Telford & Wrekin Co-operative Council

Protect, care and invest to create a better borough

Twipp

Healthy Neighbourhoods

Prevention First

Telford and Wrekin Annual Public Health Report 2026

Foreword

My report this year shines a light on neighbourhood health, the Government's new programme, which is part of the NHS 10 Year Plan. Neighbourhood Health needs a strong public health approach, with a focus on prevention so our residents stay healthy and independent, spot problems earlier, and where needed the offer healthcare close to home, rather than in hospital.

Working in neighbourhoods is far from new for local authorities, we offer a wide range of services and support in communities that impact on resident's health and wellbeing, for example – lifestyle and public health services, adults and children's social care, housing, employment and welfare support. Our work on with partners on the health and wellbeing strategy, children and young people's and adult social care prevention strategies, and the Vision 2032 are clear examples of collaboration and delivery.

Bringing together services around the needs of local people, rather than organisational boundaries, with a shared focus on improving health outcomes is a foundation of neighbourhood health.

Voluntary and Community Sector organisations, alongside local authorities will be critical partners to the NHS in its major transformation journey over the next decade. This report introduces how we are working with the NHS to develop *healthy neighbourhoods* in Shropshire, Telford and Wrekin, with particular emphasis on prevention first, rather than the shift of treatment and care out of hospital into the community which is also gathering momentum. A series of case studies in the report showcase how the council community and voluntary organisations have been working with residents and primary and community NHS services on prevention. Neighbourhood health connects well with other significant transformation programmes already underway, such as the best start in life and making prevention real in adult social care.

The case studies, framed around our agreed prevention priorities, describe how we are working differently, what impact this is having and what going further looks like. There are obvious opportunities for future action set out, and it is recommended these actions become part of the Telford & Wrekin Place Partnership delivery plan for neighbourhood health and in turn inform the Health & Wellbeing Strategy refresh during 2027.

Helen Onions
Director of Public Health
Telford & Wrekin Council

Acknowledgements

A very big thank you to the working group who have developed this report with me: Louise, Billy, Lauren and John.

We are particularly grateful to the case study contributors inside and outside the Council: Lauren, Jolene, Rachel, Jeni, Steph, Becky, Louise, Diana, Nicky, Lizzie, Wayne and Damion. Thank you for sharing your knowledge, insights and examples of good practice featured throughout this report.

Thank you to those who have been filmed for the videos and the residents who shared their experiences and stories, which help bring this report to life through our case studies.

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Telford and Wrekin FAMILY HUBS

LIVE WELL COMMUNITY HUB

Person centred care and support

mind Telford

Comprehensive delivery of NHS Prevention Programmes

(with inequalities targeting)

NHS

Early detection and treatment for Long Term Conditions

(with inequalities targeting)

FIT4ALL

Focus prevention activities to reduce inequalities

Working across the system to support those in need

Move to Thrive

Get Yourself Active

Recommendations - opportunities for action

The Government's Neighbourhood Health agenda, if fully realised, has the potential to improve health and wellbeing outcomes significantly for our residents so they start well, live well and age well. The prevention work underway across the Borough, which is showcased in this report, demonstrates the impact that information, community support and healthcare offered in neighbourhoods is having on children, young people and adults.

It is recommended that the Health & Wellbeing Board, the NHS Integrated Care Board and Telford & Wrekin Integrated Place Partnership continue to work together on the neighbourhood health agenda and agree an implementation plan, which:

- **ensures prevention work becomes centre stage, alongside the shift of treatment and care out of hospital into community and primary care in neighbourhoods;**
- **scales up prevention programmes in an equitable way, with a focus on those who need it most;**
- **adopts learning from pilot projects and continues and expands the initiatives which are delivering obvious outcomes; and**
- **supports further investment in Voluntary Community and Social Enterprise organisations allowing local prevention programmes to become sustainable.**

Improving Outcomes: Life Expectancy and Healthy Life Expectancy

Key Messages

- Life Expectancy in males in Telford and Wrekin has improved since 2001-03, but most of this improvement occurred during 2000s and early 2010s, after which progress slowed. Similarly for females life expectancy improved in the past two decades, however most of this improvement occurred during the 2000s with progress slowing markedly since 2010.
- Healthy Life Expectancy in males in Telford and Wrekin deteriorated over the last decade, this trend was also seen nationally following the pandemic, but the decline in Telford and Wrekin has been particularly marked. For female healthy life expectancy has generally declined over the past decade.
- Mental wellbeing is an important contributor to healthy life expectancy. Poor wellbeing and mental ill-health are strongly associated with lower levels of self-reported health – a key driver of healthy life expectancy.
- Improving mental wellbeing, alongside preventing and managing long-term conditions and addressing wider determinants of health such as income, education and social circumstances, will all support improvements in healthy life expectancy.

Life expectancy at birth 2023-25

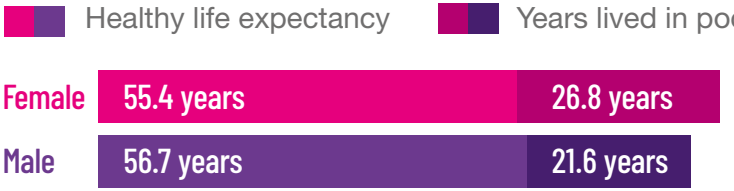
82.4
years in females
England 83.5

78.6
years in males
England 79.7

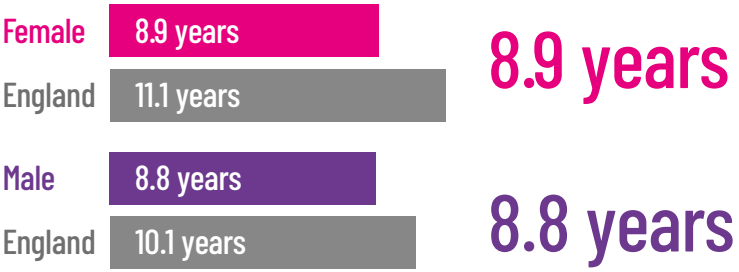
Life expectancy gap by deprivation 2022-24

Inequalities in life expectancy by deprivation within Telford and Wrekin (Slope index of inequality)

Healthy life expectancy and years lived in poor health 2022-24



Healthy life expectancy at 65 2022-24

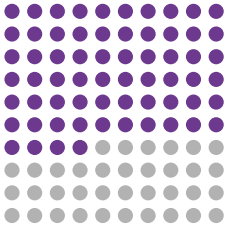


Source: Office for Health Improvement and Disparities: Health of the Region Explorer

Improving Outcomes: Starting well - living well - ageing well

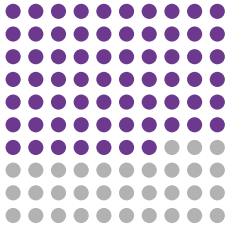
The infographics on this page shows outcomes in Telford and Wrekin across the life course at a glance. The neighbourhood health shift gives the opportunity to improve local outcomes and reduce inequalities throughout resident's lives.

Children achieving a good level of development at 2-2.5 years 2024/25



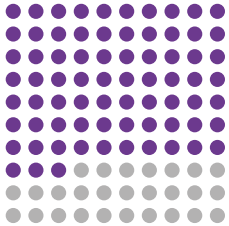
64%

Children achieving a good level of development at 5 years 2024/25



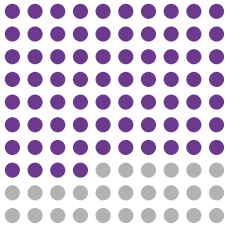
67%

Bowel screening coverage 2025



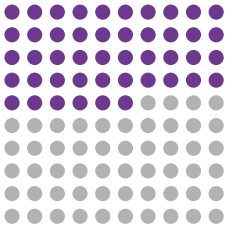
73%

Breast screening coverage 2025



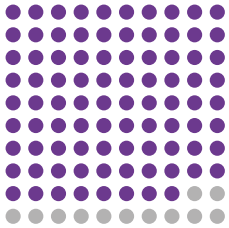
74%

Vaccination coverage: Flu (primary school aged children) 2024



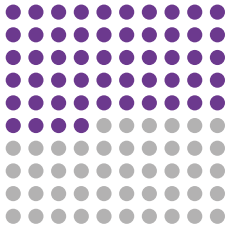
46%

Vaccination coverage: Measles, Mumps and Rubella 2024/25



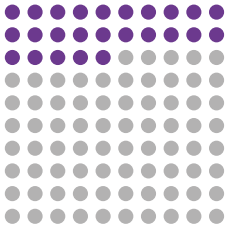
88%

Cancers diagnosed early 2022



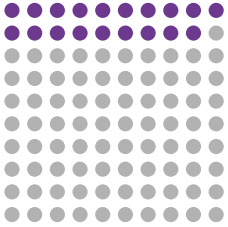
54%

NHS health checks received (40-74 year olds) 2021/22-2025/26



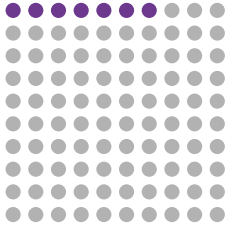
25%

High anxiety prevalence 2022/23



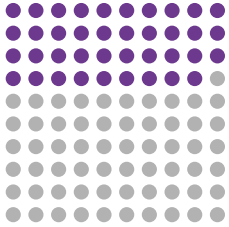
19%

Low happiness prevalence 2022/23



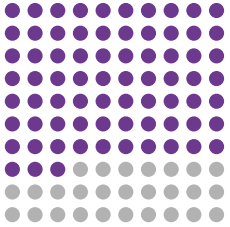
7%

Vaccination coverage: Flu (at risk adults) 2022



39%

Vaccination coverage: Flu (aged 65 and over) 2024/25



73%

Further information on health and wellbeing outcomes in the borough can be found at Telford & Wrekin Council | Telford and Wrekin Insight

Neighbourhood Health National Programme

National Neighbourhood Health Implementation Programme

Moving from treating illness in hospital to developing places which focus on prevention, early intervention and support closer to home.

The NHS 10 Year Health Plan and the 2026 **Neighbourhood Health Framework expect** neighbourhoods to be increasingly recognised as the building blocks of health and care, bringing services together around the needs of local people and communities.

Neighbourhood health is a collective approach across the NHS, local authorities, voluntary and community organisations and local residents. The goal is to create more joined-up, person-centred support, strengthen community resilience, tackle health inequalities and reduce reliance on hospital-based care wherever appropriate.

Voluntary and community organisations and local authorities with the NHS are leaders of Health & Wellbeing Boards and Place Partnership – and are already rooted in communities, working alongside residents and leading the way on prevention. They have a clear understanding of community needs, are able to reach people who may not engage with traditional health services, to reduce loneliness and social isolation, support community resilience and provide practical support and community connections. As well as addressing the wider factors of health such as housing, employment, debt and social inclusion.

Place Partnerships, at local authority level, will be taking on responsibility for planning and improving healthcare for their local populations. Neighbourhood health plans need to be developed under the collective leaderships of the well-established Health & Wellbeing Boards which are hosted by each local authority.

What is Neighbourhood Health?

The Government expects a shift from reactive, hospital-focused care towards prevention, early intervention and support shaped around people, place and community strengths. Neighbourhood health brings services, communities and local partners together to work around the needs of the local population.

Prevention: Supporting people to stay well for longer through early intervention, management of risk factors and action on the wider determinants of health such as housing, employment and social connection.

Personalised Care: Designing support around individual needs, preferences and goals, recognising that people experience health and care differently.

Care Closer to Home: Delivering more services within neighbourhood and community settings, reducing reliance on hospital-based care where appropriate.

Community-Led Approaches: Working with communities as partners, recognising local assets, lived experience and the important role of voluntary and community organisations.

Place-Based: Organising services around the needs of local neighbourhoods, with decisions and resources increasingly shaped by local circumstances and priorities.

Together, these principles support a more preventative, person-centred and community-focused approach to improving health and reducing inequalities.

Healthy Neighbourhoods in Shropshire, Telford and Wrekin

The Telford & Wrekin Place Partnership – TWIPP is steering the delivery of neighbourhood health in the Borough. TWIPP includes partners from:

- local authority children and adults services and public health;
- the four Primary Care Networks;
- NHS leads from the Integrated Care Board (ICB) and the four local hospital and community trusts; and
- our Voluntary and Community Service Alliance.

On a broader footprint the NHS with TWIPP partners are collaborating with Shropshire – the Council and voluntary sector alliance, to develop the Healthy Neighbourhoods programme.

The programme aligns with the approach being taken more widely across Staffordshire and Stoke on Trent to accelerate the shift toward neighbourhood-based models of care that enable earlier intervention and proactive care closer to home to improve patient outcomes.

The development of Integrated Neighbourhood Teams through our Primary Care Networks is the key initial focus. Data on need and demand for healthcare is being used to target prevention and earlier treatment. Four population groups are priorities, and two of those are being worked on in 2026: people living with frailty and people with long-term conditions – such as cardiovascular disease.

Healthy Neighbourhoods vision

> “Working together with our communities to create healthier, happier and well-connected neighbourhoods, where every resident has access to the care, support and opportunities they need to thrive.”

Priority Populations for Neighbourhood Health

Telford & Wrekin Co-operative Council · Telford & Wrekin VCSE Alliance · South East Telford Primary Care Network · Newport & Central Primary Care Network · TEL DOC · NHS The Shrewsbury and Telford Hospital NHS Trust · NHS Shropshire, Telford and Wrekin · NHS Midlands Partnership NHS Foundation Trust · NHS The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust · NHS Shropshire Community Health NHS Trust

Accessible information on healthy lifestyles and self-care

- Healthy Conversations
- Digital Inclusion

What this means for residents

- Having clear, easy-to-understand information about healthy eating, physical activity, sleep, mental wellbeing, smoking cessation, alcohol use and preventing disease.
- Information being available in different formats and languages reflecting diversity so that everyone, including people with disabilities, low literacy or limited digital access can benefit.
- Knowing where to go for help, support and local services when needed.
- Feeling empowered to make informed choices about their health and wellbeing.
- Having the knowledge and skills to manage minor illnesses and long-term health conditions, to stay independent for longer.
- Ensuring everybody can access the same health information and opportunities, regardless of their background or circumstances

Healthy Conversations GP screen advert

Digital Inclusion at Leegomery Community Centre, Live Well Community Hub

Healthy Conversations

Why it is important

The quality and consistency of health information is crucial given widespread disinformation available online. Healthy Conversations programme and branding is being used to reach local residents who are traditionally more difficult to engage in health conversations. The aim is to help residents recognise themselves reflected in the campaign.

How we have been working differently

A communications and marketing-led approach underpins Healthy Conversations. TWIPP collaboration has resulted in a move from generic health messaging, towards the use of imagery of real people in life situations. Vaccination uptake, an area of health inequalities which can be a challenging topic to shift attitudes on was chosen as the first campaign. The campaign directly targeted common vaccine myths and worked to bust them with clear, trusted information, while supporting frontline staff to feel confident having these conversations and to see the difference they can make to resident's lives.

Making an impact

The campaign generated whopping 3,836,830 impressions on social media, with 10,552 clicks, and an engagement rate of 5%. Our top-performing post of the campaign gave residents the opportunity to find out where to get their vaccine, which directly contributed to a strong turnout for jabs at local sessions.

Going further

Healthy Conversations is now a rolling campaign programme from TWIPP. Building on the initial success, Pharmacy First version of the campaign is being developed for the Autumn to improve access and continue breaking down barriers to vaccination.

Digital Inclusion

Why is it important?

Digital inclusion is increasingly important as more services move online and adopt a digital-first approach. Without the access, skills, support and confidence to engage with digital technology, residents may not be able to access information, services and support and experience inequalities

How have we been working differently?

AbilityNet, a UK-based charity and Capgemini tech consultancy, have been working the Council and Voluntary and community organisations to help improve the digital skills of digitally excluded individuals, including disabled adults, older people. Live Well Hubs and community outreach programmes are offering targeted, accessible support sessions, based on intelligence of communities most at risk of digital exclusion. The programme includes accessible digital support and skills courses, NHS App support in GP practices, and outreach to unpaid carers, the deaf community and Age UK groups. Fraud and scam awareness sessions with local banks and building societies and West Midlands Cyber Crime Team are also offered.

Making an impact

Supporting and expanding digital inclusion is helping residents to participate in and benefit from a modern digital society, whatever their circumstances. Our community-based digital support offer has engaged over 800 residents to gain confidence and practical skills to access online services, information and support.

> *"Brilliant support and patience. I have hearing and visual impairment."*

> *"Listens to my query and explains to me how to put right with confidence."*

Going further

A community hub model is being developed to make digital support more accessible through voluntary, community and grassroots organisations, helping to create sustainable local support networks. Devices will be allocated to residents without suitable technology, and the Digital Champions Network will be expanded. Awareness of support and opportunities to build digital skills and confidence will become part of social value initiatives, widening partnership working further.

Digital Inclusion at a Council library

Integrated Neighbourhood Teams and Community Hubs

- Live Well Community Hubs
- Best Start in Life Family Hubs

What this means for residents

- Receiving more joined-up support with GPs, nurses, social workers, pharmacists, mental health practitioners and community organisations working together.
- Finding it easier to access help through a local community hub or single point of contact, rather than navigating multiple services
- Getting support earlier, helping to prevent problems from getting worse and reducing the need for hospital admissions.
- Having care and support that is tailored to their individual needs, strengths and circumstances.
- Better connections to community groups, activities and services that support health, wellbeing and independence.
- Increased focus on prevention, wellbeing and addressing wider factors which affect health, such as housing, employment, social isolation and financial wellbeing.
- Stronger community involvement, with local people helping to shape services and identify solutions to local challenges.

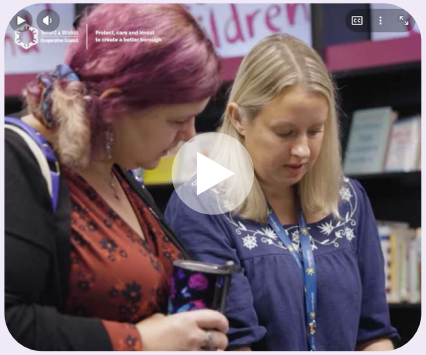
Live Well Community Hub at Hadley Community Centre

Damson Family Hub at Silver Threads Hall, Donnington

Live Well Community Hubs

Why it is important

Community hubs can bring together a range of services working together in a coordinated, integrated way in neighbourhoods. This means residents can access health, wellbeing, social care, financial support and community services in a familiar welcoming space as a one stop shop. Offering drop-in and appointment sessions in well known community venues provides support earlier and prevents issues from escalating.



Click here to watch

How we have been working differently

Live Well Hubs are currently running across the Borough in accessible community venues: Madeley, Sutton Hill, Woodside, Wellington, Donnington, Hadley, Leegomery and Malinslee. Built on the successful first Hub at the Anstice in Madeley, they integrate a wide range of services and support to improve health and wellbeing. Promotion through social media, videos and community storytelling has increased awareness and engagement. Live Hubs continue to evolve through co-production with residents, community groups and local partners, such as Town and Parish Councils.

Making an impact

Residents are receiving more holistic support through a single visit, often engaging with multiple services that they may not otherwise have accessed.

An elderly resident attended the Live Well Community Hub launch after receiving a text invitation from her GP practice. Initially seeking advice from Citizens Advice, discussions identified wider needs, including support for a terminal illness, maintaining independence at home and reducing social isolation. Through the Hub's joined-up approach, she received practical advice from the Independent Living Team on aids and equipment to support her independence in the kitchen. She was referred to a Social Prescriber for additional emotional and community support following multiple bereavements. Our resident was connected to local opportunities to reduce loneliness and an appointment was arranged through her GP surgery for ongoing support.

Going further

The Live Well Community Hub model is continuing to grow through stronger partnerships, greater community engagement and a focus on local needs and health inequalities. Expanding organisations involved, improving referrals and using resident feedback to enhance services, while ongoing platform development and promotion will increase awareness and access to support.

Best Start in Life Family Hubs

Why it is important

Life experiences from pregnancy through the early years shape children's health, development, learning and future opportunities. School readiness is measured by assessing children's level of development at aged 2-2.5 years and at 5 years old. Children with special educational needs and disabilities (SEND) and those who are disadvantaged have lower levels of school readiness. In Telford and Wrekin 67.3% of 5 year olds reached a good level of development in 2025. For 2-2.5 year olds in good level of development was 64.3%, which is lower than the England average.

How we have been working differently

The Telford and Wrekin Best Start in Life Plan sets out an ambitious partnership vision for improving early childhood outcomes. Our eight Best Start Family Hubs, delivered by the council and community and voluntary organisations such as CAB, Families in Telford and HomeStart, offer comprehensive information, advice and support for families across the Borough. Health Visitors have started to offer drop-in clinics for parents and babies from the Family Hubs and these sessions have become increasingly popular with families.

Making an impact

Drop In's are currently offered from 16 different locations across Telford and Wrekin, parents and carers can pop along, with no prior appointment or booking required to meet a Family Hubs Practitioner for support, signposting and advice around:

- Parenting and behaviour support
- Online and community safety
- Information on workshops and courses
- SEND support
- Domestic Abuse support
- Information about groups and support options in families' local communities

Click here to watch

Going further

The Best Start in Life Plan is delivering a range of initiatives to improve services and support for families. To improve joint working across the NHS and children's services a new School Readiness Integrated Neighbourhood Team is being created which will offer extra support, for example for infants with communication and language development challenges.

Damson Family Hub at Silver Threads Hall, Donnington

Person Centred Care and support

- Calm Cafe
- Social Prescribing

What this means for residents

- **Being listened to** and having their views, preferences and goals respected.
- **Having more choice and control** over decisions about their health, care and support.
- **Receiving care tailored to their individual needs,** rather than a one-size-fits-all approach.
- **Being treated as a whole person,** considering physical health, mental wellbeing, social circumstances, culture and personal strengths.
- **Working in partnership with professionals** to develop care plans and make decisions.
- **Receiving coordinated support** so services work together around the individual.
- **Getting help to stay independent** and maintain quality of life for as long as possible.
- **Support for self-care and self-management,** helping people build confidence to manage their own health and wellbeing.

Calm Café

Why it is important

Support in communities that strengthen social connections, reduce isolation and improve access to local assets can improve mental wellbeing. Young adulthood is a key stage for building independence and confidence. Accessible community-based support can strengthen resilience, social connections and self-help skills, helping young people with emotional and mental health challenges thrive and prevent issues from escalating into crisis.

How we have been working differently

The new 18-25 Calm Café has provided a youth-focused, open-access space where support is goal-focused, relationship-based and delivered in the community.

Alongside emotional wellbeing support, young adults can access practical help with housing, finances and other challenges affecting their mental health. Through consistent engagement and trusted relationships, staff can intervene early, prevent escalation and support young people to develop independence and resilience.

Making an impact

> *"For young people like XX, the Calm Café is not optional – it is essential, preventative, youth-focused, and it fills a gap that no other service currently provides."*

Going further

The Calm Café model has had very meaningful impact for young people, as it has for older adults, and these should be further developed and expanded.

Social prescribing

Why it is important

Health is shaped by much more than health care alone. Factors such as loneliness, social isolation, poor housing, financial hardship, unemployment and low confidence can have a significant impact on both physical and mental wellbeing. Social prescribing recognises these wider determinants of health and provides a person-centred approach that helps individuals access practical support, community activities and local services that improve their health and quality of life. Across Telford and Wrekin, social prescribing helps residents address issues that cannot be resolved through clinical interventions alone.

How we have been working differently

Social prescribing services are embedded within Primary Care Networks, enabling closer collaboration between GP practices, voluntary and community organisations, local authority services and wider health partners. In Telford and Wrekin, services are delivered by Telford Mind in South East Telford PCN, Newport and Central PCN, and TELDOC. The approach focuses on understanding what matters to people and connecting them with support relating to mental health, housing, finances, employment, physical activity and community participation.

Making an impact

Through personalised support, our Social Prescribers are helping people identify solutions, build confidence and connect with community resources that support long-term wellbeing.

Rebuilding Confidence After Bereavement: Following the loss of a loved one, linking with our Social Prescribing support, allowed a service user to connect with local wellbeing and community groups, helping them rebuild confidence, develop new social connections and improve their wellbeing.

Tackling Financial Stress: A resident experiencing anxiety due to debt and financial difficulties was supported to access specialist financial advice services. With practical support in place, they reduced financial stress, felt more in control and were better able to focus on their health and wellbeing.

Supporting a Return to Community Life: Our Social Prescribing service helped a resident with a long-term health condition who had become isolated and lacked confidence to engage in community activities. Through personalised support, they were connected to local groups and are now attending regularly with increased confidence and independence.

Going further

Social prescribing will continue to support residents facing challenges such as loneliness, financial hardship and poor wellbeing. We will strengthen links between primary care, community organisations and local services to help more people access timely, personalised support that improves health, wellbeing and independence.

NHS prevention programmes

- Lung Cancer Screening
- Winter flu vaccination

What this means for residents

- **Support to stay healthy and well for longer,** rather than only receiving treatment when unwell.
- **Access to vaccinations and immunisations** to protect against serious diseases.
- **Screening programmes** that help identify conditions like cancer or cardiovascular disease at an early stage.
- **Health checks and risk assessments** to detect potential health problems before they become more serious.
- **Support to adopt healthier lifestyles,** including help with stopping smoking, healthy eating, physical activity and maintaining a healthy weight.
- **Earlier intervention** to reduce the risk of developing long-term conditions such as diabetes, heart disease and respiratory illnesses.
- **Improved wellbeing and independence,** helping people remain active and connected to their communities.
- **Reduced health inequalities,** by targeting support to those most at risk of poor health outcomes.

Lung Cancer Screening and Smoking

Lung Cancer Screening

Why it is important

Quitting smoking at any age reduces the risk of smoking related illness or mortality and has both physical and mental health benefits. The NHS Lung Cancer Screening Programme offers lung health checks to people aged 55-74 with a history of smoking, helping identify lung cancer and other conditions earlier when treatment is often more effective.

How we have been working differently

With nine specialist Stop Smoking advisors, the team has more than doubled in size, with over 1000 referrals to the service over the last six months, and around half choosing to engage with stop smoking support.

Through close partnership working with NHS colleagues, primary care, acute services and community pharmacies, we've developed an integrated referral and nicotine replacement therapy (NRT) pathway, ensuring people receive timely, personalised support to quit smoking, including those who are housebound or face barriers to accessing services.

Click here to watch

Making an impact

Between January and July 2026, 549 people accessed Telford & Wrekin's Stop Smoking Service following a lung health check, with almost half successfully quitting smoking after four weeks. More than 1,000 people referred through the screening programme were contacted by the Stop Smoking Service in the first six months, with around half choosing to engage with support.

> *"Quitting together made it much easier than we ever thought it would be. The Lung Cancer Screening Programme gave us the push we needed, and the stop smoking support helped us stay on track. We both feel healthier, have more energy, are breathing better, and have more money in our pockets. Most importantly, we would not have done it without the help."*

Going further

We'll continue to strengthen partnerships across health and care services to support Telford and Wrekin's smoke free ambition. Alongside personalised behavioural support and access to evidence-based quit aids, we'll explore additional treatment pathways and improve access to support for groups at greatest risk of smoking-related harm and health inequalities.

Winter flu vaccination

Why it is important

Flu vaccination for people in certain age groups and with health conditions reduces the risk of serious illness and disruption in nurseries, schools and workplaces, as well as reducing pressure on NHS health services at a critical time of year.

How we have been working differently

To increase uptake of the flu vaccine in key groups ahead of families mixing at Christmas, the Council's Health Protection Team commissioned a local pharmacist to deliver flu vaccinations in two nurseries and a community centre. This required new dedicated work from partners across TWIPP.

Locations were selected to improve access for our most underserved communities, using working relationships developed during the pandemic. The locations, timings and the walk-in nature of the clinics was designed to make them as accessible as possible to people.

The clinics were arranged, advertised and promoted using established community relationships with schools, early years settings care homes, this built on the Healthy Conversations and vaccination education work.

Making an impact

This neighbourhood inequalities initiative aimed to improved access to vaccines in community settings outside of traditional NHS clinics. Provisional data for 2025/26 across the whole NHS flu programme shows vaccination coverage improved across all target groups in Telford and Wrekin compared to last year.

First community clinic at the Park Lane Centre in Woodside

Going further

The intention is to develop this work further over the upcoming flu season, using the experience gained to start earlier and reach a wider audience, all with a focus on reducing the impact of inequalities.

Focused prevention to reduce inequalities

- Get Yourself Active
- Move to Thrive
- Childhood immunisation

What this means for residents

- **Extra support for people and communities who face the greatest disadvantage** and health challenges, whatever the reason.
- **Earlier help to prevent illness,** especially for those at higher risk of poor health.
- **Improved access to services,** ensuring people can get the care, advice and support they need regardless of where they live or their circumstances.
- **Targeted programmes** such as smoking cessation, weight management, vaccination, screening and mental wellbeing support for those who would benefit most.
- **Reducing unfair differences in health outcomes** between different communities and population groups.
- **Helping everyone have the same opportunity to live a long, healthy life.**

Move to Thrive

Get Yourself Active

Why it is important

Being active can support physical health, mental wellbeing, independence and social connection. Yet opportunities to move are not always equally accessible for Disabled people.

How we have been working differently

Get Yourself Active Local brings together Disability Rights UK, the Energize partnership, the council and VCSE organisations with carers and people with experience of disability to create a more inclusive environment where movement is considered part of everyday support and wellbeing, rather than an optional extra. Rather than standalone initiatives, a collaborative approach has developed across three strands:

- **Training health and social care workers** to confidently encourage movement;
- **Embedding physical activity** into everyday social work practice through Moving Social Work training;
- **Co-production** working directly with disabled people to shape activities and provider offers.

Making an impact

This collaborative approach through TWIPP is helping more people to be active in ways that suit their individual needs and preferences.

- 123 Social work professionals trained in Telford and Wrekin, with strong leadership buy-in helping embed learning into everyday practice.
- Co-production training has reached 16 physical activity providers, with 24 more registered across Shropshire Telford and Wrekin.

> *"It's been a privilege to work with Disability Rights UK, our local partners, and people with lived experience to explore how we can shift the narrative around movement. This requires all of us to work together to build a system where movement can be embedded into the way we live, work, and deliver services."*
>
> **Michelle Pullen, Communities, Health and Social Care Programme Manager, Energize STW**

Going further

By continuing to bring together councils, VCSE organisations, health and social care professionals, activity providers and people with lived experience, partners are sharing learning, building understanding and maintaining momentum towards a common goal: creating more opportunities for disabled people to be active in ways that suit them.

The Council is continuing to actively seek new products, initiatives and other ways to support and encourage inactive residents to access our leisure facilities and green spaces, including with Energize and partners as part of the Sport England Place Expansion Programme.

Get Yourself Active session

Move to Thrive

Why it is important

People living with dementia and their carers can benefit greatly from opportunities to stay active, connected and engaged within their communities. However, some residents, particularly those who are housebound or living with early onset dementia, can face additional barriers to accessing suitable support and activities.

How we have been working differently

Move to Thrive, funded by the National Lottery Community Fund, provides research-based, person-centred physical activity opportunities that support wellbeing, maintain independence and help people continue doing the things that matter to them.

Age UK Shropshire Telford & Wrekin, the Alzheimer's Society, Community Resource, Adult Social Care and other local organisations have been working together to delivers twice-weekly community sessions alongside tailored support for residents who are unable to attend group activities. There is an at-home service for housebound residents and one-to-one support for people with early onset dementia, developed in response to feedback from participants and partners. Support workers and trained volunteers help people access sessions and remain connected to local opportunities.

Move to Thrive session

Making an impact

In year one:

- 102 group sessions delivered, averaging 6.4 people living with dementia per session (437 attendances in total).
- Three tailored at-home movement sessions delivered for housebound residents.
- A 10-week one-to-one programme delivered for a person living with early onset dementia.
- 12 training courses reaching 104 professionals, volunteers and carers.
- A before-and-after mood survey showed positive improvements across all measured areas, particularly confidence, self-esteem and overall wellbeing.

> *"Since coming on a Tuesday, [Stan] has grown in confidence and made friends... I am worried that if the sessions stop he will become a bit of a recluse again."*
>
> **Pat, whose husband Stan attends with early-stage Parkinson's**

Going further

Building on the success of its first year, Move to Thrive is continuing to develop dementia-friendly physical activity opportunities across the Borough. Love to Move instructors, including trained volunteers will extend the offer, so more people will stay active, connected and independent.

Childhood immunisation

Why it is important

Vaccination is a key prevention initiative and inequalities are often caused by vaccine hesitancy which includes:

- **Confidence:** Level of trust in vaccine and healthcare professionals
- **Complacency:** Perceived lack of need or value for vaccine
- **Convenience:** Barriers to accessing appointments

Working within our communities and building relationships, using clear messaging, and training health care colleagues to improve the way they communicate about vaccination can all improve vaccine uptake.

How we have been working differently

A targeted project has been designed to increase MMR and HPV vaccination uptake in young people, where levels of uptake are lower in our most underserved and disadvantaged communities.

Every professional and volunteer that parents encounter is confident to discuss vaccines. We visited schools and community groups to educate then offer a vaccination opportunity.

We worked closely with our school aged immunisation partners, education colleagues, family hub colleagues, local cancer prevention charity Lingen Davies, community and faith leaders.

We have listened to our young people, teachers and community leaders facilitating education sessions and postcode specific Facebook promotion with information in formats that are accessible. The project has been given longevity through the Making Every Contact Count principle building confidence in professionals to have healthy conversations and work in partnership.

Click here to watch

Making an impact

So far 38 targeted education sessions have taken place communicating with over 3,000+ students, 250 professional interactions, and over 130 direct family conversations, with 75 immunisations given.

> *Thank you for an engaging and expertly presented assembly. We really valued your time, enthusiasm and expertise.*
>
> **Head of Year 8, Telford Langley School**

Going further

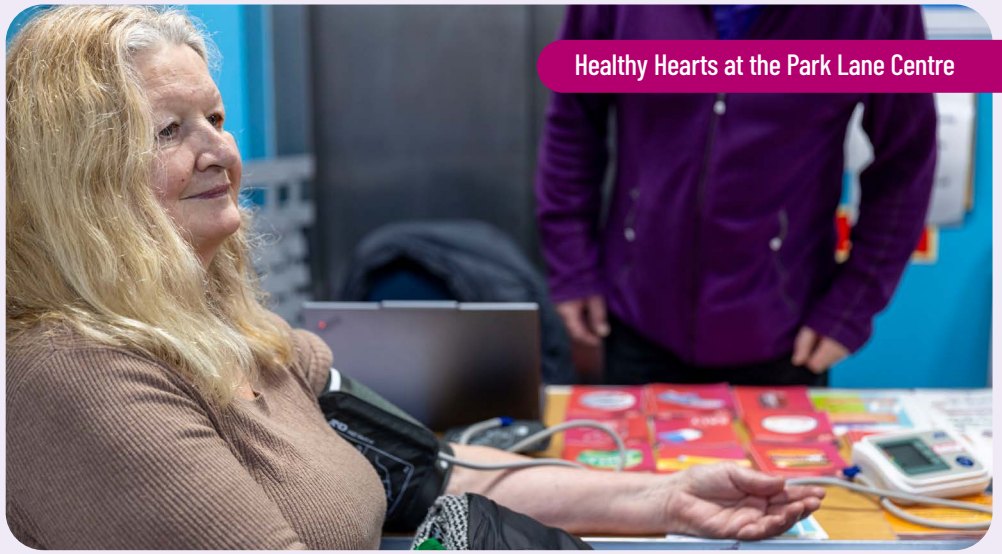
An ongoing partnership programme is being developed to sustain this important initiative. Reaching the needs and preferences of underserved communities will allow information to be shared in formats and language they relate to, from trusted voices. Students in one school alone spans 43 languages, so we are co-producing visual and easy-read resources with Year 8 and sixth form students to close this gap.

Early detection and treatment of Long Term Conditions

- Falls Prevention
- Healthy Hearts

What this means for residents

- **Identifying their health problems sooner,** often before symptoms become severe.
- **Quicker access to tests, diagnosis and treatment,** helping to prevent conditions from worsening.
- **Better health outcomes,** as many conditions can be managed more effectively when found early.
- **More support to stay independent and maintain quality of life.**
- **Reducing the risk of complications,** hospital admissions and avoidable ill health.
- **Helping people live well with long-term conditions** through ongoing care and support.



Healthy Hearts at the Park Lane Centre

Healthy Hearts at the Park Lane Centre

Falls prevention

Why it is important

As the Borough ages, falls are a leading cause of injury, hospital admission and loss of independence for older adults. Across Shropshire, Telford and Wrekin, more than 18,300 people attended hospital following a fall in the last six months. Falls can have a significant impact on confidence, mobility and wellbeing, often increasing the need for health and social care support.

Integrated working can help across residents stay active, independent and connected through falls prevention and strength and balance programmes.

How we have been working differently

Public Health, Adult Social Care, Primary Care, Community Services and wider health partners have been using local intelligence. In partnership we've expanded falls prevention support to provide accessible, person-centred options for residents across community and care settings.

- **Fit4all:** Our established falls prevention programme, taking a hybrid approach to engage residents in both community and care settings.
- **Moving On:** Community classes are helping residents to continue exercising after Fit4all, supporting long-term physical activity and independence.
- **Broader access:** Weekly online exercise sessions for care homes and extra care settings are now being offered so residents unable to attend community venues can access falls prevention.

Making an impact

Our falls prevention offer is growing fast, with over 3,500 attendances this year, up 1,502 on last year. Community Moving On classes and Digital Online sessions are helping residents like rebuild strength, confidence and independence, while over 1,100 digital attendances reached our most frail residents in care homes.

> *"C would fall quite regularly, almost weekly. C now has had only a few falls over the last six months and has told me that he feels stronger."*

Going further

A Falls Prevention Pathway, which matches individuals to the right support is being developed, including a digital at-home offer, and physical activity conversations are being embedded into routine assessments to identify support earlier. An infra-red thermal imaging pilot project in care homes, which detects falls and provides insights around an individual's behaviours and habits to prevent falls has reduced conveyances to hospital by over 80%, and the use of the technology is being extended for a further 12 months.

Fit4All session

Healthy Hearts

Why it is important

South East Telford includes neighbourhoods in the most deprived 10% nationally and rates of life expectancy are lower. The Healthy Hearts Pilot, developed with South East Telford Primary Care Network, brought preventative health services directly into communities to support earlier identification of cardiovascular risk. Almost one in four residents receiving an NHS Health Check were found to have an elevated risk of developing cardiovascular disease, showing the value of reaching residents who may not otherwise engage with preventative healthcare.

How we have been working differently

Using dedicated outreach buses, Healthy Hearts brought NHS Health Checks delivered by GP practices and the Council Healthy Lifestyles Service alongside community organisations into places where residents live and socialise. It focused on building relationships with men and communities experiencing higher disadvantage, offering health checks at community events to make access feel welcoming rather than too health-focussed or clinical.

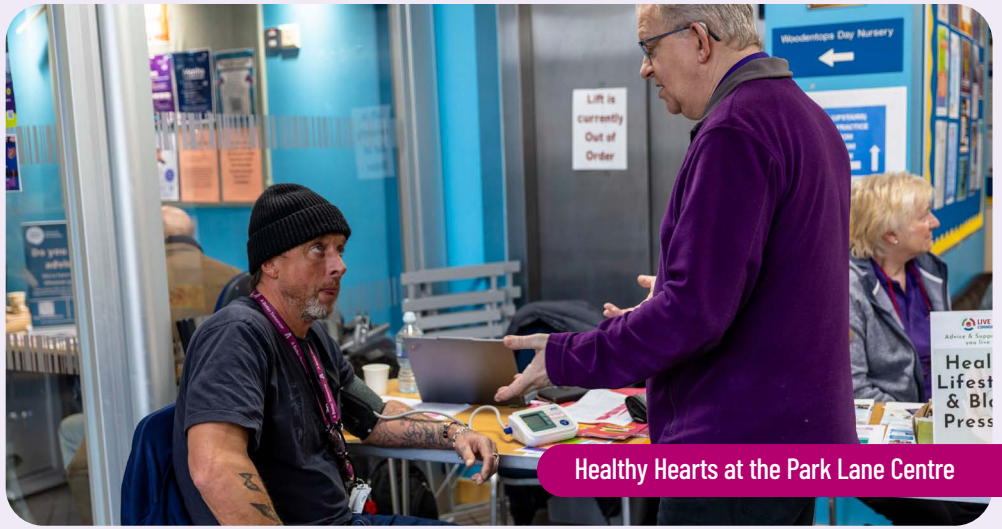
Making an impact

The pilot delivered 283 NHS Health Checks and 369 additional Blood Pressure and Mini Health Checks, through 78 community events across 16 locations. 24% of participants had a QRisk score of 10% or above, enabling earlier intervention. Promotion reached over 137,000 residents, and 26% of participants accessed the service simply by passing the bus.

> *"I would not have booked a GP appointment myself and only attended because I saw the bus advertised on Facebook."*

Going further

Learning from the Healthy Hearts is shaping future cardiovascular prevention and outreach work, focused on extending neighbourhood engagement with men and minority ethnic communities, strengthening referral pathways into Healthy Lifestyle Services, and adopting a blended drop-in and appointment model to reduce inequalities across the Borough.



Healthy Hearts at the Park Lane Centre