Dudley Health & Care Partnership

Annual Report 2023/24

Community where possible; hospital when necessary.

Black Country landmark images kindly provided by Thomas Dudley Ltd. and Mcdonald Diecasting Ltd.

Introduction from Our Chair

Welcome to the second annual report for the Dudley Health and Care Partnership. You will read about how the partnership has transformed this year within the context of a changing NHS landscape and what it has delivered during 2023/2024 and we will share plans of how we are planning to improve integrated care during 2024/25 and the intermediate priorities we have chosen to do this.

As we continue to build trust and relationships and raise awareness of our collective achievements, our workforce is starting to get a sense of our ambitions at place and vitally, their role in it.

Our clinical teams have come together to make our new model of care a reality. We have proactively established Community Partnership Teams in all our Primary Care Networks and pathway redesign is no longer an idea but reality in Dudley supported by "clinically led principles" which provide guidance to strengthen partnerships, increase trust, improve communication with the result, better patient care.

Acknowledging the challenging position we are in financially, as we continue our journey of improvement and transformation, we will focus on better use of limited resources, the power of partnerships and how bringing services out of hospital, to deliver better patient care in the community with a satisfied, motivated workforce to help us achieve our mission of "**community where possible; hospital when necessary**." Our commitment is that improving actions are focussed on causes of problems not the symptoms of problems.

I would like to thank all of our people who either work or volunteer across these services, teams and communities who are striving every day to make a difference to the people of Dudley. Progress has been good, and we are starting to make an impact; we have many collaborations to be proud of.

Chair of the Dudley Health and Care Partnership Board

CREdwards

Dr Ruth Edwards

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"Our success is due to the dedication and commitment of our colleagues across our local authority, mental health, community, primary care and acute care and our voluntary sector who are all doing amazing things every day."

Our role

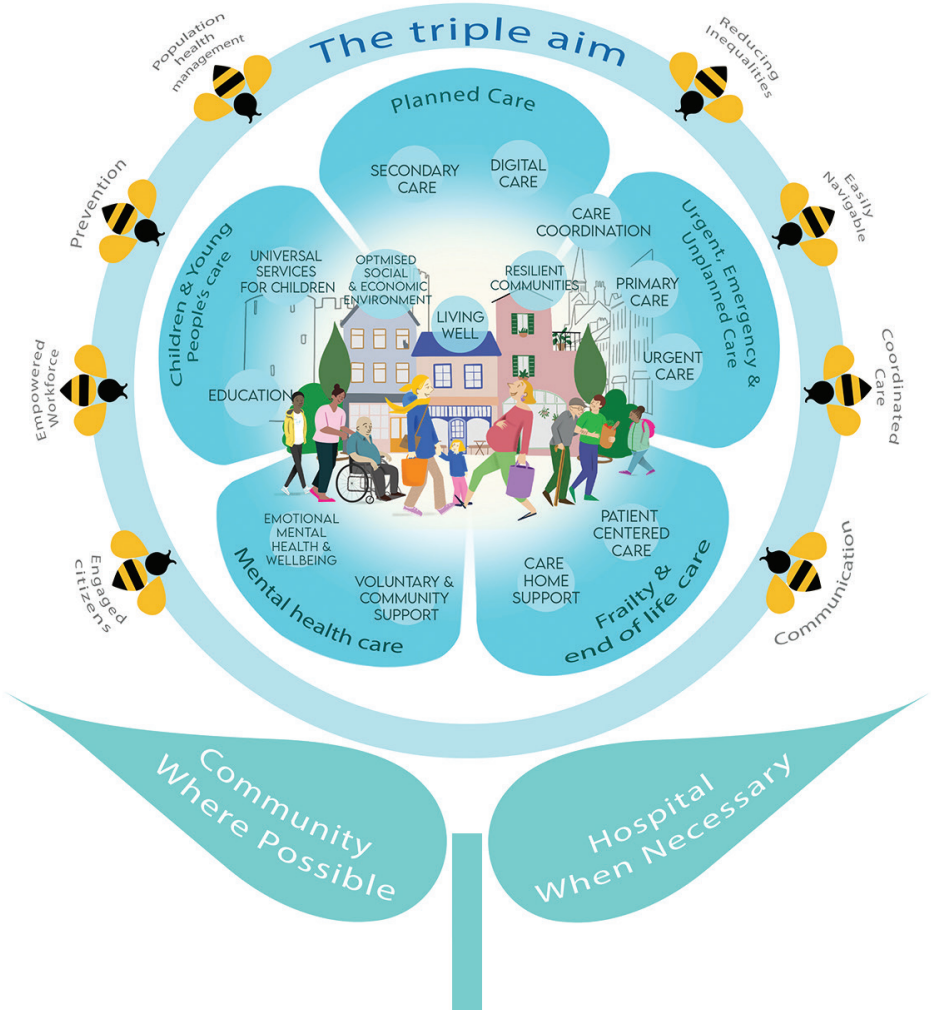
Dudley Health and Care Partnership is a collaborative arrangement formed by the organisations responsible for arranging and delivering health and care services in Dudley. It is a partnership of equals supported by a Programme Director who drives the work programmes and the delivery of a shared set of objectives.

The Partnership's 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 Model of Care

Our model of care aligns to the NHS Long Term Plan, and "Triple Aim" of improving patient experience, reducing the per capita costs of health care and improving overall population health, to better serve the population and provide care where possible in community settings, relieving pressure on acute and mental health services, but ensuring that they are accessible when required.

Rather than concentric circles of past models the new model is purposely fluid to demonstrate our ambition to have no wrong door and reduce the need for "referrals" offering patients a seamless pathway - with no organisational barriers. The "flower" is pollinated with principles depicted as bees on the pictorial representation of the model.



Our Members

Black Country Healthcare NHS Foundation Trust	Dudley Borough Council	Dudley Community & voluntary services	Dudley Group NHS Foundation Trust	Dudley Integrated Health and Care NHS Trust	Dudley Primary Care Collaborative	Dudley Health Watch

Our focus

The National Health Service Act 2006 (as amended by the Health and Care Act 2022) required Integrated Care Boards and their partner trusts to prepare a Joint Forward Plan for 2023 — 2028. All partners contributed to the Dudley plan and committed to deliver five work programmes through 8 workstreams, achieving outcomes for our patients: our organisations and our system. The plan was summarised on a page (below).

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 to be in the right place at the right time and to be in the community where possible; hospital when necessary.

Strategic Priorities

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

Health and 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 co-production 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:

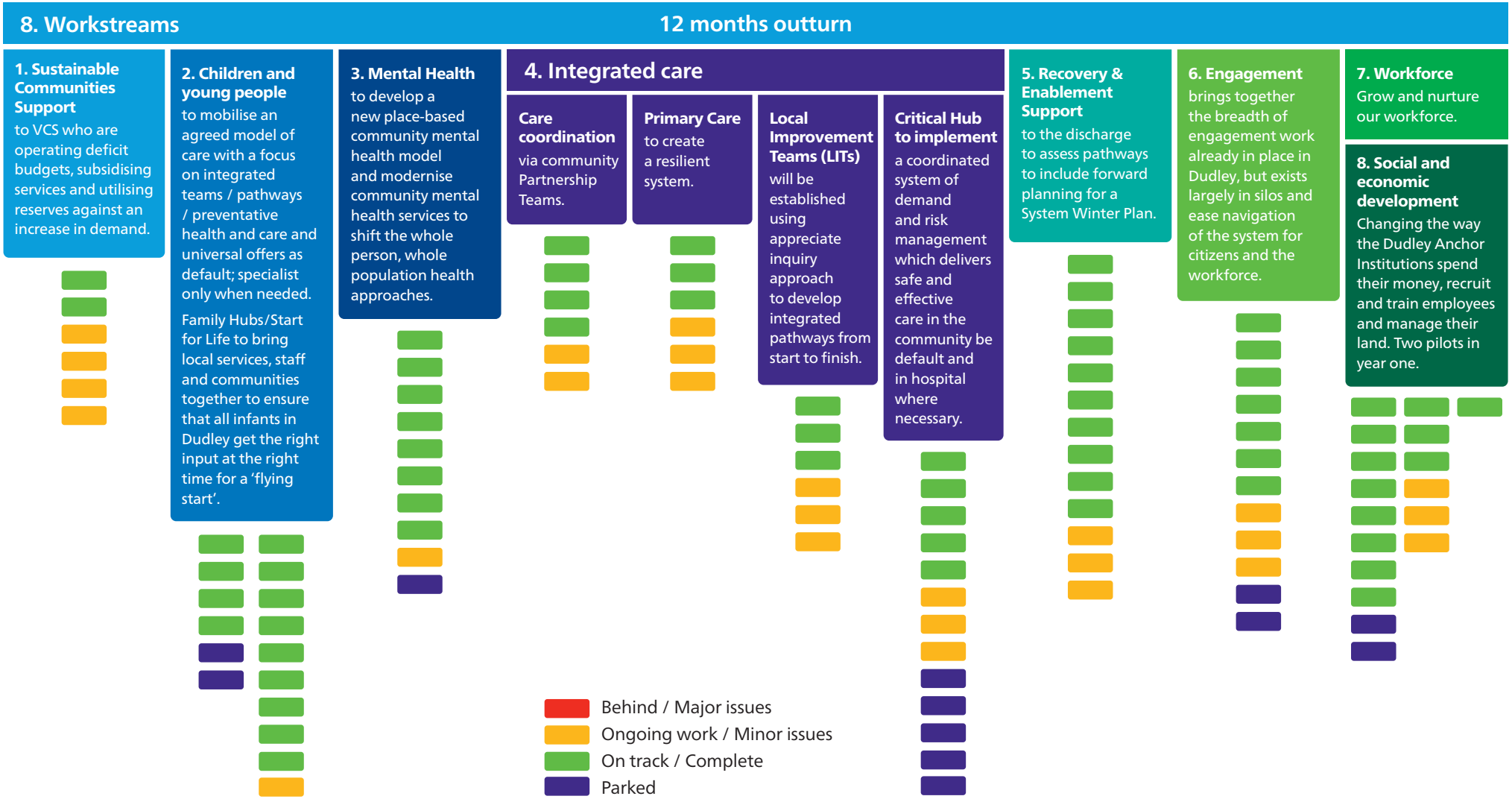
- Sustainable health and care system that includes a thriving voluntary and community sector with increased collaboration
- Improved health and wellbeing for our population
- Sustainable workforce reflective of the population we serve through the 'I can" approach
- A system engagement strategy that draws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

Work programme

Work programme	To be delivered by: Yr1	Yr2	Yr3	Yr4	Yr5
Strengthen partnership effectiveness A new model of care has been developed to provide care where possible in community settings, relieving pressure on acute and mental health services, but ensuring that they are accessible when required. We will work to ensure the sustainability of Dudley's thriving voluntary and community sector, to include establishing an Anchor network and Compact.	✔	✔			
Transform citizen experience Through Community partnership Teams and adoption of Population Health Management approaches we will deliver safe, coordinated and effective physical and mental health care support in the community, that meets the needs of our patients and utilise digital technology to support the delivery of effective health services across all partners.	✔	✔	✔		
Shift the curve of future demand To implement our Primary Care strategy including the following; access, sustainability, population health, multi-discipline teams, personalisation, collaboration, development and resilience.	✔	✔	✔	✔	✔
Health inequalities To 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.	✔	✔	✔		

Our progress

Outcomes/metrics were RAG rated (key below) at the end of the year to demonstrate in-year progress, noting this is a 5-year plan.



Our progress

There has been significant progress in all 8 Workstreams with no major concerns or need to escalate at the 12-month point. Despite this there have been some challenges and risks which were escalated throughout the year. In completing the outturn, the passion, enthusiasm and dedication of colleagues was apparent. It is acknowledged that all elements of the system are stretched, but our teams continue to provide outstanding care for our citizens and the desire to transform pathways/ services /processes /patient experience, despite the circumstances is inspiring.

The financial position of the system in the NHS has been known for some time. This has been compounded by the recent announcement that the Local Authority is introducing a range of tough, immediate, precautionary measures to safeguard their budgets amid growing pressures. As a result, is has been agreed to add a "P" (parked - funding is not currently available and / or no longer a priority / insufficient capacity) and a "G" (grey - the outcomes/metric has been superseded or is no longer appropriate and/or local/national policy has changed) rating to the RAG. The addition of these ratings reflects situations that are outside of the control of the Workstream, reduces unnecessary reporting and allows outcomes/metrics to come back into effect if/when appropriate. The list has been agreed and will be monitored by the Executive.

In addition to ongoing monitoring by the Executive Team the Board have committed to refresh the Joint Forward Plan on an annual basis, therefore the plan becomes iterative and affords opportunity for further engagement and collaboration, as well as the opportunity to continue to reflect the most appropriate delivery mechanisms and collaborative actions.

The outturn for 2023 / 2024 provided assurance that the following outcomes, as set out in the Joint Forward Plan, have been achieved in Year 1.

For our patients

Care close to home with improved outcomes – calls to the Falls pickup service increased by **31.6%** in the December following a launch event in November. Of those calls **78.4%** were supported to remain in the community.

Personalised care and improve patient experience – we have started to see the difference the Community Partnership Teams are making to the outcomes of the Dudley population. An audit of patients during the last 12 months shows a reduction in the average number of GP attendances and hospital admissions, for the cohort.

More say in their care through the co-production of health and care in Dudley – the Brockmoor and Pensnett project is giving the resident opportunity to design, commission and deliver health and care services for their community. The Growing up in Dudley insight will be used to develop an action plan which will be co-produced with participants of the insight work and existing mechanisms such as the Youth Council.

For organisations

New models of integrated and coordinated healthcare – Clinical Hub saving of **£901** per patient rather than admitted to A&E.

Improved integrated pathways – 19 Local Implementation Teams have been established. The Jaundice and Mental Health Transformation will reach identified objectives within a year. 17 Local Implementation Teams continue to meet regularly and are progressing with work plans. The new jaundice pathway has seen a **66%** increase in referrals from health visitors which would previously have required an additional GP appointment, a potential saving of **92** appointments in primary care and seamless, improved care for our vulnerable babies. Length of stay remain consistent at 1 day or less.

For our system

Sustainable health and care system that includes a thriving voluntary and community sector with increased collaboration – we have co-produced a Compact which is designed to underpin the principle of 'Dudley Community First" which is the suggestion that when opportunities arise for the deployment of resources by public sector bodies to deliver services, establish posts, carry out individual projects etc. commissioners consider how our voluntary, community, and social enterprise sector may be considered as the first option.

Sustainable workforce – we have secured 45 placements in both the Local Authority and NHS through "I Can", a project to recruit local people into local jobs.

Our achievements • Work Programme 1 • Key Strategic Actions

Despite system pressures and changing national and local priorities influencing both pace and progress, the high-level summary below demonstrates that we have improved against almost every headline objective and have either done what we set out to do or have made meaningful progress towards it.

Work programme 1 – Strengthen Partnership Effectiveness

Workstreams: Sustainable Communities (1), Integrated Care (4), Engagement (6), Workforce I Can (7)

Key Strategic Actions (high-level) 2023 – 2028: Develop and test the strength of our partnerships.

Progress 2023 - 2024:

- **Primary and Secondary Care "Principles for collaboration and partnership"** document produced socialised and signed off. Aim is to embed excellent communication channels between professionals and eliminate gaps in services, to move away from siloed working and to manage the risk at points where care is being transferred. Outcomes are: clinically led principles which provide guidance to improve work across primary and secondary care; stronger partnerships, increased trust, improved pathways – better patient care.

  Enabler – Fortnightly meeting of clinicians, managers and operational leads.

- **Two events to bring together primary and secondary care colleagues** to build relationships, develop pathways and services to improve patient outcomes and to share learning have been delivered. Outcomes are: Improved relationship between clinicians; collaborative design of services/pathways; a vehicle to showcase best practice.

  Enabler – task and finish group to plan events, use of GP Education sessions, Dudley Engagement Group.

- **Refresh of the Dudley Compact** which is an agreement between the local statutory organisations and the voluntary and community sectors in Dudley borough. It aims to define and strengthen relationships by establishing principles and commitments to which all parties to the Compact sign up to.

  Enabler – agreed values and behaviours are monitored by an oversight group with Compact Champions in all organisations.

- **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.

  Enabler – People Panels that rotate across the borough.

- **HR post in both Local Authority and NHS** to embed a culture of inclusive recruitment for all and to deliver the Dudley 'I Can' recruitment programme offering a minimum of 45 roles per year across both sectors. Dudley is the only area to have the Local Authority as a partner.

  Enabler – funding from the Commonwealth Legacy Fund.

- **Voluntary, community and faith organisations are delivering interventions** that promote social connections and mental wellbeing, access to green spaces, welfare rights, education and employment support as part of our commitment to sustain our thriving voluntary sector.

  Enabler – Black Country Healthcare has awarded £400k over 2 years to 13 Dudley voluntary sector organizations (£200k during 2023/24).

Our achievements • Work Programme 1 • Key Outcomes

Work programme 1 – Strengthen Partnership Effectiveness

Workstreams: Sustainable Communities (1), Integrated Care (4), Engagement (6), Workforce I Can (7)

Key Outcomes (high-level) 2023 – 2028: Increased delivery of community services and utilisation of shared accommodation to offer an increased number of services out of hospital.

Progress 2023 - 2024:

- **Developments within our evolving and expanding Clinical Hub include a falls community pickup**. This service enables the Urgent Community Response team to attend an incident with the correct lifting equipment and skills to assess and treat the faller with the aim of preventing unnecessary conveyances to A&E.

  Impact – 729 falls referrals; 373 were visited by the Urgent Community Response team, of which 324 remained at home post their fall (April- Dec 23). 132 patients were sent to ED at point of referral.

- **A Partnership action plan has been developed for the Clinical Hub** which has created a culture of continuous improvement through change in processes, engagement of staff and external partners. In Jan – Dec 2022 there were a total of 6529 referrals from GPs and 2366 from West Midlands Ambulance Service into the Clinical Hub. In Jan 2023 – Dec 2023 referrals increased to 21,537. The cost of a visit from an Advanced Clinical Practitioner from the Clinical Hub is £71 per visit compared with ED attendance at £299 with an overnight stay costing an additional £673.

  Enabler – Partners from Dudley Group, West Midlands Ambulance Service, Black Country Integrated Care Board, Dudley Integrated Health & Care NHS Trust, and Primary Care came together for a 5 day improvement event with a common purpose, to better understand pathways into and raise the profile of the Dudley Clinical Hub. The aim was to improve the experience for both patients, staff and external stakeholders and increase appropriate referrals.

Our achievements • Work Programme 2 • Key Strategic Actions

Work programme 2 – Transforming Citizen Experience

Workstreams: Children & Young People (2), Mental Health (3), Integrated Care (4), Recovery and Reablement (5), Engagement (6)

Key Strategic Actions (high-level) 2023 – 2028: Delivery of the new model of integrated health and care.

Progress 2023 - 2024:

- 17 **Family Hub Practitioners** form Integrated First 1001 Teams including midwifery, family support and health visiting. Posts are matrix managed and offer early interventions and support to families both universally and to those we need additional early help.

  Impact – 50% increase in families accessing additional support (other than mandatory contacts), 30% increase in speech, language and communication needs, early identification, and intervention. Increase number of expectant and new parents accessing education opportunities – targeted at those most in need. 15% increase in trained peer to peer supporters, with infant feeding peer support in all 5 Hubs. 25% increase in out of hours infant feeding support. Published Start for Life offer.

- **Community Partnership Teams** – 11 multidisciplinary teams wrap around the population in all six of our Primary Care Networks and focus on people who have complex multi-morbidity long-term conditions, very often with frailty to support them in their own homes or usual place of residence.

  Impact – During the last 12 month, we have seen a reduction in the average number of GP attendances and hospital admissions.

- **In January of 2023 a Local Implementation Team reviewed the Jaundice pathways** to enable Health Visitors to refer directly into the Paediatric Assessment Unit / Children's Services.

  Impact – an initial review (Jan – March) suggested that appropriate referrals increase as a result of the changes and that the majority of babies had a length of stay of less than one day, suggesting timely access to care.

Our achievements • Work Programme 2 • Key Outcomes

Work programme 2 – Transforming Citizen Experience

Workstreams: Sustainable Communities (1), Integrated Care (4), Engagement (6), Workforce I Can (7)

Key Outcomes (high-level) 2023 – 2028: Integrated, co-ordinated care.

Progress:

- **The Integrated Front Door Team** are a multi-disciplinary team with the aim of avoiding unnecessary admissions to hospital and where appropriate signpost to community services that enable patients to remain in their usual residence. They work in collaboration with Health, Social Care, Mental Health, GP, Housing and Volunteer services. The outcome is to optimise existing support and interventions, to minimise length of stay in ED and provide supportive discharge for patients.

  Impact – since April referrals have increase by 34%. 95 Patients referred to new support services who would not necessarily have been referred prior to the new Team. Since October, the Team has benefited from a Mental Health Nurse.

- **We have coproduced a discharge to assess model** from hospital for patients who require a pathway 1 discharge package of care. This includes a single point of referral with standard processes and referral form to transfer care and a recovery and reablement service offered by one provider, which reduces periods of uncertainty and stress for the individual and their relatives, less handoffs and continuity of care and staff.

  Impact – improved patient experience and reduction in spend, as unnecessary placement into Care Homes is avoided. Reduction in preventable admissions through ongoing support and assessment in the home by therapy staff able to increase and decrease care, this reduces handoffs at the point of review and enables immediate adjustments. In January 2024 this team facilitated and supported the discharge of 167 patient's home.

Our achievements • Work Programme 3 • Key Strategic Actions

Work programme 3 – Shift the Curve of Future Demand

Workstreams: Children & Young People (2), Mental Health (3), Integrated Care (4), Recovery and Reablement (5), Engagement (6)

Key Strategic Actions (high-level) 2023 – 2028: Implement the Dudley Primary Care Strategy 8 strands:

1. Access **2.** Sustainability **3.** Population health **4.** Multi-disciplinary teams **5.** Personalisation **6.** Collaboration **7.** Development **8.** Resilience

Progress 2023 - 2024:

- **Dudley GPs and partners have worked with the Future Primary Care Team** in the Black Country to coproduce a definition of what "good primary care" looks like in the Black Country and develop a target operating model which will become the framework for how primary care will be organised and delivered as part of an Integrated Care System. Dudley Healthwatch are undertaking a piece of engagement work with patients to help shape the model.

  Impact – tthe aim is to ensure consistent achievement of positive outcomes by reducing unwanted variation, and will set standards, establishing a cohesive structure for sustainable and effective healthcare delivery.

- **New arrangements have been agreed for the employment of Additional Role Reimbursement Scheme (ARRS) personnel** following the dissolution of the current host organisation.

  Impact – retention of Additional Role Reimbursement Scheme (ARRS) staff and continuation of the service.

- **Work is current taking place to identify appropriate support to Practices** as part of Modern General Practice and support to Primary Care Networks (PCN) to implement National Care Initiatives with webinars on topics such as capacity and demand, care navigation.

  Impact – Dudley Integrated Health and Care (DIHC) is supporting 2 PCNs (Brierley Hill and Dudley and Netherton) to participate in developing and testing a national maturity and assurance framework for PCNs (being developed by NHSE).

Our achievements • Work Programme 3 • Key Outcomes

Work programme 3 – Shift the Curve of Future Demand

Workstreams: Sustainable Communities (1), Integrated Care (4), Engagement (6), Workforce I Can (7)

Key Outcomes (high-level) 2023 – 2028: Transformation workstreams refocusing resources to prevention. Procurement – keeping the Dudley pound in Dudley/the Black Country. Local jobs for local people (I can).

Progress:

- **Using a population health management approach** supported by the Dartmouth project, Dudley's 6 PCN's and Public Health jointly funded a "Dad's Worker" to address the fact that expectant fathers told us that they often felt excluded from clinical conversations and did not know how to contribute positively to their child's development.

  Impact – there are currently 2 workers in Dudley focusing specifically on this vital area of the First 1001 Days, linked to a national evaluation on the role of fathers by the Family Nurse Partnership. Initial insight suggest the impact of peer support for fathers is under-estimated and this may be the area for focus and investment going forward. A shift in culture toward "dad inclusive practice" is required.

- **We have transformed our mental health model** to deliver a reduction in escalation of needs including through more seamless delivery of care, achieved through greater connection across primary and secondary care, in addition to the broader range of community-based interventions. The 3-2-1 model seeks to support people to live well, with seamless coordinated care that provides smooth flow through services if needed.

  Impact – the new model focuses on earlier identification and intervention, supporting patients to live well in their communities.

- **Dudley Council has received £25m from the Towns Fund** to create a higher education facility in Dudley which will have a focus on health and care. The new facility, to be known as Health Innovation Dudley, is currently under construction and partners are coproducing the design of the building and the services it will offer to ensure that the available facilities meet the requirements of all partners and to develop the best possible opportunities for our residents. Work is expected to be completed by the autumn of 2025. Dudley College will run the facility with higher academic programmes to be operated by University of Worcester.

  Impact – Access to higher qualifications for local people without needing to leave the borough; Increase in the availability of health and care related courses to support the health systems longer term workforce requirements; Increased clinical placements for students taking courses; Use of the facilities for education and training purposes by partners; Strengthening the links between the College and the Health and Care Partnership, to include a physical presence in the building offering careers advice, access to work experience etc.

- **In March 2024 procurement colleagues ran a "Meet the Buyer Event"** (led and funded by Sandwell Council). The event was opportunity for local businesses to connect with industry decision-makers, find tender opportunities and network. During the day attendees were able to meet with key buyers, showcase their offerings and explore new business opportunities.

  Impact – NHS procurement colleagues connected with over 30 local businesses and a workshop on community wealth building, social value and sustainability will ensure that small local business can articulate the value of local procurement in their bids going forward.

Our achievements • Priorities • Health Inequalities

Priority – Health Inequalities

Workstreams: Sustainable Communities (1), Children & Young People (2), Mental Health (3), Integrated Care (4), Recovery and Reablement (5), Engagement (6) Workforce - I Can (7), Social and Economic Development (8)

Key Priorities / Outcomes (high-level) 2023 – 2028: As Anchor Institutions act to support social and economic actions to address the wider determinants of health and wellbeing.

Progress 2023 - 2024:

- **In April we established a Population Health Management and Inequalities Steering Group** with subgroup addressing Prevention and the Analytical and Technical elements of the programme.

  Impact – oversight of the health inequalities project in receipt of ICB funding during 2022/23 and 2023/24. "Completion of " Growing Up in Dudley" identifying the needs of children, young people and families. Launching work on an assessment of emotional health and wellbeing needs".

- **Healthy Hearts Hubs** - training of peer leaders with lived experience to support communities to monitor and manage their blood pressure control along with delivering educational cardiovascular disease risk reduction sessions with the support of Health and well-being coaches (HWBC). The Healthy Hearts Hub will focus on Hypertension, Lipid Optimisation and Smoking Cessation with a targeted approach across Dudley with a particular focus on health inequalities. The provision of the service within the community helps to re-adjust the formality of engagement with health services and adopt a more informal style utilising a shared care model. Building trust will help patients to manage their own modifiable risk factors with appropriate support and empower them to utilise the offer of routine NHS health checks where required.

  Impact – circa 300 patients the ability for patients to engage in a more informal and relaxed environment appears to be a significant benefit and patients like the convenience of attending in the community away from formal health venues. This outreach type model helps opportunistic engagement and word of mouth promotion. This is crucial to engaging people who would traditionally be excluded from such health initiatives.

- **Life in Lye is an ambitious long-term programme** which combined actions on the wider determinants of health, access to service and asset-based community development. The programme brings together partners across the system to focus on a new way of working in line with asset-based principles and approaches, to meet desired outcomes, to harness the power of employers, networks and communities.

  Impact – the programme will focus on a single framework which starts with listening and sharing power with communities. The long-term approach is not about expecting communities to do more and save public money but about investing in more sustainable and effective approaches to reduce health inequalities. By supporting people to build on their strengths and make new connections their resilience increases and dependence on services decreases. In Year 1 the project team have successfully attracted additional funding from the West Midlands Combined Authority and the Police and Crime Commissioner.

- **Through Health Inequalities funding we supported "Advancing health equity through income maximisation"** which provides welfare rights support for people with severe mental illness with an aim to advance health equity for those furthest away from good health by maximising their income.

  Impact – 98% of people who have a check are getting less than they are entitled to. In the first 6 months in Dudley alone £319,488.07 has been raised for Dudley residents which is an average increase of income of £1936.20 per person.

- **HR post in both Local Authority and NHS** to embed a culture of inclusive recruitment for all and to deliver the Dudley 'I Can' recruitment programme offering a minimum of 45 roles per year across both sectors. Dudley is the only area to have the Local Authority as a partner.

  Enabler – funding from the Commonwealth Legacy Fund.

- **Four Cost of Living Hubs were established by Dudley Empowerment Partnership** (with Dudley and Wolverhampton Citizens Advice) to act as a base where help could be provided to clients for immediate needs and also provide information and guidance on ways to save money and access what entitled to. In May the project won the "Commissioning Project of the Year" Award at the West Midlands Public Health Conference.

  Enabler – £865,300 of Household Support Fund 4 vouchers have been gifted, £461,093 of fuel bank vouchers for prepayment meters have been offered, there was a need for 5,146 period/incontinence products and 157 foodbank vouchers. 46% of attendees have dependent children, compared to 28% of the Dudley population).

Our achievements • Priorities • Children and Young People

Priority – Children and Young People

Workstreams: Sustainable Communities (1), Children & Young People (2), Mental Health (3), Integrated Care (4), Engagement (6)

Key Priorities / Outcomes (high-level) 2023 – 2028: The information families need when they need it • Continually improving the Start for Life offer. Leadership for change.

Progress 2023 - 2024:

- **Child Friendly Dudley's ambition** is that all children and young people from birth right up to the age of 25 (for those with additional needs) have the opportunity to reach their full potential in an environment where they feel safe and secure, have access to the right services and are able to learn, play and grow. Work led by children and young people, facilitated by the Local Authority will develop a framework to embed a cultural shift amongst leaders, business and communities that put children at the heart of every decision.

  Impact – work is ongoing, with schools and colleges coproducing the framework. The right to access child friendly healthcare will be progressed in 2024/25.

- **Dudley has a Family Hub in each township** that offers expectant parents and families with children up to the age of 18 (25 with additional needs and/or physical or learning disabilities) advice, practical support and information, as well as support from other parents. The aim is to ensure babies, children and young people get the best start for life and meet their full potential and that parents and carers receive any help they need to raise their families. The Hubs offer a broad range of support services to include midwifery appointments.

  Impact – 30% increase in speech, language, communication needs, early identification/ intervention. Peer to peer infant feeding support in all 5 Hubs. 25% increase in out of hours infant feeding support.

- **Growing Up in Dudley** is a series of community conversations commissioned by Dudley Council and part funded by the Dudley Health Inequalities Grant. The findings of this qualitative needs assessment, which took place between January and September 2023, provide rich insights into the experiences of parents, children and young people in Dudley, especially in the context of a post-Covid-19 pandemic and an ongoing cost-of-living crisis. The report is based on extensive conversations with 223 people. It highlights what is working well, what is lacking and what is needed to improve their wellbeing.

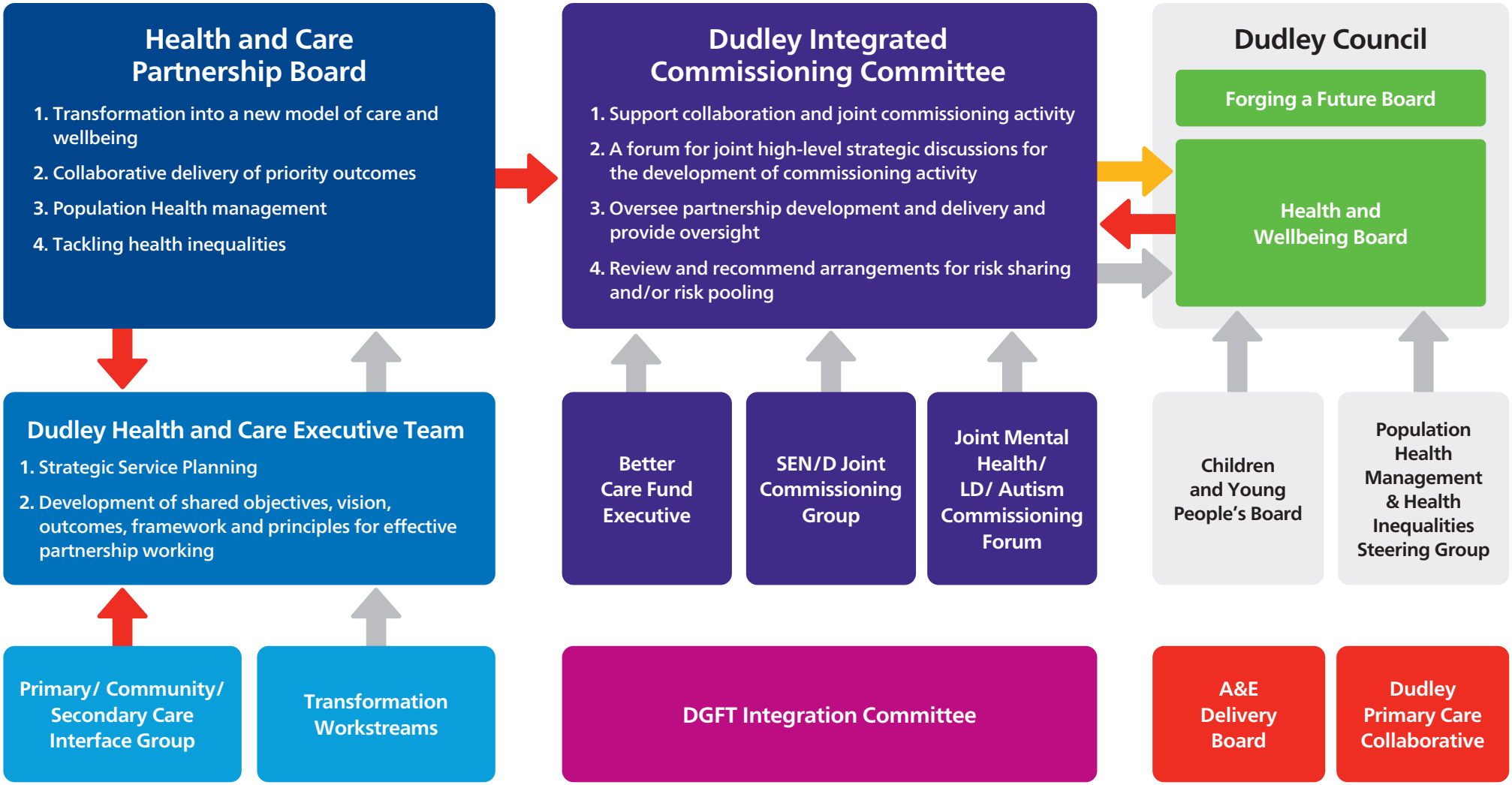
  Impact – a valuable resource for policymakers, service providers and community organisations to improve services and support the wellbeing of children, young people and their families. We are currently coproducing an action plan with participants and existing mechanisms such as the Youth Council.

Our approach • Dudley Place Based Partnership Board 2024/2025

The governance arrangements for the Partnership as of April 1st 2024, are below. The schematic shows the relationship between specialist areas and other strategic boards within Dudley and the Black Country.

Formal accountability
Place based Integration
Funding

Place level – Dudley population 313,000



Our administration

The Partnership Board has met monthly during 2023/24 and has been quorate on all but one occasion. The Board is supported by an Executive Team that acts as the Engine Room, who also meet monthly. Line Management of the Programme Director is via DGFT, the host organisation's Director of Strategy and Transformation (Integration 2024/24) with objectives set and agreed by all partner agencies.

Our budget

During 2023/2024 the Black Country ICB provided the Dudley Health and Care Partnership Board with a resource of £125,000.00 to continue the work of the Partnership. Going forward resource will need to be secured to continue delivery against the priority outcomes, meet our ambitions and to enable to Board to meet the requirements of the ICB Operating Model to include undertaking any delegated responsibilities.

Programme	Detail	Budget	Outcomes
Programme delivery	Programme Director Salary	£106,495.09	Management of Board Meetings, call for papers, agenda setting, action planning and achievement of objectives. Direction of the Partnership workstreams to include check and challenge. Completion of a 12mth JFP outturn. Coproduction of ICB Operating Model. Partnership events/newsletter. Effective partnership working.
Strengthening partnerships	Facilitator for the Combined Board Away Day	£1,057.00	External facilitation of an Away Day for all strategic boards in Dudley to reduce duplication, streamlines reporting and agree decision making.
Integrated Care	Board Meetings, Power of Partnerships Events, Room Hire refreshments etc	£1,698.00	Board Meetings and Priority Setting Sessions. Power of Partnership Events - a space for primary, community and secondary care colleagues to collaborate, supporting engagement, communications and pathway redesign.
	Carry forward 2022/23 **Budget 2023/24** **Total Spend 2023/24** **Carry forward 2023/24**	**£73,867.00** **£125,000.00** **£109,250.09** **£89,616.91**	Planned carry forward for Programme Director role in 2024/25.

Our ambitions

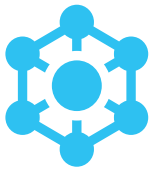
Throughout this year we have coproduced an Operating Model with the Black Country Integrated Care Board (ICB) and system partners identifying clear ambitions for our place-based partnership in anticipation of delegated functions and resources in the future.

We have shared our ambitions with the ICB, these include:

Redesigning and integrating Dudley's health and care services in line with our new model of care.

Addressing health and care inequalities, through actions supporting the implementation of the Joint Health, Wellbeing and Inequalities Strategy, supporting the development of our communities, and acting as a effective anchor network.

Delivering better outcomes



Creating a sustainable health and care system through effective joint resource and risk management.

Providing challenge, scrutiny and support from partners.

Overseeing and advising on the management and allocation of local health and care resources.

It is recognised that this is an evolutionary process over time, to support the partnership's continued development.

Our future

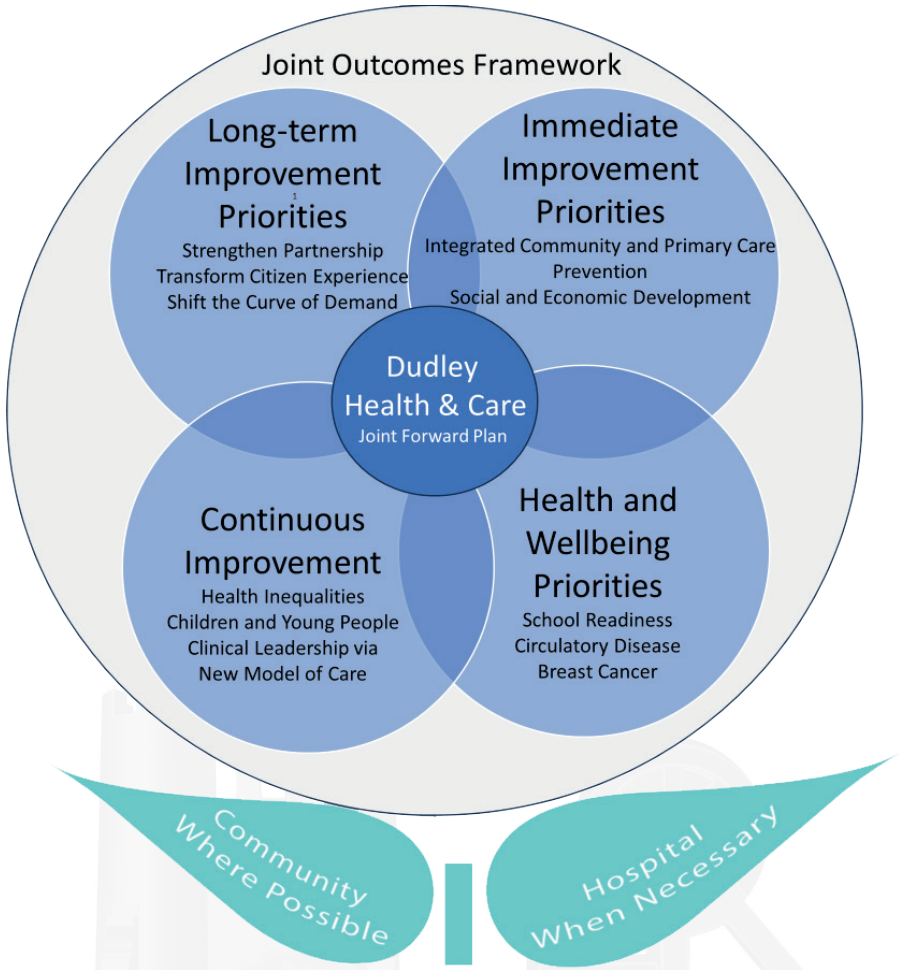
In completing the Joint Forward Plan outturn it became clear that we had been too optimistic with our ambitions for 2022/23 and despite many achievements, it was felt on reflection that we had not sufficiently prioritised our resources to make a demonstrable impact. During September and December, we ran a series of priority setting sessions during which 3 intermediate priorities we agreed for the forthcoming year.

The adjacent diagram, underpinned by the Partnership Mission, details how Intermediate improvement Priorities work alongside the Health and Wellbeing Board priorities and those of the Joint Forward Plan. Encompassing all is the Joint Outcomes Framework which will be signed off by the partnership in summer 2024.

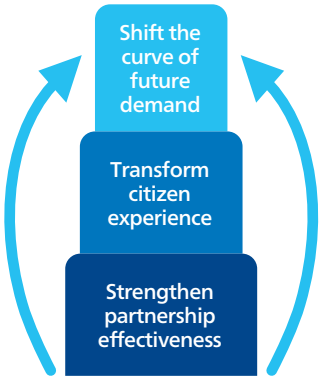
The plan on the following page has been produced which shares:

- **The Board's Priorities, as set out in the Joint Forward Plan.**
- **3 Intermediate Priorities for 2024/2025.**
- **6 recommended objectives for the Board to have oversight.**
- **Workstreams that will drive improvements.**
- **A set of KPIs for the Board to monitor.**
- **The Joint Heath and Wellbeing Board Goals.**
- **Partnership Outcomes.**

It is through this shared commitment that our workforce, patients and citizens of Dudley can hold the partnership to account, and we welcome views and feedback at **dgft.dudleyplace@nhs.net**



Our future

Health and Care Partnership Priorities	Objectives	Workstreams	KPIs	JHWIS Goals	Outcomes
Reduce inequalities in health and healthcare  **Improve outcomes for children and Young people** **2024/25 Intermediate Priorities** **1.** Integrated Community and Primary care **2.** Prevention **3.** Social and Economic Development	**1)** Reduce unplanned admissions **2)** Improve transition pathways between hospital and community settings **3)** Improve the health and wellbeing of children through the timeliness and quality of services and their opportunity to stay well in the community **4)** Support the emotional health and wellbeing of people of all ages and improve their physical health **5)** Support our local communities and create employment opportunities **6)** Reduce inequalities	Admission Avoidance and Reablement Development of Community Partnership Teams Pathway Integration Primary Care Development Sustainable Voluntary and Community Sector Anchor Network Development	▶ Non elective emergency admissions for over 65s ▶ Emergency admissions due to falls for over 65s ▶ Annual rate of older people whose long-term support needs are best met by admission to residential/ nursing care ▶ Patients discharged to their usual place of residence ▶ Clinical Hub referrals ▶ Virtual ward beds per 100,000 population and bed occupancy ▶ Adult Vaccination rates ▶ Children missing from education ▶ Childhood vaccination rates ▶ Infants breast feeding at 6/8-week check ▶ Speech Language and Communication development levels at 2-2.5 years development check ▶ Health checks for people with mental health or learning disabilities ▶ Dementia diagnosis rate ▶ Controlled hypertension ▶ Controlled diabetes ▶ Early cancer detection ▶ Breast cancer screening coverage	▶ Children are ready for school by the age of 4 ▶ Fewer people die from circulatory disease ▶ More women are screened for breast cancer	**Older Adults** ▶ People dying in chosen place of death ▶ Patients still at home 91 days after discharge **Children & Young People** ▶ Development at end of Reception ▶ Year 6 childhood obesity **Mental Health** ▶ Percentage of patients in contact with secondary mental health care living independently ▶ Improved employment level for those with a mental health condition **Cancer** ▶ 12 - month survival rate ▶ Percentage point gap in early diagnosis **Long Term Conditions** ▶ Excess winter deaths **Wider Determinants** ▶ Number of people resident in Dudley Borough employed by partner bodies

Enablers

Dudley Health & Care Partnership