the objectives, and from a health perspective, it was noted that the connectivity with health across the Borough could be seen within each of the objectives and within the aspirations themselves.

Reference was made to the draft governance framework which had been revised and had been presented to the Forging a Future Executive recently, acknowledging gaps within the framework and confirming that further work was ongoing. The intention agreed by the Local Authority and the Forging a Future Executive was that the aspirations themselves and the objectives would be owned by the Strategic Partnership Boards across the Borough which would include, the Dudley Health and Wellbeing Board, the Dudley Care Partnership Board, Safe and Sound, and two new partnerships Boards namely, the Dudley Employment and Skills Board and the Dudley Economic Growth Board.

It was noted that at a recent meeting, a review of the current situation had been undertaken together with the progress that had been made on meeting the objectives and reviewing how the different partnerships were developing their approach in adopting some of the objectives and aspirations to form one Dudley Borough Vision.

Reference was made to each of the Boards mentioned above and their priorities and structure and the overlaps within the priorities were acknowledged. With regard to the two new partnership Boards, it was reported that discussions had been held at the Forging a Future Executive Board with regard to the development and the remit of the Boards and considering where the different objectives would sit to ensure that performance could be measured.

In relation to health inequalities and the wider determinates of health and inequalities, it was noted that they would sit within the Safe and Sound

Board, the Dudley Employment and Skills Board and the Dudley Economic Growth Board. Gaps within the Boards was acknowledged, and it was noted that work would be undertaken by the Forging a Future team to target any gaps to ensure that all priorities were feeding into the vision.

In conclusion, reference was made to the Forging a Future Executive priorities being the priorities of each of the strategic partnership Boards and the Forging a Future team would focus on what of the Dudley Borough Vision would fall outside of the remit of any of the Boards' aspirations, and consideration would be given as to how to fill any gaps.

Arising from the presentation, the Chair thanked the officer for the presentation which clearly demonstrated the amount of work that had been undertaken already and had been presented in a comprehensible format.

The Service Director of Education, SEND and Family Solutions, commented that from an education and school improvement perspective he would be happy to work with the team in relation to the employment skills board and economic growth aspect.

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26 **Discussion and agreement of goals**

The Committee received a verbal report from the Acting Director of Public Health and Wellbeing on an agreement of the Board's goals.

In presenting the item, reference was made to discussions that had taken place at the recent development session attended by Board members where potential objectives for the Health and Wellbeing Board were suggested.

Subsequently, as a result of the discussions held at the development session, discussions held at this meeting and as a review of the objectives of the strategic boards presented at this meeting, the Acting Director of Public Health and Wellbeing requested that the members now consider the three priorities namely;

- reducing circulatory related disease deaths
- Improving breast cancer screening coverage
- Increasing School readiness

with all three priorities to be underpinned by a placed-based approach and to identify any synergies or duplications of priorities of other Boards with children, early start and 1001 days to be priorities for the Health and Care Board.

Arising from the proposal submitted, Members made comments as follows:

(a) Kat Jones referred to the synergise in relation to the integrated care partnership acknowledging that there was still work to be undertaken but clear links could be seen. It was felt that there would still be duplication and reference was made to the children thread throughout and the next steps to identify the areas to focus on and the need to be careful around the duplication of work. In response to a question with regard to School readiness and whether the first 1001 days supported school readiness, the Head of Adults and Public Health replied that a detailed piece of work needed to be undertaken and it was considered right that this area should be the focus of two Boards. It was noted that when considering school readiness, antei-natal and bonding and attachment at the anti-natal phase, needed to be considered as this could have an impact on school readiness, ready to learn at age 2 and ready for school at age 5. Reference was given to overlaps and it was recognised that it would need to be agreed who would cover which areas, emphasising that the first 1001 days was fundamental to school readiness and should not be separated.

(b) Councillor Buttery echoed the comments made in relation to the first 1001 days as it was believed that if a child's first 1001 days were not good, this would have a negative impact on their school readiness and recognition was given to synergise but not duplication. A question was raised in relation to what was to be done for the children who were currently not school ready, particularly the Covid-cohort of children and emphasising the need for urgent intervention. In response, the Public Health Manager made reference to the family hub Start for Life programme, comprising of a cross-partnership intervention project looking at integrated teams, focusing on the current cohort in the authority's most deprived area, a cross-partnership, cross-system piece of work that would support bringing the Board's together. The Service Director of Education, SEND and Family Solutions, concurred with the comments made reinforcing the importance of the first 1001 days as critical to setting a premise for learning and effectively engaging in learning going forward. Reference was made to not only the covid population coming through and the support required but the importance for early assessment and early support in terms of the mitigation against the need for higher level tariff interventions with families and children and the demand management around Education Health Care Plans (EHCPs) where appropriate, in terms of supporting children's development as they moved towards school age.

(c) The Strategic Partnership Manager (Forging a Future) referred to aspects around the wider determinates of health and inequalities and health, such as the impact of housing and employment, skills, and poverty, and recognising the importance of having the right vehicles in place to progress this without creating duplication with work being undertaken by the HWBB to ensure that the strategic partnerships were fit for purpose, together with knowing what individual organisations were doing within the partnerships, and it was hoped that going forward support for this could be given by the Forging a Future team but not until the mapping referred to earlier in the meeting had been undertaken.

(d) The Managing Director for Dudley – Black Country Integrated Care Board, commented that at the end of the process in June as described earlier in the meeting, an Action Plan would be required outlining clearly who would be responsible for what as part of the three priorities, and detailing which elements sat within which partnerships.

In response to a request that had been submitted in relation to expanding the priority relating to breast cancer screening to include bowel cancer screening, the Managing Director for Dudley – Black Country Integrated Care Board, suggested that the primary focus be on breast screening and commented that there may be lessons that could be learned that could be applied to other areas, trying to increase uptake, going forward. In response, the Acting Director of Public Health and Wellbeing referred to the previous strategy with its three priorities of poverty, childhood obesity and loneliness and isolation and it was noted that work was to be undertaken to evaluate what progress had been made as a result of the Board or which ones had work started prior and had not been directly influenced by the Board and she concurred with the suggestion made by the Managing Director for Dudley – Black Country Integrated Care Board to primarily focus on breast screening as taking on more screening may mean that the Board would be unable to fully focus on specific areas.

The Head of Adults and Public Health confirmed that a rapid evaluation of the previous strategy would be started as a desktop exercise, which would result in a short evaluation going into the public domain where Public Health Managers would be requested to contribute to the evaluation of each of the priorities. The evaluation would look to test whether the four principles, which had been set out in the previous strategy, had been met around developing a new relationship with new communities. It was noted that in the previous strategy there had been some particular outcomes and the Intelligence Team would be requested to review the data to assess whether progress had been made on the outcomes or not. It was noted that all of this would be in the caveat of the pandemic and the rising cost of living impacting on poverty. People would be asked to reflect on what the Health and Wellbeing Board had contributed, and whether in the new strategy for the new goals, people would suggest that things be undertake the same or done differently. It was noted that as the first drafts were developed, copies would be circulated to partners to comment, and a draft be considered by the Board in June to be signed off and published.

Referring to a recent Forging a Future Executive meeting were the meaning of the word ‘place’ had been challenged, the Public Health Manager requested that consideration be given to the terminology used.

The Chair referred to the development sessions that had been attended by a wide range of partners and the excellent discussions that had taken place and acknowledged the amount of hard work that had been undertaken to produce the three priorities that would be underpinned by a place-based approach, and thanks were expressed to all those that had been involved.

Resolved

(1) That the three Health and Wellbeing Board priorities as stated above, namely,

- reducing circulatory related disease deaths
- Improving breast cancer screening coverage
- Increasing School readiness

with all three to be underpinned by a placed-based approach, be approved.

(2) That an Action Plan be developed across each of the three priorities, detailing who would be responsible for which area, the organisational lead, and the designated person assigned from each organisation.

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

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

Meeting ended at 5.35pm

CHAIR

DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item No. 8(a)**

DATE	8th June 2023
TITLE OF REPORT	Draft Evaluation of Joint Health and Wellbeing Strategy 2017-2022
Organisation and Author	Dudley Metropolitan Borough Council Dr Mayada Abu Affan, Acting Director of Public Health mayada.abuaffan@dudley.gov.uk
Purpose	To agree the draft evaluation report
Background	At its March meeting the HWB Board agreed to evaluate the Joint Health and Wellbeing Strategy 2017-2022 to enable as assessment on whether the Board had achieved its aspirations, to summarise the work that had been done, and any lessons learnt for the new strategy.
Key Points	The evaluation includes: • A foreword from Cllr Bevan, Chair of the HWB Board • A section for each individual goal setting out the HWB Board's original aspirations, a summary of actions undertaken by HWB partners with case studies, and reflections on what worked well and what did not work so well. • Recommendations for the 2023-2028 Health, Wellbeing and Inequalities Strategy Once the Board has approved the draft, with Cllr Bevan approving his foreword, it will be typeset in the design used for the 2017-2022 strategy and published on the HWB Board website.
Emerging issues for discussion	• Are HWB Board members satisfied that the evaluation provides an accurate account of

	progress against the goals in the 2017-2022 strategy? • Do HWB Board members agree with the reflections and recommendations for the new strategy?
Key asks of the Board/wider system	The Board is asked to agree the draft evaluation.
Contribution to H&WBB key goals: • **Improving school readiness** • **Reducing circulatory disease deaths** • **More women screened for breast cancer**	This evaluation report summarises progress against the goals of the 2017-2022 strategy and makes recommendations for delivery of the new goals.
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.

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Dudley Health and Wellbeing Strategy 2017-2022
Evaluation Report

Foreword
[To be agreed by Cllr Bevan]

Dudley's Health and Wellbeing Strategy 2017-22 set out our local health and wellbeing priorities for our residents and the approaches that would be taken for everyone in Dudley to live longer, safer and healthier lives.

It focussed our energies on what we believed would have the biggest impact on reducing the effects of disadvantage and increasing the strength of our communities at that time.

Our chosen 3 goals were:

- Promoting a Healthy Weight
- Reducing the Impact of Poverty
- Reducing Loneliness and Isolation

We also identified four principles to inform the way organisations, communities and individuals could work together, what they could do and how they could show they had made a difference to health and wellbeing in Dudley. These principles were:

- A new relationship with communities
- A shift to prevention
- A stronger focus on joining up health and care services
- A stronger focus on what the strategy has achieved

Since the Health and Wellbeing Strategy was launched in 2017, the COVID-19 pandemic and subsequent cost-of-living pressures have adversely impacted on our ability to achieve these goals. During the pandemic, many people experienced increased social isolation and loneliness. Studies have shown that there was also a decrease in physical activity and increased eating and snacking. Loss of income and rising costs of food, energy and petrol have increased economic hardship for some communities, making it more difficult for people to stay healthy. As elsewhere, the persistent inequalities in Dudley have been exposed and amplified, and particularly for those living in poverty, older people, people with disabilities, and young people.

Through these unprecedented times, however, we have seen organisations, communities and individuals in Dudley building new relationships and working in partnership to keep our residents, businesses and communities safe, keep vital services running, and proactively supporting communities who have been most severely impacted. The partnership working and “can do” attitude that emerged during the pandemic is closely aligned to the guiding principles of our Health and Wellbeing Strategy.

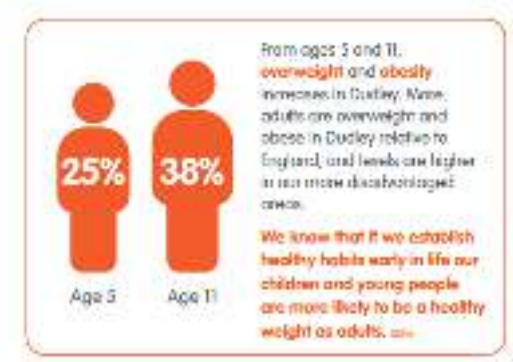
This rapid evaluation looks at how we have done in achieving the 2017-2022 strategy goals. The findings have been gathered from across Dudley Health and Wellbeing Board partners and includes evidence from across the lifetime of the strategy. It includes resident engagement and storytelling allowing us to capture our residents’ lived experiences and find out what supports and enhances people’s health and wellbeing such as access to green spaces, having strong relationships and connections with others, having opportunities to contribute and give back, to be creative and learn new things, and having a sense of purpose. We have reflected on what went well and what we should do differently or continue to focus on to make recommendations for the next strategy.

Even without a pandemic and increases in the cost-of-living it was always going to be challenging for us to achieve the ambitious goals that we set out in 2017. Despite our best efforts, and as in other areas of the country, we have seen increases in poverty, social isolation and loneliness and continued increases in children’s weight. Our reflections on what we have and have not achieved will help us with our new strategy and plans. We remain hopeful, however, that by working together we can build on the opportunities to work with our communities to create positive and long-lasting change, maintain and build upon our strong organisational partnerships for the benefit of residents, and that over time we will improve the health and wellbeing for all Dudley residents.

Cllr Ian Bevan
Chair of the Dudley Health and Wellbeing Board

GOAL: Promoting a Healthy Weight

Why was this priority important?



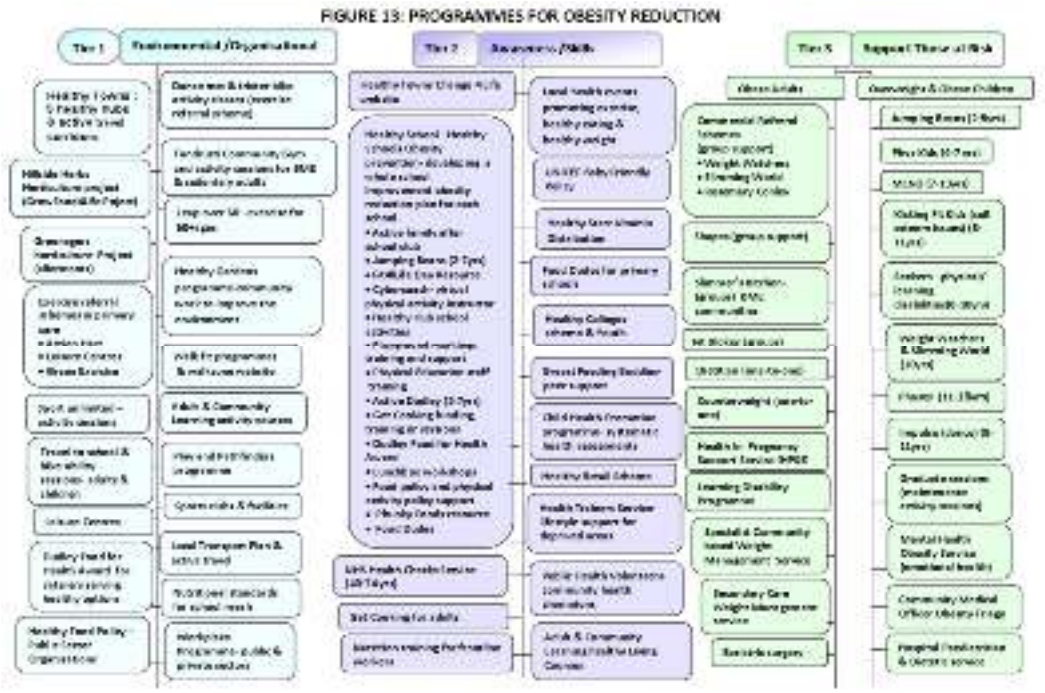
In 2017 statistics showed that being overweight and obese was increasing among primary school children in Dudley, with weight gain starting at an earlier age and inequalities between different areas locally. Promoting a healthy weight saves lives as obesity doubles the risk of dying early. Obese adults are seven times more likely to develop diabetes than adults of a healthy weight. People who are obese are more likely to get physical health conditions like heart disease and are also more likely to have poorer mental health, for example, living with depression.

What did we do?

We made a significant commitment to promoting a healthy weight, supporting a system-wide approach for both adults and children. Comprehensive pathways and services have been developed enabling residents to access the support they need to lose weight (figure 1), and training packages have been rolled out across the system. This included training over 100 health and care professionals on “How to raise the issue of weight”, training Parks Physical Activity Advisors on height/weight measurement and brief interventions, and Leisure Services staff in breastfeeding resulting in our Leisure Centres gaining UNICEF baby feeding accreditation.

Figure 1: Programmes for obesity reduction (to be reformatted and text big enough for accessibility in published version)

FIGURE 13: PROGRAMMES FOR OBESITY REDUCTION



Our services for promoting a healthy weight include:

- **Healthy Pregnancy Service**

The Healthy Pregnancy Support Service supports pregnant women from becoming overweight or obese before, during and after pregnancy. The aim is to help all women who have a baby to achieve and maintain a healthy weight and a healthy lifestyle, by adopting a balanced diet and being physically active. The service works alongside midwives in community antenatal clinics and can also see women on a one-to-one basis in their homes, to support women and their families to make healthy choices.

Case Study: Healthy Weight in Pregnancy

A pregnant woman with a Body Mass Index (BMI) of 48kg/m^2 and weighing over 130kgs was first seen by the Healthy Pregnancy Team at 10 weeks gestation. She did not have time to focus on her wellbeing as she was busy looking after her other children.

"With support this pregnant woman had a healthier pregnancy and healthier weight. She had a healthy new-born baby at term. At the 3 weeks postnatal check this mum had lost over 20kgs compared to her first pregnancy weight and accepted the offer of further support from Dudley's 'Let's Get Healthy' 12-week programme of diet management and exercise".

- **Self-help Healthy Weight Packs**

Over the past 5 years, 80% of families in Dudley requesting support with their weight have chosen to use our Self-help Healthy Weight Packs. For some families this low-level support, which they can manage themselves, will be sufficient to enable them to make lifestyle changes. For others, it is a 'stepping-stone' to accessing more specialised services.

- **Child Weight Management Service**

During COVID-19, child weight management services, including those provided by our health visitors and school nurses were paused. This provided us with the opportunity to review the services and reflect on whether there was a better way to promote a healthy weight for children. Support was offered and available to all school children, with Slimming World for the very overweight – the term Dudley parents prefer to be used – older teenagers.

In 2022 it was agreed that:

- Healthy weight support for children and young people, and their families, should be available to all and not just to those with a higher body mass index.
- The focus should be on nutrition, having a healthy relationship with food, and supporting physical activity as part of everyday life rather than just losing weight.

Case Study: Family Support with Weight Management

A local family with two children required healthy eating support. They had a face-to-face appointment with the Healthy Family Lifestyle Service, at a location easily accessible to the family. SMART goals were set together with the children around eating well and moving more. The family completed all 7 sessions and have been referred to the Phases physical activity programme for further support.

These services and the focus on providing support to all who want it have ensured that:

- there is a preventative approach to obesity and ensures that every family can access support
- a child's weight status should not be the only assessment made to determine whether a family requires lifestyle support/intervention
- less of a focus should be on weight and more emphasis placed on healthy lifestyle
- the removal of the stigma which may help engage more families

Over the years, the understanding of how to promote a healthy weight has evolved nationally and Dudley has been proactively involved in developing this understanding, and particularly around the importance of community involvement. There is now widespread recognition that a "whole systems approach" is required to tackle obesity and promote a

healthy weight. It needs to include addressing the wider determinants of health such as the environment in which we live enabling us to be able to actively travel — by bike or by walking, access to healthy and affordable foods, and regulation around the sugar content of drinks and foods.

Dudley was one of four pilot local authorities recruited to work with Leeds Beckett University and Public Health England to test a "Whole System Approach to Obesity Prevention." Our involvement in this programme not only transformed how we tackled obesity in Dudley it also contributed to national guidance on promoting a healthy weight.

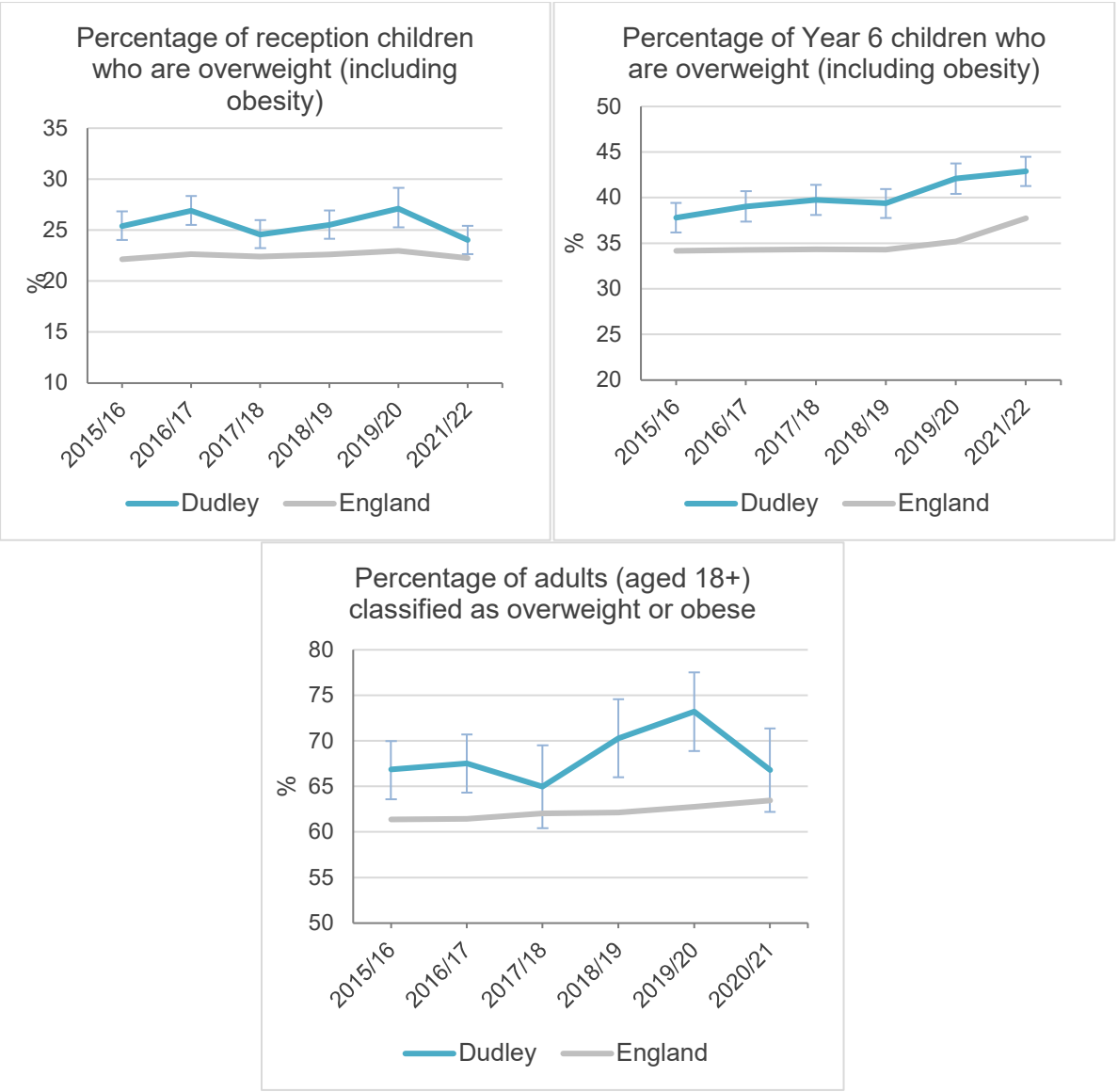
To support this, we organised a Deliberative Inquiry on promoting a healthy weight with residents from a cross-section of the communities which are most affected by obesity. The Deliberative Inquiry involved four groups representing Dudley residents from neighbourhoods in Coseley, Dudley, Brockmoor/Brierley Hill and Cradley. Of the 64 residents who were involved, 16 became Community Explorers and were supported to inquire within their own neighbourhoods and to collectively research 300 residents' views and experiences.

The final report recommended practical actions for all partners and the barriers that must be removed for the community to take action and co-produce practical solutions to the root causes of obesity. Consequently, Health Action Groups were established and began developing plans in early 2020. Unfortunately, the Covid-19 pandemic halted the momentum of this work, and consequently little progress has been made, however many of the residents who engaged with the Inquiry have remained active volunteers in Dudley with some supporting the COVID Vaccination scheme.

What difference have we made?

Despite the significant effort and investment, levels of obesity have not reduced as we would have liked in Dudley. In fact, levels of obesity continue to increase for children in year 6 **(figure 2)**. This is similar to what has been seen in other areas in England and indeed globally.

Changing prevalence in overweight and obesity in Dudley and England over time



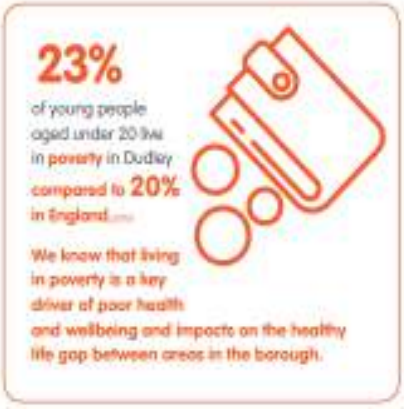
A key legacy of the work of the Health and Wellbeing Board has been the mainstreaming of conversations locally, as has happened nationally, about system approaches to tackling obesity and the importance of the wider determinants of health on people's ability to maintain a healthy weight. Engagement with residents has consistently shown that they value the borough's green and blue space, and the council continues to invest in these areas. Additionally, as new transport links are established with the Dudley Metro stations, there is work ongoing to enable "active travel" to get to them to encourage more cycling and walking.

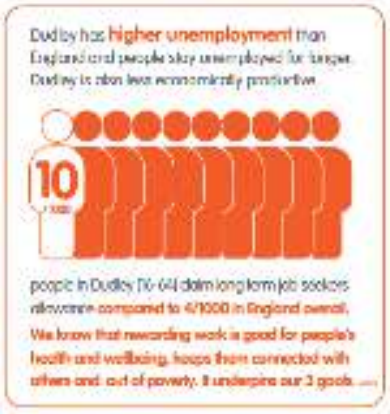
We have also shifted our approach to put more emphasis on having a healthy lifestyle – which may also help to reduce the stigma associated with obesity, the importance of good mental health in being able to

achieve this, and the recognition that interventions need to support the whole family to make a positive change. As a consequence, our services have been redesigned and continue to be adapted. Finally, the understanding and approaches from tackling a complex issue like obesity have been increasingly applied to other areas of work, including poverty.

GOAL: Reducing the Impact of Poverty

Why is this priority important?





We recognise that living in poverty is a key driver of poor health and wellbeing and underpins the healthy life gap between different areas in Dudley. When the 2017- 2022 Strategy was being developed, Dudley had more young people living in poverty and a higher unemployment rate than England.

What did we do?

Given the complexity of addressing poverty and learning from our work on promoting a healthy weight, we recognised that we needed to start taking a "whole systems approach" to poverty. This began by assembling a steering group of key stakeholders to coordinate and steer the poverty work and to develop a roadmap, and ensure a whole systems approach was being implemented. Issues that were identified included people getting access to services – improved communications have helped to address this; and navigating the system – better interagency signposting has helped as has a referral platform managed by Citizens Advice Bureau. Although progress on the roadmap was interrupted by the pandemic, the established steering group and partnership continued through the pandemic response and the more recent cost-of-living pressures.

The COVID-19 pandemic and cost-of-living pressures have meant that we have had to be reactive to the immediate needs of residents to be able to afford food, housing and energy.

Welfare support provided

- 151 residents provided with mental health support
- 1138 provided with financial support
- 514 provided with food support
- 5 referred to Adult social care
- 328 signposted to other support services

Through the pandemic, welfare support was offered to residents required to isolate under government guidance. Although similar support was available in all local authority areas, our Dudley offer provided more comprehensive support, and has been kept in place for longer than most, if not all local authorities in the region. From August 2020 to February 2022, we offered

support on 96,609 different occasions for people testing positive for COVID-19, with support given 2,130 times.

Following on from the pandemic, Dudley Council has worked with voluntary and community partners to distribute government funds to support households who have been most impacted by the increasing cost-of-living, distributing £6.7million between October 2021 and March 2022 to ours most vulnerable residents to provide immediate support. The Council has developed a central information point on its website for residents, with over 100,000 visits.

A key success of the Household Support Fund has been how it has been made easy for residents to access financial support, which is often through vouchers that can be redeemed at supermarkets. So far we have supported more than 115,000 households including 90,000 with children and 10,000 with a pensioner.

Case Study: Household Support Fund

Client A came to the hub needing help due to leaving work recently. She claimed Universal Credit and did not have any or food or money. There was only £2 on her electricity meter and she had poor mental health including a breakdown a few weeks prior to her visit.

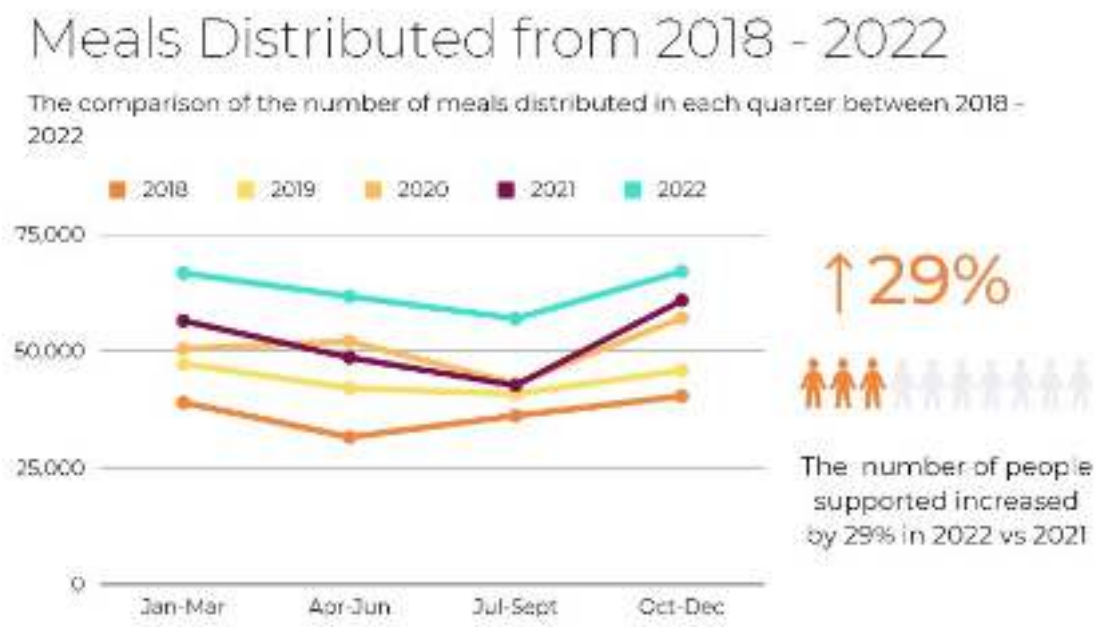
"We triaged the client and noticed she was very anxious and struggled with crowds. We took her to a quieter space to compete a needs-based assessment and shared with her the Making the most of your money a 1:1 basis. She was eligible for a Housing Support Fund voucher of £75 and a fuel voucher worth £49 to top up her electricity meter. The client was grateful for the help".

The Citizens Advice Bureau now deliver Cost of Living hubs in 3 sites in Dudley that offer a wraparound service to residents that goes beyond emergency support of food vouchers. They include a whole suite of support focusing on prevention and more sustainable support options including advice on budgeting, grants and benefits, how to save money via efficient fuel and energy usage.

What difference have we made?

These initiatives which have been delivered through a partnership approach have provided a vital mechanism for immediate support for Dudley's most vulnerable residents. Having this partnership in place enabled a quick response to the surge in demand for support experienced as the cost-of-living has increased, as exemplified by the large increases in people relying on foodbanks **(figure 3)**.

Figure 3:



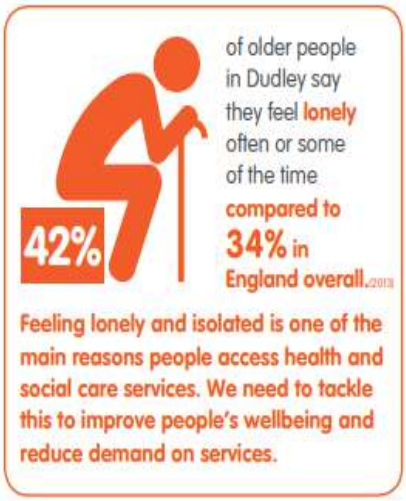
A new Strategic Mitigating Poverty Partnership has now evolved from the original group that was set up by the Health and Wellbeing Board. The Partnership aims to use data and evidence to encourage the Dudley System to help support people in poverty and help lift people out of poverty. The partnership will coordinate the ongoing work including work in schools and communications around the cost-of-living webpage and e-updates.

Dudley will be working with the charity Children North East to pilot their *Poverty Proofing the School Day* tool in local schools. *Poverty Proofing the School Day* is a powerful tool for identifying the barriers children living in poverty face to engaging fully with school life and its opportunities. Focused on listening to the voices and experiences of young people, it offers a pathway for schools to address often unseen inequalities within their activities, helping them reduce stigma, break the link between educational attainment and financial background, and supports schools to explore the most effective way to spend the Pupil Premium.

Researchers will conduct consultations with students, parents, staff and governors to understand the challenges they face, in an inclusive, straightforward and supportive process. We will then complete a Poverty Proofing audit and will identify pathways to reduce the impact of poverty on students. Schools receive a thorough written report and action plan to inform impactful decision-making, and receive accreditation pending a follow-up review. The process will also include training for staff and governors on the causes, consequences, and impact of poverty on children, young people and their families and ways to identify and mitigate barriers in their roles.

GOAL: Reducing Loneliness and Isolation

Why is this priority important?



There has been a growing recognition that loneliness is a serious problem, with far reaching implications, not just for individuals, but also for wider communities. Loneliness is a serious condition which can detrimentally affect a person's mental and physical health, increasing the pressure on a wide range of council and health services.

At the time of developing the 2017- 2022 Strategy, we knew that disproportionately more older people in Dudley said they felt lonely compared to the national average.

What did we do?

A multi-agency group directed a system wide approach to strengthen partnerships and address loneliness and isolation. The group identified, developed and implemented the following initiatives with the initial focus on older people.

- An online Dudley Community Information Directory was developed to enable communities and local people to be able to share activities, events and groups, helping people to connect with each other. The directory was developed because local people said there was lots going on in the borough but people don't know about it.
- A Voluntary Sector Innovation Fund stimulated activity within the voluntary and community sector. It provided funding and networking opportunities as well as sponsors who supported the lifetime of the project.
- Volunteers were matched with older people to provide regular contact and friendship for older people through a befriending scheme.
- A loneliness e-learning module was launched in November 2018 to raise awareness on the issue and impact of loneliness and isolation. Nearly 350 people who work alongside communities or meet with people in their role were trained to make every contact count, enabling them to identify someone who might be experiencing loneliness and signpost for help and information.

We have also developed a number of specific services that have supported people who are socially isolated or lonely, providing a gateway into mental health services, social care, adult learning and community groups.

The Pleased to Meet You Service

The Pleased to Meet You (P2MY) service launched in 2017/18 and is available to people aged 65 years or over and younger people at risk (e.g., people with an illness, disability, mental health issue or a carer), with referral from their health or care professional.

Activities included a chat helpline and involving people in local community groups. These groups helped with social connections, offering companionship and volunteering opportunities. Examples of practical support:

- assisting people to set up online accounts for services,
- completing forms for assessments,
- getting practical aids at home and
- 72 hours of support for people discharged from hospital.

The service receives an average of 50 enquiries each week with a third of these contacts receiving support for 6-12 weeks. Almost 3,000 people received support during 2020/21-2022/23.

Connecting Older People Programme

The Connecting Older People (COP) programme included engagement sessions exploring the values which were important to older people. Community groups joined in and shared their project ideas. Local residents listened and decided who received the funding by voting at the event and a variety of projects were funded including:

- health and wellbeing sessions
- social groups
- arts, music and theatre clubs
- support groups
- improvements to local green spaces

These projects helped older people to take part and contribute, as well as building relationships, making friends and staying in touch.

Integrated Plus

Integrated Plus has helped people with complex health needs connect with community assets by embedding social prescribing in GPs aligned to the six Primary Care Networks in Dudley.

Social Prescribing seeks to address people's needs in a holistic way - recognising that people's health is determined primarily by a range of social, economic and environmental factors. It also aims to support individuals to take greater control of their own health and wellbeing. Acknowledging this, Social Prescribing is most usually defined as: *"A way for local agencies to refer people to a Link Worker. Link Workers give people time, focusing on 'what matters to me' and taking a holistic approach to people's health and wellbeing. They connect people to community groups and statutory services for practical and emotional support."*

The approach combines a flexible, non-clinical, holistic package of support which focuses on the whole person's needs to jointly find solutions to problems faced. Support is independent, impartial and usually provided in people's own homes, so that the service can build a true picture of the person, their living conditions and family support networks. Staff have a 'can do' approach and attitude as the service is not tied by organisational boundaries and cultures. Quality time is spent with people, actively listening to their needs and aspirations. Staff ensure people are accessing services appropriate to their needs and help them to navigate the health and social care system. Evaluation of the service has shown that costs are being avoided through reduced use of A&E and other NHS services.

Scams Team

A new Scams Team was launched in 2017/18 by Dudley Council's Trading Standards primarily working with vulnerable residents who often find themselves victims of financial scamming. As part of the team's remit, the team work closely with social services and engage with potential scam victims in Dudley, to raise awareness, improve reporting of scams and stop financial abuse. The Team also refer people to services such as social workers, occupational health, mental health, and signpost people who feel lonely and isolated to local activities in the borough.

FACTS

- Scams affect millions of people across the UK.
- People who are scammed often experience loneliness, shame and isolation
- Only 5% of victims report being scammed
- The average loss is £1,000 per victim
- Older victims are 2.4 times more likely to die or go into care within two years of being scammed

The Scams Team have adopted a proactive and preventative approach by:

- Providing talks to community groups
- Developing ‘friends against scams’ and ‘scams champions’ training
- Shared information via an information package and quarterly e-newsletter
- Continued to deliver the approved trader’s scheme, and Fix-A-Home brochure

Dudley Scams Team have reached 1,541 people with an estimated saving of £9 million.

What difference have we made?

The thing that stands out the most is that all of our initiatives have been building up the informal and formal networks between organisations. They reach out to lonely individuals, make every contact count with opportunities for talking and understanding, and then refer and signpost to supported access. The person is the centre of any intervention offered which helps to promote independence.

Although national data demonstrates little or no change in the percentage of adults reporting feeling often or sometimes lonely, locally we know that each service has demonstrated the effectiveness of their intervention. The activities and interventions have also had a broader positive impact on health and wellbeing, beyond loneliness and social isolation.

Some of the initiatives were not specific to addressing loneliness and isolation, however, by the process or activity itself, they have made a significant contribution to the goal. The members of this group have now re-established as a ‘social connectedness network’ and continue to invest in addressing the impact of loneliness and isolation in Dudley.

10. Recommendations

The evaluation of the Health and Wellbeing Strategy 2017-22 has highlighted the following recommendations for the new strategy:

Build on the community response to the pandemic and Dudley's community assets to generate sustainable community-driven responses for long term improvements in health and wellbeing	Embed an approach to reducing health inequalities and identify more effective interventions proportionate to need across all goals	Build on Dudley's strong local partnerships, with each HWB partner clear about their role in delivery, and providing opportunities for new partners to be involved in improving health and wellbeing
Make a shift from services being delivered 'to people', to 'doing things together' with co-design and co-production – requires all partner organisations to work differently	Continue work to tackle poverty as it is a key driver of poor health and wellbeing outcomes	A greater focus on prevention, including enabling healthy behaviours and addressing the wider determinants of health
Ensure monitoring and evaluation throughout the lifetime of the strategy and sharing of progress, which includes capturing the views of our communities	Continue taking a whole systems approach – applying systems thinking, methods and practice to better understand challenges and identify collective actions	Build our capabilities as a system, particularly in digital and workforce alongside specific interventions

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

DATE	8th June 2023
TITLE OF REPORT	Draft Joint Health, Wellbeing and Inequalities Strategy 2023-28
Organisation and Author	Dudley Metropolitan Borough Council Dr Mayada Abu Affan, Acting Director of Public Health mayada.abuaffan@dudley.gov.uk
Purpose	To agree the draft strategy
Background	Following consideration of the Joint Strategic Needs Assessment (JSNA), Dudley's Health and Wellbeing Board agreed three goals for its new strategy at its March meeting, underpinned by an approach to reducing health inequalities. The draft strategy has been developed for these goals.
Key Points	The strategy includes: • A foreword from Cllr Bevan, Chair of the HWB • Views from residents and communities about what makes Dudley a great place • A section for each individual goal setting out the HWB's aspirations, including on reducing health inequalities, some background to the issue in Dudley, and what the HWB will do during the lifetime of the strategy • The commitment of HWB partner organisations. To enable communities and residents to engage with the strategy and the HWB plans, it is proposed that there are specific engagement sessions during the summer. This will gather community insight to inform work programmes and to enable completion of the strategy. This work will be led by Dudley's engagement group. (Note this will be

	the start of a programme of engagement with communities throughout the lifetime of the strategy). The proposed design of the strategy will be presented at the meeting for feedback from HWB Board members. The final strategy will be ready for launch at the HWB Board meeting in September.
Emerging issues for discussion	• Are HWB Board members satisfied that the strategy as currently drafted represents their ambitions for the health and wellbeing of the people of Dudley? • Are Board members happy with the proposed approach to community engagement to finalise the strategy?
Key asks of the Board/wider system	The Board is asked to agree the draft strategy.
Contribution to H&WBB key goals: • **Healthy weight** • **Reducing loneliness & isolation** • **Reducing impact of poverty**	Not applicable as this is the new strategy.
Contribution to Dudley Vision 2030	Directly contribute 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
Dr Sarah Dougan, Interim Consultant in Public Health
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Working together for longer, safer, healthier lives

[Foreword for Cllr Bevan to sign off]

Our vision for Dudley in 2028 is that it is a place where everyone lives longer, safer and healthier lives.

The Covid-19 pandemic caused disruption across society and within services, negatively impacting on many people's physical, mental and emotional health and wellbeing. Subsequent cost-of-living pressures have made it much more challenging for people and families on lower incomes – including those in work – to be able to live a healthy life. As elsewhere, increasing poverty is widening the gaps in physical, mental and emotional health between communities in Dudley with long term impacts on people's life chances, and particularly for our children and young people.

During these challenging times, however, we have seen our communities pull together to support each other, the strength of our voluntary organisations, and the ability of our services to respond, react, and to work differently. There has been a better understanding of the health and wellbeing needs of those who live and work in Dudley, the need to work together, and a renewed focus on tackling health inequalities – the difference in health status that exists between different communities.

Our 2023-2028 health, wellbeing and inequalities strategy for Dudley is about how we (individuals, families, communities, organisations and local politicians) can build upon our strengths and work together to improve health and wellbeing, going further and fastest in our most disadvantaged communities.

First, we need to keep doing things differently

We have identified 4 principles that will continue to inform the way we all work together and what we do to improve health and wellbeing:

• **Building community capacity and resilience** – improving and sustaining good health and positive wellbeing by building people's social support networks; enabling people to support each other, making best use of individual and community resources and assets; and making sure that people who use services get a chance to pursue their own interests and contribute to community life.

• **A shift to prevention** – challenging our organisations to invest in prevention and early intervention across services and ensuring a focus on addressing the wider determinants of health. Making it easier to make healthier choices in Dudley, enabling people and families to take an active role in looking after themselves and their family.

• **A stronger focus on family** – recognising that people do not live in isolation and taking an approach that focuses on the family will have a bigger impact. Looking at how we can better embed a family approach throughout our policies and services.

• **Services that work with and for everyone** – making more effective use of the complementary skills and assets of people, communities, and practitioners. Shifting the focus from practitioner-led service design to co-design of services with the people who use them. Ensuring that services are in places where people and families can easily access them and making it easy to find out what support is there to help.

Information about people's lives in Dudley since the Covid-19 pandemic tells us that focussing our resources and energy on 3 goals will have the biggest impacts on people's health and wellbeing:

1. **Children are ready for school**
2. **Fewer people die from circulatory disease**
3. **More women are screened for breast cancer**

Across all three of these goals we will embed **an approach to reduce health inequalities** – to close the gap in health and wellbeing for the most disadvantaged families and communities. Across our plans, we will ensure a focus on the wider determinants of health such as income and employment, unleash the potential of our communities, and deliver services furthest and fastest to those who need them most.

We all have a role to play in helping to achieve these goals – individuals, families, communities, organisations and local politicians. We are inviting everyone to play an active part in making Dudley borough a place where everyone can live longer, safer and healthier lives.

Councillor Ian Bevan
Chair of the Health and Wellbeing Board

What makes Dudley a great place?

Dudley has many strengths that are the building blocks for our work together. Here are some of the things that people in Dudley tell us they care about and value, and which support them to stay healthy and well*.

The people - time and again local people are described as being very friendly, helping each other out and always having a story to tell, so many people report positive relationships and connections with others.

"The people round here are first class; they do things – they just help you and they don't expect anything back."

"There's an inherent pride in Dudley folk – they're the salt of the earth!"

"I value having good neighbours to rely on when needed. I feel protected. It makes me feel happy."

Access to amenities and transport – good local amenities and things to do within close proximity of where people live provide a sense of place and purpose.

I feel safe and secure in my area. I enjoy access to parks, walks, nature reserves. I am able to access shops and libraries where I can then access local services. I value this access. It makes you feel that you have some control over your environment and life."

"This (Daybreak service) is the only thing I do all week. The rest of the time I'm on my own. I love coming here; it's my lifeline."

The green spaces – parks, canals, countryside; being able to reach the countryside quickly, cycle the canals and visit bluebell woods and fossil grounds.

"The thing I like is that it's (Stourbridge) on the edge of the countryside. Best of both worlds, city and country activities."

"Our garden and allotment and woodland walks got me through the seasons of lockdown!"

Activities and groups – provide many opportunities for people to contribute and learn new things **–** being involved and helping out, being able to share information with each other, provide peer support as well as try new things, learn new skills and enjoy activities with others who have a shared interest.

"Volunteering is my 'get up and go'!"

"At the forum we find out about so many things that are going on."

"The best thing about Queens Cross Network is that I can help there."

The history - from the steelworks to mining, chain making, the extinct volcano, the canals, museums, and castle. Many people feel that the local history provides a sense of identity and belonging and a source of pride.

"All of the people who worked at the steelworks used to live in close proximity and you were always welcome into anybody's house for a tea or coffee."

"I've lived in Lye since 1960 and am proud of Lye."

Taken from: Dudley, A Story of Stories, April 2018, Stories of Lye, 2019 and Looking Backwards, Moving Forwards – Stories from Covid times, May 2022

The goal: Children are ready for school

will impact on their future educational attainment and life chances, including life expectancy. five. This

School readiness is a measure of how prepared a child is to succeed in school cognitively, socially, and emotionally. It means that a child can make the most of school so that they can learn, develop relationships, know how to behave, and reach their full potential.

Being school ready starts from before birth with the First 1,001 days providing a critical opportunity to build the foundations of emotional wellbeing, communication, resilience and adaptability. Things that help to improve school readiness include parents having good mental health, parents speaking to their baby and reading with their child, being physically active, evidence-based parenting support programmes and access to high-quality early education.

Wider family circumstances have a big impact on a child being ready for school. Families in poverty and debt find it more challenging to support their child to be school ready, as do those with children with additional support needs. These issues result in inequalities in levels of school readiness in different parts of our communities. Neglect, unsuitable accommodation, domestic violence, and substance misuse also need to be addressed where children are experiencing this.

What will we do?

- Provide shared leadership to set the vision and 10-year strategic plan for whole-system early years transformation — it takes a whole village to raise a child, not just one organisation or service.
- Increase 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.

- Work 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).

How will we know if this goal has been achieved?

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.

The goal: Fewer people die of circulatory disease

In 2022, 959 people died from circulatory disease in Dudley, of which 244 (25%) were under 75 — an early death.

Circulatory disease is a general term for conditions affecting the heart, blood vessels or the blood. It can often largely be prevented by having a healthy lifestyle, which can be enabled by the wider determinants of health such as having a good income. Once somebody has circulatory disease it can be managed using medications if detected and adopting a healthier lifestyle can prevent further deterioration.

Circulatory disease is the biggest cause of early deaths in Dudley and the borough has, for many years, had a consistently higher death rate from circulatory disease compared to England. Men in Dudley have a higher death rate than men across England. It is the largest contributor to the life expectancy gap between the richest and poorest parts of Dudley, fuelling health inequalities.

Deaths from circulatory disease have been increasing since the Covid pandemic. Higher death rates from circulatory disease are likely to persist. This is because fewer people were diagnosed and treated for circulatory

disease during Covid and with ongoing pressures it has been difficult for the NHS to catch up. Some people have also been less active and have gained weight. For those struggling with the cost of living, stress, poor mental health, and the inability to buy healthier foods, will also increase their circulatory disease risks.

What will we do?

- Take action on the wider determinants of health, such as improving air quality, use of green and blue space to promote active travel, and town planning and regeneration to enable people and families to be more active.
- Make it easier to access services to support people and families to adopt a healthier lifestyle, including mental health support to enable people to make a change, and support for cost-of-living to reduce stress.
- Increase detection and ensure better management of high blood pressure within the NHS, and support for people when they have had a cardiac event to increase their chances of living a longer life.

How will we know if this goal has been achieved?

Reduce circulatory disease deaths in Dudley so that the rate is similar or lower than the national average.

In 2021, the mortality rate from circulatory disease in Dudley was 248.5 per 100,000 people significantly higher than the 230.4 per 100,000 for England

The gap in early deaths from circulatory disease between the most deprived and least deprived areas of Dudley will have narrowed.

Between 2016-2020, mortality from circulatory disease among people under 75 years was 42% higher than the Dudley average in Dudley Central but 20% lower in Stourbridge.

The goal: More women are screened for breast cancer

Nearly 14,000 (38%) Dudley women aged 50-70 years have not been screened for breast cancer putting them at risk of more developing more serious disease and avoidable death.

Dudley's breast cancer screening service was particularly impacted by Covid-19, with a bigger drop in coverage than other areas. Before Covid-19, the borough's screening rate was higher than the West Midlands and England averages.

While women in Dudley currently have similar rates of new diagnoses of breast cancer and death compared to the West Midlands and England averages, the drop in breast screening coverage may result in more Dudley women experiencing more serious disease and avoidable deaths from breast cancer in the coming years.

Women from Dudley's more deprived communities have much lower breast cancer screening rates and based on national statistics, are more likely to die from breast cancer.

As well as personal suffering from more serious breast cancer disease and early death, there are also wider impacts on women's families including grief and bereavement. Intergenerational impacts include grandchildren missing out on a relationship which is important in providing grounding and security, and their parents may miss out on emotional support and help.

What will we do?

- Work with local communities where fewer women are being screened, to increase awareness of the benefits of breast screening and understand the barriers that stop them going for screening to ensure that the service is offered in a culturally sensitive, accessible, and meaningful way.
- Identify additional locations for the breast screening van in communities with lower uptake.
- Work with GP practices with lower uptake, to make sure their patients are aware of their opportunity to be screened and train more cancer screening champions within GP practices to encourage uptake.

How will we know if this goal has been achieved?

Breast cancer screening coverage for women aged 50-70 years in Dudley will increase to reach at least pre-pandemic levels which were better than West Midlands and national averages.

In 2022, Dudley's breast cancer screening coverage was 62% compared to 76% in 2018. Regional and national averages in 2022 were 74% and 75%, respectively.

The gap between breast cancer screening coverage in the most and least deprived primary care networks will have narrowed.

Only 43% of women aged 50-70 years in Sedgley, Coseley and Gornal and 48% of women in Dudley and Netherton primary care networks had been screened for breast cancer in 2021/22 compared to nearly 70% in Halesowen primary care network.

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Everyone in Dudley can play their part in working together for longer, safer, healthier lives

What Dudley's Health and Wellbeing Board partner organisations will do:

- We will inspire and enable people and organisations to get involved, forging partnerships between the public sector, voluntary and community sector and local businesses – recognising our collective responsibility to support health and wellbeing including through Dudley's vision for Forging a Future.

- We will align or pool resources, budgets and accountabilities where it will improve services for Dudley's communities, and will consider how we can best use resources and budgets to reduce health inequalities.

- We will build capacity and resilience in our workforce, including providing high quality opportunities for local people, and equipping them with the right skills and culture to deliver our collective ambitions.

What Dudley residents and communities can do:

- This part will be completed by engaging residents and communities on our plans.

What Dudley's organisations, communities and residents can do together:

These proposals will be tested as part of our engagement with residents and communities on our plans.

- Talk and listen to each other and recognise differences across Dudley.

- Use our collective resources, skills and assets to achieve Dudley's three Health and Wellbeing goals, going further and fastest in our most disadvantaged communities.

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

DATE	8th June 2023
TITLE OF REPORT	Dudley's Approach to Reducing Health Inequalities
Organisation and Author	Dudley Metropolitan Borough Council Dr Mayada Abu Affan, Acting Director of Public Health mayada.abuaffan@dudley.gov.uk
Purpose	To agree Dudley's approach to reducing health inequalities which will be embedded through the delivery of the new strategy.
Background	At its March meeting the HWB Board agreed that focussing on neighbourhoods with the greatest needs would underpin its work across the three new strategy goals. This report is the beginning of work to describe and agree an evidence-based approach that can be implemented across all goals. It was presented at the Dudley Joint Boards Away Day in April.
Key Points	The purpose of the report: • To have a shared understanding of health inequalities in Dudley • Sets out proposed approach to reducing health inequalities based on evidence of "what works" • Provides some practical suggestions for taking this forward in Dudley The appendix provides some further details and case studies from across Dudley.

Emerging issues for discussion	• Are HWB Board members supportive of this approach? • Are there specific aspects of the approach that HWB Board members would like us to focus on in year 1 of the strategy?
Key asks of the Board/wider system	The Board is asked to agree the approach.
Contribution to H&WBB key goals: • **Improving school readiness** • **Reducing circulatory disease deaths** • **More women screened for breast cancer**	The report describes the approach to reducing health inequalities that will underpin delivery for all of these goals.
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

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Dudley Health & Wellbeing

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Proposed approach to reducing health inequalities in Dudley

Sarah Dougan

Interim Public Health Consultant

Joanna Pritchard & Sarah Owens

Public Health Managers

With thanks to the Intelligence team

Purpose

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- To have a shared understanding of health inequalities in Dudley
- Sets out proposed approach to reducing health inequalities based on evidence of "what works"
- Provides some practical suggestions for taking this forward in Dudley

Reminder – Dudley's new Health & Wellbeing Board goals:

- Improving school readiness
- Reducing circulatory disease deaths
- Improving breast cancer screening coverage

Health inequalities

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Inequalities of what?

- Health inequalities are ultimately about differences in the status of people's health.
- The term is also used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives – both of which can contribute to their health status.
- Health inequalities can therefore involve differences in:
  - health status, (e.g. life expectancy)
  - access to care (e.g. availability of services)
  - quality and experience of care (e.g. patient satisfaction)
  - behavioural risks to health (e.g. smoking)
  - wider determinants of health (e.g. quality of housing)

Inequalities between who?

- Differences in health status and the things that determine it can be experienced by people grouped by a range of factors.
- Often analysed and addressed by policy across four types of factors:
  - socio-economic factors
  - geography
  - specific characteristics including those protected in law
  - socially excluded groups
- The way these factors combine and interact with each other also influences the health inequalities people experience – called "intersectionality"

Taken from: https://www.kingsfund.org.uk/publications/what-are-health-inequalities

Impact of broader determinants on health

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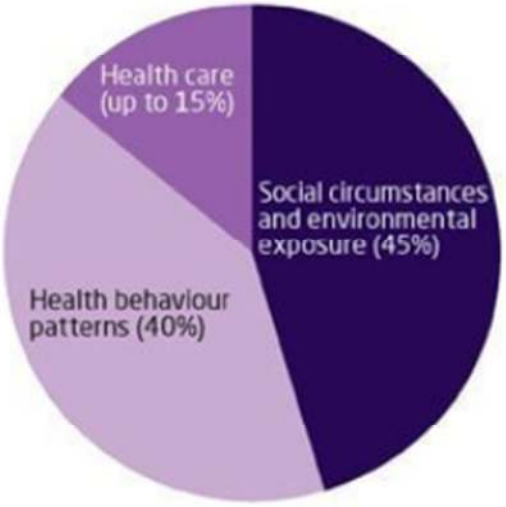
Social circumstances are the major contributor to poor health.

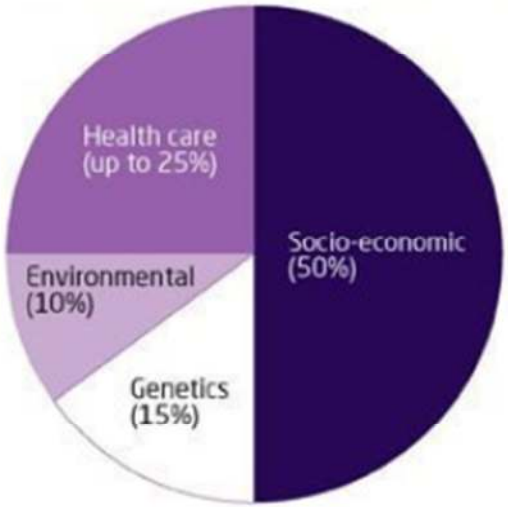
Socio-economic inequalities are associated with unequal exposure to social, economic and environmental risk factors, which in turn contribute to health inequalities.

There are cumulative impacts throughout people's lives and across generations.

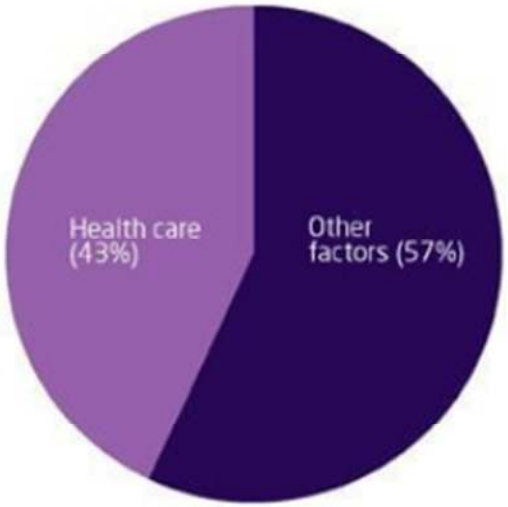
Mc Giniss et al (2002)



Canadian Institute of Advanced Research (2012)



Bunker et al (1995)



Taken from: https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health

Equality vs. equity

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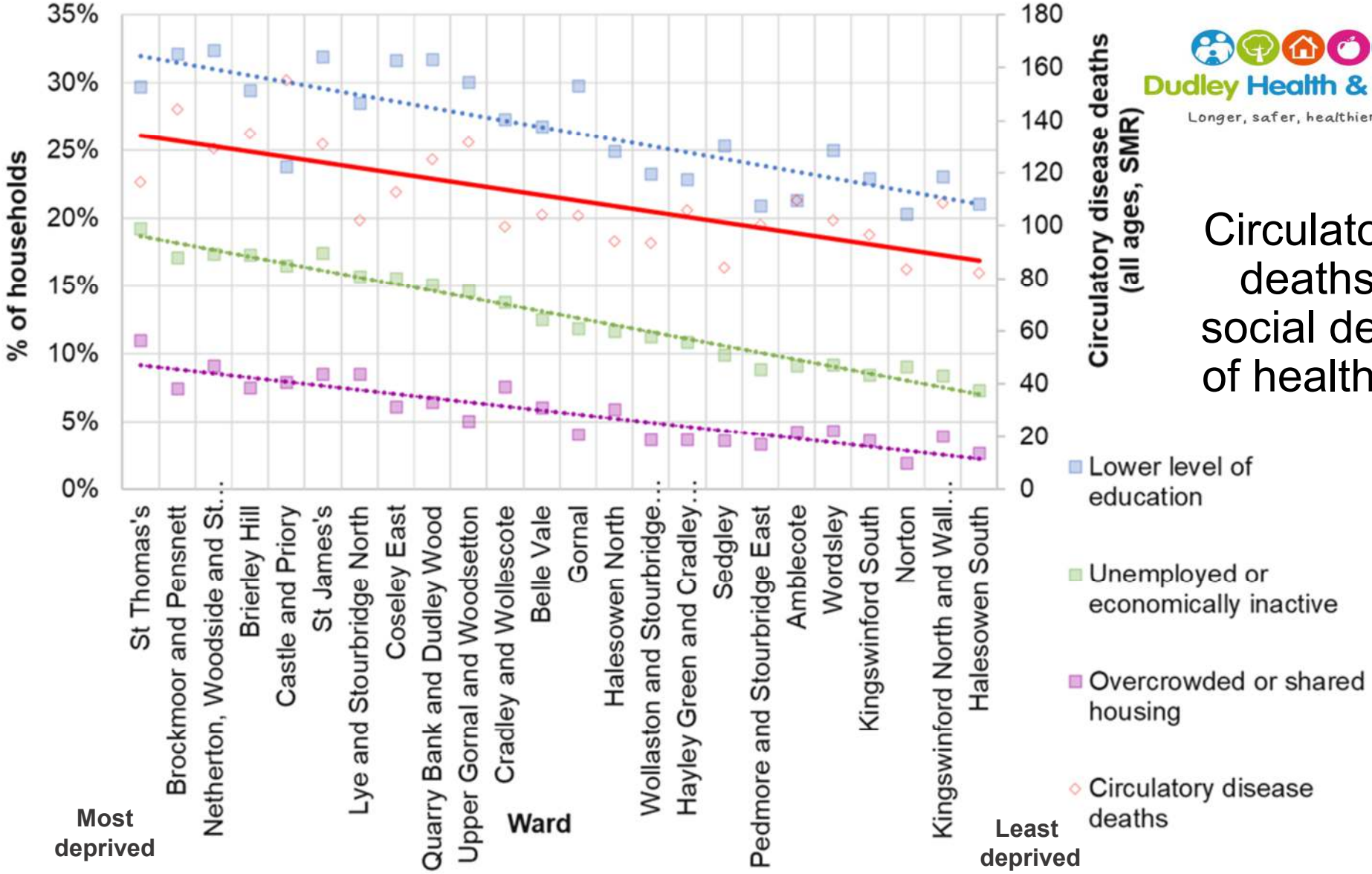
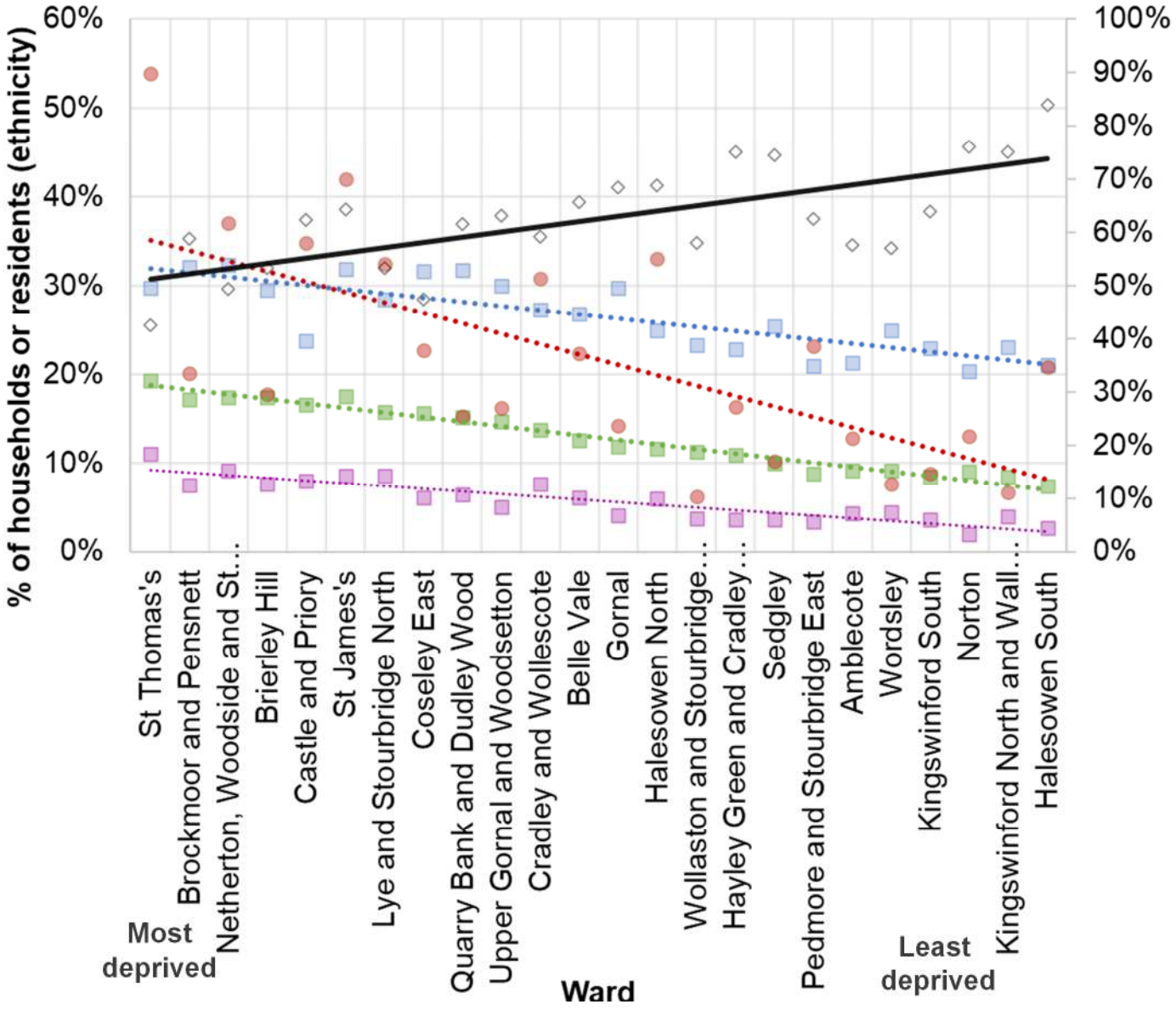
Equality means each individual or group of people is given the same resources or opportunities.

Equity recognises that each person has different circumstances, and allocates the exact resources and opportunities needed to reach an equal outcome.

Circulatory disease deaths and the social determinants of health in Dudley



Sources: Census 2021, OHID, 1997-2021, MHCLG, 2019)



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School readiness and the social determinants of health in Dudley

- Lower level of education
- Unemployed or economically inactive
- Overcrowded or shared housing
- Black, Asian and Minority Ethnic under 5s
- Good level of development at end of reception

Source: Census 2021, DfE 2022, MHCLG, 2019

What keeps people well and matters most to them?

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Dudley – A story of stories (2018)	Looking Back, Moving Forwards – Stories from Covid times (2022)	Theme / priority
Having strong relationships and connections with others	Connections with family and friends in person and online	Relationships and connections
Having something to do, a place to be, a purpose	Work and routine	Sense of purpose
Being able to contribute and give back	Supporting people and being supported	Ability to contribute and give back
Loving where we live - green spaces	The importance of green spaces and connecting with nature	Environment
Having autonomy and being in control		Sense of autonomy and control
Being of Dudley and belonging		Sense of identity
Being active	Being creative	
Learning new things, new ideas	Time to slow down and reflect	

The complex causes of health inequalities

- **people do not have the same opportunities to be healthy**
  - health inequalities stem from variations in the wider determinants of health and the presence of, or access, to psycho-social mediating and protective factors (e.g. social networks, confidence)
- **behaviour change interventions and condition management alone will likely widen health inequalities**
  - people need capability, opportunity and motivation to change and root causes – the wider determinants of health – also need to be addressed
- **resources should be allocated proportionately**
  - to address the levels of need for specific communities or populations to achieve equitable outcomes for all

System map of the causes of health inequalities

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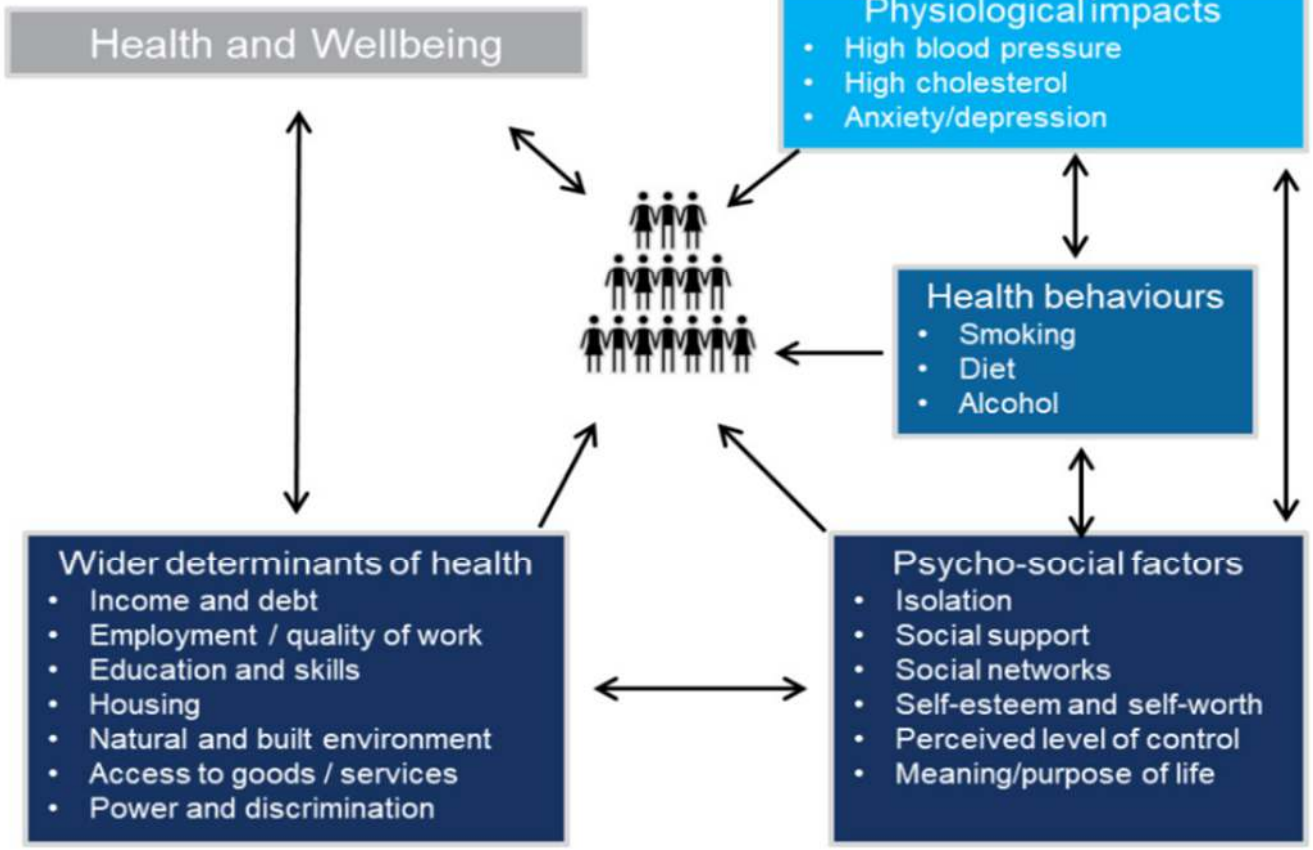

Adapted from the Labonte models, from PHE's Place-based approach for reducing health inequalities, 2021

Making an impact on inequalities

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Whole system leadership and planning

Take action on the wider determinants of health

- local authorities are a critical driving force, with opportunities through policies and regulation
- requires a wider partnership, including all public sector services and businesses

Unleash the potential within communities

- all partners, including communities themselves, need to understand and value this potential
- start with assets within communities, such as the skills and knowledge, social networks, local groups and community organisations, as building blocks for good health

Deliver services with system, scale and sustainably

- calibrated to deliver further and faster to the most disadvantaged communities
- resources (£ and people) need to be proportionately allocated
- build on and strengthen existing services rather than lots of smaller, fragmented projects

focus on joint working across the interfaces to enable the whole to become more than the sum of its parts

Proposals for practical steps

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Board level

- Hear resident stories
- Understand inequalities gaps
- Influence trade-offs in resourcing decisions
- Champion empowering community engagement
- Developing community development focused primary care
- Ensure sufficient focus on the social determinants – work with FAFE
- Champion taking approach at scale and sustainably across policies and interventions

Across all DHWB goals

- Measure health inequalities by small area / population group
- Community of practice to support learning and delivery of community centred approaches
- Work with FAFE on social determinants of health
- Work to embed a reducing inequalities approach in relevant policies, underpinned by high quality equalities impact assessments

Within individual goals

- Embed community-centred approaches to support community resilience
- Equity audits on services to inform resource alignment against need
- Assess location and co-location of services vs. need
- Identifying and addressing social needs by connecting to appropriate services
- Reduce fragmentation of services and scale-up
- Identify areas for action on social determinants of health

Summary

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- To achieve Dudley's new Health & Wellbeing goals we will need to reduce health inequalities
- Working together this will require us to:
  - Take action on the social determinants of health
  - Unleash the potential within Dudley's communities
  - Deliver services with system, scale and sustainability
- There needs to be consideration of the distribution of resources (£ and people)
- Needs to use the levers that we have across the whole of Dudley (communities, public sector, businesses) and beyond, and work in partnership to achieve it

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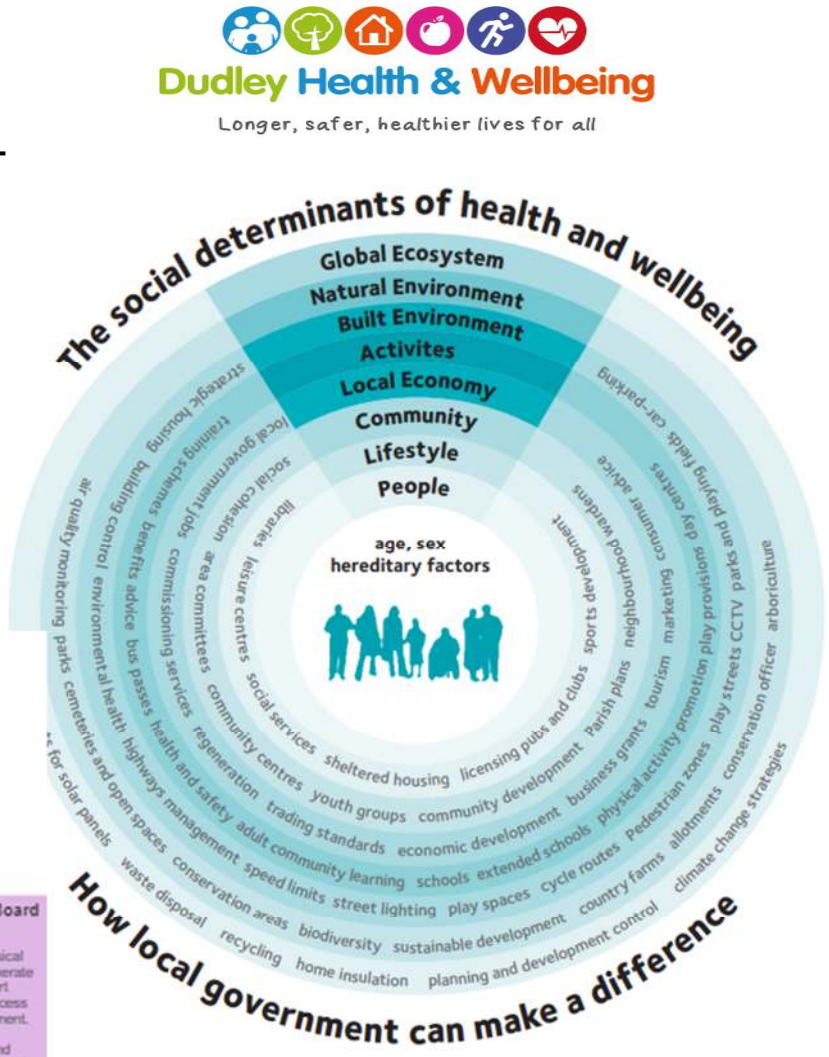
Appendix

Socio-economic interventions

- Opportunities through Dudley's Forging a Future to impact on socio-economic inequalities which will in turn, reduce health inequalities
- Largest opportunities to make a difference quickly role as anchor institutions and through the delivery of social value
  - supporting their staff on wider determinants of health (e.g. active travel, living wage, debt, domestic abuse, freight consolidation for air quality)
  - through supply chain, opportunities to proactively get people into work (e.g. people with severe mental health)



Diagrams are for illustration only

Case studies
Socio-economic interventions

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Black Country Impact

Helping young people gain employment

Added depth of service to help young people who are NEET (not in employment, education or training) access training, gain qualifications and employment, through individualised programmes that can even tackle personal barriers… single parents with child care, ex-offenders, the homeless, equipment and travel, disabilities, plus personal skills that are creating barriers.

"When I was unemployed I felt like I lacked purpose and prospects. When I tried to change my circumstance it felt like a vicious cycle where I could not get the opportunities I needed to do the job that suits me....."

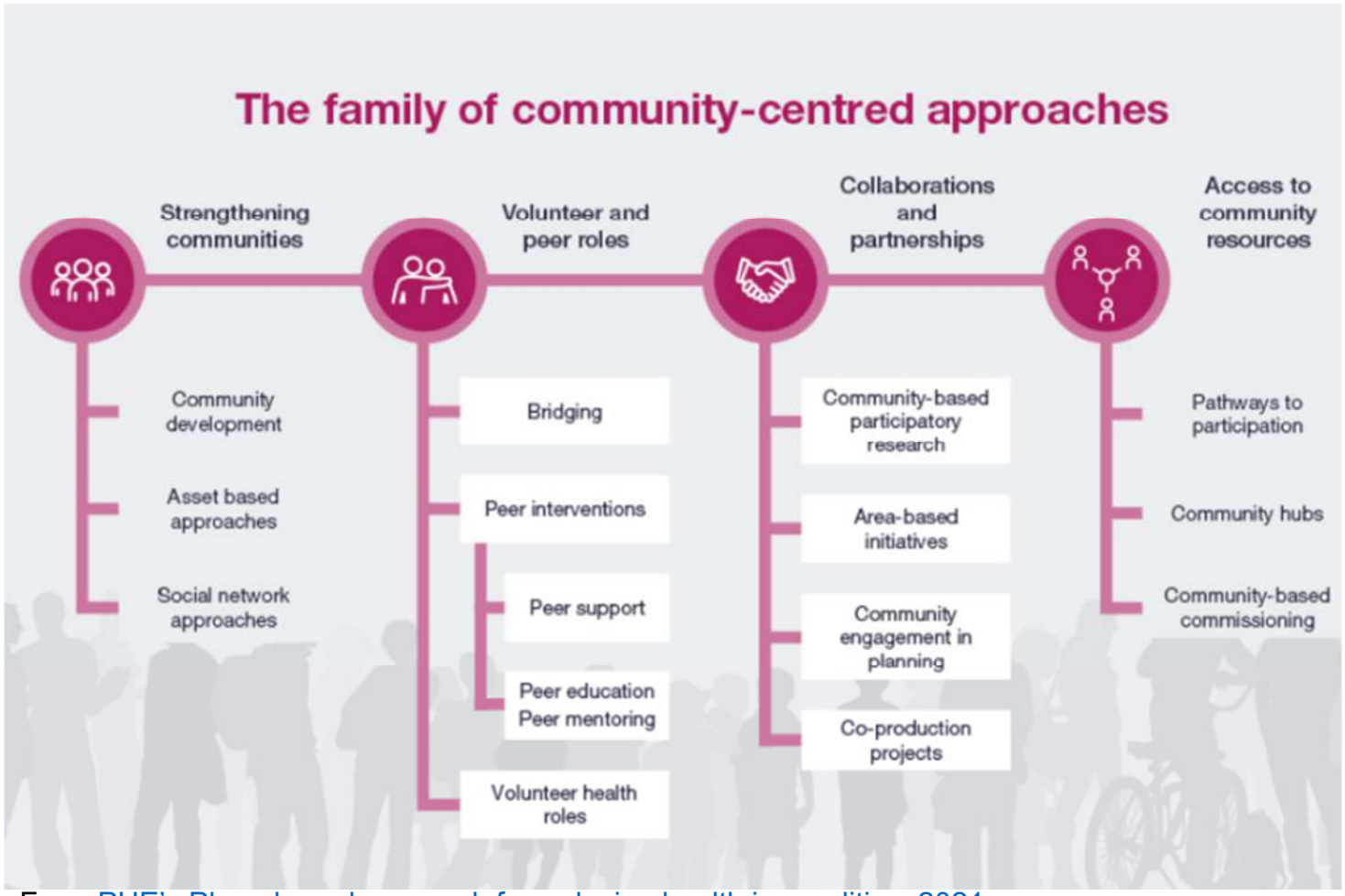
Substance Misuse Service

Employment through volunteering:

Dudley's Integrated Substance Misuse Service, provided by Change Grow Live, run a successful volunteer programme that supports their workforce development strategy. Current figures show that 32% of Dudley staff started as volunteers.

Employability skills and experience are also provided for service users, which includes volunteer opportunities within the service. In addition, the service offers apprenticeship roles and student placements to further support workforce development.

Community-centred approaches



From [PHE's Place-based approach for reducing health inequalities, 2021]

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•**Strengthening communities** - build community capacity to take action. People come together to identify local issues, devise solutions and build sustainable social action.

•**Volunteer and peer roles** - enhance individuals' capabilities to provide advice, information and support or organise activities in their or other communities. Community members use their life experience and social connections to reach out to others.

•**Collaborations and partnerships** - communities and local services working together at any stage of planning cycle. Involving people leads to more appropriate, equitable and effective services.

•**Access to community resources** - connect individuals and families to community resources, practical help, group activities and volunteering opportunities to meet health needs and increase social participation. The link between primary health care and community organisations is critical.

Case studies
Communities

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'Make it Happen!'

An asset-based community development approach:

Make it Happen! supports local people/ grassroots community groups with great ideas to deliver community-led projects.

Make it Happen! events help to identify and connect community assets and provide small amounts of investment to fill any gaps. A total of 51 projects have been supported to date.

Park Active volunteers

A volunteer and peer role:

Park Active volunteers deliver free outdoor circuit-based workouts in parks and provide encouragement and support to get people moving.

The role also provide volunteers with the opportunity to meet new people and make new friends, give something back to the community, gain experience, confidence and new skills and in some cases find a pathway into employment.

Actions on community

Informed by insight from *Dudley, A Story of Stories (2018)* and feedback from the HWB development session in January 2022

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Recommendation	What we will do differently	The difference this will make
Keep listening and discovering	Introduce a story/ case study at the beginning of every HWB meeting. Use insight and stories combined with quantitative data to inform priorities/ decision making/ service delivery.	Greater understanding, empathy and reflection. Better person-centred care and improved services. Influences change at individual practice and organisational level.
Keep building a shared future, keep learning together	Support cross sector learning, communities of practice and other opportunities for people to come together and learn. Share resources/ links to inspiration and support on HWB website.	Increased innovation, sharing of learning and good practice and reduced duplication. Increased awareness of grass roots activity and local assets to build on/ support. Embedding community-centred approaches = increased social connectedness and resilience, improved health and wellbeing.
Keep collaborating	Make it easier for people to get involved in the work of the HWB.	Increased number and diversity of people engaged in and influencing HWB in the borough.

Measuring health inequalities

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Working with analysts to look at routinely measuring and reporting outcomes and process indicators by township or PCN in Dudley, and where possible for different population groups.

This will enable the DHWB to understand where the gaps are relative to the borough average and to direct action.

Outcomes

							most deprived ← Township → least deprived				
Indicator Name	Latest Time period	Dudley Recent Trend	Dudley Count	Dudley Value	WM Value	England Value	Dudley Central	Dudley North	Brierley Hill	Halesowen	Stourbridge
Deaths from circulatory disease, all ages,...	2016 - 20	Cannot be ...	4,156	108.7		100.00	131.48	108.19	117.33	97.37	97.94
Deaths from circulatory disease, under 7...	2016 - 20	Cannot be ...	1,115	107.2		100.00	141.88	119.14	112.39	92.77	80.23

Behavioural & Risk Factors

							most deprived ← Township → least deprived				
Indicator Name	Latest Time period	Dudley Recent Trend	Dudley Count	Dudley Value	WM Value	England Value	Dudley Central	Dudley North	Brierley Hill	Halesowen	Stourbridge
Year 6: Prevalence of overweight (includi...	2019/20 - 21/22	Cannot be ...	42,630	424.1	38.92	35.79	12.77	14.14	9.43	7.68	10.67
Year 6: Prevalence of obesity (including s...	2019/20 - 21/22	Cannot be ...	26,205	260.6	24.41	21.61	26.49	30.34	22.97	22.41	23.47
Reception: Prevalence of overweight (inc...	2019/20 - 21/22	Cannot be ...	29,095	276.3	23.94	22.56	30.09	28.21	24.54	23.05	21.44
Reception: Prevalence of obesity (includi...	2019/20 - 21/22	Cannot be ...	12,775	121.3	11.02	9.88	45.59	44.49	38.54	38.46	37.47

Equalities impact assessments and equity audits

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Equalities impact assessments

- High quality, collaborative equalities impact assessments that also look at:
  - deprivation
  - intersectionality
  - cumulative impacts (and across different policies/initiatives)

Equity audits

- To look at equity in service delivery where services are already running
- Analyse across sex and age, ethnicity and deprivation whether those receiving the service are representative of the people who may need the service
- E.g. those accessing IAPT for mental health support should be representative of people with depression and anxiety

Equalities impact assessments (for policies / service change) and equity audits (to monitor ongoing service delivery) can be used to identify whether resources will be / are being appropriately distributed based on differing levels of need or use of services based on local demographic or socio-economic factors and/or if further weighting of resources (funding and/or workforce) is needed to tackle inequalities.

Case studies
Services

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School nursing

Allocating resource to areas of greatest need:

The school nurse workforce is allocated to support all schools in the borough, including primary, special (MLD), secondary, short stay (alternate provision) and Electively Home Educated (ELE) children.

Nurses were originally allocated equally to the 5 key localities in borough (Dudley North, Dudley Central, Brierley Hill, Stourbridge and Halesowen), each having a named number of schools and caseload to support. Due to the differing needs and demands in the borough, this was not the most equitable use of workforce. There is however, flexibility within the service to move staff around the localities to support where the greatest need is, ensuring each school has a named nurse and support but provision is allocated where the workload is heaviest.

During the course of the contract, some areas of the borough experience higher demand for service, examples of this are below:

- Post Covid, the number of EHE children escalated, meaning the allocated staffing support was no longer able to meet demand. The service has now redirected resource and is implementing a team to support EHE and alternate provision.
- Looked after children health assessments are higher in some areas of the borough than others, therefore, a small number of staff were constantly completing these with little time for other work. This is now addressed corporately as a team, with a whole school nursing team rota to ensure this provision and capacity is shared amongst the whole team rather than rest on one locality team. This ensures the assessments are completed on time, all staff are keeping these skills up to date, fairness of workload is achieved and prevents staff burn out.

Whole system: resource allocation to reduce health inequalities

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- While the public sector is under financial pressure it is still a significant economic force, as are other local employers.
- To reduce health inequalities need to proactively exploring doing things differently within current levels of resource – includes deploying the workforce differently, as well as the money.
- Need to understand the trade-offs:
    - equity versus efficiency
    - investing for future versus short term gains in efficiency
    - “response” versus “prevention or early intervention” E.g. domestic abuse, preventing a child from experiencing violence, and the negative impact on their health and wellbeing, could result in long term savings for the public sector. There is a role for all agencies to tackle these kinds of complex social issues through a public health approach
    - prioritising investment based on community priorities vs. professionals

DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item No. 9(b)**

DATE	**8 June 2023**
TITLE OF REPORT	**Better Care Fund Plan 2023/25 Approval**
Organisation and Author	**Joint report of the Director of Adult Social Care, Dudley MBC, and the Dudley Managing Director, Black Country Integrated Care Board**
Purpose	**To approve the Better Care Fund (BCF) Plan for Dudley for planning years 2023/2025 in line with the national approval process.**
Background	**Since 2015, the BCF has been crucial in supporting people to live healthy, independent, and dignified lives, through joining up health, social care, and housing services seamlessly around the person. This vision is underpinned by two core objectives, to:** • **Enable people to stay well, safe, and independent at home for longer.** • **Provide people with the right care, at the right place, at the right time.** **The BCF achieves this by requiring Integrated Care Boards (ICBs) and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB), governed by an agreement under Section 75 of the NHS Act (2006).**
Key Points	**The national planning guidance has been issued for 2023/25 and the required planning documents are due for submission on the 28June 2023.** **Systems are asked to submit a spreadsheet and accompanying documents demonstrating that the BCF national conditions and metrics for 2023/25 are achieved which are:** • **A jointly agreed plan between local health and social care commissioners, signed off by the HWB.** • **Implementation of BCF policy objective 1: enabling people to stay well, safe, and independent at home for longer.**

	• **Implementation of BCF policy objective 2: providing the right care, at the right place, at the right time** • **Maintain the NHS's contribution to adult social care (in line with the uplift to the NHS minimum contribution to the BCF), and investment in NHS commissioned out of hospital services.** **Evidence is provided by submitting a planning template which can be found in Appendix 1 and contains:** • **A Strategic narrative plan.** • **Income and Expenditure plan.** • **Demand and Capacity plan.** **This submission will be subject to an NHSE assurance process, and we will update the Board as to the outcome in due course.**
Emerging issues for discussion	**Meeting the conditions and metrics is challenging in today's climate due to:** • **Availability of suitable and affordable workforce** • **Growing number of complex people requiring care and specialist services** • **Demand though our urgent care interface.** **The 2022/23 plan has undergone a light touch review and evaluation to agree items for inclusion for the 2023/25 plan.** **New metrics have been published within the planning guidance. Performance will be reported against those metrics on a regular basis.** **Additional discharge funding has been allocated which sits within the governance framework of the BCF.**
Key asks of the Board/wider system	**Approve the 2023/25 Better Care Fund Plan and authorise the submission of the national planning return based on the enclosed assumptions and indicative plan.**

Contribution to H&WBB key goals: • **Improving school readiness** • **Reducing circulatory disease deaths**	**Improved health outcomes and enhanced wellbeing by using this plan to support:** • **Improving the overall quality of life for people, and reducing pressure on UEC, acute and social care services through investing in preventative services.**
• **Improving breast cancer screening coverage** **Focus on those neighbourhoods with the greatest need**	• **Tackling delayed discharge and bringing about sustained improvements in discharge outcomes and wider system flow.**
Contribution to Dudley Vision 2030	**Creating healthy, resilient and safe communities**

Contact officer details

Matt Bowsher,
Director of Adult Social Care
Dudley MBC

Neill Bucktin,
Dudley Managing Director
Black Country Integrated Care Board

DUDLEY HEALTH AND WELLBEING BOARD

DATE 8 June 2023

REPORT OF: Joint report by the Director of Adult Social Care, DMBC and the Managing Director, Black Country Integrated Care Board, Dudley

TITLE: Better Care Fund (BCF) Plan 2023/25 – Approval

PURPOSE OF REPORT:

1. To approve the Dudley Better Care Fund Plan 2023/25.

BACKGROUND

2. Since 2015, the BCF has been crucial in supporting people to live healthy, independent, and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by two core objectives, to:

   Enable people to stay well, safe and independent at home for longer.

   Provide people with the right care, at the right place, at the right time.

3. The BCF achieves this by requiring Integrated Care Boards (ICBs) and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB), governed by an agreement under Section 75 of the NHS Act (2006). This provides an important framework in bringing local NHS services and local government together to tackle pressures faced across the health and social care system and drive better outcomes for people.

4. The BCF programme underpins key priorities in the NHS Long Term Plan by joining up services in the community and the government's plan for recovering urgent and emergency care (UEC) services, as well as supporting the delivery of Next steps to put People at the Heart of Care. The BCF facilitates the smooth transition of people out of hospital, reduces the chances of re-admission, and supports people to avoid long term residential care. The BCF is also a vehicle for wider joining up of services across health and local government, such as support for unpaid carers, housing support and public health.

5. This submission covers a 2-year period to allow greater certainty to plan the use of BCF funding over a 2-year cycle. The delivery of the BCF will support two key priorities for the health and care system that align with the two existing BCF objectives:

   a. improving overall quality of life for people, and reducing pressure on UEC, acute and social care services through investing in preventative services.

   b. tackling delayed discharge and bringing about sustained improvements in discharge outcomes and wider system flow.

Key Points

6. The BCF national planning conditions for 2023/2025 are:

    - A jointly agreed plan between local health and social care commissioners, signed off by the HWB.
    - Implementing BCF policy objective 1: enabling people to stay well, safe and independent at home for longer.
    - Implementing BCF policy objective 2: providing the right care, at the right place, at the right time.
    - Maintaining the NHS's contribution to adult social care (in line with the uplift to the NHS minimum contribution to the BCF), and investment in NHS commissioned out of hospital services.

7. The BCF Plan must be submitted to the national team by the 28th of June 2023.

Adult Social Care Discharge Fund (ASCDF)

8. On 22 September 2022, the government announced its Plan for Patients. This plan committed £500 million for the remainder of 2022 to 2023 financial year, to support timely and safe discharge from hospital into the community by reducing the number of people delayed in hospital awaiting social care. Local authorities and ICBs were asked to work together, through their local Health and Wellbeing Boards, to provide plans for spending the funding from the Adult Social Care Discharge Fund (ASCDF – as an addition to existing BCF plans).

9. In Dudley, the ASCDF enhanced the current BCF Plan by providing additional bed-based services and supporting workforce, as well as piloting some additional mental health services though Black Country Healthcare NHS Foundation Trust (BCHC) as the lead provider.

10. In 2023-25 ICBs and Local Authorities have been provided with an additional discharge allocation for continuation of those schemes proven to be successful and are also included within the plan. Although under the governance of the Better Care Fund, these are identified through a separate funding stream.

Finance

11. The finances attached to BCF are outlined in the table below and are made up of several lines:

    - NHS minimum contribution to the BCF
    - Disabled Facilities Grant (DFG)
    - Improved Better Care Fund (iBCF)
    - Adult Social Care Discharge Fund

Table 1: Finances allocated to Better Care Fund

	2022/23 Plan	2022/23 Actual	2023/24 Plan	2024/25 Plan
Disabled Facilities Grant (DFG)	£6,444,209	£6,444,209	£6,444,209	£6,444,209
iBCF Contribution	£16,627,704	£16,627,704	£16,627,704	£16,627,704
Local Authority Additional Contribution	£12,823,162	£12,606,073	£15,560,393	£15,822,293
NHS Minimum Contribution	£26,901,524	£26,901,524	£28,424,150	£30,032,957
Additional ICB Contribution	£1,879,611	£1,504,962	£1,559,524	£1,047,437
Total BCF Pooled Budget	**£64,676,210**	**£64,084,472**	**£62,171,771**	**£69,974,601**
ASC Discharge Fund				
LA Plan Spend	£1,301,350	£1,301,350	£2,331,178	£3,885,297
ICB Plan Spend	£1,512,000	£1,491,356	£1,495,877	£2,791,803
Total ASC Discharge Fund	**£2,813,350**	**£2,792,706**	**£2,331,178**	**£3,885,297**
BCF + Discharge Fund	**£67,489,560**	**£66,877,178**	**£64,502,950**	**£73,859,898**

Not yet confirmed

Planning Process

12. The 2022/23 BCF Plan has undergone a process of review and light touch evaluation which also identified schemes that require more in-depth evaluation to inform the 2023/25 BCF Plan. This was done through a series of stakeholder meetings, with findings presented to the A & E Delivery Board, Urgent Care Operational Group and the Dudley Health and Care Partnership Board.

13. Each scheme was assessed against their contribution to the objectives and priorities outlined within the BCF planning guidance.

14. Following this process, it was agreed that the 2022/23 plan would continue into the 2023/25 plan but four areas were identified as offering opportunities for efficiencies and transformation. These were:

- Palliative Care - opportunity to integrate the Community Palliative Care Service. This may not reduce costs or release resources back into the system; however, this would create a more efficient way of working.
- Redesign of the Discharge Pathway 1 – opportunity to realign a number of services to deliver a more integrated service.
- Step Down Support - medical input into step down facilities provided by The Dudley Group NHS Foundation Trust. This was not utilised due to the closure of the Saltwells care home in April 2022. A potential underspend is available, and consideration will be given as to how it is used.
- Pathway 2 Stepdown Care Physiotherapy – to support intermediate care facilities, there is an opportunity to realign investment from the private sector.

15. Further schemes that meet the criteria for inclusion in the Better Care Fund and funded recurrently through the ICB have also been added to the 2023/25 plan. This includes the Clinical Hub which has a particular role in preventing unnecessary admission to hospital.

METRICS

16. Beyond the four conditions (and grant conditions), areas have flexibility in how the fund is spent across health, care and housing schemes or services, but need to agree ambitions on how this spending will improve performance against the BCF 2023 to 2025 metrics set out below.

Provide people with the right care, at the right place, at the right time.

- In 2023/24: discharge to usual places of residence
- In 2024/25: discharge to usual places of residence, proportion of people discharged who are still at home after 91 days.

Enabling people to stay well, safe, and independent for longer.

- 2023/24: admissions to residential and care homes, unplanned admissions for ambulatory sensitive chronic conditions, the proportion of older people who were still at home 91 days after discharge from hospital into reablement or rehabilitation services, emergency hospital admissions due to falls in people over 65.

- 2024/25: admissions to residential and nursing homes, unplanned admissions for ambulatory sensitive chronic conditions, outcomes following short-term support to maximise independence.

17. The Business Intelligence (BI) Teams across both the ICB and Local Authority will be working in partnership to agree a reporting schedule against these metrics and the higher cost schemes within the plan. A performance report will be submitted to the Integrated Commissioning Executive.

BCF Plan

18. The BCF plan and narrative plan can be found in Appendix 1. Following approval by this Board and subsequent submission to the national team, BCF plans will be assured and moderated regionally, as well as calibrated across regions. Following this, plans will be put forward for approval by NHSE, in consultation with the Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLUHC).

Recommendations

19. The Board is asked to approve the Dudley Better Care Fund Plan 2023/25.

Appendix 1: # BCF Narrative Plan Template 23-25

Health and Wellbeing Board(s): Dudley

Governance

The assurance and decision-making process for the implementation and continuation of the BCF is the responsibility of the Integrated Commissioning Executive, established through a Section 75 Agreement between Black Country Integrated Care Board and Dudley Metropolitan Borough Council.

Consultation on the plan has been undertaken through an iterative process with Dudley A and E Delivery Board, the Urgent Care Operational Group, and Dudley Health and Care Partnership Board prior to approval by the Health and Well Being Board.

At the beginning of 2023, a programme commenced to review the existing lines of the BCF plan with all stakeholders to inform the 2023/25 programme. For 2023/25, there will be enhanced robust monitoring of the plan throughout the year with areas for further review identified. Evaluations and progress will be governed through the Integrated Commissioning Executive and shared with other stakeholder forums. The development of a revised joint reporting framework is underway which is due to be implemented in July 2023.

Executive summary

Our joint priorities for 2023/25 are: -

- Embedding our Clinical Hub as an alternative to 999 and ambulance conveyance through increasing referrals from GPs, care homes and the West Midlands Ambulance Service
- Further developing the role of Virtual Wards
- Re-commissioning the Enhanced Health in Care Homes Scheme
- Further development of the Reablement Service
- Enhancing the management of our D 2 A pathways, ensuring there is an appropriate level of capacity to meet demand, supported by timely flow through the system.
- Develop a more robust integrated discharge Hub and smoother transition through pathways.
- Embedding the palliative care strategy and its recommendations, alongside the development of a more integrated palliative care team.
- Further developing our Community Partnership Teams
- Exploring opportunities to merge pathways 2 and & 3 to create flexibility around resource and provision.
- Exploring further opportunities to merge Pathway 1 and Own Bed Instead (OBI) provision.
- Development of the Carers' Hub working with Dudley Group NHS Foundation Trust due to open in 2023.

Review of 2022/2023 programme

A light touch evaluation took place against the priorities within the 2022/23 plan. The outcome was that most of the investment areas were key in delivering the objectives laid down in the Better Care Fund Guidance, however it identified four areas of opportunity for efficiencies and transformation. An overarching review with comments against all schemes can be found in Appendix 1. The review identified four areas for further transformation work to be undertaken during the next 2 years, as shown in Appendix 2: -

- Transform palliative care services to ensure a truly integrated team across Health and Social care.
- Review of the existing Discharge to Assess Pathways to ensure that these are integrated and represent value for money, to provide D2A/reablement pathways that are the most cost effective and responsive to ensure flow through the urgent care system.
- Review medical cover within the plan for reablement services, particularly those whose function has changed post covid.
- Align rehabilitation investments to look at opportunities for transformation and release of funds to provide additional investment elsewhere.

As we progress through the identified areas of transformation, we intend to make appropriate changes to our existing BCF Plan (Appendix 3). This is to ensure delivery of tangible impacts in line with the vision and objectives set out int the Policy Framework.

The ICB commissioned a review of Discharge to Assess pathways in 2022, and the outcomes from this review will also inform changes to the BCF Plan over the next 12 months. Further areas have also been aligned to the Better Care Fund Plan for 2023/25 where they meet the criteria, these are: -

- Dudley Clinical Hub: This provides an admission avoidance function.
- Handyman investment: To support quick and efficient discharge for those people. with housing issues where a simple intervention can reduce delays.
- Further investment into Discharge to Assess pathways bringing schemes together to ensure the most effective use of resources.

The Adult Social Care Discharge Fund for 2023/25 will continue to enhance current schemes within the existing BCF Plan, notably provision around Pathways 1, 2 and 3.

Dudley Insights

The information below provides an insight into the activity in the Dudley urgent and emergency care system. The data shows that there are significant peaks and troughs in activity and performance in Dudley and winter 2022/23 was particularly challenging.

Figure 1: ED attendances Type 1 at Dudley Group NHS Foundation Trust (DGFT).

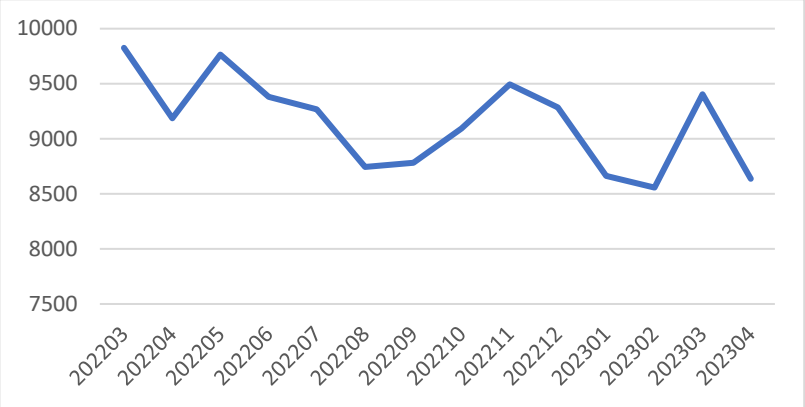


Figure 1 shows that over the last 12months we have seen a general reduction in the number of type 1 attendances at DGFT. We have not had a return to the peak in attendances we saw in March 2022.

Figure 2: Emergency admissions

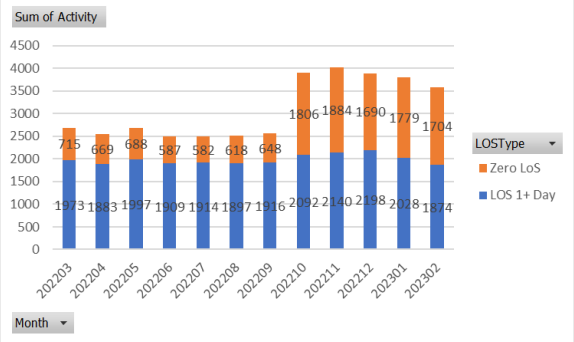
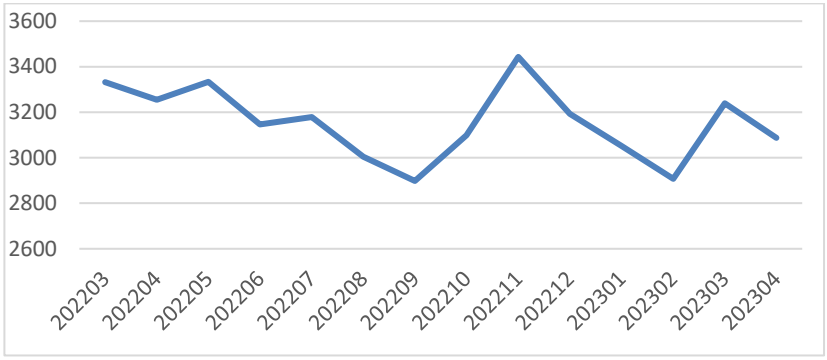


Figure 2 shows a change in activity around September/October of 2022. However, during this period DGFT changed the way Same Day Emergency Care (SDEC) activity was recorded and this is now coded as an emergency admission. The admissions have stayed relatively stable during this period.

Figure 3: Conveyances to DGFT



The admission avoidance activity has increased, and this may be why figure 3 shows a general reduction in ambulance conveyances during the previous 12 months despite the obvious peak during October – December 2022.

Figure 4: Care Home admissions:

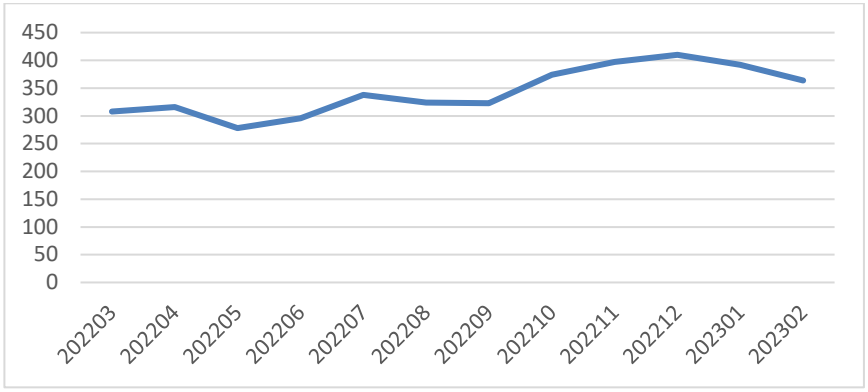
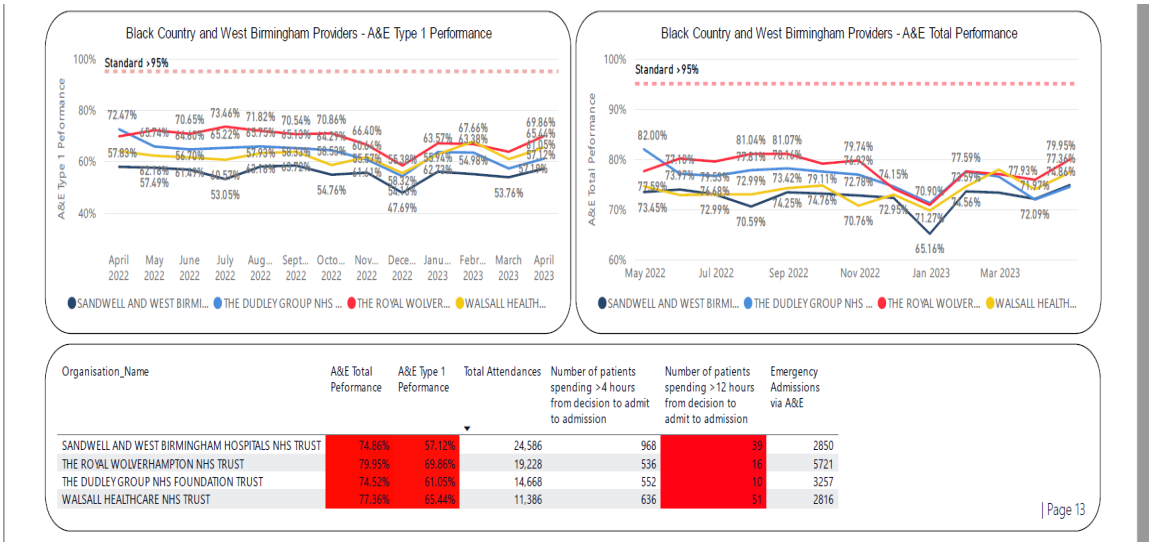


Figure 4 shows that despite an apparent reduction in the curve during recent months, care home admissions are still higher than they were in the same period last year. There is a focused piece of work with care homes working with staff on falls prevention and using appropriate admission avoidance interventions and we hope this will have a significant impact on care home admissions.

Figure 5: System wide A & E type 1 performance.



Organisation_Name	A&E Total Peformance	A&E Type 1 Peformance	Total Attendances	Number of patients spending >4 hours from decision to admit to admission	Number of patients spending >12 hours from decision to admit to admission	Emergency Admissions via A&E
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	74.86%	57.12%	24,586	968	39	2850
THE ROYAL WOLVERHAMPTON NHS TRUST	79.95%	69.86%	19,228	536	16	5721
THE DUDLEY GROUP NHS FOUNDATION TRUST	74.52%	61.05%	14,668	552	10	3257
WALSALL HEALTHCARE NHS TRUST	77.36%	65.44%	11,386	636	51	2816

Figure 5 shows that Dudley's activity is about average compared to neighbouring places and operates along the same trajectory of demand.

Our current challenges in Dudley are: -

- Too many community beds within Dudley place.
- People within a community bed having a length of stay beyond national guidance.
- Lack of specialist neuro-rehabilitation capacity
- Lack of Pathway 1 domiciliary care capacity.
- People being conveyed to hospital that could be managed through admission avoidance teams.
- Lack of pathway capacity to ensure consistent and smooth flow from an acute bed.

This BCF Plan is intended to respond to these challenges.

National Condition 1:

Overall BCF plan and approach to integration

This plan is designed to support the Dudley health and care system through: _

- Preventing inappropriate admission to hospital, residential or nursing care
- Supporting timely discharge from hospital
- Enabling people to live independent lives in supportive and resilient local communities.
- Reducing wider inequalities by enabling appropriate access to services and embedding preventative measures

Our approach to commissioning is led by the Integrated Commissioning Executive, established under the provisions of a Section 75 Agreement which governs the operation of the Better Care Fund. There is no set approach to joint commissioning, rather a set of approaches based upon what is required to address an issue – singular commissioning by either partner, aligned commissioning where each partner is responsible for their element, joint commissioning where resources are brought together to deliver a joint response.

During the period of our 2022/23 BCF Plan, a number of factors have informed our approach to the 2023/25 BCF Plan: -

- A review of our Discharge to Assess Pathways by an external organisation with a set of recommendations.
- The advent of the Adult Social Care Discharge Fund
- Lessons learned from the winter of 2022/23
- A review of existing BCF schemes

As a result of these specific changes and the challenges we have faced, our priorities for 2023/25 are as follows: -

- Further developing our Community Partnership Teams
- Embedding our Clinical Hub as an alternative to 999 and ambulance conveyance through increasing referrals from GPs, care homes and the West Midlands Ambulance Service
- Further developing the role of Virtual Wards
- Re-commissioning the Enhanced Health in Care Homes Scheme
- Further development of the Reablement Service
- Enhancing the management of our D 2 A pathways, ensuring there is an appropriate level of capacity to meet demand, supported by timely flow through the system.
- Develop a more robust integrated discharge Hub and smoother transition through pathways.
- Embed the palliative care strategy and its recommendations, alongside development of a more integrated palliative care team.
- Explore opportunities to merge pathways 2 and 3 to create flexibility around resource and provision.
- Explore further opportunities to merge Pathway 1 and Own Bed Instead (OBI) provision.
- Development of the Carers' Hub working with Dudley Group NHS Foundation Trust due to open in the 2023.

National Condition 2: Meeting BCF objective 1: Enabling people to stay well, safe and independent at home for longer.

Detailed below are some of the main schemes in our approach in Dudley to 'Enabling people to stay well, safe and independent at home for longer.'

Community Partnership Teams

Our Community Partnership Teams are at the heart of our approach to support people at home within supportive local communities. They operate within our six PCNs and bring together clinical and operational staff across primary and community care to wrap higher quality care and services around patients nearer their homes. These teams bring together Community Nursing (District and Long-Term Condition Nurses), Social Care, Voluntary Sector Social Prescribers, Mental Health Nurses as well as the GP Practice and wider PCN workforce, to have a weekly focused discussion around our most complex and vulnerable patients in our community. In the last 10 months a transformation programme has further developed these teams which fundamentally underpin the Integrated Model of Care within Dudley. This has included standardised and dedicated leadership, development of clear metrics and outcomes and the embedding of care co-ordination across primary and secondary care. Currently these teams focus on people with complex comorbidities and frailty, as well as palliative care and complex mental health patients on a monthly basis. We are also expanding the model to have a focus on complex respiratory and diabetes cases. The plan will have strong links with the virtual ward programme as part of the step up/step down pathways of care for frailty, heart failure, respiratory palliative care and care home patients. The Intermediate Care/NHS Continuing Healthcare teams have been further embedded into these Community Partnership Teams to maximise support/rehabilitation to patients within their own home, facilitate timely discharge and support the wider MDTs.

Admission Avoidance

The Clinical Hub provides Dudley with its admission avoidance function through a single point of contact. This service provides the 2-hour community response service triage through to Same Day Emergency Care (SDEC), hospital avoidance to both care homes and people in their own homes, care home educational service and the falls response service. They receive referrals from all stakeholders including primary care, care homes, GPs, social care, and ambulance service. The Urgent Community Response Service (UCR) operates seven days a week 8am-9pm, and the Care Home Educational Team operates 9am-5pm five days a week.

Activity has significantly increased over the latter part of the period. All GP referrals for medical admissions where possible come though this service so that admission avoidance interventions can be put in place if safe to do so.

Figure 6: 2-hour Community Response Activity

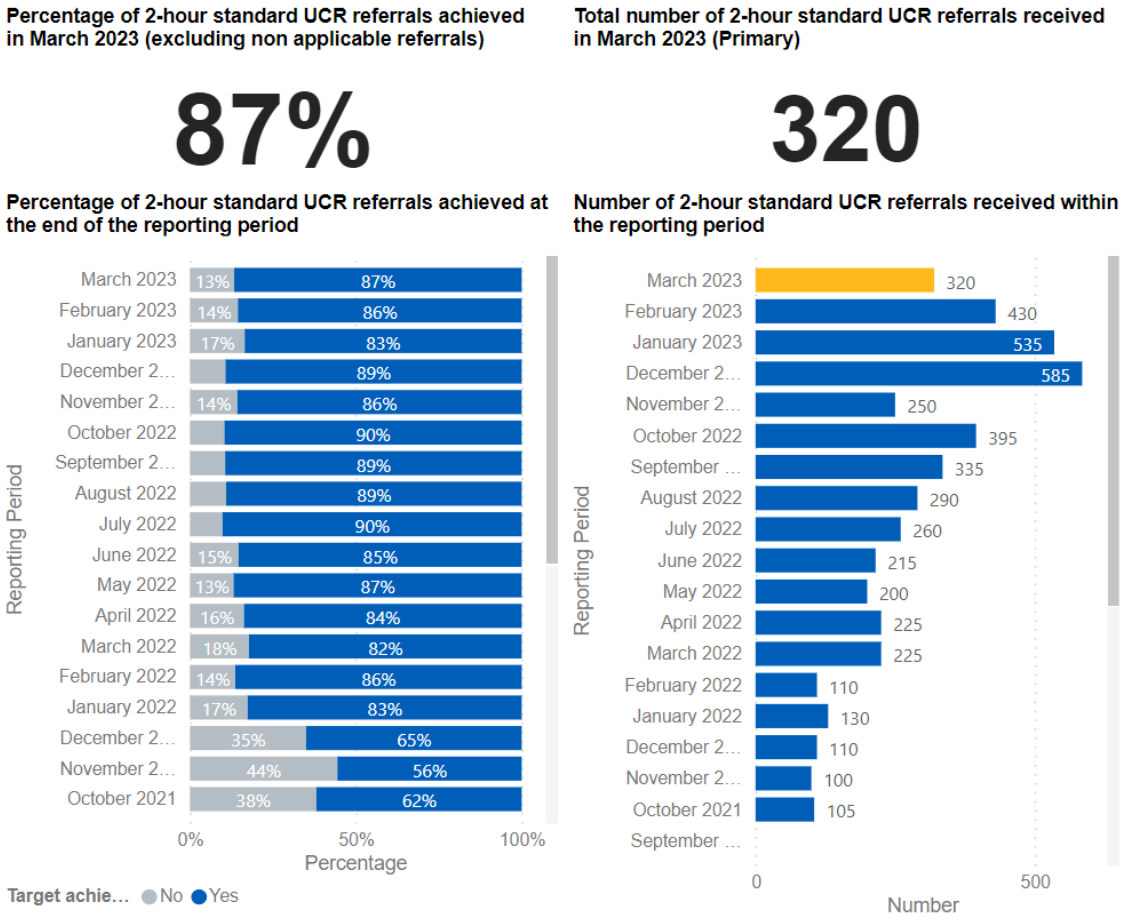


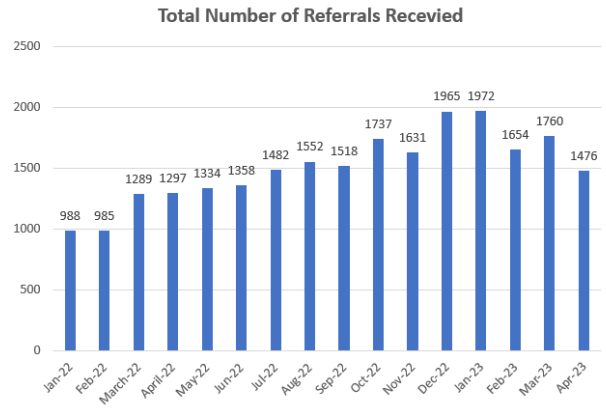
Figure 6 shows that the activity for 2 hour community response has increased over the last 12 months. We will contine to work with the Clinical Hub to ensure that the admisiosn avoidance function is maximised.

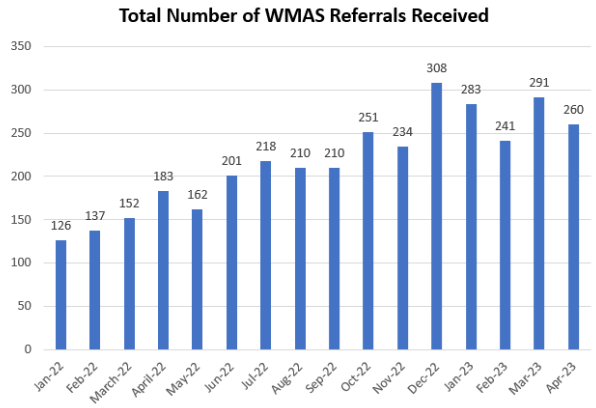
Education and oversight provision is provided for care homes by the Educational Care Home Team, focusing on 21 care homes identified as most in need. This supports care homes to ensure that a patient is not conveyed to hospital unnecessarily and ensures that there is good quality of care delivered within care homes. The Clinical Hub also supports the ongoing Covid – 19 vaccination programme in care homes, and end of life provision. If necessary, the Clinical Hub, will provide carers over night to ensure that people can be cared for within their own environment rather than being admitted to hospital.

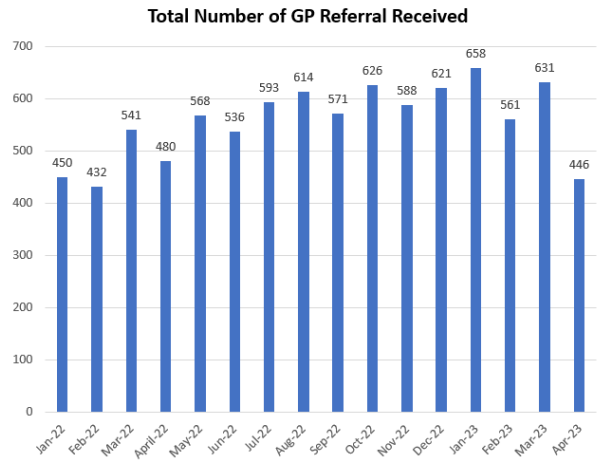
The Falls Service provides a same day response and is available to all care homes within Dudley. The team work with care homes and their residents to respond to the fall but also by providing interventions to prevent future falls. This team has only recently been set up but early data shows that they are reducing ED attendances for this cohort of people by 90%.

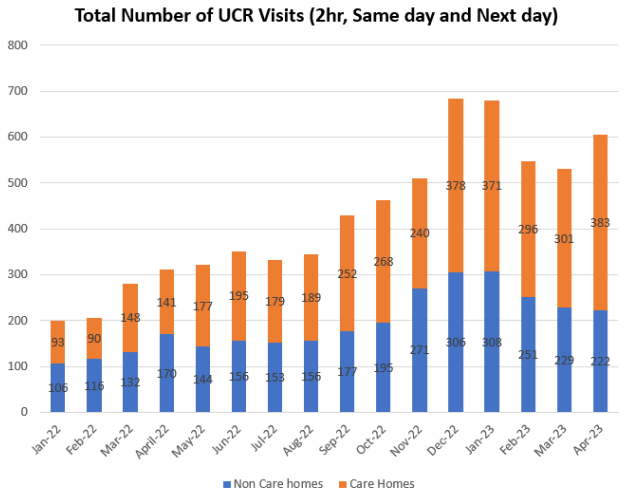
The Hub provides advice, guidance, and treatment around the 9 Core clinical pathways of the Enhanced Health and Care Home model, working in collaboration with the Care Home Education Team.

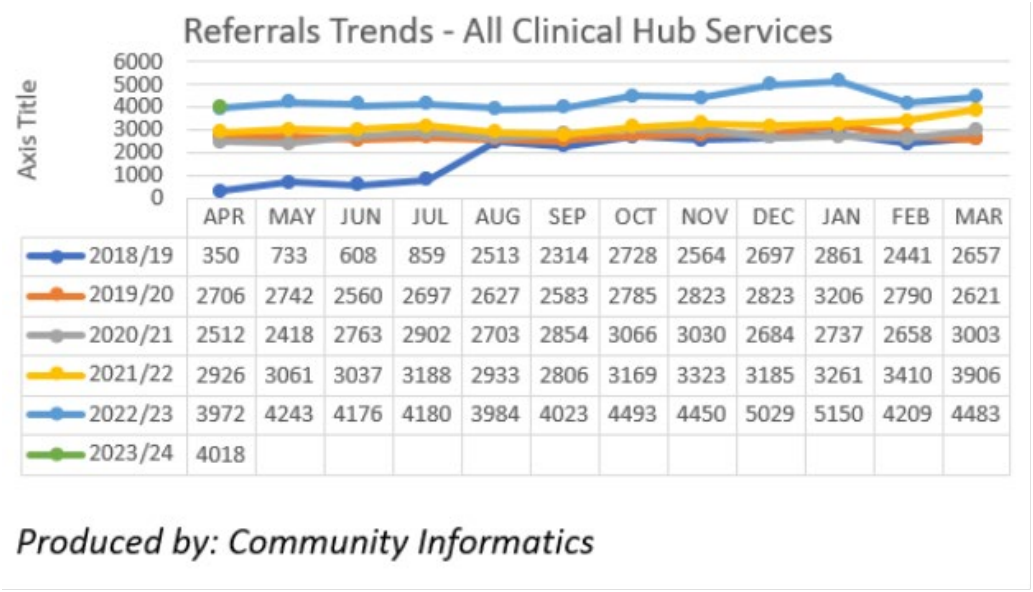
Figure 7 Clinical HUB activity from January 2022 – April 2023: again, showing the general increase in activity over the last 12 months.











	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2018/19	350	733	608	859	2513	2314	2728	2564	2697	2861	2441	2657
2019/20	2706	2742	2560	2697	2627	2583	2785	2823	2823	3206	2790	2621
2020/21	2512	2418	2763	2902	2703	2854	3066	3030	2684	2737	2658	3003
2021/22	2926	3061	3037	3188	2933	2806	3169	3323	3185	3261	3410	3906
2022/23	3972	4243	4176	4180	3984	4023	4493	4450	5029	5150	4209	4483
2023/24	4018											

Produced by: Community Informatics

Admission avoidance functions within the social care community teams offer either step-up facilities or emergency care within a person's own home. Health and social care teams work in collaboration to ensure the person can access the right care at the right time with wrap around support. Where a step-up bed is required, the teams provide the appropriate intervention and support to secure timely discharge back into the community. The hospital avoidance function provides preventative care in the community, signposting is given on direct payments, interventions for falls prevention, administering of personal budgets and health and wellbeing interventions. Reablement is provided by Therapy Services to maximise a person's potential and ensure that desired outcomes are achieved.

Virtual Wards

Dudley Group NHS Foundation Trust lead on the virtual ward programme providing eight virtual wards. The most successful programmes have been respiratory and paediatrics and there is further work required around frailty, and how this links in with the admission avoidance function. The priority so far has been in discharging people from an acute bed to a virtual ward programme, but during the next period the admission avoidance function will be enhanced, so people can be maintained at home, within a virtual ward without entering an acute hospital bed.

Single handed Care

During 2022/23 we piloted a programme of 'single handed care equipment'. This enabled a reduction in the number of carers required to keep people at home and prevent an admission but also facilitated discharge using fewer carers, hence ensuring the capacity of carers was greater. The programme involved training all staff in the use of single-handed equipment, both hospital staff and private providers, as well as a joint commitment to

ensuring this is the default pathway for those people whose needs can be met using this system. Delivery of the equipment can be done at short notice and operates 7 days a week to support admission avoidance and hospital discharge.

Palliative Care Strategy

A palliative care strategy has recently been approved by the Health and Care Partnership Board which commits to developing a system wide approach so that citizens who are in the last stages of their life receive the care they need to preserve their integrity and wellbeing and are as comfortable as possible in the place of their choosing. Providing personalised care planning, shared records and involving the carer in all aspects of care when appropriate. The strategy will be embedded into all discharge plans to ensure that the ambitions of the plan are achieved.

Housing Adaptions

The Council has its own in-house Home Improvement Team that provide a cross tenure approach to delivering Disabled Facilities Grants (DFGs) funded by the BCF, and public sector adaptations funded by the Council's Housing Revenue Account (HRA). The Home Improvement Team have strong links with both the Council's Adult Social Care team and Housing Occupational Therapy (for HRA funded adaptations) who work together to review and develop a seamless DFG service for residents, from assessment, through to referral, means testing, grant administration and delivery of works to site through a range of pre-vetted and approved contractors as part of a framework delivery. A handyman programme supports both admission avoidance and discharge, this can be something simple such as lock changing, or furniture movement to something which requires a more substantial adaption or intervention.

Demand and Capacity

Pathway 2 (bedded rehabilitation) capacity and demand modelling has been embedded since the onset of the Covid pandemic and based on work completed through the National Audit for Intermediate Care. Learning from this analysis has highlighted demand trends and where increased capacity is required. Specifically, challenges arise when there are peaks in demand and where a community facility has beds closed due to, for example, infection control issues. Capacity has been used as flexibly as possible to ensure occupancy is maximised and an innovative project providing surge social work capacity funded through the Adult Social Care Discharge Fund (ASCDF) has significantly improved flow in all Discharge to Assess beds.

One area of potential unmet demand for 2023/24 is the gap in local service provision for patients requiring discharge to specialist Neuro-rehabilitation beds. To mitigate this, work is currently ongoing with system partners to develop referral pathways and improved responsiveness to decision making. A dedicated block commissioned specialist resource is being supported to ensure access and reduce delays.

A further issue identified within the last 18 months activity data is the increased number of patients requiring 1:1 support from the acute setting into a Pathway 3 community bed. Further work is being completed in this area to explore if this is a local assessment issue or a developing trend in the acuity of need. Comprehensive reviews of all patients referred with a 1:1 requirement is also being completed.

Pathway 1 capacity has improved during the later part of 2022/23 through ongoing work with the service providers. However, capacity does still not always meet demand. Again, this is challenging during 'peaks,' and capacity may be wasted when discharges are delayed due to reasons beyond Council control.

An implementation plan for a supported hospital discharge team will provide a home first approach to support patients with wrap around care and therapy support. There is ongoing work with DGFT to model the discharges that can be supported within the financial plan and ensure there are no wasted opportunities.

The demand and capacity analysis has highlighted the need to have between 3-5 Discharge to Assess Pathway 1 discharges every day. A priority for Pathway 1 teams in 2023/24 is to further develop links with bed-based intermediate care and community reablement/Own Bed Instead to ensure as many people can be supported in their own home as possible and improve flow through community beds.

Further work will be taking place during the next period to model a process where capacity is available to meet demand but also with partners to facilitate a system where there is a consistent flow of referrals rather than when resource is available within partner organisations.

National Condition 3: Meeting BCF objective2: Provide the right care in the right place at the right time.

We have described above our approach to admission avoidance and how our Community Partnership Teams function. This section will focus on how we deal with timely discharge and flow. Some of the areas previously discussed feature both within the admission avoidance and discharge flow plans, such as the single-handed equipment programme, the application of the palliative care strategy and housing adaptions.

In Dudley data shows that:

- There is on average about a 96% occupancy level of the acute beds.
- There are on average around 100 people at any one time who have been deemed medically fit for discharge, this includes those patients who are waiting for ward actions such as a therapy review.
- About 23% of discharges happen at weekends.
- The majority of those people on the list for meeting the criteria to be discharged are not discharged due to requiring therapy review, followed by a Pathway 1 provision and a small proportion on pathway 2.
- Those delayed on pathway 2 are mainly due to the availability of specialist neuro rehabilitation beds.

Discharge to Assess and Pathways 1,2 & 3.

The Discharge to Assess Policy is now embedded in operational teams with Home First always the starting point for conversations with patients, families and carers around future destination. Own Bed Instead (OBI) dovetails into the discharge pathways with a commitment moving forward to integrate OBI into Pathway 1. Where discharges do not happen and bed days are lost, we have a mechanism in place to record the reasons for this and themes and trends are used to develop a plan for improvement. For example, where one ward has a higher level of failed discharges then there is increased support to understand why, and further interventions are put in place.

There is a working group dedicated to the development of a robust Discharge to Assess programme, collaborating with all partners to ensure that bed days are used in the most effective way and that patients who are suitable enter the D2A programme.

During 2022/23, pathways 2 and 3 were used flexibly to allow for maximisation of capacity dependent on demand. This allowed flow to be maintained by changing the usage of beds in a fluid way dependent upon patient need.

Reablement programme

We have invested in a reablement programme across health and social care. This is a joint programme working across the teams to ensure that those entering pathway 1 on discharge have a robust reablement plan in place. This is a new programme and will be developed further over the coming year.

Home before Lunch

DGFT leads a ‘Home Before Lunch’ project with all partners supporting this principle. Many of the ‘failed’ discharges are due to losing daytime hours and therefore bringing even the most complex discharges out earlier in the day, allows time to facilitate smooth discharges. There is a KPI to ensure that 70% of discharges happen before lunch. On some wards this is being achieved and on other wards further work is required to improve their performance against this KPI.

System Developments

As a place we have bespoke schemes and programmes to meet the needs of our local population, however as Dudley is part of a wider Integrated Care System (ICS), we also look at opportunities to work at scale. For example, within the Black Country ICS the Adult Social Care Discharge Fund has been used to commission system wide schemes from Black Country Healthcare NHS Foundation Trust – the lead provider for mental health, learning disability and autism services. This includes providing housing support and a social prescribing service for mental health inpatients. During the next term, we will continue to look at opportunities to commission at scale where this makes sense.

Discharge HUB

There is currently a virtual Discharge HUB in Dudley with partners meeting several times during the day to discuss discharge pathways and the no criteria to reside lists, to ensure the maximum number of complex discharges are achieved. All teams use an integrated discharge database to manage discharges and ensure smooth lines of communication with all teams. Further work will take place during the next period to enhance how this database can accurately reflect discharge positions in real time.

In line with the NHSE targets for UEC discharge HUB developments we will continue to develop this team to ensure we are maximising its capability. A recently commissioned Integrated Brokerage Team, staffed through a collaborative model across organisations, delivers an integrated response to discharge into a bed-based service. This has functioned particularly well and allows people to naturally move from one pathway to another in a seamless manner if their needs change.

Handyman Programme

This was funded through the winter of 2022/23, and we will look to continue this programme during the next period. This was an excellent example of using a simple intervention to release acute bed days by using a personalised approach to discharge planning. For example, if a person had lost their keys, required house cleansing etc, the handyman programme was utilised to provide this personalised intervention to facilitate discharge.

High Impact Change Model

The High Impact Change Model has been reviewed for this financial year. A summary of the findings and opportunities for further development are detailed below. This table provides the key themes from the high impact assessment and identified key areas for development in the coming term. These areas focus on:

- Home for lunch.
- Development of the Integrated Discharge HUB.
- Better discharges to care homes.
- Improved BI system.
- Home First approach.

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you know it has been successful?
Change 1: Early discharge planning	Some wards achieving KPI of home for lunch	Bring decision making to earlier in the day.	September 2023	Percentage increase of home for lunch
Change 2: Monitoring and responding to system demand and capacity	Dudley place has a system for monitoring demand and capacity but does not align with system partners.	Further negotiation with system partners to align system and criteria for reporting.	July 2023	All criteria across the system for reporting demand and capacity is consistent.
Change 3: Multi-disciplinary working	Good MDT working although further work to develop the discharge HUB	Benchmark current practice against standards and develop a plan for improvement.	Benchmarking has begun, action plan will be developed by August 2023.	Meet the UEC standards for an integrated discharge hub
Change 4: Home first	Dependent on ward and area of discharge, depends on home first approach.	Work with acute colleagues on messaging and upskilling discharge conversations	September 2023	Default conversation for all discharges is 'Home first'
Change 5: Flexible working patterns	Flexible approach			

Change 6: Trusted assessment	In place			
Change 7: Engagement and choice	In place			
Change 8: Improved discharge to care homes	Performance is varied.	Work with acute colleagues and the care hone sector to agree what 'good' looks like. An existing work programme is in place to take this forward.	September 2023	No incidents reported from care homes for poor discharges.
Change 9: Housing and related services	Issues arise with complex discharges in housing related matters	Ensure housing and acute colleagues develop pathways and communication channels. This work has begun.	October 2023	For discharges that require housing interventions to be smooth and zero 'wasted' bed days.

How we support unpaid carers

BCF funding is used to fund the Carers Hub and Wellbeing Service. This is delivered by the Council's Carers Network Team and a commissioned provider, providing information, advice and support including peer support, welfare benefits advice and applications, young adult carers mentoring service (18 – 25), carers assessments and a preventative carer sitting service. Funding is used to ensure support is provided for the person receiving care at home. This includes support with social worker capacity to undertake Care Act compliant assessments.

The service operates from two HUBs, one in the south and one in the north of the borough. •In 2022/23 the service engaged with approximately 3,500 carers.400 carers were referred for direct support to the Adult Carer Wellbeing Service They offer a range of services including: -

- Community-based delivery such as in local parks and libraries.
- Welfare benefits/allowance advice – supported new claims/appeals, raising £1,129,317.
- Peer Support – groups and activities
- Carers Rights and Awareness Sessions
- Young Adult Carer (18-25) Service.

The Hub delivered: -

- 244 Carers Assessments and 158 Carers Reviews.
- 113 Carers direct payments (via carers assessment) to support carers' health and wellbeing with a value £33,500.
- Provision of short-term preventative sitting service for carers. This service will be included as part of the commissioning of the Adult Carers Wellbeing Service, to ensure it meets the current needs of carers.
- Support with 'cost of living' via Household Support Fund (HSF) payments to carers
- 1,200 carers aged 65 or above received a £150 voucher and 1,800 carers aged 18 – 64 received a £50 voucher.

Following its success, this service has extended a pilot digital carers service. The digital support targets the wider carer community who may not wish to access direct support from the Hub or need support outside of normal working hours. This includes information, advice, virtual chat, and peer group meetings.

Since the start of the pilot the service has achieved 19,751 hits to its website with 67% of this outside of normal working hours, ensuring support is available 24/7. In addition, it has engaged 2,306 carers and directly supported 641 carers.

Based on the success of the pilot, we plan to include a 'digital offer' within the next Carers Wellbeing Service tender. We are also continuing to work with ADASS Regional Carers to look at a possible regional digital offer for carers.

We are continuing to work with DGFT to establish a jointly funded Carers Information Hub within the hospital, to identify and support local carers. It is anticipated that this will open in summer 2023.

The Careers Strategy and Action Plan is currently being reviewed and refreshed, consultation and engagement with local carer organisations and groups has taken place with feedback now informing key priorities for the next strategy (2023 – 2026).

Following a review of the service and consultation with carers, the Adult and Young Carers Wellbeing Service will be recommissioned with services to commence from Autumn 2023.

Disabled Facilities Grant (DFG) and wider services

Dudley Council has a published its commitment to deliver DFGs for its residents. The Council has its own in-house Home Improvement Team that provide a cross tenure approach to delivering DFGs funded by the BCF, and public sector adaptations funded by the Council's Housing Revenue Account (HRA). The Home Improvement Team has strong

links with both the Council's Adult Social Care Team and Housing Occupational Therapy (for HRA funded adaptations) who work together to review and develop a seamless DFG service for residents, from assessment, through to referral, means testing, grant administration and delivery of works to site through a range of pre-vetted and approved contractors.

There is a joint Housing, Communities and Social Care Action Plan, currently under review, to monitor and improve the service provided, with a particular focus on waiting times. There is a current Council policy for DFGs, which provides for discretion in awarding grants, incorporated into the latest Housing Assistance and Guidance Policy.

A revised Housing Assistance and Guidance Policy has now been approved following the publication of the Disabled Facilities Grant (DFG): Guidance for Local Authorities in England to ensure that the Council continues the work that has already been undertaken to develop a service to ensure flexibility of grant delivery that enables people to stay well, safe, and independent at home for longer.

Flexible use of resource has already enabled a less bureaucratic means test of resources and assisted in providing minor adaptations, hoisting equipment, and helping people to re-locate to more adaptable homes. For example, we have invested:

- £695,000 towards additional Community Equipment Service equipment for prescribers across the health and care economy to support people to maximise their independence, including bathing equipment, specialist chairs, mobility aids and hoists.
- £47,000 towards the Handyman Service for the capital expenditure on key safes and ironmongery, safety, security, and small adaptations

In future, increasing the flexibility of the grant further will enable more heating and energy saving support to be provided, help for children living in joint residency, closer working with other housing providers and a contribution to other projects.

How is Dudley Tackling Health Inequalities

Tackling inequalities in health and wellbeing is one of the overarching purposes of integration. Each new or existing service funded by the BCF or IBCF must have regard to the need to reduce inequalities in access to health and care and improve health and wellbeing outcomes.

Dudley's approach to health inequalities is based upon addressing the three pillars of access, prevention and the wider determinants of health and wellbeing. This forms the focus of activity for all partnership bodies led by the Health and Wellbeing Board's Joint Health, Wellbeing, and Inequalities Strategy.

The Health and Care Partnership Board has jointly agreed to an evidence-based Outcomes Framework that lies at the heart of our approach to Population Health Management. A Population Health Management and Inequalities Group reports to the Health and Wellbeing Board and co-ordinates this work across partners.

There has been significant learning since the last plan around health inequalities, and how these impact on both health maintenance and prevention. Whilst the overall uptake rate is the highest in the Black Country, Covid vaccine take-up has been significantly lower in some population groups in Dudley, and these populations are at higher risk of hospital admission. This continues to be an area of focus and the lessons learned in understanding the reasons behind “vaccine hesitancy” have an impact on how we can ensure wider access issues are addressed.

Part of our approach to addressing health inequalities is the creation of strong and resilient communities through our work with the voluntary and community sector. This has included investment in community led projects to address inequalities, including support for carers. These schemes will be reviewed in 2023/24 and the ICB will seek to fund sustainably if evaluations prove positive.

Dudley Council for Voluntary Service – the local umbrella body for voluntary and community sector organisations – is a key partner. As well as providing our local High Intensity User Service, their Integrated Plus workers are embedded within our Community Partnership Teams and work to support the discharge and admission avoidance processes, through the facilitation of effective social prescribing interventions to avoid the medicalisation of problems.

Appendix 1: Evaluation of Better Care Fund 2022-2023

BCF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign	To continue into 23-24
Tissue Viability Service - Assistive Technologies and Equipment	✓	✓	✓	✗	✓
Intermediate Care Team - District Nursing	✓	✓	✓	✗	✓
Step down - Occupational Therapy provided by DGFT		✓	✓	✗	✓
Step down - Physiotherapy provided by DGFT		✓	✓	💡	✓
LTC Nurses	✓	✓	✓	✗	✓
Own Bed Instead	✓	✓		✗	✓
Medical Cover into Intermediate Care Intermediate Care Support - Dr Plant		✓	✓	✗	✓

BCF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign	To continue into 23-24
Admission Avoidance Service – Beds Intermediate/ Stepdown Care - GP Respite	✓	✓	✓	✗	✓
Nursing Home Beds Intermediate/ Stepdown Care		✓	✓	✗	✓
Nursing Home Beds Pathway 3 Beds		✓	✓	✗	✓
Nursing Home Beds Intermediate/ Stepdown Care		✓	✓	✗	✓
Joint **Palliative Care** Support Team	✓	✓	✓	💡	✓

BCF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign	To continue into 23-24
Intermediate/ Stepdown Care - Physiotherapists		✓	✓		✓
Medical Cover - Saltwells Stepdown Cover – DGFT		✓	✓		✓
Highest Care Needs – coordinated palliative care community-based and inpatient care	✓	✓	✓		✓
Reablement Highest Care Needs – coordinated community-based and inpatient care	✓	✓	✓		✓

ASC DF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign
Enhanced neuro-rehabilitation capacity		✓	✓	✗
Additional Intermediate Care bed-based capacity		✓	✓	✗
Social work capacity		✓	✓	✗
Discharge to Assess – enhance model		✓	✓	✗

ASC DF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign
Therapy capacity for pathway 3 and spot purchase beds	✓	✓	✓	✗
Bridging beds		✓	✓	✗
Assessment capacity to review care packages in peoples own homes.	✓	✓	✓	✗
Therapy support in patents own homes	✓	✓	✓	✗

ASC DF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign
Additional social work capacity for mental health and LD patients		✓	✓	✗
Additional equipment	✓	✓	✓	✗
Overtime for DOM care workers and social work staff	✓	✓	✓	✗
Additional Pathway 3 beds		✓	✓	✗

ASC DF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign
Additional Pathway 1		✓	✓	✗
Additional back-office support	✓	✓	✓	✗
Administration time for planning and co-ordination	✓	✓	✓	✗
Additional Intermediate Care Nurse capacity		✓	✓	✗

ASC DF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign
Additional discharge 2 Assess joint plan (townships)	✓	✓	✓	
Support for pathway 0		✓	✓	✗
Top slice for administration	✓	✓	✓	✗
Additional beds to support discharge for those patients testing positive for covid		✓	✓	✗

ASC DF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign
Voluntary sector support for mental health inpatients	✓	✓	✓	✗
Additional pathway 3 beds managed by health teams, patients with nursing needs		✓	✓	✗

Appendix 2 - BCF 23-24 Work Plan

4 areas for review	Q1	Q2	Q3	Q4
Transform **Palliative Care Services** to ensure a true integrated team across Health and Social care.	Set up Dudley Place Palliative Care Integration Working Group. Establish core members and develop TOR	Working group to explore opportunities and potential solutions for integration	Continue to collaborate to coproduce recommendations	Recommendations to be presented to the Integrated Care Executive
Review of the existing **Discharge to Assess Pathways**, ensuring integration, value for money and ensure patient flow.	D2A Steering Group established and in place. Need to determine action plan and timelines.	Continuation of D2A Steering Group and implementation of Action Plan.	Continue to collaborate to coproduce recommendations	Continue to collaborate to coproduce recommendations
Review **medical cover** within the plan for int care services, particularly those whose function has changed post covid.	Not a priority for Q1	Review current position and recommendations taken to Integrated Commissioning Executive.	Implementation of recommendations	Complete
Align rehabilitation **(Step down physiotherapy)** investments to look at opportunities for transformation and release of funds to provide additional investment elsewhere.	Not a priority for Q1	Discussion with existing provider to identify opportunities	Implementation	Complete

Appendix 3: Planning Template

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
*Area Assurance Contact Details:	Health and Wellbeing Board Chair	Cllr	Ian	Bevan	Cllr.Ian.Bevan@dudleymbc.org.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Mr	Mark	Axcell	m.axcell@nhs.net
	Additional ICB(s) contacts if relevant	Mr	Neill	Bucktin	neill.buctin@nhs.net
	Local Authority Chief Executive	Mr	Kevin	O'Keefe	kevin.okeefe@dudley.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Mr	Matt	Bowsher	matt.bowsher@dudley.gov.uk
	Better Care Fund Lead Official	Mr	Neill	Bucktin	neill.buctin@nhs.net
	LA Section 151 Officer	Mr	Iain	Newman	iain.newman@dudley.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->	Local Authority Senior Principal Accountant	Mr	Tom	Huntbatch	thomas.huntbatch@dudley.gov.uk

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£6,444,209	£6,444,209	£6,444,209	£6,444,209	£0
Minimum NHS Contribution	£28,424,150	£30,032,957	£28,424,150	£30,032,957	£0
iBCF	£16,627,704	£16,627,704	£16,627,704	£16,627,704	£0
Additional LA Contribution	£15,560,393	£15,822,293	£15,560,393	£15,822,293	£0
Additional ICB Contribution	£1,559,524	£1,047,437	£1,559,524	£1,047,437	£0
Local Authority Discharge Funding	£2,331,178	£3,885,297	£2,331,178	£3,885,297	£0
ICB Discharge Funding	£1,495,877	£2,791,802	£1,495,877	£2,791,802	£0
Total	**£72,443,036**	**£76,651,699**	**£72,443,035**	**£76,651,699**	**£1**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£8,077,338	£8,534,515
Planned spend	£9,794,427	£10,385,991

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£17,879,723	£18,891,716
Planned spend	£17,879,723	£18,891,716

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	889.0	915.0	940.0	965.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,874.0	2,108.8
	Count	1268	1427
	Population	66258	66258

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	90.8%	90.5%	90.7%	90.9%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	789	798

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	86.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementing the BCF policy objectives	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as need)	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST	Social support (including VCS) (pathway 0)												
THE DUDLEY GROUP NHS FOUNDATION TRUST													
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST	Reablement at home (pathway 1)												
THE DUDLEY GROUP NHS FOUNDATION TRUST													
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST													
THE DUDLEY GROUP NHS FOUNDATION TRUST													
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST													
THE DUDLEY GROUP NHS FOUNDATION TRUST													
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST													
THE DUDLEY GROUP NHS FOUNDATION TRUST													
THE DUDLEY GROUP NHS FOUNDATION TRUST		168	175	140	137	149	148	175	171	159	216	150	176
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST	Rehabilitation at home (pathway 1)												
THE DUDLEY GROUP NHS FOUNDATION TRUST													
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST	Short term domiciliary care (pathway 1)												
THE DUDLEY GROUP NHS FOUNDATION TRUST													
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST	Reablement in a bedded setting (pathway 2)												
THE DUDLEY GROUP NHS FOUNDATION TRUST		13	12	10	11	10	14	12	10	13	15	14	12
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST	Rehabilitation in a bedded setting (pathway 2)												
THE DUDLEY GROUP NHS FOUNDATION TRUST		48	32	38	37	38	42	40	43	45	55	50	42
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST	Short-term residentialnursing care for someone likely to require a longer-term care home placement (pathway 3)												
THE DUDLEY GROUP NHS FOUNDATION TRUST		55	72	66	61	63	63	77	70	68	63	50	52
Totals	**Total:**	284	291	254	246	260	267	304	294	285	349	264	282

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)												
Urgent Community Response	97	80	84	83	55	84	72	83	98	113	86	113
Reablement at home	168	175	140	137	149	148	175	171	159	216	150	176
Rehabilitation at home												
Reablement in a bedded setting	55	72	66	61	63	63	77	70	68	63	50	52
Rehabilitation in a bedded setting												
Other short-term social care												

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.												
Reablement at Home	Monthly capacity. Number of new clients.	175	175	175	175	175	175	175	175	175	175	175	175
Rehabilitation at home	Monthly capacity. Number of new clients.												
Short term domiciliary care	Monthly capacity. Number of new clients.												
Reablement in a bedded setting	Monthly capacity. Number of new clients.												
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.												
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	65	65	65	65	65	65	65	65	65	65	65	65

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.												
Urgent Community Response	Monthly capacity. Number of new clients.	100	100	100	100	100	100	100	100	100	100	100	100
Reablement at Home	Monthly capacity. Number of new clients.												
Rehabilitation at home	Monthly capacity. Number of new clients.												
Reablement in a bedded setting	Monthly capacity. Number of new clients.												
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.												
Other short-term social care	Monthly capacity. Number of new clients.												

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Dudley

Local Authority Contribution			Complete:
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2	
Dudley	£6,444,209	£6,444,209	Yes
DFG breakdown for two-tier areas only (where applicable)			
Total Minimum LA Contribution (exc iBCF)	**£6,444,209**	**£6,444,209**	

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2	
Dudley	£2,331,178	£3,885,297	Yes

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2	
NHS Black Country ICB	£1,495,877	£2,791,802	Yes
Total ICB Discharge Fund Contribution	£1,495,877	£2,791,802	

iBCF Contribution	Contribution Yr 1	Contribution Yr 2	
Dudley	£16,627,704	£16,627,704	Yes
Total iBCF Contribution	**£16,627,704**	**£16,627,704**	

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding	
Dudley	£15,560,393	£15,822,293	Minimal uplift included for 24/25, will be revised as part	Yes
Total Additional Local Authority Contribution	**£15,560,393**	**£15,822,293**		

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Black Country ICB	£28,424,150	£30,032,957
Total NHS Minimum Contribution	**£28,424,150**	**£30,032,957**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	Yes	Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding	
NHS Black Country ICB	£1,559,524	£1,047,437	Uplift applied for 24/25, will be reviewed as part of	Yes
Total Additional NHS Contribution	**£1,559,524**	**£1,047,437**		
Total NHS Contribution	**£29,983,674**	**£31,080,394**		

	2023-24	2024-25
Total BCF Pooled Budget	**£72,443,036**	**£76,651,699**

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Dudley

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£6,444,209	£6,444,209	£0	£6,444,209	£6,444,209	£0
Minimum NHS Contribution	£28,424,150	£28,424,150	£0	£30,032,957	£30,032,957	£0
iBCF	£16,627,704	£16,627,704	£0	£16,627,704	£16,627,704	£0
Additional LA Contribution	£15,560,393	£15,560,393	£0	£15,822,293	£15,822,293	£0
Additional NHS Contribution	£1,559,524	£1,559,524	£0	£1,047,437	£1,047,437	£0
Local Authority Discharge Funding	£2,331,178	£2,331,178	£0	£3,885,297	£3,885,297	£0
ICB Discharge Funding	£1,495,877	£1,495,877		£2,791,802	£2,791,802	£0
Total	**£72,443,036**	**£72,443,035**	**£1**	**£76,651,699**	**£76,651,699**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£8,077,338	£9,794,427	£0	£8,534,515	£10,385,991	£0
Adult Social Care services spend from the minimum ICB allocations	£17,879,723	£17,879,723	£0	£18,891,716	£18,891,716	£0

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1001	Whole Population Prevention / Population Health Management	Locality Based Prevention Hubs	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£1,299,140	£1,299,140	
1001	Whole Population Prevention / Population Health Management	Locality Based Prevention Hubs - Carer support	Carers Services	Other	Locality Based Prevention Hubs - Carer support			Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£434,900	£434,900	
1002	Whole Population Prevention / Population Health Management	Community Equipment Stores	Assistive Technologies and Equipment	Community based equipment				Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£520,300	£527,100	
1002	Whole Population Prevention / Population Health Management	Community Equipment Stores	Assistive Technologies and Equipment	Community based equipment				Number of beneficiaries	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£616,300	£624,300	
1003	Whole Population Prevention / Population Health Management	Disabled Facilities Grant	DFG Related Schemes	Other	Disabled Facilities Grant			Number of adaptations funded/people supported	Social Care		LA			Local Authority	DFG	Existing	£6,444,209	£6,444,209	
1004	Whole Population Prevention / Population Health Management	Falls Service	Prevention / Early Intervention	Other	Falls service				Social Care		LA			Local Authority	Additional LA Contribution	Existing	£54,200	£58,400	
1005	Whole Population Prevention / Population Health Management	Careres Network Team	Carers Services	Other	Carer Advice and Support			Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£219,400	£223,400	
2001	Urgent Care Needs – Integrated Access & Rapid Response	Out of Hours	Home-based intermediate care services	Reablement at home (accepting step up and step down users)				Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£200,400	£204,200	
2001	Urgent Care Needs – Integrated Access & Rapid Response	Out of Hours	Home-based intermediate care services	Reablement at home (accepting step up and step down users)				Packages	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£34,200	£34,800	
2002	Urgent Care Needs – Integrated Access & Rapid Response	Access - SPOA	Integrated Care Planning and Navigation	Support for implementation of anticipatory care					Social Care		LA			Local Authority	Additional LA Contribution	Existing	£1,691,900	£1,819,400	
3001	Ongoing Care Needs - Enhanced Primary & Community Care	Homecare	Home Care or Domiciliary Care	Domiciliary care packages				Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£7,083,923	£7,762,816	
3001	Ongoing Care Needs - Enhanced Primary & Community Care	Homecare	Home Care or Domiciliary Care	Domiciliary care packages				Hours of care	Social Care		LA			Private Sector	IBCF	Existing	£6,426,513	£6,426,513	
3001	Ongoing Care Needs - Enhanced Primary & Community Care	Homecare	Home Care or Domiciliary Care	Domiciliary care packages				Hours of care	Social Care		LA			Private Sector	Additional LA Contribution	Existing	£1,638,664	£1,638,664	
3003	Ongoing Care Needs - Enhanced Primary & Community Care	Direct Payments	Personalised Budgeting and Commissioning						Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£147,300	£155,600	
3003	Ongoing Care Needs - Enhanced Primary & Community Care	Direct Payments	Personalised Budgeting and Commissioning						Social Care		LA			Private Sector	Additional LA Contribution	Existing	£3,582,900	£3,582,900	
3003	Ongoing Care Needs - Enhanced Primary & Community Care	Direct Payments	Carers Services	Respite services				Beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£89,100	£89,100	
3004	Ongoing Care Needs - Enhanced Primary & Community Care	Urgent care assessment and therapy	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	Additional LA Contribution	Existing	£936,450	£965,150	
3004	Ongoing Care Needs - Enhanced Primary & Community Care	Urgent care assessment and therapy	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Additional LA Contribution	Existing	£936,450	£965,150	
4001	Highest Care Needs – coordinated community-based and inpatient care	Living independentley Team - Community Reablement	Home-based intermediate care services	Reablement at home (accepting step up and step down users)				Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£724,400	£738,500	
4001	Highest Care Needs – coordinated community-based and inpatient care	Living independentley Team - Community Reablement	Home-based intermediate care services	Reablement at home (accepting step up and step down users)				Packages	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£790,300	£809,600	
4002	Highest Care Needs – coordinated community-based and inpatient care	Access & Prevention - Occupational Therapy	Prevention / Early Intervention	Other	Assessment for adaptations and preventative				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£228,100	£232,700	
4002	Highest Care Needs – coordinated community-based and inpatient care	Access & Prevention - Occupational Therapy	Prevention / Early Intervention	Other	Assessment for adaptations and preventative				Social Care		LA			Local Authority	Additional LA Contribution	Existing	£1,002,400	£1,022,800	
4003	Highest Care Needs – coordinated community-based and inpatient care	Tiled House	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)				Number of Placements	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£2,983,600	£3,031,600	
4004	Highest Care Needs – coordinated community-based and inpatient care	External reablement - packages of care	Home-based intermediate care services	Reablement at home (accepting step up and step down users)				Packages	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,235,600	£2,362,100	
4004	Highest Care Needs – coordinated community-based and inpatient care	Urgent Care - Homecare assistants	Urgent Community Response						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£536,900	£541,800	
4004	Highest Care Needs – coordinated community-based and inpatient care	Urgent Care - Homecare assistants	Urgent Community Response						Social Care		LA			Local Authority	Additional LA Contribution	Existing	£931,800	£956,300	
4005	Highest Care Needs – coordinated community-based and inpatient care	Palliative - front end	Personalised Care at Home	Other	Palliative Care				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£272,000	£277,400	
4006	Highest Care Needs – coordinated community-based and inpatient care	Supported Living - MH	Home Care or Domiciliary Care	Domiciliary care packages				Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£246,100	£260,000	
4006	Highest Care Needs – coordinated community-based and inpatient care	Supported Living - MH	Home Care or Domiciliary Care	Domiciliary care packages				Hours of care	Social Care		LA			Private Sector	Additional LA Contribution	Existing	£1,610,789	£1,610,789	
4007	Highest Care Needs – coordinated community-based and inpatient care	Integrated Discharge Pathway	High Impact Change Model for Managing Transfer of Care	Other	Bed based Packages				Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£1,063,600	£1,123,800	
4007	Highest Care Needs – coordinated community-based and inpatient care	Short Term beds	Bed based intermediate Care Services (Reablement,	Other	Discharge 2 Assess			Number of Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£204,300	£215,900	
4007	Highest Care Needs – coordinated community-based and inpatient care	Short term beds	Bed based intermediate Care Services (Reablement,	Other	Discharge 2 Assess			Number of Placements	Social Care		LA			Private Sector	IBCF	Existing	£488,901	£488,901	
4008	Highest Care Needs – coordinated community-based and inpatient care	Internal Day Care & Dementia Gateways	Community Based Schemes	Other	Internal Day Care & Dementia				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,124,700	£1,145,700	
4009	Highest Care Needs – coordinated community-based and inpatient care	Urgent Care enhanced offer	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	IBCF	Existing	£1,001,300	£1,001,300	
4010	Highest Care Needs – coordinated community-based and inpatient care	Enhanced therapy offer	Home-based intermediate care services	Other	Preventing admissions to acute setting			Packages	Social Care		LA			Local Authority	IBCF	Existing	£998,700	£998,700	
4011	Highest Care Needs – coordinated community-based and inpatient care	Enhanced review offer	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	IBCF	Existing	£216,100	£216,100	
4012	Highest Care Needs – coordinated community-based and inpatient care	Bed based Packages	Integrated Care Planning and Navigation	Other	Bed based Packages				Social Care		LA			Private Sector	IBCF	Existing	£5,934,569	£5,934,569	
4013	Highest Care Needs – coordinated community-based and inpatient care	DDS clients over 65	Home Care or Domiciliary Care	Domiciliary care packages				Hours of care	Social Care		LA			Private Sector	IBCF	Existing	£1,561,621	£1,561,621	
5001	Discharge to Assess	Enhance the discharge to Assess model and increase capacity	Home Care or Domiciliary Care	Domiciliary care packages				Hours of care	Social Care		LA			Private Sector	Local Authority Discharge Funding	Existing	£732,164	£732,164	
5001	Discharge to Assess	Enhance the discharge to Assess model	Home-based intermediate care services	Reablement at home (accepting step up and step down users)				Packages	Social Care		LA			Local Authority	Local Authority Discharge Funding	New	£1,000,000	£2,554,119	
5002	Additional Pathway 3 beds	To support discharge to assess to ensure that patients are transferred from hospital to an appropriate	Residential Placements	Short-term residential/nursing care for someone likely to require a					Social Care		LA			Private Sector	Local Authority Discharge Funding	Existing	£262,718	£262,718	
5003	Additional equipment	To reduce the number of resource for pathway 1 we require additional equipment for the single handed	Assistive Technologies and Equipment	Community based equipment				Number of beneficiaries	Social Care		LA			Local Authority	Local Authority Discharge Funding	Existing	£200,000	£200,000	
5004	Additional social work capacity for mental health and LD colleagues	Dedicated SW support for this cohort, recruitment commenced for 2 WTE	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Local Authority Discharge Funding	Existing	£136,296	£136,296	

232501	Tissue Viability Service	Provision of equipment to enable discharge of patients to their own home, mattresses/beds etc. (Drive	Assistive Technologies and Equipment	Community based equipment		1550	1750	Number of beneficiaries	Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£1,255,165	£1,263,951
232502	Clinical Hub	2 Hour Response and Admission Avoidance Service	Urgent Community Response						Community Health		NHS			NHS	Additional NHS Contribution	Existing	£598,701	£602,892
232503	Palliative and End of Life Care – dedicated Domiciliary Care Teams	Dedicated Domiciliary Care providing end of life care to people in own homes	Community Based Schemes	Other					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£1,955,912	£1,969,604
232504	Own Bed Instead (OBI)	OBI is a rehab service to support people in their own homes	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£485,391	£488,789
232505	Long Term Conditions Nurses - Hospital Avoidance Team	Long Term Conditions Nurses (Hospital Avoidance Team)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£252,080	£253,845
232506	Pathway 2 Beds	Block Pathway 2 Capacity Intermediate/ Stepdown Care	Residential Placements	Short-term residential/nursing care for someone likely to require a					Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£1,907,934	£2,444,293
232507	Additional Pathway 2 Beds capacity (ASCDF - Line 1 and 2)	Awaiting confirmation of ASDCF, finance to be agreed.	Residential Placements						Community Health		NHS			Private Sector	ICB Discharge Funding	Existing	£280,000	£400,000
232508	Pathway 3 Beds	Block Pathway 3 beds	Bed based intermediate Care Services (Reablement,	Short-term residential/nursing care for someone likely to require a					Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£1,093,476	£1,101,130
232509	Pathway 2 Neuro Rehab Beds		Bed based intermediate Care Services (Reablement,						Community Health					Private Sector	Minimum NHS Contribution	Existing	£750,000	£755,250
232510	Pathway 2 Neuro Rehab Beds ASCDF	Awaiting confirmation, finance to be agreed	Bed based intermediate Care Services (Reablement,						Community Health		NHS			Private Sector	ICB Discharge Funding	Existing	£100,000	£150,000
232511	Intermediate Care Admision Avoidance Beds	Intermediate Care Admission Avoidance beds	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£1,632,835	£1,644,265
232512	District Nursing support into Intermediate Care	District Nursing support into Intermediate Care based at Tiled House. (Provider - DGFT)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£231,166	£232,784
232513	Additional Social Work Capacity (ASCDF Line 3)	Awaiting confirmation of ASDCF, finance to be agreed.	Community Based Schemes						Community Health		NHS			NHS Community Provider	ICB Discharge Funding	New	£120,000	£150,000
232514	Extra Intermediate Care Nurse capacity to support Pathway 2 (Line 16 ASCDF)	Awaiting confirmation of ASDCF, finance to be agreed.	Community Based Schemes	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		NHS			Private Sector	ICB Discharge Funding	New	£30,000	£40,000
232515	Pathway support	Awaiting confirmation of ASDCF, finance to be agreed.		Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		NHS			NHS	ICB Discharge Funding		£220,000	£250,000
232516	Pathway 2 Medical Support - Summerhill	Medical cover provision for patients in designated intermediate care homes. (Summerhill)	Other						Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£62,759	£63,198
232517	Medical input into stepdown facilities - Saltwells	Medical input into stepdown facilities provided by DGFT (Included in the block - previously Saltwells)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£88,969	£89,592
232518																		
232519	Pathway 2 Step Down Occupational Therapy	Pathway 2 Step down - Occupational Therapy Services based at Tiled House. (Provider - DGFT)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	Existing	£548,471	£552,310
232520	Pathway 2 Step Down Physiotherapy	Step Down Physiotherapy Services provided within Local Acute Community Trust	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£211,224	£212,703
232521	Pathway 2 Step Down Physiotherapy	Step Down Physiotherapy Services provided by private provider	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£69,045	£69,528
232522	Support for discharge	Awaiting confirmation of ASDCF, finance to be agreed.	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			Private Sector	ICB Discharge Funding	Existing	£745,877	£1,801,802
232523	Pathway 2 beds	Block pathway 2 capacity Intermediate/Stepdown Care	Residential Placements	Short-term residential/nursing care for someone likely to require a					Community Health		NHS			Private Sector	Additional NHS Contribution	Existing	£960,823	£444,545

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Dudley

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	187.8	152.8	301.7	141.0	The figures have been generated using standard Excel functionality using standard forecasting. Due to the changes in the way numbers are counted it has been difficult to forecast more accurately and we will have to explore locally held data.	The avoidable admissions data has increased at DGFT but could be a result of coding. The base data used reflects COVID operating conditions and recent counting and coding changes at Dudley Group of Hospitals (Same Day Emergency Care has been included in SUS inpatient data flows since late September 2022	Yes
	Number of Admissions	704	573	1,131	-			
	Population	320,626	320,626	320,626	320,626			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Indicator value	889	915	940	965			Yes

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

			2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value		1,790.1	1,874.0	2,108.8	Falls are a key priority for Dudley place. There has been significant amount of work to reduce both falls and falls conveyances through the clinical HUB.	The Clinical Hub, 2-hour response Admissions Avoidance Service has launched a focused falls Response provision. Initial findings has shown that 90% of people who used this service have had an ED attendance avoided. Data is being collated monthly. There is a local implementation plan for this project, with	Yes
	Count		1,215	1268	1427			Yes
	Population		66,258	66258	66258			Yes

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	93.1%	94.0%	93.1%	95.0%	Acute and Social Care have a robust long standing system in place to discharge patients to their normal place of residence with existing care provision i.e. Nursing, residential or package of care.	Continuation of integrated working of daily reviews of Delayed Transfers of Care (DTOC) to ensure timely discharge. This is a well-established and robust system and utilises the DISCO database with ICB, Acute hospital and Local Authority.	Yes
	Numerator	6,251	6,300	6,350	6,408			
	Denominator	6,713	6,700	6,821	6,746			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Quarter (%)	90.8%	90.5%	90.7%	90.9%			
	Numerator	6,118	6,129	6,141	6,152			Yes
	Denominator	6,738	6,772	6,770	6,768			Yes

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	789.0	700.0	954.7	798.2	Due to the implementation of a Placement Brokerage team to support with residential and nursing placements.	Using the support of the placement brokerage team this should enable workers to complete more assessments while the brokerage team are supporting with transfer of placements from pathway 3	Yes
	Numerator	518	470	641	540			Yes
	Denominator	65,656	67,141	67,141	67,649			

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.8%	83.0%	84.6%	86.0%	Set up of Support Discharge Team which will incorporate a reablement element and with the correct screening and intervention at the right point and support with 3 discharges per day.	Supported Discharge team and Discharge to Assess Group. Looking at readmissions and inappropriate discharges and working with the hospital to see why this is.	Yes
	Numerator	199	224	750	929			Yes
	Denominator	232	270	887	1,080			Yes

Dudley Health & Wellbeing

Longer, safer, healthier lives for all

DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item No. 9(c)**

DATE	**8 June 2023**
TITLE OF REPORT	**Black Country NHS Joint Forward Plan**
Organisation and Author	**Black Country Integrated Care Board** **Neill Bucktin – Dudley Managing Director**
Purpose	**To note the Black Country NHS Joint Forward Plan**
Background	**1. The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires ICBs and their NHS partner trust to prepare a Joint Forward Plan (JFP) for a 5-year period before the start of the relevant financial year.** **2. This report notes the receipt of the ICB's first Joint Forward Plan.**
Key Points	**1. The attached summary document describes the Black Country ICB's first draft JFP.** **2. Whilst ordinarily, the legislation requires the JFP to be produced by 1 April, for the first year NHS England has relaxed the requirement and set a deadline of 30 June 2023.** **3. ICBs are required to share a draft with each Health and Wellbeing Board and consult relevant on whether the JFP takes proper account of the Joint Health and Wellbeing Strategy.** **4. The Dudley element of the plan is shown at page 11 where this Board's priorities are described.** **5. Because of the restrictions of the NHS England timetable and other ICB approval processes, the JFP has already been circulated to the Board and comments invited so that they can**

	be taken account of prior to the production and submission of the final plan.
Emerging issues for discussion	**None**
Key asks of the Board/wider system	**To note the contents of the draft plan.**
Contribution to H&WBB key goals: • **Improving school readiness** • **Reducing circulatory disease deaths** • **Improving breast cancer screening coverage**	**The Dudley element of the plan takes account of these and addressing the goals will be a key component of partnership activity in Dudley.**
Contribution to Dudley Vision 2030	**Contributes to the development of healthy, resilient, safe communities.**

Contact officer details

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NHS
Black Country
Integrated Care Board

NHS Black Country Joint Forward Plan

May 2023

Black Country Integrated Care Board

Contents

Foreward

Welcome to the Black Country draft Joint Forward Plan.

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

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

Implementation of our plan will see in the following achievements

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

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

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

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

Principles

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

Collaboration – We will work across organisational boundaries and in partnership with other system partners in the best interest of our patients, local community and the wider population

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

Productivity – We will ensure we improve productivity by making the best use of our collective resources by transforming the way we deliver services across the Black Country

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

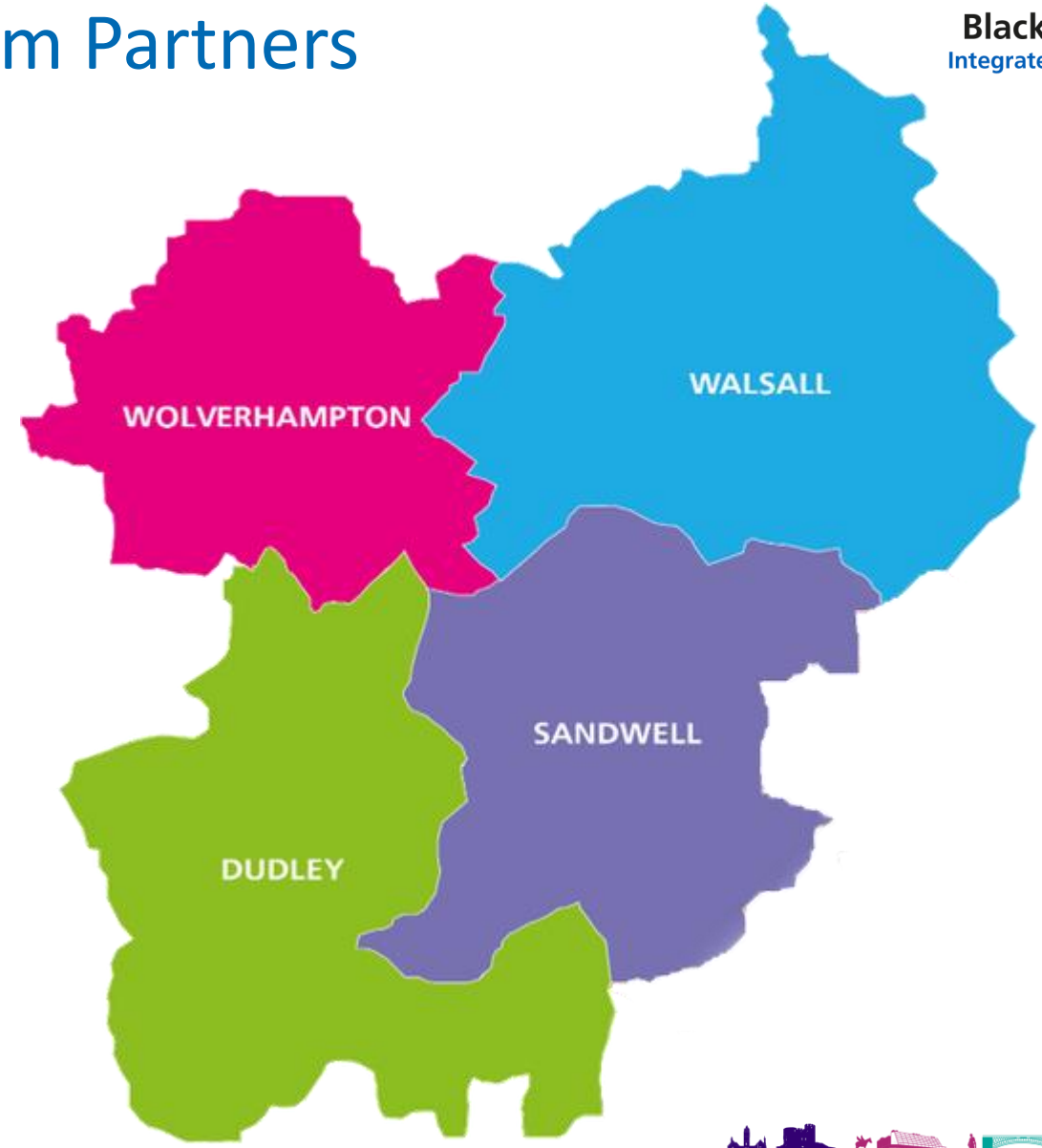
As the System transitions to a new way of working in line with our Operating Model, we have secured an Organisational Development partner to help facilitate cultural development and behaviours which will strengthen the way we work with partners across our system.

Our Places & Integrated Care System Partners

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

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

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



Our Health Challenges

NHS Black Country Integrated Care Board

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

Within the Black Country:

- Life expectancy is 77 years for males and 82 years for females, less than life expectancy of 79 years for males and 83 years for females in England
- People with mental health problems and learning disabilities have shorter life expectancies (18 years for males, 15 years for females) which is driven by their physical health.
- Healthy life expectancy is 59 years for males and 60 years for females, which is lower than the national healthy life expectancy of 63 years for males and 64 years for females.
- Wider determinants are the most important driver of health. They include income, employment, education, skills and training, housing, access to services, the environment and crime.
- Both child (43% vs 35%) and adult (72% vs 63%) obesity rates are higher than England, whilst physical activity levels (56% vs 66%) are significantly lower.
- We have some of the highest infant mortality rates in the country, whilst smoking rates in pregnancy remain high and breast-feeding rates are low.
- Locally, we have higher recorded prevalence of diabetes, chronic kidney disease, chronic heart disease (1 & or more)
- High number of premature deaths from CVD & respiratory disease, under 75 mortality rate for CVD is 99 per 100,000 & under 75 mortality rate from respiratory disease is 38 per 100,000
- Dementia Diagnosis rates are below national expectation of 66.7%, Black Country is 62%

Our Health Challenges

NHS Black Country Integrated Care Board

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

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

Wider System Challenges

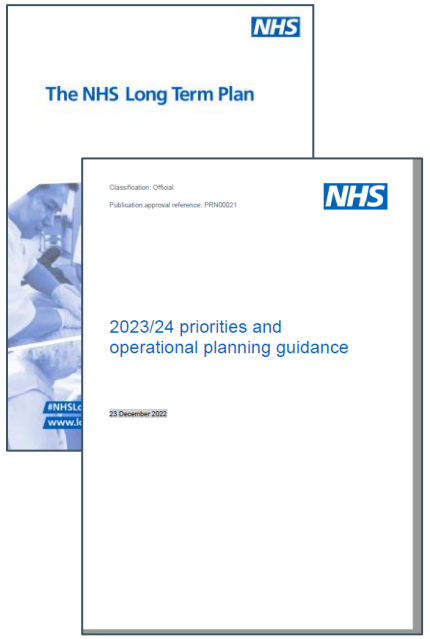
Whilst Our Joint Forward Plan sets out our ambition over the next five years, it is important to recognise the challenging landscape within which we will deliver our plan.

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

Priority Drivers

Purposes of an ICS:

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



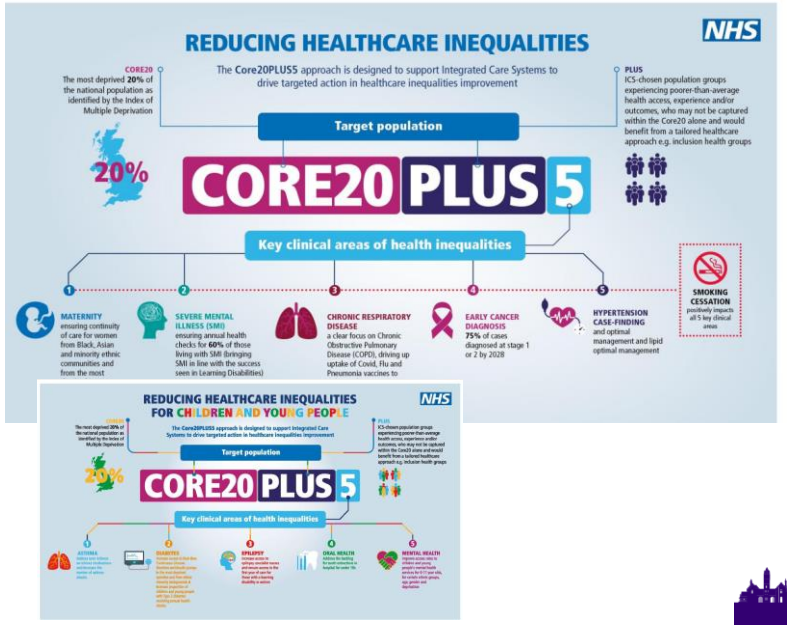
Black Country Integrated Care Board

NHS Planning Priorities:

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

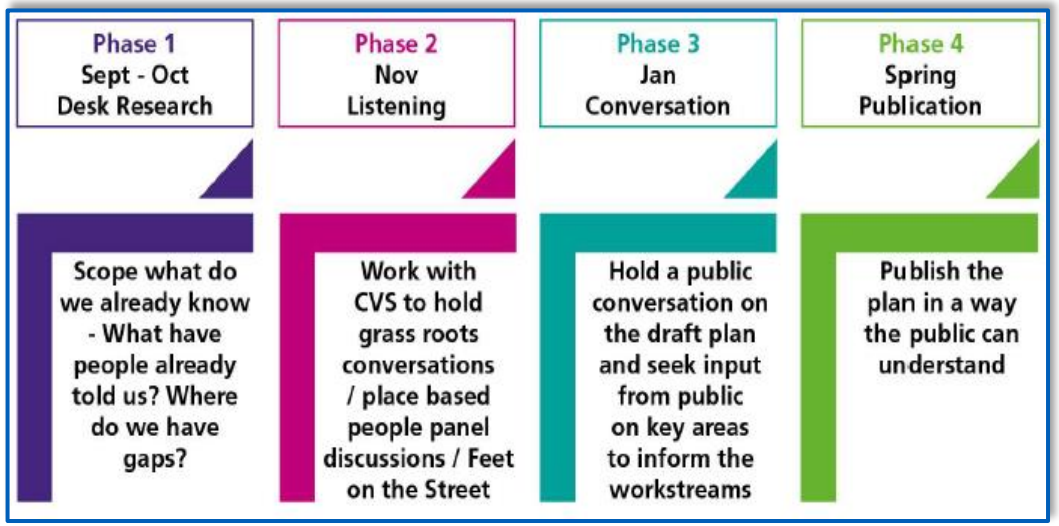
Black Country ICP Priorities:

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



NHS Core20PLUS5 Programme

Public Involvement

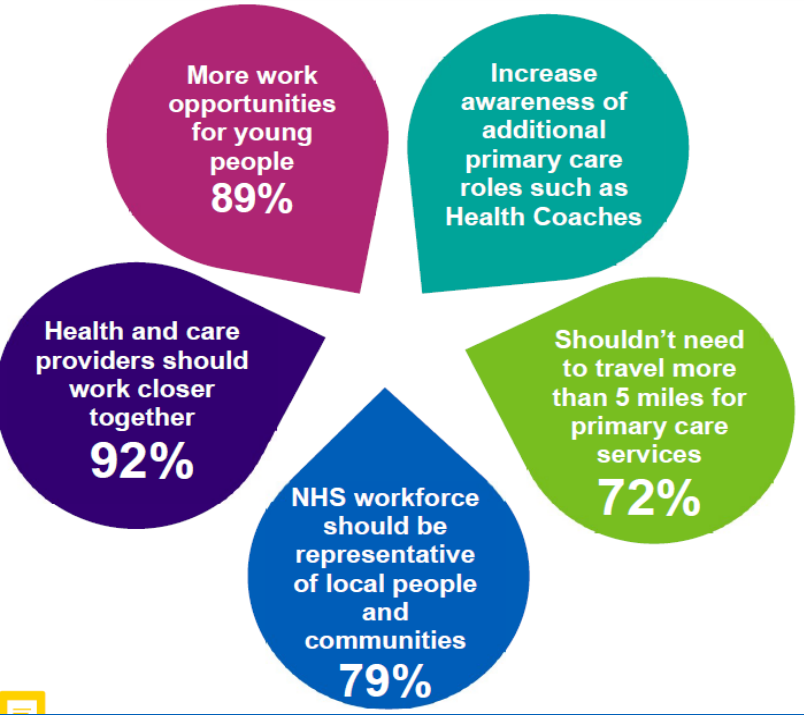


3 phase involvement approach which included desk research, public events, a survey a conversations through CVS partner services

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

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

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



People would like a focus on …

- Improved access - to appointments and emergency/urgent care, to resources and reasonable adjustments, to digital devices/data/skills
- Better preventative services
- Community focus – clinical and non-clinical
- More personalised care options and choices
- Services to tackle, loneliness, isolation and mental wellbeing
- A Cost of living theme was the 'voluntary care squeeze' - the worry of working age people caring for older/ younger dependents due to cost of care
- Cost of living will increasingly impact upon those determined as 'comfortable communities' impacting on health and care services in the short and long term

Approach to Reducing Health Inequalities

NHS Black Country Integrated Care Board

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

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

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

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

NHS Joint Forward Plan Priorities

NHS Black Country

NHS Black Country Integrated Care Board

Priority 1 : Improving access and quality of services

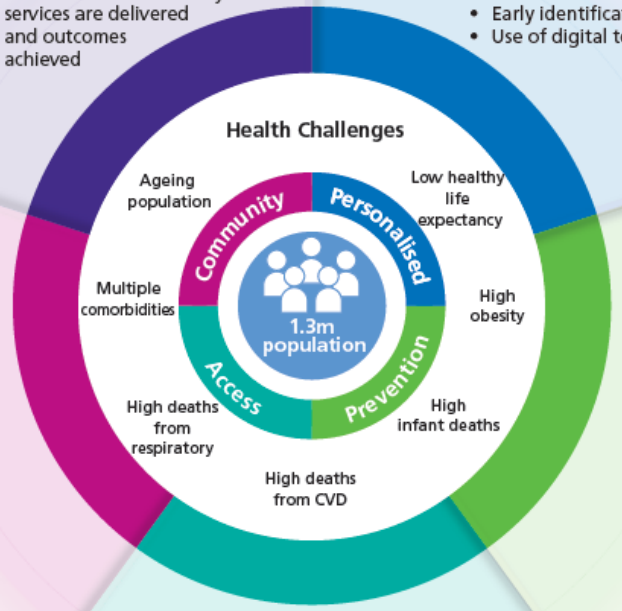
Outcomes

- Recovery from COVID 19
- Improved access to Urgent and Emergency care
- Reduced waiting times for Elective and Diagnostic Care
- Timely diagnosis and faster treatment for cancer
- Access to appointments in Primary Care
- Improved choice of care provider
- Better Patient Experience
- More joined up care
- New technologies
- Reduced variation in way services are delivered and outcomes achieved

Priority 2 : Community where possible Hospital where necessary

Outcomes

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



Priority 5 : Best place to work

Outcomes

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

Priority 3 : Preventing ill health and tackling health inequalities

Outcomes

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

Priority 4 : Giving people the best start in life

Outcomes

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

What will be different for our population?

NHS Black Country Integrated Care Board

Shorter waiting times, faster diagnosis

Increased dental & GP appointments

Increased screening uptake

Reduced waiting times for community services

For the Public

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

For our Staff

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

Improved staff survey results

SUCCESS: WHAT AND HOW?

Reduced demand for tobacco & alcohol services

Engagement with Best Start to Life Programme

Improved Core20PLUS5 outcomes

Vaccination uptake

Reduced patient readmissions

Reduced sickness levels and staff turnover

For our Organisations

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

For the System

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

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

Priority 2: Community where possible, hospital where necessary

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

Priority 4: Give people the best start in life

Priority 5: Best place to work

How will we measure delivery of our priorities?

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

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

Delivery of our Plan – Operating Model

NHS Black Country Integrated Care Board

Black Country ICS – Operating Model to support Joint Forward Plan

NHS Black Country

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

NHS
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Strategic Workstreams

Elective Care

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

NHS Black Country Integrated Care Board

Strategic Priorities

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

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

Outcomes to be Achieved

For our Patients:

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

For Organisations:

- Improved organisation, productivity and workforce resilience
- New technologies and transformed care
- Outpatient transformation (FUs, PIFU, SA)
- Increased capacity and service resilience

For our System:

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

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

Cancer

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

NHS Black Country Integrated Care Board

Strategic Priorities

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

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

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

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

Diagnostics

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

NHS Black Country Integrated Care Board

Strategic Priorities

Diagnostics plays a key role within system recovery and is at the centre of disease and patient pathways, to detect disease as early as possible and accurately guide to the right treatments. Currently, these services are predominantly based in our main hospitals, serving urgent as well as routine planned care. The need to increase capacity provides an opportunity to deliver services in a different way. We will develop our diagnostic strategy ensuring alignment with wider workstreams such as elective care and cancer.

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

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

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

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

Urgent and Emergency Care (UEC)

Our vision is to ensure patients have access to high quality urgent and emergency care services in the right place at the right time, delivered by the right professional.

NHS Black Country Integrated Care Board

Strategic Priorities

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

Outcomes to be Achieved

For our Patients:

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

For Organisations:

- Enhanced triaging and streaming to increase the number of people receiving urgent care in settings outside of the Emergency Department to include SDEC, UTC and UCR.
- Improvements in handover times between the Ambulance Service and Emergency Departments

For our System:

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

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

Out of Hospital

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

NHS Black Country Integrated Care Board

Strategic Priorities

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

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

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

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

Long Term Conditions Management

Our vision is to ensure we reduce the prevalence of people with Long Term Conditions in our population, and that we support those people living with Long Term Conditions to live longer and happier lives through effective processes of prevention, detection and treatment.

NHS Black Country Integrated Care Board

Strategic Priorities

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

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

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

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

Children and Young People Services

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

NHS Black Country Integrated Care Board

Strategic Priorities

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

Outcomes to be Achieved

For our Patients:

- Increase ability to self-manage LTC and increase quality of life (QALY)
- Co-production and ability to inform, challenge and embed service improvements
- Clear service pathways for patients

For Organisations and the System

- Developed joint commissioning, improved service efficiency and effectiveness
- Increased understanding of the need of CYP across the system, embedding all age commissioning
- Improved health outcomes for our most vulnerable including LAC, SEND, most deprived etc
- Development of an integrated specification for CYP, evidencing good partnership working and shared outcomes

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

Maternity and Neonatal Services

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

NHS Black Country Integrated Care Board

Strategic Priorities

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

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

- System leadership, supported by MNVP
- Collaboration and peer review/ learning
- Reduced health inequalities

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Perinatal Quality Surveillance Model To enhance the existing model a robust quality assurance process will be implemented, included peer review to achieve assurance of quality and safety, and delivery of Saving Babies Lives Care Bundle v2 & v3.	✓				
Workforce To further build on our progress, we will develop a workforce strategy focusing on consolidating recruitment for cross boundary working, new roles, shared recruitment and succession planning.			✓		
Maternity Continuity of Carer (CoC) To implement our 5-year transformation plan, ensuring our model reflects the needs of our population and focuses on choice of place of birth rather than geography.					✓
Reduce Perinatal Mortality and Morbidity Work collaboratively to identify improvement actions to improve outcomes and reduce health inequalities. Improving access to specialist care where required.			✓		
Perinatal Equity and Equality Strategy and Action Plan Through our dedicated EDI leads we will implement our action plan, ensuring we accelerate work to support those at greatest risk of poor health outcomes.					✓

Mental Health and People with Learning Disabilities and Autism

Our vision is to ensure our citizens have access to services that are of outstanding quality, and that support people to live their best lives as part of their local community

NHS Black Country Integrated Care Board

Strategic Priorities

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

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

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

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

Medicines Management

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

NHS Black Country Integrated Care Board

Strategic Priorities

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

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

- Reduced unwarranted variation in prescribing across our system

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Appropriate Use of Antibiotics Implement our strategy and annual work plan to deliver education to all sectors, surveillance of antibiotic usage and reduction of 'watch and reserve' antibiotics.		✓	✓	✓	✓
Medicines Safety Establish a multi-sector network and education programme to reduce high dose opioid prescribing and reduce administration errors.		✓	✓		
Covid Medicines Delivery Unit Ensure accessible services are in place to meet the needs of our population. Equitable access will be achieved through delivering treatment to the patient home.	✓	✓			
Maximise Value A Better Value Medicines Programme will be established to maximise efficiencies across sectors, along with a High Cost Drugs Group to monitor use and spend.	✓	✓			
Reduce Unwarranted Variation in Prescribing Formulary harmonisation across the system will be achieved to reduce differences in the prescribed medication available to patients.	✓				

Primary Care

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

NHS Black Country Integrated Care Board

Strategic Priorities

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

Outcomes to be Achieved

For our Patients:

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

For Organisations/ Our System:

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

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

Social, Economic, and Environmental Development

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

NHS Black Country Integrated Care Board

Strategic Priorities

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

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

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

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

Prevention

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

NHS Black Country Integrated Care Board

Strategic Priorities

Improving the population's health and preventing illness and disease is key to reducing health inequalities and is at the heart of the NHS Long Term Plan. Many conditions which can contribute to shorter healthy life expectancy are preventable. While the factors which can lead to these conditions are many and varied, through prevention our aim is to help people improve their own health, through targeted support to help people reduce their dependency on alcohol or tobacco, to offering weight management services, to cancer screening and through access to the Diabetes Prevention Programme. We will develop our prevention capacity and capability across the Integrated Care Partnership, working to harness our collective assets and embedding preventative approaches as a continuum, ensuring health equity is our golden thread.

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

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

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

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

NHS
Black Country
Integrated Care Board

Place Plans

Dudley Place

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

NHS Black Country Integrated Care Board

Strategic Priorities

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

Health & Wellbeing Priorities

- Improving school readiness
- Reducing circulatory disease deaths
- Improving breast cancer screening coverage

With a focus on those neighbourhoods with the greatest need

Outcomes to be Achieved

For our Patients:

- Care close to home with improved outcomes
- Longer healthy life expectancy
- Personalised care and improved patient experience

For Organisations:

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

For our System:

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

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

Sandwell Place

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

NHS Black Country Integrated Care Board

Strategic Priorities

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

Health & Wellbeing Priorities

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

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

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

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

Walsall Place

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

NHS Black Country Integrated Care Board

Strategic Priorities

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

Health & Wellbeing Priorities

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

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

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

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Primary Care Networks (PCN) Development Programme - To support delivery of the DES, establish stronger partnerships and join up care.					✓
Resilient Communities (Tier 0) - Working together to ensure citizens are supported to live healthy lives; Prevention, identification, early intervention & self-care.					✓
Family Hub programme - Focus on Family Hubs/ Start for Life which has 6 specific areas of action, with seamless support for families and an empowered workforce.					✓
Integrated Place Based Teams (Tier 1) - Integrated Primary, Social and Community Services, delivering care at scale through a hub & spoke model across each locality.					✓
Specialist Community Services (Tier 2) - Accessible, high quality care with local hospital teams working in a locality 'Health and Wellbeing Centres'		✓			
Intermediate, Unplanned and Crisis Services (Tier 3) - Network of care delivered from Health and Wellbeing Centres, preventing unnecessary hospital admissions		✓			
Acute and Emergency Services (Tier 4) - Access to high quality acute hospital services for patients needing specialist intervention	✓				
BCH Community Mental Health Transformation - working together to expand working relationships, review current pathways and development opportunities.					✓

Wolverhampton Place

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

NHS Black Country Integrated Care Board

Strategic Priorities

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

Health & Wellbeing Priorities

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

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

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

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

NHS
Black Country
Integrated Care Board

Enabling Workstreams

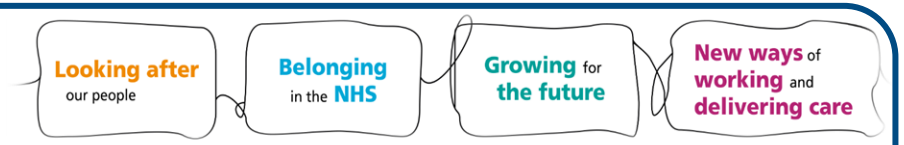
People

NHS Black Country Integrated Care Board

What?

Healthier Futures
Black Country Integrated Care System

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



Why?

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

How?

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

Underpinned with an inclusive talent management approach

Co-produce a system People Plan 2023 – 2028 that describes the priorities, actions and impact to make the Black Country the best place to work.

When?

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

Finance

NHS Black Country Integrated Care Board

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

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

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

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

Support the improvement of organisational relationships and collaboration.

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

Key Themes with the Financial Framework

NHS Black Country Integrated Care Board

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

Improving Quality

Our quality strategy will focus on embedding the benefits of working as a single strategic commissioner, in supporting an ageing, ethnically diverse population and will aim to ensure services continue to be delivered in the right way, at the right time, in the right place and with the right outcome

NHS Black Country Integrated Care Board

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

Key Priorities

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

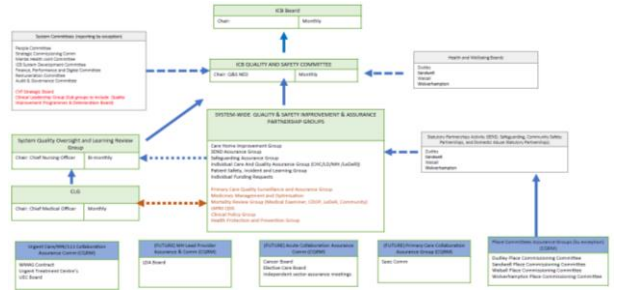
Our strategy sets out plans to improve quality across the following domains:

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

Oversight and Assurance

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

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



Personalised Care

NHS Black Country Integrated Care Board

Personalisation is about giving back power to people – focusing on placing the individual at the centre of their care, reinforcing that the individual is best placed to know what they need and how those needs can be best met (Carr, 2008). It provides an overarching lens or ethos for the care provided over the whole course of a person's life from birth to end of life and enables people to have choice and control, considering what matters to them and empowering them to have responsibility over their own health. Our Joint Forward Plan describes our commitment to implementing the Comprehensive Model of Personalised Care. The model core components and our strategic actions are set out below, further detail can be found within our wider workstreams regarding the implementation of personalised care across our Joint Forward Plan.

Shared Decision Making

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

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

Personalised Care and Support Planning

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

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

Enabling Choice, including legal rights to choose

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

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

Social Prescribing & Community Based Support

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

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

Support Self-Management

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

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

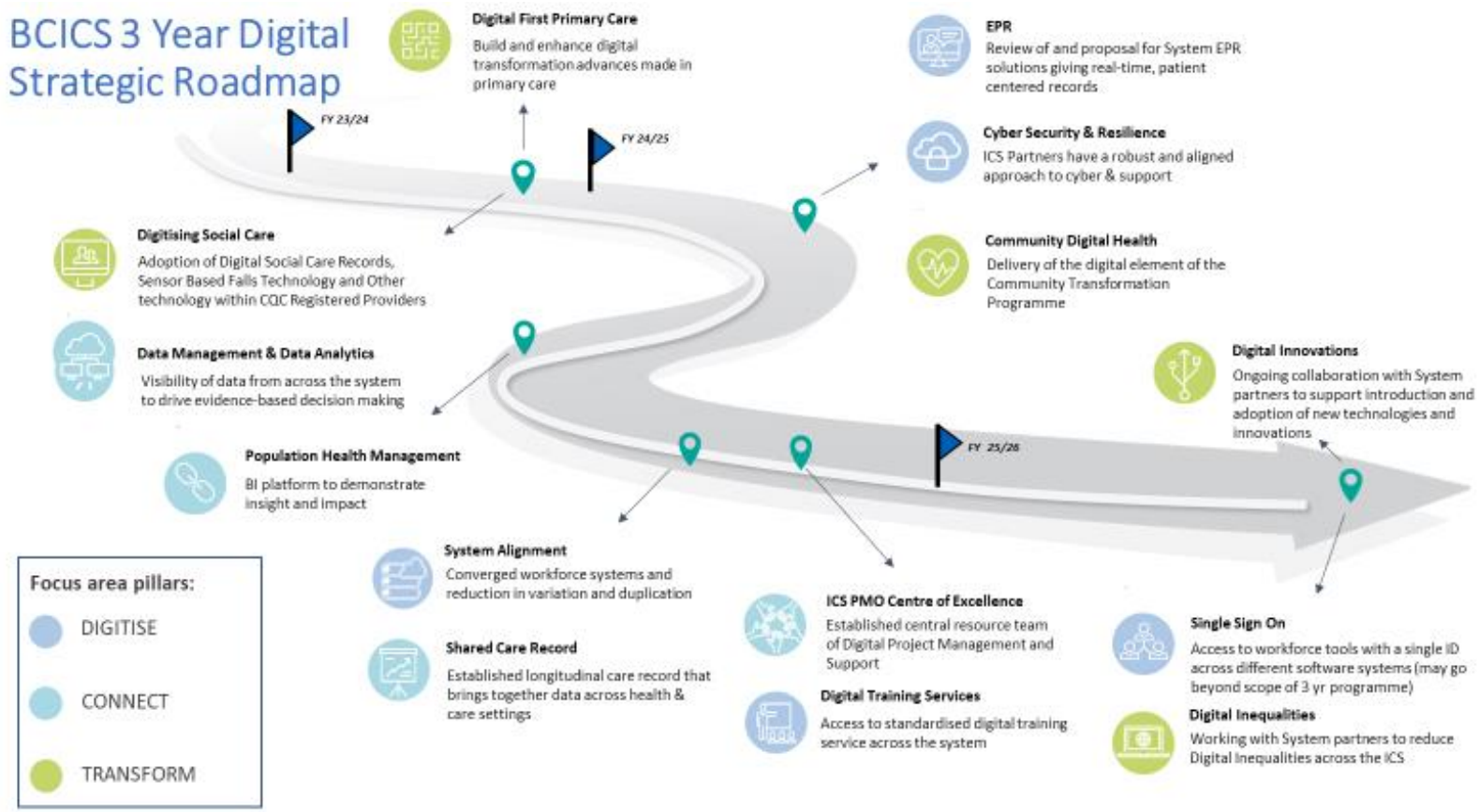
Personal Health Budgets

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

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

Digital

Our ambition for a digitally enabled Black Country NHS is to coordinate a system-wide digital programme, ensuring our staff members and partner organisation have access to the digital facilities to not only achieve our strategic priorities but do so in a way in which addresses digital inequalities, maximises innovation in both the organisation and delivery of care, and provides our workforce with an efficient working environment.
The ICS Digital Programme Board has recently agreed the systemwide Digital Strategy and costed milestone delivery plan. This was co-developed between over 80 representative across system partners and patient groups to support and enable all sections of this Joint Forward Plan, a high level roadmap is shown below.



Climate Change

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

NHS Black Country Integrated Care Board

Greener Clinical Care and Procurement

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

Digital Transformation

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

Estates and Waste Management

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

Travel and Transport

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

Medicines and Anaesthetic Gases

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

Research and Innovation

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

NHS Black Country Integrated Care Board

Research

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

Through research we will:

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

Innovation

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

Our objectives include the following:

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

Strategic Risks

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

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

Strategic Risks Cont....

NHS Black Country Integrated Care Board

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

Feedback on Plan

Thank you

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

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

Dudley POAP Edited Version 30.05.23

Dudley Place

Connecting communities and coordinating care to help citizens live longer, safer, healthier lives for all

Our mission is for health and care in Dudley in the right place at the right time and to be in the community where possible; hospital when necessary

NHS Black Country Integrated Care Board

Strategic Priorities

Our vision will be delivered through a number of work programmes set out below, which are delivered at Place by 8 workstreams with detailed delivery plans. Our health and wellbeing priorities are addressed throughout our work programme, and as a developing anchor network we will undertake actions to support social and economic determinants of health and wellbeing.

Health & Wellbeing Priorities

- Improving school readiness
- Reducing circulatory disease deaths
- Improving breast cancer screening coverage

With a focus on those neighbourhoods with the greatest need

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

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

Work Programme — To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Strengthening 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, MDT, personalisation, collaboration, development, mental wellbeing 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 6 specific areas of action, to provide seamless support for families and an empowered integrated workforce	✓	✓	✓		