Dudley Health & Care Partnership

Annual Report 2024 – 2025

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

Contents

Introduction from our chair

Welcome to the third annual report for the Dudley Health and Care Partnership. You will read how the partnership has evolved during 2024/2025 and about things that we are really proud of, but we also share our reflections on some of our challenges and how we plan to respond to these.

This year we have been really focused and concentrated on our agreed priorities that all partners can contribute to and influence. Our commitment remains to "community first" which is one of the 3 shifts required by government over the next 10 years.

There have been significant changes to our partnership this year, most notably through the introduction of a new partner, Shropshire Community Healthcare NHS Trust who are the provider of our children's 0-19 years' service and the dissolution of Dudley Integrated Health and Care NHS Trust. As a partnership we have navigated these changes through an ongoing commitment to the care of our citizens and to the integration of pathways and services to improve both health and care.

Throughout this time of uncertainty our people who either work or volunteer across these services, teams and communities have continued to strive every day to make a difference to the people of Dudley and our success is due to dedication and commitment from all partners.

Acknowledging our current financial position, we remain committed to integration and collaboration to drive improvements. To transform patient care we will prioritise optimal resource allocation, collaborative relationships and expand our reach by bringing care closer to home and supporting people in their neighbourhoods.

We are confident that the Dudley Health and Care Partnership will continue to build upon its achievements, ensuring the delivery of high-quality, integrated care for the communities of Dudley.

CREdwards

Dr Ruth Edwards
Chair of the Dudley Health and Care Partnership

Our role

Dudley Health & Care Partnership

Place-based partnerships are non-statutory collaborative arrangements within integrated care systems (ICSs) in England. They bring together NHS, local government and other organisations responsible for arranging and delivering health and care services, and others with a role in improving health and wellbeing. Dudley's Partnership mission is to provide health and care in the "Community where possible; hospital when necessary" by working together, connecting communities, enabling coordinated care for our citizens to live longer, safer, healthier lives.

Our members

In April 2024 Shropshire Community Healthcare NHS Trust who are the provider of our children's 0-19 years' service joined our partnership, Dudley Integrated Health and Care (DIHC) NHS Trust was removed as a partner organisation following its dissolution in October 2024 although many personnel remained active partners through their new employment at the Dudley Group NHS Foundation Trust.

- Black Country Healthcare NHS Foundation Trust
- Black Country Integrated Care Board
- Dudley Council for Voluntary Service
- Dudley Metropolitan Borough Council
- Healthwatch Dudley
- Dudley Primary Care Collaborative
- Shropshire Community Health NHS Trust
- The Dudley Group NHS Foundation Trust (Host)

Integrated model of care

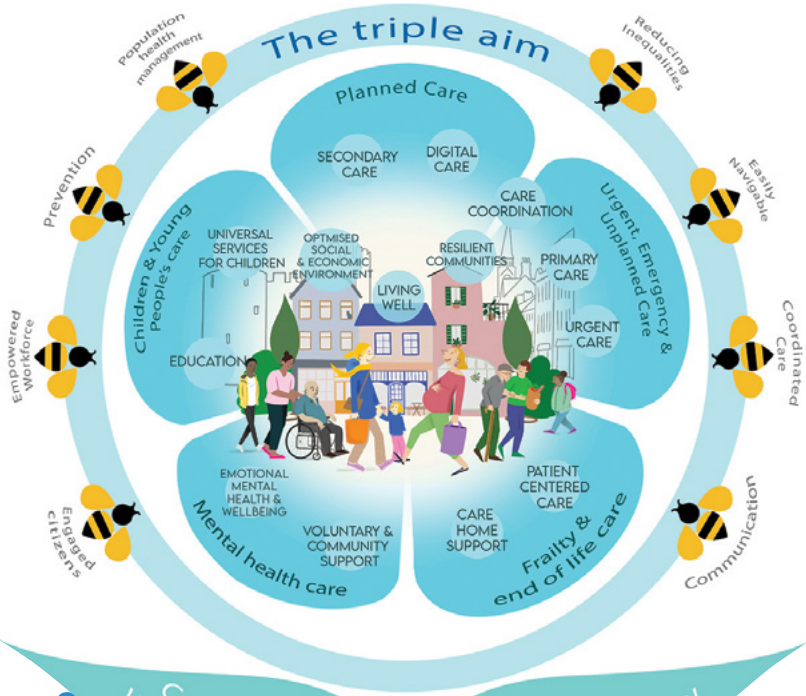
We continue to deliver against our agreed model of care which is a structured framework that outlines how Dudley's health and social care services are organised and delivered and how we are coordinating care across different settings and providers.

Its purpose is to:

- improve the quality and efficiency of healthcare services.
- ensure that patients receive the right care at the right time in the right place.
- promote patient-centred care and improve health outcomes.

Key components are:

- interprofessional collaboration – working together to improve outcomes
- care coordination – how is the care journey managed and tracked



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Our Focus

The Joint Forward Plan (JFP) 2023-2028 sets out the shared vision, priorities and ambitions for health and care services. In order to deliver the commitments made in the JFP, during this year we have focused on our agreed work programmes that all partners can contribute to and influence, as outlined below.

- Admission Avoidance & Reablement
- Community Partnership Teams
- Pathway Integration
- Primary Care Development
- Sustainability Voluntary & Community Sector
- Anchor Network Development

Our Achievements

The 2024/25 NHS operational planning guidance asked integrated care boards (ICBs) to "*establish and develop at least one women's health hub in every ICB by the end of December 2024 in line with the core specification, improving access, experience and quality of care*." In Dudley there were already strong foundations in both primary and secondary care, so our proposal built additional capacity in community-based settings across the Dudley borough closer to home for Menorrhagia (Heavy menstrual bleeding); Menopause; a Women's Health Hub Educational Programme and Educational Programme for Primary Care Clinicians. In January we launched the Black Country's Women's Health Hub in Dudley after securing funding from the ICB. The model aims to improve access to and experiences of care, improve health outcomes for women, and reduce health inequalities. We are offering nonclinical elements of the service, Menopause Cafés, at the heart of our communities in our Family Hubs.

Another area of notable success was the Black Country response to the Right Care, Right Person (RCRP) model that aims to ensure individuals needing health or social care are responded to by the right person, with the right skills, training, and experience to best meet their needs. It shifts from the police being the default first responder in many situations, especially those involving mental health, to directing those calls to the appropriate specialist agency. Black Country Healthcare NHS Foundation Trust as system lead for RCRP have been working collaboratively with partner agencies across the Black Country and West Midlands Police (WMP) jurisdiction to develop and implement the guidance and programme of work. Dudley's Local Authority Approved Mental Health Professional (AMHP) played a crucial role alongside DGFT A&E Team and the Lead for Mental Health and Complex Vulnerabilities with the Programme Director playing a vital coordination and facilitation role.

During Jan – March 2025:

Women's Health Hub Referrals received: ***50*** • *Referrals rejected/pt. declined:* ***4***

Appointments undertaken: ***55*** • *Referring practices:* ***16*** • *No. at Menopause Cafés:* ***51***

Our Success

Reduce inequalities in health and healthcare

Improve outcomes for children and young people

Shift the Curve of Future Demand*

Primary Prevention – GPs have successfully met their target of treating 80% of hypertension patients following NICE guidelines. This is a significant accomplishmnet that is expected to lead to a reduction in heart attacks, strokes, and deaths related to circulatory diseases - see figure 1

Secondary Prevention – between Aug 2024 - Feb 2025, 2,222 targeted lung heath check scans were conducted for participants from within 2 Primary Care Networks. 10 lung cancers in total have been detected; 9 with stage 1 lung cancers, and 1 participant with stage 2; all receiving rapid intervention.

Empowering self care – Dudley Community Information Directory (DCID) is a key tool for improving navigation and supporting self-care by providing accessible information about local services

Optimising health and social care delivery and efficiency – integrated First 1001 Days Teams delivered personalised care out of the 5 Family Hubs ensuring coordinated care for infants and their families. There has been a statistically significant increase in infants totally or partially breastfed and reduction in infants receiving no breast milk - see figure 2

Culture of Heath & Wellbeing – "WorkWell" supports people to both return and thrive in work.

Transform Citizen experience**

Access and convenience – Healthwatch Dudley worked with over 1000 local people who shared their experiences of GP services in Dudley, to create a patient charter that encourages practices to meet the accessibility and communications needs of local people. All GP practices in Dudley have now signed up to the Patient Charter, it is displayed on GP websites for patients to discover their rights.

Strengthen Partnership Effectiveness

Clear goals, shared vision and values and common objectives – were all agreed as part of the ICB Joint Forward Plan. In 2023/2024 17 Partnership KPIs were agreed that are both contributed to and benefit multiple partners over the year.

Open and transparent Communication – during 2024/2025 there were 11 Board meetings, 100 were quorate with agenda items proposed by all partners agreed by the Executive team.

* a long term endeavor requiring sustained investment, collaboration across sectors, and a focus on both individual and population health

** an ongoing journey that requires a commitment to understanding and responding to the needs and preferences of the peole being treated

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Spotlight – Community Partnership Teams (CPTs)

Dudley's CPTs are the foundation of our model of care and underpin our community first approach by mobilising professionals and interventions to wrap services around patients in a coordinated way.

The key principle is to deliver 'care through conversation' (between professionals from health, social care and the voluntary sector) rather than 'care through correspondence'.

Outcomes include:

- **Ensuring continuity, co-ordination, and access to a wider range of community services, as close to home as possible.**
- **Enabling patients through education and training, to manage their health optimally in order to remain independent for longer.**
- **Providing a flexible integrated community service that responds to individual patient needs when it is considered they will benefit from a more joined up approach.**
- **Ensure patients receive the best quality of care in the most appropriate setting in the most effective way.**

Preliminary analysis suggests there is a sustained reduction of hospital admissions, conveyance and bed days and a reduction in GP appointments.

Dudley's CPTs are currently reactive and focused on our most complex of patients, however our forward plan is for Dudley's CPTs to move to a more proactive model which in line with recently published NHS Guidance which aims to create a more cohesive and responsive health system that provides care that is closer to home, more personalised, and more effective in addressing the needs of the local population. Integrated Teams are one element of the vision for Neighbourhood Health Service with teams proactively identifying patients who may need additional support to prevent later ill health and hospital care, through working with general practice to support the patient to live well in the community.

Dudley's Integrated care model

Community Partnership Teams - 'Teams without walls'

Referred to as 'Neighbourhood Teams' in the fuller report

Spotlight - Dudley's Primary, Community and Secondary Care Interface

Relationships between partners across the primary, community and secondary care interface continue to improve with a dedicated space for clinical conversations and a vehicle to collaborate on integrated pathway design. The Primary, Community and Secondary Care Interface Group (PCSCIG) has senior clinicals from both primary and secondary care, senior operational directors, commissioners and leaders of integration.

Objective	Example
To improve patient outcomes by optimising access to care, enhancing communication between health professionals, and eliminating service gaps utilising the "Principle of Collaboration" which provides guiding principles for healthcare professionals to ensure timely, appropriate, and well-understood actions, with the patient at the centre of decision-making.	The Principles of Collaboration have been socialised in all settings and are being used by clinicians to appropriately challenge behaviours and activities that are not in line with the principles either directly through clinician-to-clinician conversations or thematically via queries raised via the Shared Inbox.
To ensure any proposed changes affecting the primary/community/secondary care interface are tested with colleagues in terms of their clinical and operational implications, effective communication agreed, and implementation supported.	All clinicians are invited to share proposals for pathway re-design / development at one of the fortnightly meetings. The meetings are used to explore any unintended consequences, impact on partners and then to communicate in a coordinated manner
To communicate regularly with clinicians providing an integrated communication providing consistent, good quality communication that has considered unintended consequences on partners prior to publication.	A fortnightly newsletter follows the PCSCIG meeting providing a regular, trusted form of communication. In addition, GP Education sessions are used to explore pathway and service change in a proactive rather than reactive way.
To provide oversight to a shared email inbox intended to improve relationships, reduce administrative burdens, and create a more efficient system by addressing process issues and identifying themes.	An interface "Inbox" was established in October to improve relationships between the primary, community and secondary care interface within Dudley with the inbox serving as a conduit to highlight any primary, community or secondary care interface process issues/concerns.

6 "Asks" responded to:

The Dudley Place Shared Inbox was launched in October 2024 and received 125 queries in Q3 and 95 queries in Q4.

Queries were thematically analysed and identify 5 themes impacting the interface which generated 6 "asks" and the first clinically led task and finish group focusing on "Better Management of Shared Workload" generated a series of recommendations that will have a positive impact during 2025/2026. Further task and finish groups to address the other 3 areas have been diarised for next year and will focus on culture and relationships; communications; pathway integration and continuous improvement.

- **Communication**
- **Onward Referral**
- **Prescribing**
- **Clinical Responsibility**
- **Fit Notes / Med 3**
- **EMIS Templates**

Dudley Health & Care Partnership

Communication – we will ensure robust systems are in place for patients to receive results of investigations, are kept fully informed regarding their care and what is going to happen next.

Where actions are required by the general practice, we will make this clear and easy to identify in correspondence.

Onward Referral – internal referrals will be made by Trust staff ensuring the best management of shared workload and we will avoid asking general practice to organise specialist tests.

Prescribing – we will avoid asking general practice to prescribe following outpatient appointments.

Clinical responsibility – whoever requests a test is responsible for the results of that test.

Fit Notes / Med 3 – if patients need a fit note, we will provide one and ensure that this is for an appropriate period rather than a standard 2 week note by default.

Our duty to involve

Dudley Engagement Group has grown both in numbers and in strength over this year and provides a platform for Dudley's diverse range of NHS organisations, voluntary organisations, Public Health and wider local authority and other relevant organisations alongside community groups and local businesses. Opposite is a spotlight on some engagement events that took place over the year, acknowledging there were many more to include events to celebrate Dudley Council for Voluntary Service's 50th Birthday.

The Partnership is committed to listen better to our communities and those with lived experience enabling them to take an active part in protecting their health and aiding their community's resilience by providing mutually beneficial spaces that promotes meaningful conversation, deep listening and which leads to stronger relationships, wiser action, and real collaboration.

Spotlighted engagement events 24/25

7 NOV — Pensioner's Fayre

Around 60 people attended as above. DEG was instrumental in gaining participation by members.

12 NOV — Women's Health Hub

Around 30 people attended and a report was produced and the idea of a menopause café was suggested with champions.

10 DEC — People Panel

NHS 10-year plan. Workshop organised by BCICB but facilitated with DHCP to gain views on the 10-year plan.

4 FEB — Menopause Café

Event chaired by Dr Vicky Hobbs. 22 ladies attended and spoke candidly about their experiences of menopause.

19 FEB — Blackmoor & Pensnett Community Event

A community event held at St Marks School with many partners providing interactive activities, support and signposting.

20 FEB — Fibromyalgia Workshop

Over 150 participants booked on with the aim of developing a 6-week self-management programme that is co-designed with patients.

Our duty to involve (cont.)

In addition, Healthwatch Dudley, the borough's local independent Health and Social Care champion, have ensured that the voices of local people lead to change in services in Dudley, notably through the work with local partners to create a Patient Charter for Primary Care, after over 1000 local people shared their experiences of GP services in Dudley. The aim of the charter is to encourage GP practices to meet the accessibility and communication needs of local people. Whether people struggle to speak English, read and write or are unable to use the internet, this charter supports patients' rights to care. All GP practices across the Dudley borough have now signed up to the Patient Charter, it is displayed on GP websites for patients to discover their rights. Praising the team at Healthwatch Dudley, Chief Executive of Healthwatch England, Louise Ansari said:

"This project stood out because it shows exactly why listening to local people and acting on their views is key to helping unlock better health and social care services.Congratulations to everyone involved. "

Healthwatch has the legal power to visit health and social care settings as part of its work through Enter & View visits. These visits provide an opportunity to make observations and speak to people who access NHS and council services, carers and relatives to understand their experiences. Following each visit, Healthwatch publish a report containing recommendations for providers to improve services for people who access them. Findings are published **www.healthwatchdudley.co.uk**

Collaborating closely with the Care Home Quality Partnership, four local care providers were selected. During these recent visits, Healthwatch spoke to 40 people about their experiences. One of the visits was conducted in partnership with Dudley Voices for Choice, focusing on a supported living facility for adults providing us best practice information and facilitating accessible feedback methods. Feedback was collected in multiple formats, including online and paper surveys resulting in over 30 responses. As a result of its recommendations, relatives now feel more reassured that communication about their loved ones' care will be improved. Healthwatch work collaboratively with service providers to ensure its Enter & View reports are balanced and constructive and are fed into the recommendations made by the Partnership.

During 2024/2025 a number of our partners have been accredited or completed inspections:

- **Dudley CVS received Local Infrastructure Quality Accreditation (LIQA)**
- **The Area SEND inspection of Dudley Local Area Partnership reported that practitioners from different services work well together. They share information effectively, and this results in an efficient multi-disciplinary approach to providing services for children and young people. Across those services working with children and young people, there is a strong sense of partnership working and a shared vision for all children and young people.**
- **Dudley Adult Social Care submitted a self-assessment pending a CQC inspection.**

Supporting Health and Care Navigation

Dudley Community Information Directory (DCID) is an online platform (www.dudleyci.co.uk), hosting a searchable directory of local activities, services and events, as well as during 2023/2024 the SEND Local Offer. A link is provided to the Family Information Service, with plans to integrate this Ofsted-regulated childcare directory into the site during 2024.

Local groups and providers add their own information by creating an account and are required to regularly check and update this information. All entries are moderated prior to publication to maintain a high standard of content, although a disclaimer applies. Information on regulated care (e.g. Care Homes, Personal Care) is added directly from a CQC feed.

The platform is an excellent central resource for local people and staff to access information and be connected to things going on in Dudley borough. The site is currently well-used with an annual summary of visits, social media coverage and 10 ten searches show in the adjacent infographic.

For health care practitioners, this resource is well-placed to support strength-based conversations and connect people to community assets, removing the need to maintain other local directories of community information. It was identified by partners as one of the enablers required to support integrated services and is considered an integral tool in the Engagement Workstream of the Joint Forward Plan.

The engagement workstream brings together the breadth of engagement work already in place in Dudley, to prevent it existing in silos, and aims to ease navigation of the system for citizens and the workforce.

Our progress

The partnership is showing strong progress in prevention, management of long-term conditions, and early years health, but faces pressures in hospital capacity, emergency admissions, and virtual ward utilisation. Most indicators show steady improvement or stability compared to previous years, though a few remain below target. Continued focus on integration, discharge planning, and community-based prevention will be key to meeting 2024/25 targets.

Domain	Metric	2024/25 Target	Performance		
			2024/25	2023/24	2022/23
Better Care Fund	Emergency Admissions Due To Falls for Over 65s		1,318	1,360	
	Rate of Older People Whose Long-Term Support Needs Are Met By Admission to Residential and Nursing Care, per 100,000 Population		2,114	2,302	2,112
	Patients Discharged to Their Usual Place of Residence		94.4%	93.5%	93.1%
Cancer	Early Cancer Detection				
	Breast Cancer Screening Coverage			70.9%	67.9%
Clinical Hub	Number of Referrals to Dudley Clinical Hub		34,779	24,057	
Controlled Hypertension	Hypertension: treatment to recommended age specific thresholds (all ages) (%)		82.7%	78.6%	
Education	Children Missing From Education		145	282	265
Emergency Admissions	Non Elective Emergency Admissions for Over 65s		16,948	15,538	14,924
Infant Checks - Breastfeeding rates at 6 – 8 weeks (Health Visitor visit)	Infants totally or partially breastfed		61.2%	53.8%	50.6%
	Infants totally breastfed		34.0%	32.8%	30.6%
	Infants partially breastfed		27.0%	20.9%	20.0%
	Infants not at all breastfed (formula)		39.0%	46.2%	49.5%
Childhood Vaccinations	% Vaccinated - DTaP/IPV/Hib/HepB (12m)	95%	93.8%	93.1%	94.7%
	% Vaccinated - PCV first dose (12m)	95%	95%	94.9%	95.8%
	% Vaccinated - Rotarix (12m)	95%	91.9%	90.7%	91.9%
	% Vaccinated - MenB (12m)	95%	93.6%	92.9%	94.7%
	% Vaccinated - 24m DTaP/IPV/Hib/Hep (24m Booster)	95%	95.0%	94.5%	95.7%
	% Vaccinated - PCV (24m Booster)	95%	92.4%	91.9%	93.5%
	% Vaccinated - Hib/MenC (24m)	95%	93.0%	92.1%	93.1%
	% Vaccinated - MMR1 (24m)	95%	92.9%	92.1%	93.5%
	% Vaccinated - MenB (24m Booster)	95%	91.7%	90.6%	92.7%
	% Vaccinated - DTaP/IPV/Hib/HepB 5y Booster)	95%	94.9%	95.4%	96.1%
	% Vaccinated - MMR (5y 1st Dose)	95%	94.5%	95.1%	96.0%
	% Vaccinated - MMR (5y 2nd Dose)	95%	88.7%	88.8%	90.8%
	% Vaccinated - DTaP/IPV (5y)	95%	87.5%	88.1%	90.1%
	% Vaccinated - Hib/MenC (5y)	95%	93.4%	93.9%	95.2%
Virtual Ward	Virtual Ward Bed Occupancy		113.8%		
DQOFH	The percentage of the practice's predicted dementia prevalence which is identified on the practice register	43-72%	62.2%	59.8%	
	The percentage of people with a diagnosis of diabetes who have achieved all three nda defined treatment targets for HBA1C blood pressure and cholesterol in the last 12 months	32-44%	45.8%	41.9%	32.6%
	Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check	64-88%	92.5%	90.0%	83.6%
	People with severe mental illness receiving a full annual physical health check and follow up interventions	50-80%	74.2%	69.1%	58.3%

Emergency Admissions Due To Falls for Over 65s - March 2025 was not available at the time of reporting

Children Missing Education snapshot figure as of March 2025

Cancer metrics are published in arrears - the latest available data for early cancer is 2021 (Calendar year) - 60.1%, Breast Cancer Coverage 24/25 data is not available at the time of reporting

Virtual Ward Bed Occupancy is a snapshot figure as of 24th March 2025

Our approach

The governance arrangements for the Partnership were unchanged from the previous year.

Our administration

The Partnership Board has met monthly during 2024/25 and has been quorate. Commitment to the Partnership and the workstreams has continued despite pressures already referenced in this report. The Executive Team has developed during the year to include Trust Operational Leads which has enabled the Team to act as the engine room for the Partnership as intended.

The Programme Manager continues to drive the work programmes with objectives set and agreed by all partner agencies as part of the priority setting that takes place annually and in line with the commitments of the Joint Forward Plan. A performance review by partners in included in the annual appraisal process

Our budget

Dudley Health and Care Partnership does not have a budget and the shortfall in the Programme Director salary for 2024/2025 was provided by The Dudley Group NHS Foundation Trust who host the Partnership.

Our future

The Partnership is primarily about doing things that individual organisations cannot do alone, and understanding this is critical to being humble, open and curious with partners. There has been an acknowledgement that elements of the 2024/2025 workplan remained single agency with existing reporting mechanisms. Consequently, the Board undertook an exercise to consolidate and streamline and ensure the Partnership priorities align with wider system priorities to include Dudley's Better Care Plan Fund and with the emerging planning guidance for the NHS.

In addition, Partners have committed to support the DGFT aim "that by 31st March 2026, DGFT will create community first pathways that ensure patients receive early interventions in community settings without the need for hospital visits." The agreed outcomes have been interwoven into the partnership workplan.

The partnership view is that every action, every voice and every effort matters!

NHS 3 Shifts

1. Hospital to community
2. Sickness to prevention
3. Analogue to digital

Multiyear Commitments

- Shift care from hospital to community
- Value our people
- Make best use of our resources
- Improve speed of access to planned care
- Develop thriving Partnerships

Health & care Partnership Priorities

1. Integrated Community Health and Care Services for adults and children
2. Prevention
3. Social and economic development

Objectives

1. To reduce unplanned admissions to hospital, residential, nursing and domicillary care for adults and children and improve timely transition to their usual residence, supported within vibrant communities
2. Support the emotional health and wellbeing of people of all ages and improve their physical health
3. Support our local communities and create employment opportunities
4. Reduce inequalities

KPIs

1. Neighbourhood health & care for adults and children
2. Sustainable voluntary and community sector
3. Anchor network development

Community First Value Stream Alalysis (Cells)

1. **Generally Healthy**
   - Community Navigation Centre
   - Social Prescribing Discharge Pathway
   - Self-Referral Pathways
   - Patient Passport
2. **Long Term Conditions**
   - Community partnership teams
   - Care transfer hub
   - Timely step-up beds
3. **High Need / Specialist Pathways**
   - Children & young people
   - Chronic pain pathway
   - Care home pilot
   - Community frailty hub

Outcomes

1. **Older Adults**
   - People dying in chosen place of death
   - Patients still at home 91 days after discharge
2. **Children & Young People**
   - Development at end of Reception
   - Year 6 childhood obesity
3. **Mental Health**
   - Percentage of patients in contact with secondary mental health care living independently
   - Improved employment level for those with a mental health condition
4. **Cancer**
   - 12 - month survival rate
   - Percentage point gap in early diagnosis
5. **Long Term Conditions**
   - Excess winter deaths
6. **Wider Determinants**
   - Number of people resident in Dudley Borough employed by partner bodies

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