Partnerships and communities

Score: 3

3 - Evidence shows a good standard

What people expect

I have care and support that is coordinated, and everyone works well together and with me.

The local authority commitment

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

Telford and Wrekin had strong partnership working links with health partners, neighbouring authorities, the voluntary and community sector, and regional organisations to ensure strategic and operational plans met national and local objectives. Senior leaders told us how national and regional objectives, concerns, and areas of best practice were shared through membership and joint working with multiple cross-boundary boards and committees. These included the Association of Directors of Adult Social Services (ADASS), the West Midlands ADASS Executive Council, learning from the lives and deaths of people with a learning disability and autistic people (LeDeR), and a number of sector specialist forums and professional associations.

Partnership-working priorities and funding arrangements were agreed through the Strategic Commissioning Board and TWIPP, with oversight from the ICS board and the Health and Wellbeing Board, to ensure strategies aligned across partners, with clear lines of accountability and arrangements for oversight. Staff and leaders told us of good working relationships with health and community partners to ensure the best outcomes for people using services.

The local authority had a number of shared partnership boards with key priorities and strategic focus. For example, the jointly funded Autism Partnership Board had recently been looking at leisure facilities to improve accessibility, and the Learning Disability Partnership Board had been looking at access to paid employment opportunities. People told us how paid employment opportunities were limited at present, with voluntary employment through local cafes being supported by the voluntary and community sector.

Staff told us working relationships between health partners and the local authority had not always been effective across the board. Public concerns with the hospitals and disputes about budgets had been detrimental to the prevention agenda, which meant primary care services were overwhelmed. Governance arrangements and improved engagement in partnership boards had started to address this, improving people's experiences of hospital discharge.

Feedback from partners was positive; they told us of close working arrangements, genuine representation on multiple partnership boards, and the inclusion of people with lived experience in decision making. We saw multiple examples of sharing information and data to monitor shared priorities in areas such as hospital discharge and admission avoidance. Staff told us of safeguarding links between the local authority, health, police, and housing to support effective hospital discharges, with multi-agency discharge events looking at delayed discharges and reviewing the barriers to these. The local authority had integrated its care and support functions with health partners to support preventative services in primary care and reduce the need for inappropriate accident and emergency visits, for example, through improving access to GP surgeries.

People told us partnership working had positive impacts form them. For example, jointly commissioned mental health 'crisis crash pads' where people could take themselves to, or be supported to go to by the police, avoided more formal support under the Mental Health Act 1983. They also told us of mental health social workers who worked outside of office hours in the calm café to support people to make management plans and consider how to support themselves, ensuring a person-centred approach to managing their own care needs.

Hospital discharge pathways were supported by TICAT and included Adult Social Care staff based in hospitals to support service provision upon discharge. People's experiences of joint hospital discharge pathways were positive and showed good levels of multi-disciplinary working to promote outcomes for people.

Health partners stated good working relationship helped to support operational challenges during occasions of peak demand. All partners showed a real willingness to engage and to ensure integration around Adult Social Care and the voluntary and community sector. Discharge pathways had been streamlined, and an accelerated neighbourhood approach using community resources to support admission avoidance and proactive care, were having clear positive impacts on local health services.

Partners told us there was a strong joint support offer for unpaid carers. This included the carers champion scheme within GP surgeries, information on notice boards in GP surgeries, coproduction of carer friendly employer offers, the new All-Age Carers strategy, and Carers Network, as well as engagement in the Modern-day Partnership Board.

Arrangements to support effective partnership working

The local authority ensured there were clear arrangements for quality assurance monitoring, information sharing, and accountability through effective use of the partnership board governance arrangements. The ICS, ICB and ICP linked into the Strategic Commissioning Board and TWIPP to enable oversight and scrutiny of all joint strategic decisions. The Health and Wellbeing Board, and the TWSP Board provided data to enable informed choices and the Focused Partnership Boards ensured strategic implementation. Whilst there is no official ICS Director of Place, the role was split with a Director of Strategy and a Director of Operations. Both roles worked jointly with the local authority via TWIPP to support a place-based approach to service provision.

The TWIPP strategic plan (2022-2025) identified 5 key priorities: Population health; prevention and early intervention; integrated response to inequalities; working together stronger; primary care integration. The plan set out how these priorities would be achieved and identified clear roles and responsibilities across partners. For example, the Wellbeing and Independence Partnership was a collaboration with voluntary and community organisations providing a first point of contact for Adult Social Care enquiries, giving information and advice to people who were not known to statutory services. Shropshire, Telford, and Wrekin partners in care represented independent care and support providers, giving them a voice on partnership boards and across the integrated care system.

The local authority used opportunities to pool budgets and jointly fund services with partners to achieve better outcomes. BCF contributions through Section 75 agreements were used to build community resilience by supporting unpaid carers, providing independent advocacy services, and recruiting volunteers and befrienders. The need for more complex support was reduced through the provision of equipment, assistive technologies and sensory aids. Care Navigators (based within GP surgeries), unpaid carers support (available through hospital drop-in sessions), and the provision of healthy lifestyle advisors and social prescribers were employed to work with local community services such as community centres, libraries, and leisure centres.

BCF contributions were used to support urgent care needs: TICAT supported discharge planning; enablement therapists supported frontline social work teams; and discharge pathway 1 supported personal care needs. Occupational therapy supported the Planned Overnight Care team, and Rapid Response teams supported admission avoidance. However, data provided by the BCF Board (which reported to the Health and Wellbeing Board via TWIPP) showed demand for these services was outstripping expected use, leading to strained budgets and gaps in funding. Plans to address these funding shortfalls included a review of complex discharge pathways and promotion of pathway 0 and 1 (less-complex cases and 'home-first' approaches), as well as the introduction of an Accelerated Discharge programme and improved use of Virtual Wards (using smart hubs and a device called 'Ethel'). This work was part of the ICS's 'Urgent Care Programme' to improve discharge performance.

Impact of partnership working

Partnership working was monitored and evaluated by the local authority and partners to identify areas of positive impact and inform ongoing development and continuous improvement opportunities. People with lived experience, as well as independent board members, formed part of the monitoring and scrutiny process, and boards reported data and insight to TWIPP, giving feedback on the outcomes and the experience of people using services. For example, feedback from the Telford and Wrekin Safeguarding Partnership (TWSP) Board had led to training for accident and emergency staff in identifying self-neglect linked to mental health and dementia, enabling earlier intervention and improved outcomes for people affected by hoarding.

Partners, staff, and leaders told us about the rollout of digitalised care monitoring systems (devices and systems using technology to monitor people's needs and risks to support their independence), funded by NHS England, to support the transition from paper-based to digitalised records and care plans across the borough and neighbouring local authorities. The initiative was aimed at reducing waste and improving the security and accuracy of personal information records. Telford and Wrekin have a 91% compliance rate, compared to the target of 80% nationally by the end of 2025.

Mental health partners spoke about the local authority being supportive and easy to work with and people told us least restrictive options were always explored. For example, people described staggered discharges back into the community, supported by multi-disciplinary agencies, enabling people to return home successfully. Partners described how changes to local autism services diagnostic pathways meant people could be assessed more locally, reducing cancellations, and ensuring people got the right support and access to services.

Health partners told us about a jointly funded hydration and nutrition project, working with service providers to raise awareness of the signs of poor nutrition and hydration, and the importance of safe, effective support in this area. This work had reduced people going into hospital with urinary-tract infections. Other partners told us of joint working with the police and probation services to create a Domestic Abuse Local Partnership Board supporting survivors of domestic abuse and looking at ways to reduce the prevalence and impact.

People described how improved links with housing, the voluntary and community sector, and Public Health was improving outcomes for autistic people at risk of homelessness. Awareness sessions with links into the learning disability community team, physiotherapists, and speech and language therapists, were giving services more confidence in recognising people in need. Other people told us how the local authority was tackling the impacts of deprivation and cost of living by providing essential kitchen equipment, food, and clothing.

Working with voluntary and charity sector groups

Telford and Wrekin worked collaboratively with voluntary and community organisations to understand and meet local social care needs. The local authority provided funding, and other support opportunities, to encourage growth and innovation. The local authority used a joint population health management approach, working across the borough, NHS Shropshire, Telford, and Wrekin, to identify areas of support need by comprehensive community engagement, coproduction, and use of local, regional, and national data.

Staff and leaders told us one of the strongest areas of joint working with voluntary and community organisations was within mental health support; alliance agreements brought partners together to discuss cases of complex mental health needs. This ensured the voluntary sector were not left holding the risk and support was shared equally across all services to get the best outcomes for the person. Calm Cafés were delivered in partnership between Telford Mind and Telford & Wrekin's mental health social work team. A specific Calm Café had also been set up for Armed Forces Personnel and veterans. People told us the cafés had become very well regarded in the local area and recognised as being a notable example of place-based preventative support, with up to 300 people attending each month.

Whilst some voluntary and community organisations highlighted improvements needed around sharing of personal information, feedback was mostly positive, with clear examples of genuine coproductive working arrangements, communication and interaction with senior leaders, and opportunities for people with lived experience to influence service changes. For example, faith groups worked closely with Ghanian, Afghan and Syrian communities.
