Telford & Wrekin Co-operative Council

Protect, care and invest to create a better borough

Adult Social Care Prevention Strategy

2026/27

Introduction

Welcome to Telford & Wrekin Council's Adult Social Care Prevention Strategy. This strategy sets out our approach to working with our internal and external partners to manage our demand through a preventative approach to care.

In its broadest sense, prevention is action to maximise wellbeing, independence, and social inclusion so that people can live valued lives in their community. From an Adult Social Care perspective, Skills for Care (2019) have defined prevention as:

- Supporting people to live as healthily as possible, both mentally and physically.
- Reducing the use of health services, including primary care, emergency services, and hospitals.
- Preventing or reducing the escalation of health issues.
- Supporting people to remain as independent as possible.

Our aim is to promote well-being for all residents of Telford & Wrekin regardless of their care and support needs, to achieve the best outcomes for individuals, their families and unpaid carers. Effective prevention reduces and delays the need for support, therefore enabling the Council and our partners to focus resources on those with the most need.

In summary, our preventative approach focuses on enabling people to live and age as independently and well as possible. Through our preventative work, we aim to help people to have choice, control and support to live the life they want to lead.

Clare Hall-Salter
Interim Director: Adult Social Care

Councillor Paul Watling - Cabinet Member for Adult Care & Independent Living

Our Vision, Priorities, and Values

Our Adult Social Care vision is based on Telford & Wrekin Council's vision to **'Protect, Care, and Invest to create a better borough'.**

Adult Social Care Vision:

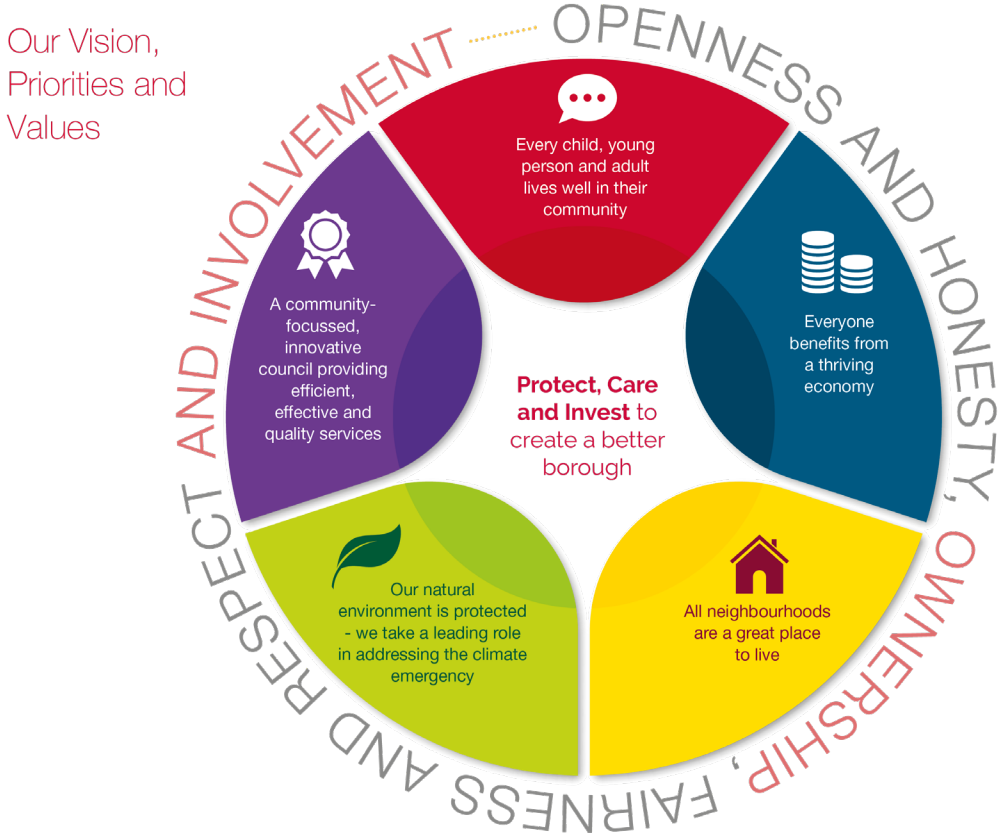
Working together with people, key partners and communities to enable people to live well and independently in Telford and Wrekin.

To achieve our vision, our work is also underpinned by the Council's priorities (see Figure 1), particularly 'every child, young person and adult lives well in their community', which aligns with Adult Social Care's key priorities to:

- Provide early information and advice so people can help themselves and make informed choices.
- Enable people to live independently in their own homes for as long as possible.
- Work with people, communities and partners to deliver better outcomes.

The Council's co-operative values (see Figure 1) provide the framework for how care and support is designed and delivered in Telford & Wrekin. We believe that how we do things is just as important as what we do, and our values form the basis of the Council's relationship with residents and partners.

Figure 1 – Council Priorities and Values



Our Strategic Context

To determine our priorities for this strategy, we have considered a wide range of internal and external data sources, such as Adult Social Care activity and performance data, the Joint Strategic Needs Assessment, census data, and feedback from people and partners.

We have also drawn on insights from the *Making Prevention Real* diagnostic review of Telford and Wrekin Adult Social Care, carried out in 2024/25. This review aimed to build on existing prevention approaches by identifying opportunities to further enhance independence and improve outcomes for people. Its findings were informed by a broad evidence base, including case reviews, analysis of care and support arrangements, staff workshops, and engagement with experts by experience and key partners.

This Prevention Strategy also takes account of our assessment by the Care Quality Commission (CQC) in 2024. We achieved a 'Good' rating from CQC, and the feedback from their assessment helped us to identify our strengths and areas for further focus.

Alongside this, the strategy has been informed by national and local policy.

National drivers for increasing prevention work include:

- Care Act 2014
- NHS 10-year Health Plan NHS England » Fit for the Future: 10 Year Health Plan for England
- The Marmot Review 2010 and Marmot Review 10 Years On

Our local partnership strategic frameworks and plans include:

- Telford & Wrekin Adult Social Care Strategic Plan
- Telford & Wrekin Safeguarding Adults Board Strategic Plan Safeguarding Adults Board Living Strategic Board 2024-2027
- Telford & Wrekin Ageing Well Strategy Celebrating later life in Telford and Wrekin
- Telford & Wrekin Carers Strategy all_age_carers_strategy_2024_2029_supporting_carers_in_telford_and_wrekin.pdf
- Telford & Wrekin Health and Wellbeing Strategy Health & Wellbeing Strategy 2023–2027
- NHS Shropshire Telford & Wrekin Integrated Care Strategy and Joint Forward Plan
- Telford & Wrekin Integrated Place Partnership (TWIPP) Neighbourhood Health Implementation Plan

Our Population

THERE ARE 195,952
people living in Telford and Wrekin

4th LARGEST
increase in aged 65+ population.

More than
1 in 5
of the population in Telford and Wrekin are disabled

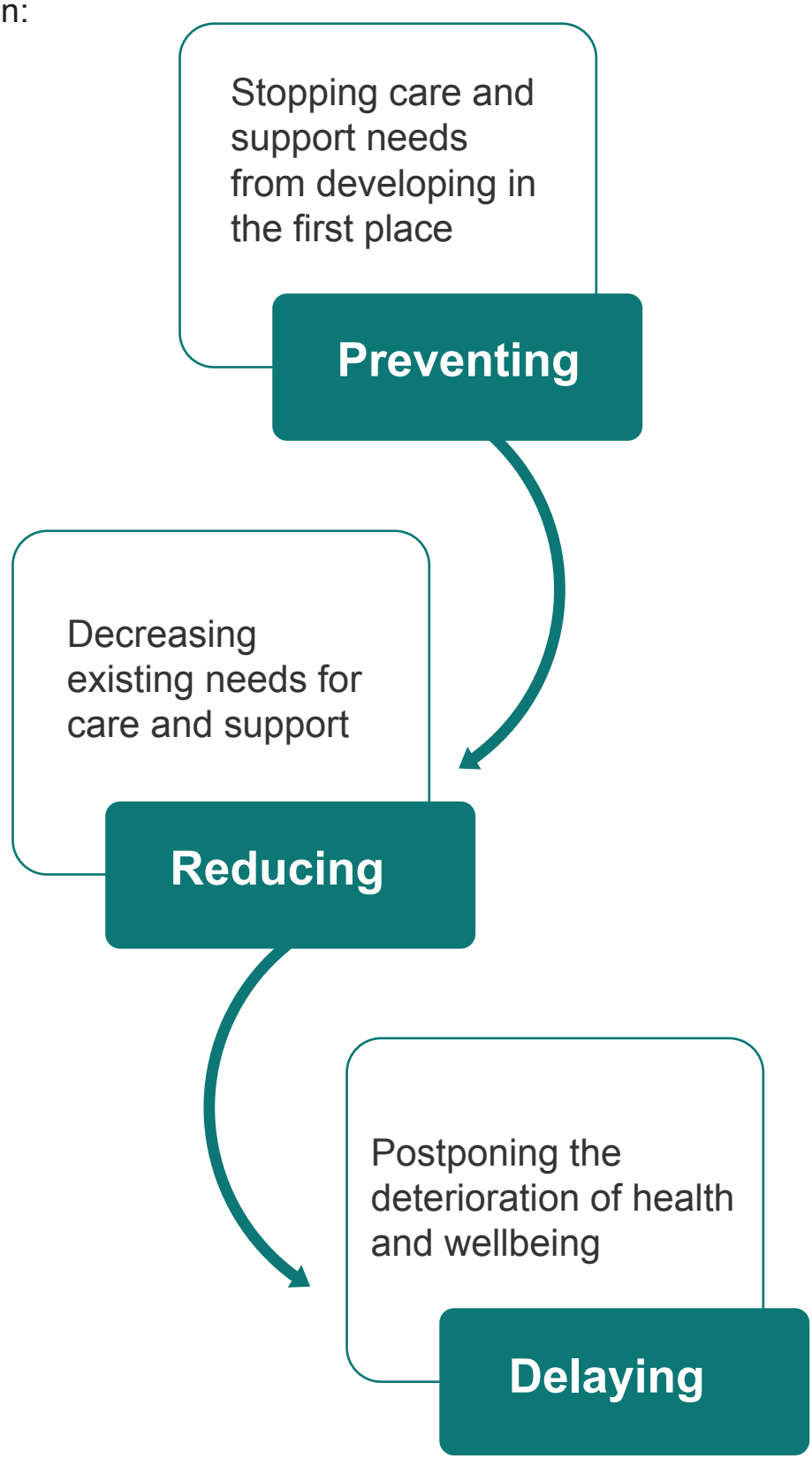
24%
of Telford and Wrekin population live in areas that are within the most deprived 20% areas nationally

The gap in life expectancy between our least and most deprived neighbourhoods is
8.7 years for women
and
9.6 years for men

At the end of March 2026,
2,130
people were receiving long-term care and support

Preventative Services – Our Statutory Duties

The Care Act 2014 states that councils should focus on three core areas of prevention:



We also have a duty to provide information and advice relating to care and support, including how to access services and how to raise concerns about the safety or wellbeing of a person with care needs. This strategy aligns with these statutory duties.

Making Prevention Real

Our Prevention Programme

To ensure that prevention is embedded across a person's care journey, we have developed a Making Prevention Real (MPR) programme, which focuses on three priority strategic outcomes:

- **Priority Outcome 1: Strengthening Prevention to Reduce Front Door Demand** Intervening earlier for those not currently supported, to prevent, reduce or delay their need for Adult Social Care.
- **Priority Outcome 2: Reducing and Delaying the Need for Long-term Care and Support**
  Using short-term enablement and independence-focused assessments to reduce and delay the need for long-term support.
- **Priority Outcome 3: Preventing Escalation in Long-term Care Demand**
  Supporting those already receiving long-term care to remain as independent as possible and minimise escalation.

Our prevention programme links directly to our Adult Social Care (ASC) vision and priorities (see Section 2) and supports the Care Act requirements for us to 'prevent, reduce and delay ', as described in Section 5. The programme also supports our Safeguarding Adults Board's strategic plan, which includes a focus on prevention linked to Making Safeguarding Personal principles.

Our MPR programme is underpinned by **four core principles:**

Person-centred and empowering practice

Recognise the unique needs, strengths and circumstances of each individual and empowering people with the knowledge, skills, and resources to make informed decisions about their own well-being.

Early intervention

Identifying risks and potential issues early allows for timely interventions that can prevent longer-term needs.

Collaboration

A co-produced approach, working with people, unpaid carers, VCSE groups, providers, partners, and other internal teams, such as Children's Safeguarding, Housing and Public Health to ensure a joined up, systematic approach to prevention.

Holistic approach

Prevention that addresses a wide range of factors influencing people's lives, including physical, mental, social, and economic aspects.

Priority Outcome 1

Strengthening Prevention to Reduce Front Door Demand

What we aim to do:

- Provide timely, accessible and needs-based information, advice and guidance (IAG) to enable people and their unpaid carers to help themselves and make informed choices about how to live well, stay safe, and remain independent, ensuring that IAG is up to date, comprehensive, easy to navigate and inclusive for all.
- Use local relationships and commissioned VCSE services to connect people and unpaid carers to support available in the community.
- Increase awareness and education about the importance of good physical health and mental wellbeing, and ensure residents have access to a broad \ range of universal activities to support good physical and mental health.
- Provide a clear front door for Adult Social Care services and ensure that people, unpaid carers, and professionals know how to access support and raise safeguarding concerns.

What is already being delivered:

Live Well Telford	An online community directory that provides self-service information on a wide range of services, activities and organisations in Telford & Wrekin, to help everyone find the support they need to live healthy independent lives.
Independent Living Centre (ILC)	Located in Telford Town Centre, the ILC provides information and advice on equipment, assistive technology and other ideas to help people live independently at home. In addition, the ILC hosts regular drop-ins that anyone can access, for example for people with sensory impairments or adults with a learning disability, as well as the **Telford Autism Hub.** The team also go out into the community to deliver talks on independent living to a wide range of groups.
Carers Centre	ASC commissions a local VCSE organisation to run the Carers Centre, which provides free information, advice and support to unpaid carers of all ages across Telford & Wrekin. The Centre works with the carer using a strengths-based STAR model to jointly develop an action plan focused on seven areas, including health, finances, work, and managing at home. In partnership with the Council, the Centre has also produced a Carers Wellbeing Guide, which co-ordinates information, support and advice alongside key contacts for unpaid carers to easily find the services available in Telford and Wrekin.
Live Well Community Hubs and Here to Help Bus	Local hubs that bring together a range of services at eight community venues in areas of the borough with significant health inequalities. They provide a one stop shop to help people manage their health, wellbeing, social and care needs. Each hub is staffed by a range of professionals, including ASC staff, who can signpost residents to the right services, offer practical advice, and help people navigate the health and social care system. The Here to Help Bus, a mobile live well hub with a focus on supporting people with their health, skills, and keeping safe, was launched in March 2026 by the Council and a range of partners and is initially focusing on three areas of South Telford with the poorest health outcomes.

Healthy lifestyle advice	ASC work closely with the Council's Healthy Lifestyle Service, which provides free, confidential advice to support people to make a change to live a healthier life, for example help to stop smoking. Anyone can self-refer for six 1:1 support sessions and the Healthy Lifestyle Advisors also attend community events and the live well hubs to proactively educate people about the importance of keeping healthy. Through the Council's 'Do it For' campaign, residents can also make a pledge to improve their health and receive 12 weeks of online support and resources on being active, healthy eating, and more.
Health champions	Our 138 volunteer health champions help to promote public health messages in their own communities, and take part in health prevention initiatives, such as community blood pressure checks. The Telford & Wrekin Integrated Place Partnership (TWIPP) have also started a co-ordinated series of **healthy conversations** where TWIPP partners, including ASC, help to jointly promote and amplify an agreed seasonal health message e.g. seasonal flu vaccination take-up.
Health and wellbeing activities	The Council commissions and directly delivers a wide range of activities available to all residents to help people live well in their community. This includes an extensive inclusive leisure offer Inclusive leisure Information - Telford and Wrekin Leisure Services and concessions scheme, which provides affordable access to a wide range of activities for unpaid carers and older and disabled people. There is also a wide range of support for emotional wellbeing and to prevent loneliness, for example Age UK's befriending service, funded through the Better Care Fund (BCF).
Knowing where to go communications	A key communications campaign to raise awareness of how to access support. This has included co-producing a 'knowing where to go' guide Telford & Wrekin Council I Adult social care - knowing where to go leaflet with our Making It Real Board.
Safeguarding through prevention	Proactive promotion to act before harm occurs, for example through monthly safeguarding drop-ins for ASC staff and external professionals, including housing providers, nursing and care home staff, and anyone working with vulnerable adults. All new ASC staff, including our in-house care workers, complete training with the Safeguarding Lead, which has also been extended to a wider audience, including probation services, Telford College, domiciliary care staff, and children's services workers. Our preventative focus extends beyond ASC with 96% of Council employees completing Adult Safeguarding online training (June 2026). The Safeguarding Partnership also raise awareness across the borough, for example in 2025 they organised a programme of events for Adults Safeguarding Week around the theme 'Prevent – act before abuse'.
Digital front door	The ASC self-service portal, created with our experts by experience, which people and professionals can use to request care and support, as well as assessments and reviews. We also provide a comprehensive single point of contact front door, **Family Connect**, for people who don't use the portal.

Prevention in Action

SAFEGUARDING THROUGH PREVENTION

Mr J, 64, was referred to the Safeguarding Team by his housing association due to escalating concerns about hoarding, rat infestation, mould and damp, alongside repeated non-engagement with support, placing him at critical risk of harm and tenancy loss.

Working with a prevention-focused approach, Safeguarding coordinated information from Housing, Environmental Health, the Hoarding Panel and Early Intervention Services to build a fuller picture of risk and identify proportionate support. Through persistent engagement, Mr J was supported to access Citizens Advice to maximise his benefit entitlement, enabling him to fund pest control and begin improving his living conditions. As his circumstances stabilised, he was motivated to declutter his home, rebuild communication with his housing provider and avoid court action. He was also signposted to Mental Health Services to address the underlying emotional factors linked to relationship breakdown.

This early, coordinated intervention reduced risk, improved wellbeing, and housing stability, and prevented the need for statutory intervention, enabling Mr J to remain safely in his home with ongoing support from his housing provider.

BUILDING HEALTHIER HABITS

M, 44, with a learning disability, lives in supported accommodation and receives support from Adult Social Care.

Working 1:1 with a Healthy Lifestyle Advisor, M has increased his physical activity levels, reduced his sugar intake, and made healthier dietary choices. M has made sustained and meaningful progress towards his health goals, has lost weight and reduced his BMI. His proudest achievement was successfully climbing the Wrekin hill and completing the Bayley Mile, a community running event, with his brother.

Current areas of focus

- **Improving the accessibility and quality of Live Well Telford -** installing new accessibility and AI tools and strengthening search accuracy to make it easier for people to find the information they need in the Live Well Telford online community directory. We will also establish physical information points at key sites to complement digital IAG.
- **Keeping in touch –** sending quarterly newsletters to Family Connect contacts and registered unpaid carers promoting preventative services and community support available.
- **Further developing our carer support offer –** during Carers Week 2026, introducing a new Telford & Wrekin carers card that the Carers Centre will support unpaid carers to register for so that they can access local support and concessions.
- **Extending our inclusive leisure offer –** launching a new assisted exercise gym, offering low-level intervention to encourage our inactive populations into exercise. Our physical activity consultants will support people to use the new automated equipment.
- **Activity buddies –** exploring the introduction of a new 'buddy' volunteer role to accompany people travelling to and attending activities and preventative services in the community.
- **Automated telephony in Family Connect –** exploring the introduction of automated telephony to proactively stay connected with people who contact us and collect feedback about their experience on an ongoing basis.

Priority Outcome 2

Reducing and Delaying the Need for Long-Term Care and Support

What we aim to do:

- Ensure people with care and support needs, unpaid carers and those who are the subject of safeguarding concerns are quickly, consistently, and effectively triaged and assessed.
- Embed strengths-based practice across all areas of Adult Social Care that empowers people to work towards the independent outcomes they want to achieve.
- Provide targeted preventative services to intervene early to improve the health of people who are more likely to need long-term care and support.
- Support people through effective short-term enablement to regain skills, confidence, and resilience to maximise their independence.
- Provide equipment, assistive technology, and adaptations to support people to remain living independently at home.
- Provide an effective commissioned support offer for unpaid carers.

What is already being delivered:

Front-door triage team	A new pilot multi-disciplinary triage function at the ASC front door, positioned between Family Connect and specialist services. The aim is to deliver faster, proportionate assessments and reduce unnecessary escalation to long-term care through integrated working. This approach is already showing benefits such as more independent outcomes and reduced demand on health services.
Hybrid team	A team trained as both adult practitioners and occupational therapy (OT) assistants, who conduct holistic assessments in a single visit at a range of community locations including the ILC. This approach has reduced waiting times and provides a better experience for people and their carers. We have recently added a second assessment suite at one of our extra care settings to be able to see more people more quickly.
Targeted preventative health services	Examples that are particularly relevant to ASC include: • Calm cafes – delivered in partnership with Telford Mind, the calm cafes provide a safe space for people with emotional and mental health needs to be offered coping mechanisms to help reduce the risk of crisis. There are now six calm cafes, including a dual diagnosis café and one for young people aged 18-25. • Move to Thrive – a project working with people with dementia and their carers, including those with early onset dementia. • Activity for All - 13 different activity programmes for adults with a learning disability and their carers, ranging from swimming to yoga. • Moving on classes – a weekly exercise class for people who have completed the 20-week NHS falls prevention course, with 1.6% of participants going on to having a fall compared to 33% before attending.

Neighbourhood multi-disciplinary teams	We have established integrated multi-disciplinary teams across our primary care networks, including ASC, that proactively coordinated care for high-risk patients.
Home-first enablement	The Telford Integrated Care Assessment Team (TICAT), working closely with the integrated Care Transfer Hub (CTH), have increased their focus on home-first enablement wherever possible. This has led to an increase in the percentage of people being discharged home from hospital or to community settings from 47.6% (February 2025) to 68.0% (May 2026). This has been supported by BCF investment into additional community therapists to improve enablement effectiveness.
Equipment and assistive technology	Alongside an extensive range of aids and adaptations, assistive technology is used to maximise people's independence, for example Ethel large screen tablets that sit in people's homes, enabling them to connect instantly via video to family and carers, and providing virtual support like medication reminders. We have also developed our own **virtual house** which takes people on an interactive tour to show people how a range of equipment and assistive technology can help people around the home. Our Moving and Handling Occupational Therapist also provides targeted advice and equipment for unpaid carers to be able to safely move the person they care for.
Carer support offer	Our recently enhanced offer includes a one-off annual direct payment used flexibly to enable unpaid carers to look after their health and wellbeing and take time for themselves outside of their caring role. Alongside the annual payment, we also offer low-level support hours for respite and practical assistance, based on the cared-for person's existing support arrangements, which can be up to 20 hours where no formal support is in place.

Prevention in Action

MENTAL HEALTH SUPPORT IN THE COMMUNITY

B, 26, experienced a decline in mental health after the death of his mother, for whom he had been the main carer. Remaining in the family home increased his isolation and affected his confidence with cooking, medication, and travel.

Through person-centred support, B moved to a new property, received help from a housing worker, began attending community activities such as the Calm Café, and was provided with assistive technology to improve safety at home. Following travel training, he now uses public transport independently and takes part in swimming and gardening groups. The next focus is supporting him into a voluntary role while maintaining his independence and wellbeing.

CARER SUPPORT

P came to the Independent Living Centre for a Carers Assessment; he was living at home with his parents who both had significant health conditions.

Before his caring role, P was very sociable and liked to go out. During the assessment he explained that he had stopped going out completely as he felt he was a burden to the people around him and had his own health concerns, which had developed after gaining weight. A direct payment was agreed for P for membership at his local leisure centre to help him with his aim to lose weight and rebuild his confidence. P was also signposted to other support, including the Carers Centre and the Healthy Lifestyles Service. P proactively contacted the team to say that the support would 'make a real difference in his life'.

HOME-FIRST ENABLEMENT

A was admitted to hospital with a fall, and on discharge, there were initial concerns about his mobility due to Parkinsons.

The TICAT team worked closely with clinicians, community therapists, the care provider and A's family to put in place 4 daily calls and a 2 –person care package that enabled A to return home as he wanted. Through this enablement support, A was able to regain his independence and improve his mobility so that care could be safely stepped down.

Current areas of focus

- **Front-door triage team -** extending and expanding the triage team, bringing in additional disciplines, including a single-handed care Occupational Therapy Assistant and Assistive Technology Officer.

- **Sport England Place Programme – ** through funding secured by a partnership between the Council, Sport England, Energize Telford & Wrekin and a range of VCSE organisations, one of only 27 selected in England, dedicated resource in ASC will deliver the Moving Social Work Programme, embedding physical activity into routine practice. ASC will also provide evidence and intelligence to support a second, larger funding application to extend investment to March 2028.

- **Proactive prevention pilot –** using data already held by the Council, proactively identifying a cohort of people not currently known to ASC but at elevated risk of needing long-term care and support in the future e.g. because of increased likelihood of having a fall. This group will be offered a package of short-term interventions e.g. environmental adjustments and falls prevention training, to assess the benefits of a wider rollout. This will be supported by a Council-wide **data transformation project** that will bring together fragmented data across multiple systems.

- **Sutton Hill Community and Neighbourhood Health Centre (NHC) –** opening a new-build centre by 2028 in Sutton Hill, an area with high levels of deaths from preventable causes and the lowest life expectancy in the borough. Funding has been secured for a new permanent NHC, which will replace the monthly live well hub and will be used flexibly by a range of health partners to provide preventative health services in the community, such as screening, clinics and health visitor and outpatient appointments. Plans for a Mental Health Neighbourhood Centre (MHNC) are also being discussed with partners such as Midlands Partnership University Foundation NHS Trust (MPFT) and VCSE organisations, such as Telford Mind.

- **Enablement effectiveness –** evaluating a test and learn pilot that is live in the Enablement Team using a new quantitative planning tool (valuing good lives) to assess the strengths and needs of people undergoing enablement in both home and residential care settings and to measure and track enablement effectiveness and improved outcomes.

Priority Outcome 3

Preventing Escalation in Long-term Care Demand

What we aim to do:

- Regularly review the needs of people already receiving long-term care and support to consider options to sustain independence, ensuring that reviews are necessary and proportionate.
- Ensure a sufficient supply of specialist and supported housing to enable long-term independent living.
- Support people in bed-based settings to stay safe, live well, and prevent incidents, such as falls, that could lead to escalation in their needs.

What is already being delivered:

Targeted review programme	A key focus of the MPR programme has been prioritising reviews for people with the highest care and support needs, increasing the timeliness and independent outcomes, supported by a home first positive risk-taking approach, and increased use of assistive technology.
Specialist and supported homes	Over 500 new units of specialist and supported housing have been facilitated or directly delivered by the Council over the last 2-3 years, including extra care housing, retirement living flats, and supported housing across Learning Disability & Autism, Mental Health, Transition and the Transforming Care Programme. We have also remodelled our Supporting People Short Term Supported Accommodation Services including 100 units of accommodation and commissioned housing related support focused on prevention.
Falls prevention and safeguarding in care homes	A 12-month project using infra-red thermal imaging technology in several care homes has detected falls and provided insights around an individual's behaviours and habits that has prevented falls and conveyances to hospital by over 80%. In addition, care homes take part in online group chair-based exercise sessions to reduce the risk of falls for residents. Alongside this, our Safeguarding Team hold team meetings in a different care home each month. This approach helps providers to become familiar with the team, promotes approachability, and has enabled strong, positive relationships.

Prevention in Action

LION HOUSE, A HOME OF THEIR OWN

In December 2025, we opened Lion House, a council-led supported living development on a former stalled site providing 11 modern, self-contained accommodation for adults with learning disabilities and/or autism, enabling them to live independently within their local community.

Residents hold their own tenancies and receive tailored person-centred care on site, aligning with Building the Right Support and wider national priorities. The scheme has enabled people to return from long-term out of borough residential placements to live nearer their families and support networks, has helped to build residents' confidence and life skills and has created new friendships and a real sense of community, including residents forming the Lion House band *Roar.*

ASSISTIVE TECHNOLOGY

AS has an acquired brain injury and long-term ASC support, including 34 hours a week at home, specialist day provision and assistive technology for seizure detection.

This includes a wrist-worn epilepsy sensor, a bed sensor, and a memo minder. Without this support, he would need 24-hour care. After one seizure was missed by his equipment, we added an 'Ethel' device that prompts hourly check-ins when he is home alone. If he does not respond, his care provider follows up. Together, this support enables AS to live independently in his own home.

Current areas of focus

- **Strengths-based mapping** - extending use of the valuing good lives tool with working-age adults and people with learning disabilities to further support strengths based decision-making and reviews that lead to more independent outcomes for people.
- **Extension of the falls prevention project** – extending the successful use of the infra-red technology for a further 12 months to prevent falls in care homes.
- **New supported and specialist housing schemes** – continuing the pipeline of new schemes, with a particular focus on supported accommodation for adults with a learning disability and high needs extra care. Schemes in the pipeline include council-led delivery of 27 apartments for people with dementia due to open in 2028, two new supported accommodation schemes for transition, and expanding referrals for under 55s into the borough's main registered provider's retirement living schemes. Longer-term plans will be informed by a review of the Specialist and Supported Housing Strategy in 2027, and the delivery of a larger portfolio of council-led housing delivery through the Social and Affordable Homes Programme (SAHP), including further specialist & supported housing.
- **Safeguarding training for vulnerable adults** – developing a tailored safeguarding awareness package delivered directly to vulnerable adults within care settings, focusing on how to recognise and report safeguarding concerns.
- **Age friendly borough** – linked to our Ageing Well Strategy, working towards becoming part of the UK network of age-friendly communities UK Network of Age-friendly Communities | Centre for Ageing Better, enabling people to age well and live a good later life. The development of a complementary feedback AI enabled text message/telephone system to support identifying people who are struggling earlier in a more proactive way. This would involve evidencing progress against the Age friendly Communities Framework eight domains, including housing, transport, community support, and health services. We are also exploring developing a local **8@80 programme**, building on the success of our 10 by 10 and 5 by 5 schemes for children and young people, which we were the first council nationally to introduce.

Assessing Our Impact

We will assess the impact this strategy by monitoring delivery of the current areas of focus alongside key success measures.

Priority Outcome 1 Success Measures

- Increase the proportion of people who use services who find it easy to find information about services (Adult Social Care Survey).
- Increase the proportion of carers who use services who find it easy to find information about services (Survey of Adult Carers in England).
- Sustain average customer satisfaction with Family Connect at >90%.
- Increase the % of people who are not known to ASC who are supported at the front door.

Priority Outcome 2 Success Measures

- Reduce the median waiting time for a Care Act or Carers Assessment.
- Increase the % of Care Act and Carers Assessments completed in 14 days.
- Increase the proportion of people who received reablement during the year, who previously were not receiving services, where no further request was made for ongoing support.
- Reduce the average support provided at the end of enablement compared to the start and reduce the average length of time between the end of enablement until new or next request for support.
- Reduce the proportion of people accessing long-term care as a proportion of the population (18-64 and 65+).
- Improve carers reported quality of life (Survey of Adult Carers in England).
- Increase overall satisfaction of carers with social services (Survey of Carers in England).

Priority Outcome 3 Success Measures

- Reduce the median waiting time for planned reviews.
- Improve the adjusted social-care related quality of life score (Survey of Adult Carers in England), which assesses the impact of social care for people who draw on care and support.
- Improve overall satisfaction with people who use services for care and support (Survey of Adult Carers in England).
- Increase the proportion of people who receive long-term support who live in their home or with family, aged 18 to 64.
- Increase the proportion of people who receive long-term support who live in their home or with family, aged 65 and over.

Next Steps

It is important that this strategy not only delivers our statutory duties, but also what we should do to ensure the current and future wellbeing of our residents. We will achieve this by further developing preventative services and continuing to embed co-production and strengths-based practice.

We will also proactively monitor progress and outcomes. On an annual basis, we will report to the Senior Management Team (SMT), Cabinet, and Health Scrutiny on the latest performance data, delivery of preventative work over the previous 12 months, and seek approval for future areas of focus.