Dudley Health & Wellbeing

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Agenda Item No. 6(e)

DUDLEY HEALTH AND WELLBEING BOARD

DATE	14th September 2023
TITLE OF REPORT	**Joint Health, Wellbeing and Inequalities Strategy 2023-28 - Action Plans** • Reducing circulatory disease deaths Action Plan • More women screened for breast cancer Action Plan
Organisation and Author	**Reducing circulatory disease deaths Action Plan** • Dr Mayada Abu Affan, Acting Director of Public Health, DMBC (Mayada.abuaffan@dudley.gov.uk) • Dr Duncan Jenkins, Associate Director, Pharmacy and Clinical Divisional Director, Pharmacy and Population Health Management, DIHC (duncan.jenkins@nhs.net) • **More women screened for breast cancer Action Plan** David Pitches, Head of Healthcare Public Health- Dudley MBC, (david.pitches@dudley.gov.uk) • Joanne Essex, Dudley Wolverhampton and South West Staffordshire Breast Screening Program Manager, (joanne.essex@nhs.net) Contact officer details - Casual Public Health Project Manager, Public Health, DMBC (louise.grainger@dudley.gov.uk)
Purpose	This report is to: • Provide a short briefing to the Board on current progress on the actions plans for improving breast cancer screening coverage and reducing circulatory disease deaths, including inequalities. • The Board will have the opportunity to fully understand these proposals when each goal comes for a “deep dive” at the December and March meetings.
Background	• On 8 June 2023, Dudley’s Health and Wellbeing Board (HWB) agreed to select reducing deaths from circulatory disease and improving breast cancer screening uptake as two out of three of its priority goals for inclusion within Dudley’s Joint Health, Wellbeing and Inequalities Strategy 2023-28. All goals were to be underpinned by work to reduce health inequalities.
Key Points	• Goal leads have been identified and have been working to pull together action plans for each of the goals. These plans focus on the first year to begin with but will be further developed to cover the whole of the Strategy period (2023-2028) in time and following feedback. • In addition to specific actions with identified leads and asks of the HWB Board, leads have identified how their approach will tackle

	health inequalities and also how progress will be measured. Some of this work is still in progress and will be further developed over time.
Emerging issues for discussion	• Appreciating that the Board have only had a quick overview at this meeting, are Board members satisfied with progress and that work is moving in the direction expected? If not, what should goal leads do differently? • Do Board members have a preference for the order of the deep dives on these goals? It is proposed that one comes to the December meeting and the other to the March one.
Key asks of the Board/wider system	• To agree the 2023-24 action plans
Contribution to H&WBB key goals: • **Improving school readiness** • **Reducing circulatory disease deaths** • **More women screened for breast cancer**	• Directly contributes to reducing circulatory disease deaths and more women being screened for breast cancer.
Contribution to Dudley Vision 2030	Directly contributes to Dudley being a place of healthy, resilient, safe communities with high aspirations and the ability to shape their own future and the 2030 goal of improved health outcomes and higher wellbeing.

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DHWB JHWIS Goal - Action Plan

JHWIS goal:	**Reducing deaths from circulatory disease**	**Year:**	2023-24
DHWB leads:	Dr Mayada Abu Affan, Acting Director of Public Health, DMBC Dr Duncan Jenkins, Associate Director, Pharmacy and Clinical Divisional Director, Pharmacy and Population Health Management, DIHC		
Intended Outcome(s):	Overarching outcome: Reduce circulatory disease deaths in Dudley so that the rate is similar or lower than the national average. Inequalities outcome: The gap in circulatory disease deaths between the most deprived and least deprived areas of Dudley in people aged under 75 years will have narrowed		
JHWIS goal objective(s):	**Overarching outcomes:** 1. **Increase awareness** of healthy food choices and its importance, alongside working to increase availability of skills to adopt healthier lifestyles across the Borough. 2. **Make it easier** for people and families to adopt a healthier lifestyle and access services in the Borough including smoking cessation, weight management, mental health and cost of living support. 3. **Take action** on the wider determinants of health, to enable people and families in Dudley be more active and achieve the minimum physical activity as recommended within national guidelines. 4. **Increase** the GP recorded prevalence of hypertension in patients 18 years and over from 22% to 24% 5. **Increase** the percentage of patients with hypertension controlled to age-appropriate blood pressure target from 69% to 80%. 6. **Increase** percentage of people with cardiovascular disease treated with lipid modifying drugs from 69% to 90%, 7. **Increase** percentage of people with CVD treated to target cholesterol values from 32% to 35%. 8. **Increase** the ‘triple control’ of diabetes from 33% to 44%		

	Inequalities outcomes: 9. **Target interventions** at those communities at higher risk of circulatory disease using existing data to make the case for action 10. **Enhance access** to NHS Health Checks, through provision of services in local communities where evidence of uptake amongst the eligible population is lowest.

1. KEY ACTIONS TO CONTRIBUTE TOWARDS GOAL

ACTION TOWARDS SHORT & MEDIUM TERM OBJECTIVES: Reducing the risk of developing circulatory disease ("upstream" behavioural and lifestyle factors) and the risks for people already living with circulatory diseases ("downstream" clinical interventions)					
Objectives	**Proposed Actions**	**Start Date**	**End Date**	**Action Owner**	**Ask of DHWB**
General project planning	Establishment of four task and finish workstreams. Given the complex, multi-facetted nature of upstream interventions, the following groups	Sept 2023	Mar 2028	**Mayada Abu Affan/Sarah Dougan**	Support the establishment of the task and finish workstreams

	will be established to deliver or oversee workstreams which are evidenced to reduce the risk of circulatory disease. These areas are to: - • Increase healthier food choices • Increase physical activity • Decrease unhealthy lifestyle choices I.e. smoking and alcohol, • Take action on the wider determinants of health				To receive reports and recognise areas of collaborative working within other boards or organisations Advocate and support the four key workstream topics.
Increase uptake of healthier food choices	To include: - Increase awareness of healthy food choices and its importance in prevention of circulatory disease deaths and illness via a communications plan utilising existing literature, developing new information and utilising several communication channels using culturally sensitive and appropriate materials, Promote and support healthy start to life initiatives such as distribution of	Sept 2023 Sept 2023	Mar 2024 Mar 2028	**Nikki Cheung/ Shelley Brooks** **Angela Cartwright**	

	healthy start vitamins, breast feeding, cook for life etc, Work with partners, including school nurses, environmental health, voluntary sector to promote healthy eating and healthy eating initiatives	Sept 2023	Mar 2024	**Krishna Vyas**	
Increase physical activity	To include: - • Campaign on benefits of physical activity • Consideration of proposals to make active travel more accessible and achievable by wider population • Review of use of current leisure activities in the borough and schemes to increase use • Engagement with leisure, parks, education, planning and other council services to create active environments and societies, and increase physical activity amongst their staff and wider population	Sep 2023	Mar 2024		

Decrease unhealthy lifestyle choices	Making it easier for people and families to adopt a healthier lifestyle to include: - Successful mobilisation, implementation and integration of Dudley's newly commissioned Health Improvement Service,			**Krishna Vyas**	Recognition and promotion of the new commissioned Health Improvement Service.
Take action on the wider determinants of health	Undertake a review and mapping exercise of all current commissioned services, workstreams and assets within the Borough which can contribute to reducing the risk factors contributing to circulatory disease, for example poverty, employment, parks and leisure facilities, air quality, active travel Utilise this information to facilitate collaborative working, establish referral pathways and maximise	Nov 2023	March 2024	**Krishna Vyas/ Bal Johal**	

	benefits to health and better outcomes Collate, maintain, share and publicise this information to all stakeholders involved in prevention or treatment of circulatory disease			**Nikki Cheung/ Shelley Brooks**	
Increase prevalence of GP recorded hypertension in patients aged 18 and over from 22% to 24%.	Increase opportunistic blood pressure monitoring and diagnostic capacity through use of the community pharmacy blood pressure service.	Apr 2023	Mar 2028	**Duncan Jenkins**	To ensure the target is included in the Health and Wellbeing Board's Pharmaceutical Needs Assessment to address any gaps in service provision, particularly in deprived areas.
Increase the % of patients with hypertension controlled to age-appropriate blood pressure target from69% to 80% in all practices.	Utilise practice-based pharmacists to improve hypertension management in practices.	Apr 2023	Apr 2028	**Duncan Jenkins**	Support from primary care and ICB to prioritise hypertension management as clinical focus for structure medication reviews undertaken by practice-based pharmacy team.

Increase % of people with CVD treated with lipid modifying drugs to 90%.	Targeting of practices in deprived areas with System Transformation Fund inequalities project (ICB) which aims to improve management of cholesterol and reduce cardiovascular risk.	Apr 2023	Mar 2024	**Duncan Jenkins**	Continued inclusion of cholesterol related metrics in ICB prescribing incentive scheme. Inclusion of cholesterol related metrics in the Dudley Quality Outcomes Framework for Health (DQOFH).
	Support to practices from Practice-based pharmacists with pathways, case-finding tools and structured medications reviews.	Apr 2023	Mar 2028	**Duncan Jenkins**	Support from primary care and ICB to prioritise cholesterol management as clinical focus for structure medication reviews undertaken by practice-based pharmacy team.
Increase % of people with CVD treated to cholesterol threshold (non HDLC to < 2.5 or LDLC to < 1.8) to 35%	Targeting of practices in deprived areas with System Transformation Fund inequalities project (ICB)			**Duncan Jenkins**	Support from primary care and ICB to prioritise cholesterol management as clinical focus for structure medication reviews undertaken by practice-based pharmacy team.
	Support to practices from Practice-based pharmacists with pathways, case-finding tools and structured medications reviews	Apr 2023	Mar 2028	**Duncan Jenkins**	
Increase triple control in diabetes (blood	Implement population health	Apr 2023	Mar 2028	**Duncan Jenkins**	Continued inclusion of triple control metric in the Dudley

pressure, blood sugar and cholesterol) to 44%.	management approach at PCN or practice level using PALM tool. Develop targeted approach through diabetes Community Partnership Teams.				Quality Outcomes Framework for Health (DQOFH). Prioritisation of diabetes for development of a collaborative working (through Community Partnership Teams) by all Dudley health and care providers.
Increase prevalence of detected hypertension to 18% with a specific focus on practices with a Core 20 level of deprivation (IMD > 33)	1. Engage community pharmacies to deliver blood pressure service in targeted areas, facilitation collaborative working with GP practices. 2. Utilise practice based pharmacists to improve efficiency of hypertension detection in practices. 3. Undertake a specific needs assessment with respect to targeting of community pharmacy blood pressure service	Apr 2023	Mar 2028	**Duncan Jenkins**	Support inclusion of blood pressure service in Pharmaceutical Needs Assessment. Support hypertension detection through ICB inequalities project.

Increase the uptake of physical health checks for people with severe mental health illness in Dudley. This is currently below the national average.	• Gather information on pilots/innovative approaches to SMI checks with practices in Dudley and other areas. • Joint Primary Care/Public Health development group to work on a new model for SMI checks to increase uptake • Liaise with Black Country Health care on opportunities				
Offer community support for people who initiate smoking cessation programme in hospital.	Review the current pathway and process for patients commencing smoking cessation in hospital when discharged into the community Implement recommendations from the review which may include clearer communication channels, automatic referrals to Integrated Health Improvement Service (ABL Health)			**Krishna Vyas**	

Increase the efficacy of the NHS Health Checks programme to support early diagnosis and management of circulatory diseases.	• Use existing data to help target eligible populations or areas in the Borough with low uptake, • Consider automatic referral from NHS Health check template in primary care to lifestyle services where modifiable behaviours are identified. • Collaborate with the newly commissioned Lifestyle Service provider to undertake more local community health checks • Implement digital health checks in Dudley when this becomes available nationally • Expand access to blood pressure and lipid testing to support digital health checks			**David Pitches/ Shelagh Cleary** **Krishna Vyas**	Promotion of NHS Health Checks amongst eligible population Promotion of the importance of NHS Health Checks to providers of the service

Increase use and awareness of Healthy Heart Hubs	• Training of peer leaders with lived experience to support communities to monitor and manage their BP control along with delivering educational CVD risk reduction sessions with the support of Health and well-being coaches (HWBC). • The Healthy Hearts Hub will focus on Hypertension, (Lipid Optimisation – TBC) and Smoking Cessation with a targeted approach across Dudley with a particular focus on: ○ Areas with high deprivation indices ○ Black, Asian and Minority Ethnic Communities ○ Pregnant smokers and their support network			**Dr Lloyd Baron** **Dr Lloyd Baron/**	

	Establish a connection between Healthy Heart Hubs and newly commissioned provider of Health Improvement Services			**Krishna Vyas**	
Undertake a co-ordinated communications campaign to: - **Increase public and staff awareness on how to reduce their risk and access services** **Increase awareness of importance of treatments and secondary prevention in those already living with circulatory diseases**	• Dedicated comms campaign during 23/24 focussed on prevention, detection and treatment of circulatory disease • Targeting those most at risk of circulatory disease, areas with high deprivation indices and those already identified and on treatment for circulatory disease	Sep 2023	Mar 2024	**Nikki Cheung/ Shelley Brooks**	Support and advocate the promotional campaign across Dudley both to the public/patients and to their staff

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Improve the quality of information of service providers available to support high risk individuals identified in primary care and the referral pathway	• Explore option of adding EMIS alerts in primary care to identify individuals at high risk from circulatory disease and possible referral pathways for wider support • Develop data sharing, consent agreements to facilitate improved collaboration between primary care and providers of community services • Model potential impact on lifestyle services			**Shelagh Cleary**	Encourage primary care to adopt
Improve collaborative working by bringing together different services and initiatives together	• Look at where services are based (e.g. make services accessible by basing at cost of living centre and/or lifestyle service with Healthy Hearts Hub etc., employment specialists). All partners to work together on this.			**Krishna Vyas**	Support for co-location approach Agreement to co-locate relevant services Facilitate premises availability process

	• Check that the locations are in the places with the highest needs, services are addressing the community's specific needs, and that there is equitable access across the borough. • Work with regeneration team at DMBC to identify empty premises that may be suitable for "pop up" centres if no other community venues available.				
ACTION TOWARDS LONG TERM OUTCOMES: Impacting on the "causes of the causes" — the wider determinants of health					
Objective	**Proposed Actions**	**Start Date**	**End Date**	**Action Owner**	**Ask of DHWB**
Improve active travel availability and uptake	Complete the Transport and Health strategy with annual action plan.		Sep 2024	**Bal Johal**	Review and contribute to development of the strategy. NHS sites to enable / actively promote

	Carry out insight work on residents' barriers and motivations to active / sustainable travel to inform future work in this area and production of report. Produce follow up action plan with steering group partners.	 Sep 2023	 Aug 2023 Mar 2024		opportunities for active or sustainable travel Encourage NHS sites to implement recommendations facilitating active travel to and from sites.
Use of Town Planning and regeneration process to help facilitate workstream aims and objectives	Explore the option of using vacant high street locations for 'pop up' NHS services. Ensure that the emerging Dudley Local Plan (replacing the Black Country Plan) includes measures to make town centres supportive to walking and cycling Continue Public Health input into Lye Regeneration work Discuss incorporating Public Health as a standard consideration into all significant planning consultations			**Bal Johal**	Identify services that could be delivered using this model. HWB members support this approach when the plan goes out for consultation.

Improve the use and availability of green and blue space	Influence the funding from WMCA delivered through Commonwealth Active Communities (CAC) programme Deliver work programme of the Commonwealth Active Communities, with a focus on activating green and blue spaces.	Sep 2023	Sep 2026	**Bal Johal** **Bal Johal**	Support funding going to areas with highest rates of circulatory disease mortality Strengthen social prescribing to use green and blue spaces for HWB gains. Work with integrated plus, pharmacy and ICS
Reduce the availability or sale of illegal tobacco / vapes	Continue a program of test purchasing, sampling raids and legal proceedings to remove illegal products from marketplace	Aug 2023	Mar 2028	**Chris King**	Support enforcement by reinforcing messages of dangers of illicit tobacco and vapes. Education to children of risk.
Monitoring of, and propose or support initiatives to improve, air quality in Dudley	Ongoing monitoring of air quality by Environmental Health. Support of West Mids Combined Authority strategy to improve air quality. Education in schools initiative.	Aug 2023	Mar 2028	**Chris King**	Support and promotion of initiatives. Consider initiatives within the Council which will contribute to improved air quality and sustainability
Monitor and respond to Noise complaints	Respond to complaints of statutory noise nuisance from business and commercial premises which negatively impact residential amenity.	Aug 2023	Mar 2028	**Chris King**	Support and promotion of service

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APPROACH TO REDUCING HEALTH INEQUALITIES

Approach to reducing health inequalities in the most deprived areas

Approach to reducing health inequalities in the most deprived areas
Circulatory disease (CD) remains the leading cause of premature deaths in England, with the impact in Dudley being greater than the England average. It is also one of the conditions most strongly associated with health inequalities, with people living in England's most deprived areas being almost four times more likely to die from premature CD than those in the least deprived. As well as living, on average, shorter lives, the conditions or risk factors associated with CD also significantly impact on their quality of life. Much of the ill health and many of the deaths associated with CD are potentially preventable by modifying risk factors and the use of readily available evidence-based, cost-effective interventions and treatments. In addition, the risk factors for CD e.g. smoking, obesity, inadequate physical exercise and also risk factors for cancer, diabetes, dementia and other long-term conditions so by addressing these as part of the CD board it is also addressing other issues. Although complex and multi-facetted, by tackling CD risk factors it is contributing to wider improvement of population health and reducing health inequalities, NHS and social care demand and costs. Approaches include: - • Identifying new, additional appropriate locations and co-location of all services so that they are focussed in the most deprived areas of the borough where circulatory disease mortality is highest, • Considering co-location of additional services which impact on the wider determinants of health e.g job centres, cost of living hubs • Where appropriate, incorporating into contracts for commissioned services a focus on inequalities, including deprivation • Reviewing current policies and strategies to ensure they are sufficiently focussed on reducing health inequalities by deprivation. • Targeting of communications messages and undertake community engagement events in deprived areas in a culturally sensitive and meaningful way.

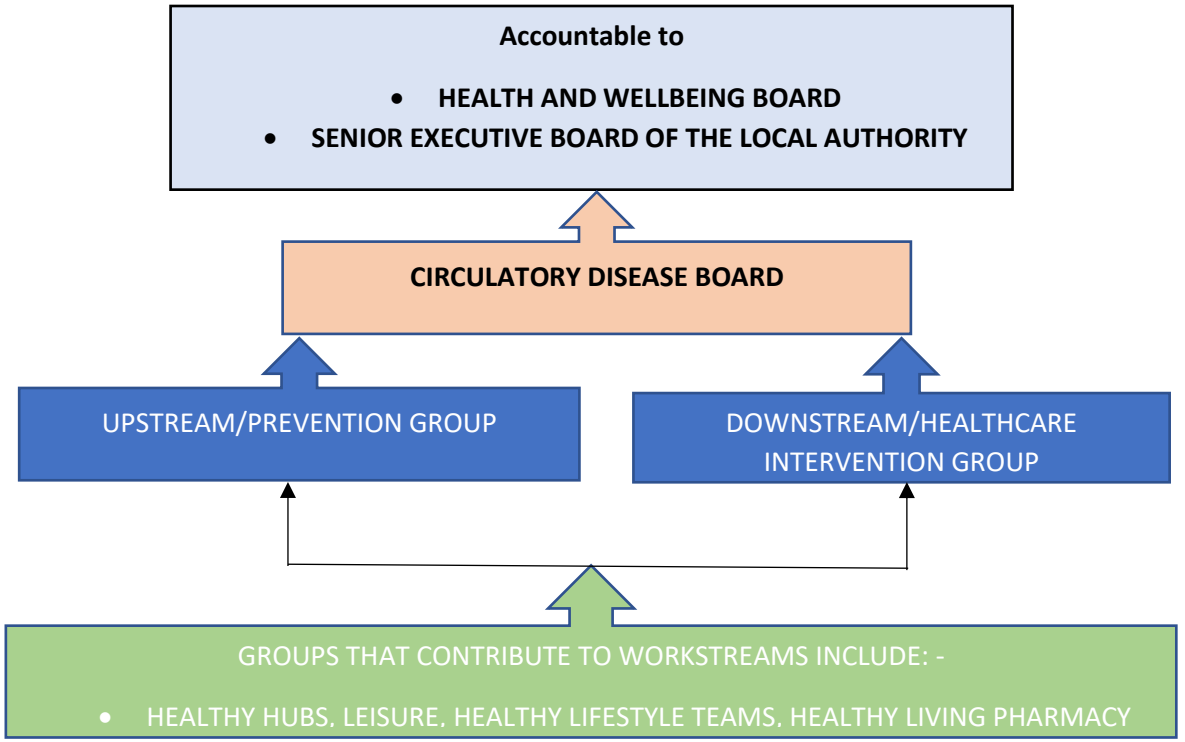
• Undertaking equity audits of service delivery / health needs (e.g. for BP management and control) to highlight where more action is required.

Approach to reducing health inequalities for groups with disproportionately poor health

Approach to reducing health inequalities for groups with disproportionately poor health
As above and in addition: - • Undertake a literature review into effective upstream interventions that increase positive and decrease negative behaviours or risk factors that contribute to circulatory disease • Review data on those eligible for NHS Health checks and target cohorts both at higher risk of CD and those with no or low attendance rates. • Review and embed learnings from other programmes and areas that have successfully engaged with and improved the health of marginalised groups • Work closely with primary care, mental health and learning difficulties workforce to identify approaches to behavioural changes and reduce barriers to access services • Engage with individuals with severe mental illness and support organisations to provide additional information and access to physical health checks and subsequent management of any conditions • Enhance knowledge, understanding, skills and confidence of wider workforce in areas such as smoking cessation, use of vapes etc to make every contact count.

2. GOVERNANCE

Governance diagram



The Circulatory Disease Board and workstream groups will be chaired by DHWB leads and alternate meetings monthly as per Terms of Reference document.

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Key stakeholders

Name	Job title	Organisation	Email
Balraj Johal	Public Health Manager	Dudley MBC	
David Pitches	Head of Healthcare Public Health	Dudley MBC	
Jas Johal	Pharmaceutical Advisor, Service Development	DIHC	
Jo Taylor	Strategic Commissioning and Transformation Lead	DIHC	
Krishna Vyes	Public Health Manager	Dudley MBC	
Laura Brookes	SMI physical health	Black Country Healthcare	
Lloyd Baron	Clinical lead for Inequalities and GP	DIHC	
Matt Banks		Dudley Group	
Piotr Gass		DIHC	
Rebecca Lewis	Clinical lead for mental health and GP	DIHC	
Sarah Dougan	Interim Head of Adults and Older People	Dudley MBC	
Shelagh Cleary	Public Health Manager	Dudley MBC	

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3. HIGH-LEVEL RISKS AND ISSUES

Risk or issue	Mitigation	RAG rating
Risk of competing demands and priorities from other services collaborated with due to complex nature of upstream interventions impacting on meeting objectives	• Engagement with stakeholders on workstreams • Support from HWBB of priority • Robust evaluation of interventions and workstreams to demonstrate value	
Lack of resources – both financial and personnel	• Financial planning • Robust evaluation to include myths busting, business case development and sharing of good practice • Consider use of wider workforce, peer workers and voluntary sector in health promotion • Build in Public Health goals throughout the wider council considerations	
GP capacity and lack of financial incentives to engage in interventions	• Early engagement with ICB • Engagement with GP Lead/GP on Circulatory disease board membership • Consideration of other workforce delivery models for some interventions where appropriate	
Behavioural change and prevention or reduction in risk of circulatory disease is	• Use of local insight and evidence to inform interventions	

complex, multi-facetted, and long-term process	• Key milestones implemented into workstreams to demonstrate progress to objectives • Regular board meetings	
Wider factors impacting on workstreams I.e., cost of living crisis, poverty challenging healthy eating process	• Consideration of colocation of relevant services addressing wider determinants of health, • Mapping and signposting to services providing wider support	

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APPENDIX 1: OUTCOMES FRAMEWORK

To be initially supplied by health intelligence colleagues for feedback from team delivering on this action.

JHWIS goals and impact	How goal will be monitored and how often?
Overarching outcome: Reduction in circulatory disease deaths in Dudley so that the rate is similar or lower than the national average.	Monitored through national fingertips data which is updated annually
Inequalities outcome: The gap in circulatory disease deaths between the most deprived and least deprived areas of Dudley in people aged under 75 years will have narrowed by ensuring greater reduction in deaths in the most deprived population.	Monitored through national fingertips and local data which is updated annually

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JHWIS goal objective(s):	Measures of success	How progress towards success will be monitored and data source
Overarching outcomes		
Increase uptake of healthier food choices	To be determined by workstream – examples to include: - • Percentage of adults aged 16 and over meeting the "5-a-day" fruit and vegetable consumption recommendation • Breastfeeding prevalence at 6-8 weeks after birth	Annual review of Fingertips data/local insight Annual review of fingertips data/contract data
Increase physical activity	To be determined by workstream – examples to include: - • Adults cycling/walking for travel at least three days per week • Percentage of physically active children and young people/adults	Annual review of fingertips data Annual review of fingertips data
Decrease unhealthy lifestyle choices	To be determined by workstream – examples to include: - • Smoking prevalence in adults (15+) • Smoking in early pregnancy • Adults in treatment at specialist alcohol misuse services	Annual review of fingertips data Annual review of fingertips data Annual review of fingertips data/contract service KPI's
Take action on the wider determinants of health	To be determined by workstream – examples to include: - • the proportion of all children aged 0 to 15 living in income deprived families • Number of people accessing local mental health support services	Annual review of fingertips data Local service data
	Increase the GP recorded prevalence of hypertension in patients 18 years and over from 22% to 24%	Quarterly review of CVDPREVENT data

	Increase the percentage of patients with hypertension controlled to age-appropriate blood pressure target from 69% to 80%.	
	Increase percentage of people with cardiovascular disease treated with lipid modifying drugs from 69% to 90%,	Quarterly review of CVDPREVENT data
	Increase percentage of people with CVD treated to target cholesterol values from 32% to 35%.	Quarterly review of CVDPREVENT data
	Increase the 'triple control' of diabetes from 33% to 44%	Quarterly review of CVDPREVENT data
Inequalities outcomes		
Enhance access to NHS Health Checks, through provision of services in local communities where evidence of uptake amongst the eligible population is lowest	• Reduced gap between highest and lowest or most socioeconomically deprived performing PCNs • Number of community NHS Health checks completed in areas of deprivation	• Annual tracking through Fingertips data • Local contract performance data
Target interventions at those communities at higher risk of circulatory disease using existing data to make the case for action	• Increased interventions in areas where population have highest recorded cases of circulatory disease or highest risk factors	• Review of interventions

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DHWB 2023-28 JHWIS Goal - Action Plan

JHWIS goal:	Breast Cancer Screening	**Year:**	2023-24
DHWB leads:	**David Pitches** (DP) Head of Healthcare Public Health- Dudley MBC **Joanne Essex** (JE) Dudley Wolverhampton and South West Staffordshire Breast Screening Program Manager		
Intended Outcome(s):	**Overarching outcome**: Breast cancer screening coverage for women aged 50-70 years inclusive in Dudley will increase to reach at least pre-pandemic levels, which exceeded the acceptable standard and were higher than West Midlands and national averages. Coverage is the percentage of women eligible for screening who have been adequately screened at least once in the last three years. The national standard for an acceptable level, which all breast screening services should be attaining, is 70%; the level considered achievable is 80%. **Inequalities outcome:** The gap between breast cancer screening coverage in the most and least deprived primary care networks (PCNs) will have narrowed.		
JHWIS goal objective(s):	**Overarching outcomes:** 1. **Increase awareness** of breast cancer screening and its importance, alongside service availability amongst the eligible population, in accordance with the service delivery schedule in the locality 2. **Improve the quality and recording of data** as well as the timely sharing of accurate information between partners 3. **Establish primary care cancer screening champions and advocates** throughout the locality 4. **Reduce the number of women who 'Do Not Attend' (DNA)** their appointments **Inequalities outcomes:** 5. **Enhance access** to breast cancer screening, through provision of service in communities, venues and events where uptake of screening amongst the eligible population is lowest 6. **Improve the invitation uptake** to eligible women including those who are yet to attend an appointment as well as women with physical and learning disabilities and mental health		

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1. KEY ACTIONS TO CONTRIBUTE TOWARDS GOAL

SHORT TERM GAINS: improved understanding of current challenges			
Objective	**Proposed Actions**	**Owner**	**Ask of DHWB**
General project foundations	Explore what is the most recent available breast cancer screening data including at ward, borough, GP practice and PCN level including number of women eligible, screened, uptake and coverage across the Dudley borough and map these against socioeconomic deprivation and when screening is due	AB	Support appropriate data sharing
	Identify new, additional appropriate locations for the breast screening van closer to the populations least likely to be accessing breast screening	DP	Support use of new screening venues where identified
	Share with DHWB board members the breast screening service schedule and sequence of practices from which women will be called for screening	JE	Anticipate when and where to expect changes in rates
	Review service workforce and capacity to reflect potential increase in demand	JE	Support increased rates of breast screening as a priority for Dudley
Improve the quality and recording of data and timely sharing of information	Explore adding EMIS alerts in primary care to women who have missed previous screening opportunities or never before been screened	SC	Encourage primary care to adopt
	Encourage GP practices to record breast screening codes on patient records and ensure these are “cleansed” and up to date before women are due to be invited women to ensure the appropriate women are recalled according to eligibility criteria	ICB	Encourage primary care practices to recognise the value of this
	Develop data sharing arrangements with primary care that enable the breast screening service to identify women with specific vulnerabilities (e.g. learning difficulties) and invite through alternative channels	ICB	Support information sharing and development of data sharing agreements

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MEDIUM TERM GAINS: increased awareness of, and confidence in promoting and accessing cancer screening			
Increase awareness of breast cancer and the importance of screening for early detection	Identify and utilise promotional assets including information leaflets for the public and awareness raising events and publicity in culturally sensitive and meaningful ways bespoke to the communities in Dudley. Adopt Black Country ICB educational material to myth bust and inform prevention interventions In Dudley.	PB	Advocate use of Black Country ICB and national screening program materials across the borough; support promotional events and publicity
	Develop a communications toolkit for primary care, DMBC, local voluntary, community and social enterprise (VCSE) organisations to promote the service immediately before, during and shortly after women in each location and GP practice are invited to attend screening	DP	Promote use of toolkit
Establish primary care screening champions and cancer coordinators	Using the Black Country and Dudley Cancer Champion Model, recruit and train additional cancer screening champions in each primary care practices and establish at least one cancer care coordinator in each PCN to encourage and advocate	ICB	Advocate training opportunities for new cancer screening champions and support cancer care coordinators in each PCN
	Develop a breast cancer screening topic guide and standard operating procedure document to assist champions and coordinators with encouraging woman to book screening appointments	SC	Encourage use of SOP across champions and coordinators
Reduce the number of women who 'Do Not Attend' (DNA) appointments	Explore sending a reminder text message from the breast screening service to everyone 24-48 hours before their appointment asking people to confirm attendance, cancel or rearrange	JE	Support service to trial this initiative
	Breast screening service to provide GPs with list of women who DNA'd three years earlier for practice cancer screening champion to contact the woman before her screening appointment to encourage her to attend	JE	Encourage primary care practices to prioritise, especially in more disadvantaged areas
	Primary Care Cancer Champions and Cancer Care Coordinators to carry out targeted interventions with women that 'Did Not Attend' (DNA) screening before the six months close of cycle, e.g. by sending a bespoke letter, text message, or telephoning patients to discuss any barriers to attendance.	PB	Encourage primary care practices to prioritise, especially in more disadvantaged areas
	Learn from and consider replicating the Breast Screening Service initiative carried out in Wolverhampton to engage with patients that have not attended Breast Screening for six years or more	JE	Encourage primary care practices to prioritise, especially in more disadvantaged areas

ACTIONS TOWARDS LONG TERM OUTCOMES: Impacting on the "causes of the causes" — the wider determinants of health			
Avoid barriers to screening in the workplace	Identify and mitigate any organisational barriers that prevent staff in DHWB partner organisations from attending screening when invited	DP	Enable staff in DHWB partner organisations to access screening when invited

APPROACH TO REDUCING HEALTH INEQUALITIES

Approach to reducing health inequalities in the most deprived areas
At the end of 2022 Dudley & Netherton (DN) and Sedgley, Coseley & Gornal (SCG) PCNs had the lowest breast screening coverage in the Black Country ICB and were significantly lower than the England average. Dudley & Netherton PCN includes some of our areas of highest deprivation, but no suitable sites for the breast screening van have been identified and are in use. In contract SCG PCN had relatively high coverage before the pandemic so may regain that position more easily. Working in partnership with DMBC public health and other stakeholders, the Breast Screening Service will therefore seek to enhance access to breast cancer screening, through provision of the service closer to communities where coverage and uptake amongst the eligible population is lowest. This will include: • Organising community engagement events in areas of low uptake to raise awareness of cancer screening programmes in culturally sensitive and meaningful ways, and capture learning about barriers to access screening (based on insights from the approach taken in Lye) • Identifying new, additional appropriate locations for the breast screening van closer to the populations least likely to be accessing breast screening

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Approach to reducing health inequalities for groups with disproportionately poor health

There is lower uptake of breast screening in areas of higher levels of deprivation and amongst vulnerable populations, including those with physical and learning disabilities, mental health and minority ethnic groups. This has been exacerbated by the COVID pandemic which caused a substantial temporary reduction in screening across the borough which we are now recovering from.

Adoption of community-centred approaches for groups with disproportionality poor health will be supported by the following:

- Undertake a literature review into effective interventions that increase uptake of breast cancer screening amongst low uptake, marginalised and underserved groups
- Review and embed the learning from other programmes that have successfully engaged and improved health of marginalised groups, including COVID vaccination and maternity programmes
- Build on assets-based approaches to working with marginalised communities, including engaging with faith leaders, community leaders and community development workers to make every contact count with regards to awareness of the value of breast screening and how to get screened
- Review imagery and language barriers based on community insights work and coproduce promotional assets
- Adapt invitations and timings based on findings of community insights – for example in certain communities grandparents provide much informal childcare and it cannot be assumed therefore that they will be available to attend appointments that are provided during the normal working daytime
- Identify women with special health or learning difficulties who may benefit from additional information or support to access facilitated screening (e.g. at Russells Hall)
- Work closely with physical and learning disabilities and mental health workforce and primary care leads to identify approaches to improve uptake of screening and implement these into practice
- Ensure that cancer screening awareness is embedded in annual checks for people with physical and learning disability
- Identify training needs about cancer screening for those working with people with learning disabilities and mental health service users
- Deliver cancer screening awareness training to those working with people with learning disabilities and mental health service users

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2. MILESTONES

Milestone	Date to be achieved
Identify priority areas (wards, PCNs and practices) based upon latest available data	December 2023
Develop baseline uptake amongst those women that DNA following second invitation letter then take up screening within a year to benchmark future improvements against.	April 2024
Identify potentially suitable sites for screening van in central Dudley and Netherton	April 2024
Significant increase in uptake in women who have DNA'd then taken up screening compared to baseline	April 2025
Training of a cancer screening champion in every primary care practice and a cancer care coordinator in every primary care network	April 2025
Increase in coverage and uptake amongst women in Dudley & Netherton and Sedgley, Coseley and Gornal PCNs	April 2026
Reduction in gap between highest and lowest performing PCNs	April 2026
Improvement in overall breast screening rate for Dudley	April 2026

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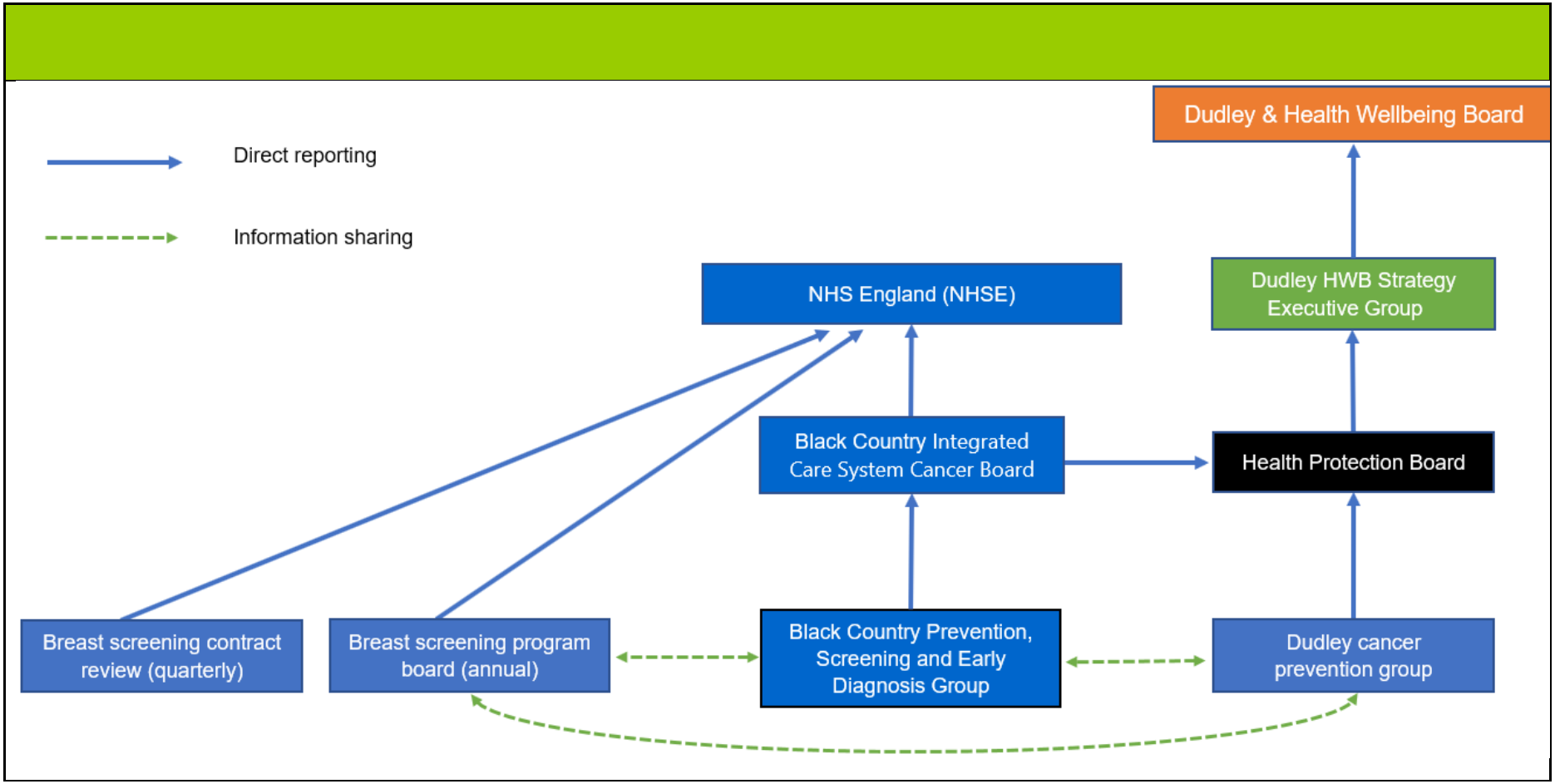
3. GOVERNANCE



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Key stakeholders		
Name	**Job title**	**Organisation**
Andy Baker (AB)	Head of Integrated & Knowledge Services	Public Health Intelligence, Dudley MBC
Parminder Bhatia (PB)	Health Improvement Practitioner	Health Care Public Health, Dudley MBC
Shelley Brook (SB)	Senior Manager	Communications & Public Affairs, Dudley MBC
Jayne Burness (JB)	Health Inequalities Lead	Dudley, Wolverhampton and South West Staffordshire Breast Screening Programme
Shelagh Cleary (SC)	Public Health Manager	Health Care Public Health, Dudley MBC
Esther Collinson (EC)	Cancer Care Co-ordinator	Dudley and Netherton PCN
Lisa Cowley (LC)	CEO	Beacon Vision
Jo Essex (JE)	Programme Manager	Dudley, Wolverhampton and South West Staffordshire Breast Screening Service
Mandy Marsh (MM)	Learning Disabilities Manager	Black Country Healthcare NHS Foundation Trust
Dr David Pitches (DP)	Head of Healthcare Public Health	Health Care Public Health, Dudley MBC
Joanne Pritchard (JP)	Public Health Manager	Healthy Communities, Public Health, Dudley MBC
Christine Stewart (CS)	Cancer Care Coordinator	Brierley Hill And Amblecote PCN
Dr Poonam Tank (PT)	Clinical Lead for Cancer, End of Life Care & Macmillan GP	Dudley Integrated Health & Care NHS Trust
Caroline Webb (CW)	Manager	White House Cancer Support
To be confirmed	Cancer facilitator	Black Country Integrated Care Board
To be confirmed	Mental health lead	Dudley Integrated Health & Care NHS Trust

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4. HIGH-LEVEL RISKS AND ISSUES

Risk or issue	Mitigation	RAG rating
Information sharing between primary care organisations and the breast screening service may not enable the service to separately identify and invite women with specific vulnerabilities (e.g learning disabilities)	Develop data sharing agreements with primary care that overcome this limitation	
Brest screening service cannot identify those women who are about to become eligible for their first screen, and treaching them is important as those who undergo their first screening are more likely to attend later.	Develop initiatives in primary care to reach women about to become eligible for screening through age.	
Breast Screening cycle runs every three years, and underperforming practices will not have their patients invited until the next round. This would have an impact on measuring uptake difference pre and post intervention in a timely manner. This is a particular issue in Dudley and Netherton PCN which contributes the most to lowering the overall Dudley breast screening uptake. However, patients registered within this area will not be invited to screening until 2024-5 and as validated data is published one year later, improvements in uptake for this PCN, and overall rate for Dudley, may not be seen until 2025-6.	Start awareness work in conjunction with the screening cycle to utilise 6-month window of opportunity to reach those that 'Did Not Attend' their previous appointment. Plan and develop interventions to inform women and address barriers to attendance within this community, in the period coming up to their screening round	
Breast Screening Service may not have the capacity to screen unpredictable or increased numbers of women in an area of focus as the duration of appointments, number per day and time of appointment (including outside normal working hours) in different areas is based upon past performance.	Work closely with Breast Screening service when planning targeted interventions to build in adequate buffer time to screen those that decide to accept having previously not taken up the invitation.	
Seasonal pressures on screening service staff	Advocate healthy working practices and flu vaccination for screening program staff including radiographers	

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APPENDIX 1: OUTCOMES FRAMEWORK

JHWIS goals and impact	How goal will be monitored and how often?
Overarching outcome: Breast cancer screening coverage for women aged 50-70 inclusive years in Dudley will increase to reach at least pre-pandemic levels which were better than West Midlands and national averages. **Inequalities outcome:** The gap between breast cancer screening coverage in the most and least deprived primary care networks will have narrowed.	Reporting against high level indicators will be based on national Fingertips data which is updated annually Service level data cannot be published until validated but will be used to guide local priorities and monitor progress against baseline

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JHWIS goal objective(s):	Measures of success	How progress towards success will be monitored and data source
Overarching outcomes		
Increase breast cancer screening coverage through improved awareness of and access to screening opportunities amongst the eligible population	Increased coverage of breast cancer screening Increased uptake of breast cancer screening Breast screening coverage in women with learning disabilities aged 50-69	Annual review of Fingertips data at GP practice, PCN and borough level
Establish primary care cancer screening champions and cancer care coordinators across the locality	Cancer screening champion in every GP practice in Dudley Cancer care coordinator in every PCN in Dudley	Regularly reviewing which practices and PCNs already have these positions and who is newly undertaking training
Reduce the number of women who “Do Not Attend” (DNA) their appointments	Increased screening uptake, especially in areas and GP practices associated with historically high DNA rates	Reviews of breast screening service local data following each period of sending invitations to screening
Inequalities outcomes		
Enhance access to breast cancer screening, through provision of service closer to communities where uptake of screening is lowest	Reduced gap between highest and lowest or most socioeconomically deprived performing PCNs	Annual tracking through Fingertips national data at PCN level
Improve the uptake in eligible women who are yet to attend an appointment as well as women with physical, mental health and learning disabilities	Increased screening uptake, especially in populations associated with historically high DNA rates	Reviews of breast screening service local data following each period of sending invitations to screening