



Telford & Wrekin Integrated Place Partnership Prevention Projects Progress Delivery Report

Background Information & Summary

The neighbourhood health prevention and inequalities initiatives funded through the ICB Prevention Grant for 2025/26 all have delivery plans, and the initiatives encompass both borough-wide programmes and targeted interventions in areas of deprivation. These initiatives reflect TWIPP’s commitment to reducing health inequalities and improving access to prevention and wellbeing support across Telford & Wrekin.

Across all prevention initiatives, strong multi-agency collaboration, effective project planning, and high levels of community engagement have been consistent strengths. Projects demonstrate inclusive, person-centred approaches, with many successfully embedding services within community settings to improve reach and accessibility.

Notable achievements include the launch of new services such as Calm Cafés, multiple Live Well Community Hubs, mobile health outreach through Healthy Hearts, highly successful communications activity for flu vaccinations, and the establishment of new roles such as All-Age Care Navigators. Several programmes have delivered early health benefits, including identifying undiagnosed conditions, improving mental wellbeing, and enabling timely referrals.

Despite significant progress, several shared challenges exist across projects. Short-term funding and limited capacity particularly within smaller voluntary sector partners is impacting on sustainability and delivery.

Operational challenges have included recruitment delays, logistical barriers, venue limitations, and difficulties engaging specific target populations. Some projects have faced issues with data systems, including inconsistent or manual data capture and limited interoperability between partner systems. Additionally, growing demand is stretching partner organisations without proportionate resource.

Calm Cafés for Children & Young People transitioning to adulthood

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Key achievements For period Jun 2025 to end of Jan 2026	<ul style="list-style-type: none"> ● Successfully recruited a multi-agency team – including social care, A Better Tomorrow and Telford Mind ● Agreed operational protocols & promotional materials between partners ● Promoted the service with key referrers e.g. Children Services

	<ul style="list-style-type: none"> • Started to deliver sessions – first session held on 29 November 2025 • Amended LAS (adult social care recording platform) to ensure activity can be captured from social care side. • Monitoring templates established by Mind and ABT • Developed Community links to enhance the offer and develop move on plans. For example: <ul style="list-style-type: none"> - Lawley Community Hub – for service promotions - Smallwoods – connected to volunteering opportunities and offer of use of premises for the café - Boardroom café – using their space for cafes and supporting move on in a safe place - Autism drop-in on a Friday - MPFT psychology group - Smashlife to promote the opportunity for care leavers - Community Grocery – setting up accounts for people in financial crisis
Project performance data/outcomes <i>(e.g. no. of people engaged)</i>	As at 17/12/25 <ul style="list-style-type: none"> • 11 young adults have been referred via the Adult Social Care team • 3 more potential referrals from Redwoods – in reach will be provided whilst they remain inpatients • 3 referrals pending following discussions with allocated workers • Adult Social Care is recording the frequency of 1:1 required for YP before engagement or attendance at café – it’s noted that this is higher than for the other cafes. The voluntary sector • Highest number of YP to attend a Calm Café – currently 7 though it’s still early days
Case study / success story	<p>Referral received from CATE team. Young adult is living with family, highly dependent on their Mum to complete all daily tasks, they are isolated, have mental health needs, neglects her personal care and a history of complex trauma including domestic abuse and sexual abuse. She was supported by the Calm Café team on an outreach basis to develop her confidence, self-esteem and independence including skills around the home. Since receiving the support, she has informed the team that she is now sometimes leaving the house to visit a friend, she goes to the local shop, cooks with her Mum and is attending to her self-care.</p> <p>Her main focus now is getting back to education and very focused on Health & Social Care. Previous professionals have mentioned an EHCP. The Calm Café team have discussed seeking support through SENDIASS. She was not aware of them but was happy for a referral to be made. She has previously been referred to a number of other local services but didn’t feel these worked for her.</p> <p>She is interested in attending the café but for now is keen to continue with the outreach part of the support. Her mother feedback: ‘we could have done with you this time last year’.</p>
Health inequalities focus	<p>The project support people who experience health inequalities relating to their mental health.</p>
Issues / challenges for TWIPP Committee	<p>We are unclear if there is a process to reapply for funds if the project is successful.</p>

	The LA is drafting a section 25 agreement to formally transfer the commissioning remit to them. ICB and LA colleagues are supportive of this. This latest café could be part of this agreement long term.
Plans for next period (Feb-Mar 2026)	<ul style="list-style-type: none"> • Explore an alternative venue to Dawley • Arrange community-based meeting points possibly small groups which will support move on • Develop clear ‘exit’ strategies for calm café (part of wider calm café stock take and review) • Develop activity planner to include guest speakers from key services or community groups as determined by needs of cohort. • Utilise social media to engage young people and publicise what the café offers

Live Well Community Hubs	
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Key achievements For period Jun 2025 to end of Jan 2026	<ul style="list-style-type: none"> • Appointment of a dedicated project lead • Governance structures established including a steering group and funded coordination roles across CVS and Citizens Advice • Opening of Wellington and Donnington Hubs • Extension of the Southeast PCN offer (Madeley) to include Sutton Hill and Woodside • Secured regular support from several core partners • VISS translation service now attending at Wellington Hub • Live Well Telford Directory fully updated with new hub information • Promotional support provided by Wellington Medical Practice & Wrekin Housing Group • Distribution of Winter Packs from Telford Crisis • Partner feedback form developed to improve information sharing and monitoring of partner impact • Strengthened cross sector information sharing and learning
Project performance data/outcomes	<ul style="list-style-type: none"> • Supported 254 local residents
Case study / success story	<p>Live Well Hub Silver Threads Hall (Donington):</p> <p>An 80-year-old lady had her blood pressure taken and was signposted to her local Community Pharmacy after a high reading - she later attended her GP Practice and began 7-day monitoring. She also received digital support to set up her NHS App, with assistance from the Social Prescriber (Newport and Central PCN). She was so impressed that she plans to return in the New Year. Her friend -also attending – received valuable Citizens Advice support to manage her utility bills.</p>

	<p>Live Well Hub Silver Threads Hall (Donnington): A lady aged 60+, from Lawndale Assisted Living visited seeking information about English courses. The Hub Coordinator referred her to Learn Telford, who have since engaged with her. Digital Support identified she had no phone credit and could not make essential calls. She was issued a National Databank SIM card offering 40GB of data, unlimited calls and texts for 6 months. Housing Plus Group reviewed accommodation concerns she raised and identified that she would benefit from financial support help via their Money Matters team.</p> <p>Lingen Davies: A gentleman undergoing treatment for skin and prostate sought information about radiotherapy. He was signposted to discuss treatment options with his urologist. He also shared difficulties travelling to Shrewsbury hospital, and hospital transport options were discussed. travelling to Shrewsbury hospital via bus, we discussed the option of hospital transport. We discussed our Bins for Boys project and the difficulty he had getting access to toilets - he was provided with a radar key to improve access to disabled toilets.</p>
Health inequalities focus	Deprivation; marginalised communities; social isolation; digital exclusion; adults with learning disabilities
Issues / challenges for TWIPP Committee	<ul style="list-style-type: none"> • Previous data feedback processes were not fit for purpose – new processes now in place via MS Forms and a QR code. • Awaiting feedback form TW Insight Team regarding historical data collected under the previous system • Limited space for partner organisations at some hubs • Difficulty engaging the right residents • Growth of Live Well Community Hubs is stretching core partners who receive no financial support for attendance.
Plans for next period (Feb-Mar 2026)	<ul style="list-style-type: none"> • Development of the Hadley Live Well Community Hub • Continued promotion of the existing offer with partner support • Ongoing design and communication work on flyers, A-boards and Pull-ups.

Healthy Hearts

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Key achievements For period Jun 2025 to end of Jan 2026	<ul style="list-style-type: none"> • Appointment of a dedicated project coordinator • Successful identification and deployment of clinical nursing teams and Healthy Lifestyle Advisors to deliver the outreach NHS Health Check Programme • Strong collaboration with partners including Dr Bike, Lingen Davies, Telford and Wrekin CVS, National Diabetes Prevention Programme, Live Well Hubs, MIND and Together as One.

	<ul style="list-style-type: none"> • Mobile mini health checks and blood pressure checks have enabled the early identification of individuals eligible for an NHS Health Check, leading to onward referrals to the Healthy Lifestyle Service, community pharmacies, Live Well Hubs and GP practices - health checks have helped uncover previously undiagnosed conditions and ensured individuals receive prompt follow up care. • Dr Bike working alongside the Active Travel Team has been a successful addition to the Healthy Hearts Tour – free bike repairs and safety checks have boosted engagement and footfall for NHS Health Checks while also encouraging active travel. • Building on this success, the Re-wheeled Scheme will be extended from January 2026 to individuals and families supported by the Healthy Lifestyles Service in Brookside and Stirchley. The Healthy Hearts Bus will act as a collection and training hub, supporting increased uptake of cycling for exercise, travel and leisure among residents who may otherwise face financial or practical barriers.
<p>Project performance data/outcomes (e.g. no. of people engaged)</p>	<ul style="list-style-type: none"> • 46 Events delivered across 12 locations in Southeast Telford. • 194 NHS Health Checks completed • 164 Mini Health Checks and standalone Blood Pressure Checks, contributing to the Community Blood Pressure Project. • 358 residents engaged through the Healthy Hearts Project in Q1 • NHS Health Check profile - 46% Male, 54% Female. • Distribution of checks - 62% Stirchley and Sutton Hill Medical Practice, 30% Court Street and 8% Woodside Medical Practice. • Outcomes included: 4 patients prescribed or advised to start statins (1 referred for vascular support); 1 new diagnosis of Type 2 Diabetes; 1 new diagnosis of Pre-diabetes with referral to the NDPP; 3 new diagnoses of stage 1 hypertension. • 24% of all NHS Health Checks identified a QRisk Score above 10% • 21 referrals to the Healthy Lifestyles service
<p>Case study / success story</p>	<p>A resident attended the Healthy Hearts Bus after noticing it was parked close to their home. Blood tests taken during the visit indicated a potential diabetes diagnosis. Following this the individual underwent further testing and discussions with their GP which confirmed Type 2 Diabetes. Early detection enabled swift support from their GP, practice nurse and the Healthy Lifestyles Service including 1:1 support. The resident reported that the intervention has been life-changing and expressed strong appreciation for the accessible and supportive approach.</p>
<p>Health inequalities focus (e.g. areas of deprivation, target population groups)</p>	<p>The project targets communities in Southeast Telford, with a specific focus on men and BAME communities aged 40-74 in line with NHS priorities.</p> <p>The Geography of Southeast Telford includes areas of high deprivation - Stirchley, Randlay, Brookside, Sutton Hill, Woodside and Madeley.</p> <p>96% of NHS Health Checks delivered by SET PCN were for residents in TF7 (52%), TF3 (37%) and TF4 (7%) – all IMD 1-2 areas.</p> <p>Among male attendees, 22% were from BAME communities.</p>

Issues / challenges for TWIPP Committee	<ul style="list-style-type: none"> • Affinion machines and cartridges are sensitive to low temperatures, leading to equipment failure and waste during winter months. Improved storage and transport processes are required. • The two vehicles used for delivery differ in appearance and facilities, causing confusion for the public and affecting footfall. • Clinical support is currently provided by Stirchley Medical Practice via a rota. A sustainable model will require participation from all practices. • Significant manual data entry is required, due to limited interoperability between digital systems • Accurately identifying pre-existing conditions and GP registration details is challenging when reliant on self-reporting • Often public attending are already prescribed CVD medications – higher non-adherence to medications has been noted particularly among BAME residents • Parking permits and site permissions need further streamlining across internal Telford and Wrekin Council teams
Plans for next period (Feb-Mar 2026)	<ul style="list-style-type: none"> • Enhanced engagement with BAME communities and men aged 40+, including targeted outreach via community groups, faith settings and workplaces • Increased engagement with local business to promote upcoming sessions. • Launch of the expanded Re-wheeled Scheme in January 2026

Healthy Conversations – flu vaccinations

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Key achievements For period Jun 2025 to end of Jan 2026	<ul style="list-style-type: none"> • First TWIPP communications campaign – running paid for and organic promotion • Impressions: 4,445,299 • Engagement: 5.09% • Clicks: 12,467 • Best post for engagement focussed on inviting people to vaccination clinic towards campaign end, giving opportunity to act after campaign exposure – 15 vaccinations at a nursery setting and 9 at a community venue, both with relatively short notice owing to difficulty in securing a provider • STAW uptake up across most eligible groups, e.g. 2- & 3-year-olds (a key targeted demographic) up 3.8% • STAW overall uptake 4.7% higher than national average
Project performance data/outcomes (e.g. no. of people engaged)	<p>PAID FOR:</p> <ul style="list-style-type: none"> • Impressions: 4,445,299 • Engagement: 5.09% • Clicks: 12,467 • Across council websites, Meta, WhatsApp, Snapchat, Google and other search engines <p>ORGANIC:</p> <ul style="list-style-type: none"> • Press releases advocating for flu vaccine take up

	<ul style="list-style-type: none"> • Digital advertising screens borough wide with information and to reinforce branding and visuals • Posters in community centres, libraries etc • Flyers in similar locations • Teams backgrounds, lockscreens and pop ups for internal council staff • Article in Leader’s Weekly news including extended feature in clickable footer • Social media: <ul style="list-style-type: none"> ○ Impressions: 57,014 ○ Engagement: 0.32% ○ Clicks: 69 ○ Likes: 36 ○ Reshares: 9 ○ No negative comments
Case study / success story	Securing of contracts with local pharmacists to provide accessible local clinics, and provision of clinics in time for Christmas. Good uptake was achieved after targeted advertising using a range of methods, especially through settings such as care homes and nurseries, for whom the Health Protection Hub is a trusted partner.
Health inequalities focus <i>(e.g. areas of deprivation, target population groups)</i>	<p>All eligible residents:</p> <ul style="list-style-type: none"> • 65+ • Pregnant women • 2- & 3-year-olds • School-aged children • Those with certain health conditions • Health and social care workers • Carers • With a focus on people from areas of deprivation, ethnic groups with low uptake and “at-risk” groups with low uptake, using regularly updated data from ICB data analysts
Issues / challenges for TWIPP Committee	<ul style="list-style-type: none"> • Lack of feedback from communications colleagues, not picked up more widely beyond Council efforts
Plans for next period (Feb-Mar 2026)	<ul style="list-style-type: none"> • Confirmation of topics required from TWIPP – will now be a delay due to design time.

All-Age Care Navigators

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Key achievements For period Jun 2025 to end of Jan 2026	<ul style="list-style-type: none"> • Successful establishment and embedding of the All- Age Learning Disability and Autism Navigator service across community, health, and VCSE settings. • Partnerships emerging with Primary Care Networks (TELDOC), Adult Social Care, Citizens Advice, and a wide range of VCSE and community organisations. • Consistent community-based delivery through Live Well Hubs and Sunflower Brookside Community Cafe, improving accessibility for people who may not engage with

	<p>traditional services.</p> <ul style="list-style-type: none"> • Development of robust infrastructure and systems, including shared mailboxes, a dedicated phone line with voicemail-to-email functionality, SharePoint resource hub, feedback mechanisms, and referral tracking tools. • Delivery of Autism Champion Training to over 24 professionals across two sessions, contributing to increased autism awareness and inclusive practice across multiple sectors. • Implementation of Fast Track CAB appointments, enabling quicker access to advice and support where required.
<p>Project performance data/outcomes (e.g. no. of people engaged)</p>	<ul style="list-style-type: none"> • Autism Champion Training: 24 attendees across 2 sessions (July and November 2025) • Fast Track CAB Referrals: 4 referrals received (1 seen same day, 1 seen next day, 1 resolved via telephone advice, 1 awaiting engagement) • Weekly face to face attendance at Live Well Hubs LWH Data for Nov and December – TWCVS Reach (All Services) = 26 people • Supper Club = 50 attendances during the period June 2025-January 2026) • Regular presence in community cafés (Sunflower Café) including Friendly Friday sessions • 10 responses in our satisfaction survey
<p>Case study / success story</p>	<p>Collaborative Support for a Client with Complex Needs</p> <p>This case study demonstrates the impact of a coordinated, person-centred approach delivered jointly by Citizens Advice and the All-Age Learning Disability Navigator, working alongside the CVS team. The client was referred by a social prescriber and presented with multiple and interconnected needs spanning mental health, housing stability, wellbeing, and community engagement.</p> <p>The client had recently completed a 12-week holistic support course, which had provided a structured environment that significantly benefited their wellbeing. Due to the end of programme funding, the client no longer had access to this support and expressed a need for ongoing help to build self-esteem, maintain positive mental health, and remain engaged in their local community.</p> <p>Intervention</p> <p>Building community participation Over several weeks, the Navigator team have worked to support the client to re-engage with appropriate local activities. This included:</p> <ul style="list-style-type: none"> • Encouraging attendance at Men’s Sheds, providing peer support and practical activities. • Offering supported visits to such opportunities as Smallwoods, arranged for the next week, to assess suitability for longer-term involvement. These opportunities aim to help the client regain routine, develop social connections, and build confidence in a relaxed, welcoming environment. <p>Exploring funding for continuity of support to maintain the client’s positive progress, the Navigator team made enquiries with:</p> <ul style="list-style-type: none"> • Telford Lions, and • A local Parish Council, to explore funding that could continue the client’s previous placement or secure alternative structured support. Responses are forthcoming.

	<p>Financial and practical support recognising that financial security is closely linked to wellbeing, the service arranged:</p> <ul style="list-style-type: none"> • A future appointment to review benefits and income, ensuring the client is receiving all possible relevant entitlements. • Access to a fast-track Citizens Advice appointment to discuss energy bills, helping the client manage rising household costs. <p>Multi-agency collaboration as part of ongoing support, the team conducted regular welfare calls. The client is now:</p> <ul style="list-style-type: none"> • Receiving housing support from Trident, • Communicating actively with TACT, • And has been successfully signed off by social prescribers, indicating stabilisation and progress. <p>Outcomes & Impact</p> <ol style="list-style-type: none"> 1. Increased stability and independence. The client is now linked into the appropriate housing and advice services, improving their ability to manage day-to-day challenges independently. 2. Improved wellbeing and social confidence through supported introductions to community groups such as Men’s Sheds and Smallwoods, the client has re-engaged socially and begun rebuilding self-esteem and routine. 3. Strengthened financial resilience planned benefits review and energy advice will help to maximise income and reduce financial stress. 4. Clear evidence of effective partnership working this case highlights the positive outcomes achieved when Citizens Advice, the All-Age Learning Disability Navigator service, CVS teams, and wider community organisations collaborate around the needs of one individual. <p>Client Feedback</p> <p>The client expressed gratitude for the personalised, flexible, and community-based support, noting that this approach made them feel understood, supported, and motivated to stay engaged.</p>
<p>Health inequalities focus <i>(e.g. areas of deprivation, target population groups)</i></p>	<ul style="list-style-type: none"> • The service has focused on community settings in areas of higher deprivation, including Madeley, Brookside, Wellington, Donnington, and Hadley. • Target populations include people with learning disabilities, autistic people, those awaiting diagnosis, carers, and individuals facing digital exclusion or barriers to accessing statutory services. • Easy Read resources, informal engagement spaces, and flexible access routes (drop-ins, phone, in-person support) have been prioritized to reduce inequality in access. • Partnership with CAB aims to address financial insecurity and benefits access, key driver of health inequality.
<p>Issues / challenges for TWIPP Committee</p>	<ul style="list-style-type: none"> • Staffing instability within the LD Navigator role during the period created short-term capacity pressures: Mitigations are in place: additional CAB hours to sustain delivery and 8 additional TWCVS hours to utilise funds which were unspent during recruitment lead times. • Data capture has been initially qualitative due to the focus on embedding and relationship-building. Due to the nature of the ‘Drop in’ offer engagement with surveys is low.

Plans for next period (Feb-Mar 2026)	<ul style="list-style-type: none"> • Maintain consistent delivery across Live Well Hubs, Sunflower Café, and Friendly Friday. • Finalise and distribute PIP/UC Easy Read materials, incorporating lived-experience feedback. • Strengthen links with Adult LDC Autism Team, Lead Care Navigator, DWP Digital Inclusion, My Options, and Telford Voices. • Continue Autism Champion Training delivery. • Increase focus on outcome data collection.
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Group Lifestyle Clinics

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Key achievements For period Jun 2025 to end of Jan 2026	<ul style="list-style-type: none"> • Significant progress has been made towards delivery of the prevention project, and the PCN is now exceptionally close to entering the initial delivery phase. • Key achievements include identification of two target patient cohorts (patients living with four or more long-term conditions, patients wanting support with menopause), agreement of clear project aims, and finalisation of the delivery model. The PCN has refined its initial approach to ensure the programme is sustainable, aligned with neighbourhood health working, and reactive to patient demand. • A strategic decision was taken to deliver the programme using the PCN's existing ARRS workforce rather than short-term recruitment. This has enabled improved value for money, extended delivery timeframes, and stronger alignment with PCN priorities around prevention and proactive care.
Project performance data/outcomes (e.g. no. of people engaged)	<p>At this stage, performance data relates to project setup and readiness rather than delivered activity. Outputs to date include:</p> <ul style="list-style-type: none"> • defining of patient cohorts across the Newport and Central area and expansion of project to include menopause support cohort • agreed programme aims and outcomes • identification of PCN staff to support delivery • planning of group clinic structure and content <p>Delivery is expected to commence shortly, with outcome data to be collected during the next reporting period, including patient attendance, engagement levels, and early indicators of impact on wellbeing and GP contact.</p>
Case study / success story	<p>The redesign of the delivery model represents an early success of the project. By choosing to utilise experienced ARRS staff already embedded within the PCN, the programme benefits from existing patient relationships, local knowledge, and multidisciplinary expertise. This approach supports trust, continuity, and sustainability, and allows the programme to move beyond a short-term intervention towards an embedded neighbourhood-based prevention offer that can evolve over time. Adapting to</p>

	<p>this approach has also allowed us to diversify the project to cover two significant patient cohorts rather than the initially planned singular cohort, with the addition of menopause for all support groups.</p>
<p>Health inequalities focus <i>(e.g. areas of deprivation, target population groups)</i></p>	<p>This project is designed to tackle health inequalities by improving access to tailored, proactive care for patients at greatest risk of poor outcomes, including those living with four or more long-term conditions—a group with higher service use and complexity. Delivery follows neighbourhood health principles, ensuring support is local, responsive, and accessible within the Newport and Central area.</p> <p>As the delivery phase has been extended, the PCN will introduce targeted group sessions for specific communities within this cohort. Planned groups include support for the Deaf community, patients with autism, learning disabilities and neurodiversity (ALD), and inclusive menopause clinics for all patients. These sessions will be adapted to communication needs, sensory considerations, and preferred learning styles, ensuring equitable participation.</p> <p>The extended timeframe also enables the PCN to identify emerging needs and develop additional targeted sessions, maintaining relevance and avoiding a one-size-fits-all approach. Risk stratification and neighbourhood intelligence will guide outreach to priority groups and geographic areas, supported by a robust engagement process using personalised invitations, non-digital contact routes, and practice-led follow-up to minimise digital exclusion.</p> <p>Through these approaches, the project actively reduces health inequalities by improving access, tailoring delivery, and addressing barriers for underserved populations.</p>
<p>Issues / challenges for TWIPP Committee</p>	<p>During the reporting period, the PCN experienced significant personnel changes within the management team, which resulted in a short delay to the mobilization and early delivery phase of the project. This transition temporarily impacted capacity to progress planning activity at pace while maintaining continuity of core PCN business.</p> <p>However, the PCN has now re-established management oversight and momentum, enabling the project to move rapidly towards delivery. The delay has been used constructively to review and strengthen the delivery model, resulting in a more sustainable approach aligned to neighborhood health principles and improved value for money through reprofiling of funding.</p> <p>As part of this review, the patient cohort has been reprofiled to include inclusive menopause group clinics, responding to clear patient feedback and demand for better support in this area. This addition ensures the program addresses a wider range of health needs and reflects local priorities.</p> <p>Importantly, while the initial bid was for 10 programmes, the revised and more sustainable model will now enable the PCN to deliver a minimum of 10 general wellbeing groups and 10 menopause-for-all groups, with potential for additional sessions as efficiencies are realized. This expansion demonstrates improved value for money and greater impact for the local population.</p> <p>No additional risks requiring escalation have been identified, and the project is now back on track with delivery expected to commence imminently.</p>

Plans for next period (Feb-Mar 2026)	<ul style="list-style-type: none"> • Commence delivery of group health and wellbeing and menopause for all clinics • Finalise referral and invitation processes for identified patients • Monitor early engagement and attendance levels • Begin collection of baseline wellbeing and service-use measures • Use learning from early sessions to refine content and delivery
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Wellbeing Activities at Halfway House

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Key achievements For period Jun 2025 to end of Jan 2026	<p>Developing Halfway House as a community hub for improving health and wellbeing using innovative approaches.</p> <p>Families accessed circus skills with excellent engagement.</p> <p>There were several weekends of music in the pagoda with local bands and singers creating a festival type experience. Poetry recitals and music evenings.</p> <p>In summer months we had several days of activities and wildlife pursuits improving wellbeing. As summer ended, we hosted a whole school walk up the Wrekin with Halfway House as the base.</p> <p>Mental health walks have taken place across the Wrekin with guides showing different routes starting from Halfway House which improved well-being. At the start of term, we hosted a whole school ascent up the Wrekin. In the autumn we hosted Art and creative days.</p> <p>As the winter approached, we did cooking and nutrition using the kitchen and kiosk with people recovering from addiction. A horticultural project was hosted which was good for mental health, supporting those with autism learning to plan and practical outdoor activity.</p> <p>Hosted an ultra-sporting event for 27 people with world record holder who went up and down the Wrekin 56 times in 48 hours. Then over Christmas and New Year, circus skills events for families and craft in the pavilion.</p> <p>In January we had our first school group of year 8s who had circle time alongside an ascent and challenges on the Wrekin.</p>
Project performance data/outcomes (e.g. no. of people engaged)	Total visits - 5,335 from August to mid Jan 8 in-depth case studies are available.
Case study / success story	JH has been a client with Yellow Ribbon and now is a volunteer within our organisation. He has benefited from being involved in the horticulture project and supporting other clients going up and down the Wrekin. By his own admittance, his mental and physical

	health has improved, and his self-confidence has grown immensely. JH now supports on other projects within Yellow Ribbon such as co delivering on the Foundation course and assisting clients going to the job centre and sign posting them to other agencies.
Health inequalities focus <i>(e.g. areas of deprivation, target population groups)</i>	A wide range of diverse groups engaged and relationships established. Men's and women's mental health, addiction recovery and social isolation.
Issues / challenges for TWIPP Committee	
Plans for next period (Feb-Mar 2026)	<p>South Telford schools focus planned for project at Feb half term 14-21 Feb... With activities using trees and wildlife to improve well-being</p> <p>Introduce group therapy in lounge of the Halfway House and walk and talk sessions led by Trauma Informed Lead.</p> <p>In March starting a wellbeing cafe on Tuesdays - the volunteers have been trained. These are a mix of people who are recovering from addiction and over 50s</p> <p>Improving physical health, reducing blood pressure etc</p>