Supporting people to lead healthier lives

Score: 2

2 - Evidence shows some shortfalls

What people expect

I can get information and advice about my health, care and support and how I can be as well as possible – physically, mentally and emotionally.

I am supported to plan ahead for important changes in my life that I can anticipate.

The local authority commitment

We support people to manage their health and wellbeing so they can maximize their independence, choice and control, live healthier lives and where possible, reduce future needs for care and support.

Key findings for this quality statement

Arrangements to prevent, delay or reduce needs for care and support

Telford and Wrekin's 'Borough Vision 2032' saw the local authority working closely with internal and external partners to collate population data and to engage the local community in identifying health inequalities and future needs. This information was used to plan the availability of a range of services, facilities, and resources to promote independence, and to prevent, delay and reduce the need for more complex care and support.

The local Health and Wellbeing Board and TWIPP, along with Public Health strategies set out a framework of support for people throughout their lives, reinforced by 'all-age' strategies for people with mental health needs, people with learning disabilities, and autistic people. Emerging trends were identified in the local authority's Joint Strategic Needs Assessment (JSNA 2024) and the local authority collaborated closely with neighbouring authorities and the ICS Population Management team, using a prevalence tool and NHS data to help identify unmet needs.

Public Health services worked closely with Adult Social Care leaders and teams to identify and target national, regional, and local health priorities. For example, the main causes for average life expectancy being below national average were cancer and cardiovascular conditions combined with the impact of deprivation in the area. Public Health worked with the Integrated Care Board (ICB) on primary prevention work linking improvements in cardiovascular conditions and mental health needs with the benefits of smoking cessation.

The local authority used community based 'Live Well' hubs and projects to connect people to community resources and practical help, supported by health champions. Telford and Wrekin had coproduced and implemented a number of strategies, jointly funded with health partners, to provide information, advice and support around a range of universal health needs. For example, obesity, physical activity, sexual health, falls prevention, vaccinations, and blood pressure. These prevention services were targeted towards communities where engagement required further work, for example, immunisation and blood pressure awareness events supported by faith groups within the local Ghanian and Windrush communities, leisure centre links to tackle obesity, and calm cafes to support mental health needs, funded by Public Health grants and the ICB with a grant agreement in place with providers for delivery.

The local authority's 'making every contact count' initiative was used to ensure every opportunity was taken to identify opportunities for health promotion, and to embed preventative strategies in the everyday working of frontline teams. People and partners told us this approach not only supported people to live independently for longer but increased assessment referral rates in communities with protected characteristics. For example, referrals to the armed forces network supporting veterans (a characteristic the local authority had chosen to class as protected under the Equality Act 2010) had increased by 50% following awareness sessions within the community.

Staff and leaders told us early help and prevention functions within all frontline teams helped embed the making every contact count initiative in practice. People spoke highly of the amount of prevention and early intervention services available, how easy these services were to access, and how much they had benefitted from their support. For example, we heard about family relationships improving due to the holistic approaches taken by frontline teams to include whole families in assessments of need and how, by giving people the opportunity to support themselves, services only needed to be provided on a short-term basis. ASCS data (2023) showed 74.83% of people who had received short term support no longer require support (England average 66.26%). Further data provided by the local authority suggested this rate had improved in 2024.

The Making it Real Board had designed a directory of support services, available online and in multiple printed and audio formats. The directory promoted advice, support services, and awareness events such as Disability Awareness month and LGBTQ+ Pride events. These events were used as opportunities to engage with seldom heard groups, with healthy lifestyle advisors, occupational therapists and mental health services on hand to offer advice, and to break down barriers preventing communities accessing support. For example, mental health services had recently been focusing on people from ethnic minority groups, who were less likely to engage with preventative services.

Specific consideration was given to unpaid carers, with the local Carers Centre producing a wellbeing guide, and the newly coproduced All-Age Carers strategy ensuring unpaid carers needs were considered as part of every assessment process. Support offered to unpaid carers included wellbeing checks, up to 25 hours respite per year, planning for emergencies, and employment, education, and training opportunities. SACE data (2024) showed 62.50% of carers found it easy to access information and advice (England average 59.06%).

The local authority had taken steps to identify people with unmet care and support needs, with work currently being undertaken to upskill unpaid carers, and encouraging whole-family smoking cessation, as well as providing bespoke healthy-lifestyle training in a joint prevent and reduce initiative using Public Health grant monies. Future targeted approaches to help prevent, reduce, delay more complex support included supporting older people with mental health needs, learning disabilities and autistic populations by promoting healthy lifestyles to tackle obesity, support smoking cessation, and offer drugs and alcohol support. The local authority Supported & Specialist Housing Strategy identified specific housing need to promote people's independence and was developed with all services.

Provision and impact of intermediate care and reablement services

Telford and Wrekin worked with neighbouring authorities, voluntary and community partners, the ICS, and other health partners (including Severn Hospice Telford and Wrekin), to deliver intermediate care and reablement services, and to support people to return to their optimal independence.

The local ICS footprint covered both Telford and Wrekin and neighbouring Shropshire, with 3 hospitals, and 5 community hospitals as well as mental health services run by the Midland's Partnership University NHS Foundation Trust. Governance arrangements, through the ICB and the Integrated Partnership Board (ICP), ensured strategic commissioning linked with the health and wellbeing and TWIPP strategic plans to effectively use the Better Care Fund (BCF) to improve hospital discharge, safety and readmission rates, as well as improving access to GP surgeries.

Hospital discharge pathways were supported by the Telford Integrated Community Assessment Team (TICAT), with the jointly funded integrated Discharge and Reablement team, providing enablement intervention and intermediate care for up to 6 weeks after discharge. These teams included nurses, physiotherapists, and occupational therapists who could implement strength-based assessments and support, including equipment, assistive technology, and Family Unpaid Carer Support programmes to improve recovery rates and reduce over-reliance on support. Urgent Community Response teams also provided up to 72 hours admission avoidance support in conjunction with the Rapid Response team and Virtual Wards programme where necessary.

The local authority Hybrid and Community Specialist teams then worked closely with the voluntary and community sector, as well as commissioned care providers, such as the innovative Planned Overnight Care team, to support longer-term needs or signpost people to further support through the Independent Living Centre. Whilst the preference was to support people to remain at home, staff and leaders told us there were suitable step-down arrangements for intermediate care beds commissioned within the independent sector to meet demand. In addition to this, additional intermediate care beds with daily therapy had been commissioned in June 2024 and a pilot programme to use extra care units for enablement was about to commence.

National Adult Social Care Outcomes Framework (ASCOF) data, which shows how well care and support services achieve the outcomes which matter most to people, showed in 2023 3.92% of people 65+ received reablement/rehabilitation services after discharge from hospital. This is slightly above the England average of 2.91%. However, only 70.00% of people 65+ were still at home 91 days after discharge from the hospital into reablement/rehab, significantly below the England average of 82.18%. Further data provided by the local authority suggested this rate had improved in 2024.

There was a system reliance on bed-based care, with partners telling us of over-prescription of support upon discharge from hospital leading to reduced opportunities for independence promotion and increase risk of longer-term support needs. This indicated community provision to support people to independence and multi-agency working still needed strengthening. Health partners told us they were working closely with the local authority and the Urgent and Emergency Care and Delivery Board to review avoidable admissions, and figures for the latest reporting year (currently unpublished but provided by the local authority) suggested readmission rates had improved to become more in line with national averages. A Care Transfer Hub, developed through integrated working with the previous Integrated Discharge Team, was being developed with implementation planned for October 2024. The Housing commissioning function within the local authority also delivered bespoke solutions to reduce reliance on bed-based care post hospital discharge.

Health partners told us the local authority were working closely with the ICP to meet increased demand in complex hospital discharges (20% increase in 2022-2023 compared to the previous year) with the Shropshire, Telford & Wrekin Integrated Care System Urgent Care Transformation programme aiming to increase the percentages of complex discharges home from 50% to 70%.

People's experiences of hospital discharge and the support received was positive, with people telling us of services helping them to remain at home and effective communication and advocacy supporting decisions in the best interest of the person receiving support. Data provided by the local authority showed less than 1% of discharges during the first quarter of 2024-2025 were delayed due to lack of social care service capacity; none of these delays resulted in delays of more than 72 hours.

Access to equipment and home adaptations

The local authority ensured people could access equipment, assistive technologies, and home adaptations to maintain their independence and continue living in their own homes. The provision of equipment was jointly commissioned with a neighbouring local authority and Shropshire, Telford and Wrekin ICB, and allowed for rapid assessment and provision of 'low-level' basic equipment (for example, through the Hybrid Team) as well as provision of more complex home adaptations.

The local authority's Independent Living Centre was a 'one-stop-shop' for all support, information and advice around equipment, assessments, adaptations, and assistive technologies, with a 'Virtual House' programme available to help people see and understand how technology worked. The Virtual House was an online interactive tour showing examples of occupational therapy, assistive technology and sensory aids, equipment and solutions which could be helpful to residents and/or their families to support independence at home.

Increase demand for occupational therapy assessments as well as staffing shortages meant there were significant waiting lists particularly for more complex assessments, with 39.3% of assessments completed within the local authority's target of 28 days. Whilst updated data shared by the local authority showed waiting times for assessments for sensory needs had slightly improved, the number of people waiting for assessments overall had increased by 34.7%. Staff and leaders told us of staff recruitment plans included the increased use of Adult Practitioner/Occupational Therapy Assistants or 'Hybrid' Workers to tackle waiting lists, and risk profiles were closely monitored to prioritise assessments based on need.

People told us the equipment and adaptations they received had been helpful, particularly following discharge from hospital and follow-up reviews and support were available when needed. Most people felt listened to by occupational therapists and assistive technologies helped to maintain their independence, however, people found out of hours commissioned support when equipment broke down was not always timely. The local authority was working with the equipment provider to address these concerns and improve the out of hours service provision.

Staff told us of overly complex processes when applying for Disabled Facilities Grants which delayed processes and often restricted the availability of finances for more intense adaptations such as wet rooms, doorway access or adaptations to kitchens and bedrooms. The local authority told us they had initiated a review of the process across Housing, Adult Social Care, and Children's services.

Provision of accessible information and advice

People told us they could easily access information and advice on their rights under the Care Act 2014, and ways to meet their care and support needs. This included unpaid carers and people who funded or arranged their own care and support. National data showed 63.06% of people who used services (ASCS 2023), found it easy to find information about support (compared to an average of 66.26% for England). Further data provided by the local authority (but not yet published) suggested this had improved for 2024.

Staff and leaders told us the local authority had accessible information standards processes, as well as translation services enabling people to access advice, information, and support in multiple languages, writing and audio formats, large-print and easy-to read versions.

The Making it Real Board, as well as staff champions within the local authority, were consulted on all new strategies and marketing plans to ensure accessibility. For example, the Making it Real Board had recently been involved in codesigning the 'knowing where to go' document, which was a guide to support services. Members of the board supported the production of the guide in multiple formats, including a video featuring board members themselves.

Staff and leaders told us of multiple locations and opportunities for accessing information and advice. For example, the Family Connect team (the main point of access for all referrals and concerns) could be contacted via telephone, email, and the local authority's website. Other frontline teams and senior leaders made themselves, and information, accessible through community hubs, newsletters, leaflets, and magazines.

However, despite this, people told us of some inconsistencies and poor experiences in communication, feedback, and an over-reliance on families translating for people who did not speak English as their first language. We also heard of people with sensory impairments who had mixed experiences of support from frontline teams, for example with emails and letters sent in normal font sizes despite prior knowledge of the persons' sensory needs.

Direct payments

Staff and leaders told us there was low uptake of direct payments, partially due to staff training, awareness, and resources. Short and Long-Term data returns and ASCOF data for 2023 show only 1.79% of unpaid carers received direct payments (significantly below the national average) and 20.10% of people receiving services used direct payments, significantly below the average of 26.22% in England. Whilst updated data provided by the local authority for 2023-2024 (yet unpublished) showed improvement in direct payment uptake, figures were still below national averages.

The time taken to set up the direct payment once an individual budget had been agreed was dependent on all relevant information (such as bank details) being present and an agreed Personal Assistant with availability to meet the support plan needs identified. The person, or their advocate, were supported through the process by the local authority. Delays were uncommon but could be met through commissioned support to bridge the gap until direct payments began if the person had an assessed eligible need.

People told us there was 'confusion' amongst frontline staff about direct payments processes and advice given was often incorrect. The local authority had responded to these concerns by introducing a new direct payments board, as well as increasing the size of the direct payments team and providing training for all frontline staff. They had also commissioned a voluntary and community organisation to raise awareness of direct payments amongst unpaid carers. Staff told us since the introduction of the direct payments team the support available for frontline staff had improved, including drop-in sessions and fact sheets, but needed time to embed before they could say it was being consistently used. Updated data provided by the local authority showed the number of people using direct payments since the introduction of the new processes had increased by 37.8%.

The new board had also introduced weekly drop-ins, videos, and advice for people thinking of using direct payments. Despite the lack of understanding and poor uptake of direct payments, where they were used, people told us of positive outcomes and improved control of their care and support needs. For example, people had used payments for yoga sessions, fridge freezers and tumble dryers to improve independence, confidence, and health.
